

STATE OF INDIANA

Family and Social Services Administration
Office of Medicaid Policy and Planning

**INDIANA MEDICAID MEDICAL ASSISTANCE PROGRAM
MEDICAL POLICY MANUAL****TABLE OF CONTENTS**

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I. PREFACE

Health Care Excel, Incorporated, is a private, not-for-profit corporation established for the purpose of providing clinically-based, objective, and independent monitoring of the quality, appropriateness, and medical necessity of health care services. Health Care Excel, in its role as the Indiana Health Coverage Programs' (IHCP) Medical Policy and Review Services contractor, is responsible for the Medical Policy (MP), Prior Authorization (PA), and Surveillance and Utilization Review (SUR) business functions. The Medical Policy Manual has been developed to ensure the success of the IHCP. This manual will be used as a reference handbook for the Family and Social Services Administration's (FSSA) Office of Medicaid Policy and Planning (OMPP), Health Care Excel (HCE), and other State contractors and partners.

Within the Medical Policy and Review Services contract, the formulation of, and support for, IHCP medical policies will involve an array of individuals and a complex set of tasks for each policy. The management of medical policy must involve the careful consideration of the stakeholders—the State, the practitioner and provider community, and the IHCP member community. It must be collaborative in nature to promote a positive, effective, and responsive approach to customer service. By its unique nature, medical policy must strengthen the foundation of the IHCP, irrespective of the governing agency or health care delivery system.

This manual addresses the policies of the IHCP. The information regarding prior authorization, payment methodology, and maximum fees may vary for providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system. Detailed descriptions of all IHCP covered services, as well as exclusions and limitations, are also included. The objective is to take a proactive approach in the development of new policy and the review of existing policies to ensure the manual is reflective of the IHCP. The manual will serve as a living document, providing flexibility to accommodate change, and promote ease of use.

II. INDIANA HEALTH COVERAGE PROGRAMS OVERSIGHT AND DELIVERY SYSTEMS

A. Overview of the Indiana Family and Social Services Administration

The Indiana Family and Social Services Administration (FSSA) is the umbrella agency responsible for administering Indiana's public assistance programs. FSSA includes the offices and divisions listed below.

- ◆ Office of Medicaid Policy and Planning (OMPP)
- ◆ Division of Disability and Rehabilitative Services (DDARS)
- ◆ Division of Family Resources (DFR)
- ◆ Division of Mental Health and Addiction (DMHA)
- ◆ Division of Aging (IDA)

The Director of Medicaid and Health Policy is responsible for OMPP. Other agencies that administer programs that impact IHCP include the Division of Disability and Rehabilitative Services, Division of Family Resources, Division of Mental Health and Addiction, and Division of Aging. These agencies are described below.

- ◆ **Division of Disability and Rehabilitative Services (DADRS)** manages aging and in-home services, guardianship, and adult protective services, and determines medical eligibility for the Supplemental Security Income (SSI) and Social Security Disability (SSD) programs for the Federal government. It provides case management services for persons with developmental disabilities including supervision services for four developmental centers for clients with disabilities, operation of several State institutions, vocational rehabilitation case management services, independent living services for the deaf and hard of hearing, and services for the blind and visually impaired.
- ◆ **Division of Family Resources (DFR)**, through its county offices, is responsible for determining eligibility for IHCP services. Following the eligibility determination, county offices enroll individuals meeting eligibility standards and maintain eligibility files using the Indiana Client Eligibility System (ICES) for the IHCP member population.

- ◆ **Division of Mental Health and Addiction (DMHA)** ensures the availability of accessible, acceptable, and effective mental health and substance abuse related disorder services for Hoosiers. The division is responsible for providing funding support for mental health and addictions services to target populations with financial need through a network of managed care providers, certifying all community mental health centers and managed care providers (licensing inpatient psychiatric hospitals and operating State behavioral health hospitals), and administering Federal funds earmarked for substance abuse prevention projects.
- ◆ **Division of Aging (IDA)** provides in-home and community based services to older adults and people of all ages with disabilities. Services focus on areas such as prevention, early intervention, protection, and advocacy. The IDA collaborates with communities and local organizations to provide appropriate services to individuals and their families to ensure community resources are accessible.

In-home services provide assistance to enable independent living, private homes and community living settings. These services include attendant care, homemaker, home health services and supplies, respite care, home delivered meals, adult day care, transportation, CHOICE (Community and Home Options to Institutional Care for the Elderly and Disabled), and other appropriate services.

Community based services provide a variety of services. These services include Adult Guardianship, Title V Senior Employment, Pre-Admission Screening Annual Resident Review, Indiana Pre-Admission Screening, Assistance to Residents in County Homes, Room and Board Assistance, USDA Meals Reimbursement, Title III/VII of the Older Americans Act, Long Term Care Ombudsman, Money Management Program, and the Developmental Disabilities Waiver Ombudsman. Community based services are also accessible to family members of older and/or disabled people to increase community outreach and continuity of services.

Adult protective services (APS) address and investigate reports of abuse, neglect, and exploitation of adults. The state of Indiana coordinates with Indiana's prosecuting attorneys, law enforcement, and the Family and Social Services Administration to ensure the safety of adults in need. Multiple services are available through APS which is dependent upon the level-of-need of the individual.

B. Indiana Health Coverage Programs Eligibility

In 2004, the IHCP provided medical assistance to approximately 760,000 eligible members. This estimate includes the categorically needy population, as well as, those individuals eligible for, or receiving, federally-aided financial assistance or deemed categorically needy, and eligible for services under Federally-authorized waiver programs.

Persons in the categorical groups listed below are eligible for the IHCP, subject to income and asset criteria.

- ◆ Aged, blind, and disabled people
- ◆ Families receiving assistance through the Temporary Assistance for Needy Families (TANF) program
- ◆ Children under nineteen years of age with family incomes at or below a designated percent of the Federal poverty level
- ◆ In addition, limited IHCP benefits are available to certain population groups, as listed below.
- ◆ Qualified Medicare Beneficiaries (QMB)
- ◆ Pregnant women whose family income exceeds TANF program limits, but is at or below a designated percent of the Federal poverty level
- ◆ Qualified Disabled Working Individuals (QDWI) who lost Medicare Part A due to employment status
- ◆ Specified Low Income Medicare Beneficiaries (SLIMB)
- ◆ Undocumented or unqualified aliens

C. Medicaid Waiver Programs

1. Overview of CMS' Medicaid Waivers

States may apply to the Centers for Medicare and Medicaid Services (CMS) for waivers of certain Federal regulations. There are three major types of waivers; 1115, 1915(b), and 1915(c). Of these, Indiana has no 1115 waivers, but does have one 1915(b) waiver, and several waivers under 1915(c). States have the flexibility to design each waiver program and select the mix of waiver services to best meet the needs of the population they wish to serve. Waiver services may be provided statewide or may be limited to specific geographic

subdivisions. The following Waiver services are provided statewide in Indiana.

- ◆ CMS' Home and Community-Based Waivers
- ◆ CMS' Freedom of Choice Waivers
- ◆ CMS' Research and Demonstration Waivers

2. Indiana Waiver Program Overview

The eight home-and community-based waivers currently offered through the Indiana Medicaid program are listed below.

- ◆ Aged and Disabled
- ◆ Assisted Living
- ◆ Autism
- ◆ Traumatic Brain Injury
- ◆ Developmental Disability
- ◆ Medically Fragile Children
- ◆ Support Services
- ◆ Severely Emotionally Disturbed (SED) Children

FSSA's DDARS administers the Home and Community Based Services (HCBS) waiver program with assistance from, and oversight by, OMPP. The HCBS waivers provide services to eligible recipients to address special health care needs for persons who would be institutionalized in the absence of community-based services.

The IHCP Medical Policy Manual will no longer contain policies specific to Medicaid Waiver Programs. Clarification of policies for Medicaid Waiver Programs can be found by contacting the Medicaid Waiver Unit by phone at 1-800-545-7763, or in writing at the following.

Medicaid Waiver Unit
Bureau of Aging and In-Home Services
Division of Disability, Rehabilitative Services
402 West Washington Street, W-454
Post Office Box 7083, MS-21
Indianapolis, IN 46207-7083

D. Traditional Medicaid

1. Overview

The Traditional Medicaid program provides coverage for health care services rendered to the following eligibility groups.

- ◆ Wards and foster children who do not voluntarily enroll in a managed care program
- ◆ Persons in nursing homes and other institutions, such as ICF/MR facilities
- ◆ Undocumented aliens
- ◆ Waiver or hospice services
- ◆ Spenddown recipients

Eligible members receive health care services from enrolled IHCP providers. Providers bill services rendered to members enrolled in Traditional Medicaid subject to fee-for-service (FFS) directly to the IHCP claims processing contractor, EDS. Providers are required to sign a Medicaid Provider Agreement.

2. Delivery System

Traditional Medicaid is part of the FFS delivery system and includes four benefit packages.

- ◆ Standard Plan—Members enrolled in the Traditional Medicaid are eligible for full coverage.
- ◆ Spenddown—Some members with income in excess of the Traditional Medicaid threshold can be enrolled under the spenddown provision. These members are enrolled in Traditional Medicaid with a spenddown. Spenddown is similar to a deductible in that members must incur medical expenses in the amount of their excess income each month before becoming eligible for Traditional Medicaid. It is the member's responsibility to provide verification of incurred medical expenses to the county Division of Family Resources (DFR) office. When spenddown is met, the member becomes eligible for the remainder of the month. Members eligible for assistance under the spenddown provision are listed below.
 - Aged 65 and over
 - Blind

- Disabled
- QMB-Also in combination with another aid category
- Those who spenddown their income to the correct percentage of the federal poverty level in any given month according to *Hayes versus Paine*
- ◆ Waiver–Waiver programs cover a variety of Home and Community-Based Services (HCBS) not otherwise reimbursed by the IHCP. Waiver programs are available to those IHCP-eligible members who require the level-of-care (LOC) provided in a nursing facility, hospital, or intermediate care facility for the mentally retarded (ICF/MR), but choose to remain in the home. Eligibility for all waiver programs requires the following.
 - The member must meet IHCP guidelines
 - The member would require institutionalization in the absence of the waiver or other home-based services
 - The total IHCP cost of serving the member on the waiver (waiver cost plus other IHCP services) cannot exceed the total cost to IHCP for serving the member in an appropriate institutional setting
 - Providers must verify member eligibility and if a member is enrolled in managed care, the member needs to be disenrolled from managed care to participate in the HCBS Waiver Programs
- ◆ Qualified Medicare Beneficiary (QMB)–Federal law requires that state Medicaid programs pay Medicare premiums, coinsurance, and deductibles for certain elderly and disabled people. QMBs must meet the following eligibility criteria to receive assistance with Medicare-related costs.
 - Entitled to Medicare
 - Low income
 - Age 65 years or older, or younger than 65 years old and entitled to Medicare
 - Few personal resources

QMB coverage falls into the following three categories.

- QMB-Only coverage: the member's benefits are limited to payment of the member's Medicare premiums as well as

deductibles and coinsurance for *Medicare-covered services only*

- QMB-*Also* coverage without spenddown: the member's benefits include payment of the member's Medicare premiums, deductibles, and coinsurance on Medicare-covered services in addition to Traditional Medicaid benefits throughout each month of eligibility
- QMB-*Also* coverage with spenddown: the member's benefits include payment of the member's Medicare premiums, deductibles, and coinsurance on Medicare-covered services in addition to Traditional Medicaid benefits beginning with the date on which the monthly spenddown is met and continuing through the end of the month

Claims processing and payment for these three types of QMBs differ as follows.

- All QMBs—Medicaid pays the Medicare Part B premiums as well as Medicare deductibles and coinsurance on Medicare-covered services for which the Medicare payment amount is less than the Medicaid allowed reimbursement amount. The member is never responsible for the amount disallowed (paid at zero) when Medicare paid more than the Medicaid allowed amount for the service.
- QMB-Only—IHCP pays for only those services covered by Medicare. For these member's claims, the IHCP pays the member's Medicare deductible and coinsurance on Medicare-covered services only. Claims for services not covered by Medicare are denied as Medicaid non-covered services. The member must make payment in full for medical supplies, equipment, and other services not offered by Medicare, such as routine physicals, dental care, hearing aids, and eyeglasses.
- QMB-Also Without Spenddown—Medicaid claims for services not covered by Medicare must be submitted as regular Medicaid claims and not as crossover claims. These QMB-Also members are enrolled in the *Medicaid Select* program and their care is managed by a primary medical provider (PMP).
- QMB-Also coverage with spenddown—In addition to coverage for Medicare-related costs, QMBs who are also eligible for another Medicaid aid category under the spenddown provision have Traditional Medicaid benefits for a portion of the months in which they meet their

spenddown. When spenddown is met for the month, the member becomes eligible for the full array of services covered by the Traditional Medicaid program. However, as with the QMB-Only, the member must pay for services not covered by Medicare if the Medicare non-covered service is provided prior to the date when spenddown is met.

IHCP eligibility verification systems are designed to inform a provider of a member's Traditional Medicaid/QMB dual eligibility status when spenddown has not been met for the month. If the QMB member is only eligible for the coinsurance and deductible for Medicare covered services, Medicare does not cover the service and Traditional Medicaid does not cover the service.

Members enrolled in Traditional Medicaid are not assigned to a PMP and certification codes are not required. However, prior authorization is required for services as designated by IAC 405-5.

E. Hoosier Healthwise

1. Overview

Hoosier Healthwise is Indiana's Medicaid Managed Care program administered by OMPP and the Office of the Children's Health Insurance Program (CHIP). The State of Indiana requested approval of this program through a waiver under the authority of Section 1915(b)(1) of the Social Security Act. The objective of the waiver program is to reduce costs, prevent unnecessary utilization, reduce inappropriate utilization, and assure adequate access to primary care by Medicaid members.

Hoosier Healthwise provides coverage for parents and children who receive Temporary Assistance for Needy Families (TANF) and for low-income pregnant women and children. This program encompasses the following four member eligibility packages.

- ◆ Package A—Standard Plan
- ◆ Package B—Pregnancy Coverage Only
- ◆ Package C—Children's Health Insurance Plan (CHIP)
- ◆ Package E—Emergency Services Only (in FFS only)

OMPP began phasing in Hoosier Healthwise for TANF members and low-income pregnant women and children in selected counties in July 1994. The program became statewide on July 1, 1996.

All Hoosier Healthwise participating primary medical providers (PMP) in Indiana must enroll with an MCO in the RBMC delivery system.

The goals of Hoosier Healthwise are listed below.

- ◆ To ensure access to primary and preventive care services
- ◆ To improve access to all necessary health care services
- ◆ To encourage quality, continuity, and appropriateness of medical care
- ◆ To provide medical coverage in a cost-effective manner

2. Delivery System

The Office of Medicaid Policy and Planning (OMPP) implemented a statewide Hoosier Healthwise mandatory risk-based managed care (RBMC) enrollment for all Indiana counties in 2005. This transitioned PrimeStep Hoosier Healthwise managed care members from Primary Care Case Management (PCCM) into local managed care organizations (MCOs) in the RBMC delivery system. OMPP submitted a request for federal approval for modification of Indiana's 1915(b) waiver to the Centers for Medicare and Medicaid Services (CMS). The State anticipated that these counties will be approved for mandatory MCO enrollment as well. This mandatory transition was expected to be completed November 2005.

Under RBMC, OMPP contracts with Managed Care Organizations (MCOs). MCOs are paid a capitated rate per month, per enrolled Medicaid member by OMPP. Members in RBMC must obtain most services from the network of the MCO in which they are enrolled.

The RBMC delivery system is a fully capitated prepayment plan in which the MCOs are at risk to arrange for or administer the provision of a comprehensive set of covered services to Hoosier Healthwise members. The MCO accepts a per-member-per-month fee to provide an agreed upon bundle of services, including high-cost services such as inpatient hospitalization. Hoosier Healthwise member enrollees enter the RBMC system by choosing as their PMP a primary care physician who has contracted with an MCO.

The MCO must purchase reinsurance from a commercial reinsurer and must establish reinsurance agreements meeting the requirements stipulated by OMPP. The attachment point must be equal to or less

than \$125,000. The MCO electing to establish commercial reinsurance agreements with an attachment point greater than \$125,000 must receive approval from OMPP before changing the attachment point. The MCO must receive reinsurance coverage of at least \$2,000,000 per member per year.

3. Primary Medical Providers

A basic and pervasive tenet of Hoosier Healthwise is that eligible members are allowed to select their PMP. Physicians enrolled in Hoosier Healthwise as PMPs provide preventive and primary care through an ongoing patient/physician relationship, as well as authorization and referral for most specialty services. The PMP or a designee must be available 24 hours a day, seven days a week. The PMP assists the member in gaining access to the health care system and monitors, on an ongoing basis, the member's condition, health care needs, and service delivery. The PMP is responsible for locating, coordinating, and monitoring all primary care and other medical and rehabilitation services on behalf of members enrolled in Hoosier Healthwise.

The Hoosier Healthwise program encourages eligible Medicaid members to select a PMP. However, if a member in the mandatory program fails to make a PMP selection within 30 days of being determined eligible for Medicaid (or re-determined eligible), a PMP is assigned to the member through an auto-assignment process.

The intent of Hoosier Healthwise is to enhance existing provider-patient relationships, or to establish a relationship when none exists. Members enrolled in Hoosier Healthwise are restricted to services included under Hoosier Healthwise either from the chosen or assigned PMP or from another qualified provider to whom the member was referred by the PMP. The member's health care will be managed by the PMP. However, the member is allowed self-referral for the following services.

- ◆ Chiropractic services
- ◆ Dental services
- ◆ Diabetes self management services
- ◆ Emergency services
- ◆ Family planning services
- ◆ HIV/AIDS targeted case management
- ◆ Vision services (except eye care surgical services)

◆ Podiatry services

A PMP must be a physician qualified in General Practice, Family Practice, General Pediatrics, General Internal Medicine, or Obstetrics/Gynecology (OB/GYN). Primary care physicians in any setting are eligible to be PMPs and may serve as the PMP for any member within their normal scope of practice. Physicians who enroll in Hoosier Healthwise agree to be listed as a PMP in the listing of approved practitioners and agree to accept a panel.

The PMP is responsible for providing or authorizing most primary and preventive care services. PMP services include, but are not limited to: physician services; hospital inpatient and outpatient services; and some ancillary services such as laboratory and radiology; orthotic/prosthetics; audiology; durable medical equipment and supplies; home health services; and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). PMPs who authorize another provider to render services must document the referral in the patient's medical record.

4. Process for Primary Medical Provider Enrollment

A physician interested in becoming a PMP is referred to one of the participating Hoosier Healthwise MCOs and is required to sign a contract with one MCO to participate in the RBMC delivery system. A PMP can only contract with one MCO, however, specialists and other providers may participate in more than one MCO. This does not prohibit the PMP from rendering fee-for-service treatment for non-Hoosier Healthwise members or from serving as a PMP in *Medicaid Select*.

5. Process for Member Enrollment

In the DFR county offices, applicants for medical assistance receive a brief presentation on Medicaid managed care, how to select a PMP, and a description of the RBMC Hoosier Healthwise program from a Benefit Advocate (BA). Benefit Advocates are employed by AmeriChoice through a contract with OMPP. Videotapes and brochures are available to describe the managed care programs. Information provided includes a toll-free number to call for further assistance. The member also is given: (1) a list of qualified PMPs serving the member's geographic area; (2) a form for choice of a PMP in RBMC; and (3) brochures for any risk-based managed care MCOs in their geographic region. Qualified PMPs include only those PMPs who are currently accepting new enrollees into the RBMC Hoosier Healthwise program.

Newly eligible members and members whose eligibility has been re-determined have up to 30 days to choose a PMP. The member must indicate a choice of a PMP by either mailing in the form or telephoning the program. The member is then enrolled with the selected PMP if he or she is accepting new members.

Qualified PMPs are free to encourage patients to choose them as a care manager. When a provider is not on the list of qualified PMPs, the member may encourage the provider to enroll or contact the program to see if the provider qualifies. OMPP and its contractors market enrollment to non-participating providers. If the member does not choose a PMP within thirty (30) days, Hoosier Healthwise assigns the member to a qualified and suitable PMP via an auto-assignment process.

The member and the PMP are informed by mail of the member's enrollment. The PMP may refuse the assignment if he or she does not feel medically qualified to accept the case or if no further assignments are being accepted. With the exception of newborns, enrollment in managed care is not retroactive, so services rendered before the effective date of Hoosier Healthwise enrollment are not subject to the waiver's referral requirements.

F. *Medicaid Select*

1. Overview

Beginning January 1, 2003, IHCP implemented a new aged, blind, and disabled (ABD) managed care program.

OMPP began phasing in *Medicaid Select* for ABD members in January 2003. The program became statewide in 2004. The goals of *Medicaid Select* are listed below.

- ◆ To ensure access to primary and preventive care services
- ◆ To improve access to all necessary health care services
- ◆ To encourage quality, continuity, and appropriateness of medical care
- ◆ To provide medical coverage in a cost-effective manner

2. Delivery System

Medicaid Select operates as a PCCM System. The PMP is responsible for providing or authorizing most primary and preventive care services. PMP services include, but are not limited to: physician services; hospital inpatient and outpatient services; and some ancillary services such as laboratory and radiology; orthotic/prosthetics; audiology; durable medical equipment and supplies; home health services; and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). PMPs who authorize another provider to render services must document the referral in the patient's medical record.

Members will continue to have the same ID number and will use the same Hoosier Health Card. PMPs will be required to provide a referral by phone or in writing, which will include the Provider ID number and a special two digit certification code that will allow the rendering provider to bill and receive reimbursement.

There are no certification code requirements for Medicare crossover claims in *Medicaid Select*. However, for services that Medicare does not cover but Medicaid does, a certification code is required.

Some services are self-referral and will not require PMP authorization. These services include the following.

- ◆ Chiropractic services
- ◆ Dental services
- ◆ Diabetes self management services
- ◆ Emergency services
- ◆ Family planning services
- ◆ HIV/AIDS targeted case management
- ◆ Vision services (except eye care surgical services)
- ◆ Podiatry services

In addition to an administrative fee payment of \$4.00 per member/per month, PMP's will be reimbursed, as usual, based on the fee-for-service schedule. Claims will be submitted to the state's fiscal agent, EDS, for processing and payment.

3. Primary Medical Providers

Medicaid Select has five standard PMP categories: Family Practitioner, General Practitioner, Internist, Pediatrician and

Obstetrician / Gynecologist. In addition, any physician specialist, such as a Cardiologist, Psychiatrist, or Urologist, may serve as a PMP.

Medicaid Select members are encouraged to select a PMP. Members will have up to 60 days to select a PMP before they are auto-assigned to the five traditional PMP types or to a non-traditional PMP type (specialist), if they have previously been linked to a non-traditional PMP on a self-selection basis. However, members are able to change their PMP if they are auto-assigned or choose to see a different doctor than originally selected.

4. Process for Primary Medical Provider Enrollment

Providers contact a Provider Services Representative at AmeriChoice to receive information regarding enrollment in *Medicaid Select*. To serve as a PMP, providers must be enrolled as an IHCP provider and are required to sign a Medicaid Provider Agreement Addendum to provide services to *Medicaid Select* members.

The five standard PMP categories are allowed member panels of 50 to 1000. All specialist provider types are allowed panels of 1-1000. A specialist may enroll as a PMP to see only one or two existing patients. The *Medicaid Select* panel is maintained separately and cannot be combined with the Hoosier Healthwise panel.

5. Process for Member Enrollment

Medicaid Select includes all Medicaid recipients in the following aid categories.

- ◆ Children receiving adoptive services
- ◆ Aged recipients
- ◆ Blind recipients
- ◆ Physically and mentally disabled recipients
- ◆ Medicare and Medicaid dual eligible recipients
- ◆ Individuals receiving room and board assistance

The following individuals are excluded from enrollment in *Medicaid Select*.

- ◆ Breast and cervical cancer group
- ◆ Wards of the court and foster children
- ◆ Persons in nursing homes

- ◆ Intermediate Care Facilities for the Mentally Retarded and state-operated facilities
- ◆ Waiver recipients
- ◆ Hospice service recipients
- ◆ Individuals for whom Medicaid pays only the Medicare premiums
- ◆ Spenddown recipients

6. Managed Care Administrative Contracts

OMPP has contracted many of the administrative activities essential for managed care, such as development of a management information system, claims processing, and member and provider enrollment. In addition to the contracts with risk-based managed care providers, there are (in 2005) three major administrative contracts: AmeriChoice, primarily for member education and enrollment; Electronic Data Systems (EDS) as a part of a larger contract to act as the State's fiscal agent and pharmacy benefits manager; and HCE, which serves as the Medical Policy and Review Services contractor.

AmeriChoice has the following specific responsibilities.

- ◆ Member education and enrollment facilitation
- ◆ Member hotline development and management
- ◆ Member outreach and follow-up
- ◆ Deployment of benefits advocates and related database development and management
- ◆ Administrative plan development and execution
- ◆ *Medicaid Select* Provider recruitment and orientation
- ◆ Quality assurance/quality control execution, including member and provider surveys
- ◆ Submission of program monitoring reports

EDS responsibilities in relation to managed care are stated below.

- ◆ Development and administration of an information system for managed care as a component of *IndianaAIM*
- ◆ PMP enrollment
- ◆ Fee-for-service claims processing

- ◆ Monthly administrative payments to PMPs participating in *Medicaid Select*
- ◆ Monthly capitation payments to MCOs participating in the RBMC program
- ◆ Processing encounter claims from MCOs (MCOs are paid a capitated rate but are expected to provide encounter-based data in the form of shadow claims)

HCE responsibilities in relation to Hoosier Healthwise are listed below.

- ◆ Assessing and coordinating existing medical policy
- ◆ Evaluating input from providers, members, and operational activities and determining if there are policy implications, including consideration of who is impacted, what policy needs to be addressed, why the policy implication is important, when a policy should be changed or added, where the impact will be felt the most, and how to best address identified issues
- ◆ Coordinating the resolution of issues that bridge operations and policy areas
- ◆ Recommending new medical policy to address emerging issues
- ◆ Determining and analyzing indicators to evaluate utilization of services, access, preventive care, quality of care, and disease management
- ◆ Prior authorization
- ◆ Surveillance and Utilization Review

G. Indiana Health Coverage Programs Provider Participation

Within the restrictions of federal and state law, OMPP (through its contractors) enrolls various types of medical practitioners, providers of institutional care, other agencies, and managed care organizations to provide services to IHCP members.

A provider is said to be participating in the IHCP during a particular time period if the provider bills for services rendered to IHCP members during that time. The number and participation rate of enrolled IHCP providers fluctuates. The number of participating providers can decrease when some providers cease to treat IHCP members. Increases in the number of participating providers can be seen when a new service is added or previous restrictions are lifted. In 2004, there were approximately 46,000 providers approved to participate in the IHCP. The IHCP places a high

priority on provider participation so that IHCP members may have appropriate access to care and choice of providers.

H. Indiana Health Coverage Programs Provider Payment Methodologies

Within the limitations prescribed by federal laws and regulations, the State has established various methods of determining provider reimbursement levels for the provision of IHCP covered services. These methods are described briefly below. It should be noted that, with the exception of copayment requirements, federal law requires providers to accept IHCP payment in full, thereby prohibiting providers from billing members for additional payment. In general, federal regulations require that reimbursement rates be sufficient to ensure that the availability of health care services to IHCP members is no less than that for the general population. The payment methodologies currently utilized by the IHCP are as follows.

- ◆ Diagnosis-Related Grouping (DRG) is used for pricing hospital inpatient claims. If the inpatient claim can be grouped into one of the established DRG numbers, a DRG number is assigned by IndianaAIM, the claims processing system used by the IHCP. The principal diagnosis, surgical procedure code, patient discharge status, and member's age and sex are used to group the claim into one of the established DRG numbers. Claims that do not group into an established DRG number will be paid based on diagnoses, surgical procedures, and revenue codes reported on the claim. Burn treatment, rehabilitation, and psychiatric inpatient claims are paid according to the level-of-care.
- ◆ Facility-specific per diem rates are used for nursing homes, Intermediate Care Facilities for Mentally Retarded (ICF/MR), Community Residential Facilities for the Developmentally Disabled (CRF/DD), and Psychiatric Residential Treatment Facilities (PRTF).
- ◆ A case mix reimbursement methodology was implemented, effective October 1, 1998, for IHCP nursing facilities that provided both skilled and intermediate care to residents. Under this methodology, payment is based upon one Medicaid rate, determined each quarter, for all Medicaid residents in a Medicaid-certified and duly licensed nursing facility.
- ◆ The Resource Based Relative Value Scale (RBRVS) system is used to reimburse most services provided by physicians and other practitioners.

- ◆ The lowest of the state maximum allowable charge (SMAC), amount billed, federal upper limit or estimated acquisition cost (EAC) (for legend drugs), plus a dispensing fee where applicable, is used for pharmacy claims.
- ◆ Deductible and coinsurance amounts are paid by Medicaid for Medicare crossover claims, so long as the Medicaid payment does not exceed the Medicaid allowable for the service.
- ◆ Dental, Current Procedural Terminology (CPT), and Health Care Common Procedure Coding System (HCPCS) codes not subject to RBRVS are priced based on the lower of a maximum fee or the submitted charge.
- ◆ Payment for hospital outpatient services depends on the revenue codes billed. Surgery revenue codes are priced using Ambulatory Surgical Center (ASC) rates on file. Treatment room revenue codes are priced using a flat rate on file. Laboratory revenue codes are priced using the laboratory pricing methodology described below. Radiology revenue codes are priced based on the lower of a maximum fee or the submitted charge. All other revenue codes are priced using a flat rate on file.
- ◆ Laboratory fees are calculated at the Medicare-allowed amount based upon the HCPCS procedure codes with a pricing indicator for laboratory.
- ◆ In the RBMC delivery system, capitation fees are paid to contracted managed care organizations (MCO).
- ◆ In the PCCM delivery system, an administrative fee of four dollars (\$4.00) per member per month is paid to the Primary Medical Provider (PMP). In addition, the PMP is paid according to the fee-for-service schedule for services provided.
- ◆ Home health services are paid according to overhead and wage rates.
- ◆ Hospice services are reimbursed according to one of four all-inclusive per diem rates, based on levels of service.

III. OTHER STATE PROGRAMS

The State of Indiana also funds various other medical assistance programs for its population. Other State-funded programs are listed below.

- ◆ The 590 Program provides coverage for certain health care services provided off-site to members who are residents of state-owned facilities. These facilities operate under the direction of the Family FSSA, DMHA, and the Indiana State Department of Health (ISDH).
- ◆ Aid to Residents in County Homes (ARCH) provides case review services to certain residents of county nursing homes.

IV. SERVICES, LIMITATIONS, AND EXCLUSIONS

A. Services

Covered services, prior approval requirements, and limitations of coverage for the Indiana Medicaid program are set out in the Indiana Administrative Code (IAC) at 405 IAC 5.

B. Limitations

Medicaid limits the provision of certain covered services. 405 IAC 5 specifies the limited services and the conditions of the limitations.

Certain covered services as specified in 405 IAC 5 are available only with prior authorization. The provider must submit a properly completed Medicaid prior review and authorization request and receive written notice indicating the approval for provision of such service prior to providing any Medicaid service that requires prior authorization except as provided in 405 IAC 5-3-2, which allows for specific providers to request prior authorization by telephone for specific services.

Any non emergent Medicaid service requiring prior authorization, which is provided without first receiving prior authorization, shall not be reimbursed by Medicaid. Services provided out-of-state with exceptions, require prior authorization. Any authorization of a service by the contractor is limited to authorization for payment of Medicaid allowable charges and is not an authorization of the provider's estimated fees.

Requests for prior authorization are reviewed for appropriate completion of the request form, the medical and social information provided on the request form or documentation accompanying the request form, the criteria set out in 405 IAC 5 for the service requested, and the medical reasonableness and necessity of the requested service based upon current professional standards commonly held to be applicable to the case. Refer to Section V, page 30, for additional information about the prior authorization function.

Certain Medicaid members have restricted utilization of their Medicaid cards when it has been determined that services must be controlled. A provider other than the one to whom the member is restricted may provide treatment to the member with a referral from the authorized provider, or without a referral form if the diagnosis is an emergency diagnosis.

All Indiana Medicaid providers are subject to ongoing surveillance and utilization review (SUR) activities. The SUR responsibilities have been contracted to HCE. Based on paid claim information, statistical profiles are established on provider peer and class groups to monitor the delivery and receipt of medical services to identify misutilization and aberrant practices by analyzing and comparing providers to their peer groups. Based on the results of the off-site review and/or medical record review the specific aberrant practice and billing patterns are identified and prepayment review criteria are developed, unique to each provider. The established criteria describe specifically what documentation and/or practice is expected, and what procedure will be followed for each of the review measures.

The provider will be notified and the prepayment reviewer will initiate the appropriate system file changes to ensure that the provider's claims that meet the prepayment review criteria suspend for manual adjudication. A minimum of three months of documentation submitted with the dates of service during the prepayment review period must be reviewed to determine compliance with the IAC and review criteria before the prepayment review status can be terminated.

C. Exclusions

The following services are not covered by Medicaid.

1. Services that are not medically reasonable or necessary according to current professional standards commonly held to be applicable to the case.
2. Services provided outside the scope of a provider's license, registration, certification, or other authority to practice under state or federal law.
3. Experimental drugs, treatments, or procedures, and all related services.
4. Any new product, service, or technology not specifically covered in IAC. The product, service, or technology will remain a noncovered product, service, or technology until such time as the OMPP authorizes the coverage of the product, service, or technology. This does not apply to legend drugs.
5. Personal comfort or convenience items, including, but not limited to, television, radio, or telephone rental.
6. Services for the remediation of learning disabilities.
7. Treatments or therapies of an educational nature.

8. Experimental radiological or surgical or other modalities and procedures, including, but not limited to, the following items.
 - ◆ Acupuncture
 - ◆ Biofeedback therapy
 - ◆ Carbon dioxide five percent inhalator therapy for inner ear disease
 - ◆ Hyperthermia
 - ◆ Hypnotherapy
9. Hair transplants
10. Fallopian tuboplasty (reanastomosis of the fallopian tubes) for infertility or vasovasostomy (reanastomosis of the vas deferens). This procedure is covered only in conjunction with disease
11. Augmentation mammoplasty for cosmetic purposes
12. Dermabrasion surgery for acne pitting or marsupialization
13. Rhinoplasty or bridge repair of the nose in the absence of a significant obstructive breathing problem
14. Otoplasty for protruding ears unless one of the following applies to the case.
 - ◆ Multifaceted craniofacial abnormalities due to congenital malformation or maldevelopment, for example, Pierre Robin Syndrome
 - ◆ A member has pending or actual employment where protruding ears would interfere with the wearing of required protective devices
15. Scar removals or tattoo removals by excision or abrasion
16. Ear lobe reconstruction
17. Removal of keloids complicating pierced ears unless one of the following is present
 - ◆ Keloids are larger than three centimeters
 - ◆ Obstruction of the ear canal is 50% or more
18. Rhytidectomy
19. Penile implants
20. Perineoplasty for sexual dysfunction
21. Reconstructive or plastic surgery unless deformity is related to disease or trauma
22. Sliding mandibular osteotomies unless related to prognathism or micrognathism

23. Blepharoplasties when not related to a significant obstructive vision problem
24. Radial keratotomy
25. Miscellaneous procedures or modalities, including, but not limited to the following items
 - ◆ Autopsy
 - ◆ Cryosurgery for chloasma
 - ◆ Conray dye injection supervision
 - ◆ Day care or partial day care or partial hospitalization except when provided pursuant to 405 IAC 5
 - ◆ Formalized and predesigned rehabilitation programs, including, but not limited to, the following programs
 - Pulmonary
 - Cardiovascular (Cardiac Rehabilitation Phase 3 is non-covered.)
 - Work-hardening or strengthening
 - ◆ Telephone transmitter used for transtelephonic monitor
 - ◆ Telephone, or any other means of communication, consultation from one doctor to another
 - ◆ Artificial insemination
26. Cognitive rehabilitation, except for treatment of traumatic brain injury
27. Ear piercing
28. Cybex evaluation or testing or treatment
29. High colonic irrigation
30. Services that are not prior authorized under the level-of-care methodology as required by 405 IAC 5-19
31. Amphetamines when prescribed for weight control or treatment of obesity
32. Under federal law, drug efficacy study implementation drugs not covered by Medicaid
33. All anorexics, except amphetamines, both legend and nonaligned
34. Physician samples

V. PRIOR AUTHORIZATION

The Indiana Medicaid Program allows reimbursement for those services which are outlined in the Covered Services and Limitation and Medical Policy Rule 405 IAC 5. The IAC contains the rules and regulations that govern IHCP, and serves as a comprehensive reference to covered services and prior authorization (PA) procedures and parameters. It is the responsibility of each IHCP provider to read the portions of the IAC that apply to his/her area of service. Specific prior authorization criteria should be obtained from 405 IAC 5.

The Health Care Excel Prior Authorization department reviews all requests for prior authorization for traditional Medicaid, the 590 Program, and the Hoosier Healthwise and *Medicaid Select* PCCM programs on an individual case-by-case basis. The risk-based managed care companies, or their designees, review requests for prior authorization for members enrolled in the Hoosier Healthwise Risk-Based Managed Care program. The decision to authorize, modify, or deny a given request is based upon medical reasonableness and necessity and other criteria set forth in the IAC. Prior Authorization decisions may also be based on OMPP approved internal criteria, in addition to the IAC prior authorization guidelines.

The primary objective of prior authorization review is to allow payment only for those treatments and/or services that are medically necessary, appropriate, cost-effective, and to reduce over-utilization and/or abuse of certain services.

MEDICAL POLICY FACT SHEET

TITLE: ABORTION

DESCRIPTION:

Surgical abortion is the induced termination of pregnancy before the fetus has developed to a viable state. This does not include a spontaneous abortion, missed abortion, incomplete abortion, or medical interventions required in the case of ectopic pregnancy.

MEDICAL TOPICS CROSS-REFERENCES:

Gynecology – Laminaria
Gynecology – Pelvic Exam under Anesthesia

RULES, CITATIONS, AND SOURCES:

42 CFR 50 Subpart C Abortions and Related Medical Services in Federally Assisted Programs
42 CFR 441.200 Services: Requirements and Limits Applicable to Specific Services Abortions
405 IAC 5-28-7 Medical and Surgical Services--Abortion
405 IAC 5-27-6 Radiology Services-- Sonography
Indiana State Department of Public Welfare Medical Policy Manual 1991
Indiana Medical Assistance Program Provider Manual 1994
Indiana Health Coverage Programs Provider Manual 1999

Initial Policy	Issue	Effective Date	Implementation Date	Retroactive Date
405 IAC 1-7-14 Repealed 8/24/97	Surgical Services	01/01/1992		
405 IAC 1-7-19(e) Repealed 8/24/97	Sonography	01/01/1992		
Revisions:				
42 CFR 441.200	Abortions	10/01/1997		
405 IAC 5-28-7	Abortion	08/24/1997		
405 IAC 5-27-6	Sonography	08/24/1997		

APPLICABLE INDIANA A/M EDITS AND AUDITS:

4012-Abortion Diagnosis/Procedure Indicated

4022-Abortion Diagnosis/Procedure Indicated

COVERAGE CRITERIA:

Medicaid reimbursement is available for abortions only if performed to preserve the life of the pregnant woman or in other circumstances when the abortion is required to be covered by Medicaid under federal law subject to limitations and restrictions set out in 42 CFR Subpart C Sec.50.301, 50.302, 50.303, 50.304, 50.306, 42 CFR 441.200 Sec 441.200, 441.201, 441.202, 441.203, 441.206, 441.207, 441.208, 405 IAC 5-28-7 and 405. All appropriate documentation must be attached to the claim and to claims for directly related services before reimbursement shall be made.

**ABORTION FACT SHEET
ADDENDUM A**

Note: This addendum contains provider notifications that have been published since the review of the Abortion Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BT200511 **Publication Date:** 06/01/2005

Subject: Abortion Diagnosis/Procedure Claim Notes

Date Added to Manual: 07/29/2005

Text of Publication

In the claim note, the IHCP accepts indication of medical documentation that supports the need to save the mother's life or a police report that indicates rape or incest.

MEDICAL POLICY FACT SHEET

TITLE: ANESTHESIA SERVICES

DESCRIPTION

Stedman's Medical Dictionary defines anesthesia as the loss of sensation resulting from pharmacologic depression of nerve function or from Neurologic dysfunction. Additionally, anesthesia is a broad term for anesthesiology as a clinical specialty.

Anesthesia services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to give a patient anesthesia care deemed optimal by the anesthesiologist to reduce or mitigate pain during any procedure. The services include the usual preoperative and postoperative visits, anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (for example, ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry.) Other monitoring services (for example, intra-arterial, central venous, and Swan-Ganz) are not included.

SUMMARY OF CURRENT POLICY

Indiana Health Coverage Programs (IHCP) reimbursement is available for covered anesthesia services subject to the limitations and restrictions set out in the Indiana Administrative Code (IAC). Providers who are eligible for reimbursement include licensed anesthesiologists, certified registered nurse anesthetists (CRNA), and licensed anesthesiologist assistants. Anesthesia services associated with canceled surgeries are not reimbursed.

The IHCP provides separate reimbursement for the following types of anesthesia, when provided by a physician other than the operating surgeon.

- Epidural
- Field Block
- Inhalation
- Intravenous
- Nerve Block
- Regional
- Spinal

Health Insurance Portability and Accountability Act (HIPAA) requirements mandated the adoption of standards for anesthesia CPT codes. Providers submitting claims for anesthesia services must use anesthesia CPT codes 00100 through 01999, effective October 16, 2003. Anesthesia charges must be submitted using the anesthesia CPT code that corresponds to the surgical procedure performed. General regional or epidural anesthesia administered by the same provider who performs the surgical or obstetrical delivery procedure is not reimbursable as it is included in the surgical delivery fee.

COVERAGE CRITERIA (Including Billing Requirements)

Anesthesia services are reimbursed according to a statewide fee schedule calculated on the total base units, time units, add-on units, and additional units for specific physical modifiers (as applicable), multiplied by the anesthesia conversion factor established by the Office of Medicaid Policy and Planning (OMPP). Providers submitting anesthesia services must use the anesthesia CPT codes 00100 through 01999. Anesthesia charges must be submitted using the anesthesia CPT code that corresponds to the surgical procedure performed.

Time

Time starts when the anesthesiologist or CRNA begins preparing the patient for the procedure in the operating room or other appropriate area. It is not appropriate to start counting time when the preoperative examination occurs. The preoperative exam is reimbursed via the base units. Time ends when the anesthesiologist or CRNA releases the patient to the postoperative unit and is no longer in constant attendance.

Base relative value units (RVU's) are loaded in *IndianaAIM*. However, the actual time of the procedure in minutes, is indicated in Locator 24G of the CMS-1500 claim form or the 837P electronic transaction. *IndianaAIM* calculates the time units. One unit is allowed for each 15-minute period or fraction thereof.

Base Units

Base unit values have been assigned to each CPT code that would normally include anesthesia. Providers should not report the base units on claims. The *IndianaAIM* claims processing system automatically determines the base units for the procedure code as submitted on the CMS-1500 claim form or the 837P electronic transaction. The system converts each 15 minute block of time to one unit.

For the following procedure codes, *IndianaAIM* calculates one time unit or each fifteen minute block of time billed in the first hour of service, and for subsequent hours of service, calculates one unit of service for every sixty minute block of time or portion thereof billed.

- 01960 – Anesthesia for vaginal delivery only
- 01967 – Neuraxial labor analgesia for anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug

injection and/or any necessary replacement of an epidural catheter during labor)

Additional Units

The IndianaAIM claims processing system recognizes the following circumstances and calculates any additional units appropriate for reimbursement.

- **Patient age** – IndianaAIM applies additional units to the base units for members under one year of age or over seventy years of age
- **Procedure code 99140** – Use this code on a separate line item of the claim to indicate that the anesthesia provided was complicated by emergency conditions
- **Physical status** – Providers must use the appropriate modifier to denote any patient conditions that may warrant payment of additional units these are listed in Table 1, below

Table 1 – Physical Status Modifiers for Anesthesia

Modifier	Description	Additional Units Allowed
P1	A normal healthy patient for an elective operation	0 units
P2	A patient with mild systemic disease	0 units
P3	A patient with severe systemic disease that limits activity but is not incapacitating	1.0 units
P4	A patient with a severe system disease that is a constant threat to life	2.0 units
P5	A moribund patient who is not expected to survive without the operation	3.0
P6	A declared brain-dead patient whose organs are being removed for donor purposes	0 units

Anesthesiologists performing the following procedures must bill with the AA modifier. These procedures must be billed in **units**, instead of minutes.

- 36555 – Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age
- 36556 – Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older
- 36568 – Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; under 5 years of age
- 36569 – Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older
- 36580 – Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access

- 36584 – Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump through same venous access
- 36620 – Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
- 36625 – Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown
- 93503 – Insertion and placement of flow directed catheter (for example, Swan -Ganz) for monitoring purposes
- 99116 – Anesthesia complicated by utilization of total body hypothermia
- 99183 – Physician attendance and supervision of hyperbaric oxygen therapy, per session
- 99185 – Hypothermia, regional

Medical Direction and CRNA

The IHCP reimburses 30 percent of an anesthesia CPT procedure code's allowed amount when an anesthesiologist submits for medical direction of qualified anesthetists. Anesthesia details submitted by a CRNA are reimbursed at 60 percent of the procedure code's allowed amount.

CRNAs must use anesthesia CPT codes (00100-01999) and bill with the appropriate medical direction and/or physical status modifiers. CRNA providers use the same physical status modifiers that apply to anesthesiologists, shown in **Table 1** on the preceding page. **Table 2 – Anesthesia Modifiers** lists the only modifiers used to identify services provided by CRNAs.

Table 2 – Anesthesia Modifiers

Modifier	Description
QS	Monitored anesthesia care service
QX	Certified Registered Nursing Anesthetist (CRNA) service, with medical direction by a physician
QZ	CRNA without medical direction by a physician

Reimbursement is available for medical direction of a procedure involving an anesthetist only when the direction is by an anesthesiologist, and only when the anesthesiologist medically directs two, three, or four concurrent procedures involving qualified anesthetists. An anesthesiologist billing for medical direction uses modifier QK, *Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals*. An anesthesiologist involved in medically directing more than one and up to four procedures may not be personally performing procedures at the same time. Criteria for medical direction include the following.

- Ensure that only qualified people administer anesthesia
- Monitor anesthesia at frequent intervals
- Participate in the most demanding portions of the procedures including induction and emergence, if applicable
- Perform the preoperative evaluation

- Perform the postoperative evaluation
- Prescribe anesthesia plan
- Remain immediately available and not perform other services

The IHCP does not allow medical supervision by an anesthesiologist for more than four concurrent procedures. Therefore, reimbursement is not allowed for services billed with the AD modifier.

Regional Anesthesia

Regional anesthesia or nerve blocks involve blocking nerve impulses with a local anesthetic, steroid, narcotic, or other agent. It is administered by a physician and requires special techniques and attention, especially during the initial phase of instituting the block. Nerve blocks performed as a surgical procedure for the treatment of a condition such as chronic pain are billed with the appropriate nerve block code, quantity of one, with no anesthesia modifier.

When billing regional anesthesia as the anesthesia type for a given surgical procedure that is performed by a qualified anesthesia professional, regional anesthesia is billed and paid in the same manner as a general anesthetic, using base units plus time. (See the section entitled “Coverage Criteria”.) The bilateral procedure code modifier 50 is not used in conjunction with anesthesia modifiers.

Monitored Anesthesia

Monitored anesthesia care (MAC) involves the intraoperative monitoring of patient vital signs in anticipation of the need for administration of general anesthesia or the development of adverse physiological patient reaction to the surgical procedure or anesthesia. MAC also includes the performance of a preanesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (such as Atropine, Demerol, or Valium), and the provision of indicated postoperative anesthesia care.

The IHCP allows payment for medically reasonable and necessary MAC services on the same basis as other anesthesia services. The QS modifier must be added to the appropriate CPT code in addition to other applicable modifiers to identify the services as monitored anesthesia care.

Postoperative Pain Management Services

The IHCP reimburses for postoperative epidural catheter management services using CPT procedure code 01996. Procedure code 01996 is not separately paid on the same day the epidural is placed. Rather, this code is billed on subsequent days when the epidural is actually being managed. This code is used for daily management of patients receiving continuous epidural, subdural, or subarachnoid analgesia, and is limited to one unit of service for each day of management. Procedure code 01996 is only reimbursable during active administration of the drug. When monitored by an anesthesia provider, no modifier is appended. Claims submitted with anesthesia procedure codes and the postoperative pain management codes listed in **Table 3 – CPT Codes for Postoperative**

Pain Management, in **Table 3**, billed on the same day of surgery, must be used in conjunction with modifier 59, *Distinct procedural service*, and is subject to post payment review.

TABLE 3 – CPT Codes for Postoperative Pain Management	
CPT CODE	DESCRIPTION
62310	<i>Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substances(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic.</i>
62311	<i>Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substances(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)</i>
62318	<i>Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substances(s) (including anesthetic, antispasmodic, opioid, steroid, or solution), epidural or subarachnoid; cervical or thoracic</i>
62319	<i>Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substances(s) (including anesthetic, antispasmodic, opioid, steroid, or solution), epidural or subarachnoid; lumbar, sacral (caudal)</i>
64412	<i>Injection, anesthetic agent; spinal accessory nerve</i>
64413	<i>Injection, anesthetic agent; cervical plexus</i>
64415	<i>Injection, anesthetic agent; brachial plexus, single</i>
64416	<i>Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration</i>
64417	<i>Injection, anesthetic agent; axillary nerve</i>
64420	<i>Injection, anesthetic agent; intercostal nerve, single</i>
64421	<i>Injection, anesthetic agent; intercostal nerves, multiple, regional block</i>
64445	<i>Injection, anesthetic agent; sciatic nerve, single</i>
64446	<i>Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration</i>
64447	<i>Injection, anesthetic agent; femoral nerve, single</i>
64448	<i>Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration</i>
64449	<i>Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily</i>

TABLE 3 – CPT Codes for Postoperative Pain Management	
CPT CODE	DESCRIPTION
	<i>management for anesthetic agent administration</i>
64450	<i>Injection, anesthetic agent; other peripheral nerve or branch</i>

ANESTHESIA FOR DENTAL SERVICES

IHCP reimbursement for general anesthesia, billed using code D9220 for the first 30 minutes and D9221 for each additional 15 minutes, is only covered in a dentist's office for individuals under the age of 21 years of age. General anesthesia is covered for adults only if the procedure is performed in a hospital (inpatient or outpatient) or an ambulatory surgical center. Nitrous oxide analgesia is covered only for members twenty years of age and younger.

Reimbursement for IV sedation in a dental office for IHCP members of all ages when provided for oral surgery services only. Documentation in the member's record must include specific reasons why such services are needed and is subject to post payment review.

Documentation for general anesthesia (adults or children) should include why the individual could not receive necessary dental services unless general anesthesia was administered. These records must be retained in the member's file for at least three years.

Adult dental patients who may qualify for hospital or surgical center general anesthesia include, but are not limited to adults with the following medical conditions.

- Mental incapacitation such that the member's ability to cooperate with procedures is impaired, including mental retardation and organic brain disease
- Severe physical disorders affecting the tongue or jaw movements
- Seizure disorders
- Significant psychiatric disorders resulting in impairment of the recipient's ability to cooperate with procedures
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication

A dental cap of \$600 applies to IHCP dental services provided in a dental office. **Table 4 – CDT Codes Included in the \$600 Dental Cap**, on the following page, describes anesthesia codes that are included in the dental cap for IHCP members. Providers can bill their usual and customary charge to the member for any services provided after the cap has been exhausted. However, if a service is partially paid by the IHCP because of the cap limit, the member can only be billed for the difference between what the IHCP would have reimbursed to the provider and what the IHCP actually paid. The following guidelines must be met for the IHCP provider to hold a member responsible for payment.

- The service rendered by the provider must be an IHCP non-covered service
- The member has exceeded program limitations for a particular service
- The member failed to inform the provider of eligibility. The provider must maintain documentation to show that the provider billed the IHCP member of that the provider requested the information within one year of the filing limit
- The member must understand before receiving the service that the service is not covered by the IHCP, and that the member is responsible for the charges associated with the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service knowing that the IHCP would not cover the service.

Table 4 – CDT Codes Included in the \$600 Dental Cap

HCPCS Code	Description
D9220	Deep sedation/general anesthesia – first 30 minutes
D9221	Deep sedation/general anesthesia – each additional 15 minutes
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9248	Non-intravenous conscious sedation
D9610	Therapeutic drug injection, by report

Monitored sedation for children (Dental procedures)

IHCP reimbursement for monitored sedation, provided in a dentist's office, is available for members under the age of 21. Monitored sedation is the administration of subcutaneous, intramuscular, intravenous or oral sedation, in combination with monitoring the patient's vital signs. This service should be billed utilizing procedure code D9248, *Non-intravenous conscious sedation*.

ANESTHESIA SERVICES FOR OBSTETRICAL SERVICES

General, regional, or epidural anesthesia administered by the same provider who performs the surgical or obstetrical delivery procedure is not reimbursable as it is included in the surgical delivery fee.

Providers billing anesthesia services for vaginal or cesarean deliveries must use the appropriate anesthesia CPT codes as listed in **Table 5 – Anesthesia CPT Procedure Codes for Vaginal or Cesarean Delivery**. This method of billing is the same as for any other surgery, and should be used for obstetrical anesthesia, regardless of the type of anesthesia provided, e.g. general or regional, including epidural anesthesia.

Table 5 – Anesthesia CPT Procedure Codes for Vaginal or Cesarean Delivery

CPT Procedure Code	Description
01960	Anesthesia for vaginal delivery only
01961	Anesthesia for cesarean delivery only
01962	Anesthesia for urgent hysterectomy following delivery

Table 5 – Anesthesia CPT Procedure Codes for Vaginal or Cesarean Delivery

CPT Procedure Code	Description
01963	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care
01964	Anesthesia for abortion procedures
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)
*10968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (list separately in addition to code for primary procedure performed)
*01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (list separately in addition to code for primary procedure performed)

* Add-on codes that must be used in conjunction with 01967

When an anesthesiologist starts an epidural anesthesia for labor, and it becomes necessary to switch to a general anesthetic for a delivery, the total times are combined and billed for the procedure performed, such as vaginal delivery or cesarean section (C-section).

When a provider, other than the surgeon or obstetrician, is billing for epidural anesthesia, that provider is reimbursed in the same manner as is reimbursed for general anesthesia.

MANAGED CARE

The same policies and procedures pertaining to anesthesia services for traditional Medicaid apply to the PrimeStep program. Anesthesiology services do not require the PMP certification code for payment. Risk Based Managed Care (RBMC) may have other, specific standards and practices. For RBMC specific policies, please consult the appropriate managed care organization.

RELATED MEDICAL TOPICS

Consultations – Second Opinion

Dental Services

Obstetric Care

Surgery – Multiple Procedures/Same Operative Session

Surgery – Removal of Implants

Surgery – Services Requiring Prior Authorization

Surgery – Surgeon and Assistant Surgeon, Same Provider

Surgery – Surgical Services

Surgery – Suture of Wounds

RULES, CITATIONS, AND SOURCES

405 IAC 5-10 - Anesthesia Services

405 IAC 5-14-11 - Analgesia (Dental)

405 IAC 5-14-15 - General Anesthesia and Intravenous Sedation (Dental)

405 IAC 5-25-1 - Physician Services

405 IAC 5-28-1(h) – Medical and Surgical Services (Reimbursement Limitations)

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Indiana Health Coverage Programs Provider Banner

BR199947 – General Anesthesia – Dental Services

BR200350 – Modifiers for Medical Direction and CRNA Billing Requirements

Indiana Health Coverage Programs Provider Bulletin

BT200324 – Changes to the \$600 Dental Cap

BT200353 – HIPAA requirements

BT200401 – 2004 Annual HCPCS Update

Origination Date: 12/31/2000

Revisions and Reviews	Reason	Date
Indiana State Dept. Of Public Welfare Medical Policy Manual 1991	Anesthesia Services Global Fee billing	07/01/1991
470 IAC 5-9-27 Transferred	Anesthesia Services	07/01/1991
405 IAC 1-7-26 Repealed 8/24/97	Anesthesia Services	01/01/1992
405 IAC 1-7-26 (1)	Anesthesia Reimbursement	12/01/1993
Indiana Medicaid Update Bulletin 95-21, 05/02/95	Anesthesia Services	02/25/1995
Indiana Medicaid Update Bulletin 96-26,	Anesthesia Services	07/29/1996
405 IAC 5-25-1	Physician Services	08/24/1997
405 IAC 5-10	Anesthesia Services	08/24/1997
405 IAC 5-14-11 and 405 IAC 5-14-15	Analgesia for Dental Procedures; General Anesthesia and Intravenous Sedation for Dental Procedures	08/24/1997
Indiana Medicaid Update Bulletin 8-03	Anesthesia Services	01/06/1998
405 IAC 5-28-1(h)	Medical and Surgical Services, Reimbursement limitations	07/27/2001
Revision - Updates	HIPAA requirements, Dental Services,	04/29/2005

APPLICABLE INDIANA AIM EDITS AND AUDITS

6002 – Any Two Anesthesiology Provider Same Procedure Requires Review

6096 – The CPT/HCPCS Code Billed Is Not Payable According to the PPS

Reimbursement Methodology

6156 – Procedure 99140 Must Be Billed With Anesthesia Code

6652 – Multiple Surgeries Must Be Billed on Same Claim

6666 – Anesthesia Services Not Allowed by Provider Billing for Surgery

MEDICAL POLICY FACT SHEET

TITLE: BARIATRIC SURGERY AND REVISIONS

DESCRIPTION

Morbid obesity is defined as a body mass index¹ (BMI) of at least 35 kilograms per meter squared, with co-morbidity or co-existing medical conditions, such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or a BMI of at least 40 kilograms per meter squared without a co-morbidity.

This document is intended to serve as a general summary of the IHCP policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

I. BARIATRIC SURGERY

Bariatric surgery is a procedure of last resort, used to treat morbid obesity, when other methods of weight management have failed. The term “bariatric surgery” is a collective term, used to refer to procedures that involve restricting the stomach size with or without a bypass of the stomach to alter the digestive system. The primary goal of bariatric surgery is to achieve weight loss through restriction of the ability to eat, restriction of the body’s ability to absorb nutrients and calories, or a combination of both. These surgeries are categorized as “restrictive” or “malabsorptive” dependent upon the procedure utilized.

Restrictive Operations

Restrictive operations limit food intake but do not interfere with the normal digestive process. This type of surgery restricts the patient’s ability to eat large quantities of food at one sitting.

- ◆ Adjustable gastric banding – a hollow band made of special material is placed around the stomach near its upper end, creating a small pouch and a narrow passage into the larger remainder of the stomach. The band is then inflated with a saline solution and can be tightened or loosened over time to change the size of the passage by increasing or decreasing the amount of saline solution.
- ◆ Vertical banded gastroplasty (VBG) – VBG has been the most common restrictive operation for weight control. Staples are used to create a small stomach pouch. A

¹ Body mass index is equal to weight in kilograms divided by height in meters squared.

band of non-absorbable material is placed to limit the emptying of food from that pouch.

Malabsorptive Operations

Malabsorptive operations are the most common gastrointestinal surgeries for weight reduction. These operations restrict the amount of food a patient is able to eat, as well as limit the ability to absorb calories and nutrients.

- ◆ Roux-en Y gastric bypass (RGB) – RGB is the most common and successful malabsorptive surgery. A small stomach pouch is created to restrict food intake. A Y-shaped section of the small intestine is attached to the pouch to allow food to bypass the lower stomach. This bypass reduces the amount of calories and nutrients the body absorbs.
- ◆ Biliopancreatic diversion (BPD) – BPD is a more complicated operation that involves removal of a portion of the stomach. The small pouch that remains is connected directly to the final segment of the small intestine. This procedure is used less frequently because of the higher risk for nutritional deficiencies.

COVERAGE CRITERIA – BARIATRIC SURGERY

Bariatric surgery is recognized as medically necessary when used for the treatment of morbid obesity. All types of bariatric surgery require prior authorization (PA) and are subject to the following conditions.

1. Scope and duration of failed weight loss therapy **must meet the following criteria.**
 - a. Morbid obesity has persisted for at least five years duration, **and**
 - b. Physician-supervised non-surgical medical treatment² has been unsuccessful for at least 18 consecutive months.

Or

Member has successfully achieved weight loss after participating in physician-supervised non-surgical medical treatment but has been unsuccessful at maintaining weight loss for two years [> 3 kg (6.6 lb.) weight gain].

Successful weight loss therapy is defined as the ability to reduce body weight by approximately 10% from baseline in a period of eight months. Unsuccessful weight loss maintenance is defined as a weight regain of > 3 kg (6.6 lb.) in two years and the inability to maintain a sustained reduction in waist circumference of at least four centimeters.

2. Age and maturity requirements must include both of the following.
 - a. Member must be between 21 and 65 years of age.

² Includes a diet to help create a 500 to 1,000 kcal/day deficit; an increase in physical activity; and strategies to change eating and physical activity behaviors.

- b. Member must be physically mature as shown by sexual maturity and the closure of growth plates.

Documentation in the member's medical record must be maintained to substantiate the following.

1. A psychological or psychiatric evaluation by a Health Service Provider in Psychology (HSPP) or a psychiatrist is required prior to surgery. Members with the following contraindications will **not** be candidates for bariatric surgery.
 - a. Active abuse of alcohol, illicit and/or social drugs and other chemicals, and/or tobacco use during the six months prior to the request.
 - b. DSM IV criteria for Bulimia or Binge Eating Disorder (BED).
 - c. Other eating patterns that are deemed likely to interfere with post-surgical safety and success.
 - d. Active psychosis.
 - e. Uncontrolled depression.
 - f. Borderline personality disorder.
 - g. Other complex psychiatric problems that might interfere with a successful weight-loss outcome.
2. Member is able to understand, tolerate, and comply with all phases of care and is committed to long-term follow-up requirements.
3. Member is abstinent from alcohol use, illicit drug use, and tobacco use; member has a negative urine drug screen.
4. Member's treatment plan includes pre-operative and post-operative dietary evaluations.
5. Member has received a thorough explanation of the risks, benefits, and complications of the procedure.
6. Member's post-operative expectations have been addressed prior to the bariatric surgery.
7. Member has agreed in writing to participate in all pre-operative and post-operative evaluations and sessions considered essential to his or her having a successful outcome to the bariatric surgery.

NONCOVERED SERVICES

The IHCP does not provide reimbursement for the following.

1. Procedures that are considered investigational and/or not meeting safety and/or efficacy standards will not be covered.
2. Panniculectomy following gastric bypass procedures performed for **cosmetic** reasons, even if performed incidentally to a ventral herniorrhaphy, is a non-covered service.
3. The IHCP will not provide reimbursement for bariatric surgeries reported with miscellaneous CPT procedure codes. Refer to the billing guidelines in this document for further information.

PRIOR AUTHORIZATION – BARIATRIC SURGERY

All bariatric surgeries, as described in **Table 1** in the “Billing Requirements – Bariatric Surgery” section of this document, require PA. Surgical procedures performed to correct or revise the initial surgical procedure require PA and are described in the “Surgical Revisions” section of this document.

HCPCS code S2083, *Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline*, does not require PA. This procedure is considered a routine, frequently performed, office procedure that involves accessing a subcutaneous port, using a needle and syringe, and injecting or aspirating saline and is not a surgical procedure. Injection or aspiration of saline results in an increase or decrease in the diameter of the gastric band. The adjustment of the gastric band diameter is based on the patient’s symptomatology and weight loss, as determined by the surgeon.

Documentation of an attempt to follow a physician-supervised, non-surgical medical treatment for a minimum of 18 consecutive months must be presented with the request for PA. Documentation of unsuccessful weight loss or unsuccessful weight maintenance after successful weight loss must be submitted.

The physician requesting PA is responsible for referral of the member to a psychiatrist or an HSPP at any time before or during the non-surgical treatment. The consultation would include an assessment for any psychosocial needs with recommendation for treatment, if necessary.

Additionally, the request for PA for bariatric surgery must be accompanied by the following documentation requirements.

1. A signed statement from the member acknowledging an understanding of pre- and post-operative expectations.
2. Documentation by the primary care physician of the results of the physician-supervised non-surgical weight loss program for at least 18 consecutive months, including unsuccessful weight loss or maintenance after successful weight loss.
3. Documentation by a psychiatrist or psychologist licensed as an HSPP that reflects a psychiatric evaluation for possible behavioral health conditions that are contraindications to the surgery.
4. Consultation reports from other practitioners who have seen the member for evaluation (eg. anesthesiologist, pulmonologist, cardiologist, etc).

II. SURGICAL REVISIONS

COVERAGE CRITERIA – REVISIONS

Members may require subsequent surgery due to a complication during the perioperative period or a revision to correct a technical failure post-operatively. Re-operation to repair

a complication or to correct a technical failure requires PA. Examples of perioperative complications of surgery include, but are not limited to, the following.

1. Gastrointestinal leakage.
2. Stomal stenosis.
3. Anastomatic leakage.
4. Abscess.

Post-operative technical failures of the primary operation include, but are not limited to, the following.

1. Staple line disruption - documented by x-ray or endoscopy.
2. Gastrogastic fistula with weight gain.
3. Expanded outlet - documented by gastroscopy.
4. Enlarged anastomosis -- documented by gastroscopy.
5. Intolerance to solid food after a band procedure.
6. Intractable reflux after a band procedure.
7. Weight loss as a result of anastomotic stenosis.
8. Stomal ulceration.

PRIOR AUTHORIZATION – REVISIONS

PA is required for re-operation to repair a complication or to correct a technical failure. PA for revision or conversion to Roux-en-Y shall include a medical review of documentation. Documentation of medical necessity must include the reason for the failure and the date of the original surgery. Examples of peri-operative complications and technical failures are provided in the coverage criteria for surgical revisions.

PA for revision of bariatric surgery due to reasons other than technical failure or due to noncompliant behavior of the member requires six months of documentation in the medical record to include the following.

1. Member participation in all pre-operative and post-operative evaluations and sessions included in the treatment plan.
2. Consultations with the bariatric dietician with documentation in the medical record of member's compliance with the post operative dietary treatment plan.
3. When failure is at least in part due to noncompliant behavior of the member, evaluation by a psychiatrist or psychologist licensed as an HSPP that reflects the absence of behavioral health contraindications to a successful outcome to revision of the bariatric surgery.

MANAGED CARE

Members enrolled in Primary Care Case Management (PrimeStep) are subject to the same benefit limits, restrictions, and medical necessity criteria as those individuals enrolled in traditional Medicaid. Providers should contact the individual managed care organizations to determine any additional criteria or requirements for bariatric surgery. Senate Enrolled Act 360 from the 2005 session of the Indiana General Assembly outlines the following criteria for Risk Based Managed Care (RBMC).

- Morbid obesity is defined as a body mass index* of at least 35 kilograms per meter squared, with co-morbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or a body mass index of at least 40 kilograms per meter squared without co-morbidity.

*Body mass index is equal to weight in kilograms divided by height in meters squared.

- Physician-supervised non-surgical medical treatment has to have been unsuccessful for at least 18 consecutive months.
- Members less than 21 years of age must have documentation in the medical record by two physicians who have determined that bariatric surgery is necessary to save the life of the member, or restore the member's ability to maintain a major life activity defined as self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency.

BILLING REQUIREMENTS

The IHCP will provide reimbursement for the bariatric procedures described in **Table 1**. Providers must report ICD-9-CM diagnosis code 278.01, *Morbid obesity* with the most specific procedure code available that represents the procedure performed.

Table 1 – Bariatric Surgery Codes

Code	Description
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty

Table 1 – Bariatric Surgery Codes

Code	Description
43845	Gastric restrictive procedure with partial gastrectomy, pylorus preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion from duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43770	Laparoscopy, surgical; gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port)
43771	Laparoscopy, surgical; gastric restrictive procedure; revision of adjustable gastric band component only
43772	Laparoscopy, surgical; gastric restrictive procedure; removal of adjustable gastric band component only
43773	Laparoscopy, surgical; gastric restrictive procedure; removal and replacement of adjustable gastric band component only
43774	Laparoscopy, surgical; gastric restrictive procedure; removal of adjustable gastric band and subcutaneous port components
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric band (separate procedure)
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only
43999	Unlisted procedure, stomach

The IHCP does not provide reimbursement for HCPCS code S2083, *Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline*, during the 90-day global period for CPT code 43770, 43773, 43771, 43886, or 43888.

RELATED MEDICAL TOPICS

Anesthesia Services
Consultations – Second Opinion
Diagnostic Studies
Gastroenterology
Radiology

RULES, CITATIONS, AND SOURCES

Indiana Health Coverage Programs Provider Manual
405 IAC 5-3-13 Services Requiring PA
405 IAC 5-29 Non-Covered Services
Indiana Health Coverage Programs Bulletin BT200410
Indiana Health Coverage Programs Bulletin BT200430
Medical Policy Administrative Report May 2004
Senate Enrollment Act 360

Origination Date 10/01/2000

REVIEW AND REVISIONS	REASON	DATE
Review	Add new codes	02/01/2005
Revision	Senate Enrollment Act 360 and addition of PA criteria for bariatric surgery revisions	10/31/2005

APPLICABLE INDIANA AIM EDITS AND AUDITS

- 3000 – Units Exceed PA Master
- 3001 – Date(s) of Service Not on PA Database
- 3010 – Out-of-State Provider Requires Prior Authorization
- 3011 – Out-of-State Provider Requires Prior Authorization-Rendering Provider
- 6002 – Any Two Anesthesiology Providers Same Procedure Requires Review
- 6003 – Manual Pricing for Split Care Billing
- 6022 – Components Not Payable When Global Paid-Digestive Services
- 6023 – Global Payable at a Reduced Fee When Components Paid-Digestive Services
- 6034 – Global Surgery Payable at Reduced Amount When Components of Surgical Care Paid
- 6035 – Components of Surgical Care Not Payable when Global Surgery Paid
- 6037 – One Assistant Surgeon Allowed for Select Surgeries
- 6040 – Co-Surgeon Paid at Reduced Amount when Assistant Surgeon Paid
- 6096 – CPT/HCPCS Code Billed is Not Payable According to the PPS Reimbursement Methodology
- 6652 – Multiple Surgeries Must be Billed On Same Claim
- 6661 – Duramorph Cannot Be Billed on Same Day as Surgery
- 6666 – Anesthesia Services Not Allowed by Providers Billing for Surgery

MEDICAL POLICY FACT SHEET

TITLE: CARDIAC REHABILITATION

DESCRIPTION:

Progressive exercise programs have demonstrated benefit in the management and rehabilitation of individuals with cardiac disease, especially following certain cardiac events. Cardiac rehabilitation programs are typically divided into three stages. The initial stage (Phase I) involves the most intensive supervision and occurs in an inpatient setting. A Phase I program is typically initiated during the acute convalescent period following a cardiac event. Phase II begins with an overall treatment plan including a physician's prescription for progressive exercise based on the individual's clinical status and physical capacity. Phase II programs incorporate close monitoring and individualized progressive increases in the intensity of physical activity, as well as lifestyle changes such as dietary modifications and smoking cessation. Phase II exercise programs for cardiac patients may be conducted in specialized, freestanding, cardiac rehabilitation clinics, as well as in outpatient hospital departments. Phase III is an ongoing maintenance period, consisting of continued lifestyle changes and aerobic exercise. All phases of cardiac rehabilitation programs include individualized exercises and behavior change therapy with the intention of returning the patient to an active life with minimized symptoms.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

IHCP mirrors Medicare guidelines and regulations for the Cardiac Rehabilitation Phase I and Phase II services. The cardiac rehabilitation program is to include a medical evaluation, and a program to modify cardiac risk factors, such as nutritional counseling, prescribed exercise, education, and behavioral counseling. Phase I is included in the inpatient DRG; therefore, IHCP does not provide separate reimbursement. IHCP does not provide reimbursement for Phase III programs.

Reimbursement is available for Phase II cardiac rehabilitation programs when considered medically reasonable and necessary. Members must be referred by the physician, and have at least a moderate level of risk stratification.

The member must have either of the following criteria.

1. Stable angina pectoris (ICD-9-CM diagnosis codes 413.0 or 413.9) with reduced activity tolerance substantially altering lifestyle. Stable angina is defined as exertional chest pains with a constant threshold, predictable symptoms, and the ability to adjust one's activity and medications in order to avoid symptoms. Members who qualify for a Phase II cardiac rehabilitation program are expected to have a functional classification of Class II or Class III on the Canadian Cardiovascular Society Functional Classification, as follows.
 - **Class I**
Ordinary physical activity, such as walking and climbing stairs, does not cause angina. Angina may occur with strenuous, rapid, or prolonged exertion at work or recreation
 - **Class II**
Slight limitation of ordinary activity including, walking or climbing stairs rapidly walking uphill, walking or stair climbing after meals, in cold, in wind, or when under emotional stress, or only during the few hours after awakening. Walking more than two blocks on a level surface and climbing more than one flight of ordinary stairs at a normal pace and under normal conditions
 - **Class III**
Marked limitation of ordinary physical activity. Walking one to two blocks on a level surface and climbing more than one flight in normal conditions
 - **Class IV**
Inability to carry on any physical activity without discomfort; anginal syndrome may be present at rest
2. Have had one of the following preceding the initiation of the Phase II program.
 - Coronary artery bypass surgery
 - Acute myocardial infarction (within the previous twelve months)
 - Old myocardial infarction (that is less than 52 weeks from the date of the infarction)
 - Heart valve repair/replacement
 - Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
 - Heart or heart-lung transplant

Cardiac rehabilitation programs may be provided either by the outpatient department of a hospital or in a freestanding cardiac rehabilitation facility. Cardiac rehabilitation services must be conducted only when a physician is on the premise and is available to perform medical duties at all times the facility is open. The IHCP member must be under the care of a hospital or clinic physician. The facility must have available for immediate use all

the necessary cardiopulmonary emergency diagnostic and therapeutic life saving equipment accepted by the medical community as medically necessary, such as oxygen, cardiopulmonary resuscitation equipment, and defibrillator.

Services provided in connection with a cardiac rehabilitation exercise program may be considered reasonable and necessary for up to 36 sessions, usually a maximum of three sessions a week, in a single 12- week period. Coverage for continued participation in cardiac exercise programs beyond 12 weeks are approved on a case-by-case basis with exit criteria taken into consideration.

Documentation in the medical record must show the medical necessity for unusual frequency or duration of Phase II. Documentation must be specific in terms of exit criteria and/or setbacks that changes the exercise prescription. Claims for Phase II accompanied documentation indicating the member has not reached an exit level within 12 weeks are considered on a case-by-case basis. Reimbursement is not available for Phase II exceeding a maximum of 24 weeks.

A member may be progressed to the maintenance (Phase III) program when the following criteria are met.

1. The member has achieved a stable level of exercise tolerance without ischemia or dysrhythmia as evidenced by electrocardiogram (ECG)
2. Symptoms of angina or dyspnea are stable at the member's maximum exercise level
3. The member's resting blood pressure and heart rate are within normal limits, or are stable on optimal medical therapy
4. The stress test is not positive during exercise. (A positive test in this context means an ECG with a junctional depression of greater than or equal to 2 mm associated with slowly rising, horizontal, or down-sloping ST segment)

A routine cardiac rehabilitation visit must include at least one of the following services.

1. Continuous ECG telemetric monitoring during exercise
2. ECG rhythm strip with interpretation and physician's revision of exercise prescription
3. Physician evaluation to assess the member's performance, adjust medication, or other treatment changes. This physician evaluation is considered an element of the cardiac rehabilitation visit, and is not a separate reimbursement. Additional physician reimbursement requires documentation of a separately identifiable evaluation and management (E/M) service

Other cardiac rehabilitation services may include, but are not limited to, the following.

1. New patient comprehensive evaluation, including history, physical, and preparation of initial exercise prescription. One comprehensive evaluation is allowed and separately payable at the beginning of the program, if not

already performed by the member's attending physician, or if the evaluation performed by the member's attending physician is not acceptable to the program's director. An assessment performed by a nurse or other personnel does not meet this requirement.

2. ECG stress test (treadmill or bicycle ergometer) with physician monitoring and report. One is allowed at the beginning of the program and one after 3 months (usually at the completion of the program). Pharmacologic stress testing may be indicated in certain circumstances and would be allowed only on a case-by-case basis with appropriate documentation of medical necessity.

PRIOR AUTHORIZATION

Prior authorization is not required for Cardiac Rehabilitation services.

BILLING GUIDELINES

Phase II Cardiac Rehabilitation services are to be reported with the appropriate CPT procedure code as noted in **Table 1** and an appropriate ICD-9-CM Diagnosis code as described in **Table 2**. According to the ICD-9-CM coding narratives, cardiac rehabilitation that begins within eight weeks of the date of the infarction should be coded as 410.00 - 410.92. Cardiac rehabilitation beginning eight weeks or greater from the date of the infarction (but less than 52 weeks) should be coded as 412 or 414.8.

Table 1–CPT Procedure Codes for Phase II Cardiac Rehabilitation

Code	Description
93797	Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798	Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

Table 2–ICD-9-CM Diagnosis Codes for Phase II Cardiac Rehabilitation

Code	Description
410.00	Acute myocardial infarction of anterolateral wall; episode of care unspecified
410.01	Acute myocardial infarction of anterolateral wall; initial episode of care
410.02	Acute myocardial infarction of anterolateral wall; subsequent episode of care
410.10	Acute myocardial infarction of other anterior wall; episode of care unspecified
410.11	Acute myocardial infarction of other anterior wall; initial episode of care
410.12	Acute myocardial infarction of other anterior wall; subsequent episode of care
410.20	Acute myocardial infarction of inferolateral wall; episode of care unspecified
410.21	Acute myocardial infarction of inferolateral wall; initial episode of care
410.22	Acute myocardial infarction of inferolateral wall; subsequent episode of care
410.30	Acute myocardial infarction of inferoposterior wall; episode of care unspecified

Table 2–ICD-9-CM Diagnosis Codes for Phase II Cardiac Rehabilitation

Code	Description
410.31	Acute myocardial infarction of inferoposterior wall initial episode of care
410.32	Acute myocardial infarction of inferoposterior wall subsequent episode of care
410.40	Acute myocardial infarction of other inferior wall; episode of care unspecified
410.41	Acute myocardial infarction of other inferior wall; initial episode of care
410.42	Acute myocardial infarction of other inferior wall; subsequent episode of care
410.50	Acute myocardial infarction of other lateral wall; episode of care unspecified
410.51	Acute myocardial infarction of other lateral wall; initial episode of care
410.52	Acute myocardial infarction of other lateral wall; subsequent episode of care
410.60	Acute myocardial infarction true posterior wall infarction; episode of care unspecified
410.61	Acute myocardial infarction true posterior wall infarction; initial episode of care
410.62	Acute myocardial infarction true posterior wall infarction; subsequent episode of care
410.70	Acute myocardial infarction subendocardial infarction; episode of care unspecified
410.71	Acute myocardial infarction subendocardial infarction; initial episode of care
410.72	Acute myocardial infarction subendocardial infarction; subsequent episode of care
410.80	Acute myocardial infarction of other specified sites; episode of care unspecified
410.81	Acute myocardial infarction of other specified sites; initial episode of care
410.82	Acute myocardial infarction of other specified sites; subsequent episode of care
410.90	Acute myocardial infarction unspecified site; episode of care unspecified
410.91	Acute myocardial infarction unspecified site; initial episode of care
410.92	Acute myocardial infarction unspecified site; subsequent episode of care
412	Old myocardial infarction
413.0	Angina decubitus*
413.9	Other and unspecified angina pectoris
414.8	Other specified forms of chronic ischemic heart disease
V15.1	Surgery to heart and great vessels
V42.1	Organ or tissue replaced by transplant; heart
V42.2	Organ or tissue replaced by transplant; heart valve
V43.3	Organ or tissue replaced by other means; heart valve
V45.09	Cardiac device in situ; other specified cardiac device
V45.81	Postsurgical status, aortocoronary bypass
V45.82	Percutaneous transluminal coronary angioplasty status

*Includes nocturnal angina

It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code listed above does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this policy.

The appropriate revenue code for cardiac rehabilitation services is 943. All charges associated with the elements of a cardiac rehabilitation service as noted previously in this document, including telemetry and supplies for telemetry, are to be included in this charge. Separate reimbursement for charges for telemetry, electrodes, etc. are not provided. One unit equals one cardiac rehabilitation visit. The number of units must be shown on the UB-92 in field 46. A stress test may be billed using revenue code 482. The date of onset or surgery must be indicated on the UB-92 in fields 32-35 with occurrence code 11. The date of the first cardiac rehabilitation session must be indicated in fields 32-35 with occurrence code 46. The total number of cardiac rehabilitation visits from the start of care, including the current claim, must be entered on the UB-92 in fields 39-41 with value code 53.

Reasons for Denial

The IHCP will deny reimbursement for, but not limited to, the following reasons. Although members may meet a provider's protocol for cardiac rehabilitation services, they must also meet the IHCP coverage criteria for medical necessity.

1. Lack of documentation of a covered diagnosis
2. Lack of documentation of the elements of a cardiac rehabilitation visit
3. Duration beyond 12 weeks without documentation showing medical necessity as indicated above
4. Services determined to be not reasonable and necessary as stated previously in this document

Documentation Requirements

The diagnosis of stable angina should be substantiated with a physician history and physical, a hospital discharge summary, or a physician statement to confirm the diagnosis. The member's medical record must contain documentation that fully supports the medical necessity for cardiac rehabilitation, as it is covered by IHCP. This documentation includes, but is not limited to, medical records confirming the diagnosis, evidence of the elements of a cardiac rehabilitation session (e.g., telemetry monitoring strips), and medical reason for extension of the 12-week limit.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in *Medicaid Select* PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the *Medicaid Select* Manual for Primary Care Providers and Office Staff for further information.

RELATED MEDICAL TOPICS

Medical/Surgical
Hospital Inpatient
Hospital Outpatient

RULES, CITATIONS, AND SOURCES:

405 IAC 5-2-17 – Medically reasonable and necessary service
Indiana Health Coverage Program Provider Manual, Version 5.1

Origination Date: 12/31/2002

Review and Revision	Reason	Date
405-IAC-5-2-17	Medically reasonable and necessary service	07/25/1997
Review	Scheduled	01/31/2007

APPLICABLE INDIANA AIM EDITS AND AUDITS:

6096 – The CPT/HCPCS Code Billed is Not Payable According to the PPS
Reimbursement Methodology
6652 – Multiple Surgeries Must be Billed On the Same Claim
6768 – Services Not Covered for Telemedicine

MEDICAL POLICY FACT SHEET

TITLE: CASE MANAGEMENT—PREGNANT WOMEN

DESCRIPTION

Case management (care coordination) for pregnant women is an active, ongoing process of assisting a member to identify, access, and utilize community resources. Care coordinators perform prenatal risk assessments to identify Indiana Health Coverage Programs (IHCP) benefit eligible women whose pregnancies are at risk of preterm birth, low birth weight, or poor pregnancy outcomes. Case managers coordinate the services to meet member needs by locating community resources, making appointments for services, and following up to verify or reschedule appointments. Pregnant women, identified by the *Prenatal Risk Assessment Form* as high-risk members due to medical or psychosocial conditions, may also receive pregnancy care coordination services through the IHCP. The *Prenatal Risk Assessment Form* can be located on the IHCP website at www.indianamedicaid.com, under forms.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations and Sources" section of this document for further information.

COVERAGE CRITERIA

IHCP reimbursement is available for care coordination services provided to eligible pregnant women by any of the following providers.

- A physician licensed by the state
- A registered nurse licensed by the state
- A social worker with a baccalaureate or master's degree from a school accredited by the Council on Social Work Education
- A social worker certified by the state
- A dietitian registered with the Commission on Dietetic Registration of the American Dietetic Association and with certified training in pregnancy case management to combat poor pregnancy outcomes
- A community health worker may perform all care coordination services except the home encounter portion of the initial assessment and the postpartum or newborn assessment

A care coordinator must be certified by and have successfully completed perinatal care coordination training from a program approved by the Office of Medicaid Policy and Planning (OMPP). Care coordination includes the following services.

- Case finding
- Risk assessment
- Plan-of-care development
- Coordination
- Referral
- Linkage
- Follow-up monitoring

All eligible pregnant women may receive initial assessment services; however, only those deemed at risk, according to a prenatal risk assessment form approved by OMPP, are eligible for additional services. Reassessment and postpartum assessment are not covered services, when an initial assessment determines a pregnancy is not at risk. However, services may be covered later in the pregnancy if risk factors from the prenatal risk assessment form, which were not evident or present during the initial assessment, are discovered.

Care coordination services are exempt from prior authorization (PA) requirements, except for members with Primary Care Case Management (PCCM). PCCM pregnancy care coordination services require authorization by the member's Primary Medical Provider (PMP).

Pregnancy care coordination services are designed to prevent preterm births or poor pregnancy outcomes by facilitating the linking of the pregnant women to all necessary services, including medical, health promotion, and social services. The following services, available on a trimester basis, may be provided by physicians, registered nurses, social workers, and registered dietitians with certified training in pregnancy case management to combat poor pregnancy outcomes.

- Home visits, including the initial and postpartum home visit
- Referral to social service agencies
- Follow-up activities to ensure services were received

Intensive intervention by the pregnancy care coordinators must occur if the initial prenatal risk assessment indicates a high-risk condition that could potentially result in a poor pregnancy outcome. The pregnancy care coordinator should conduct up to two additional prenatal reassessments and a postpartum assessment, as well as the required home visit following the delivery to gather vital information about the pregnancy outcome and assessment of the newborn care needs. The postpartum visit is the **only** service that requires a completed copy of the *Care Coordination Outcome Report* to be attached to the claim.

Effective for claims with dates of service of November 20, 2001 and later; the IHCP requires the use of the new *Prenatal Care Coordination Outcome Report Form*. The new form permits accumulation of statistical data regarding care coordination services in Indiana. In the past, the *Care Coordination Outcome Report* was completed by the care coordinator and submitted with the postpartum visit billing claim sent to EDS. Prenatal care coordinators no longer send claims or outcome reports to EDS unless a client is in *Medicaid Select* or not enrolled in a Managed Care Organization (MCO). In addition, Risk-Based Managed Care (RBMC) is mandatory in all counties. The assessment forms for RBMC members are sent to the MCO in which the member is enrolled. To reduce reports received by the MCOs the data found on the *Care Coordination Outcome Report* has been incorporated into the *Combined Initial and Reassessment Prenatal Care Coordination Assessment Form (CIRPNCCAF)* and the *Postpartum Assessment Form (PPAF)*. All providers are required to complete the CIRPNCCAF and the PPAF. These forms can be located on the IHCP website at www.indianamedicaid.com, under forms.

A member may not appear to be high-risk by traditional assessment methods. Physicians/practitioners may acquire additional information regarding the risk of preterm delivery by performing the salivary estriol test, which would allow them to take steps to treat the member. Please refer to the Medical Policy (MP) Fact Sheet regarding Laboratory Services-Salivary Estriol Test for Preterm Labor Risk Assessment for additional information.

PRIOR AUTHORIZATION

PA is not required for care coordination services. However, PCCM members require authorization from the member's PMP.

MANAGED CARE

For members enrolled in RBMC, providers must contact the member's MCO for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), PCCM, and RBMC delivery systems.

IHCP members enrolled in *Medicaid Select* PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the *Medicaid Select* Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

Services that will be reimbursed by the IHCP include a prenatal risk assessment, one initial assessment and follow-up, one reassessment and follow-up per trimester (occurring

after the initial assessment), and one home visit postpartum assessment. The following codes are used to report these services.

- Healthcare Common Procedure Coding System (HCPCS) codes that are used to report prenatal care coordination for the initial assessment and re-assessments are as follows.
 - H1000, *Prenatal care, at-risk assessment-initial*
 - H1004, *Prenatal care, at-risk enhanced service; antepartum management-reassessment*
- Current Procedural Terminology (CPT) code 99501, *Home visit for postnatal assessment and follow-up care*, is used to report the postpartum visit and is the only service that requires a copy of the *Care Coordination Outcome Report* form be completed by the care coordinator and submitted with the claim when billing for the visit.

RELATED MEDICAL TOPICS

Family Planning

Gynecology–Pelvic Exam under Anesthesia

Laboratory Services–Salivary Estriol Test for Preterm Labor Risk Assessment

Obstetric Care

Surgery–Surgical Services

Transportation Services

RULES, CITATIONS, AND SOURCES

405 IAC 5-11, *Case Management Services for Pregnant Women*

Indiana Health Coverage Programs Provider Manual 2006

Indiana Health Coverage Programs Provider Bulletin

BT200014-Salivary Estriol Test For Preterm Labor Risk Assessment

Indiana Health Coverage Programs Provider Bulletin

BT200353-HIPAA-Mandated Elimination of Local Codes and Local Code Modifiers

Indiana Health Coverage Programs Provider Bulletin

BT200604-Assessment Forms and Outcome Report as a Result of State-Wide

Hoosier Healthwise Mandatory MCO Transition

Indiana Health Coverage Programs Provider Banner

BR200207

Indiana Health Coverage Programs Provider Banner

BR200214

Indiana Health Coverage Programs Provider Banner

BR200316

Indiana Health Coverage Programs Provider Banner

BR200317

Indiana Health Coverage Programs Provider Newsletter

NL200508

Origination Date: 07/01/1991

Revisions and Review	Reason	Date
470 IAC 5-9-25.1 Transferred	Case Management Services For Pregnant Women	07/01/1991
405 IAC 1-7-24 Repealed 08/24/1997	Care Coordination Services For Pregnant Women	01/01/1992
405 IAC 5-11	Case Management-Pregnant Women	08/24/1997
405 IAC 5-11-1 Amended	Case Management-Pregnant Women	10/27/1999
405 IAC 5-11-7 Amended	Case Management-Pregnant Women	10/27/1999
Review	Scheduled	10/31/2006

APPLICABLE INDIANA A/M EDITS AND AUDITS

6050-Care Coordinator-Reassessment

6051-Care Coordinator-Initial Assessment

6052-Care Coordination Post-Partum Assessment/Outcome

6096-The CPT/HCPCS Code Billed Is Not Payable

6652-Multiple Surgeries Must Be Billed On Same Claim

6768-Services Not Covered For Telemedicine

6800-Care Coordination-Transportation For Home Visits

6801-Care Coordination-Transportation For Home Visits

6802-Care Coordination-Transportation (Postpartum)

6916-Global-Home Uterine Monitoring

6917-Components-Home Uterine Monitoring

MEDICAL POLICY FACT SHEET

TITLE: CHIROPRACTIC SERVICES

DESCRIPTION

Chiropractic services are defined in Indiana Code (IC) 25-10 as the diagnosis and analysis of any interference with normal nerve transmission and expression, the procedure preparatory to and complementary to the correction thereof by an adjustment of the articulations of the vertebral column, its immediate articulation, and includes other incidental means of adjustments of the spinal column and the practice of drugless therapeutics.

COVERAGE CRITERIA

Indiana Health Coverage Programs (IHCP) reimbursement is available for covered services provided by a licensed chiropractor subject to restrictions and limitations set out in the Indiana Code (IC) 25-10-1-1, 5.5, 13, 14, and the Indiana Administrative Code (IAC) 405 IAC 5-12 and 407 IAC 3-12. Reimbursement is not available for any chiropractic services provided outside the scope of IC 25-10-1 and 846 IAC 1-1, or for any chiropractic service for which federal financial participation is not available.

Effective July 1, 2003, reimbursement is limited to a total of fifty visits and spinal manipulations or physical medicine treatments per member per rolling twelve month period. As part of this limitation, reimbursement will be made for no more than five office visits out of the total fifty visits allowed per member per rolling twelve month period. New patient office visits are reimbursed once per lifetime, per recipient, per provider, or provider of the same specialty and in the same practice within a three year time period. Reimbursement is not available for the following types of extended or comprehensive office visits.

- New patient detailed
- New patient comprehensive
- Established patient detailed
- Established patient comprehensive

Reimbursement is not available for durable medical equipment (DME) provided by chiropractors. Additionally, electromyogram (EMG) testing is no longer a covered IHCP service for chiropractors.

Reimbursement is limited to one set of full spinal x-rays per year. Chiropractors must provide the actual x-ray films previously taken at no cost to IHCP members when requested. The IHCP will not reimburse for additional x-rays necessitated by the failure of a practitioner to forward x-rays or related documentation to a chiropractic provider when requested. Chiropractors are entitled to receive x-rays from other providers at no charge to the member upon the member's written request to the other providers and upon reasonable notice.

Claim payment is limited for chiropractic practitioners (specialty 150) to the Current Procedural Terminology (CPT) procedure codes listed in tables one through four and the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes listed in the tables five and six included in this document.

Prior Authorization

Manual muscle testing services require prior authorization according to 405 IAC 5-12-5. Package C chiropractic services are restricted to five visits and fourteen procedures per rolling 12 month period. Additional procedures that are medically necessary may be reimbursed subject to prior authorization according to 407 IAC 3-12-2. There is a 50 treatment limit per rolling 12 month period, which includes no more than five office visits.

Managed Care

Chiropractic services are self-referral for Risk Based Managed Care (RBMC). Self-referral services do not require Primary Medical Provider (PMP) authorization.

Benefits under Hoosier Healthwise Package A - Standard Plan - have not been modified. Reimbursement is limited to a total of 50 visits, which includes no more than five office visits per recipient per rolling 12 month period.

Benefits under the Hoosier Healthwise Package B - Pregnancy Coverage Only - have not been modified. Coverage is limited to services related to pregnancy, conditions that may complicate the pregnancy, or urgent care services. Three principal diagnosis codes were covered specifically for Package B members effective July 1, 2003 and are listed in table five in this document. Refer to the Obstetric Care Fact Sheet for more information regarding billing chiropractic services for Package B members.

Benefits under the Hoosier Healthwise Package C - Children's Health Insurance Program - have not been modified. Package C chiropractic services are restricted to five visits and fourteen procedures per rolling 12 month period. Additional procedures that are medically necessary may be reimbursed subject to prior authorization. There is a 50

reatment limit per rolling 12 month period, which includes no more than five office visits.

Tables one through four identify the procedure codes that can be billed to the IHCP by chiropractors.

Table 1–Covered IHCP Chiropractic Codes for Office Visits	
CPT Code	Description
99201	Office or other outpatient visit for evaluation and management of new patient, problems are self-limited or minor
99202	Office or other outpatient visit for evaluation and management of new patient, presenting problems are of low to moderate severity
99203	Office or other outpatient visit for evaluation and management of new patient, presenting problems are of moderate severity
99211	Office or other outpatient visit for the evaluation and management of an established patient, presenting problem(s) are minimal
99212	Office or other outpatient visit for the evaluation and management of an established patient, presenting problem(s) are self-limited or minor
99213	Office or other outpatient visit for the evaluation and management of an established patient, presenting problem(s) are low to moderate severity

Table 2–Covered IHCP Chiropractic Codes for Manipulative Treatment	
CPT Code	Description
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions
98942	Chiropractic manipulative treatment (CMT); spinal, five regions
98943	Chiropractic manipulative treatment (CMT); extraspinal, one or more regions

Chiropractors may perform laboratory tests, which fall within their scope of practice for the State of Indiana (IC 25-10-1 and Title 846, which include blood analysis and urinalysis).

Table 3–Covered IHCP Chiropractic Codes for Radiology	
CPT Code	Description
72010	Radiologic examination, spine, entire, survey study, anteroposterior and lateral
72020	Radiologic examination, spine, single view, specify level
72040	Radiologic examination, spine, cervical; two or three views
72050	Radiologic examination, spine, cervical; minimum of four views
72052	Complete, including oblique and flexion and /or extension studies
72069	Radiologic examination, spine, thoracolumbar, standing (scoliosis)
72070	Radiologic examination, spine, thoracic, two views
72072	Radiologic examination, spine, thoracic, three views
72074	Radiologic examination, spine; thoracic, minimum of four views
72080	Radiologic examination, spine; thoracolumbar, two views
72090	Radiologic examination, spine; scoliosis study, including supine and erect studies
72100	Radiologic examination, spine; lumbosacral, two or three views
72110	Radiologic examination, spine; lumbosacral, minimum of four views
72114	Radiologic examination, spine; lumbosacral, complete, including bending views
72120	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views
72170	Radiologic examination, pelvis; one or two views
72190	Radiologic examination, pelvis; complete, minimum of three views
72200	Radiologic examination, sacroiliac joints; less than three views
72202	Radiologic examination, sacroiliac joints; three or more views
72220	Radiologic examination, sacrum and coccyx, minimum of two views
73000	Radiologic examination; clavicle, complete
73010	Radiologic examination; scapula, complete
73020	Radiologic examination, shoulder; one view
73030	Radiologic examination, shoulder; complete, minimum of two views
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction
73060	Radiologic examination; humerus, minimum of two views
73070	Radiologic examination, elbow; two views
73080	Radiologic examination, elbow; complete, minimum of three views
73090	Radiologic examination; forearm, two views
73100	Radiologic examination, wrist; two views
73110	Radiologic examination, wrist; complete, minimum of three views
73120	Radiologic examination, hand; two views
73130	Radiologic examination, hand; minimum of three views

Table 3–Covered IHCP Chiropractic Codes for Radiology

CPT Code	Description
73140	Radiologic examination, finger (s), minimum of two views
73500	Radiologic examination, hip, unilateral; one view
73510	Radiologic examination, hip, unilateral; complete, minimum of two views
73520	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis
73550	Radiologic examination, femur, two views
73560	Radiologic examination, knee; one or two views
73562	Radiologic examination, knee; three views
73564	Radiologic examination, knee; complete, four or more views
73565	Radiologic examination, knee; both knees, standing, anteroposterior
73590	Radiologic examination; tibia and fibula, two views
73600	Radiologic examination, ankle; two views
73610	Radiologic examination, ankle; complete, minimum of three views
73620	Radiologic examination, foot; two views
73630	Radiologic examination, foot; complete, minimum of three views
73650	Radiologic examination; calcaneus, minimum of two views
73660	Radiologic examination; toe(s), minimum of two views

Table 4–Covered IHCP Chiropractic Codes for Medicine Services

CPT Code	Description
95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
95832	Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side
97010	Application of a modality to one or more areas; hot or cold packs
97012	Application of a modality to one or more areas; traction, mechanical
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97016	Application of a modality to one or more areas; vasopneumatic devices
97018	Application of a modality to one or more areas; paraffin bath
97020	Application of a modality to one or more areas; microwave
97022	Application of a modality to one or more areas; whirlpool
97024	Application of a modality to one or more areas; diathermy
97026	Application of a modality to one or more areas; infrared
97028	Application of a modality to one or more areas; ultraviolet
97032	Application of modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of modality to one or more areas; iontophoresis, each 15 minutes

Table 4–Covered IHCP Chiropractic Codes for Medicine Services	
CPT Code	Description
97034	Application of modality to one or more areas; contrast baths, each 15 Minutes
97035	Application of modality to one or more areas; ultrasound, each 15 Minutes
97036	Application of modality to one or more areas; Hubbard tank, each 15 Minutes
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic Exercises to develop strength and endurance, range of motion and flexibility.
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97139	Therapeutic procedure, one or more areas, each 15 minutes; unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (e.g. mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

Tables five and six identify diagnosis codes appropriate for chiropractic services billed to the IHCP. Table five lists principal diagnosis codes and table six lists secondary diagnosis codes.

Table 5– Diagnosis Codes for Chiropractic Services, Principal ICD-9-CM Codes	
Principal ICD-9-CM Codes	
Diagnosis Codes	Description
646.93*	Unspecified complication of pregnancy, antepartum condition or complication
648.73*	Bone and joint disorders of the back, pelvis, and lower limbs, antepartum condition or complication
648.93*	Other current conditions classifiable elsewhere, antepartum condition or complication
739.0	Nonallopathic lesions, not elsewhere classified – Head region
739.1	Nonallopathic lesions, not elsewhere classified – Cervical region
739.2	Nonallopathic lesions, not elsewhere classified – Thoracic region
739.3	Nonallopathic lesions, not elsewhere classified – Lumbar region
739.4	Nonallopathic lesions, not elsewhere classified – Sacral region
739.5	Nonallopathic lesions, not elsewhere classified – Pelvic region
739.6	Nonallopathic lesions, not elsewhere classified – Lower extremities
739.7	Nonallopathic lesions, not elsewhere classified – Upper extremities
739.8	Nonallopathic lesions, not elsewhere classified – Rib cage

*Limited to medically necessary services rendered to Package B members effective July 1, 2003.

Table 6–Diagnosis Codes for Chiropractic Services, Secondary ICD-9-CM Codes	
Secondary ICD-9-CM Codes	
Diagnosis Codes	Description
307.81	Tension headache
333.83	Spasmodic torticollis
346.00	Classical migraine without mention of intractable migraine
346.01	Classical migraine with intractable migraine, so stated
346.10	Common migraine without mention of intractable migraine
346.11	Common migraine with intractable migraine, so stated
346.20	Variants of migraine without mention of intractable migraine
346.21	Variants of migraine with intractable migraine, so stated
346.80	Other forms of migraine without mention of intractable migraine
346.81	Other forms of migraine with intractable migraine, so stated
346.90	Migraine, unspecified, without mention of intractable migraine
346.91	Migraine, unspecified, with intractable migraine, so stated
353.0	Brachial plexus lesions

Table 6–Diagnosis Codes for Chiropractic Services, Secondary ICD-9-CM Codes	
Secondary ICD-9-CM Codes	
Diagnosis Codes	Description
353.1	Lumbosacral plexus lesions
353.2	Cervical root lesions, not elsewhere classified
353.3	Thoracic root lesions, not elsewhere classified
353.4	Lumbosacral root lesions, not elsewhere classified
353.8	Other nerve root and plexus disorders
353.9	Unspecified nerve root and plexus disorder
354.4	Causalgia of upper limb
354.8	Other mononeuritis of upper limb
354.9	Mononeuritis of upper limb, unspecified
719.40	Pain in joint, site unspecified
719.48	Pain in joint, other specified sites
719.49	Pain in joint, multiple sites
720.0	Ankylosing spondylitis
720.1	Spinal enthesopathy
721.0	Cervical spondylosis without myelopathy
721.2	Thoracic spondylosis without myelopathy
721.3	Lumbosacral spondylosis without myelopathy
721.6	Ankylosing vertebral hyperostosis
721.7	Traumatic spondylopathy
721.90	Spondylosis of unspecified site without mention of myelopathy
722.0	Displacement of cervical intervertebral disc without myelopathy
722.10	Lumbar intervertebral disc without myelopathy
722.11	Thoracic intervertebral disc without myelopathy
722.2	Displacement of intervertebral disc, site unspecified, without myelopathy
722.30	Schmorl's nodes, unspecified region
722.31	Schmorl's nodes, thoracic region
722.32	Schmorl's nodes, lumbar region
722.4	Degeneration of cervical intervertebral disc
722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
722.52	Degeneration of lumbar or lumbosacral intervertebral disc
722.6	Degeneration of intervertebral disc, site unspecified
722.80	Postlaminectomy syndrome, unspecified region
722.81	Postlaminectomy syndrome, cervical region
722.82	Postlaminectomy syndrome, thoracic region
722.83	Postlaminectomy syndrome, lumbar region
722.90	Other and unspecified disc disorder, unspecified region

Table 6—Diagnosis Codes for Chiropractic Services, Secondary ICD-9-CM Codes	
Secondary ICD-9-CM Codes	
Diagnosis Codes	Description
722.91	Other and unspecified disc disorder, cervical region
722.92	Other and unspecified disc disorder, thoracic region
722.93	Other and unspecified disc disorder, lumbar region
723.0	Spinal stenosis in cervical region
723.1	Cervicalgia
723.2	Cervicocranial syndrome
723.3	Cervicobrachial syndrome (diffuse)
723.4	Brachial neuritis or radiculitis NOS
723.5	Torticollis, unspecified
723.8	Other syndromes affecting cervical region
723.9	Unspecified musculoskeletal disorders and symptoms referable to neck
724.00	Spinal stenosis, unspecified region
724.01	Spinal stenosis, thoracic region
724.02	Spinal stenosis, lumbar region
724.09	Spinal stenosis, other
724.1	Pain in thoracic spine
724.2	Lumbago
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
724.5	Backache, unspecified
724.6	Disorders of sacrum
724.70	Unspecified disorder of coccyx
724.79	Disorders of coccyx, other
724.8	Other symptoms referable to back
724.9	Other unspecified back disorders
728.71	Plantar fascial fibromatosis
728.85	Spasm of muscle
729.1	Myalgia and myositis, unspecified
729.4	Fasciitis, unspecified
732.0	Juvenile osteochondrosis of spine
737.0	Adolescent postural kyphosis
737.10	Kyphosis (acquired) (postural)
737.12	Kyphosis, postlaminectomy
737.19	Kyphosis, other
737.20	Lordosis (acquired) (postural)
737.21	Lordosis postlaminectomy
737.22	Other postsurgical lordosis
737.29	Lordosis, other
737.30	Scoliosis [and kyphoscoliosis], idiopathic

Table 6–Diagnosis Codes for Chiropractic Services, Secondary ICD-9-CM Codes	
Secondary ICD-9-CM Codes	
Diagnosis Codes	Description
737.31	Resolving infantile idiopathic scoliosis
737.32	Progressive infantile idiopathic scoliosis
737.34	Thoracongenic scoliosis
737.39	Kyphoscoliosis and scoliosis – other
737.40	Curvature of spine, unspecified
737.41	Curvature of spine associated with other conditions, kyphosis
737.42	Curvature of spine associated with other conditions, lordosis
737.43	Curvature of spine associated with other conditions, scoliosis
737.8	Other curvatures of spine
737.9	Unspecified curvature of spine
738.4	Acquired spondylolisthesis
754.1	Certain congenital musculoskeletal deformities of sternocleidomastoid muscle
754.2	Certain congenital musculoskeletal deformities of spine
756.11	Spondylolysis, lumbrosacral region
756.12	Spondylolisthesis
784.0	Headache
839.00	Cervical vertebra, closed – cervical vertebra, unspecified
839.01	Cervical vertebra, closed – first cervical vertebra
839.02	Cervical vertebra, closed – second cervical vertebra
839.03	Cervical vertebra, closed – third cervical vertebra
839.04	Cervical vertebra, closed – fourth cervical vertebra
839.05	Cervical vertebra, closed – fifth cervical vertebra
839.06	Cervical vertebra, closed – sixth cervical vertebra
839.07	Cervical vertebra, closed – seventh cervical vertebra
839.08	Cervical vertebra n, closed – multiple cervical vertebra
839.20	Lumbar vertebra, closed
839.21	Thoracic vertebra, closed
846.0	Sprains and strains of sacroiliac region, lumbosacral (joint) (ligament)
846.1	Sprains and strains of sacroiliac region, sacroiliac ligament
846.2	Sprains and strains of sacroiliac region, sacrospinatus (ligament)
846.3	Sprains and strains of sacroiliac region, sacrotuberous (ligament)
846.8	Sprains and strains of sacroiliac region, other specified sites of sacroiliac region
846.9	Sprains and strains of sacroiliac region, unspecified site of sacroiliac region
847.0	Sprains and strains of other and unspecified parts of back, neck
847.1	Sprains and strains of other and unspecified parts of back, thoracic
847.2	Sprains and strains of other and unspecified parts of back, lumbar
847.3	Sprains and strains of other and unspecified parts of back, sacrum
847.4	Sprains and strains of other and unspecified parts of back, coccyx
847.9	Sprains and strains of other and unspecified parts of back, unspecified site of back
907.3	Late effect of injury to nerve root(s), spinal plexus(es), and other nerves of trunk

Table 6—Diagnosis Codes for Chiropractic Services, Secondary ICD-9-CM Codes	
Secondary ICD-9-CM Codes	
Diagnosis Codes	Description
953.0	Injury to nerve roots and spinal plexus, cervical root
953.1	Injury to nerve roots and spinal plexus, dorsal root
953.2	Injury to nerve roots and spinal plexus, lumbar root
953.3	Injury to nerve roots and spinal plexus, sacral root
953.4	Injury to nerve roots and spinal plexus, brachial plexus
953.5	Injury to nerve roots and spinal plexus, lumbrosacral plexus
956.0	Injury to peripheral nerve(s) of pelvic girdle and lower limb, sciatic nerve
956.1	Injury to peripheral nerve(s) of pelvic girdle and lower limb, femoral nerve
956.2	Injury to peripheral nerve(s) of pelvic girdle and lower limb, posterior tibial nerve
956.3	Injury to peripheral nerve(s) of pelvic girdle and lower limb, peroneal nerve
956.4	Injury to peripheral nerve(s) of pelvic girdle and lower limb, cutaneous sensory nerve, lower limb
956.5	Injury to peripheral nerve(s) of pelvic girdle and lower limb, other specified nerve(s) of pelvic girdle and lower limb
956.8	Injury to peripheral nerve(s) of pelvic girdle and lower limb, multiple nerves of pelvic girdle and lower limb
956.9	Injury to peripheral nerve(s) of pelvic girdle and lower limb, unspecified nerve of pelvic girdle and lower limb

RELATED MEDICAL TOPICS

Consultation – Second Opinions

Diagnostic Studies

Physical Rehabilitation Services

Medical Supplies and Equipment

Out-of-State Services

Package B

Obstetric Care

RULES, CITATIONS, AND SOURCES

IC 25-10-Chiropractors

405 IAC 5-12-Chiropractic Services

407 IAC 3-12-Chiropractic Services

846 IAC-Chiropractic Examiners

Indiana Health Coverage Programs Provider Bulletins

BT200323

BT200329

Indiana Health Coverage Programs Provider Newsletter

NL2004099

State Medicaid Plan - Chiropractors' Services

Origination Date: 12/31/2000

Revisions and Reviews	Reasons	Date
405 IAC 5-12-1	Chiropractic Services	08/24/1997
405 IAC 5-5	Out-of-State services	08/24/1997
405 IAC 5-12-2	Office Visits	08/24/1997 modified 05/01/2003
405 IAC 5-12-3	Chiropractic X-ray Services	08/24/1997 modified 05/01/2003
405 IAC 5-12- 4	Laboratory Services	08/24/1997 modified 05/01/2003
405 IAC 5-12-6 Repealed 5/1/2003	Electromyography Services	08/24/1997
405 IAC 5-12-7	Durable Medical Equipment	08/24/1997 modified 05/01/2003
Indiana Health Coverage Provider Bulletins BT200323 and BT200329	Changes in Chiropractic Services Chiropractic Service Limitations	07/01/2003
Indiana Health Coverage Provider Newsletter NL2004099	Addition of Pregnancy Diagnosis Codes for Package B Members	04/30/2005

APPLICABLE INDIANA A/M EDITS AND AUDITS

- 4070 - Select Radiological Procedures Billed by a Chiropractor (inactive)
- 4071 - Lab Services Billed by Chiropractor Require Review (inactive)
- 6098 - Chiropractic Services Limited to Procedure and Diagnosis Codes Identified
- 6100 - Max of 50 Chiropractic Therapeutic Physical Medicine Treatments
- 6101 - Chiropractic Restrictive Office Visits Codes (NP)
- 6102 - Chiropractic Office Visits Limited to 5 Per Year
- 6103 - Component Spinal X-Rays vs Full Spine X-ray
- 6104 - DME Rental from Chiropractor of More Than 1 Month
- 6105 - One Full Spine X-Ray Per Year for Chiropractor
- 6106 - Component Spinal X-Rays Greater Than \$95.00/Year
- 6107 - Full Spinal X-Ray Payable at Reduced Amount When Component Previously Paid
- 6108 - Global Payable at a Reduced Fee When Components Paid
- 6111 - Chiropractic Office Visits Limited to Five per Year
- 6112 - Maximum of 14 Chiropractic Therapeutic Physical Medicine Treatments Per Calendar Year
- 6122 - Chiropractic Therapeutic Physical Medicine Treatments 15 Through 50 Require Prior Authorization

MEDICAL POLICY FACT SHEET

TITLE: CLINIC SERVICES—FQHC AND RURAL HEALTH CLINIC SERVICES

DESCRIPTION

Federally Qualified Health Clinics (FQHC) and Rural Health Centers (RHC) are facilities for physical examination and treatment of ambulatory patients who are not hospitalized where preliminary diagnosis is made and treatment is provided. Often, a RHC may provide services to a medically underserved area.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

Reimbursement is available for IHCP members seeking medical care in rural health clinics and other qualified health clinics. The provider may be a physician, nurse practitioner, physician assistant, clinical psychologist, or clinical social worker. A valid encounter visit is described as a face-to-face encounter between a clinic patient and a provider, as noted above.

IHCP reimbursement is available for services and supplies incidental to such services, which would otherwise be covered if furnished by a physician or an incident to a physician's services. Services to a home bound individual are only available in the case of those FQHCs located in an area with a shortage of home health agencies as determined by Medicaid. Any other ambulatory service included in the IHCP state plan is considered a covered FQHC service if the FQHC offers such a service. FQHC services are defined the same as services provided by RHCs.

FQHCs receive funds through the Public Health Services and receive FQHC status from the Centers for Medicare and Medicaid Services (CMS). To enroll as an FQHC with the IHCP, the CMS letter granting the FQHC status must be forwarded to EDS Provider Enrollment with a completed application. RHCs receive their Medicare designation

through the CMS and must contact the Indiana State Department of Health (ISDH) to receive RHC status as an IHCP provider.

IHCP reimbursement is limited to one encounter per IHCP member, per provider, per day unless the diagnosis differs. Should a member visit an office twice on the same day with a different diagnosis, the second claim can be submitted. This policy does not allow a provider to bill multiple claims for one visit with multiple diagnoses by separating the diagnoses on different claims. Documentation includes, but is not limited to, the following.

- Visits performed at separate times of the day that indicate the times and reasons for each visit on the face of the claim or on a claim attachment
- Visits provided by different providers on the same day that indicate the type of provider that rendered each visit and denote which practitioner treated which diagnosis
- Documentation in the medical record supports the medical reason for an additional visit and includes presenting symptoms or reason for the visit, onset of symptoms and treatment rendered
- Documentation that the diagnosis for each encounter is different

IHCP reimbursement is also available for services and supplies incidental to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, filling and dispensing prescriptions, or providing optician services do not constitute encounters. These services can be included in the encounter reimbursement when performed in conjunction with the office visit to a valid provider. These services are not reimbursable through claim submission if performed without a face-to-face visit to a valid provider.

FQHCs and RHCs can provide preventive services and encounters, care coordination, and Health Watch services. Refer to the IHCP Provider Manual or the Health Watch Early and Periodic Screening, Diagnostic & Treatment Program supplemental provider manual for further information about those services.

The valid FQHC/RHC encounter code list is reviewed annually and is published on the Myers and Stauffer [the rate setting contractor for the Office of Medicaid Policy and Planning (OMPP)] Website at <http://www.mslcindy.com>.

PRIOR AUTHORIZATION

FQHCs and RHCs are subject to the same prior authorization (PA) requirements for IHCP services as Traditional Medicaid. The provider may contact the PA department for specific information regarding requirements and guidelines. Additionally, further information can be located in the IHCP Provider Manual, Chapter 6, Prior Authorization.

MANAGED CARE

An FQHC/RHC can participate with a managed care organization (MCO). The MCO provider contract must specify the contractual arrangements to ensure that the FQHC or RHC is reimbursed for services.

Claims for members in a Risk-Based Managed Care (RBMC) plan should continue to be billed in the manner applicable to the specific MCO. The T1015 encounter code should not be included on these claims. All MCO claims will be reconciled to the provider specific Prospective Payment System (PPS) rate on a quarterly basis by the rate setting contractor and settlements will be made at that time. These reconciliations will continue until such time that the MCOs adapt the systems to the PPS methodology.

Claims submitted for members currently in the *Medicaid Select* Managed Care will continue to include all Primary Medical Provider (PMP) information on the CMS-1500 claim form and the 837P electronic transaction. PMP information is required on the claim in the following fields: 17, PMP name; 17a, PMP's nine-digit IHCP provider number; and 19, the PMP's two-digit certification code.

BILLING REQUIREMENTS

All FQHC and RHC facilities are required to submit claims using the appropriate HCPCS code and HCPCS code T1015, *Clinic visit/encounter, all inclusive*. HCPCS code T1015 is reimbursed at a facility-specific PPS rate determined by the rate-setting contractor for the specific FQHC/RHC provider enrollment file.

For claims submitted with a Place of Service 50, *Federally Qualified Health Center*, 72, *Rural Health Clinic*; 11, *Office*; 12, *Home*; 31, *Skilled Nursing Facility*; or 32, *Nursing Facility*, providers must use both the T1015 encounter code and the appropriate CPT or HCPCS procedure code. If the claim contains both T1015 and one of the allowable procedure codes from a list of valid CPT/HCPCS codes approved by OMPP, the CPT or HCPCS code will correctly deny. The T1015 encounter code will be reimbursed according to the usual and customary charge as established in the provider's file.

If the CPT or HCPCS code billed is not on the list of allowable procedure codes from the encounter criteria for place of service 50, 72, 11, 12, 31, or 32 the claim will deny. Services provided at these place of service locations that are not valid encounters with the appropriate provider, such as injections performed by a nurse without a corresponding visit to satisfy the valid encounter definition, should instead be reflected in the facility's end of year cost report.

Claims submitted with a Place of Service 20-26, described in **Table 1** on the next page, will reimburse each line item detail at the current rate for that CPT/HCPCS code. It is not necessary to include the T1015 encounter code on claims with Place of Service 20-26. These services are not considered FQHC/RHC services by a valid provider.

**Table 1 – Place of Service Codes for Other Than
RHC/FQHC Setting**

Code	Description
20	Urgent Care Center
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility

Only one valid encounter per IHCP member, per provider, per day is allowed unless the diagnosis code differs. Valid encounters with differing diagnosis codes for a member that exceeds the allowed one encounter per day can be submitted to the IHCP for manual processing.

All Third Party (TPL), patient liability, and co-payments will continue to apply as appropriate. Previous TPL payments and spenddown will be applied to the total amount due. All Medicare crossover claims are excluded from the PPS logic as well as the crossover reimbursement methodology, and will continue to pay co-insurance and deductible amounts.

DENTAL CLAIMS

Dental claims for FQHC/RHC are to be billed on a dental claim form using Current Dental Terminology (CDT) codes. The T1015 encounter code should not be included on the dental claim form. Dental claims will be reconciled to the provider-specific PPS rate. Reconciliation of claims will occur until a national dental code is established to act as an all inclusive code on the dental claim form.

RELATED MEDICAL TOPICS

Evaluation and Management Services
Family Planning
Nursing Services

RULES, CITATIONS, AND SOURCES

405 IAC 5-16-5 Rural health clinics and federally qualified health clinics; reimbursement
405 IAC 5-16-6 Free-standing clinics and surgical centers; limitations
Indiana State Department of Public Welfare Medical Policy Manual 1991
Indiana Health Coverage Programs Provider Bulletins
BT200318, Change in Method of Filing Claims

BT200357, Update of FQHC/RCH Valid Encounters
BT200340, Hoosier Healthwise Mandatory MCO Transition
Indiana Health Coverage Programs Provider Manual
Version 5.1, March, 2005

Origination date: 12/31/2000

Revisions and Reviews	Reason	Date
Indiana State Department of Public Welfare Medical Policy Manual 1991	Rural Health Clinics	07/1/1991
470 IAC 5-8-11 Transferred	Rural Clinics, FQHC	07/1/1991
405 IAC 1-6-11 Repealed 8/24/97	Home Health Agency, Clinic, FQHC, and Laboratory Services	01/1/1992
405 IAC 5-16-5	RHC and FQHC; reimbursement	08/24/1997
405 IAC 5-16-6	Free-standing clinics and surgical centers; limitations	08/24/1997
Review	Scheduled	10/31/2006

APPLICABLE INDIANA AIM EDITS AND AUDITS:

- 4124 – FQHC and RHC Services Must be Billed According to the PPS reimbursement methodology
6096 – The CPT/HCPCS code billed is not a valid encounter

MEDICAL POLICY FACT SHEET

TITLE: CLINICAL TRIALS

DESCRIPTION

On September 19, 2000, Medicare established guidelines to cover the routine costs of approved clinical trials, as well as reasonable and necessary items and services used to diagnose and treat complications arising from beneficiaries' participation in clinical trials. In 2000, the Office of Medicaid Policy and Planning (OMPP) began following Medicare's guidelines to reimburse for routine costs and complications of clinical trials. In 2003 the IHCP 1) developed a definition of experimental and investigational services; 2) defined investigational and experimental procedures, and routine costs in the context of clinical trials; and 3) adopted IHCP policy for coverage of clinical trials based on Medicare policy.

SUMMARY OF CURRENT POLICY

The IHCP covers the routine costs of approved clinical trials as well as reasonable and necessary items and services used to prevent complications and to diagnose and treat complications arising from participation in all clinical trials. Routine costs include items and services that would otherwise be covered by the IHCP if they were not provided in a clinical trial. The investigational item(s) or service(s) of the clinical trial are experimental or investigational, are not considered routine costs involved in the trial and are not covered by the IHCP.

RELATED MEDICAL TOPICS

Experimental services
Investigational services
Investigational new drug
Investigational device exemption
Wegener's Granulomatosis
Crohn's Disease

RULES, CITATIONS, SOURCES

§1862 (a)(1)(E) of the Social Security Act

Coverage Issues Manual 30-1, Clinical Trials

IC 25-22.5-1-2.1

Anthem Blue Cross Blue Shield of Kentucky – Definition of

Experimental/Investigational Services

Washington State Administrative Code WAC 284-44-043 (2) – Disclosure Requirements
for Experimental or Investigational Services

Blue Cross of Oregon – Definition of Experimental or Investigational Services

21 CFR312 – Investigational New Drug Application

21 CFR812 – Investigational Device Exemption,

21 CFR 405.201 and 405.203 - Class I-III devices

HCFA Fact Sheet – Medicare Coverage Routine Costs of Beneficiaries in Clinical Trials

ORIGINATION, REVISION, AND REVIEWS

Origination Date: 10/31/04

Revisions and Reviews	Reason	Date
Medical Policy Administrative Report – Clinical Trials	Clinical Trials Policy – Approved by OMPP	10/29/04

APPLICABLE AIM EDITS AND AUDITS

None

EXPERIMENTAL AND INVESTIGATIONAL SERVICES

The terms “experimental” and “investigational” are used interchangeably, are described under the same definition, and have the same coverage guidelines. Medicare defines an experimental item or service as for “research use only” or for “investigational use only.” Section 1862(a)(1) of the Social Security Act states experimental services are denied for coverage as not reasonable and necessary because they are not proven safe and effective.

DEFINITION OF EXPERIMENTAL AND/ OR INVESTIGATIONAL SERVICES

Experimental or Investigational Services: Procedures, treatments, supplies, devices, equipment, drugs, biologicals, hospitalizations, or medical services (hereinafter called services) which are:

1. Not of proven benefit for the particular diagnosis or treatment of the member’s particular condition. (This would include services currently covered by the IHCP for specific diagnoses, but that are being tested for use outside the scope of coverage);
2. Not yet approved by the U.S. Food and Drug Administration for other than experimental, investigational, or clinical trials testing;
3. Provided or performed in special settings for research purposes or under a controlled environment or clinical protocol or subject of a Phase I, II, or III clinical trial;
4. Not generally recognized in peer-reviewed medical literature as having a definitive positive effect on health outcomes (i.e., the service’s medical benefits do not outweigh any harmful effects); or
5. Not recognized by a federal government agency or a national professional medical society as effective or appropriate for the particular diagnosis or treatment of the member’s particular condition.

CLINICAL TRIALS - DEFINED

A clinical trial is a research study in human volunteers to answer specific health questions. Clinical trials are performed to find new ways of using known treatments and to determine whether new drugs, devices, and procedures are both safe and effective for general use. Carefully conducted clinical trials are the fastest and safest way to determine what new treatments will be effective in improving the health of the public.

Clinical trials are conducted in four phases.

- **Phase I** – Researchers test a new drug, treatment, or device in a small group for the first time to evaluate safety, determine dosage range, and identify side effects.

- **Phase II** – Expands the study to a larger group of people to further evaluate safety and effectiveness.
- **Phase III** – A still larger group is studied to confirm effectiveness, monitor side effects, and compare to commonly used treatments.
- **Phase IV** – Studies performed after drug, treatment, or device is marketed. Study is continued to collect information about the effect of the drug, treatment, or device in various populations and to identify any side effects associated with long-term use.

All clinical trials must have peer-reviewed, written protocol with clear definitions and statements that describe the study objectives and trial criteria. The trial criteria should include specifications of study size, study duration, statistical requirements and endpoints, patient eligibility criteria, diagnostic protocol, and treatment protocol. Every clinical trial in the U.S. must be approved and monitored by a federally registered Institutional Review Board (IRB). The IRB is an independent committee of physicians, statisticians, community advocates, and others that ensures a clinical trial is ethical and that the rights of study participants are protected.

A clinical trial is sponsored or funded by an organization or individual that initiates, but does not actually conduct, the investigation. Sponsors can include physicians, medical institutions, foundations, pharmaceutical companies, and federal agencies. Some of the foremost federal agencies that sponsor clinical trials are the National Institute of Health (NIH), the Department of Defense (DOD), the Department of Veteran Affairs (VA), the U.S. Food and Drug Administration (FDA), and the Centers for Disease Control (CDC).

EXPERIMENTAL AND INVESTIGATIONAL PRODUCTS AND PROCEDURES RELATED TO CLINICAL TRIALS

Drugs and Devices

In order for a drug or device to be tested in a clinical trial, it must be approved by the FDA and/or an IRB. Most drugs must have an approved Investigational New Drug (IND) Application to qualify for clinical trials (see 21 CFR 312.2 for exemptions). Medical devices must have an approved Investigational Device Exemption (IDE) to qualify for clinical trials. If the device poses a significant risk, meaning that it presents a potential for serious risk to the health, safety, or welfare of a clinical trial subject, it must be approved by the FDA before studies can begin. If the device does not pose a significant risk, the study can be approved by an IRB. Table 1 defines IND, IDE, and related terms.

Procedures

Procedures are not regulated by the FDA or other guiding entities. In order for a procedure to be tested in a clinical trial, an organization must conclude that the procedure is appropriate for further evaluation in a clinical trial and agree to sponsor the research. The principal investigator must write protocol for the trial and submit it to an IRB for approval and monitoring during the trial.

Table 1 – Clinical Trial Terms

TERM	SOURCE	DEFINITION
Experimental drug	Clinicaltrials.gov	A drug that is not FDA licensed for use in humans, or as a treatment for a particular condition.
Investigational New Drug (IND)	21 CFR 312.3	IND means a new drug or biological drug that is used in a clinical investigation. The term also includes a biological product that is used in vitro for diagnostic purposes.
IND application	21 CFR 312.1	An investigational new drug for which an IND application is in effect in accordance with this part is exempt from the premarketing approval requirements that are otherwise applicable and may be shipped lawfully for the purpose of conducting clinical investigations of that drug.
IND exemption	21 CFR 312.2	Certain drugs can be lawfully marketed or studied in the U.S. without having to be approved by the FDA through an IND application. Some examples include drugs that are not intended to be reported to the FDA with a new indication for use, the drug is already marketed in the US and the investigation is not going to significantly change the advertising of the drug, etc. Refer to the CFR for further details.
Investigational Device	21 CFR 812.3 (g)	Investigational device means a device, including a transitional device, which is the object of an investigation.
Investigational Device Exemption	21 CFR 812.1	An approved investigational device exemption permits a device that otherwise would be required to comply with a performance standard or have premarket approval to be shipped lawfully for the purpose of conducting investigations of that device.
Experimental / Investigational (Category A) Devices	42 CFR 405.201	The FDA assigns devices with an FDA-approved IDE to one of two categories: A&B. Category A includes innovative devices believed to be in Class III for which “absolute risk” of the device type has not been established (that is initial questions of safety and effectiveness have not been resolved and the FDA is unsure whether the device type can be safe and effective)
Non-experimental / Investigational (Category B) Devices	42 CFR 405.201	The FDA assigns devices with an FDA-approved IDE to one of two categories: A&B. Category B includes devices believed to be in Class I or Class II, or a device believed to be in Class III for which the incremental risk is the primary risk in question (that is, underlying questions of safety and effectiveness of the device type have been resolved), or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained FDA approval for that device type.
Class I	42 CFR	Devices for which general controls of the Food, Drug, and

Table 1 – Clinical Trial Terms

TERM	SOURCE	DEFINITION
	405.201	Cosmetics Act, such as adherence to good manufacturing practice regulations, are sufficient to provide a reasonable assurance to safety and effectiveness.
Class II	42 CFR 405.201	Devices that, in addition to general controls, require special controls, such as performance standards or postmarket surveillance, to provide a reasonable assurance of safety and effectiveness.
Class III	42 CFR 405.201	Devices that cannot be classified into Class I or Class II because insufficient information exists to determine that either special or general controls would provide reasonable assurance of safety and effectiveness. Class III devices require premarket approval.

(NOTE: Categories assigned to devices by the FDA prior to clinical trials are subject to change during and after clinical trials. The Centers for Medicare and Medicaid Services (CMS) uses the categorization of the device as a factor in making Medicare coverage decisions.)

CLINICAL TRIAL COVERAGE

Routine Costs - Defined

This section provides definitions and examples of routine costs and investigational costs. General case examples of routine costs in national clinical trials are presented. Two specific case examples of clinical trials in which IHCP participation was requested are also outlined to illustrate proposed IHCP coverage of routine costs.

The IHCP will pay most of a member's costs in a clinical trial once the clinical trial is considered an approved clinical trial. Specifically, the IHCP will cover the routine costs involved in the clinical trial that are provided in either the experimental or the control arms of a clinical trial. The routine items must not be items that are otherwise excluded from coverage by the program. There are five types of covered routine costs associated with a clinical trial.

1. Items and services that would otherwise be covered by the program if they were not provided in the context of a clinical trial. For example:
 - Nursing/staffing fees
 - Patient monitoring and evaluation
 - DME equipment
 - IVs/catheters/line placement
2. Items or services required for the administration and provision of the investigational item or service, up to but not including the actual cost of the investigational item or service. For example:
 - Administration fee for investigational chemotherapeutic agent

- Equipment and ancillary staffing for the implantation of investigational device
 - Provision of a nebulizer to administer an investigational drug
 - Room and board as part of a hospital stay required as part of the clinical trial
3. Items or services required for the clinically appropriate monitoring of the effects of the investigational item or service. For example:
 - ECGs, EEGs,
 - Monitoring blood pressures
 4. Items and services required for the prevention of complications. For example:
 - Costs of anti-nausea drug for investigational chemotherapeutic agent
 5. Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service – in particular, for the diagnosis or treatment of complications. For example:
 - Treatment of pneumonia caused by an investigational lung procedure

The IHCP also adopted a Medicare policy on coverage of routine costs for items and services that are the subject of a clinical trial, but are already covered items or services under policy. The IHCP will extend coverage to routine care provided in clinical trials, but not withdraw IHCP coverage for items and services that are currently covered outside the context of a clinical trial as a result of, national coverage policies, statutes, rules, etc. The policy also does not expand coverage beyond what would ordinarily be covered outside a clinical trial. Therefore, if a clinical trial is investigating an item or service that is covered outside the context of a clinical trial, the IHCP would continue to cover the investigational item or service in accordance with existing coverage rules and regulations. The IHCP policy on clinical trials will not render these investigational items or services noncovered.

Investigational Costs

Items that are not considered routine costs and are not covered by the IHCP include the following.

1. The investigational item(s) or service(s).
2. Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient. For example:
 - Monthly CT scans for a condition usually requiring only a single scan.
 - Weekly blood draws not needed to monitor side effects.
 - Quarterly PAP smears for a condition requiring yearly PAP smears.
3. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial. For example:
 - Peak flow meters will not be reimbursed in a respiratory trial if the sponsor provides them free of charge to the enrollees.

Clinical Trials Case Examples

On the following pages are several case examples of clinical trials. Cases 1 and 2 illustrate clinical trial policy applied to current national clinical trials. Case 3 applies the policy to an actual clinical trial that the IHCP reimbursed in 2003 for a member with Crohn's disease. Case 4 illustrates application of the policy to a request for clinical trial coverage received from Northwestern Hospital on behalf of a member with Wegener's Granulomatosis. This trial has not been reimbursed by the IHCP because the trial is not funded and the member has not been able to raise the funds necessary to cover the investigational costs.

Case 1

Title	Diagnostic Study of CT Scans in Women at High Risk for Lung Cancer
Description	To determine the ability of CT to detect early lung abnormalities in women at high risk for lung cancer, and determine the number of abnormal findings detected by CT that develop into lung cancer in these patients.
Outline of the Clinical Trial	<ol style="list-style-type: none"> 1. Questionnaire including medical history and demographics. 2. CT scans without contrast for all patients. <ol style="list-style-type: none"> a. Patients with normal results receive additional CT every 12 months. b. Patients with abnormal results receive diagnostic CT scan with contrast. 3. Patients with indeterminate nodules have repeat scans at 6 months and 1 year. 4. Patients with abnormalities suspicious for malignancy undergo bronchoscopy with biopsy and bronchoalveolar lavage (BAL). <ol style="list-style-type: none"> a. If no confirmed malignancy, repeat CT scans at 6 months and 1 year. b. If confirmed malignancy, refer for definitive treatment.
Coverage	<ol style="list-style-type: none"> 1. Non-routine, non-covered items include the questionnaire, the initial CT scans, and any additional CT scans not necessary for the direct clinical management of the patient. These are noncovered costs because they are items and services provided to satisfy data collection and analysis. 2. If policy allows for a repeat CT scan of an indeterminate finding at 6 months, or a bronchoscopy with biopsy for a suspicious abnormality, these procedures would be considered routine costs and would be reimbursable. 3. Complications such as reactions to anesthesia during bronchoscopy, reactions to contrast dye, or development of infection after bronchoscopy would be considered routine reimbursable costs.

Case 2

Title	Combination Chemotherapy in Treating Patients With Advanced Cancer
Description	To determine the effects of the combination of Flavopiridol, Fluorouracil, and Leucovorin Calcium with and without Irinotecan on the destruction of tumor cells in patients who have advanced cancer with no known therapies.
Outline of the Clinical Trial	<ol style="list-style-type: none"> 1. Two patient groups reside in the hospital for 5 days every 3 weeks while receiving chemotherapy. 2. One group receives the combination chemotherapy only. 3. The second group of patients receives the combination chemotherapy plus

	<p>Irinotecan.</p> <p>4. Tumors will be monitored by CT, MRI, or other appropriate clinical determinants.</p>
Coverage	<ol style="list-style-type: none"> 1. Noncovered services would include the actual chemotherapeutic drugs being administered because the trial protocol indicated there are no known standard therapies for these tumors. The CTs, MRIs, etc. would also be noncovered for the same reasons. 2. Routine care services that would otherwise be reimbursed by the IHCP if not included in the context of a clinical trial encompasses nursing services, room and board, and supplies that would be used to administer the chemotherapy, (e.g., intravenous pumps and tubing). 3. Services required for the administration of investigational items or services would also be covered such as administration of the chemotherapeutic agents. 4. Other routine costs include prevention of complications such as treatment of nausea and treatment of complications such as an electrolyte imbalance, or an acute toxicity reaction.

Case 3

Title	Immune Ablation with Chemotherapy followed by Stem Cell Transplant for Patients with Severe Crohn's Disease
Description	To determine the safety and efficacy of immune ablation with high-dose cyclophosphamide and anti-thymocyte globulin followed by autologous peripheral blood stem cell rescue in patients with severe Crohn's disease.
Outline of the Clinical Trial	<ol style="list-style-type: none"> 1. Mobilization of peripheral stem cells with cyclophosphamide IV on the first day and filgrastim beginning on the third day until adequate blood counts are reached. 2. Undergo leukapheresis for approximately 10 days until target number of cells are reached. 3. A central line is placed, and an immune-ablation conditioning period is initiated on a 5 day countdown with cyclophosphamide IV days 5-2 and anti-thymocyte globulin IV on days 4-2. 4. Undergo autologous T lymphocyte-depleted peripheral stem cell transplant after completing routine labs and tests on day 1. 5. Receive filgrastim on day 0. 6. Follow-up visits with serial small intestine absorption assessments at 3, 6, and 12 months, then annually thereafter.
Coverage	<ol style="list-style-type: none"> 1. Noncovered services include all chemotherapeutic agents because chemotherapeutic agents are not peer-approved, nationally approved, or FDA approved drugs for the treatment of Crohn's disease. The chemotherapeutic agents include cyclophosphamide, anti-thymocyte, and filgrastim. The leukapheresis would be noncovered even though it is a covered code by the IHCP because leukapheresis is not a procedure normally performed on patients with Crohn's disease, but it is a procedure that is part of the investigational component of this trial. The stem cell

Case 3

Title	Immune Ablation with Chemotherapy followed by Stem Cell Transplant for Patients with Severe Crohn's Disease
	<p>transplant is also noncovered as an investigational procedure because a peripheral stem cell transplant for Crohn's disease is outside the scope of coverage for stem cell transplant. Serial small intestine absorption assessments would not be covered because these are services to satisfy data collection.</p> <ol style="list-style-type: none"> 2. Routine costs include placement of the central line, administration fees for all drugs, including the investigational chemotherapeutic agents, and Methylprednisone, room and board for any necessary hospital stay during the conditioning phase and the transplant, and the costs of the labs and tests (that have not been performed in the last 90 days) that are required for the transplant. 3. Methylprednisone is covered because this is an approved treatment for Crohn's disease. The costs of services to prevent side effects, such as the cost of the MESNA would be covered because MESNA is a drug used to prevent side effects of Cytosan. 4. The costs of the labs and tests prior to the transplant are covered if they have not already been performed within the last 90 days because IHCP policy states that the policy is to extend coverage to routine care provided in clinical trials, but not to withdraw coverage for items and services that are currently covered outside the context of a clinical trial. The IHCP current policy for stem cell transplant requires that these tests must have been done within the last 90 days. 5. Routine costs will also include any physician or nursing fees, monitoring fees, or equipment fees that may arise during the clinical trial that would normally be considered a covered service if not performed in the context of a clinical trial. If any additional medications are needed to prevent side effects or if complications occurred, these would also be covered services.

Case 4

Title	Hematopoietic Stem Cell Therapy for Patients with Systemic Necrotizing Vasculitis (Wegener's Granulomatosis)
Description	To determine the safety and efficacy of immune ablation with high-dose cyclophosphamide and anti-thymocyte globulin followed by autologous peripheral blood stem cell rescue in patients with Wegener's Granulomatosis.
Outline of the Clinical Trial	<ol style="list-style-type: none"> 1. Mobilization of peripheral stem cells with Cytosan 2gm/m² (cyclophosphamide) and filgrastim 10 mcg/kg until adequate blood counts are reached. 2. Undergo leukapheresis for approximately 4 days until target number of cells

Case 4

Title	Hematopoietic Stem Cell Therapy for Patients with Systemic Necrotizing Vasculitis (Wegener's Granulomatosis)
	<p>are reached.</p> <ol style="list-style-type: none"> 3. Rest for approximately 3-4 weeks. 4. A central line is placed, and an ablation conditioning period is completed with combinations of high-dose Cytoxan 50mg/kg, Rabbit ATG 0.5mg/kg, Methylprednisone 1gm, and MESNA 50mg/kg per day for 6 days. 5. Undergo stem cell transplant after checking routine labs and tests. 6. Receive filgrastim 5mcg/kg the day after transplant. 7. Inpatient transplant recovery as needed.
Coverage	<ol style="list-style-type: none"> 1. The trial is sponsored by Northwestern Hospital which would not make it an automatically qualified clinical trial; however, the trial has an approved investigational new drug application by the FDA which does qualify it as an approved clinical trial. Therefore, routine costs would be covered. 2. Noncovered services include all chemotherapeutic agents except the Cytoxan used in the mobilization phase of therapy. The Cytoxan used in the mobilization phase of therapy is dosed at 2gm/m². Cytoxan is a prescribed treatment for Wegener's Granulomatosis at this dose. The remainder of the chemotherapeutic agents are not peer-approved, nationally approved, or FDA approved drugs for the treatment of Wegener's. The chemotherapeutic agents include Cytoxan 50mg/kg, filgrastim, and Rabbit ATG. The leukapheresis would be noncovered even though it is a covered code by the IHCP because leukapheresis is not a procedure normally performed on patients with Wegener's Granulomatosis, but it is a procedure that is part of the investigational component of this trial. The stem cell transplant is also noncovered as an investigational procedure because a transplant for Wegener's is outside the scope of coverage for stem cell transplant. 3. Routine costs include placement of the central line, administration fees for all drugs, including the investigational chemotherapeutic agents, coverage of the MESNA and Methylprednisone, room and board for any necessary hospital stay during the conditioning phase and the transplant, and the costs of the labs and tests (that have not been performed in the last 90 days) that are required for the transplant. 4. The cost of the MESNA is covered because MESNA is a drug used to prevent side effects of Cytoxan. Methylprednisone is covered because this is an approved treatment for Wegener's. 5. The costs of the labs and tests prior to the transplant are covered if they have not already been performed within the last 90 days because IHCP policy states that the policy is to extend coverage to routine care provided in clinical trials, but not to withdraw coverage for items and services that are currently covered outside the context of a clinical trial. The IHCP current policy for stem cell transplant requires that these tests must have been done within the last 90 days. 6. Routine costs will also include any physician or nursing fees, monitoring fees, or equipment fees that may arise during the clinical trial that would

Case 4

Title	Hematopoietic Stem Cell Therapy for Patients with Systemic Necrotizing Vasculitis (Wegener's Granulomatosis)
	normally be considered a covered service if not performed in the context of a clinical trial. If any additional medications are needed to prevent side effects or if complications occurred, these would also be covered services.

IHCP CLINICAL TRIALS POLICY

The IHCP covers the routine costs of approved clinical trials as well as reasonable and necessary items and services used to prevent complications and to diagnose and treat complications arising from participation in all clinical trials.

Routine costs of a clinical trial include all items and services that are available to IHCP members (i.e., there exists a benefit category and the item or service is not listed as a noncovered service in the Indiana Administrative Code) that are provided in either the experimental or the control arms of the trial.

Routine costs in clinical trials include the following.

- Items and services that would otherwise be covered by the program if they were not provided in the context of a clinical trial.
- Items or services required for the administration and provision of the investigational item or service, up to but not including the actual cost of the investigational item or service (e.g., administration for a noncovered chemotherapeutic agent).
- Items required for the clinically appropriate monitoring of the effects of the investigational item or service.
- Items and services required for the prevention of complications.
- Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service; in particular, for the diagnosis or treatment of complications.
- Items or services already covered by the IHCP will be considered a routine cost in accordance with existing coverage rules and regulations even if the item or service is the investigational item or service. The IHCP policy on clinical trials will not render these investigational items or services noncovered. However, if the investigational item or service is currently covered only for certain medical conditions and is being tested for use outside the scope of coverage, the item or service will still be considered investigational.

Items that are not considered routine costs in a clinical trial and are not covered by the IHCP include the following.

- The investigational item(s) or service(s).
- Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single CT scan).
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

All investigators requesting IHCP coverage of routine costs for a clinical trial must first meet the following three requirements.

1. The subject or purpose of the trial must be the evaluation of an item or service that would be covered under Indiana Administrative Code (IAC) guidelines. The items or service being investigated must not be a non-covered item or service as listed under 405 IAC 5-10-5, 5-19-18, 5-24-3, 5-29-1, or 5-30-3.
2. If a clinical trial has one objective, it must have a therapeutic intent. If a clinical trial has multiple objectives, it must have a therapeutic intent as a primary objective. It must have some ability to improve a subject's condition such as prolongation of life, shrinkage of a tumor, or improved quality of life even though cure or dramatic improvement may not necessarily be affected. The trial cannot be designed exclusively to test toxicity or disease pathology.
3. Trials of therapeutic intervention only must enroll members with diagnosed disease rather than healthy members. Trials including diagnostic interventions may enroll healthy members in order to have a proper control group.

The three requirements above are insufficient by themselves to qualify a clinical trial for IHCP coverage of routine costs. In order for the IHCP to cover the routine costs involved in clinical trials, the clinical trial must be deemed "automatically qualified" under Medicare guidelines. The following clinical trials are deemed to be automatically qualified as approved clinical trials.

- Trials funded by the NIH, CDC, AHRQ, CMS, DOD, or VA.
- Trials supported by centers or cooperative groups that are funded by the NIH, CDC, AHRQ, CMS, DOD, or VA including but not limited to the FDA, NHLBI, National Human Genome Research Institute, NCI, NIDDK, NIMH, and others.

- Trials conducted under an Investigational New Drug (IND) application reviewed by the FDA.
- Drug trials that are exempt from having an IND under 21 CFR 312.2 (b)(1) will be deemed automatically qualified.

MEDICAL POLICY FACT SHEET

**TITLE: COLLAGEN IMPLANTS FOR STRESS URINARY
INCONTINENCE**

DESCRIPTION

Stress urinary incontinence (SUI) can be caused by incompetence of the urethral sphincter mechanism at the bladder neck. This type of SUI may be caused by scarring from previous surgery (e.g. prostatectomy), urethral hypermobility, myelomeningocele, epispadias, trauma, radiation, or sacral cord lesions or by any process that limits the ability of the proximal sphincter to form an effective watertight seal.

Collagen implants, such as Contigen are used to control urinary incontinence due to SUI caused by intrinsic sphincter deficiency. The collagen implant is injected endoscopically into the submucosal tissue of the urethra and/or bladder neck, increasing tissue and urethral resistance. Collagen injections thicken the urethra sphincter mechanism at the bladder neck, allowing the proximal urethra to form a watertight seal during bladder filling and to maintain this seal during physical stress.

Collagen is a natural fibrous protein found in human bone, cartilage, and connective tissue. The collagen used for treatment of SUI is sterile, biocompatible, biodegradable, purified bovine dermal collagen. Allergic reactions to collagen are infrequent but can occur, so patients must be evaluated preoperatively to limit the possibility of adverse reactions to collagen. Urologists who perform this treatment must complete training programs specifically related to this treatment.

RELATED MEDICAL TOPICS

Anesthesia Services
Consultations – Second Opinion
Diagnostic Studies
Surgery – Global Billing/Payment Guidelines
Surgery – Services Requiring Prior Authorization
Surgery – Surgical Services

RULES, CITATIONS, AND SOURCES

Indiana Medicaid Update Bulletin 95-21
Indiana Health Coverage Programs Provider Manual

ORIGINATION, REVIEWS, AND REVISIONS

Origination date: 7/11/94

Review and Revisions	Reason	Date
Review and Revision	Routine	10/29/04

APPLICABLE INDIANA A/M EDITS AND AUDITS

6061
6706

COVERAGE CRITERIA

Indications for the implants are as follows.

- ◆ Indicated for the treatment of urinary incontinence due to Intrinsic Sphincter Deficiency (ISD) – Diagnosis: Code 599.82
- ◆ Should be considered after a patient with ISD has demonstrated consistent symptoms and signs of urinary incontinence for at least twelve months.
- ◆ Since the collagen is potentially immunogenic, the patient must be evaluated by a skin test prior to treatment.
- ◆ Providers should be skilled in the endoscopic procedures necessary to carry out the injection and have credentials to perform these procedures in the respective institution. Additionally, FDA requirements mandate that the performing physician must have completed a Contigen Implant Training Program.
- ◆ Repeat injections of the collagen should be performed no less than seven days after the initial treatment. Patients who have failed to demonstrate improvement after five injection sessions are considered treatment failures; further attempts to use collagen should not be undertaken.

Restrictions and limitations to the use of collagen implants are as follows.

- ◆ Limit 12 injections per member for same date of service

- ◆ Five units (sessions) per member per lifetime
- ◆ Diagnosis code 599.82 Intrinsic Sphincter Deficiency (ISD) must be included on the claim
- ◆ Prior authorization is not required
- ◆ Contraindications for collagen therapy include:
 - a. Untreated urinary tract infections
 - b. Unmanaged detrusor muscle instability
 - c. Known hypersensitivity to bovine collagen
- ◆ Place of service: Inpatient/Outpatient/Physician Office

BILLING INFORMATION

Medicaid reimbursement is available for collagen implants used to control urinary incontinence due to intrinsic sphincter deficiency, demonstrated by consistent symptoms and signs of urinary incontinence for at least twelve months. Appropriate HCPCS codes for billing are listed in **Table 1 – HCPCS CODES**. Prior authorization is not required. Diagnosis code 599.82, *Intrinsic Sphincter Deficiency*, must be included with the HCPCS code in the request for reimbursement.

Table 1 – HCPCS CODES

HCPCS CODE	DEFINITION	LIMITATIONS/ RESTRICTIONS
L8603	Collagen implant, urinary tract, per 2.5cc syringe, includes shipping and necessary supplies	Limit 12 injections per recipient for each date of service
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	Five units (sessions) per lifetime.
Q3031	Collagen skin test	To be administered and evaluated over a four week period.
95028	Intracutaneous (intra dermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests	

MEDICAL POLICY FACT SHEET

TITLE: CONSULTATIONS—SECOND OPINIONS

DESCRIPTION

A consultation is the rendering of a medical opinion by a physician regarding evaluation or management of a specific condition requested by another physician. It requires the consulting physician to examine the patient, unless the applicable standard of care does not require a physical examination.

Second or third opinions (confirmatory consultation) may be requested for members having a procedure for which a choice of treatment modalities may be applicable, such as surgical procedures.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

The following four subcategories of consultations are covered by the IHCP.

- Office or other outpatient consultation
- Confirmatory consultation
- Initial inpatient consultation
- Follow-up inpatient consultation

Reimbursement for an initial consultation is limited to one per consultant, per member, per inpatient hospital or nursing facility admission. The IHCP will not reimburse consultation codes when a member is referred for management of a condition or the consulting physician assumes management of the member’s care.

The medical record must contain written documentation of the request for consultation by the requesting physician, if a consultation code is billed. This documentation should be maintained in the member’s medical record by both the physician requesting a consultation and the physician providing the consultation.

Reimbursement is available for consultative pathology and radiology services. These consultations do not require the consulting physician to examine the member.

Office Consultation (CPT codes 99241 – 99245)

A consulting physician may initiate diagnostic or therapeutic services. An office or other outpatient consultation must address a specific condition not previously diagnosed or managed by the consulting physician. If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used by the consulting physician again. If the consulting physician initiates a follow-up visit, the follow-up visit is reported using the appropriate office or other outpatient code for established patients (CPT codes 99211-99215).

Confirmatory Consultation

A confirmatory consultation must be specifically requested by the member or the IHCP contractor and is used for second and third opinions or advice only. A confirmatory consultation to substantiate medical necessity may be required as part of the prior authorization (PA) process.

Initial Inpatient Consultation (CPT codes 99251 – 99255)

Only one initial consultation may be reported by a consultant per admission. The request for consultation must be documented. These codes are used to report consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting. These codes should be utilized by the consulting physician for the initial encounter with the patient and then subsequent hospital care codes for additional encounters thereafter.

Follow-up Inpatient Consultation

A follow-up consultation is a subsequent visit needed to complete the initial consultation or subsequent consultative visits requested by the attending physician. These consultative visits include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status. If the consulting physician has initiated treatment at the initial consultation, and participates thereafter in the patient's management, the codes for subsequent hospital care should be used (CPT codes 99231 – 99233).

Pathology Services

Consultative pathology services are reimbursable if they are requested by the member's attending physician in writing and meet the following criteria.

- The consult relates to a test result that lies outside the clinically significant normal or expected range in view of the condition of the member
- The consultant provides a written narrative report to be included in the member's medical record
- Medical judgment is required by the consulting physician.

Dental Services

The American Dental Association (ADA) has indicated that a consultation is to be used as a second opinion. When billing for a dental consultation, providers are to report CDT code D9310, *Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)*, or one of the oral evaluation codes, not both on the same date of service, for the same member, by the consulting dentist. Please refer to the MP Manual fact sheet on Dental Services for further information.

Podiatry Services

A second or third opinion substantiating the medical necessity or approach may be required for bunionectomy procedures and all surgical procedures involving the foot. A confirmatory consultation is required regardless of the setting in which the surgery is performed, including ambulatory surgical centers, hospitals, clinics, or in the office. Please refer to the MP Manual fact sheet on Podiatry for further information.

Consultation services rendered by a podiatrist in a nursing facility are not covered when performed on members on a routine basis for screening purposes, except in those cases where a specific foot ailment is involved. Documentation must be maintained in the member's medical record. Please refer to the MP Manual fact sheet on Podiatry Services for further information.

PRIOR AUTHORIZATION

The CPT codes for evaluation and management (E&M) services that are used to report second opinion and consultative services and that also require prior authorization after 50 visits per member per provider per rolling calendar year are listed in **Table 1 – Services Requiring PA After 50 Visits per Member per Rolling Calendar Year**. The Billing Requirements section of this fact sheet provides information regarding appropriate use of the codes listed in **Table 1** for reporting second opinion and consultation services provided to IHCP members.

**Table 1 - Services Requiring PA
After 50 Visits per Member per Rolling Calendar Year***

CPT Code Ranges for E&M Services	Description
99201-99205	Office or other outpatient visit for the evaluation and management of a new patient
99211-99215	Office or other outpatient visit for the evaluation and management of an established patient
99241-99245	Office or other outpatient consultation for a new or established patient
99271-99275	Confirmatory consultation for a new or established patient

*This table contains the E&M codes used for second opinion and consultative services and is not meant to be inclusive of all E&M codes.

MANAGED CARE

The Hoosier Healthwise PrimeStep member's primary medical provider (PMP) must make a referral for a second opinion if requested by the member. Hoosier Healthwise members may choose a qualified Hoosier Healthwise provider from whom they desire to seek a second opinion. The PMP certification code is required for the consultative physician services to be reimbursed. Any subsequent treatment by the second opinion provider, if necessary, requires a separate referral.

Hoosier Healthwise members enrolled in Risk-Based Managed Care (RBMC) are allowed to receive a second medical opinion and consultative services. Hoosier Healthwise members that are enrolled in RBMC are the financial responsibility of the managed care organization (MCO) in which the member is enrolled. The MCO may have its own requirements for authorization of second opinion and consultative services; therefore, providers must contact the MCO for further information regarding the referral process.

BILLING INFORMATION

Using the appropriate modifier, consultations and second opinions may be reimbursed according to Medicaid guidelines. Documentation may be requested to determine medical necessity for the claim to be paid. In the claim note information on the electronic 837 claim, the provider can indicate the medical reason for a second opinion during the 15 days before or after the billed consultation.

Consultation codes should not be used for the evaluation of a self-referred or non-physician referred patient. A consultation implies collaboration between a requesting and a consulting physician. Follow-up visits in the consultant's office or other outpatient facility initiated by the consulting physician are reported using office visit codes for established patients, 99211-99215. If an additional request for an opinion or advice about a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used again.

A physician providing a confirmatory consultation (CPT codes 99271–99275) is expected to provide an opinion and/or advice only. Any services provided subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care.

The IHCP provides reimbursement to providers billing CPT codes 99251-99255 for initial inpatient consultations with new or established patients in the inpatient hospital setting. The IHCP recognizes CPT codes 99261-99263 for follow-up inpatient consultations.

RELATED MEDICAL TOPICS

Dental Services
 Diagnostic Studies
 Evaluation and Management Services
 Physician Services
 Podiatry Services
 Surgery – Surgical Services

RULES, CITATIONS, AND SOURCES

405 IAC 5-8 - Consultations and Second Opinions
 405-IAC 5-9-1 - Evaluation and Management Services, Limitations
 405 IAC 5-18-4 - Nonanatomical laboratory procedures
 405 IAC 5-26-2 (4) – Podiatric Services, General restrictions
 405 IAC 5-26-10 – Surgical Procedures; Confirmatory Consultations
 Hoosier Healthwise Manual for Primary Medical Providers and Office Staff, January, 2003
 Indiana Health Coverage Programs Provider Manual
 1999
 Version 5.1, March 2005
 Indiana Health Coverage Programs Provider Bulletins
 BT200262 - PrimeStep PMP Certification Code Changes
 BT200511 – HIPAA Modifications

Origination Date: 12/31/2000

Revisions and Review	Reason	Date
470 IAC 5-9-8; 5-9-9 Transferred	Consultations; Second Opinions	7/1/91
405 IAC 1-7-8; 1-7-9 Repealed 8/24/97	Consultation And Second Opinions	1/1/92
405 IAC 5-8	Consultations and Second Opinions	8/24/97
Review	Scheduled	7/29/05

APPLICABLE INDIANA A/M EDITS AND AUDITS:

- 6006 – Only 1 New Patient Visit Per Three (3) Years
- 6011 – Therapeutic or Diagnostic Injections
- 6012 – Medical Services 30 per year
- 6014 – Global Payable at a Reduced Fee When Component Paid
- 6019 – Initial/Established Visits Not Payable Same Day of Service
- 6028 – Initial and Periodic Visits Not Payable Same Day of Service
- 6041 – E&M Codes Not Reimbursable With Prenatal Codes
- 6042 – Prenatal Codes Not Reimbursable with E&M Codes
- 6064 – Components Not Payable When Global Paid Medical System
- 6069 – Office Visits 50 per Year
- 6090 – Office Visits Limited to One per Year – Podiatrist
- 6091 – One Initial Office Visit per Recipient - Podiatrists
- 6096 – The CPT/HCPCS Code Billed is Not Payable According to the PPS Reimbursement Methodology
- 6098 – Chiropractic Services Limited to Procedure and Diagnosis
- 6099 – Reimbursement is Limited to 50 Chiropractic Services
- 6101 – Chiropractic Restrictive Office Visit Codes (NP)
- 6102 – Chiropractic Office Visits Limited to 5 per year
- 6111 – Chiropractic Office Visits Limited to Five per Year
- 6122 – Chiropractic Therapeutic Physical Medicine Treatment
- 6150 – Consultation Billed 15 Days Before or After Another
- 6151 – Consultation Billed 7 Days Before or After Surgery
- 6152 – Surgery Payable at Reduced Amount When Consult Paid
- 6236 – Dental Services Limited \$600 for 21 and Over
- 6238 – Dental Services Limited \$600 for 21 and Over
- 6610 – Routine Vision Exam Limit to 1/12 Months Age 1-18 years
- 6611 – Routine Vision Exam Limited to 1/24 Months Ages 19-999 years
- 6637 – Drug Administration is Not Payable on the Same Day of Service
- 6649 – Surgery Payable at Reduced Amount When Related POS
- 6652 – Multiple Surgeries Must Be Billed on the Same Claim
- 6653 – Post Op Care Within 00-90 Days of Surgery
- 6654 – Pre-Operative Care Within 1 day of Surgery
- 6655 – Surgery Payable at Reduced Amount When Pre-op Care
- 6656 – Post-Op Care Within 10 Days of Select Surgery
- 6657 – Pre-Op Care on Day of Surgery
- 6658 – Surgery Payable at Reduced Amount When Pre-Op Care
- 6659 – Surgery Payable at Reduced Amount When Related POS
- 6660 – Pre/Post-Operative Care Billed with Unlisted Surgery
- 6903 – PCCM Limits Office Visits Greater Than 30 Visits

MEDICAL POLICY FACT SHEET

TITLE: DENTAL SERVICES

DESCRIPTION:

Dental services include diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession. These include treatment of the teeth and associated structures of the oral cavity, disease, injury, or impairment that may affect the oral or general health of the member. Other services include those offered by dental specialists, such as endodontists, orthodontists and periodontists.

COVERAGE CRITERIA**Procedure Code Multiple Units**

The Indiana Health Care Programs (IHCP) accepts multiple units per service line for applicable dental procedure codes. The dental provider will be able to submit multiple units on one claim service line. For example, D1110, *Prophylaxis, adult*, is not appropriate for submitting multiple service units; however, D4341, *Periodontal scaling and root planning, four or more contiguous teeth or bounded teeth spaces, per quadrant*, can be submitted with up to four units on one service line with the number of quadrants treated on the date of service.

The multiple units must be rendered on the same date of service and a single service line cannot span more than one date. All procedure code limitations remain in place and services that exceed these limitations are reduced to the unit limitation allowed for the procedure code. This change is effective for dates of service November 14, 2003, and after.

Dental Extractions

Effective for dates of service on or after January 1, 2004, the following billing requirements and reimbursement policies apply to tooth extractions. Only one tooth number is allowed per service line for dental extractions.

A provider submitting a claim for D7140, *Extraction, erupted tooth or exposed root (elevation and/or forceps removal)*, must indicate the tooth number for each tooth extracted on a separate service line in Field 59 on the American Dental Association (ADA) 2000 Dental Claim form. The IHCP will pay 100 percent of the maximum allowed amount or the billed amount, whichever is less, for the initial extraction. For multiple extractions within the same quadrant on the same date of service, the IHCP will pay 90 percent of the maximum allowed amount for procedure code D7140 or the billed amount, whichever is less.

Dental Cap

Effective March 1, 2003, The Office of Medicaid Policy and Planning (OMPP) established a \$600 cap for members 21 years of age and older. The affected procedures are limited to a total of \$600 of services per member, per calendar year. Dental services included in the dental cap are considered non-covered when the cap is reached for that calendar year. For years 2004 and beyond, the calendar year for the dental cap will begin on January 1 and end December 31. If additional dental services are needed for a member beyond the \$600 cap during a specific calendar year, providers can hold members financially responsible. For a list of codes included in the \$600 dental cap, please refer to Table 8.86 in Chapter 8, Section 4 of the IHCP Provider Manual.

The dental cap applies only to the IHCP paid dental services provided in a dental office. Dental services for root planing and scaling, intravenous sedation provided in conjunction with oral surgery, and osseous surgery are excluded from the dental cap.

In certain circumstances, providers can bill their usual and customary charge, provided that the cap has been exhausted. However, if the service is partially paid by the IHCP because of the cap limit, the member can only be billed for the difference between what the IHCP would have reimbursed to the provider and what the IHCP actually paid.

Diagnostic and Preventative

IHCP members are eligible for diagnostic and preventive services; however, many of the services offered to IHCP members are included in the \$600 dental cap.

Currently, a member can receive one (1) periodic oral evaluation (D0120) every six (6) months. Likewise, D0150, *Comprehensive oral* evaluation, and D0160, *detailed and extensive oral evaluation*, are limited to two visits per member per year. Other diagnostic and preventive services that members are eligible to receive include, D0140, *limited oral evaluation-problem focused* and D0170, *Re-evaluation-limited, problem focused (established; patient; not post operative visit)*.

Prophylaxis is a covered IHCP service, but is limited to the following restrictions. The program allows for one (1) application of prophylaxis every six months, for non-institutionalized members twelve (12) months of age up to their twenty first birthday. One (1) unit of prophylaxis is allowed, every 12 months, for non-institutionalized members that are twenty-one (21) years of age and older. Institutionalized members may receive up to one unit of prophylaxis every six months, regardless of age. Members 12 months of age and younger are not eligible for prophylaxis service.

Prophylaxis and fluoride that is provided on same date of service, should be billed under one code—D1201, *topical application of fluoride*. Likewise D1110, *prophylaxis-adult*, and D1204, *topical application of fluoride (prophylaxis not included)*, are no longer separately reimbursed. D1204 is a non-covered procedure code. Providers should be billing this joint service using either D1201 for children up to the age of 12 and D1205 for children 13 up to age 21, when fluoride and prophylaxis are provided on the same day.

Either full mouth series radiographs or panorex x-rays are limited to one (1) set per member every three (3) years. Bitewing, intraoral, and extraoral radiographs are limited to one (1) set per recipient every twelve months. One (1) set of bitewings is defined as a total of four (4) single films.

Restorative

IHCP reimburses for dentures and partials once every six years, but only with prior authorization (PA) and if medically necessary. IHCP also reimburses for relines and repairs to dentures and partials, provided PA is obtained and that the service is for members 21 years of age and older. Repairs and relines are only approved to extend the useful life of a prosthesis that is at least six (6) years old. Eight posterior teeth in occlusion, four maxillary and four mandibular teeth in functional contact with each other, are considered adequate for functional purposes. If a member is taking parenteral/enteral nutritional supplements, dentures and partials will not be approved unless the dentist submits a plan of care with the PA request that indicates dentures or partials are needed to wean the member from the nutritional supplements.

Local codes for complete and partial dentures were eliminated effective January 1, 2004. Reimbursement rates for dentures are determined by the age of the member. Complete and partial dentures do not require PA for members under twenty-one (21), while those 21 and older do require PA. Repairs and relines require PA and are only approved to extend the life of the prosthesis that is at least six years old.

Providers must submit D7999 to denote supernumerary tooth extractions. A claim attachment (note of explanation) is required with the ADA Claim Form when billing D7999. The attachment should indicate the type of extraction performed and whether it is an erupted or an impacted tooth. An impacted tooth must be documented as to whether it is soft tissue, partially bony, completely bony, with unusual complications, and so forth.

IHCP provider bulletin *BT200433*, published December 23, 2004, stated that procedure code D7283, *placement of a device to facilitate eruption of an impacted tooth*, was a covered service effective January 1, 2005. Further review indicates that this procedure is performed as an orthodontic service. The IHCP covers comprehensive orthodontic services with PA, as outlined in IHCP provider bulletin *BT200230*, published June 19, 2002. Procedure code D7283 includes placement of an orthodontic bracket or band to facilitate eruption of an unerupted tooth after surgical exposure. Placement of an orthodontic bracket is included in the reimbursement for comprehensive orthodontic services; therefore, procedure code D7283 is not separately reimbursed.

Resin crown codes D2336, D2337, D2335, and D2932 are covered by IHCP. IHCP will also pay for resin fillings, amalgam fillings and steel crowns.

Dentures and the \$600 Dental Cap

Dentures are subject to the annual \$600 dental cap for members age 21 or older. Services subject to the dental cap that are provided after the cap has been reached are not covered by the IHCP. If the member has exceeded the annual \$600 dental cap, the provider must inform the member of

the non-covered services as described in the IHCP Provider Manual. If the member has been informed of the amount of the non-covered charge(s) prior to the service being rendered, the provider can charge the member the usual and customary fee for the service(s).

If the member exhausted the cap during the course of treatment, the member is responsible only for the Medicaid allowed amount over the annual \$600 dental cap. The following scenario demonstrates the correct method for charging a member when the dental cap is exhausted during treatment. The member receives dental services that exhaust \$400 of the dental cap. During the same year, the member requires a complete upper denture, a service that is also included in the dental cap. The current IHCP maximum reimbursement for a complete upper denture (D5110) is \$391.25. Therefore, the member will exceed the \$600 cap and the member will be responsible for \$191.25, if notified of the charges prior to the delivery of the dentures. The provider must maintain documentation to substantiate member notification of the member's portion of financial responsibility prior to providing the service. The *IHCP Provider Manual, Chapter 4, Section 5*, describes the policy for charging members for non-covered services.

Example:

\$600 cap - \$400 cap exhausted = \$200 cap remaining

\$391.25 maximum fee - \$200 cap remaining = \$191.25 billable to the member

The service of providing dentures to any patient is not complete until the completed denture has been delivered to the patient. The date of the provision of the finished product is the date of service that must be used for claims filing and must be supported by record documentation. The provider must bill the IHCP according to when the services are rendered. The IHCP requires that provider records be maintained in accordance with *405 IAC 1-5-1*. Per *405 IAC 1-5-1(b)(4)*, the medical record must contain the date when the service was rendered. In addition, according to *405 IAC 1-1-4*, denial of claim payment can occur if the services claimed are not documented in accordance with *405 IAC 1-5-1*.

If the member is no longer eligible, the former member can be charged for the dentures. The IHCP policy for charging members for non-covered services does not apply if the member is no longer eligible; therefore, a non-covered services waiver is not required.

Providers are responsible for verifying member eligibility prior to rendering services. Providers are urged to advise members that if their eligibility is terminated prior to the dentures being completed, the cost of the dentures will be the member's responsibility. If the provider has verified that the member is no longer eligible, the provider can charge the member according to the provider's usual practices for other customers not enrolled in the IHCP.

Members Under Twenty One

Reimbursement is available for treatment of dental caries, extraction of teeth, and space maintenance in children with deciduous molar teeth. General anesthesia, nitrous oxide analgesia, and pre-anesthetic medication are also covered under IHCP reimbursement for general anesthesia provided in the dentist's office and available only for members under twenty-one (21) years of age.

IHCP offers reimbursement for monitored sedation ‘provided in the dentist’s office’ for recipients under the age of twenty-one (21). Monitored sedation is the administration of either subcutaneous, intramuscular, intravenous or oral sedation, in combination with monitoring of the patient’s vital signs.

Prophylaxis is a covered IHCP service, but is limited to the following restrictions. The program allows for one (1) application of prophylaxis every six months, for non-institutionalized members twelve (12) months of age, up to their twenty first birthday. One (1) unit of prophylaxis is allowed, every 12 months, for non-institutionalized members that are twenty-one (21) years of age and older. Institutionalized members may receive up to one unit of prophylaxis every 12 months. Members 12 months of age and younger are not eligible for prophylaxis service.

Prophylaxis and fluoride that is provided on same date of service, should be billed under one code—D1201, *topical application of fluoride*. Likewise, D1110, *prophylaxis-adult* and D1204, *topical application of fluoride (prophylaxis not included)* are no longer separately reimbursed. Providers should be billing this joint service using either D1201 for children up to the age of 12 and D1205 for children 13 up to age 21, when fluoride and prophylaxis are provided on the same day.

Periodontics

D4341, *scaling and root planing* is limited to four quadrants per lifetime for members 21 years of age and older who are not institutionalized. Institutionalized members are restricted to four (4) quadrants every two years. Providers billing D4341 must attach documentation that demonstrates that the member has periodontal disease by showing pocket markings, or evidence of attachment loss, and that the procedure was necessary for the removal of cementum and dentin that is rough, permeated by calculus, or contaminated with toxins or micro-organisms.

Periodontics surgery is a covered service for cases of drug-induced periodontal hyperplasia; prior authorization is required. Admission of a member to a hospital for performing any elective dental service, or any elective dental service performed on an inpatient basis, requires prior authorization. IHCP providers shall be required, based upon the facts of the case, to obtain a second or third opinion substantiating the medical necessity or approach for maxillofacial surgery related to diseases and conditions of the jaws and contiguous structures.

Orthodontics and Oral Surgery

Orthodontic procedures for IHCP are covered only for members younger than 21 years old. The OMPP requires PA, effective August 5, 2002 for all orthodontic services. Prior authorization requests must be submitted on the *IHCP Medical Prior Authorization Form* **not** the *IHCP Prior Authorization Dental Request Form*.

The patient must be diagnosed by a member of a recognized craniofacial anomalies team, such as a member of the American Cleft Palate-Craniofacial Association. The patient must be treated by a licensed practitioner, who minimally accepts routine craniofacial patients for orthodontic services, such as those patients with the cleft lip and palate.

A signed statement from the practitioner, who is a member of a hospital based craniofacial team, must certify the correct craniofacial diagnosis and malocclusion. The diagnosis must include information descriptive of facial and soft tissue, skeletal, dental/occlusal, functional, and applicable medical or other conditions. Documentation for orthodontic services must be maintained in the patient's dental or medical record, as required by 405 IAC 1-5-1, *Medical records; contents and retention*.

Procedure code D8680, *Orthodontic retention-removal of appliances, construction and placement of retainer(s)* is non-covered and is included in the reimbursement for orthodontic treatment. Procedure codes D8691, *Repair of orthodontic appliance*, and D8692, *Replacement of lost or broken retainer* are also non-covered. These services are included in the reimbursement for orthodontic treatments and will not be separately reimbursed.

General anesthesia is covered for adults only if the procedure is performed in a hospital (inpatient or outpatient) or an ambulatory surgical center. Reimbursement for IV sedation and nitrous oxide analgesia is available to all members, regardless of age.

Mobile Dental Services

Effective July 1, 2002, 828 IAC 4-1-1 requires providers of mobile dental services to be licensed as a mobile dental facility. Providers of mobile dental services should contact the Health Professions Bureau at (317) 234-2010 for an application and forward a copy of the mobile dental license to EDS Provider Enrollment.

Dental Forms and Provider Billing Issues

Dental providers wishing to submit paper claims must do so only on the ADA 2000 approved claim form. Effective January 1, 2004, dental providers will be using CDT-4 codes exclusively for billing.

During the week of June 6, 2005, the IHCP identified a high number of claim denials for edit 1008, *rendering provider must have an individual number*. This error occurs when a provider submits a billing group number in the detail line. According to IHCP provider bulletin *BT200511*, published June 1, 2005, all group providers must use their rendering provider numbers. To expedite claims, providers should follow these guidelines:

- **Group provider using a paper claim** – Enter the group number and location codes in field 44A. Enter the individual rendering numbers in the Administrative column adjacent to each detail submitted.
- **Group provider using Web InterChange** – Enter the group number and location code in the provider number field. Enter the individual rendering number in the rendering provider field.
- **Individual billing provider using a paper claim** – Enter the individual billing number and location code in field 44A. Enter the individual billing number in the Administrative column adjacent to each detail submitted.

- **Individual billing provider using Web InterChange** – Enter the individual billing number and location code in the provider number field. Enter the individual billing number in the rendering provider field.

Dental Rendering Provider Information at the Service Line Level

For all dental claims, dental providers are required to submit rendering provider information at the service line level when the billing provider is a group. Rendering providers are required to be associated with the billing provider's group. The requirement to record the individual dentist performing the service is an added HIPAA requirement. The IHCP captures the rendering provider information at the service line level.

The provider must include rendering provider number in the administrative column on the *ADA 2000 Dental Claim* form. Providers may also submit dental rendering provider information via Web InterChange. Dental rendering provider information is contained in the 835 transaction.

Identification of Supernumerary Tooth Extractions

If using the claim note segment, the provider should identify the affected tooth by one of the following:

- Adult – Designate the tooth ID by the appropriate tooth number followed by an A
- Child – Designate the tooth ID by the appropriate tooth letter followed by a 1

RBMC Carve Out Dental Guidelines

Dental services, which are performed by the following dental specialists and billed on the ADA 1999 Version 2000 Dental Claim Form (*ADA 2000*) or the 837 Health Care Claim: Dental (837D) electronic transaction, are carved out or excluded from the responsibility of Hoosier Healthwise Risk-based Managed Care (RBMC). The specialties include:

Endodontists

General Dentistry Practitioners

Oral Surgeons

Orthodontists

Pediatric Dentists

Periodontists

Mobile Dentists

Prosthodontists

Dental Clinic

All dental services billed using CDT-5 procedure codes must be submitted to EDS using either the *ADA 2000* claim form or the 837D transaction.

Dental providers that provide treatment for medical conditions may be billing the E/M codes, and these services may include treatment of sleep apnea or Temporomandibular joint (TMJ) syndrome. The scope of practice, defined in *IC 25-14-1-23*, allows for diagnosis or treatment of the human oral cavity, teeth, gums, maxillary or mandibular structures.

When dental services will be provided in an inpatient, outpatient hospital setting, or an ASC for an RBMC member, the dental providers must first contact the member's managed care organization (MCO) before rendering services to determine whether prior authorization is required. When the provider obtains MCO authorization and provides services, the services must then be billed as follows:

Dental-related facility charges must be billed on a *UB-92* claim form. Dental services provided in an inpatient, outpatient, or ASC setting can be billed with CDT-5 codes on a dental claim form. These services are carved out of RBMC, and must be billed to EDS using the *ADA 2000* claim form or the 837D transaction. All other associated professional services (such as oral surgery, radiology, and anesthesia) as well as ancillary services related to the dental services must be billed to the MCO on the *CMS-1500* claim form or the 837P transaction, along with appropriate authorization information.

Package E Dental Provider Notice

Dental providers may have received inappropriate reimbursement for non-emergency services rendered to Package E members. With the assistance of the Dental Advisory Panel (DAP), the IHCP created a table of the *CDT-5* codes that are allowed for reimbursement of emergency services provided to Package E members.

CDT-5 Codes Allowed for Package E Members

CDT-5 Code	Description
D0140	Limited oral evaluation– problem focused
D0210	Intraoral – complete series (including bitewings)
D0220	Intraoral– periapical– first film
D0230	Intraoral– periapical– each additional film
D0240	Intraoral– occlusal film
D0270	Bitewing– single film
D0272	Bitewings– two films
D0274	Bitewing– four films
D0330	Panoramic film
D7111	Extraction, coronal remnants– deciduous tooth *
D7140	Extraction, erupted tooth or exposed root
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth– soft tissue
D7230	Removal of impacted tooth– partially bony
D7240	Removal of impacted tooth– completely bony
D7241	Removal of impacted tooth– completely bony, with unusual surgical complications

CDT-5 Codes Allowed for Package E Members

CDT-5 Code	Description
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280	Surgical access of unerupted tooth (impacted tooth not intended for extraction)
D7282	Mobilization of erupted or malpositioned tooth to aid eruption
D7285	Biopsy of oral tissue– hard
D7286	Biopsy of oral tissue– soft
D7288	Brush biopsy– transepithelial sample collection
D7510	Incision and drainage of abscess– intraoral soft tissue
D7511	Incision and drainage of abscess– intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)
D7520	Incision and drainage of abscess– extraoral soft tissue
D7521	Incision and drainage of abscess– extraoral soft tissue– complicated (includes drainage of multiple fascial spaces)
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla– open reduction (simple fracture)
D7620	Maxilla– closed reduction (simple fracture)
D7630	Mandible– open reduction (simple fracture)
D7640	Mandible– closed reduction (simple fracture)
D7650	Malar and/or zygomatic arch– open reduction (simple fracture)
D7660	Malar and/or zygomatic arch– closed reduction (simple fracture)
D7670	Alveolus– closed reduction, may include stabilization of teeth (simple fracture)
D7671	Alveolus– open reduction, may include stabilization of teeth (simple fracture)

Radiographs must only be billed when the member presents with symptoms that warrant the diagnostic service. In addition, providers are encouraged to refer to the IHCP Provider Manual and IHCP provider newsletters *NL200410* and *NL200504* for related information.

NL200410 reminded dental providers of the importance of eligibility verification prior to rendering services to IHCP members. It is important to verify eligibility prior to each visit, as eligibility can change, be terminated, or include service limitations dependent on the program in which the member is enrolled.

NL200504 reiterated the policy stated in the *IHCP Provider Manual* about field 53 of the *ADA Dental Claim Form*. Field 53 is a required field and must be used to specify if the services

performed were for emergency care. Providers must indicate “Yes” for all emergency care. All services are subject to post-payment review and documentation must support medical necessity for the services performed.

MCO Billing Codes

Refer to **Table 6.4, Dental Related Anesthesia, Surgery, Radiology, and Laboratory CPT Codes** for a list of CPT codes that may be billed to a member’s managed care organization (MCO). Dental providers should only bill the codes listed in Table 6.4 when a CDT-5 is not appropriate.

Table 6.4
Dental Related Anesthesia, Surgery, Radiology, and Laboratory CPT Codes

Code	Description
00100– 00352	Anesthesia (Head and Neck)
10021– 11646	Removal of Lesions or Skin Tags
12001– 16036	Wound Repair, Skin Grafts and Flaps, Burns
17000– 17999	Lesions
20150– 20694	TMJ Treatments, Biopsy
20900– 20926	Grafts
20999	Unlisted Procedure, Musculoskeletal System, General
21010– 21499	Musculoskeletal System Repairs
29800– 29804	Arthroscopy, TMJ
40490– 42999	Oral Surgery (above Esophagus)
64716	Neuroplasty and/or Transposition; Cranial Nerve
70100– 70380	Radiology
71010	Radiological Exam, Chest, Single View, Frontal
72020	Radiological Exam, Spine, Single View, Specify Level
72040	Radiological Exam, Spine, Cervical; Two or Three Views
72072	Radiological Exam, Spine, Thoracic, Three Views
72146	MRI, Spinal Canal and Contents, Thoracic
72285	Diskography, Cervical or Thoracic, Radiological Supervision and Interpretation
76100	Radiological Exam, Single Plane Body Section, other than with Urography
76536	Ultrasound, Soft Tissues of Head and Neck, B-Scan, and/or Real Time with Image
80048– 89399	Pathology and Laboratory Codes

Note: If a member is enrolled in the PCCM delivery system, the PMP must authorize services rendered in an inpatient, outpatient, or ASC setting for providers to receive reimbursement.

MANAGED CARE

The MCOs are responsible for determining which services require PA for its members. The MCOs' decisions to authorize, modify, or deny a given request is based on medical necessity, reasonableness, and other criteria. A provider must make requests for reviews and appeals by contacting the appropriate MCO.

RELATED MEDICAL TOPICS

Anesthesia Services

EPSDT - HealthWatch

Locum Tenens

Radiology

Surgery— Surgery and Anesthesia by the Same Provider

Surgery Surgical Services

RULES, CITATIONS, AND SOURCES

42 CFR 440.100 Dental Services

42 CFR 440.50 Physicians' services and medical and surgical services of a dentist

42 CFR 440.120 Prescribed drugs, dentures, prosthetic devices, and eyeglasses

405 IAC 5-14 Dental Services

405 IAC 5-1-5 Global fee billing; codes

405 IAC 5-2-2 Definitions

405 IAC 5-13-4 Intermediate Care Facilities for the Mentally Retarded

IHCP Provider Bulletin BT200511

IHCP Provider Bulletin BT200433

IHCP Provider Bulletin BT200326

IHCP Provider Bulletin BT200324

IHCP Provider Bulletin BT200321

IHCP Provider Bulletin BT200318

IHCP Provider Bulletin BT200313

IHCP Provider Bulletin BT200311

IHCP Provider Bulletin BT200302

IHCP Provider Bulletin BT200250

IHCP Provider Bulletin BT200230

IHCP Provider Bulletin BT200227

IHCP Provider Bulletin BT200141

IHCP Provider Bulletin BT200142

IHCP Provider Bulletin BT200003

Indiana Medicaid Update Bulletin 98-32

Indiana Medicaid Update Bulletin 98-23

Indiana Medicaid Update Bulletin 98-07

Indiana Medicaid Update Bulletin 98-03

Indiana Medicaid Update Bulletin 95-21

IHCP Provider Banner BR200532
IHCP Provider Banner BR200526
IHCP Provider Banner BR200318
IHCP Provider Banner BR200310
IHCP Provider Banner BR200309
IHCP Provider Banner BR200308
IHCP Provider Banner BR200305
IHCP Provider Banner BR200245
IHCP Provider Banner BR200243
IHCP Provider Banner BR200241
IHCP Provider Banner BR200224
IHCP Provider Banner BR200219
IHCP Provider Banner BR200213
IHCP Provider Banner BR200208
IHCP Provider Banner BR200207
IHCP Provider Banner BR200206
IHCP Provider Banner BR200149
IHCP Provider Banner BR200104
IHCP Provider Banner BR200049
IHCP Provider Banner BR200045
IHCP Provider Banner BR200038
IHCP Provider Banner BR200226
IHCP Provider Banner BR199945
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Indiana Medicaid Banner Page 1/5/99
Indiana Medicaid Banner Page 8/11/98
Indiana Medicaid Banner Page 8/4/98
Indiana Medicaid Banner Page 7/28/98
Indiana Health Coverage Programs Provider Manual 2003
HealthWatch Manual

Table 1 Sources For Policy Issues and Updates

Revisions and Review	Reason	Date
Indiana State Department of Public Welfare Medical Policy Manual 1991	Dental; second opinion procedures, dental; out-of-state medical services; intermediate care facilities for the mentally retarded;	7/1/91
470 IAC 5-8-8 Transferred	Dental services	7/1/91
405 IAC 1-6-8 Repealed 8/24/97	Coverage of dental services	1/1/92
Indiana Medicaid Update Bulletin 95-21 (DATED 5/2/95)	IndianaAIM Medicaid Medical Policy Update- Dental Services Requiring Anesthesia on an Outpatient Hospital or Ambulatory Surgical Center (ASC)	2/20/95
Indiana Medicaid Update Bulletin 94-42 (dated 9/6/94)	Dental Services	10/5/94
405 IAC 5-13-4	Intermediate care facilities for the mentally retarded	8/24/97
405 IAC 5-14	Dental services policy	8/24/97
405 IAC 5-1-5	Global fee billing; codes	8/24/97
405 IAC 5-2-2	Definitions—ADA	8/24/97
42 CFR 440.100	Dental services	10/1/97
42 CFR 440.50	Physicians' services and medical and surgical services of a dentist.	10/1/97
42 CFR 440.120	Prescribed drugs, dent-rues, prosthetic devices, and eyeglasses.	10/1/97
828 IAC 4-1-1	Licensing of Mobile Dental Units	7/1/02
405 IAC 5-14-2	Covered Services	2/10/03
405 IAC 5-14-4	Topical Fluoride	2/10/03
405 IAC 5-14-6	Prophylaxis	2/10/03
405 IAC 5-14-11	Analgesia	2/10/03
405 IAC 5-14-15	Anesthesia	2/10/03
405 IAC 5-14-16	Periodontics; surgical	2/10/03
405 IAC 5-14-17	Oral surgery	2/10/03
405 IAC 5-14-18	Hospital Admission	2/10/03
405 IAC 5-14-1	\$600 Dental Cap	3/1/03
Indiana Medicaid Update Bulletin 94-42	Dental services	10/5/94

Revisions and Review	Reason	Date
Indiana Medicaid Update Bulletin 95-21	IndianaAIM Medicaid medical policy update—dental services requiring anesthesia in an outpatient hospital or ambulatory surgical center (ASC)	2/20/95
Indiana Medicaid Update Bulletin 98-03	Dental Services	9/1/97
Indiana Medicaid Update Bulletin 98-07	Dental services and managed care organizations	8/1/98
Indiana Medicaid Update Bulletin 98-23	Dental changes: Rate Increase PA Lifted RBMC Changes	5/1/98 9/1/97 8/1/98
Indiana Medicaid Update Bulletin 98-32	Update on dental procedure codes	6/5/98
IHCP BT199933	Smoking Cessation TX	10/27/99
IHCP BT200003	Coverage of dentures and partials	1/14/00
IHCP BT200141	Dental claim instructions	11/01/01
IHCP BT200142	D7999, D9999	12/17/01
IHCP BT200201	Locum Tenens Policy	1/18/02

Revisions:

Revisions and Review	Reason	Date
IHCP BT200227	Dental code changes	7/29/02
IHCP BT200230	Criteria for orthodontic services	8/05/02
IHCP BT200250	End dating and limitations of dental codes	11/01/02 10/15/02
IHCP BT200301	Implementation of the \$600 dental cap	1/15/03
IHCP BT200302	Implementation of the \$600 dental cap	1/15/03
IHCP BT200310	\$600 dental limit for members 21 and older	3/1/03
IHCP BT200311	Delayed implementation of the \$600 dental cap	3/1/03
IHCP BT200313	New 2003 HCPCS Coding Systems.	4/1/01
IHCP BT200318	Change in method of filing RHC and FQHC claims.	3/07/03
IHCP BT200321	Correct Codes for Billing of IHCP Dental Services	4/1/01
IHCP BT200324	Changes to the \$600 Dental Cap	06/01/03
ICHP BT200326	Change in Dental Coverage	5/31/03

APPLICABLE INDIANA AIM EDITS AND AUDITS

0261, Tooth number missing
 0262, Tooth number invalid
 0263, One or more of the tooth surface codes billed is invalid
 0266, Insufficient number of valid tooth surface codes
 3011, Out-of-state provider requires prior authorization- rendering provider
 4211, Tooth number/procedure code combination invalid
 5010, Exact duplicate- tooth surface
 5011, Possible duplicate- tooth surface
 6000, Manual pricing required
 6032, Extraction/surgical procedures payable at reduced amount when suturing paid
 6033, Prophylaxis limited to two treatments every six months- institutionalized
 6036, Oral surgery payable at reduced rate when apicoectomy previously paid
 6199, Fluoride limited to one treatment every six months
 6200, Panoramic/full mouth versus bitewings/periapical
 6201, More than one reline/rebase/repair of dentures within three years
 6202, Palliative versus other emergency services
 6203, Relines and rebases vs. initial denture lower placement
 6204, Pulpotomy versus root canal therapy

- 6205, Apicoectomy versus oral surgery
- 6208, Occlusal films limited to two units
- 6209, Full mouth or panoramic x-rays limited to once every three years
- 6210, Prophylaxis limited to one treatment every six months for non-institutionalized age 18 months to 21 years.
- 6211, Periodic/limited oral evaluation limit one every six months
- 6212, Fluoride treatments limited to one every six months for members ages 18 months through 18 years of age
- 6213, Prosthodontic adjustment
- 6214, Root canal payable at reduced amount when pulpotomy paid
- 6216, Lower denture relines limited to one per 36 months
- 6217, Gingival curettage payable at a reduced amount
- 6218, One pulp cap per tooth per lifetime
- 6219, Periodontal scaling and planing- two quadrants per day
- 6220, Replacement greater than three teeth- denture partial or complete
- 6221, Periodontal root planing and scaling limited to four treatments every two years non-institutionalized
- 6222, Periodontal root planing and scaling limited to four treatments every two years member regardless of age
- 6223, Periodontal root planing & scaling non-institutionalized member 21 years or older limited to 4 treatments per lifetime
- 6224, One tooth extraction per tooth per lifetime
- 6225, One sealant per tooth per lifetime/21 years or younger
- 6226, Comprehensive/extensive oral examination limited to one per lifetime
- 6227, Emergency services versus palliative treatment
- 6228, Denture reline versus denture repair
- 6229, Relines and rebases versus initial denture upper replacement
- 6232, Prophylaxis- adult will be limited to one treatment every six months for institutionalized members 13 years old and older
- 6234, Suturing versus extractions and surgical procedures
- 6235, Prophylaxis non-institutional 21 years or older limited to 1 (one) per 12 months
- 6236, Dental services limited to \$600 for members 21 years old or older

MEDICAL POLICY FACT SHEET

TITLE: DERMATOLOGY

DESCRIPTION

As defined in *Dorland's Medical Dictionary, Edition 28, 1994*, dermatology is the medical specialty concerned with the diagnosis and treatment of diseases of the skin.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

The IHCP will provide for reimbursement for dermatology services billed with an appropriate procedure code when medically necessary. Generally, prior authorization (PA) is not required; however, specific procedure codes may require PA. Documentation in the medical record must support medical necessity. According to Indiana Administrative Code (IAC) citation 405 IAC 5-29-1, the following are noncovered services :

- Dermabrasion surgery for acne pitting or marsupialization
- Scar removals or tattoos removals by excision or abrasion
- Removal of keloids from pierced ears when they are less than 3 centimeters or they obstruct fifty percent of the ear canal

PRIOR AUTHORIZATION

Generally, prior authorization is not required.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in Medicaid Select PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the Medicaid Select Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

Providers must bill for dermatology services using the established billing guidelines.

RELATED MEDICAL TOPICS

Consultations - Second Opinion
Evaluation and Management Services
Physician Services

RULES, CITATIONS, AND SOURCES

405 IAC 5-29-1 Noncovered services
Indiana Health Coverage Programs Provider Manual
Version 5.1, March 2005

Origination Date: 12/31/2000

Revisions and Review	Reason	Date
470 IAC 5-9-1 Transferred	Global Billing Fee	07/01/1991
405 IAC 1-7-1 Repealed 8/24/97	Global Fee Billing	01/01/1992
405 IAC 1-6-1; 1-6-9; 1-6-15; 1-7-15; Repealed 8/24/97	Noncovered Services	01/01/1992
405 IAC 5-1-5	Global Billing Fee	08/24/1997
405 IAC 5-29-1	Noncovered Services	08/24/1997

Revisions and Review	Reason	Date
405 IAC 5-29-1 Amended	Noncovered Services	10/27/1999
Review	Scheduled	10/31/2006

APPLICABLE INDIANA AIM EDITS AND AUDITS

6649 – Surgery Payable at Reduced Amount When Related POS
6651 – Surgical Cutback Procedure – 50%
6653 – Post Op Care Within 00-90 Days of Surgery
6654 – Pre-Operative Care Within 1 Day of Surgery
6655 – Surgery Payable at Reduced Amount When Pre-Op Care
6656 – Post Op Care Within 10 Days of Select Surgery
6657 – Pre-Operative Care on Day of Surgery
6658 – Surgery Payable at Reduced Amount When Pre-Op Care
6659 – Surgery Payable at Reduced Amount When Related POS
6660 – Pre/Post-Operative Care Billed with Unlisted Surgery

MEDICAL POLICY FACT SHEET

TITLE: DIABETES SELF-MANAGEMENT TRAINING

DESCRIPTION

Indiana Health Coverage Programs' (IHCP) diabetes self-management training services are intended to enable or enhance the member's ability to properly manage their diabetic condition. The purpose of these services is to optimize personal therapeutic treatment regimens.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

The IHCP will provide reimbursement for diabetes self-management training services when medically necessary, ordered in writing by a physician or podiatrist, and provided by a health care professional licensed under applicable Indiana law. The health care professional providing the service must have specialized training in the management of diabetes. Some examples of the training include, but would not be limited to, instruction regarding the diabetic disease state, nutrition, exercise and activity, medication counseling, blood glucose self-monitoring training, insulin injection training, foot, skin, eye, and dental care.

The IAC citation, 405 IAC 5-36 mandates coverage limitations of diabetes self-management training to a total of sixteen units with each unit equaling 15 minutes. IHCP reimbursement of diabetes self-management training services is limited to a total of eight units of G0108, *Diabetes outpatient self-management training services, individual, per 30 minutes*, and G0109, *Diabetes self-management training services, group session (2 or more), per 30 minutes*, for diabetes self-management training services per member, per rolling calendar year, applicable under any of the following circumstances.

- Receipt of a diagnosis of diabetes
- Receipt of a diagnosis that represents a significant change in the insured's symptoms or condition
- Re-education or refresher training

Practitioners, both ordering and rendering, are to maintain sufficient documentation of the diabetes self-management training services provided to substantiate medical necessity and the provision of the service itself. Examples of documentation that are to be maintained by the provider include, but are not limited to, the following.

- Written order(s) for the service
- Date of service
- Amount of time used for the training session
- General content of the training session
- Units of service billed and charge amount
- Pertinent patient history and clinical data
- Practitioner notes from the training sessions

PRIOR AUTHORIZATION

Prior authorization is NOT required for initial units of diabetes self-management training services that do not exceed the established limits for the service. However, additional units may be authorized through the standard prior authorization request process. Documentation must be maintained to provide evidence of medical necessity for additional units requested.

It is the responsibility of the ordering physician or podiatrist to ensure that initial and all subsequent orders for diabetes self-management training are fully substantiated by medical necessity of the service.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and RBMC delivery systems.

IHCP members enrolled in *Medicaid Select* PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the *Medicaid Select* Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

Providers must bill for diabetes self management training service on the HCFA 1500 claim form or 837P electronic transaction, utilizing HCPCS procedure codes G0108, *Diabetes outpatient self-management training services, individual, per 30 minutes*, and G0109, *Diabetes self-management training services, group session (2 or more), per 30 minutes*. Fractional units of service can be billed on the CMS 1500 with allowance for

two decimal places when submitting partial units. The IHCP does not provide reimbursement for a diabetes self-management training service which is provided to the general public at no charge, including diabetes self-management training services.

RELATED MEDICAL TOPICS

Endocrinology – Insulin
Nursing Services
Podiatry

RULES, CITATIONS, AND SOURCES

Indiana Senate Enrolled Act No. 184, IC 27-8-14.5, effective January 1, 1998
Indiana Medicaid Update Bulletin 98-05
Indiana Health Coverage Programs Provider Manual
Version 5.1, March 2005
Medicaid Select Manual for Primary Care Providers and Office Staff, 2003

Origination Date: 12/31/2000

Revisions and Reviews	Reason	Date
Indiana SEA No. 184, IC 27-8-14.5; Indiana Medicaid Update Bulletin 98-05	Diabetes Self-Management Training	01/01/1998
Revision	405 IAC 5-36 Amended	10/27/1999
Review	Scheduled	10/31/2006

APPLICABLE INDIANA A/M EDITS AND AUDITS

6096 – The CPT/HCPCS Code Billed is Not Payable
6652 – Multiple Surgeries Must Be Billed on Same Claim
6798 – Services Not Covered for Telemedicine
6920 – Diabetes Management Limited to 8 Units in 12 Months

MEDICAL POLICY FACT SHEET

TITLE: DIAGNOSTIC STUDIES

DESCRIPTION:

Diagnostic Studies are invasive and non-invasive tests completed to determine the probable cause of the patient's signs and symptoms. These studies can be done as an inpatient or outpatient, dependent on the severity of the signs and symptoms and the treatment they require.

SUMMARY OF CURRENT POLICY:

Medical diagnostic services may not be fragmented and billed separately.

MEDICAL TOPICS CROSS-REFERENCES:

Consultations – Second Opinion

Endocrinology - Insulin

Gastroenterology

Hematology

Mental/Behavioral Health – Inpatient Services

Mental/Behavioral Health – Outpatient Services

Obstetric Care

Oncology

Physician Services – Visits/New patient vs. Established Patient Visits: Office, Home,
Nursing Facility, Emergency Room

Urology

RULES, CITATIONS, AND SOURCES:

405 IAC 5-28-2

Indiana State Department of Public Welfare Medical Policy Manual 1991

Indiana Health Coverage Programs Provider Manual

Initial Policy	Issue	Effective Date	Implementation Date	Retroactive Date
470 IAC 5-9-1 Transferred	Global Fee Billing	7/1/91		
405 IAC 1-7-1 Repealed 8/24/97	Coverage of Diagnostic Procedures	1/1/92		
Revisions:				
405 IAC 5-28-1	Diagnostic Studies	8/24/97		
405 IAC 5-28-2	Diagnostic Studies	8/24/97		

APPLICABLE INDIANA A/M EDITS AND AUDITS:

6001

6011

6014

6024

6025

6026

6064

APPLICABLE INDIANA AIM EDITS AND AUDITS**COVERAGE CRITERIA****Cardiopulmonary Resuscitation (CPR)**

Cardiopulmonary resuscitation (92950) is an all inclusive procedure. Therefore, separate charges for central venous pressure catheterization (36488, 36489), insertion of arterial lines (36620), endotracheal intubation (31500), and cardioversion (92960) will be denied as included in the charge for CPR. Additional charges for care of the member on the same day by the same physician (for example, intensive care visits, hospital visits, emergency room visits) will also be denied as included in the charge for the cardiopulmonary resuscitation.

1. Payment in full is allowed for a Swan-Ganz in addition to the CPR charge.
2. These guidelines apply when the same physician bills separately for CPR and any of the above components. Physicians other than the primary physician will be paid for services they provide during the cardiopulmonary resuscitation.
3. These guidelines apply when the same physician bills separately for CPR and any of the above components. Physicians other than the primary physician should be paid for services that they provide during the cardiopulmonary resuscitation.

MEDICAL POLICY FACT SHEET

TITLE: EMERGENCY MEDICINE—EMERGENCY ROOM

DESCRIPTION

Emergency services are services provided in the emergency department of a hospital. Emergency services include services provided to an Indiana Health Coverage Programs (IHCP) member after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the member's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

SUMMARY OF CURRENT POLICY

Reimbursement is available for emergency department services provided by IHCP enrolled providers. Emergency services (as described above) do not require prior authorization. Emergency services are excluded from co-payment requirements. However, non-emergency services treated in an emergency department setting are subject to co-payments. Members on restricted utilization may receive treatment without a referral from the authorized provider if the diagnosis is an emergency diagnosis.

Members enrolled in the RBMC component of Hoosier Healthwise can seek emergency care from providers not contracted with the managed care organization without prior authorization, subject to the prudent layperson standard for emergency medical conditions. This means that a layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the health of the individual or, in the case of a pregnant women, the health of the woman or her unborn child; (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

The Primary Care Case Management (PCCM) component of the Hoosier Healthwise managed care program does not require Primary Medical Provider (PMP) authorization for federally required medical screening examinations performed by a physician in the emergency department of a hospital. CPT codes reflecting the appropriate level of screening exam must be billed on a HCFA 1500 form:

99281	Emergency Department Visit for evaluation and management; presenting problem(s) are self limiting or minor
99282	Emergency Department Visit for evaluation and management; presenting problem(s) are low to moderate severity

99283	Emergency Department Visit for evaluation and management; presenting problem(s) are of moderate severity
99284	Emergency Department Visit for evaluation and management; presenting problem(s) are high severity; require urgent evaluation by physician but do not pose immediate threat to life or physiologic function
99285	Emergency Department Visit for evaluation and management; presenting problem(s) are high severity and pose immediate threat to life or physiologic function

Related services that do not have an emergency diagnosis and emergency indicator on the claim will be denied if the claim does not contain the PMP authorization.

If a physician uses an emergency room as a substitute for his or her office for non-emergency services, these visits should be billed as office visits and will be reimbursed as such.

RELATED MEDICAL TOPICS

Emergency Medicine – Cardiopulmonary Resuscitation (CPR)

Emergency Medicine – Emergency Services

Hospital Outpatient

Physician Services – Visits/New patient vs. Established patient visits: Office, Home, Nursing Facility, Emergency Room

Out-of-State Services

RULES, CITATIONS, AND SOURCES

IC 12-15-15-2.5 Payment for physician services provided in the emergency department of a hospital

405 IAC 5-2-9 “Emergency service” defined

405 IAC 5-3-12 Prior authorization; exceptions

Indiana Medicaid Update Bulletin 96-36

Indiana Medicaid Update Bulletin 95-51

Indiana Medical Assistance Program Provider Manual 1994

Indiana Health Coverage Programs Provider Manual 1999

Indiana Health Coverage Programs Provider Manual 2003

Origination Date 7/1/91

REVIEW AND REVISIONS	REASON	DATE
470 IAC 5-9-1 Transferred	Global Fee Billing	7/1/91
405 IAC 1-7-1 Repealed 8/24/97	Global Fee Billing	1/1/92
Indiana Medicaid Update Bulletin 95-51	Medical Screening Exams in the Emergency Room	1995
Indiana Medicaid Update Bulletin 96-36	COPAYMENTS FOR EMERGENCY ROOM VISITS	1/1/97
IC 12-15-15-2.5	Payment for Physician Services Provided in the Emergency Department of a Hospital	5/13/97
405 IAC 5-2-9	"Emergency Service" Defined	8/24/97
405 IAC 5-3-12	Prior Authorization; Exceptions	8/24/97
405 IAC 5-9-2	Evaluation and Management Services-- Restrictions	8/24/97
IC 12-15-15-2.5(f)	Payment for Physician Services Provided in the Emergency Department of a Hospital	7/1/99
405 IAC 5-3-12 AMENDED	Prior Authorization; Exceptions	10/27/99
Review	Scheduled	7/30/04

APPLICABLE INDIANA AIM EDITS AND AUDITS:

440
6514

Provider Type and Specialty List

PROVIDER TYPE	Provider Specialty
31 Physician	315 Emergency Medicine Practitioner

MEDICAL POLICY FACT SHEET

TITLE: EMERGENCY MEDICINE—EMERGENCY SERVICES

DESCRIPTION

Emergency services include unscheduled episodic services provided to IHCP members who require immediate medical attention.

SUMMARY OF CURRENT POLICY

IHCP reimbursement is available for emergency services provided to IHCP members. As defined by the prudent layperson provision in the Omnibus Budget Reconciliation Act (OBRA) of 1986, an emergency may be perceived by the sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, and (3) serious dysfunction of any bodily organ or part.

Hoosier Healthwise Package E members (aliens, non-citizens) receive only emergency services and the services are reimbursed as fee for service. Package E services must meet emergency criteria as noted in the paragraph above. In the case of pregnant women eligible for coverage under Package E, labor and delivery services are also considered emergency medical conditions.

Providers must denote that a provided service was emergent by indicating such in the appropriate field on submitted claim forms.

COVERAGE CRITERIA

IHCP provides reimbursement for emergency services; guidelines for these services are subject to the member's program enrollment. Hoosier Healthwise Programs A and B enrollees are required to pay a copayment for non-emergency services provided in the emergency department. Per federal regulations, IHCP providers may not deny services to any member due to the member's inability to pay the copayment on the date of service. This federal requirement does not apply to a member who is able to pay, nor does a member's inability to pay eliminate his or her liability for the copayment. It is the member's responsibility to inform the provider that he or she cannot afford to pay the copayment on the date of service. The provider may bill the member for copayments not

made on the date of service. The following information discusses emergency services by program area, as applicable.

Cardiopulmonary Resuscitation

The IHCP reimburses cardiopulmonary resuscitation. Refer to the Medical Policy fact sheet on Emergency Services – Cardiopulmonary Resuscitation for specific coverage information.

Emergency Dental Services

The IHCP reimburses medically necessary emergency dental services. Hoosier Healthwise Package E members are eligible only for services to treat an emergency medical condition. Preventive treatments such as sealants, prophylaxis, and fluoride treatments do not meet the definition of an emergency medical condition. Package E members who seek dental services that are non-emergencies are responsible for payment of such services.

Field 53 on the ADA dental claim form must be used to specify if the services performed were for emergency care. Providers must indicate *Yes* for emergency care rendered to Package E members. All services are subject to post-payment review, and documentation must support medical necessity for the services performed.

Palliative treatment of facial pain, such as an abscess incision and drainage is limited to emergency treatment only. HCPCS code D0140 can be billed for the emergency exam. If the procedure for the palliative care has a corresponding ADA code, the code for the procedure is billed rather than the code for palliative care.

Emergency Services Related to Hospice

When an IHCP member elects the IHCP hospice benefit, care for the terminal condition comes under the supervision of the IHCP hospice provider. The IHCP covers the IHCP hospice member's medical care for conditions not related to the terminal illness.

If emergency services are related to the terminal illness and the hospice member has not revoked the hospice benefit, the hospice provider is responsible for hospice and transportation charges associated with all emergency services. If the emergency services are unrelated to the terminal illness, the IHCP covers transportation and facility services associated with the emergency services according to the member's program enrollment, (i.e. Fee-for-Service and Hoosier Healthwise). Refer to the Indiana Health Coverage Programs Hospice Provider Manual and the Medical Policy fact sheet on Hospice Services for specific coverage information.

Inpatient Services

Inpatient services for diagnoses reimbursed under the level of care payment methodology and emergency substance abuse require prior authorization (PA). Emergency inpatient admissions for these diagnoses must be reported to PA within forty-eight hours of admission, not including Saturdays, Sundays, or legal holidays in order to receive IHCP reimbursement.

Pharmacy Services

Pharmacy services are exempt from copayment requirements when emergency services are provided in a hospital, clinic, office, or other facility equipped to furnish emergency care.

In accordance with federal law, the IHCP allows for the provision of at least a 72 hour supply of a prescribed drug in an emergency situation, without otherwise applicable PA (such as, on a weekend, holiday, and so forth). Pharmacy providers should document the circumstances that support providing the *emergency* supply and are subject to post payment review. Providers should refer to the Medical Policy fact sheet on Pharmacy Services for specific coverage and billing information.

Emergency Department Physicians

ICHP reimbursement is available to emergency department physicians who render medically necessary emergency service to IHCP members. PCCM members are not required to obtain a PMP authorization for the federally required medical screening examinations performed by a physician in the emergency department of a hospital. One of the CPT codes listed below, reflecting the appropriate level of screening exam, must be billed on the CMS 1500 claim form or the 837P transaction.

- 99281 – Emergency department visit for evaluation and management, usually, presenting problem(s) are self limiting or minor
- 99282 – Emergency department visit for evaluation and management, usually, presenting problem(s) are of low to moderate severity
- 99283 – Emergency department visit for evaluation and management, usually, presenting problem(s) are of moderate severity
- 99284 – Emergency department visit for evaluation and management, presenting problem(s) of high severity, require urgent evaluation by the physician, do not pose significant threat to life/physiologic function
- 99285 – Emergency department visit for evaluation and management, presenting problem(s) of high severity, pose immediate significant threat to life/physiologic function

Psychiatric Services

The physician or HSPP must be available for emergencies and must either see the patient or review the information obtained by the mid-level practitioner within seven days of the intake process. IHCP reimbursement is available for emergency mental health admissions in cases of a sudden onset of a psychiatric condition manifesting in acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in danger to the member or to others. Refer to the Medical Policy fact sheets for Mental and Behavioral Health Services for inpatient hospitalization and outpatient services for specific coverage information.

Transportation Services

Emergency transportation services are covered by the IHCP. Refer to the Medical Policy Fact sheet on Transportation Services for specific coverage information.

BILLING REQUIREMENTS

Facility payments for services rendered in the emergency department are the same for emergent and non-emergent care. Under federal regulations (42 CFR 447.53), emergency services are excluded from copayment requirements.

Revenue codes 70X, 71X, 72X, and 76X are reimbursed at a flat rate regardless of the diagnosis code on the claim. For a service to be considered an emergency, an applicable emergency diagnosis code must be entered as the principal diagnosis in Locator 67 on the UB-92.

Providers submitting claims for reimbursement of services to Hoosier Healthwise Package E members must indicate *emergency* in the proper form locator on the claim form. The diagnosis codes must include an appropriate code from the comprehensive list of codes considered as emergencies, located in the Provider Manual, Chapter 8, entitled “Emergency Department Diagnosis Codes.”

PRIOR AUTHORIZATION

Prior authorization (PA) is not required for emergency services.

Emergency inpatient admissions for diagnoses reimbursed under the level of care payment methodology and emergency substance abuse inpatient admissions must be reported to PA within forty-eight (48) hours of admission, not including Saturdays, Sundays, or legal holidays, in order to receive IHCP reimbursement. IHCP reimbursement is available for emergency mental health admissions only in cases of a sudden onset of a psychiatric condition manifesting in acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in danger to the member or to others.

Continuation of inpatient treatment and hospitalization, following out-of-state emergency services is subject to prior authorization requirements. Refer to the Medical Policy fact sheet for Out-of-State Services for further information.

MANAGED CARE

IHCP members enrolled in Hoosier Healthwise programs are encouraged to take responsibility for the choices they make in seeking medical care, particularly with regard to use of the emergency room. Each Hoosier Healthwise member has chosen or been assigned to a primary medical provider (PMP) who is available 24 hours a day to give medical advice. Members are educated to contact their PMP prior to seeking treatment in

the emergency room except in cases of true emergencies. Members are encouraged to seek emergency room treatment only when it is appropriate. Thus, to the extent permitted by federal and state regulations, a copayment is charged when there is not a true emergency and the emergency room setting was chosen without the authorization of the PMP.

While authorization is not required for emergencies, non-authorized services, such as facility charges, labs, and x-ray services, rendered to a PCCM member without an emergency diagnosis may not be covered. These claims may be suspended for review to determine if the prudent layperson standard (see page 1 of this fact sheet) for an emergency medical condition has been met. If the review results in the determination that the prudent layperson standard has not been met, the claim will be denied. If the prudent layperson standard has been met, then only revenue code 45X will be paid, as long as the eight digit PMP license number is indicated in Field 83B of the UB-92 claim form. As noted previously on page 3, a PMP authorization is not required for a federally required medical screening examination performed by a physician in the emergency department of a hospital.

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's MCO for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and RBMC delivery systems.

RELATED MEDICAL TOPICS

Dental Services

Emergency Medicine – Emergency Room

Emergency Medicine – Cardiopulmonary Resuscitation

Hospice Services

Hospital Outpatient

Mental Health Services – Inpatient

Out-of-State Services

Physician Services – Visits/New patient vs. Established patient visits: Office, Home, Nursing Facility, Emergency Room

Transportation Services

RULES, CITATIONS, AND SOURCES

42 CFR 447.15 – Member copayment

405 IAC 5-2-9 – “Emergency service” defined

405 IAC 5-3-12 – Prior authorization; exceptions

405 IAC 5-4-2 – Provider agreement requirements for transportation services

405 IAC 5-17-3 – Emergency; weekend inpatient admissions

405 IAC 5-20-6 – Emergency admissions

Indiana Medicaid – Update Bulletins

95-17, 96-36, and 98-04

Indiana State Department of Public Welfare Medical Policy Manual 1991

Indiana Health Coverage Programs Hospice Provider Manual, March 2004, Version 4.0

Indiana Health Coverage Programs Provider Bulletin BT200311 – Package E Dental Services

Indiana Health Coverage Programs Provider Newsletter NL200410 – Dental Services

Indiana Health Coverage Programs Provider Manuals
1999

July 2004, Version 5.0

ORIGINATION, REVISIONS AND REVIEWS**Origination Date:** 12/31/2000

Revisions and Reviews	Reason	Date
Indiana State Department of Public Welfare Medical Policy Manual 1991	Emergency Services	7/1/91
Indiana Medicaid Update Bulletin 95-17	MCOs' Coverage Of Emergency Services	3/28/95
Indiana Medicaid Update Bulletin 96-36	Copayments For Urgent And Nonemergency Services Provided In An Emergency Room	1/97
405 IAC 5-2-9	"Emergency service" defined	8/24/97
Indiana Medicaid Update Bulletin 98-04,	Emergency Room Transportation	2/9/98
Indiana Health Coverage Programs BT 200311	Package E Dental Services	2/7/03
Review	Scheduled	4/29/05

APPLICABLE INDIANA A/M EDITS AND AUDITS

440 – Emergency Indicator Invalid

4090 – Drug and Supply Codes are Included in Treatment

4091 – Add-on Service was Billed Without a Treatment Room

6514 – No More than One Emergency Room Visit per Day

EMERGENCY MEDICINE – EMERGENCY SERVICES ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Emergency Medicine – Emergency Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200539 **Publication Date:** 09/27/2005

Subject: Emergency Department Diagnosis Codes

Date Added to Manual: 10/31/2005

Text of Publication

Beginning October 1, 2005 please use the following updated International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes. The new, revised, and discontinued codes may be viewed at <http://www.cms.hhs.gov/medlearn/icd9code.asp>. To ensure Health Insurance Portability and Accountability Act (HIPAA) compliance, the 90-day grace period no longer applies to ICD-9-CM updates. Providers must use the appropriate ICD-9-CM diagnosis and procedure codes that are valid for the date of service. Codes not valid for the dates of service will deny. The ICD-9-CM diagnosis and procedure codes are billable and reimbursable October 1, 2005.

The following new ICD-9-CM diagnosis codes will be added to Table 8.13 – *Emergency Department Diagnosis Codes* in the *IHCP Provider Manual, Chapter 8, Section 2*. These codes are effective October 1, 2005.

ICD-9-CM Diagnosis Codes Added to Table 8.13 *Emergency Department Diagnosis Codes*

276.50	567.38	651.70	770.12	770.86	996.44
276.51	567.39	651.71	770.13	779.84	996.45
276.52	567.81	651.73	770.14	799.01	996.46
567.21	567.82	760.77	770.15	799.02	996.47
567.22	567.89	760.78	770.16	996.40	996.49
567.23	585.6	763.84	770.17	996.41	V46.14
567.29	599.60	770.10	770.18	996.42	V62.84
567.31	599.69	770.11	770.85	996.43	

The following ICD-9-CM diagnosis codes will be removed from Table 8.13 – *Emergency Department Diagnosis Codes* in the *IHCP Provider Manual, Chapter 8, Section 2* effective October 1, 2005. These codes are no longer valid codes.

**ICD-9-CM Diagnosis Codes Removed from Table 8.13 Emergency Department
Diagnosis Codes**

276.5	567.2	567.8	599.6	770.1	799.0	996.4
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The following new ICD-9-CM diagnosis codes will be added to Table 8.63 – *High Risk Pregnancy – ICD-9-CM Diagnosis Codes* in the *IHCP Provider Manual, Chapter 8, Section 3*. These codes are effective October 1, 2005.

**ICD-9-CM Diagnosis Codes Added to Table 8.63 High Risk Pregnancy – ICD-9-CM
Diagnosis Codes**

276.50	291.82	567.38	585.5	V46.13	V85.25	V85.37
276.51	362.07	567.39	585.6	V46.14	V85.30	V85.38
276.52	426.82	567.81	585.9	V62.84	V85.31	V85.39
278.02	567.21	567.89	599.60	V85.0	V85.32	V85.4
287.30	567.22	585.1	599.69	V85.21	V85.33	
287.31	567.23	585.2	651.70	V85.22	V85.34	
287.33	567.29	585.3	651.71	V85.23	V85.35	
287.39	567.31	585.4	651.73	V85.24	V85.36	

The following ICD-9-CM diagnosis codes will be removed from Table 8.63 *High Risk Pregnancy – ICD-9-CM Diagnosis Codes* in the *IHCP Provider Manual, Chapter 8, Section 3* effective October 1, 2005. These diagnosis codes are no longer valid.

**Invalid ICD-9-CM Diagnosis Codes Removed
from Table 8.63 High Risk Pregnancy – ICD-9-CM Diagnosis Codes**

287.3	585			
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The following new ICD-9-CM procedures are not covered by the IHCP. According to the Indiana Administrative Code (IAC) 405 IAC 5-29-1 (3), experimental treatment or procedures are not covered by the IHCP.

ICD-9-CM Non-Covered Services Code Description

37.41	Implantation of prosthetic cardiac support device around the heart
84.58	Implantation of interspinous process decompression device

MEDICAL POLICY FACT SHEET

TITLE: EPSDT/HEALTHWATCH

DESCRIPTION

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, referred to as HealthWatch in Indiana, is a federally mandated preventive health care program designed to improve the overall health of eligible infants, children and adolescents. Special emphasis is given to early detection and treatment since these efforts can reduce the risk of more harmful and costly treatment or hospitalization, when detection is delayed. IHCP members from birth to age twenty-one (21) may participate in the program on a voluntary basis. Division of Family and Children staff from each of the 92 counties are responsible for HealthWatch program outreach and for informing IHCP eligible persons about the availability of HealthWatch services. The Hoosier Healthwise program plays a significant role in the administration of the EPSDT program. Hoosier Healthwise enrollees must consult their managed care organization (MCO) for outreach and information on EPSDT services.

SUMMARY OF CURRENT MEDICAL POLICY

EPSDT program services covered by the IHCP are subject to certain coverage limitations. The purpose of EPSDT is to facilitate the introduction of young IHCP members into a continuing health care system that will detect abnormalities before such abnormalities become chronic or debilitating.

An initial screening is performed by the EPSDT screening provider when referred by the Office of Medicaid Policy and Planning (OMPP) or its designee or upon the initial request of the member for EPSDT services. The initial screening and subsequent, periodic screenings must be performed in accordance with the *HealthWatch Periodicity and Screening Schedule* (periodicity schedule) shown on **Table 1**. A comprehensive health and developmental history includes assessment of both physical and mental health development and a comprehensive unclothed physical exam. Provisions are outlined for other services such as nutritional assessment, developmental assessment, appropriate vision and hearing testing, dental screening, health education, including anticipatory guidance, and include administration of or referral for any other test, procedure or immunization that is medically necessary or clinically indicated.

Any treatment found necessary to correct or ameliorate defects and physical and mental illnesses and conditions as a result of a diagnosis identified during an initial or periodic screening may be provided subject to any prior authorization requirements for the services. If a service is not covered by the IHCP, it is still available to EPSDT eligible members, only if it is necessary to correct or ameliorate defects and physical or mental illnesses and

conditions discovered by the screening services, subject to prior authorization requirements of 405 IAC 5-4

Table 1: HealthWatch/EPSDT Periodicity and Screening Schedule
Periodicity & Screening Schedule

AGE	INFANCY ₁								EARLY CHILDHOOD ₂					MIDDLE CHILDHOOD ₃					ADOLESCENCE ₄				
	NEWBORN ¹	2-4ds	By 1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	12y	14y	16y	18y	20y	
HISTORY: INITIAL/INTERVAL	•	•																					
MEASUREMENTS																							
Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Head Circumference	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Blood Pressure														•	•	•	•		•	•	•	•	
SENSORY SCREENING																							
Vision ¹	S	S	S	S	S	S	S	S	S	S	S	O ₂	O	O	S	S	O	O	S	S	O	S	
Hearing ²	S/R	S	S	S	S	S	S	S	←	←	←	←	O	O	S	S	O ₂	O ₂	S	S	O ₂	S	
DEVELOPMENTAL																							
BEHAVIOR ASSESSMENT	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
PHYSICAL EXAMINATION	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
PROCEDURES - GENERAL																							
Immunization ³	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Lead Screening ¹⁴																							
Hematoctrit or Hemoglobin																							
Urinalysis																							
PROCEDURES - PATIENTS																							
AT RISK																							
Tuberculin Test ¹⁵									R	R	R	R	R	R	R	R	R	R	R	R	R	R	
"Skin Cell Test" ¹⁶	•																						
Drug/HIV Testing ¹⁷	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	
STD Screening ¹⁸																							
Pelvic Exam																							
ANTICIPATORY GUIDANCE																							
Injury Prevention	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Dental Referral	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Dental Observation ¹⁹	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Newborn Infant Screen ¹³	•	•																					

Please Consult the EPSDT-HealthWatch Program Provider Manual for immunization schedules and risk factor definitions

Key: • = to be performed R = to be performed on patient at risk S = subjective, by history O = objective, by a standard testing method

↔ = range during which a service may be provided, with the dot or number indicating the preferred age

RELATED MEDICAL TOPICS

Immunizations
Laboratory Services
Pediatrics
Screening Services – Newborn screening
Speech and Hearing

RULES, CITATIONS, AND SOURCES

405 IAC 5-15 Early and Periodic Screening, Diagnostic, and Treatment Services
405 IAC 5-14-19 Prior authorization for early and periodic screening, diagnostic, and treatment covered services
405 IAC 5-14-2 Covered services
405 IAC 5-23-3 Covered vision care services
Department of Health and Human Services Health Care Financing Administration Transmittal No. 12 September 1998
HealthWatch EPSDT Provider Manual, Version 1.0, February 2002
Indiana Health Coverage Programs Provider Manual, July 2004

ORIGINATION, REVISIONS, AND REVIEWS

Origination Date: August 25, 1997

Revisions and Reviews	Reason	Date
405 IAC 5-2-10	“EPSDT” defined	8/25/97
405 IAC 5-15	Early and Periodic Screening, Diagnostic, and Treatment Services	8/25/97
405 IAC 5-14-19	Prior Authorization	8/25/97
405 IAC 5-14-2	Covered Services	8/25/97
HealthWatch EPSDT Provider Manual	Provider Manual	2/2002
BT 200207	New HCPCS Codes	2/15/02
BR200217	RHC and FQHC Coding Change	4/23/02
BT 200353	Elimination of Local Codes X3067 (<i>Missed Appointment</i>)	8/15/03
IHCP Provider Manual	Vaccines for Children	7/04
Review	Schedule Routine Review	10/04

APPLICABLE INDIANA A/M EDITS AND AUDITS:

6028 – Initial and periodic visits not payable on same date of service

6702 – Newborn screening limited to one per lifetime

9050 – EPSDT pricing

COVERAGE CRITERIA

Member Requirements

Hoosier Healthwise Primary Care Case Management (PCCM) or risk-based managed care (RBMC) enrollees receive HealthWatch/EPSDT screening examinations from physicians enrolled in the IHCP as Hoosier Healthwise primary medical providers (PMPs). Children who are not enrolled in PCCM or RBMC can receive screenings from any IHCP provider. EPSDT screenings for children not enrolled in Hoosier Healthwise are provided at designated federally qualified health centers (FQHC) and rural health clinics (RHC).

HealthWatch Screening Examinations

The primary goal of the HealthWatch/EPSDT program is to ensure that all IHCP eligible children receive necessary, age-appropriate, comprehensive, preventive services. Components of the screening examinations and recommended frequency of the screens are listed in the periodicity schedule. The periodicity schedule is listed in the Indiana Administrative Code (IAC) 405 IAC 5-15-8. These screenings or any portion of the screening is not required when lack of medical necessity is documented by the provider.

However, when a member receives components of an EPSDT screening or is referred elsewhere for these components, they must be accurately reflected in the member's medical record.

Any treatment found necessary as a result of a diagnosis reached during an initial or periodic screening may be provided subject to any prior authorization requirement for the specified service. If a service is not covered by the IHCP, it is still available to a HealthWatch/EPSDT-eligible member if it is necessary to correct or improve a physical or mental illness or condition discovered during a screening subject to prior authorization requirements.

HealthWatch/EPSDT screens are reimbursed at a higher rate than other child exams. Reimbursement for the initial patient exam is limited to the first screen performed by the screening provider during the member's lifetime. In order to claim a higher reimbursement, the following components of the screening must be provided and documented in the member's medical record.

- A health and developmental history, including assessment of both physical and mental health development
- An unclothed physical exam
- A nutritional assessment
- A developmental assessment
- Vision observation at each screening and direct referral to an optometrist or ophthalmologist starting when objective screening methods indicate a referral is warranted
- Hearing observation at each screening and objective testing with audiometer at four years, administered or referred
- Dental observation at each screening. Direct referral to a dentist starting at 24 months old. Dental referrals may be made as early as 12 months old when indicated.
- Laboratory tests, including blood lead level assessment appropriate for age and risk factors
- Immunizations administered or referred, if needed at time of the screening
- Health education, including anticipatory guidance

Further details of the components of HealthWatch/EPSDT screenings are available in the HealthWatch EPSDT Provider Manual.

Billing HealthWatch/EPSDT Screening Examinations

HealthWatch/EPSDT visits are billed on the CMS-1500 claim form or 837P transaction. HealthWatch/EPSDT claims billed to the IHCP must be coded with the following.

- The appropriate patient examination code (99381-99395, 99391-99395) must be included on the first detail line of the medical claim form

- The preventive health diagnosis code, V20.2 (*Routine infant or child health check*), as the **primary** diagnosis. Physicians are encouraged to include all applicable diagnosis codes (up to four) and procedure codes on the claim for each HealthWatch/EPSTD visit
- The appropriate EPSTD reimbursement rate for the initial or established patient exam billed.

The required examination codes providers are to use vary by the age of the member. The appropriate examination procedure codes are listed in **Table 2** by age.

Table 2: EPSTD Screening Examination Codes

Age	Initial Patient Exam	Established Patient Exam
Less than one year	99381	99391
One to four years	99382	99392
Five to 11 years	99383	99393
12 to 17 years	99384	99394
18 to 20 years	99385	99395

HealthWatch/EPSTD screening services are not subject to third party liability (TPL). Providers do not have to submit EPSTD claims for TPL payment prior to submitting the claim to IHCP

Providers may bill and be reimbursed for services provided in addition to the EPSTD visit. In this instance, the problem-oriented exam can be billed separately, with the -25 *modifier* (separately significantly identifiable E/M service). The visit must require additional moderate level evaluation to qualify as a separate service on the same date. IHCP reimbursement will be at the lesser of the submitted charge or the maximum fee for each additional service.

Members who miss HealthWatch/EPSTD appointments or follow-up appointments must be identified and their names forwarded to the Hoosier Healthwise Helpline or the Hoosier Healthwise benefit advocate. Claim submission for missed appointments is not required and reimbursement will not be made for missed appointments. Providers may not bill IHCP members for missed appointments.

Required EPSTD Referrals

HealthWatch/EPSTD providers are required to make dental, vision, hearing, and lead screening referrals when screening results indicate a problem. Providers may refer members for dental services beginning at 24 months old or as early as 12 months, if indicated in the screening. Vision referrals must be made when objective screening methods indicate a problem is present. Newborns with hearing deficit identified under the universal newborn screening program must be referred to the First Steps program. Older members in need of additional testing should be referred for additional testing and treatment when screening results indicate a possible hearing deficit. **Tables 2, 3, and 4** show the schedules for dental, vision and hearing observation and screenings

**Table 3: Periodicity Schedule for HealthWatch/EPSTD
Dental Observation and Screening**

Age of Child	Recommended (S) or Required (R)	Services
12 to 24 months	S	Direct referral to a dentist if necessary
24 months	R	Direct referral to a dentist for examination, preventive dental care, and anticipatory guidance
24 months through 20 years	R	Regular dental assessments at intervals defined by the dentist, approximately every six months. The individual member assessment should include examination, preventive dental care, and anticipatory guidance.

**Table 4: Periodicity Schedule for HealthWatch/EPSTD
Vision Observation and Screening**

Age of Child	Recommended (S) or Required (R)	Services
Up to 3 years	S	Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality is suspected.
3 to 5 years	R	Annual objective screening test by standard testing method. If warranted, refer child to an appropriate specialist.
6,8,14,16,18 years	S	Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality is suspected.

Table 4, con't.

Age of Child	Recommended (S) or Required (R)	Services
10, 12, 18	R	Objective screening test by a standard testing method. If warranted, refer child to an appropriate specialist.

**Table 5: Periodicity Schedule for HealthWatch/EPSTD
Hearing Observation and Screening**

Age of Child	Recommended (S) or Required (R)	Services
Newborn	S	Newborn hearing screening via fully automated brain stem response, if available
Newborn	R	All members considered to be at risk for hearing deficit should be screened at this time.
Under 12 months	S	Subjective screening, by history and/or other infant screening using standard testing method. Refer those at risk or suspected of hearing deficit to a specialist, if warranted.
12 months through 3 years	R	As early as possible, perform an objective screening using standard testing method. Refer those at risk or suspected of hearing deficit to a specialist.
4-5 years	R	Audiometric screening with an audiometer or audioscope (refer to audiologist if necessary). Refer child at risk or suspected of hearing deficit to an appropriate specialist.

Table 5, con't.

Age of Child	Recommended (S) or Required (R)	Services
4, 8, 14, 16, 20 years	S	Subjective screening, by history and/or other method; refer child with suspected hearing deficit to an appropriate specialist.
10, 12, 18 years	R	Objective hearing screening by a standard testing method; (hearing tests are given by Indiana Dept. of Education in grades 1, 4, 7, and 10 – several schools also test kindergarten students). Do not duplicate school screenings unless a child is considered at risk and rescreening is warranted.

Blood lead screenings must be performed at the nine-month, 12 month, and 24 month visits. If the member is at high risk for lead exposure, the initial screening should be done at the six-month visit. The OMPP recommends that blood samples drawn for lead screening be sent to labs participating in the Indiana Childhood Lead Poisoning Prevention Program (ICLPPP). Providers that send blood samples to ISDH/ICLPPP laboratories can use code 36415, *collection of venous blood by venipuncture*, to indicate that blood draws were made. Sending blood samples to a participating lab ensures that the results are recorded in the ILCPPP database. The three ILCPPP laboratories are the Vanderburgh County Department of Health, Marion County Department of Health, and the Indiana State Department of Health in Marion County. The ILCPPP provides medical supplies, mailing containers and postage for providers registered in the program and tracks blood lead screening results geographically to identify areas at risk. The IHCP will not reimburse a conveyance fee for sending samples to the lab if the ILCPP postage paid kit is used. Providers that send blood sample to private labs should use the codes in **Table 2**, as appropriate.

Table 6: CPT Codes for Blood Samples Sent to Private Labs

CPT Code	Definition
36415	Collection of venous blood by venipuncture
99000	Handling and/or conveyance of specimen for transfer from physician's office to a laboratory
99001	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to laboratory (distance may be indicated)

Vaccines for Children

The Vaccines for Children (VFC) program is a federally funded program that works to raise childhood immunization levels in the United States by supplying health care providers with free vaccines for children 18 years old and younger. To be eligible for the VFC program, a child must meet one of the following criteria.

- Enrollment in IHCP
- Without health insurance
- Identified by parent or guardian as American Indian or Alaskan native
- Underinsured, for example, the child has health insurance that does not cover immunizations

The VFC program currently offers free vaccines against the following diseases.

- Diphtheria
- Hemophilus influenza type B (Hib)
- Hepatitis B(HepB)
- Measles, mumps and rubella (MMR)
- Pertussis (Whooping cough)
- Polio
- Tetanus
- Varicella (Chickenpox)
- Pneumococcal disease

IHCP providers are not required to participate in this program. If a provider chooses not to participate in this program, they must provide appropriate vaccine referrals, patient follow-up, and documentation of immunization history. If a Hoosier Healthwise provider chooses not to participate in the program, they must have a mechanism in place to ensure that members under their care are immunized.

VFC vaccines provided by fee-for-service providers are reimbursed at the lesser of the submitted charge or the current VFC administration fee. Reimbursement under the RBMC delivery system is administered by the managed care organizations.

To bill the IHCP for VFC vaccine administration ICD-9 code V20.2 must be the primary diagnosis and the appropriate procedure code for the specific vaccine being administered. Providers are not to bill for more than the VFC vaccine administration time on the date of service. The IHCP only allows one vaccine administration fee per encounter, regardless of the number of vaccines given at one time. If the only service provided during the encounter is vaccine administration, the provider may not bill for an office visit. An office visit can only be billed if a separate, identifiable service is performed during the same visit **Table 7** shows the procedure codes for vaccines covered in the VFC program.

Table 7: Procedure Codes for VFC Vaccines

Procedure Code	Vaccine
90645	Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648	Hemophilus influenza b vaccine (Hib) PRP-T conjugate (4 dose schedule), for intramuscular use
90655	Influenza Virus Vaccine, split virus, preservative free, for children 6-35 months dosage, for IM or jet injection use, per 0.25 ml
90656	Influenza Virus Vaccine, split virus, preservative free, for children and adults three years of age and above, dosage for IM or jet injection use, per 0.5 ml
90657	Influenza Virus Vaccine, split virus, for children 6-35 months dosage, for IM or jet injection use, per 0.25 ml
90658	Influenza Virus Vaccine, split virus, for children and adults three years of age and above, dosage for IM or jet injection use, per 0.5 ml
90660	Influenza virus vaccine, live, for intranasal use
90669	Pneumococcal Conjugate, polyvalent, for children under 5 years for intramuscular use
90700	DTaP
90702	DT
90707	MMR
90713	Inactivated Polio Vaccine (e-IPV)
90716	Varicella
90718	Td
90721	DTaP-HIB
90723	DTaP-IPV-HepB, brand name Pedirix
90744	HEP B-Ped
90748	HepB-Hib combination, brand name Comvax

EPSDT-HEALTHWATCH FACT SHEET ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the EPSDT-Healthwatch Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: NL200506 **Publication Date:** 06/2005

Subject: Vaccines for Children and Injectables

Date Added to Manual: 07/29/2005

Text of Publication

Provider-Purchased Vaccine

When a provider administers immunizations using the provider's private stock, refer to IHCP provider bulletin, *BT200151*, for use of the administration code 90788, as appropriate, for the additional \$2.75 rate.

Administration Fee

Separate reimbursement is allowed when the administration of the drug is the only service billed by the practitioner. In addition, if more than one injection is given on the same date of service and no E/M code is billed, providers may bill a separate administration fee for each injection using 90788. When billing for privately purchased vaccine, bill an administration code in addition to the CPT code to obtain reimbursement for both vaccine and its administration. Do not bill an administration CPT code when billing for VFC vaccine. VFC vaccines must be billed with the CPT code for the vaccine and the provider's charge (not to exceed \$8) for VFC vaccine administration. Medicaid maximum fee information can be found on the www.indianamedicaid.com Web site. Be aware of the member's primary medical provider assignment, managed care delivery system assignment, and third party liability resource(s).

RHCs and FQHCs

Note: RHC- and FQHC-specific encounter rates already include payment for immunizations.

When submitting RHC and FQHC claims to track encounters (such claims will be denied), bill no more than the \$8 VFC administration fee for use of VFC influenza vaccine **or** bill the usual and customary rate for the influenza vaccine CPT® plus the administration CPT 90782 for use of providerpurchased meningococcal vaccine. All immunization dollars should be included and totaled on the line specific for immunizations in cost reports submitted to Myers & Stauffer.

EPSDT-HEALTHWATCH FACT SHEET ADDENDUM B

Note: This addendum contains provider notifications that have been published since the review of the EPSDT Healthwatch Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200539 **Publication Date:** 09/27/2005

Subject: EPSDT Annual Exam or Well-Baby Exam

Date Added to Manual: 10/31/2005

Text of Publication

This notification clarifies the policy and billing requirements regarding problem-oriented exams rendered on the same date as an EPSDT annual exam or well-baby exam. The *HealthWatch Provider Manual* states, “If a patient is evaluated and treated for a problem during the same visit as an EPSDT annual exam or well child service, the problem-oriented exam can be billed separately accompanied by the -25 modifier (separate significantly identifiable E&M service). The problem must require additional moderate level evaluation to qualify as a separate service on the same date.”

Some have interpreted this statement from the manual to mean that Evaluation and Management (E&M) codes 99211, 99212, or 99213 could not be reimbursed if provided on the same date as the EPSDT annual or well baby exam. This is incorrect.

IHCP reimburses for all E&M codes billed by a physician who is providing a problem-oriented exam on the same date as the EPSDT annual or well-baby exam. This includes E&M codes 99211 through 99215. These services should be billed with modifier -25 to identify a separate significantly identifiable E&M service.

MEDICAL POLICY FACT SHEET

TITLE: EVALUATION AND MANAGEMENT SERVICES

DESCRIPTION

Evaluation and management (E&M) services are those that are provided for the assessment of a member's health or condition and direction of a member's health care. E&M services must include the following three components: (1) obtaining a medical and social history, (2) a physical examination, and (3) medical decision making.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other appropriate sources. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

E&M services must be appropriate to the diagnosis and treatment given, and providers are advised to select the CPT code that most closely describes the services rendered, and includes the three components listed above. IHCP reimbursement is available for office visits, limited to a maximum of 50 per year, per member, without prior authorization (PA). If a physician uses an emergency room as a substitute for the physician's office for nonemergency services, such services should be billed as office visits with the site of service indicated.

New patient office visits are limited to one per member, per provider within the last three years. A new patient is one who has not received any professional services from a provider within the same specialty and group practice, within the preceding three years.

If a surgical procedure is performed during the course of an office visit, the surgical fee includes the medical visit unless the member has never been seen by the provider prior to the surgical procedure, or the determination to perform surgery is made during the evaluation of the member. If an evaluation of a separate clinical condition is performed on the same day as the surgery, both the evaluation and the surgery may be billed separately.

The IHCP will provide reimbursement for eye examinations that are reported using an appropriate E&M code. Providers are advised to select the most descriptive code for the

service rendered from the E&M codes listed in **Table 1**. Refer to the Medical Policy fact sheet for Ophthalmological Services for further information.

Table 1 – Evaluation and Management Services to Report Eye Examinations

CPT Code	Description
92002 – 92014	Ophthalmological services: medical examination and evaluation with initiation of diagnostic treatment program
99201 – 99205	Office or other outpatient visit for the evaluation and management of a new patient
99211 – 99215	Office or other outpatient visit for the evaluation and management of an established patient
99241 – 99245	Office consultation for a new or established patient
99251 - 99255	Initial inpatient consultation for a new or established patient
99261 - 99263	Follow-up inpatient consultation for an established patient
99271 - 99275	Confirmatory consultation for a new or established patient

An initial prenatal visit can be reported with the appropriate E&M codes (CPT codes 99201 through 99215), and the appropriate trimester modifier and the expected date of delivery. Additionally, outpatient office visits rendered to pregnant members, if related to a concurrent medical condition requiring medical care or consultative referral, are to be reported with the appropriate E&M codes. Medical problems that complicate labor and delivery management may require additional resources that are reported utilizing an appropriate E&M code. Refer to the Medical Policy fact sheet for Obstetrical Services for further information.

PRIOR AUTHORIZATION

E&M services as described in **Table 2**, which exceed 50 visits, per rolling calendar year, per member require prior authorization (PA). Additionally, PA is required for any physician service that is rendered during an inpatient hospital stay and reimbursed using a level-of-care methodology, such as psychiatric, rehabilitation, and burn treatment.

Table 2 – Evaluation and Management Services Requiring PA After 50 Visits Per Member Per Rolling Calendar Year

CPT Code	Description
99201 – 99205	Office or other outpatient visit for the evaluation and management of a new patient
99211 – 99215	Office or other outpatient visit for the evaluation and management of an established patient
99241 – 99245	Office consultation or a new or established patient
99271 - 99275	Confirmatory consultation for a new or established patient
99381 – 99387	Initial comprehensive preventive medicine evaluation and management of an individual
99391 – 99397	Periodic comprehensive preventive medicine reevaluation and management of an individual

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for guidelines about E&M codes specific to the MCO. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in Hoosier Healthwise PrimeStep (PCCM) receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the Hoosier Healthwise Manual for Primary Medical Providers and Office Staff for further information.

Hoosier Healthwise providers must report family planning office visits with the appropriate E&M codes for the initial and each established patient office or outpatient visit. Appropriate documentation should be maintained in the member's medical record to support the level of coding appropriate to the service rendered.

BILLING REQUIREMENTS

Professional services rendered during the course of a hospitalization must be submitted on the CMS-1500 or via an 837P electronic transaction. If a physician uses an emergency department as a substitute for the physician's office for nonemergency services, these visits should be billed with a CPT code used for a visit in the office with the site of service indicated. Providers who perform procedures in an outpatient setting or place of service 22, 23, or 62, which are normally provided in a physician's office, are subject to a site of service payment adjustment, which is 80 percent of the practice expense component of the statewide RBRVS IHCP Fee Schedule. The IHCP does not provide reimbursement for E&M codes reported with treatment room or emergency room revenue codes 45X, 51X, 52X, 70X, 71X, 72X, and 76X.

New patient office visits are limited to one visit per member, per provider, within the last three years. A new patient is one who has not received any professional services from a provider within the same specialty and group practice, within the preceding three years.

If a surgical procedure is performed during the course of an office visit, the surgical fee includes the medical visit unless the member has never been seen by the provider prior to the surgical procedure, or the determination to perform surgery is made during the evaluation of the member. If an evaluation of a separate clinical condition is performed on the same day as the surgery, both the evaluation and the surgery may be billed separately. Providers are advised to report the appropriate E&M code with Modifier 25, *Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*, to indicate that there was a significant, separately identifiable E&M service by the same physician on the same day of a procedure. Modifier 57, *Decision for surgery*, is to be reported to indicate that an

E&M service resulted in the initial decision to perform surgery. Appropriate documentation must be included in the medical record to substantiate the need for an office visit code in addition to the procedure code on the same date of service.

The first prenatal visit can be billed with E&M codes, CPT codes 99201 through 99215, with the appropriate trimester modifier and the expected date of delivery indicated on the CMS-1500 or 837P electronic transaction.

RELATED MEDICAL TOPICS

Chiropractic Services
Clinic Services – FQHC and Rural Health Clinic Services
Consultations – Second Opinion
Emergency Medicine – Emergency Services
EPDST
Family Planning
Hospital Inpatient
Hospital Outpatient
Obstetric Services
Ophthalmological Services
Podiatry

RULES, CITATIONS, AND SOURCES

405 IAC 5-9-1 - Evaluation and Management Services
Hoosier Healthwise Manual for Primary Medical Providers and Office Staff
January 2003
Hoosier Healthwise EPSDT Provider Manual
Version 1.0, February 2002
Indiana Health Coverage Programs Provider Manual
1999
Version 5.1, March 2005
Indiana Health Coverage Programs Provider Bulletins
BT199916 – Changes in Policy and Billing of Vision Services
BT200136 – Outpatient Hospital and Ambulatory Surgical Centers

Origination Date: 12/31/2000

Revisions and Review	Reason	Date
Revision	407 IAC 5-9-9 Transferred - Second Opinions 470 IAC 5-9-10; 5-9-11 Transferred - Office Visits	7/1/91
Revision	405 IAC 1-7-9 - Second Opinions - Repealed 8/24/97 405 IAC 5-9 - Evaluation and Management Services	1/1/92
Review	Scheduled Review	10/31/05

APPLICABLE INDIANA A/M EDITS AND AUDITS:

- 4108 – No ASC on file.
- 6004 – Established Intermediate Office Visit (One Every 30 Days)
- 6005 – Established Extended Office Visit (One Every 60 Days)
- 6006 – Only One New Patient Visit per Three Years
- 6009 – Medical Versus Medical Overlaps Previous In-Hospital Care
- 6010 – Excessive Physical Exam/One Physical Exam (Same Provider Within 12 Months)
- 6012 – Medical Services 30 per Rolling Calendar Year
- 6013 – Multiple In-Hospital Visits Same Day Same Provider
- 6014 – Global Payable at a Reduced Fee When Components Paid – Respiratory System
- 6019 – Initial or Established Visits Not Payable Same Date of Service as W6511 or W6512
- 6027 – Select Medical Services Reimbursable Only Once per Day
- 6028 – Initial and Periodic Visits Not Payable Same DOS (EPSDT)
- 6041 – E&M Codes Not Reimbursable with Prenatal Codes
- 6042 – Prenatal Codes Not Reimbursable with E&M Codes
- 6064 – Components Not Payable When Global Paid – Medical System
- 6069 – Office Visits 50 per Year
- 6082 – Nursing Facility Visits Versus DME Service
- 6090 – Office Visits Limited to One per Year - Podiatrist
- 6091 – One Initial Office Visit per Member - Podiatrist
- 6096 – CPT/HCPCS Code Billed is Not Payable According to the PPS Reimbursement Methodology
- 6098 – Chiropractic Services Limited to Procedure and Diagnosis Codes Identified
- 6099 – Reimbursement is Limited to 50 Chiropractic Services
- 6101 – Chiropractic Restrictive Office Visits Codes (New Patient)
- 6102 – Chiropractic Office Visit Limited to Five per Year
- 6111 – Chiropractic Office Visits Limited to Five (5) per Calendar Year
- 6150 – Consultation Billed 15 Days Before or After Another Consultation
- 6151 – Consultations Billed Seven Days Before or After Surgery

- 6152 – Surgery Payable at Reduced Amount When Consultation Paid Days Before or After Surgery
- 6211 – Periodic/Limited Oral Eval Limit One Every Six Months
- 6508 – Same Day Discharge
- 6610 – Routine Vision Exam Limited to One Exam per Twelve (12) Months for ages 1-18 years
- 6611 – Routine Vision Exam Limited to One Exam per Twenty-four (24) Months for ages 19-999 years
- 6637 – Drug Administration is Not Payable on the Same DOS
- 6649 – Surgery Payable at Reduced Rate Amount When Related Postoperative Care Paid
- 6650 – Lifetime Procedures are Limited to One per Lifetime
- 6653 – Postoperative Care Within Zero to 90 Days of Surgery
- 6654 – Preoperative Care Within One Day of Surgery
- 6655 – Surgery Payable at Reduced Amount When Preoperative Care Paid
- 6656 – Postoperative Care Within 10 Days of Select Surgery
- 6657 – Preoperative Care on Day of Surgery
- 6658 – Surgery Payable at Reduced Amount When Preoperative Care Paid Same Date of Service
- 6659 – Surgery Payable at Reduced Amount When Related Postoperative Care Paid
- 6660 – Preoperative and Postoperative Care Billed With Unlisted Surgeries Requires Review
- 6858 – Excessive Nursing Home Visits – More Than One per 27 Days
- 6903 – PCCM Office Visits Greater than 30 Visits per Member per Year Requires PA
- 6911 – Therapeutic or Diagnostic Injection

MEDICAL POLICY FACT SHEET

TITLE: FAMILY PLANNING

DESCRIPTION

Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Such services include the following.

- ◆ Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated
- ◆ Follow up care for complications associated with contraceptive methods issued by the family planning provider
- ◆ Health education and counseling necessary to make informed choices and understand contraceptive methods
- ◆ Laboratory tests, if medically indicated as part of the decision making process for choice of contraceptive methods
- ◆ Limited history and physical examinations
- ◆ Pregnancy testing and counseling
- ◆ Provision of contraceptive pills, devices, and supplies
- ◆ Screening, testing, and counseling of members at risk for HIV and referral and treatment
- ◆ Tubal ligations, Essure sterilization procedure
- ◆ Vasectomies
- ◆ Abortions, in accordance with 405 IAC 5-28-7 (consult the MP fact sheet entitled “Abortion.”)

SUMMARY OF CURRENT POLICY

Indiana Health Coverage Programs (IHCP) reimbursement is available for family planning services rendered by IHCP enrolled providers, including but not limited to physicians, certified nurse-midwives, family planning clinics, and hospitals. The IHCP does not place any restrictions on access to family planning services for members of childbearing age and who desire such services and supplies. Hoosier Healthwise members may obtain information about accessing family planning services from their Primary Medical Provider (PMP).

PAP smears are included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines. The Task Force has

concluded that most cases of cervical cancer occur in women who are not screened adequately. The guidelines recommend cervical cancer screening every one to three years, based on the presence of risk factors such as early onset of sexual intercourse and multiple sexual partners. However, PAP smear annual frequency may be reduced if three or more annual smears are normal.

IHCP reimbursement for abortions is available only if the procedure is performed to preserve the life of the pregnant woman or in other circumstances when the abortion is required to be covered by Medicaid under federal law. The IHCP reimburses for medical abortion by oral ingestion of medication using the same coverage criteria applicable to surgical abortions. For more information on abortion guidelines, please consult the MP fact sheet entitled "Abortion."

RELATED MEDICAL TOPICS

Abortion

Clinic Services – FQHC and Rural Health Clinic Services

EPDST

Gynecology – Pelvic Exam under Anesthesia

Gynecology – Services Requiring Prior Authorization

Pharmacy

Sterilization

RULES, CITATIONS, AND SOURCES

42 CFR 441.20 Family Planning Services

42 CFR 431.51(b)(2) Free Choice of Providers

IC 12-15-5 Services Provided

IC 16-36-1-3 – Consent to own health care; minors

405 IAC 5-24-7 Pharmacy Services-- Copayment for legend and nonlegend drugs

405 IAC 5-22-3 Nursing and Therapy Services-- Certified nurse midwife services

State Medicaid Plan 08/01/95

Social Security Act, Section 1905 (a)(4)(C)

Indiana Medicaid Update Bulletin 95-17

Indiana Medicaid Update Bulletin 96-38

Indiana Medical Assistance Program Provider Manual 1994

Indiana Health Coverage Programs Provider Manuals 1999, 2002, and 2004

HealthWatch EPSDT Provider Manual, Version 1.0, February 2002

Hoosier Healthwise Manual for Primary Medical Providers and Office Staff, January 2003

Indiana Health Coverage Programs Newsletter NL200403

Indiana Health Coverage Programs Newsletter NL200405 – Essure Sterilization

Indiana Health Coverage Programs Bulletin BT200433

Indiana Health Coverage Programs Newsletter NL200412
 State of Indiana Request for Proposals (RFP) 4-79 –“Solicitation for Managed Care
 Organization Services”

ORIGINATION, REVIEWS, AND REVISIONS

Origination date: 12/31/2000

Review and Revisions	Reason	Date
Revision –Bulletin 96-38	MCO's coverage of Family Planning	7/1/91
Revision - 470 IAC 5-8-19 Transferred	Nursing and Therapy Services	7/1/91
Revision - 405 IAC 1-6-20 Repealed 08/24/97	Nursing and Therapy Services	1/1/92
Revision - 405 IAC 1-6-21.1 Repealed 08/24/97	Family Planning and Pharmacy Services	11/4/93
Revision - State Medicaid Plan	Family Planning and Copay exemptions	8/1/95
Revision - 405 IAC 5-24-7	Pharmacy Services-- Copayment For Legend And Nonlegend Drugs	8/24/97
42 CFR 441.20	Family Planning Services	
405 IAC 5-22-3	Nursing And Therapy Services-- Certified Nurse Midwife Services	8/24/97
IC 12-15-5-1 Services Provided	Public Law 2-1992, SEC. 9; Amended by Public Law 24-1997, SEC. 48; Public Law 149-2001, SEC.1.	
405 IAC 1-8-4 Client copayment		12/02/93, readopted 6/27/01
Review and Revision	Scheduled review, Essure Sterilization Procedure, Medical Abortion by Oral Medication	1/31/05

APPLICABLE INDIANA A/M EDITS AND AUDITS

1011 – Member's PMP Is Missing
 6704 – Family Planning/One Within 12 Months
 6998 – Sterilization Consent Form Improperly Completed

COVERAGE CRITERIA

Contraception

Norplant and related services are reimbursable once per member, per five years. If removal and re-implantation at the same or different incision site is performed prior to five years from the previous implantation, reimbursement is available for the removal only. Specific information for reimbursement of the Norplant system is available in the Provider Manual, Chapter 8.

Condoms are considered medically necessary for men and women in the prevention of pregnancy and to reduce the risk of sexually transmitted disease. Therefore, reimbursement is available for HCPCS code A4267, *Contraceptive supply, condom, male* for both male and female IHCP members.

Sterilization (Essure device)

The IHCP covers the Essure implant device as a sterilization option. Essure is an implant device providing a non-incision permanent sterilization option. The implant can be performed by a medical doctor (MD) or a doctor of osteopathy (DO) trained in the procedure and can be performed in the office, at an outpatient hospital facility, or in an Ambulatory Surgical Center (ASC).

An outpatient hospital facility or ASC must adhere to the following billing instructions to receive reimbursement in addition to the outpatient ASC rate. No additional reimbursement is available if the service is performed in an inpatient setting.

- ◆ Outpatient hospitals and ASCs must bill for the device using HCPCS code A9900, *Miscellaneous supply, accessory, and or service component of another HCPCS code* on the CMS-1500 claim form under their professional number or durable medical equipment (DME) number.
- ◆ Outpatient hospitals and ASCs must submit a cost invoice with the claim to support the actual cost of the device. Reimbursement will be the lesser of the following amounts.
 - 130 percent of the amount listed on the cost invoice
 - The provider's usual and customary charge
 - The Statewide maximum
- ◆ Providers must submit a valid, signed *Sterilization Consent Form* with the claim.
- ◆ Providers must enter **ICD-9-CM V25.2 – Sterilization** as the primary diagnosis on the claim.
- ◆ Providers must print “Essure Sterilization” in the body of the claim form or on the accompanying invoice.

The following instructions must be followed when the procedure is performed in the office.

- ◆ Providers must submit the professional service on the CMS-1500 claim form using Current Procedural Terminology (CPT) code 58565, *Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants*.
- ◆ Providers must submit the signed *Sterilization Consent Form* with the claim.
- ◆ Providers must bill the device on a separate line item on the claim using HCPCS code A9900.
- ◆ Providers must submit a cost invoice with the claim to support the actual cost of the device. Reimbursement is the lesser of the following amounts.
 - 130 percent of the amount listed on the cost invoice
 - The provider's usual and customary charge
 - The statewide maximum

Sexually Transmitted Diseases (STDs)

Based on CMS' policies, initial diagnosis and treatment of STDs, HIV testing and counseling **provided during a family planning encounter** are considered part of the family planning services. Ongoing follow-up of STDs and visits for treatment of chronic STDs are not part of family planning services. Referral to the primary medical provider should be made for ongoing treatment and follow up of chronic STDs to maintain continuity of patient care.

BILLING INFORMATION

Services and supplies not classified as drugs or biologicals must be billed using the CMS claim form 1500 or 837P. These services should be billed using appropriate CPT or HCPCS codes and appropriate ICD-9-CM diagnosis codes for the services rendered or the condition treated.

Physicians and family planning clinics using the appropriate NDCs on the *IFSSA Drug Claim Form* can bill for contraceptive pills, devices, and supplies, including Norplant. For specific information regarding claims filing, refer to the IHCP Provider Manual, under Family Planning Services.

Family planning services and supplies furnished to members of child-bearing age are exempt from the pharmacy services co-payment requirement, including oral contraceptives. Pharmacy services provided to RBMC members follow the specific guidelines of the appropriate MCO.

Specific billing information for the Essure device is available in the Coverage Criteria section of this fact sheet.

Hoosier Healthwise/Risk Based Managed Care

Family planning services under Federal regulation 42 CFR 431.51(b)(2) require a freedom of choice of providers and access to family planning services and supplies. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy including, but not limited to, birth control pills. Hoosier Healthwise members may not be restricted in choice of a family planning service provider. The IHCP Provider Manual provides a complete and current list of family planning services.

The MCOs participating in Hoosier Healthwise must allow their members to obtain birth control pills on a self-referral basis. OMPP recognizes the need for appropriate management of prescription medication in the interest of the member's health; however, OMPP also recognizes the importance of removing barriers to family planning services. To reduce potential barriers to obtaining birth control pills, which may include, but may not be limited to, transportation to pharmacies for periodic refills, the MCOs must, at a minimum, reimburse for the dispensation of up to a 90 calendar day supply for birth control pills at one time per member, if prescribed.

For more information on family planning in the Risk Based Managed Care program, please consult the individual MCO.

Hoosier Healthwise/Primestep

The Hoosier Healthwise Manual for Primary Medical Providers (PMPs) and Office Staff Section 4.12, Family Planning, page 23, indicates family planning is covered in the following manner.

Members may seek family planning services from any qualified IHCP enrolled provider without PMP authorization. However, if a family planning provider diagnoses a particular condition in a member and subsequently initiates treatment (i.e. sexually-transmitted diseases) the family planning provider must refer the patient back to the PMP if treatment continues for more than one month. At that time, the PMP will assume case management and determine whether or not further treatment is medically necessary. If additional treatment is required, the PMP may either continue treatment at the PMP site or authorize the family planning provider to do so.

FAMILY PLANNING FACT SHEET ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Family Planning Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200539 **Publication Date:** 09/27/2005

Subject: HCPCS code J7303, *Contraceptive supply, hormone containing vaginal ring, each*, and J7305, *Contraceptive supply, hormone containing patch, each*

Date Added to Manual: 10/31/2005

Text of Publication

This article advises providers that the Indiana Health Coverage Programs (IHCP) has approved coverage of Healthcare Common Procedure Coding System (HCPCS) codes J7303 – *Contraceptive supply, hormone containing vaginal ring, each*, and J7304 – *Contraceptive supply, hormone containing patch, each*, effective October 1, 2005. Providers must bill J7303 and J7304 instead of a miscellaneous supply code because they are more specific to the service being supplied. HCPCS code J7303 reimburses a max fee rate of \$41.48 and HCPCS code J7304 reimburses a max fee rate of \$14.31. Direct questions about this article to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

MEDICAL POLICY FACT SHEET

TITLE: GASTROENTEROLOGY

DESCRIPTION

Gastrointestinal disorders are disorders that affect the digestive system including, but not limited to, the esophagus, stomach, small intestines, and large intestines. Such disorders often simultaneously affect multiple digestive organs. Symptoms associated with these disorders include, but are not limited to, abdominal pain, flatulence, bleeding, difficulties swallowing, poor appetite, nausea, and vomiting.

Diagnostic procedures utilized to determine appropriate treatment methods include endoscopy, computed tomography (CT)/magnetic resonance imaging (MRI), and manometry. Below are brief descriptions of these diagnostic procedures.

- **Endoscopy**

This procedure utilizes a flexible tube to view different internal structures. Evidence of abnormalities such as inflammation, infection, or tumors may be detectable. Laparoscopy is an examination of the abdominal cavity with an endoscope. Other uses for this procedure include obtaining tissue samples and reparative procedures.

- **Computed Tomography (CT)/Magnetic Resonance Imaging (MRI)**

A magnetic field allows cross-sections of organs to be evaluated. The visual image contains scans of the underlying organs. These diagnostic procedures determine size and location of abnormalities in organs such as tumors, changes in the path and size of blood vessels, and inflammation.

- **Manometry**

A tube connected to pressure gauges is inserted in the esophagus. This test determines whether the muscle contractions of the esophagus are adequate for swallowing purposes.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

IHCP reimbursement is available for medically necessary gastrointestinal services for the evaluation, diagnosis, and treatment of such disorders.

PRIOR AUTHORIZATION

Services must be medically reasonable and necessary and required for the care and well-being of the member. Services must be provided in accordance with generally accepted standards of medical or professional practice. Gastroplasty and gastrointestinal surgeries require prior authorization (PA). Services rendered without appropriate PA are noncovered. Refer to the medical topics cross reference section of this fact sheet and the IHCP Provider Manual for specific procedure requirements and limitations.

The following information describes the coverage for the diagnostic examinations computerized tomography and upper gastrointestinal studies. Services rendered outside of these guidelines are noncovered.

Computerized tomography

Diagnostic examinations performed by computerized tomography (CT) scanners are covered services and do not require PA. These examinations are subject to the following guidelines.

- The scan should be reasonable and necessary for the individual member.
- The use of a CT scan must be found to be medically appropriate considering the member's symptoms and preliminary diagnosis.
- Reimbursement will be made for CT scans performed with equipment certified by the Food and Drug Administration.
- CT scans for the treatment of cancer, whole abdomen or whole pelvis areas (greater than 20 cuts), are reimbursable.

Upper gastrointestinal studies

Medicaid reimbursement is available for upper gastrointestinal (GI) studies when performed for the detection and evaluation of diseases of the esophagus, stomach, and duodenum.

- An upper GI study is not a covered service for a patient with a history of duodenal or gastric ulcer disease unless recently symptomatic.
- An upper GI study is not a covered service in the preoperative cholecystectomy patient unless symptoms indicate an upper GI abnormality in addition to the cholelithiasism or if the etiology of the abdominal pain is uncertain.

BILLING REQUIREMENTS

Multiple diagnostic and operative procedures billed on the same day, by the same provider, are subject to the IHCP multiple surgery and reimbursement guidelines.

MANAGED CARE ORGANIZATIONS

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the IHCP

Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and RBMC delivery systems.

IHCP members enrolled in *Medicaid Select* receive the same benefit coverage, and are subject to the same limitations as Traditional Medicaid FFS. Refer to the *Medicaid Select* Provider Manual for Primary Medical Providers and Office Staff for further information.

MEDICAL TOPICS

Anesthesia Services
Bariatric Services
Consultations – Second Opinion Services
Diagnostic Services
Emergency and Evaluation Management Services
Home Health Services
Inpatient Hospital Services
Managed Care Organization Services
Nursing Services
Outpatient Hospital Services
Pharmacy Services
Radiology
Surgery Services
Transplant Services
Weight Reduction Services

RULES, CITATIONS, AND SOURCES

Indiana Administrative Code (IAC)

- 405 IAC 5-3-13 – Services requiring prior authorization
- 405 IAC 5-1-5 – Global Fee Billing
- 405 IAC 5-27-3 – Computerized tomography; general
- 405 IAC 5-27-5 – Upper gastrointestinal studies
- 405 IAC 5-28-1 – Medical and Surgical Services; Reimbursement limitations
- 405 IAC 5-28-2 – Medical and Surgical Services; Medical diagnostic procedures
- 405 IAC 5-29-1 – Services Not Covered by Medicaid; Noncovered services

Indiana Health Coverage Programs Banner (BR)

- BR200513 – Gastrointestinal Tract Imaging

Indiana Health Coverage Programs Bulletin (BT)

- BT200306 – All Pharmacy Providers and Prescribing Practitioners

Indiana Health Coverage Programs (IHCP) Provider Manual

- 1994
- 1999
- 2005

Origination Date: 12/31/2000

Revisions and Reviews	Reason	Date
Revision	470 IAC 5-9-1 Transferred Global Fee Billing	07/01/1991
Revision	405 IAC 1-7-1 Repealed 08/24/1991 Global Fee Billing	01/01/1992
Review	405 IAC 1-7-19 Repealed 08/24/1997 Radiology Services-Upper GI studies	01/01/1992
Review	405 IAC 5-27-5 Radiology Services Upper gastrointestinal studies	08/24/1997
Review	405 IAC 5-29-1 Services Not Covered By Medicaid—Noncovered Services	08/24/1997
Revision	405 IAC 5-1-5 Global Fee Billing; Codes	08/24/1997
Review	405 IAC 5-29-1 Amended Services Not Covered By Medicaid—Noncovered Services	10/27/1999
Review	Scheduled	10/31/2006

APPLICABLE INDIANA A1M EDITS AND AUDITS

6022— Components not billable when global fee paid

6023— Global payable at a reduced fee when components paid

MEDICAL POLICY FACT SHEET

TITLE: GENETIC TESTING – BRCA1 AND BRCA2 FOR BREAST AND OVARIAN CANCER

DESCRIPTION

Two genes (BRCA1 and BRCA2)¹ are associated with susceptibility to breast and ovarian cancer. Often, family members of those diagnosed with breast or ovarian cancer share a gene mutation. Therefore, testing of the diagnosed individuals and family members can identify those family members at higher risk of developing breast or ovarian cancer. Presence of a gene mutation does not predict the certainty of cancer, but indicates the individual is at higher risk for developing breast or ovarian cancer and can utilize increased surveillance and screening measures, as well as make appropriate lifestyle changes to decrease the likelihood of developing a malignancy.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources, as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

The IHCP provides reimbursement for BRCA1 and BRCA2 genetic testing when determined to be medically necessary for women with a personal history of breast cancer, developing contralateral disease (disease in the opposite breast), or families with history of breast and ovarian cancer. IHCP members referred to an oncologist or geneticist for BRCA1 and BRCA2 testing must have a completed personal and family cancer history that should include three generations on both maternal and paternal sides of the family in the member's medical record to include the following.

- a. relatives with breast, ovarian, and other relevant cancers, such as prostate and colon cancer
- b. age at diagnosis in affected family members
- c. other significant factors, such as ethnic background

¹ The acronym BRCA has been given to the genes that are specific to breast and ovarian cancer.

PRIOR AUTHORIZATION

Prior authorization will be given for BRCA1 and BRCA2 genetic testing, utilizing the HCPCS codes listed in **Table 1**, when medically necessary in the following circumstances.

1. Clinically affected individuals (invasive breast cancer or ovarian cancer at any age) meeting at least one of the following criteria.
 - a. One or more first (mother, father, sister, or daughter) or second-degree (aunt, uncle, grandmother, niece, or granddaughter) relatives with invasive breast cancer diagnosed before age 50
 - b. One or more first or second-degree relatives with ovarian cancer
 - c. One or more first or second-degree relatives with male breast cancer
2. Individuals with a personal history of at least one of the following (no family history required).
 - a. Invasive breast cancer before age 50
 - b. Ovarian cancer at any age
 - c. Both invasive breast cancer and ovarian cancer at any ages
 - d. Male breast cancer at any age
3. Individuals with a family member (related by blood) with a known BRCA1 or BRCA2 mutation.
4. Individuals with Ashkenazi (Eastern European) Jewish ancestry with invasive breast cancer at any age, or meeting any of the above listed (1-3) criteria.

Table 1–HCPCS Codes for Reporting BRCA Genetic Testing

HCPCS Code	Description	Comments
S3818	Complete gene sequence analysis; BRCA1 gene	S3818 and S3819 are not covered for ICD-9-CM diagnosis codes in Table 2 . (Refer to S3820.) However, reimbursement may be available for testing for other types of cancer, such as pancreatic carcinoma.
S3819	Complete gene sequence analysis; BRCA2	
S3820	Complete BRCA1 and BRCA2 gene sequence analysis for susceptibility to breast and ovarian cancer	S3820 encompasses the testing for all the genetic variations involving BRCA1 and BRCA2. Testing required is more extensive than required for the specific gene variations reported by S3822 and S3823.
S3822	Single mutation analysis (in individual with a known BRCA1 or BRCA2 mutation in the family) for susceptibility to breast and ovarian cancer	S3822 designates the test required for detection of BRCA gene mutation for an individual with a family known to have BRCA1 or BRCA2 mutation.

Table 1–HCPCS Codes for Reporting BRCA Genetic Testing

HCPCS Code	Description	Comments
S3823	Three-mutation BRCA1 and BRCA2 analysis for susceptibility to breast and ovarian cancer in Ashkenazi individuals	S3823 reports genetic testing for individuals of Ashkenazi Jewish descent. Since there are known to be fewer and more specific changes in this population group, the amount of testing required is significantly less than the general population.

Men rarely develop breast cancer and, thus, there may not be an affected first-degree relative, and the size of the family may not permit analysis of possible autosomal dominant inheritance.² BRCA testing of men with breast cancer is considered medically necessary for either of the following indications.

1. To assess the man's risk of recurrent breast cancer; or
2. To assess the breast cancer risk of a female member where the affected male is a first or second degree blood relative of that member. BRCA1 and BRCA2 testing to assess the risk of breast or prostate cancer in men without breast cancer is considered not medically necessary.

MANAGED CARE

Hoosier Healthwise members enrolled in risk-based managed care (RBMC) are allowed to receive genetic testing services for breast and ovarian cancer that are determined to be medically necessary. Hoosier Healthwise members that are enrolled in RBMC are the financial responsibility of the managed care organization (MCO) in which the member is enrolled. The MCO may have its own requirements for authorization of genetic testing services; therefore, providers must contact the MCO for further information.

BILLING REQUIREMENTS

The IHCP provides reimbursement for BRCA1 and BRCA2 genetic testing billed with the appropriate HCPCS codes, noted in **Table 1**, and with the appropriate ICD-9-CM diagnosis code, reflected in **Table 2** on the next page.

HCPCS codes S3820, S3822, and S3823 are limited to once per lifetime. If the member has S3820 completed, the IHCP will not provide reimbursement for S3822 and S3823.

HCPCS codes S3818 and S3819 will not be covered for the ICD-9-CM diagnosis codes noted in **Table 2**. S3818 and S3819 are components of S3820.

² This is a type of genetic inheritance which can be inherited from a single affected parent. Sons and daughters have an equal chance of inheriting the gene.

Table 2 – ICD-9-CM Codes Supporting Medical Necessity

Code	Description
174.0	Malignant neoplasm of female breast; nipple and areola
174.1	Malignant neoplasm of female breast; central portion
174.2	Malignant neoplasm of female breast; upper-inner quadrant
174.3	Malignant neoplasm of female breast; lower-inner quadrant
174.4	Malignant neoplasm of female breast; upper-outer quadrant
174.5	Malignant neoplasm of female breast; lower-quadrant
174.6	Malignant neoplasm of female breast; axillary tail
174.8	Malignant neoplasm of female breast; other specified sites of breast
174.9	Malignant neoplasm of female breast; unspecified
175.0	Malignant neoplasm of male breast; nipple and areola
175.9	Malignant neoplasm of male breast; other and unspecified sites of male breast
183.0	Malignant neoplasm of ovary and other uterine adnexa; ovary
183.2	Malignant neoplasm of ovary and other uterine adnexa; fallopian tube
183.3	Malignant neoplasm of ovary and other uterine adnexa; broad ligament
183.4	Malignant neoplasm of ovary and other uterine adnexa; parametrium
183.5	Malignant neoplasm of ovary and other uterine adnexa; round ligament
183.8	Malignant neoplasm of ovary and other uterine adnexa; other specified sites of uterine adnexa
183.9	Malignant neoplasm of ovary and other uterine adnexa; uterine adnexa, unspecified
V10.3	Personal history of malignant neoplasm of breast
V10.43	Personal history of malignant neoplasm of ovary
V16.3	Family history of malignant neoplasm of breast
V16.41	Family history of malignant neoplasm of ovary

RELATED MEDICAL TOPICS

Laboratory Services

Oncology – Breast and Ovarian Cancer

RULES, CITATIONS, AND SOURCES

Indiana Administrative Code

405 IAC 5-3-13

Indiana Health Coverage Programs Provider Manual

Version 5.1, March 2005

Indiana Health Coverage Programs Provider Notifications

BT200605 – Billing Requirements and PA Criteria

Origination Date: April 28, 2006

Revisions and Review	Reason	Date

APPLICABLE INDINAAIM EDITS AND AUDITS

6177 – S3818, S3819, S3822, S3823 Not Allowed if S3820 Pd

6178 – S3820, S3822, and S3823 Are Limited to Specific Dx

6179 – Genetic Testing Codes not Reimbursed with Specific Dx

6650 – Lifetime Procedures Are Limited to 1 per Lifetime

MEDICAL POLICY FACT SHEET

TITLE: GYNECOLOGY SERVICES

DESCRIPTION

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding gynecologic services. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

As defined by Stedman's Electronic Medical Dictionary, V.5.0, gynecology is the medical specialty concerned with diseases of the female genital tract, as well as endocrinology and reproductive physiology of the female. Many gynecologic conditions create infertility.

CURRENT COVERAGE**A. Pelvic Exam Under Anesthesia**

A pelvic exam performed under anesthesia may be done as part of another gynecological surgical procedure or as a single procedure. The IHCP provides reimbursement when the member requires anesthesia/conscious sedation to enable the practitioner to complete the exam. Based on accompanying documentation, medically necessary care provided prior to surgery will be reimbursed. If the examination is completed in adjunct with a surgical procedure, it will be included in the global fee schedule with the appropriate reduction applied.

Procedures requiring prior authorization (PA) cannot be rendered before acquiring PA. For such services, reimbursement will be denied if PA is not obtained. Prior authorization must be requested for emergency procedures within 48 hours of the admission or on the next business day if on a weekend or holiday.

B. Laminaria

Laminaria is derived from a perennial kelp plant, *Laminaria digitata*, which is hydrophilic. When placed in the cervical canal, laminaria gradually absorbs moisture, swells, and gently dilates the cervix. Laminaria is most frequently used to induce abortion and can be utilized to assist the dilatation of the cervix when labor is induced.

The IHCP will provide reimbursement for the laminaria, when it is used for induction of labor and the delivery is paid. When the HCPCS CPT code 59200, *Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate code)* appears with a code

indicating an abortion procedure, the claim will be denied and documentation of medical necessity will be requested.

C. Hysterectomy

Hysterectomy is a covered service only when the member has given her informed consent. The member must have been informed orally and in writing that this procedure will render her permanently incapable of reproducing, and has signed a written acknowledgement of receipt of that information. The IHCP does not provide reimbursement for a hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing, whether performed as a primary or secondary procedure.

The “acknowledgement requirement”, which must be signed by the member or member’s representative, is NOT required in the following situations.

1. The member is already sterile.
2. A life-threatening emergency situation exists for which the physician determines prior acknowledgement is not possible.

However, in the situations noted above, the physician performing the hysterectomy must certify **one of the following** in writing.

1. The member was already sterile at the time the hysterectomy was performed, and states the cause of the sterility at the time of the hysterectomy.
2. The hysterectomy was performed under a life-threatening emergency situation and that prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

Retroactive Eligibility

The IHCP will provide reimbursement for hysterectomies performed during a period of a member’s retroactive Medicaid eligibility, if the physician, who performed the hysterectomy, certifies in writing **one of the following**.

1. The member was informed before the operation that the hysterectomy would make her permanently incapable of reproducing.
2. The member was already sterile before the hysterectomy.
3. The member requires a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment is not possible. The physician who performed the hysterectomy must also include a description of the nature of the emergency.

Documentation Requirements

No specific format is mandated and examples are provided in the IHCP Provider Manual including the information necessary to satisfy IHCP documentation and certification requirements for hysterectomy procedures. The sterilization consent form cannot be used for hysterectomy procedures under any circumstances.

PRIOR AUTHORIZATION

The IHCP advises providers to report the appropriate CPT code that describes the service provided. **Table 1** lists CPT codes used to report services that include total or partial hysterectomies. This list may not be inclusive and PA requirements are as noted.

Table 1 – CPT Codes for Reporting Total or Partial Hysterectomy

CPT Code	Description	PA Requirement
51925	Closure of vesicouterine fistula; with hysterectomy	No
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	Yes
58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tubes(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz type)	Yes
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	Yes
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)	No
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	No
58260	Vaginal hysterectomy, for uterus 250 grams or less	Yes
58262	Vaginal hysterectomy for uterus 250 grams or less; with removal of tubes(s), and/or ovary	Yes
58263	Vaginal hysterectomy for uterus 250 grams or less; with removal of tubes(s), and/or ovary, with repair of enterocele	Yes
58267	Vaginal hysterectomy, for uterus 250 grams or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	Yes
58270	Vaginal hysterectomy, for uterus 250 grams or less; with repair of enterocele	Yes
58275	Vaginal hysterectomy, with total or partial vaginectomy	Yes
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele	Yes
58285	Vaginal hysterectomy, radical (Schauta type operation)	No
58290	Vaginal hysterectomy, for uterus greater than 250 grams	Yes
58291	Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)	Yes
58292	Vaginal hysterectomy, for uterus greater than 250 grams; with	Yes

Table 1 – CPT Codes for Reporting Total or Partial Hysterectomy

CPT Code	Description	PA Requirement
	removal of tube(s) and/or ovary(s), with repair of enterocele	
58293	Vaginal hysterectomy, for uterus greater than 250 grams; with colp-urethrocytopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control	Yes
58294	Vaginal hysterectomy, for uterus greater than 250 grams; with repair of enterocele	Yes
58550	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less	Yes
58552	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)	Yes
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams	Yes
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary (s)	Yes
58951	Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy	No
58953	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking	No
58954	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy	No
58956	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy	No
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)	No

Prior authorization will be granted for members with documentation supporting **one of the following**.

1. Non-malignant uterine tumor causing abnormal pressure or bleeding (lasting > eight days for > two cycles, requiring additional bleeding protection defined as large clots and gushes, limiting activity).
2. Non-malignant uterine tumor causing **one of the following**.
 - Uterus of 12 week gestational size or larger, with ill defined adnexa (<12 week gestational size, or <8 cm could have vaginal procedure).
 - Post-menopausal enlargement (>12 week gestational size necessitates abdominal procedure).
 - Rapid uterine growth over last six months.
 - Pressure on adjacent organs.
3. Cervical intraepithelial neoplasia (CIN) III diagnosed by endocervical curettage uncontrolled by conservative surgery, such as laser excision, loop electrosurgical

excision procedure (LEEP), large loop excision of transformation zone (LLETZ), or loop surgical excision.

4. Fibroids in premenopausal woman with **both of the following**.
 - Uterus >12 weeks size or documentation of need for abdominal, rather than vaginal, approach.
 - And **one of the following**.
 - Abnormal bleeding.
 - Uterus size doubled within one year.
 - Ureteral compression by ultrasound (US) or intravenous pyelogram (IVP).
 - Other symptoms, such as pelvic or abdominal pain or discomfort without other explanation, urinary frequency or urgency, or dyspareunia.
5. Fibroids in postmenopausal woman with **all of the following**.
 - Uterus >12 weeks size or documentation of need for abdominal rather than vaginal approach.
 - And **one of the following**.
 - Uterus size doubled within any time period.
 - Ureteral compression by US or IVP.
 - Other symptoms, such as pelvic or abdominal pain or discomfort without other explanation, urinary frequency or urgency, or dyspareunia.
 - Papanicolaou (PAP) smear within six months.
6. Dysfunctional uterine bleeding with **all of the following**.
 - Premenopausal woman.
 - Abnormal bleeding uncontrolled by conservative therapy, such as hormonal therapy.
 - No evidence of cancer demonstrated by hysteroscopy, endometrial biopsy, Dilation and Curettage (D&C) or transvaginal ultrasound.
 - PAP smear within six months.
7. Postmenopausal bleeding with **all of the following**.
 - Abnormal bleeding continued after change in or discontinuation of hormone replacement therapy.
 - No evidence of cancer demonstrated by hysteroscopy, endometrial biopsy, D&C or transvaginal ultrasound.
 - PAP smear within six months.
8. Pelvic inflammatory disease with **one of the following**.
 - Suspected rupture or leakage of pelvic abscess.
 - Unsuccessful management with antibiotics for 10-14 days.
 - Surgery for residual, inactive but symptomatic, disease if conservative therapy not possible.
 - Chronic Pelvic Inflammatory Disease (PID) with **both of the following**.
 - Chronic pelvic pain.
 - Adhesions, scarring, or hydrosalpinx.
9. Recurrent abnormal uterine bleeding (lasting > eight days for > two cycles, requiring additional protection defined as large clots and gushes, with limitations

- of normal activity) and benign endometrial biopsy after failed medication therapy [excluding members on birth control pills or with an Intrauterine Device (IUD)].
10. Chronic incapacitating pelvic pain, unresponsive to conservative therapy, such as analgesics, and evidence of normal gastrointestinal/genitourinary (GI/GU) evaluations.
 - A four to six month failed trial of oral contraceptives, diuretics, anti-inflammatories, or induced amenorrhea.
 - Negative examinations of urinary tract (UT), GI tract, and musculoskeletal.
 - Psychological and psychosexual counseling reveals no etiology of pain.
 11. Post-menopausal bleeding > one year after last menstrual period (LMP), (with D&C or endometrial biopsy within past six months). Positive cytology of cervix requires abdominal procedure (cervical intra-epithelial neoplasia including carcinoma-in-situ).
 12. Pre-malignant adenomatous hyperplasia or adenocarcinoma of the endometrium, confirmed by pathology report.
 13. Post-menopausal (> one year) with benign or malignant ovarian tumor and/or cyst.
 14. Abdominal procedure when associated with abdominal procedure for correction of urinary stress incontinence or vaginal repair of cystocele, rectocele, enterocele, or uterine prolapse.
 15. Uncontrolled postpartum bleeding within six hours of delivery uncontrolled by drug therapy (e.g., Pitocin, Methergine, or Prostaglandin therapy) or D&C.
 16. Endometriosis uncontrolled by hormonal therapy (e.g., depot medroxyprogesterone, oral contraceptives, GnRH agonist, or danazol), surgical ablation, or excision.
 17. Tubo-ovarian abscess.
 18. Urinary incontinence due to fistula into vagina, uterus, or perineum, and fistula demonstrated by cystoscopy, radiological examination, visual inspection, or probing.
 19. Uterine prolapse, second or third degree **and one of the following**.
 - Pain.
 - Pelvic pressure.
 - Stress incontinence.
 - Ulceration of vaginal mucosa or cervix with bleeding or spotting.
 - Vaginal splinting.

BILLING REQUIREMENTS

The appropriate documentation must be attached to the claim form, or sent separately to the Electronic Claims and Attachments address for claims submitted electronically. All providers rendering hysterectomy related services (e.g. anesthesiologist, etc.) must attach an EXACT photocopy of the appropriate sterilization acknowledgement or physician certification statement(s) to the claim(s). To ensure timely reimbursement, the primary service provider is advised to forward copies of the sterilization acknowledgement or physician certification statement(s) to these related service providers.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for specific guidelines. Refer to the IHCP Provider Manual, Chapter 1, for detailed information about fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in Hoosier Healthwise PrimeStep (PCCM) receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the Hoosier Healthwise Manual for Primary Medical Providers and Office Staff for further information.

RELATED MEDICAL TOPICS

Abortion
Anesthesia Services
Case Management Services – Pregnant Women
Clinic Services – FQHC and Rural Health Clinic Services
Family Planning
Hospital Inpatient Services
Hospital Outpatient Services
Obstetric Services
Pathology Services
Surgery-Multiple Procedures/Same Operative Session
Surgery-Office Visits
Surgery-Surgeon and Assistant Surgeon, Same Provider
Surgery-Surgery and Anesthesia By the Same Provider
Surgery-Surgical Services
Surgery-Suture of Wounds

RULES, CITATIONS, AND SOURCES

Code of Federal Register 42 CFR 441.255
Indiana Administrative Code
 405 IAC 5-17 – Hospital Services
 405 IAC 5-28 – Medical and Surgical Services
 405 IAC 5-28-7 – Abortion
Indiana State Department of Public Welfare Medical Policy Manual 1991
Indiana Health Coverage Programs Provider Manual
 1999

March 2005, Version 5:1
 Indiana Medical Assistance Program Provider Manual 1994
 Indiana Health Coverage Programs Provider Notifications
 Banner Page 8/19/97

Origination Date: 12/31/2000

Revisions and Review	Reason	Date
	470 IAC 5-9-1 – Global Fee Billing 470 IAC 5-9-3 – Prior Authorization 5-9-9 – Second Opinions 470 IAC 5-9-12 – Medical Services Surgical Services 470 IAC 5-9-14 – Surgical Services Specifically Gynecology Transferred	7/1/91
	Indiana State Department of Public Welfare Medical Policy Manual 1991 - Laminaria or Dilateria	7/1/91
	405 IAC 1-7-1 – Global Fee Billing 405 IAC 1-7-3 – Services Requiring Prior Authorization 405 IAC 1-7-9 – Second Opinions 405 IAC 1-7-12 & 14 – Surgical Services	1/1/92
	405 IAC 5-1-5 – Global Fee Billing 405 IAC 5-3 – Prior Authorization 405 IAC 5-8 – Consultations and Second Opinions 405 IAC 5-17-2 – Hospital Services- Prior Authorization 405 IAC 5-17-3 – Hospital Services- Emergency, Weekend Inpatient Admissions 405 IAC 5-28 – Medical and Surgical Services	8/24/97
Revision	Combination of Gynecology – Hysterectomy, Laminaria, and Pelvic Under Anesthesia	01/31/06

APPLICABLE INDIANA A/M EDITS AND AUDITS

- 4012 – Abortion Diagnosis/Procedure Indicated
- 4073 – Hysterectomy Requires Manual Review
- 6002 – Any Two Anesthesiology Providers Same Procedure Requires Review
- 6003 – Manual Pricing for Split Care Billing
- 6023 – Global Payable at a Reduced Fee When Components Paid – Digestive System
- 6034 – Global Surgery Payable at Reduced Amount When Components of Surgical Care Paid
- 6035 – Components of Surgical Care Not Payable When Global Surgery Paid
- 6037 – Only One Assistant Surgeon Allowed for Select Surgeries
- 6039 – Assistant Surgeon Not Payable When Co-Surgeon Paid
- 6040 – Co-Surgeon Paid at Reduced Amount When Assistant Surgeon
- 6061 – Components Not Payable When Global Paid – Urinary/Reproductive Systems
- 6096 – The CPT / HCPCS Code Billed Is Not Payable According to the PPS Reimbursement Methodology
- 6649 – Surgery Payable at Reduced Amount When Related Postoperative Care Paid
- 6650 – Lifetime Procedures Are Limited to One Per Lifetime
- 6652 – Multiple Surgeries Must be Billed on Same Claim
- 6653 – Postoperative Care Within Zero to 90 Days of Surgery
- 6654 – Preoperative Care Within One Day of Surgery
- 6655 – Surgery Payable at Reduced Amount When Postoperative Care Paid
- 6656 – Postoperative Care Within 10 Days of Select Surgery
- 6657 – Preoperative Care on Day of Surgery
- 6658 – Surgery Payable at Reduced Amount When Preoperative Care Paid Same Date of Service
- 6659 – Surgery Payable at Reduced Amount When Related Postoperative Care Paid
- 6660 – Preoperative and Postoperative Care Billed with Unlisted Surgeries Requires Review
- 6706 – Global Payable at a Reduced Fee When Components Paid – Genital Urinary/Reproductive Systems

MEDICAL POLICY FACT SHEET

TITLE: HIV/AIDS CARE COORDINATION

DESCRIPTION

According to the Centers for Disease Control and Prevention, the Human Immunodeficiency Virus (HIV) is a viral infection that gradually destroys the immune system. The compromised immune system leaves the body vulnerable to a variety of life-threatening illnesses. Common bacteria, yeast, parasites, and viruses, that ordinarily do not cause serious disease in people with fully functional immune systems, can cause fatal illnesses in people with HIV. People with severely compromised immune systems are diagnosed with Acquired Immune Deficiency Syndrome (AIDS). AIDS is the final and most serious stage of the HIV viral infection.

HIV/AIDS can be transmitted from person to person in several manners. Blood, semen, vaginal secretions, and breast milk have been the only proven secretions to transmit the diseases. Most transmissions of HIV/AIDS occur by sexual contact, blood transfusion, needle sharing, mother to fetus through shared blood circulation, and mother to infant through breastfeeding. Other transmission methods are rare and include accidental needle injury, artificial insemination with donated semen, and through a donated organ.

Treatment for HIV/AIDS may delay the progression of diseases for many years and improve the quality of life. Most treatments are used to strengthen the immune system and increase the T-cell counts.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC), or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

HIV/AIDS care coordination is a specialized form of case management for members with HIV/AIDS diagnoses. Care coordination consists of goal-oriented activities that facilitate, coordinate, and monitor the full-range of HIV-related health and human services including, but not limited to, medical, psychological, social, and educational services. To assure freedom of choice, members sign a *Freedom of Choice/Intent to Participate Form* acknowledging an understanding of the services provided and identifying the chosen care coordination provider.

PRIOR AUTHORIZATION

Prior authorization is not required for this service. Refer to the following sections outlining member eligibility, member services, and provider enrollment for other relevant information.

Member Eligibility

To be eligible for HIV/AIDS care coordination services, members must be a Traditional Medicaid member, a Hoosier Healthwise member, or a *Medicaid Select* member with a documented HIV viral infection/AIDS diagnosis. Medical documentation or verification of a related medical diagnosis must be maintained in the member's care coordination file. The diagnosis may be verified with the following types of documentation.

- Confidential positive HIV test result
- Physician's statement
- Hospital discharge statement or other medical reports which verify the diagnosis
- Medical prescription for Azidothymidine (AZT), Didanosine (ddl), or Zalcitabine (ddC)
- Copy of approval for participation in the AIDS Drug Assistance Program (ADAP) or the Early Intervention Program (EIP)

The provider must verify that the member is eligible for Medicaid services during the specific month in which services are provided. Failure to do so may result in denial of payment. The member's name must appear on the claim form exactly as it appears on the eligibility file. Eligibility must be checked each time that a service is rendered.

HIV/AIDS Care Coordination Services

HIV/AIDS care coordination providers must maintain written documentation of all services provided. Documentation is subject to post-payment review by the Office of Medicaid Policy and Planning (OMPP) or its agent. The following records must be available in each member's file and updated annually, if applicable.

- Determination of eligibility
- Documentation of verified diagnosis of HIV/AIDS diagnosis
- Intake form
- Assessment and re-evaluations of the member's presenting problems, indications of medical/physical status, indications of psychological status, quality of social supports, living arrangements, and status on other relevant factors
- Documentation of service provider referrals
- Progress notes
- Comprehensive plan of care
- Documentation of member and service provider contacts, including face-to-face contacts
- Signed release of information form

Providers must comply with all regulations delineated by OMPP and the Division of Disability, Aging, and Rehabilitative Services (DDARS). The following information outlines these guidelines.

- Providers must permit access and examination of records by persons authorized by the OMPP, its agent, and Federal personnel. Records must be maintained for seven years. Record destruction must be done in a confidential manner such as burning or shredding of documents.
- Providers must obtain input from members on service satisfaction and summarize this input at least annually. This information must be available for review.
- Providers are required to provide quarterly reports to the DDARS on the approved forms.
- Providers must have data collection and analysis capability required to prepare monthly statistical reports concerning member demographics, including but not limited to, age, race, gender, risk exposure category, and other relevant data in a format approved by the DDARS.
- Providers must develop and maintain a current listing of support services in the community and the established referral process.
- Providers will be required to maintain member files in a secure area to protect member confidentiality. Information stored on computerized data systems must have password protection.
- Providers must adopt and adhere to a written policy protecting confidentiality that states that all information regarding the member is confidential information.
- Providers may not use any information obtained about the member in any manner except as necessary for the proper discharge of responsibilities. All information, personal facts and circumstances concerning the member, must be treated as privileged communication and may not be divulged without the written consent of the member or the member's legal representative.
- Providers will assure that services will be available to all eligible members regardless of age, race, gender, sexual/affectional orientation or preference, ethnicity, religion, national origin, or handicap.
- Providers must comply with licensing and accreditation standards as required by the OMPP or its agent.
- Providers will determine if a member is eligible for receipt of services in accordance with OMPP and the DDARS established policies and procedures.
- Providers will comply with procedures for administrative review of appeals for applicants and members.

There are specific services with limitation that must be followed when care coordinators provide services to eligible members. The following information outlines the HIV/AIDS care coordinator services provided to IHCP members.

A. Intake and Assessment

The care coordinator completes a *Freedom of Choice/Intent to Participate Form* and an *Assessment of Care Coordination/Worksheet for Data Entry Form*. As

determined by the *Assessment of Intensity of Care Coordination/Worksheet for Data Entry Form*, care coordination services may not exceed a maximum of 128 units (32 hours), per calendar quarter (three month period), per member. This form should be completed at the beginning of each quarter to determine the maximum number of hours allowed per member. It is expected that most members will require between 6.6 and 9 hours per quarter with some using less. Furthermore, it is anticipated that few members will require more than nine hours per quarter. This form describes the supporting factors for the number of care coordination hours used. Supporting factors must be substantiated through self-report, medical records, caregiver records, other agency reports, and physical observation. Substantiation of services must be documented in each member's file. Sections of the assessment must contain information regarding presenting problems, medical/physical status, indicators of psychosocial status, indicators of developmental and intellectual status, living arrangements, and other relevant factors.

Once the maximum number of hours allowed is determined in a given quarter, the need for additional hours will require the submission of a new and updated *Assessment of Intensity of Care Coordination/Worksheet for Data Entry Form*.

B. Plan of Care Development

Based upon the information gathered in the assessment, the care coordinator and the member develop a comprehensive plan of care. Services are structured and time is goal oriented. The plan of care must be developed on or before the 30th day following the date of the initial intake. The following factors must be considered in the development of the plan.

- Prioritizing the needs that were identified in the assessment
- Developing outcome goals that will address the identified needs
- Identifying factors that may impinge upon the implementation of the plan of care
- Proposing and discussing preliminary strategies for meeting outcome goals and obtaining signed approval forms from the member or representative
- Specifying the time frame for meeting outcome goals
- Developing evaluation criteria to measure whether outcome goals are met
- Identifying specific services, costs, and sources of payment
- Contracting with the member or representative to apportion the rights and responsibilities between the member and the care coordinator
- Developing procedures for emergency situations

C. Implementation

To implement the plan of care, the care coordinator negotiates agreements with service providers, coordinates delivery of service, and maintains the member's record. In addition, the care coordinator acts as a facilitator in resolving access problems that arise in implementing the plan of care, as well as, advocating for the development of new services. It is the responsibility of the care coordinator to ensure services are cost effective and not duplicated.

D. Monitoring

The care coordinator assures implementation of the services identified in the plan of care by monitoring planned interventions in a timely fashion and obtaining confirmation of scheduled interventions by the member, the service provider, or both.

E. Evaluation

The care coordinator periodically engages in the following activities to measure the quality and effectiveness of the plan of care. The following describes the evaluation process.

- Analysis of information generated through monitoring the quality and effectiveness of interventions, appropriateness of goals and strategies, the member's or representative's commitment to participate in the plan of care, and the member's or representative's satisfaction with the plan of care
- Comparison of plan of care objectives with actual outcomes of intervention

F. Re-evaluation

The care coordinator schedules plan of care re-evaluations to determine continuing or changing needs the member may have. Evaluations and re-evaluations require ongoing contact with the member. The *Assessment of Care Coordination/Worksheet for Data Entry Form* should be completed from the date of the initial intake and the beginning of every quarter, as part of the re-evaluation process. Where there is a change in a member's needs, the care coordinator will do one of the following.

- Revise plan of care outcome goals
- Re-evaluate the priority of member needs
- Revise plan of care strategies
- Realign technical service resources
- Propose and discuss new strategies for meeting outcome goals subject to the member's or representative's approval
- Specify new time frames for meeting outcome goals
- Enter into a new contract with the member or representative to reapportion the rights and responsibilities of the member and the care coordinator

G. Termination

Upon re-evaluation of the plan of care, the care coordinator and the member or representative determines whether services should continue. The decision will be made based on the following information.

- HIV/AIDS care coordination services are still required
- Member or representative elects to continue care coordination services
- Member or representative is upholding the contracted agreement set forth in the plan of care
- Member or representative is cooperating with agreed upon plan of care
- Member is aggressive or non-cooperative with the care coordinator

HIV/AIDS Care Coordinator Eligibility

In order to receive reimbursement for HIV/AIDS care coordination services, the service provider must be enrolled as an IHCP provider. In addition, the care coordinator must meet the following minimum qualifications described below.

- Registered Nurse licensed in Indiana with a minimum of one year case management experience
- Master of Social Work/Master of Social Sciences or equivalent degree with a minimum of one year case management experience
- Bachelor of Social Work or equivalent degree with a minimum of one year case management experience
- Master of Science in Nursing or equivalent master's nursing degree with a minimum of one year case management experience
- Bachelor of Science in Nursing or equivalent nursing degree with a minimum of one year case management experience

All HIV/AIDS care coordinators are required to enroll and complete a State-approved HIV/AIDS specific care coordination training course prior to certification. If training is not available within six weeks of the provider's letter of intent to enroll, the provider may request a temporary waiver for this training. If the waiver is granted, the training will need to be completed within three months of the conditional enrollment. The request to waive may be made under these circumstances.

- If the provider has at least one year of documented HIV/AIDS care coordination experience
- If the provider is under the supervision of a currently enrolled HIV/AIDS care coordinator

Once minimum qualifications are met, the provider may complete enrollment documents and submit them to the Medicaid Waiver Unit. These documents may be requested from the following address.

Medicaid Waiver Unit
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-5710

Once the enrollment process is completed, the provider will be notified in writing of the assigned care coordinator provider number. Additionally, the provider will receive the appropriate provider manual along with an initial supply of forms. All changes in status, location, or personnel should also be reported in writing to the Medicaid Waiver Unit.

MANAGED CARE

HIV/AIDS care coordination services are self-referral services under the Hoosier Healthwise and *Medicaid Select* managed care programs. Providers serving members in the risk-based managed care (RBMC) delivery system should contact the appropriate managed care organization to file claims.

HIV/AIDS care coordination claims are not subject to managed care edits; therefore, there is no requirement for a PMP certification code or a provider number on the HCFA-1500 claim form.

BILLING REQUIREMENTS

HIV/AIDS care coordinator, provider specialty 211, is reimbursed for the Healthcare Common Procedural Coding System (HCPCS) code G9012, *Coordinated care fee, risk adjusted maintenance, other specified care management*. Effective October 1, 2004, this code is the only procedure code that will be reimbursed. Additionally, providers must use primary diagnosis code 042, *Human Immunodeficiency virus {HIV} disease*, for billing purposes. Each unit of the HCPCS code G9012 is equal to 15 minutes of services.

Non-billable Services

Non-billable services include time spent completing or reviewing claim forms for care coordination, implicit paperwork, and activities not related to a particular member. Administrative expenses are not billable; however, these expenses are included in the reimbursement rate. Transporting members and general provider recruitment are not billable.

Early and Periodic Screening, Diagnosis, and Treatment/HealthWatch Program

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch services may be provided to IHCP members younger than 21 years old. Primary Medical Providers (PMP) are not required to provide or authorize HIV/AIDS targeted case management services. Reimbursement for case management services is on a fee-for-service basis.

Targeted Case Management Services for Pregnant Women

HIV-related targeted case management services for pregnant women are limited to 60 hours per quarter. Coverage is limited to services related to pregnancy, including prenatal, delivery, and postpartum services, as well as, conditions which may complicate the pregnancy or urgent care services. The following Current Procedural Terminology (CPT) codes must be used for HIV testing and screening.

- CPT code 86701, *HIV-1*
- CPT code 86689, *HIV antibody confirmatory test (e.g., Western Blot)*

RELATED MEDICAL TOPICS

Early and Periodic Screening, Diagnosis, and Treatment/HealthWatch Services
Inpatient Hospital Services
Laboratory Services
Managed Care Services
Obstetric Care
Outpatient Hospital Services
Screening Services–Newborn Screening
Targeted Case Management Services for Pregnant Women
Waiver Services

RULES, CITATIONS, AND SOURCES

Indiana Administrative Code (IAC)
 405 IAC 5-15 – Early and Periodic Screening, Diagnosis, and Treatment Services
Indiana Code (IC)
 IC 16-41-6 – Communicable Disease: Mandatory Testing of Individuals with
 Communicable or Dangerous Diseases
Indiana Health Coverage Programs Provider Manual
 1999
 2005 Version 5.1
Medicaid Provider Manual for Waiver Providers
Indiana Health Coverage Programs Provider Banner (BR)
 BR200510 – IHCP Policy for Billing HIV Care Coordination Services
 BR200433 – HIV Care Coordinator Provider Code Set
Indiana Health Coverage Programs Provider Bulletin (BT)
 BT200526 – Notice of Program Change Due to the New Medicare Prescription
 Drug Coverage PDPs must cover all, or substantially all, drugs in the
 following six categories
 BT200424 – Early and Periodic Screening, Diagnosis, and Treatment/
 HealthWatch Services CPT codes HIV Aesting
 BT200360 – DRG Relative Weight Table
 BT200359 – Antiviral (Anti-Herpetic) Agents, W5A; HMG CoA Reductase
 Inhibitors, M4E Valtrex Pravachol
 BT200255 – Preferred Drug List–Pravastatin (PravacholÒ)
 BT200006 – Package C Claim Submission and Coverage Information
 BT199909 – Removal of Services from Prior Authorization

Origination Date: 04/13/2006

Revisions and Reviews	Reason	Date
Indiana Medical Assistance Program Provider Manual	HIV/AIDS	1994
IC 16-41-6	Communicable Disease: Mandatory Testing of Individuals with Communicable or Dangerous Diseases	1993;1996; 1998
Review	Scheduled	10/31/2006

APPLICABLE INDIANA AIM EDITS AND AUDITS

1020 – Rendering Provider Specialty Not Eligible to Render Procedure Code
6051 – Care Coordinator – Initial Assessment
6053 – HIV Case Management
6800 – Care Coordination Transportation for Home Visits (Initial Assessment)
6801 – Care Coordination – Transportation for Home Visits (Reassessment)

MEDICAL POLICY FACT SHEET

TITLE: HOME HEALTH SERVICES

DESCRIPTION

Home health services are available to Indiana Health Care Programs (IHCP) members medically confined to home, when services are ordered by the member's physician, and performed in accordance with the written plan of care. IHCP members who, because of illness or injury, are unable to leave home without assistance of another person or an assistive device such as a wheelchair or walker, or for whom leaving the home is contrary to medical advice are considered to be medically confined to home. Home health services may be utilized for: care and treatment of acute or chronic conditions, rehabilitation, education regarding care, coordination of community services, or to avoid prolonged or repeated hospitalizations and/or higher and more costly levels of care.

SUMMARY OF CURRENT POLICY

IHCP reimbursement is available to home health agencies for skilled nursing care services provided by a registered nurse (RN) or licensed practical nurse (LPN), home health aide (HHA) services, physical, occupational, or speech therapy services, respiratory therapy services, renal dialysis, and tocolytic infusion therapy subject to limitations in 405 IAC 5-3, 5-16, and 5-22.

All home health services require prior authorization (PA) except those services provided by a RN, LPN, or HHA ordered in writing by a physician prior to the member's discharge from a hospital and that do not exceed 120 hours within 30 days of discharge. Services may not continue beyond 30 calendar days unless PA is received. Any combination of therapy services ordered in writing by a physician prior to the member's hospital discharge does not require initial PA, but may not continue beyond 30 hours, sessions, or visits in 30 calendar days unless PA is received.

Home health care is available to eligible IHCP members who are in need of intermittent or part-time home health services. The type and extent of service required must be documented in the plan of treatment and included with the PA request. Home health care services must be rendered as indicated on the plan of treatment. The plan of treatment must be signed by the attending physician and reviewed every 60 days. The PA request, the plan of treatment, supporting documentation and hourly determination guidelines will be when considered when evaluating the number of hours to approve for home health care services. The hourly determination guidelines are used as an aid, but do not take the place of clinical judgment when determining appropriate hours of service.

Case management services for pregnancy and HIV/AIDS, and Diabetes Self Management Training services can be provided in a home setting, but are not included under home health care services. Each of these services has specific coverage criteria for reimbursement. See individual policies for details.

DEFINITIONS

Encounter: An encounter occurs when a home health care provider enters a home, provides services to one or more individuals within that home, and then departs.

Multiple member care situation: A home care situation in which more than one member is receiving home health services in a single household. When this situation occurs, care must be coordinated in the most efficient manner. Multiple care member situations must be reported on each member's individual PA request. When one member of a home health agency provides care to multiple members during an encounter, only one overhead may be billed.

Home Health Care Provider: Registered Nurse (RN), Licensed Practical Nurse (LPN), Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), Speech Language Pathologist (SPL), Respiratory Therapist (RT), or a home health aid (HHA)

RELATED MEDICAL TOPICS

Aged and Disabled –Waiver Services
Autism – Waiver Services
Case Management - Pregnant Women
Case management - HIV/Aids Coordination
Diabetes Self-Management Training
Hospice
Intermediate Care Facilities for the Mentally Retarded
Medical Supplies and Equipment
Medically Fragile Children – Waiver Services
Nursing Services
Physical Rehabilitation Services

RULES, CITATIONS, AND SOURCES

405 IAC 5-16 Home Health Agency and Clinic Services
405 IAC 5-16-1 Providers eligible for reimbursement
405 IAC 5-16-2 Home health agency services
405 IAC 5-16-3 Home health agency services; limitations
405 IAC 5-3-13 Prior Authorization--Services requiring prior authorization
405 IAC 5-19-6 Durable medical equipment subject to prior authorization
405 IAC 5-19-12 Home hemodialysis equipment
405 IAC 5-22 Nursing and Therapy Services
405 IAC 5-11 Case management Services for Pregnant Women
405 IAC 5-34 Hospice Services
405 IAC 5-36 Diabetes Self Management Training
405 IAC 5-35 Case Management Services for Infants and Toddlers With Disabilities
Indiana Code 16-41-6 Communicable Disease
42 CFR 441.15 Subpart A--General Provisions
405 IAC 5-19-6 Durable medical equipment subject to prior authorization
405 IAC 5-19-12 Home hemodialysis equipment
42 CFR 441.15 Subpart A--General Provisions
42 CFR 440.70 Subpart A--Definitions
Indiana Medicaid Update Bulletin 97-12-- Overhead Component
Indiana Medicaid Update Bulletin 97-14--Home Tocolytic Infusion Therapy Utilizing A
Home Uterine Monitoring Device
Indiana Medicaid Update Bulletin 97-05 --Clarification of Indiana Medicaid
Indiana Medicaid Update Bulletin 97-03--Billing Procedures for Home Infusion/Enteral
State Medicaid Plan 01/01/95--Home Health Services
Indiana medical Assistance Provider Manual 1994
Indiana Health Coverage Programs Manual 1999
Indiana Health Coverage Bulletin BT200353 – HIPPA-Mandated Elimination of Local
Codes and Local Code Modifiers
Indiana Health Coverage Programs Home Health Care Hourly Determination Guidelines
Indiana Health Coverage Banner BR200207
Indiana Health Coverage Bulletin BT200237 – Required Documentation for Prior
Authorization Requests for Home Health Services
Indiana Health Coverage Bulletin BT200349 – Change in Reimbursement Rates for
Home Health Providers
Indiana Health Coverage Banner BR200411
Indiana Health Coverage Provider Manual 2003

ORIGINATION, REVISION, AND REVIEWS

Origination Date: 12/31/00

Revisions and Reviews	Reason	Date
Indiana Medicaid Update Bulletin 97-14	Tocolytic Home Infusion and Uterine Monitoring Device	5/27/95
Indiana Medicaid Update Bulletin 97-06	Clarification of Policies	1/1/97
Indiana Medicaid Update Bulletin 97-03	Home Health Infusion	3/1/97
Indiana Medicaid Update Bulletin 97-12, 3/31/97	Home Health Services	5/27/97
405 IAC 5-3-13	Prior Authorization-Services Requiring Prior Authorization	8/24/97
405 IAC 5-16	Home Health Agency and Clinic Services-	8/24/97
405 IAC 5-19-6	Durable Medical Equipment Subject to Prior Authorization	8/24/97
405 IAC 5-19-12	Home Hemodialysis Equipment	8/24/97
42 CFR 441.15	Subpart A-General Provisions	10/1/97
42 CFR 440.70	Subpart A-Definitions	10/1/97
405 IAC 5-16-2 Amended	Home Health Agency and Clinic Services-	9/27/99
405 IAC 5-16-3 Amended	Home Health Agency and Clinic Services-	9/27/99
405 IAC 5-19-3.1 Amended	Home Health Agency and Clinic Services-	9/27/99
405 IAC 5-16-2 Amended	Home Health Agency and Clinic Services-	10/1/99
405 IAC 5-16-3 Amended	Home Health Agency and Clinic Services-	10/1/99
Revision	Home Health Care hourly Determination Guidelines	4/30/04
BT200335	HIPAA-Mandated Elimination of Local Codes and Love Code Modifiers, Updated	4/30/04
BT200117	PA Requests for Home Health, Quarterly Update	7/30/04
BR200207	PA Request Criteria, Quarterly Update	7/30/04
BT200237	Required Documentation for Prior Authorization Requests for Home Health Services, Quarterly Update	7/30/04
IHCP Provider Manual 2003	Medically Confined to Home, Billing Requirements, Quarterly Update	7/30/04

APPLICABLE INDIANA AIM EDITS AND AUDITS:

515
551
552
3016
6073
6260
6261
6752
6753
6916
6917

COVERAGE CRITERIA

HOME HEALTH CARE

IHCP reimbursement is available to members medically confined to home for intermittent or part-time home health care services provided by home health care providers. In order for home health services to be approved, the services must be medically reasonable and necessary, and home care must be less expensive than alternative modes of care.

Home health services may consist of the following.

- ◆ skilled nursing services provided by a registered nurse or licensed practical nurse;
- ◆ home health aide services;
- ◆ physical, occupational, and speech therapy services;
- ◆ respiratory therapy services;
- ◆ renal dialysis; and
- ◆ home tocolytic infusion therapy

Home health services require prior authorization (PA), *except* in the following circumstances.

- ◆ Services provided by a registered nurse, licensed practical nurse, or home health aid which have been ordered in writing by a physician prior to the member's discharge from a hospital that do not exceed one hundred twenty (120) hours within thirty (30) days of discharge do not require PA. These services may not continue beyond thirty (30) calendar days unless prior authorization is received.
- ◆ Any combination of therapy services which have been ordered in writing by a physician prior to the member's hospital discharge that does not exceed thirty (30) units in thirty (30) calendar days does not require PA. These services may not continue beyond 30 days following discharge unless prior authorization is received.
- ◆ Home tocolytic infusion therapy does not require PA, effective April 4, 2002.

The PA request for home health services must contain information required for all prior authorizations, as specified in 405 IAC 5-3-5, including but not limited to:

- ◆ the appropriate diagnosis and related information
- ◆ services or supplies requested with the appropriate codes
- ◆ name of suggested provider of services and supplies

- ◆ description of previous services or supplies
- ◆ plan of treatment
- ◆ rehabilitation potential

In addition, the following information must be submitted with the PA request form for home health services:

- ◆ An estimate of the costs for the services ordered by the physician and set out in the written plan of treatment. The cost estimate must be provided with the plan of treatment and signed by the attending physician. The estimate must reflect the cost of each service requested, plus the overhead rate for the time period(s) requested, as reflected on the plan of treatment.
- ◆ PA requests for home health services should provide documentation of all services received by the IHCP member. For example, Medicare, CHOICE, IHCP waiver programs, private insurance, and any other paid caregivers. The number of hours per day and the number of days per week should be listed for each service.
- ◆ PA requests for home health services should indicate the number of non-paid caregivers, (even if there are none) available to provide care for the member, including consideration of whether the caregiver works outside the home or attends school outside the home. A copy of the caregiver's work schedule from the employer or the class schedule from the school must be submitted with the PA request. The provider is responsible for coordinating home care services with the caregiver's work or school schedule to meet the member's needs, and should clearly document caregiver information on the PA request form.
- ◆ PA requests for home health services should document whether the member works or attends school outside the home, including what assistance is required.
- ◆ When there is a multiple member situation and more than one member is receiving home health services in a single household, care must be coordinated in order to utilize service in the most efficient manner. Only one overhead component can be billed per encounter. Agencies are responsible for reporting this aspect of the case, and should indicate this fact on the PA request submitted for each member of the household.

A copy of the current plan of treatment, developed by the attending physician, therapist(s), and agency personnel, and signed by the attending physician, must also be included with the PA request for home health services. The plan of treatment should include the date of onset of the medical problem(s) and progress notes regarding the necessity, effectiveness, and goals of therapy services. The plan of treatment should detail the types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitation, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, and any other relevant items.

NON-COVERED SERVICES

The following services are noncovered home health services, except as specified under the applicable IHCP Waiver Service programs.

- ◆ Transportation to and from grocery stores, drug stores, banks, etc.
- ◆ Homemaker services, including shopping, laundry, cleaning, meal preparation, etc.
- ◆ Companion or sitter services, including escort services, activity planning, etc.
- ◆ Chores, including picking up prescriptions, household supplies and/or groceries, etc.
- ◆ Respite care

HOME HEALTH CARE HOURLY DETERMINATION GUIDELINES

The following are guidelines for determining the appropriate number of hours reimbursable for general categories of home health care services. These are guidelines only and do not override medical decisions based on individual case review.

Factors for consideration when determining the hours of service to be approved include:

- ◆ Severity of illness and symptoms
- ◆ Stability of the condition and symptoms
- ◆ Change in medical condition that affects the type or units of service that can be authorized
- ◆ Intensity of care required to meet needs
- ◆ Complexity of needs
- ◆ Amount of time required to complete treatment tasks
- ◆ Treatment plan, including identified goals
- ◆ History of previous response to care
- ◆ Whether the member works or attends school outside of the home, including what assistance is required
- ◆ Caregivers available to provide care for the member, including the following considerations:

- Number of caregivers available.
 - Physical limitations of available caregiver(s) that limit that ability of the caregiver(s) to provide care to the member.
 - Number of hours requested, compared to availability of caregiver(s) available time.
 - If the caregiver has additional child care responsibilities.
 - If the caregiver works outside the home.
- ◆ Other home care services currently being utilized including, but not limited to, Medicare, Medicaid Waiver Programs, CHOICE, vocational rehabilitation, and private insurance.

12-16 HOURS/DAY HOME HEALTH CARE SERVICES

Members requiring 24-hour monitoring may be authorized for up to 12 hours/day skilled nursing or home health aide services to prevent deterioration in life sustaining systems. Examples of these conditions include, but are not limited to:

- ◆ Severe respiratory conditions resulting from pulmonary disorders such as, bronchopulmonary dysplasia, severe respiratory complications of cystic fibrosis, bronchitis, asthma; central nervous system disorders, cardiovascular disorders such as cardiac anomalies; neuromuscular disorders such as muscular dystrophy, Guillain Barré syndrome,
- ◆ Dependency on mechanical ventilator assistance
- ◆ Tracheostomy

Special situations may occur where home health hours may be approved for up to 16 hours per day of skilled care on an ongoing basis, although each individual situation must be evaluated with a PA request. These special situations include but are not limited to:

- ◆ A single caregiver is available who also works full-time (or a significant number of hours part time) outside the home. This also applies to situations where there may be two adults present but one is unable to provide any, or a very limited amount, of care due to physical disability or severe physical limitations. The disabled caregiver's physician must substantiate this in writing.
- ◆ Significant additional childcare responsibilities. Significant is defined as:
 - a) three or more children under the age of six, or four or more children under the age of 10,
 - b) one or more children in the home with special medical care needs requiring extensive medical and physical care above and beyond the needs of the average well child. If Medicaid is not providing services to this child at home also, the child's physician must provide a statement of the child's medical

needs. The same caregiver(s) must be caring for these children as well as the member for whom the PA request has been submitted.

Special situations may occur where additional home health hours may be authorized on a short term or temporary basis, that are evaluated individually, on a case-by-case basis. Examples of these situations are as follows:

- ◆ Significant deterioration in the condition of the member, particularly if additional hours will prevent an inpatient or extended inpatient hospital admission.
- ◆ Major illness or injury of the caregiver with expectation of recovery, including, but not limited to:
 - a) illness or injury that requires an inpatient acute care stay;
 - b) chemotherapy or radiation treatments; or
 - c) a broken limb, which would impair the caregiver's ability to lift the member.
- ◆ Temporary, but significant, change in the home situation, including, but not limited to:
 - a) a caregiver's call to military duty; or
 - b) temporary unavailability due to employment responsibilities.(These must be substantiated in writing by the commanding officer, other military representative, or by the employer.)
- ◆ Significant permanent change in the home situation, including, but not limited to, death or divorce with loss of a caregiver. Additional units of service may be authorized for a short period of time to assist in providing a transition.

8 HOURS /DAY HOME HEALTH CARE SERVICES

Members who require extensive care and daily monitoring of their medical/physical condition, but do not possess the same degree of potential to deteriorate quickly into life threatening situations as do members requiring 24-hour monitoring, may receive up to 8 hours of care daily. An additional hour or two may be allowed for transportation to and from work in situations where the caregiver(s) work full time outside the home. Examples of these situations/conditions may include, but are not limited to:

- ◆ Chronic, debilitating conditions such as severe forms of cerebral palsy, muscular dystrophy, spina bifida, and other congenital anomalies, and quadriplegia.
- ◆ Conditions that require equipment or treatment needs with potential for serious complications. For example, central lines, or Hickman catheters.
- ◆ Frequent treatments such as respiratory therapy required (in the form of updrafts, CPT, etc.)
- ◆ Nutrition is provided by hyperalimentation or by gastrostomy tube feedings in addition to one of the above.
- ◆ Skilled nursing assistance required to attend school.
- ◆ The member receives multiple medications that require monitoring for severe side effects or responses.

Special situations may occur in which additional home health hours may be authorized on a short term or temporary basis. These will be evaluated individually, on a case-by-case basis. Examples of these situations are:

- ◆ Significant deterioration in the condition of the member, particularly if additional hours will prevent an inpatient or extended inpatient hospital admission.
- ◆ Major illness or injury of the caregiver with expectation of recovery, including, but not limited to:
 - a) illness or injury that requires an inpatient acute care stay;
 - b) chemotherapy or radiation treatments; or
 - c) a broken limb, that impairs the caregiver's ability to lift the member.
- ◆ Temporary, but significant, change in the home situation, including, but not limited to:
 - a) a caregiver's call to military duty; or
 - b) temporary unavailability due to employment responsibilities.
(These must be substantiated in writing by the commanding officer, other military representative, or by the employer.)
- ◆ Significant permanent change in the home situation, including, but not limited to, death or divorce with loss of a caregiver. Additional units of service may be authorized for a short period of time to assist the member with a transition.

3 - 7 HOURS/DAY HOME HEALTH CARE SERVICES

Members without the severity of conditions noted above, who require primarily heavy physical care, with some skilled nursing monitoring to avoid deterioration, may receive 3 to 7 hours of care per day. These members are generally chronic but stable and may have conditions such as congenital anomalies, neuromuscular disorders, central nervous system disorders, or other disorders that severely disrupt the capacity to care for self.

Adults requiring care/assistance must be homebound as certified by the attending primary physician. However, consideration may be given to paraplegics, quadriplegics, or other disabled members unable to provide self-care such as bathing or dressing, who are able to drive mechanically altered vehicles in order to maintain meaningful employment and a relationship with the community. Such adults may be considered for assistance from a Home Health Aide for up to 3-4 hours per day. The agency may split the hours between morning and evening to attend to the bedtime needs of the member. This service is subject to medical necessity and documentation must demonstrate the need.

BILLING PROCEDURES

- ◆ The following is the computation of the total reimbursement rate:
 - ◆ The overhead cost rate; plus
 - ◆ The staffing cost rate multiplied by the number of hours spent performing billable patient care activities.

- ◆ Each component of the total home health reimbursement rate is based on statewide weighted median costs calculated for each component. The statewide weighted median rate for each component is determined by calculating the per visit or per hour cost of each component for each home health agency. These costs are ranked from the highest to the lowest, calculating the cumulative number of Medicaid visits or hours, and locating the point on the array in which half of the respective Medicaid visits or hours were provided by agencies with a higher cost and half were provided by agencies with a lower cost.
- ◆ The overhead cost rate per visit for each home health provider is based on total patient-related costs, less the direct staffing and employee benefit costs, less the semi-variable costs, divided by the total number of home health agency visits during the Traditional Medicaid reporting period for that provider. The result of this calculation is the overhead cost per visit for each home health provider that was included in the statewide overhead array. The semi-variable cost was removed from the overhead cost rate calculated, and included in the staffing cost rates.
- ◆ The staffing cost rate per hour for each discipline in the home health agency is based on the total patient-related direct staffing and employee benefit costs, plus the semi-variable cost divided by the total number of home health agency hours worked. The result of this calculation is the staffing cost rate per hour per discipline for each home health agency.

Occurrence Codes

Providers should use the UB-92 Occurrence Code, Occurrence Date, and Occurrence Span for Locators 32–36, a–b, on the *UB-92* to indicate the appropriate overhead fees. The following six codes can be used to identify the overhead rate:

- ◆ **Code 61** indicates that one encounter with the member occurred on the date shown.
- ◆ **Code 62** indicates that two encounters occurred on the date shown:
 - These may be the same service or a combination of services provided on one day.
 - *Example:* One skilled nurse encounter and one home health aide encounter or two home-health aides encounters of care.
- ◆ **Code 63** indicates that three encounters occurred on the date shown:
 - These may be the same service or a combination of services provided on one day.
 - *Example:* One physical therapy encounter, one skilled nurse encounter, and one home-health aide encounter.
- ◆ **Code 64** indicates that four encounters occurred on the date shown:
 - These may be the same service or a combination of services provided on one day.
 - *Example:* In limited pediatric cases, the need for more than three overhead charges in one 24-hour period may occur.

- ◆ **Code 65** indicates that five encounters occurred on the date shown:
 - These may be the same service or a combination of services provided on one day.
 - *Example:* In limited pediatric cases, the need for more than four overhead charges in one 24-hour period may occur.
- ◆ **Code 66** indicates that six encounters occurred on the date shown:
 - These may be the same service or a combination of services provided on one day.
 - *Example:* In limited pediatric cases, the need for more than five overhead charges in one 24-hour period may occur.

All home health visits must be documented on any PA request submitted on behalf of members. All home health claims utilizing occurrence codes 64, 65, and 66 which indicate more than three visits a day are subject to post-payment review and will continue to be monitored closely by the OMPP.

If the dates of service billed are not consecutive, the provider should enter the correct occurrence code corresponding to each date-of-service billed on the UB-92 in the Occurrence Code and Occurrence Date fields, Locators 32–35 a–b, on the UB-92. If the dates of service billed are consecutive, and one encounter was provided per day, then Occurrence Code 61 and the dates of service being billed are entered in the Occurrence Span Code field, locator 36 a-b. Occurrence Codes 62 through 66 may not be used in the Occurrence Span Code field.

Providers that submit more than one UB-92 claim form in a multiple member care situation should submit only one of the forms with the overhead attached. As long as the overhead is attached to only one member, it does not matter to which member it is attached.

Multiple Visit Billing

When multiple visits for the same prior authorized service are made to a member in one day, providers should bill all visits on the same claim form. Billing these same-day services on one claim form allows the system to bypass duplicate editing. If these services are billed on separate claim forms, one or more of the services will be denied as a duplicate service. It is not appropriate for home health agency (HHA) providers to rotate personnel in the home merely to increase billing.

Partial Units of Service

Partial units of service must be rounded to the closest whole unit when calculating reimbursement. A partial unit of service of 30 minutes or more should be rounded up to the next highest unit. A partial unit of service of 29 minutes or less should be rounded down to the next lowest unit. One unit of service equals 60 minutes.

- ◆ *Example 1:* 85 minutes spent on billable patient care activities is rounded down to one unit.
- ◆ *Example 2:* 95 minutes spent on billable patient care activities is rounded up to two units.

HOME HEALTH SERVICES GENERAL GUIDELINES CPT/HCPCS CODES

Local codes effective on or before 12/31/03	CROSSWALKED CODES EFFECTIVE 1/1/04
Y0601 – Skilled nurse, per hour	99600 TD – Skilled nurse, RN
Y0501 – Home health aide, per hour	99600 – Home health aide
X3069 – Licensed practical nurse, per hour	99600 TE – Skilled nurse, LPN/LVN
Z5016 – Home tocolytic therapy	S9349 – Home infusion therapy, tocolytic infusion therapy
W6503 – Physical therapy, individual, by the unit; modalities not requiring use of capital equipment	G0151 – Services of physical therapist in home health setting, each 15 minutes
W7402 – Occupational therapy, by the unit, individual	G0152 – Services of occupational therapist in home health setting, each 15 minutes
W9083 – Speech therapy, home health	G1053 – Services of speech and language pathologist in home health setting, each 15 minutes

TOCOLYTIC THERAPY

Local code effective on or before 12/31/03	Crosswalked Code in effect 1/1/04 – 3/31/04	2004 HCPCS code change effective 1/1/04
Z5017 – Home tocolytic therapy	99553 – Home infusion for tocolytic therapy, per visit	99601 – Home infusion, up to 2 hours
		99602 – Home infusion, each additional hour

Indicators for Home Health Services

ONE of the following indicators from each category must be present for a member to be eligible for home health services.

Category I: Member

- ◆ The member is at risk of respiratory failure, severe deterioration or hospitalization without constant monitoring.
- ◆ The member requires total care 24 hour/day monitoring.
- ◆ The member desires to stay in the home, rather than a long term care facility.
- ◆ The medical condition of the member has deteriorated, creating the need for more intense short-term care. (Physician's statement required)
- ◆ The member does not have a primary caregiver or access to other care.

Category II: Caregiver

- ◆ Primary caregiver(s) is employed and absent from the home, or is unable to provide the necessary care.
- ◆ Primary caregiver(s) has additional child care responsibilities disallowing the time needed to care for the member. (3 or more under 6 years of age, or 4 or more under the age of 10 years.)
- ◆ Primary caregiver(s) also has additional child(ren) with special needs to care for. (One or more children with special health care needs requiring extensive medical and physical care.)
- ◆ Major illness or injury of caregiver(s) with expectation of recovery. (Physician's statement required)
- ◆ Temporary but significant change in the availability of caregiver(s) for example, military service. (Commanding officer, other military representative, or employer's statement required)
- ◆ Significant permanent change in status of caregiver(s), for example, death or divorce with loss of one caregiver. (Physician's statement required)

HOME HEALTH CARE FOR CENTRAL NERVOUS SYSTEM DISORDERS

CPT/HCPCS CODES

Local codes effective on or before 12/31/03	CROSSWALKED CODES EFFECTIVE 1/1/04
Y0601 – Skilled nurse, per hour	99600 TD – Skilled nurse, RN
Y0501 – Home health aide, per hour	99600 – Home health aide
X3069 – Licensed practical nurse, per hour	99600 TE – Skilled nurse, LPN/LVN
Z5016 – Home tocolytic therapy	S9349 – Home infusion therapy, tocolytic infusion therapy
W6503 – Physical therapy, individual, by the unit; modalities not requiring use of capital equipment	G0151 – Services of physical therapist in home health setting, each 15 minutes
W7402 – Occupational therapy, by the unit, individual	G0152 – Services of occupational therapist in home health setting, each 15 minutes
W9083 – Speech therapy, home health	G1053 – Services of speech and language pathologist in home health setting, each 15 minutes

Indicators for CNS Disorders

ONE of the following indicators must be present for a member to receive home health care for CNS disorders.

- ◆ Altered level of consciousness
- ◆ Respiratory distress
- ◆ Potential for increased intracranial pressure
- ◆ Body temperature fluctuations (hypothalamus involvement)
- ◆ Posturing (decerebrate/decorticate)
- ◆ Seizure activity (current)
- ◆ Spasticity (severe)
- ◆ Pain
- ◆ Impaired motor/sensory function to include
 - paresis
 - paralysis
 - vision impairment
 - hearing impairment
 - impaired gag reflex
 - decreased tactile sensation
- ◆ Potential for self injury
- ◆ Need for constant supervision

ONE of the following services must also be necessary to receive either skilled or non-skilled nursing care for CNS disorders.

SERVICES REQUIRING SKILLED CARE	Services Requiring Non-Skilled Care
<ol style="list-style-type: none"> 1. Vital signs 2. Ventilator operation/maintenance 3. Central line maintenance/dressings 4. Complex treatment modalities (sterile dressings, soaks, packing, etc.) 5. Parenteral/Enteral nutrition 6. Oxygen therapy 7. Respiratory treatments 8. Tracheostomy maintenance/change 9. Suctioning (frequency/secretion type) 10. Stimulation (verbal/tactile) 11. Tube feedings/maintenance of tube 12. IV medication administration 13. Urinary catheter maintenance/change 14. Exercise (active/passive) 	<ol style="list-style-type: none"> 1. Bathing/linen change/dressing 2. Catheter care 3. Skin care 4. Minor treatment modalities 5. Oral care 6. Stimulation 7. Continue plan of OT/PT 8. Assist with transfers/ambulation 9. Positioning 10. I & O records 11. Assist with oral feedings 12. Splint or brace application 13. Exercise (active or passive) 14. Ensure safety measures (seizure precautions) 15. Vital signs

HOME HEALTH CARE FOR GASTROINTESTINAL DISORDERS

CPT/HCPCS CODES

Local codes effective on or before 12/31/03	CROSSWALKED CODES EFFECTIVE 1/1/04
Y0601 – Skilled nurse, per hour	99600 TD – Skilled nurse, RN
Y0501 – Home health aide, per hour	99600 – Home health aide
X3069 – Licensed practical nurse, per hour	99600 TE – Skilled nurse, LPN/LVN
Z5016 – Home tocolytic therapy	S9349 – Home infusion therapy, tocolytic infusion therapy
W6503 – Physical therapy, individual, by the unit; modalities not requiring use of capital equipment	G0151 – Services of physical therapist is home health setting, each 15 minutes
W7402 – Occupational therapy, by the unit, individual	G0152 – Services of occupational therapist in home health setting, each 15 minutes
W9083 – Speech therapy, home health	G1053 – Services of speech and language pathologist in home health setting, each 15 minutes

Indicators for Gastrointestinal Disorders

ONE of the following indicators must be present for a member to receive home health care for gastrointestinal disorders.

- ◆ Nutritional impairment
 - malabsorption
 - mechanical cause
- ◆ Stomatitis, pharyngitis, esophagitis
- ◆ Swallowing disorders
- ◆ Gastric reflux
- ◆ Vomiting
- ◆ Anorexia
- ◆ Pain
- ◆ Orthostatic B/P
- ◆ Significant rapid weight loss
- ◆ Morbid obesity >200% optimal weight
- ◆ Periorbital/perirectal lesions
- ◆ Unhealed wound(s)
 - surgical
 - fistula, abscess, fissures
- ◆ Bacterial/parasitic infections
- ◆ Diarrhea

- ◆ Constipation
- ◆ Subtotal/total gastrectomy
- ◆ Ostomies
- ◆ Anemia
- ◆ Weakness and fatigue

ONE of the following services must also be necessary to receive either skilled or non-skilled nursing care for gastrointestinal disorders.

Services Requiring Skilled Care	Services Requiring Non-Skilled Care
<ol style="list-style-type: none"> 1. Vital signs 2. IV medication administration 3. Parenteral/Enteral nutrition 4. Administration/maintenance 5. Central line maintenance 6. Oral medication administration 7. Gastric tube medication administration 8. Placement of nasogastric tubes 9. Complex treatment/wound care, sterile dressings/wound packing/medicated soaks, etc. 10. Ostomy care/irrigation 11. Oxygen therapy 12. Bowel training 13. Weight 14. I & O 	<ol style="list-style-type: none"> 1. Bathing/linens/dressing 2. Oral care 3. Skin care 4. Feedings (oral) 5. Force fluid 6. Assist with ambulation 7. Exercise active\passive 8. Reinforce teaching of OT/PT/ST 9. I & O 10. Weight

HOME HEALTH CARE FOR MUSCULOSKELETAL DISORDERS

CPT/HCPCS CODES

Local codes effective on or before 12/31/03	CROSSWALKED CODES EFFECTIVE 1/1/04
Y0601 – Skilled nurse, per hour	99600 TD – Skilled nurse, RN
Y0501 – Home health aide, per hour	99600 – Home health aide
X3069 – Licensed practical nurse, per hour	99600 TE – Skilled nurse, LPN/LVN
Z5016 – Home tocolytic therapy	S9349 – Home infusion therapy, tocolytic infusion therapy
W6503 – Physical therapy, individual, by the unit; modalities not requiring use of capital equipment	G0151 – Services of physical therapist in home health setting, each 15 minutes
W7402 – Occupational therapy, by the unit, individual	G0152 – Services of occupational therapist in home health setting, each 15 minutes
W9083 – Speech therapy, home health	G1053 – Services of speech and language pathologist in home health setting, each 15 minutes

Indicators for Musculoskeletal Disorders

ONE of the following indicators must be present for a member to receive home health care for musculoskeletal disorders.

- ◆ Pain
- ◆ Loss of locomotor ability
- ◆ Decreased muscle strength
- ◆ Stiffness
- ◆ Joint pain, swelling, redness, tenderness
- ◆ Muscle wasting
- ◆ Paralysis
- ◆ Post amputation
- ◆ Multiple fractures
- ◆ Muscle spasms
- ◆ Potential for injury to self

ONE of the following services must also be necessary to receive either skilled or non-skilled nursing care for musculoskeletal disorders.

SERVICES REQUIRING SKILLED CARE	SERVICES REQUIRING NON-SKILLED CARE
<ol style="list-style-type: none">1. Assist with prostheses, braces, splints2. Treatments requiring sterile procedures	<ol style="list-style-type: none">1. Bathing/linen/dressing2. Assistance with ADL's3. Assistance with transfers/ambulation4. Assist with prostheses, braces, splints5. Exercise active or passive6. Position changes7. Non-invasive treatments, comfort measures

HOME HEALTH CARE FOR RESPIRATORY DISORDERS

CPT/HCPCS CODES

Local codes effective on or before 12/31/03	CROSSWALKED CODES EFFECTIVE 1/1/04
Y0601 – Skilled nurse, per hour	99600 TD – Skilled nurse, RN
Y0501 – Home health aide, per hour	99600 – Home health aide
X3069 – Licensed practical nurse, per hour	99600 TE – Skilled nurse, LPN/LVN
Z5016 – Home tocolytic therapy	S9349 – Home infusion therapy, tocolytic infusion therapy
W6503 – Physical therapy, individual, by the unit; modalities not requiring use of capital equipment	G0151 – Services of physical therapist in home health setting, each 15 minutes
W7402 – Occupational therapy, by the unit, individual	G0152 – Services of occupational therapist in home health setting, each 15 minutes
W9083 – Speech therapy, home health	G1053 – Services of speech and language pathologist in home health setting, each 15 minutes

Indicators

ONE of the following indicators must be present for a member to receive home health care for respiratory disorders.

- ◆ Dyspnea
 - quality of respiration (shallow, air hunger, etc.)
 - rate of respiration's
 - dyspnea at rest
 - dyspnea with exertion
 - cyanosis
 - use of accessory muscles
 - apnea/bradycardia
- ◆ Abnormal breath sounds
- ◆ Splinting respirations
- ◆ Strenuous coughing
- ◆ Excessive, tenacious secretions
- ◆ Ineffective airway clearance
- ◆ Abnormal ABG's
- ◆ Decreased ability to be mobile due to dyspnea
- ◆ Irritability/depression
- ◆ Fatigue/weakness
- ◆ Anxiety

ONE of the following services must also be necessary to receive either skilled or non-skilled nursing care for respiratory disorders.

SERVICES REQUIRING SKILLED CARE	SERVICES REQUIRING NON-SKILLED CARE
<ol style="list-style-type: none">1. Oral medication administration2. IV medication administration3. Parenteral/Enteral nutrition4. Vital signs5. Ventilator operation/maintenance6. Tracheostomy maintenance/change7. Suctioning8. Complex treatment modalities (sterile dressing, wound care)9. Respiratory treatments	<ol style="list-style-type: none">1. Assist with bathing, dressing, ADL's (total care may be required)2. Skin care3. Oral care4. Force fluids as instructed5. Assist with ambulation6. Exercise active/passive7. Assist with meals (oral feeding)8. Vital Signs

HOME TOCOLYTIC INFUSION THERAPY**TOCOLYTIC THERAPY CODE Z5016**

Local code effective on or before 12/31/03	Crosswalked code effective 1/1/04
Z5016 – Home tocolytic therapy	S9349 - Home infusion therapy, tocolytic infusion therapy

TOCOLYTIC THERAPY CODE Z5017

Local code effective on or before 12/31/03	Crosswalked code effective 1/1/04 – 3/31/04	2004 code change effective 1/1/04
Z5017 – Home tocolytic therapy	99553 – Home infusion for tocolytic therapy, per visit	99601 – Home infusion, up to 2 hours
		99602 - Home infusion, each additional hour

Indicators

ALL of the following indicators must be present for a member to receive home health care for home tocolytic infusion therapy.

- ◆ The member must be at least 24 to 34 weeks gestation;
- ◆ The member must be in current preterm labor (preterm labor being defined as greater than or equal to six contractions per hour);
- ◆ The member must have a cervical dilation of greater than or equal to 1 cm, or an effacement of greater than or equal to 75%;
- ◆ The member must have experienced secondary failure to wean from infused tocolytics, or have failed oral therapy and requires continued infusion therapy; and
- ◆ The member must have direct home telephone access to providers.

Agency guidelines for home tocolytic infusion therapy

Home Health care agencies must meet the following minimum guidelines to be reimbursed for home tocolytic infusion therapy.

- ◆ Provide home health care to the pregnant member on a 24 hour/day, 7 day/week basis;
- ◆ Provide the member with a tocolytic infusion pump and a uterine monitoring device (including set up and delivery); provide member education regarding the use of the equipment and be available for trouble shooting for the equipment on a 24 hour/day, 7 day/week basis;
- ◆ Provide pharmacological consultation regarding the use of tocolytics and individualized member dosing on a 24 hour/day, 7 day/week basis;
- ◆ Provide member education regarding uterine contractions and other subtle symptoms of preterm labor.

- ◆ Contact the member's physician at least weekly for updates on member condition/compliance.

HOME HEALTH CARE FOR URINARY/RENAL DISORDERS

CPT/HCPCS CODES

Local codes effective on or before 12/31/03	CROSSWALKED CODES EFFECTIVE 1/1/04
Y0601 – Skilled nurse, per hour	99600 TD – Skilled nurse, RN
Y0501 – Home health aide, per hour	99600 – Home health aide
X3069 – Licensed practical nurse, per hour	99600 TE – Skilled nurse, LPN/LVN
Z5016 – Home tocolytic therapy	S9349 – Home infusion therapy, tocolytic infusion therapy
W6503 – Physical therapy, individual, by the unit; modalities not requiring use of capital equipment	G0151 – Services of physical therapist in home health setting, each 15 minutes
W7402 – Occupational therapy, by the unit, individual	G0152 – Services of occupational therapist in home health setting, each 15 minutes
W9083 – Speech therapy, home health	G1053 – Services of speech and language pathologist in home health setting, each 15 minutes

Indicators for Urinary/Renal Disorders

ONE of the following indicators must be present for a member to receive home health care for urinary/renal disorders.

- ◆ Anemia
- ◆ Dyspnea
- ◆ Increased BUN/creatinine
- ◆ Decreased mental acuity
- ◆ Increased B/P
- ◆ Abnormal electrolytes
- ◆ Oliguria
- ◆ Weakness/fatigue
- ◆ Decreased mobility
- ◆ Neuropathies
- ◆ New diagnosis of renal failure
- ◆ Vascular access
- ◆ Newly initiated hemodialysis
- ◆ Recent admission for renal failure
- ◆ Recent admission for urinary tract surgery
- ◆ Peritoneal dialysis
- ◆ Pain
- ◆ Edema
- ◆ Potential for self injury

ONE of the following services must also be necessary to receive either skilled or non-skilled nursing care for urinary/renal disorders.

SERVICES REQUIRING SKILLED CARE	SERVICES REQUIRING NON-SKILLED CARE
<ol style="list-style-type: none">1. Complex treatment modalities<ul style="list-style-type: none">▪ sterile dressings▪ special catheter care (ureteral catheters, irrigation, etc.)2. Urinary, suprapubic catheter care3. I & O4. Weight5. Vital signs	<ol style="list-style-type: none">1. Assist bathing/linens/dressing2. Skin care3. Oral care4. Assist with exercise and ambulation5. Reinforce nutritional teaching6. Weight7. I & O8. Vital signs9. Safety measures

HOME HEALTH SERVICES ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Home Health Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: NL200509 **Publication Date:** 09/2005

Subject: Physician Signature Stamps

Date Added to Manual: 10/31/2005

Text of Publication

Effective January 24, 2004, CMS Transmittal 59 allows for the acceptance of a physician's rubber stamp signature for clinical record documentation, provided it is permitted by Federal, state, and local law, and authorized by the home health agency's or hospice agency's policy. This newsletter article addresses the impact this new policy will have on the Medicaid prior authorization process for home health and hospice services by referring providers to the appropriate regulations for Medicaid.

Chapter 6 of the IHCP Provider Manual and state regulations at 405 IAC 5-5-5 specify that the provider must approve the Indiana Prior Review and Authorization Request form by personal signature, or providers and their designees may use a signature stamp. Providers that are agencies, corporations, or business entities may authorize one or more representatives to sign requests for prior authorization (PA). Providers should note that this section of the IHCP Provider Manual and state regulation address permissible signature requirements for the Indiana Prior Review and Authorization Request form, and must be differentiated from the signature requirements for physician orders and care plans. Under the above-mentioned regulation, it is permissible for the agency to use a signature stamp for the Indiana Prior Review and Authorization Request form.

The following state regulations apply to Medicaid prior authorization request for home health services and can be viewed on the internet at www.accessindiana.com :

- 405 IAC 5-16-3.1 Home health agency services; limitations: does not address physician signature stamps for physician orders or written care plans.
- 405 IAC 5-22-2 Nursing services; prior authorization requirements does not address physician signature stamps for prior authorization of nursing services.

In conclusion, physician signature stamps may be used on the Indiana Prior Review and Authorization Request form when requesting Medicaid prior authorization for home health services; however, any physician order or plan of treatment that is attached to the Indiana Prior Review and Authorization Request form must include an original signature by the physician.

State regulations for the Medicaid hospice benefit do not specifically provide for physician signature stamps. The following regulations do apply to Medicaid prior authorization request for hospice services with regard to the hospice physician certification and the hospice plan of care. They can be viewed on the internet at www.accessindiana.com.

- 405 IAC 5-34-5 Physician certification
- 405 IAC 5-34-7 Plan of care

In order to ensure that the medical director or physician member of the hospice reviewed the plan of care, an original signature is required.

In conclusion, physician signature stamps may be used on the Indiana Prior Review and Authorization Request form when requesting Medicaid prior authorization for hospice services; however, any Medicaid Hospice Physician Certification form or Medicaid Hospice Plan of Care that is attached to the Indiana Prior Review and Authorization Request form must include an original signature by the physician.

Furthermore, the IHCP notes that electronic signatures are not acceptable on plans of care submitted to the HCE Prior Authorization Unit.

Home health and hospice providers should contact the Acute Care Division of the Indiana State Department of Health at (317) 233-7474 with regard to ISDH home health and hospice survey rules.

Information To Be Read In Conjunction with Provider Bulletin BT200117 Prior Authorization Request for Home Health

This information should be read in conjunction with information already published in BT200117 (April 27, 2001 release date). BT200117 may be viewed on the Indiana Medicaid Web site at www.indianamedicaid.com.

Providers are informed that there have been no changes to Medicaid state regulations at 405 IAC 5-16-3(d)(2)(G), which requires a home health agency to state the amount of time required to complete the treatment task on the plan of care. However, the IHCP has made a change to the directions in BT200117, which specified that the Indiana Prior Review and Authorization Request form and the signed plan of care must reflect the specific frequency and duration of care.

This newsletter notes the following change:

- The Indiana Prior Review and Authorization Request form may now reflect the maximum amount of time it may require for the home health agency to care for the patient; however, the provider should only bill the IHCP the actual service units provided on each visit.

ISDH regulations regarding patient care and the medical plan of care that were referenced in BT200117 have changed. The new home health regulations may be viewed by

accessing the IAC on the Web site at www.accessindiana.com . The new regulations may be viewed as follows:

- Encounter defined may be viewed at 410 IAC 17-9-12.
- Frequency of visits defined may be viewed at 410 IAC 17-9-13.
EDS Page 4 of 20 P.O. Box 7263 Indianapolis, IN 46207-7263 For more information visit www.indianamedicaid.com Indiana Health Coverage Programs Provider Monthly Newsletter NL200509 September 2005
- Information regarding patient care and the medical plan of care may be viewed at 410 IAC 17-13-1.

It is the responsibility of home health providers to ensure that their plans of care are compliant with Medicaid regulations and ISDH survey regulations.

Home health providers may direct any questions regarding the ISDH home health survey process to the ISDH Acute Care Unit at (317) 233-7472. Home health providers may direct any questions regarding Medicaid home health prior authorization to the HCE Prior Authorization Unit at (317) 347-4511 or 1-800-457-4518.

MEDICAL POLICY FACT SHEET

TITLE: HOSPICE

DESCRIPTION:

The Indiana Health Coverage Programs (IHCP) hospice benefit program mirrors the covered services and reimbursement methodology of the Medicare hospice program. IHCP hospice providers are required to comply with the federal hospice regulations located in the Code of Federal Regulations (CFR), *42 CFR Part 418 et al* implementing the *Balanced Budget Act of 1997*. These regulations require hospice providers to list all hospice covered services in frequency and scope on the hospice plan of care necessary to treat the terminal illness and related conditions. Additionally, IHCP hospice providers must be Medicare-certified and licensed as hospice providers by the Indiana State Department of Health as a condition of provider enrollment.

Hospice providers are health care providers who own or operate hospice programs/facilities that use interdisciplinary teams directed by licensed physicians. These programs provide planned and continuous care for hospice program members and their families. Hospice programs are designed to alleviate the physical, emotional, social, and spiritual discomforts of a member who is experiencing the last phase of a terminal illness or disease.

This document is intended to serve as a general summary of the IHCP policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC), or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

The IHCP consults hospice criteria published by the fiscal intermediary for Indiana Medicare hospice providers, Palmetto Government Benefits Administrators, LLC. Palmetto has established these guidelines as a matter of protocol for medical criteria. Providers are to use current professional guidelines, including the Local Medical Review Policy (LMRP), to determine when members meet medical necessity for hospice services. Hospice providers are reminded that the IHCP recognizes the LMRP is a guideline to determine when members are appropriate for hospice and palliative services. The LMRP is not meant to replace the overall clinical evaluation by the hospice provider,

IHCP, or its contractor when evaluating the unique clinical condition of each hospice member.

Any IHCP member, who is terminally ill and meets medical necessity criteria, may receive services from an IHCP hospice provider. Additional to service compliance with *42 CFR Part 418 et. al* and the *Balanced Budget Act of 1997*, providers are required to document in the member's hospice medical record support for a terminal diagnosis versus a chronic condition.

PRIOR AUTHORIZATION

Hospice care is dependent upon a physician's certification endorsing a member's prognosis of life-expectancy to be six months or less, if the terminal condition runs its normal course. Hospice services must be reasonable and meet medical necessity for the palliation and management of the terminal illness. Coverage for hospice care is strongly dependent upon documentation of the member's condition and the overall decline in the member's health status as recorded in the physician certification and the hospice plan of care. Additionally, documentation must include any co-morbidities. Documentation is utilized in the prior authorization (PA) and review processes to determine medical necessity. Each case is evaluated on its own merit. The IHCP, Medicare, and its contractors are not prevented from requesting medical documentation regarding hospice members at any time during the member's enrollment the hospice program. This practice is consistent with the IHCP provider agreement.

All IHCP hospice providers are required to be Medicare-certified and licensed as a hospice by the Indiana State Department of Health before enrolling as an IHCP hospice provider. Each hospice agency must ensure that the medical documentation submitted to Health Care Excel (HCE) meets Medicare conditions of participation. The IHCP requires hospice providers to request PA for members at the beginning of each hospice benefit period. PA requests for hospice services may be modified by the HCE PA department. When entering the third hospice benefit period of 60 continuous days, hospice providers must submit specific medical documentation that supports the need of continued hospice care. If the HCE PA department determines that the information is insufficient to process the request, the PA hospice reviewer will return it for the required documentation. The following information must be documented and sent to the PA department for initial and continued hospice care.

- Member has a terminal prognosis, as well as, a physician certification that meets the Medicare guidelines for participation.
- Clinical evidence must support a terminal diagnosis at the time of the initial certification and each subsequent certification.
- Documentation must describe why a member's condition is terminal, not chronic (Medical history may provide clarification for documentation that reflects a chronic condition).

- For each hospice benefit period, the interdisciplinary team must assess the member's condition and service appropriateness. Documentation must distinguish between exacerbation and stabilization, as well as, exacerbation and deterioration.
- Documentation must include the most specific and appropriate terminal diagnosis from the *International Classification of Diseases 9th Edition, Clinical Modification* (ICD-9-CM).
- Documentation must specify any necessary medications, treatments, and services that are considered aggressive treatments.
- Document must detail the member's decline.
- Document must describe how the systems of the body are in a terminal condition.

Hospice Forms

IHCP hospice providers must complete and submit the appropriate forms for each member. Required forms are dependent upon the member's status and requested actions. Refer to the IHCP Hospice Provider Manual and the Indiana Family and Social Services Administration web site for detailed information regarding these forms. Below is a brief description of the hospice forms available to providers.

- *Medicaid Hospice Election*

Members complete this form to elect the hospice benefit. Additionally, it is used to select a particular hospice provider. Election of the hospice benefit requires the member to waive: (a) other forms of health care treatment of the terminal illness for which hospice care was elected or for treatment of a condition related to the terminal illness; (b) services provided by another provider that are equivalent to the care provided by the elected hospice provider; and (c) hospice services other than those provided by the elected hospice provider or its contractors.

- *Medicaid Physician Certification*

Providers complete this form in conjunction with the Hospice Election Form and the Hospice Plan of Care when requesting the first hospice benefit period. Assuming the information is sufficient and accurate, an initial benefit period of 90 days is approved. If benefit periods beyond the first 90 days are necessary, then recertification on the IHCP Physician Certification form and an updated Hospice Plan of Care is required for hospice authorization of the next benefit period.

- *Medicaid Hospice Plan of Care*

Providers complete this form must be completed by an interdisciplinary team member and who must confer with at least one other member of the interdisciplinary team. One of the conferees must be a licensed physician or nurse. All team members must review the plan of care. All of the services stipulated within the plan of care must be reasonable and necessary for palliation or management of the terminal illness and related condition. The

plan of care must be signed by the hospice medical director and include two other signatures from any of the disciplines listed on the IHCP Hospice Plan of Care.

- *Hospice Authorization Notice for Dually-Eligible Medicare/Medicaid Nursing Facility Residents*
Providers complete this form for dully-eligible Medicare/Medicaid members. These members must elect, revoke, and change providers under both the Medicare and the IHCP programs at the same time. The hospice provider is required to notify both programs of any changes in the dually-eligible Medicare/IHCP member's hospice care status. The IHCP requires that the hospice provider submit all the required certification forms
- *Hospice Provider Change Request Between Indiana Hospice Providers*
Providers complete this form when a member, or representative of the member, is not satisfied with the hospice provider. A member may change hospice providers once during any benefit period. This change does not constitute a revocation of services.
- *Change in Status of Medicaid Hospice Patient*
Providers complete this form when there is an eligibility status change.
- *Medicaid Hospice Discharge*
Providers complete this form when a hospice provider discharges a member from future services. Refer to the section, *Discharge by a Provider*, to determine appropriate discharge criteria.
- *Medicaid Hospice Revocation*
Providers complete this form when a member, or representative of the member, is not satisfied with hospice care and revokes hospice services. This form includes a signed statement that the individual revokes the election of IHCP hospice services for the remaining days in the election period. A member can elect to receive hospice care intermittently, rather than consecutively, over the three benefit periods and can therefore elect and revoke hospice coverage an unlimited number of times.

Covered Services

Hospice core services are covered services in the Medicare and IHCP hospice per diem that must be provided directly to the member by hospice employees. *Hospice core services* include nursing services, medical social work services, and counseling services (including bereavement, dietary, spiritual, and other services). *Hospice noncore services* are services in the Medicare or IHCP hospice per diem not identified as *hospice core services*. The following list includes *hospice services* included in the Medicare and Medicaid hospice per diem:

- Nursing care provided by or under the supervision of a registered nurse

- Medical social work services provided by a social worker with at least a bachelor's degree working under the supervision of a physician
- Physician services provided by the medical director or a physician part of the interdisciplinary team participating in services as follows.
- General supervising services, participating in the plan of care, conducting periodic reviews, establishing governing policies, and providing direct-care to members
- Counseling services provided to the member, member's family, and other people caring for the member
- Short-term inpatient care provided on a hospice inpatient unit, participating hospital, and nursing home setting
- Medical equipment and supplies, including palliative drugs, related to the palliation and management of the member's terminal illness
- Home health services furnished by qualified aides
- Homemaker services that assist in providing a safe and healthy environment
- Physical therapy, occupational therapy, and speech-language pathology services provided for the purpose of symptom control
- Inpatient respite care
- Room and board (dually-eligible hospice members) residing in long-term care facilities
- Room and board for IHCP-only hospice members who reside in long-term care facilities
- Any other item or service specified in the member's plan of care, if the item or service is a covered service under the Medicare program

Treatment of Nonterminal Conditions

The IHCP covers medical care for conditions unrelated to the terminal illness. The IHCP expects the hospice provider to actively interface and coordinate these services with other IHCP providers. Medical care for nonterminal conditions may be met by one of the following methods.

- Outpatient physician services
- Inpatient and outpatient hospital admissions
- Emergency admissions to a nursing facility from a private home

If the IHCP hospice member requires an inpatient or outpatient hospital admission for conditions unrelated to the terminal illness, the hospital must bill the IHCP directly for these services. The hospice provider coordinates the inpatient or outpatient hospital services. Hospice provider responsibility for the treatment of nonterminal conditions is case specific. The following guidelines provide clarification for hospice providers regarding this issue.

- If the hospice member currently does not receive treatment for a nonterminal condition, the hospice provider is required to locate appropriate IHCP services for the treatment of a nonterminal condition.

- To ensure that the hospice member is not billed for these services, the hospice provider must ensure that the hospital is enrolled as an IHCP hospice provider.
- The hospice provider must communicate and coordinate with the hospital's medical personnel does not compromise the member's hospice care.
- If the IHCP hospice member is admitted to the hospital from a private home, the hospice provider must submit to the HCE PA department a *Change in Status of Medicaid Hospice Patient* form. This form reflects the hospice member's change of care. The same form must be completed once the hospice member is discharged from the hospital to either another institutional care setting or to a private home.

The IHCP provider billing for the treatment of the nonterminal illness must obtain PA for these services. The following services do NOT require PA for the treatment of nonterminal conditions.

- Pharmacy services not related to the member's terminal condition
- Dental services
- Vision care services

Discharge by Hospice Provider

Once a hospice provider chooses to admit a member, the provider may not automatically or routinely discharge the member at its discretion, even if the care is costly or inconvenient. The election of the hospice benefit is the member's choice, rather than the hospice's choice; therefore, the hospice may not revoke the member's election. Additionally, hospice providers may not request or demand hospice revocation. Reasons a hospice provider may discharge a member from care include the following situations.

- Member dies
- Member's prognosis is determined to be greater than six months
- Member moves out of the hospice service area
- Member's safety or hospice staff safety is compromised

When a member moves out of the service area, the hospice provider notifies the fiscal intermediary of the discharge so that hospice services and billings are terminated as of the discharge date. In this situation, the member loses the remaining days in the benefit period; however, there is no increase cost to the member.

For circumstances when a member's safety is compromised, the hospice must make every effort to resolve these problems satisfactorily before discharge is considered an option. All efforts by the hospice to resolve the problem must be documented in detail in the member's record. The hospice must notify the fiscal intermediary and the State Survey Agency (SA) of the circumstances surrounding the impending discharge. Hospice providers must submit specific forms to facilitate the discharge. For reimbursement, hospice program guidelines must be followed.

- Hospice providers may fax the *Medicaid Hospice Discharge* form to the HCE PA department, as long as all the hospice benefit periods preceding the hospice discharge date have been previously authorized.
- For members residing in nursing facilities, hospice providers are encouraged to provide a copy of the discharge form to the appropriate staff in the nursing facility to ensure the form is included in the hospice member's nursing facility clinical record. These coordination procedures ensure staff is aware of the exact date that the hospice provider discharged the member. Additionally, hospice providers must provide a copy of this form to the nursing facility billing department.
- Hospice providers must bill the IHCP for the hospice per diem for nursing facility room and board for the hospice discharge date.
- Nursing facilities may resume billing the IHCP directly for nursing facility care for the date of service following the hospice discharge date once the hospice provider has provided a copy of the PA form reflecting an updated hospice discharge claim.
- Hospice providers are reminded that it is a violation of medical records standard to predate the hospice discharge. The documented discharge date cannot precede the actual discharge.

Noncompliance

As part of the admissions process, hospice providers should explain to members covered hospice services, actions that may constitute noncompliance with the hospice care philosophy, and charges members may be responsible for paying. When a hospice provider believes a member has reflected significant noncompliance with the hospice plan of care, documentation standards outlined below must be followed.

- Must have clear written admissions policies
- Must have informed the member of the hospice benefit responsibilities
- Must have thorough documentation of the noncompliance issues

Once the hospice provider follows these guidelines, the SA must be contacted. The SA contacts the Centers for Medicare and Medicaid Services (CMS) for further discharge consideration.

Dually-Eligible and Medicaid-Only Hospice Members in Nursing Facilities

The IHCP hospice benefits must comply with the *Omnibus Budget Reconciliation Act of 1989 (OBRA 1989)*. *OBRA 1989* requires dually-eligible Medicare/IHCP members to elect, revoke, or change providers under both the Medicare and the IHCP programs simultaneously. Hospice providers are required to notify both programs of any changes in the member's hospice care status. Additionally, hospice providers are required to coordinate regularly with nursing facility providers. To ensure that the IHCP member's enrollment in the IHCP hospice benefit is clear to both hospice and nursing facility staffs, the hospice provider must furnish the nursing facility staff and the nursing facility's billing department with the member's Medicaid hospice forms.

Waiver Members

Once hospice service criteria are met, IHCP waiver members are eligible for hospice services. Waiver members are not required to disenroll from the waiver program; however, they must be under direct-care of an IHCP hospice provider for those services that both programs have in common. Member may receive waiver services unrelated and non-duplicative of the hospice services. Hospice providers must coordinate with nonhospice providers to ensure overall care is met and the hospice plan of care is not compromised. The number of hours related to the member's nonterminal condition is determined on a case specific basis. Additional waiver services should not be provided due to the hospice election.

MANAGED CARE ORGANIZATIONS

Members enrolled in an IHCP Managed Care Organization (MCO) must disenroll. Disenrollment is necessary for hospice authorization to be completed. Members become eligible for hospice services the day following disenrollment from the MCO.

To facilitate the hospice authorization process, the hospice provider may fax the *Medicaid Hospice Election* form to the HCE PA department initiating MCO disenrollment. The corresponding *Medicaid Hospice Physician Certification* form and *Medicaid Hospice Plan of Care* form must be sent to the HCE PA department within ten business days. If the hospice provider fails to verify IHCP eligibility or fails to fax the *Medicaid Hospice Election* form to the HCE PA department, the hospice provider will not receive payment for these dates of service the member is MCO member.

REIMBURSEMENT INFORMATION

Hospice providers must provide care based on the medical acuity of the member at one of four distinct hospice levels of care: routine home care, continuous home care, general inpatient hospice care, and inpatient hospice respite. Hospice inpatient care must be provided in an inpatient unit or contracted inpatient facility that meets the parameters at *42 CFR Part 418.100 et al.* The following information describes the four levels of service and the two levels of care available to members. **Table 1** outlines the hospice reimbursement methodology.

- Routine home care delivered in a private home
- Continuous home care delivered in a private home
- Routine home care delivered in a nursing facility
- Continuous home care delivered in a nursing facility
- Inpatient respite care (available to private home hospice members only)
- General inpatient hospice care

Table 1 Hospice Reimbursement Methodology

Revenue Code	Revenue Code Descriptions and Explanations
180	Nursing Facility Bed Hold Non-Paid Revenue Code*** The hospice provider should bill the IHCP using this revenue code for leave days when the nursing facility occupancy is less than 90%. This code generates an IHCP denial; however, providers may charge members for the nonreimbursed bed hold days.
183	Nursing facility bed hold for hospice therapeutic leave days*** Therapeutic leave days are reimbursed at 50% of the 95% of the nursing facility room and board per diem rate. Eighteen therapeutic leave days are reimbursable per member per calendar year. Hospice providers should not bill the IHCP using this revenue code when the nursing facility occupancy rate is below 90%.
185	Nursing facility bed hold for hospitalization for services unrelated to the terminal illness*** Bed holds for hospitalization for services unrelated to the terminal illness are reimbursed at 50% of the 95% of the nursing facility room and board per diem rate. Fifteen days per hospitalization is reimbursable. Hospice providers should not bill the IHCP using this revenue code when the nursing facility occupancy rate is below 90%.
651	Routine home care in a private home The hospice provider is paid at the routine home care rate for each day the member is at home, under the care of the hospice provider, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services.
652	Continuous home care in a private home * Continuous home care per diem rate is calculated into an hourly rate. The hourly rate is reimbursed to the hospice provider to 24 hours a day. Home health aides may supplement the nursing care in the total continuous care hours. All hours must be counted. Documentation must clearly indicate the nature of the medical crisis, need for skilled intervention, and illustrate hourly and daily what level of staffing and the services provided.
653	Routine home care in a nursing facility The hospice provider is paid at the routine home care rate for each day the member is in a nursing facility, under the care of the hospice provider, and not receiving continuous home care. The rate is paid without regard to the volume or intensity of routine home care services. The hospice provider is paid an additional room and board per diem at 95% of the lowest nursing facility rate for contracted nursing facility cost.

Revenue Code	Revenue Code Descriptions and Explanations
654	<p>Continuous home care in a nursing facility The continuous home care rate is calculated into an hourly rate. The hourly rate is reimbursed up to 24 hours a day. Home health aides may supplement the nursing care in the total continuous care hours. All hours must be counted. Documentation must clearly indicate the nature of the medical crisis, need for skilled intervention, and illustrate hourly and daily what level of staffing and the services provided. The hospice provider is paid an additional room and board per diem at 95% of the lowest nursing facility rate for contracted nursing facility cost.</p>
655	<p>Inpatient respite care** Respite care is an occasional, short-term inpatient care provided to hospice members to relieve caregivers. Respite care is available to members residing in private homes. The hospice provider is paid at the inpatient respite care rate for each day the member resides in an approved inpatient facility and receives respite care. Payment for respite care is for a maximum of five consecutive days per stay. Payment for the sixth day and subsequent days is at the routine home care rate.</p>
656	<p>General inpatient hospice care The hospice provider is paid at the general inpatient hospice rate for each day the member resides in an approved inpatient hospice facility and receives general inpatient hospice care. Inpatient hospice care is for pain control and acute/chronic symptom management not manageable in other settings.</p>
657	<p>Hospice direct-care physician services Physician services, hospice provider employee or authorized hospice provider, are separately reimbursable on a fee-for-service basis. Services are billed by the hospice provider utilizing the hospice provider number. This code may be billed on the same day other hospice revenue codes are billed.</p>
659	<p>Room and Board for Dually-eligible Medicare/Medicaid nursing facility members only (Room and board portion of the hospice per diem rate) The hospice provider must bill Medicare for the hospice services and Medicaid for room and board. The hospice provider is paid 95% of the lowest nursing facility per diem to cover the room and board cost incurred by the contracted nursing facility. Revenue code 659 may not be billed with the hospice related revenue codes 651, 652, 653, 654, 655, or 656. These codes are designated for IHCP-only hospice services.</p>

*Continuous home care is provided only during a period of crisis requiring continuous care for acute medical symptoms, palliation and management treatments. A nurse, registered or licensed practical nurse, must provide over half the total care. This care need not be continuous and uninterrupted.

**Inpatient facility is defined as a hospital, long-term care facility, or the facility of a hospice provider that provides care 24 hours a day.

***Please have hospice revenue codes 180, 183, and 185 follow hospice revenue code 659 in the table.

Reimbursement for Room and Board on Date of Death or Date of Physical Discharge

The OMPP does not pay the nursing facility per diem or room and board services for the day a member is discharged from the nursing facility. When a hospice member dies in a nursing facility, the date of death follows the same reimbursement procedures as the date of physical discharge from the nursing facility. If a hospice member is admitted and dies in the nursing facility on the same day, the nursing facility is not paid the room and board per diem for that day; however, hospice providers may bill the IHCP for the hospice per diem for either a physical or death discharge. Providers bill revenue code 653 or 654 with occurrence code 51.

Hospice Member Liability Residing in a Nursing Facility

An IHCP member (dually-eligible Medicare/IHCP or IHCP-only) residing in a nursing facility is responsible for the member's portion of the payment before the IHCP pays the remaining balance of nursing facility care (i.e., room and board services). Member liability includes, but is not limited to, personal savings account, Medicare pension funds, or Social Security funds. Member liability is deducted the first date of service the member resides and eligible for the IHCP nursing facility LOC.

Hospice providers can obtain a member's patient liability for a particular month by contacting EDS Customer Assistance or using one of the eligibility verification system (EVS). When a provider obtains the patient liability amount, the RA is used to determine how EDS calculates the paid amount. The following formula is used if the RA does not match the rates the provider submitted on the claim.

1. Nursing facility case mix rate on file x 95% (.95) = allowed amount on the RA for room and board
2. (Number of dates of service x allowed amount on RA) minus member liability = room and board amount

Prior Authorized Physician Services

Additional reimbursement is available for an independent physician's direct-care services in accordance with the IHCP reimbursement physician service methodology. Hospice providers may not bill these services under the hospice provider number. Services must be the physician's professional services. Costs for services related to the terminal condition, such as laboratory or X-rays, may not be included in this billing. These services are included in the per diem rates.

Emergency Service Charges

Emergency service charges related to the terminal illness for hospice members are the responsibility of the hospice provider. These responsibilities include all hospice and transportation charges associated with emergency. Emergency service charges unrelated to the terminal illness are separately reimbursable by the IHCP by the appropriate provider.

NURSING FACILITY QUALITY ASSESSMENT

The IHCP began retro rate adjustments to nursing home rates for the nursing facility quality assessment fee July 2005. The change in nursing facility rates, due to the quality assessment fee results in retro rate adjustments for room and board to hospice providers retroactive to July 1, 2003. Hospice and nursing facility providers are reminded that all coordination and payment arrangements should be reflected in the hospice contract with the nursing facility. Hospice claims reflecting room and board payments for the dates of service July 1, 2003 to present are included in the retro rate adjustment. *OBRA 1989* and *405 IAC 1-16-4* require the IHCP to reimburse hospice providers nursing facility room and board payments; Hospice providers reimburse nursing facilities according to their contract. The IHCP pays the hospice 95% of the nursing home rate on file to the hospice.

INDIANA HEALTH COVERAGE PROGRAMS HOSPICE PROVIDER MANUAL 4.0

The IHCP Hospice Provider Manual provides a comprehensive, single-source document outlining policies and procedures associated with the IHCP hospice program. The manual does not address general aspects of IHCP policy such as IHCP member eligibility, third party liability, medical policy, PA, utilization review, or inspection of care. The manual is divided into nine main sections.

- **Section 1: Introduction**

This section outlines key policies and procedures

- **Section 2: Provider Enrollment**

This section outlines the conditions for provider participation and enrollment procedures. Special attention is given to provider certification requirements, locational service issues, and institutional policies.

- **Section 3: Member Eligibility**

This section outlines the target group by population category, hospice benefit periods, and member certification requirements.

- **Section 4: Election and Revocation**

This section explains election and revocation hospice services, discharging hospice members, and changing hospice providers.

- **Section 5: Hospice Authorization Process**

This section defines the procedures and policies that determine the framework of a member's hospice services. Emphasis is placed on the informational requirements associated with the hospice benefit periods and the prior authorization process for services unrelated to the terminal condition.

- **Section 6: Reimbursement**

This section describes reimbursement for hospice services detailing billing revenue codes and level-of-care categories.

- **Section 7: IHCP Recoupment**

This section describes methods of IHCP recoupment and overpayment.

- **Section 8: Most Common Error Codes**

This section describes common reimbursement denials, explanation of benefit codes, and methods to correct errors.

- **Section 9: Hospice Contracts with Nursing Facilities**

This section explains hospice provider and nursing facilities contracts.

RELATED MEDICAL TOPICS

Emergency Services
Home Health Services
Hospital Inpatient Services
Hospital Outpatient Services
Long-Term Care Services
Managed Care Organization Services
Mental Health Services
Nursing Facilities Services
Out-of-State Services
Pharmacy Services
Therapy Services
Waiver Services

RULES, CITATIONS, AND SOURCES

Code of Federal Regulations (CFR)

42 CFR 1001.952 – Safe Harbor Regulation

42 CFR 418 – Conditions of Participation for Hospice Care

Indiana Administrative Code (IAC)

405 IAC 1-16 – Reimbursement for Hospice Services

405 IAC 5-2-10.2 – “Hospice Program” defined

405 IAC 5-5-1 – Out-of-State Services; general

405 IAC 5-34 – Hospice Services

Indiana Code (IC)

IC 4-21.5-3-33 – Adjudicative Proceedings, Records

IC 16-25-3 – Licensure of Hospices

Indiana Health Coverage Programs Provider Manual

1999

Revised 2005, Version 5.0

Indiana Health Coverage Programs Hospice Provider Manual

Revised March 2004, Version 4.0

Indiana Health Coverage Programs Banner Page (BR)

BR200536 – Retro Rate Adjustments under Hospice

BR200513 – Information about Hospice Retro Rate Room and Board Adjustment Procedures

BR200503 – Change Order to Expedite the Adjustment of Hospice Claims for Room and Board

BR200502 – Hospice and Nursing Facility Change Order

BR200501 – Hospice and Nursing Facilities Claims Changes

BR200452 – Hospice and Nursing Facilities Update

BR200446 – Hospice for Managed Care Member Update

BR200442 – Hospice Update

BR200413 – Hospice Counties 1-9 EOB code 4014

BR200412 – Hospice Update as in *BT200372*

BR200411 – Hospice Changes to Authorization Process

BR200410 – Hospice Providers Enrolled in MCO and Hospice Authorization Update

BR200331 – Hospice Verification Responses

BR200315 – Hospice Update

BR200216 – Hospice Rule Change

BR200043 – Hospice Agency Review Process

BR200025 – Hospice Benefits Clarification

BR199919 – Hospice Claims Mass Adjustments

BR12-29-1998 – Hospice Forms

BR12-15-1998 – Hospice “Private Pay”

BR11-10-1998 – Medicaid Hospice Forms

Indiana Health Coverage Programs Provider Bulletin (BT)

BT200372 – Changes in Hospice Authorization Process

BT200367 – Hospice Rates Effective October 1, 2003 and Hospice Benefits Updates

BT200365 – Pharmacy Hard Edits and Hospice Review Process

BT200331 – Changes to the Hospice Benefit Rules

BT200259 – Detailed Explanation of Rule Changes and the Impact of the Changes on Hospice Providers for IHCP Hospice Authorization

BT200234 – System Changes Affecting Hospice Revenue Codes 655 and 656
 BT200147 – Hospice Rates Effective October 1, 2001
 BT200146 – Nursing Facility Bed Hold Days
 BT200116 – Nursing Facility Retro Rate Adjustments for Hospice Members
 Receiving Hospice Care Prior to July 1, 1999
 BT200112 – Revised Indiana Health Coverage Programs Hospice Rates Effective
 April 1, 2001
 BT200107 – Notification of Systems Issues Regarding Incorrect Payments to
 Hospice Providers for Room and Board Payments on Member's
 Date of Death
 BT200102 – New Hospice Rate Effective October 1, 2000
 BT200041 – Incorrect Payment to Hospice Providers for Room and Board
 Payments for Member's Date of Death
 BT200030 – Revised Hospice Provider Manual
 BT200011 – New Hospice Policy for Nursing Facility Residents
 BT200002 – Use of Forms 450B and OMPP 450B SA/DE
 BT199940 – New Rates
 BT199939 – Billing Procedures, Edit1024
 BT199925 – Policies and Procedures for Treatment for Non-Terminal Conditions
 BT199924 – Treatment for Non-Terminal Conditions for Hospice Recipients
 Admitted to a Nursing Facility After a Hospital Stay.
 BT199919 – New Effective Date OMPP Recoupment Based on Noncompliance
 with 405 IAC 1-16-4
 BT199905 – Exceptional Services Managed Care (Medicaid Hospice)
 Information
 BT199904 – Election of Hospice Services by Home and Community-Based
 Waiver Recipients Information
 BT199846 – New Hospice Rates
 BT199840 – Updated Form 450B Information
 BT199838 – Hospice Authorization and Claim Payment Issues
 BT199836 – Contracted Hospice Services in Nursing Facility
 BT199830 – Reimbursement and Survey Issues (Hospice Benefits)
 BT199817 – Procedures to Request Hospice Forms
 BT199802 – Medicaid Hospice Billing Procedures
 Indiana Health Coverage Programs Provider Newsletter (NL)
 NL200411 – Hospice Services
 Omnibus Budget Reconciliation Act of 1989 (OBRA 1989)
 Social Security Act, Section 1902(a)(57)

Origination Date: 12/31/2000

Revision and Review	Reason	Date
Revision	E97-25 New Hospice Benefit	07/01/97
Revision	E98-15 New HCPC Procedure Codes	01/01/98

Revision and Review	Reason	Date
Revision	E98-02 Medicaid Hospice Billing Procedures	01/09/98
Revision	E98-30 Reimbursement and Survey Issues Related to the Hospice Benefit	09/18/98
Revision	E98-17 Procedures to Request Hospice Forms	09/18/98
Revision	E98-46 New Hospice Rates	10/01/98
Revision	E98-37 Recoupment Based on <i>405 IAC 1-16-4</i>	11/06/98
Revision	E98-36 Contracted Hospice Services in Nursing Facilities	11/06/98
Revision	E98-38 Issues Regarding Hospice Authorizations and Hospice Claims Payment	11/06/98
Revision	E99-04 Election of Hospice Services by Home and Community-Based Services Waiver Recipients	01/26/99
Revision	E99-05 Parameters and Procedures for Reimbursement for Exceptional Circumstances for Managed Care Recipients Who Elect Hospice	01/26/99
Revision	Medicaid Hospice Benefit Provider Manual Policy and Procedures	02/01/99
Revision	E99-19 New Effective Date for OMPP Recoupment Based on Non-Compliance	06/14/99
Revision	E99-24 Treatment for Non-Terminal Hospice Conditions	07/30/99
Revision	E99-25 Policies and Procedures for Treatment for Non-Terminal Conditions	07/30/99
Revision	E99-40 New Rates	11/17/99
Revision	E99-39 Billing Procedure and Edit 1024	12/01/99
Revision	E00-11 New Policy	02/25/00
Revision	E00-30 New Hospice Provider Manual	07/01/00
Review	Scheduled	07/31/06

APPLICABLE INDIANAA/M EDITS AND AUDITS

387 – Service Is Not Payable
 403 – Hospital “From” Date Invalid
 404 – Hospital “Thru” Date Invalid
 439 – Hospice Services Being Billed (Manual Payout)
 499 – Claims Correction Form Not Returned Within Days
 513 – Recipient’s Number Does Not Match the Recipient’s Name

- 547 – Hospital Leave Billed Without Accommodation
- 564 – Revenue Code Is Not Allowed for this Recipient's Eligibility
- 641 – Patient Reported as Deceased
- 646 – Coordination With Hospice Provider
- 665 – Patient Enrolled Under Managed Care
- 1001 – Billing Provider Not Eligible to Bill on this Program
- 1002 – Rendering Provider Not Eligible to Render Service on this Program
- 1003 – Billing Provider Not Eligible to Bill on this Program for the Date of Service
- 1004 – Rendering Provider Not Eligible to Render Service on this Program for the Date of Service
- 1015 – Provider Not Authorized to Render this Service for this Program Without PA
- 1024 – Billing Provider Not Listed As Member's LTC Provider
- 1025 – Billing Provider Not Eligible to Bill on this Program for the Dates of Service
- 1032 – Billing Provider Not Eligible to Bill this Claim
- 1035 – Hospice Provider Billing for Hospice Services
- 1036 – Rendering Provider Not Eligible
- 1037 – Private Duty Nurse
- 1039 – Services Rendered By Out of Network Provider
- 1042 – Certification Code Missing
- 2003 – Recipient Ineligible on Date of Service
- 2018 – Recipient Ineligible on Date(s) of Services
- 2023 – Recipient Ineligible on Dates of Service Due to Enrollment in a Managed Care Organization
- 2024 – Patient Ineligible for Hospice Level-of-Care
- 2025 – Hospice Recipient Billed Without Hospice Services
- 2026 – Hospice Recipient Ineligible for Nursing Home
- 2027 – Hospice Service Not Billed Correctly
- 2034 – Medical and Non-Medical Supplies and Routine DME Items are Covered in the Per Diem Rate
- 4014 – No Pricing Segment on File
- 4214 – Hospice/Waiver Duplicative Services
- 4233 – Date of death/discharge not covered
- 5001 – Duplicate of Another Claim
- 6748 – Hospice Respite Limited to Five Days
- 9064 – Hospice Pricing (Rate on File)
- 9069 – Room and Board Not Paid on Date of Death/Discharge
- 9070 – Payment is Based on the Lessor of the Billed
- 9090 – State Enforced Rate Reduction

MEDICAL POLICY FACT SHEET

TITLE: HOSPITAL INPATIENT

DESCRIPTION:

“Inpatient” defined is a patient required to be admitted to the hospital to treat a condition requiring close monitoring or skilled professional management.

SUMMARY OF CURRENT POLICY:

Inpatient hospital services can be covered when they are medically reasonable and necessary and can be performed only in an inpatient hospital setting. Most inpatient admissions are reimbursed by Diagnosis Related Groupings (DRG) methodology. Catastrophic cases are given special consideration and are reimbursed based on outliers of the case.

Admissions reimbursed by level of care are psychiatric admissions, physical rehabilitation admissions, and burn admissions.

Medicaid does require prior authorization for all out-of-state admissions, in-state psychiatric admissions, substance abuse admissions, physical rehabilitation admissions, and burn admissions. Prior Authorization must be obtained for all admissions requiring prior authorization within forty-eight (48) hours, excluding Saturday, Sunday, and legal holidays. Concurrent review is necessary beyond the approved days. (Prior Authorization requirements may be found in 405 IAC 5-3.)

MEDICAL TOPICS CROSS-REFERENCES:

Family Planning
Hospital Inpatient – Readmissions/General/Same Provider
Mental Health/Behavioral Health – Inpatient Services
Mental Health/Behavioral Health – Outpatient Services
Nursing Facilities

RULES, CITATIONS, AND SOURCES:

405 IAC 5-17 Hospital Services

Initial Policy	Issue	Effective Date	Implementation Date	Retroactive Date
470 IAC 5-8-9 Transferred	Hospital services	7/1/91		
405 IAC 1-6-9 Repealed 8/24/97	Hospital Services	1/1/92		
Revisions:				
405 IAC 5-17-1 405 IAC 5-17-2	Hospital Services	8/24/97		
405 IAC 5-17-3	Emergency Inpatient Admission	8/24/97		

APPLICABLE INDIANA A/M EDITS AND AUDITS:

2020
 2021
 3007
 3014
 4081
 4085
 4087
 4092
 4099
 4103
 4106
 4116
 4202
 6046
 6508
 6509

Coverage Criteria

INPATIENT ACUTE CARE HOSPITAL ADMISSIONS

405 IAC 5-17 provides the rules governing hospital services.

Inpatient hospitalizations for medical conditions other than mental health, burns or rehabilitation following a traumatic injury, are reimbursed utilizing the DRG methodology and do not require prior authorization. (See 405 IAC 1-10.5 for DRG reimbursement methodology)

Inpatient hospitalizations for the immediate treatment of burns DO require prior authorization. However, considering these admissions are usually emergent in nature, the facility has 48 hours from the time of admission, excluding weekends and holidays, in which to request authorization. Additional days are based on medical necessity and the percentage of the body involved.

NOTE: Effective January 10, 2001, the Office of Medicaid Policy and Planning (OMPP) determined that the prior authorization requirement for inpatient burn admissions was no longer required. It was determined that the prior authorization requirement is hard coded in the IndianaAIM system and would require a Customer Service Request (CSR) to have the hard coding removed. The CSR will not be able to be completed until after HIPPA implementation in October 2003. In the interim, the HCE Prior Authorization department has created a work around process that allows for information to be received from the provider and entered in the IndianaAIM system. The provider can be instructed that there are no further clinical updates required and request that the provider call the department with a discharge date so that the number of days can be added to the prior authorization approval.

Surgical procedures typically performed on an outpatient basis, when performed as an inpatient, must be prior authorized (405 IAC 5-17-2). These may be the result of technical or medical difficulties during the outpatient procedure; presence of physical or mental conditions making prolonged pre or postoperative observation by skilled medical personnel necessary, a simultaneous procedure requiring hospitalization or the likelihood of an additional procedure requiring hospitalization.

Substance abuse admissions are also reimbursed utilizing the DRG methodology, but do require prior authorization, as outlined under “Mental Health”.

All out-of-state services require prior authorization. (See 405 IAC 5-5-2 and Claims Resolution Manual ESC 3010) [Exception—405 IAC 5-5-2(3)(4)]

Hospitalization**Adult burns
(Age 10 and over)****Overview****General Information:**

Prior authorization is required for all Medicaid covered burn inpatient stays that are reimbursed under the level of care methodology described in 405 IAC 1-10-5. Days that are not prior authorized under the level of care methodology as required by this rule will not be covered by Medicaid.

405 IAC 5-17-3 Emergency inpatient admissions for diagnoses reimbursed under the level of care payment methodology must be reported to the office within forty-eight (48) hours of admission, not including Saturdays, Sundays, or legal holidays, in order to receive Medicaid reimbursement. At that time, the same standards for prior authorization will be applied as would have been applied if the authorization had been requested before the admission.

First degree: Superficial. Damage is limited to the epidermis. Erythema appears. Between 10 and 20 % total body surface area-minor burn.

Second degree: Deep partial thickness burns of the eyes, ears, face, hands, feet or perineum; or burns complicated by fractures or respiratory damage; electrical burns; and all burns in poor-risk patients.
Involvement of less than 15% total body surface area-minor burn.
Involvement of 15% - 25% total body surface area-moderate burn.
Involvement of more than 25% total body surface area-major burn.

Third degree: Full thickness burns covering less than 3% of the body, excluding the eyes, ears, face, hands, feet or perineum = minor burn.

OR

Full thickness burns of the eyes, ears, face, hands, feet or perineum covering > 3% and < 10% total body surface area = moderate burn.

OR

Full thickness burns of more than 10% of the total body surface-major burn.

Revenue Code**Narrative Description****207****Admissions for burns. One (1) unit = one (1) day.****405 IAC 5-17-2 (a)****Indicators**

The admission may be approved without referral for physician review if ONE of the following is present: (recent onset)

1. Loss or damage of skin $\geq 15\%$ of TBS (total body surface) area.
2. High voltage burn with devitalized skin, fat, or muscle.
3. 2nd or 3rd degree burns of one of the following: Face, hands, perineal region, encircling neck or extremities, anterior or posterior neck or limbs.
4. $T \geq 104.0^{\circ} \text{ F}$
5. $T \geq 102.0^{\circ} \text{ F}$ and ONE of the following:
 - $\text{WBC} \geq 18,000/\text{cu.mm}$
 - $\text{WBC} \geq 15,000/\text{cu.mm}$ with $\geq 7\%$ bands
1. $T \geq 100.5^{\circ} \text{ F}$ and ONE of the following:
 - Absolute neutrophil count $\leq 500/\text{cu.mm}$
 - $\text{WBC} \leq 1,500/\text{cu.mm}$
2. Admission for an invasive procedure which necessitates an inpatient setting AND is scheduled for the same day as admission.

AND ONE of the following treatments is being provided: (at least daily)

1. Post surgery or procedure care ≤ 3 days and at least TWO of the following:
 - IV fluids $\geq 100 \text{ mL/h}$
 - IV, IM, or ED analgesics

- IV or IM antiemetics
- Graft or wound care

1. Burn therapy with at least THREE of the following:

- IV electrolyte (K, Ca, Mg, P)
- IV fluids ≥ 100 mL/h
- IV plasma expanders
- O₂ $\geq 28\%$ (4L) or Hyperbaric
- TPN

OR at least THREE of the following treatments are being provided:

1. Blood or blood products
2. Complex burn, graft, or wound care
3. IV fluids ≥ 100 mL/h
4. Restorative PT or OT at least 2x/24h
5. TPN
6. IV or IM corticosteroids at least 3x/24h
7. IV or IM diuretics at least 2x/24h
8. IV or IM analgesics at least 4x/24h
9. IV or IM antiemetics at least 4x/24h
10. IV or IM anti-infectives at least 3x/24h

References

Information obtained from the Medicare MDC Criteria Manual.

Hospitalization**Pediatric Burns
(Age 10 and under)****Overview**

Prior authorization is required for all Medicaid covered burn inpatient stays that are reimbursed under the level of care methodology described in 405 IAC 1-10-5. Days that are not prior authorized under the level of care methodology as required by this rule will not be covered by Medicaid.

405 IAC 5-17-3 Emergency inpatient admissions for diagnoses reimbursed under the level of care payment methodology must be reported to the office within forty-eight (48) hours of admission, not including Saturdays, Sundays, or legal holidays, in order to receive Medicaid reimbursement. At that time, the same standards for prior authorization will be applied as would have been applied if the authorization had been requested before the admission.

The following descriptions are for age clarification purposes only.

Newborn=birth to 28 days

Infant=28 days to 18 months

Preschool=18 months to 6 years

Preadolescent=6 years to 12 years

Adolescent=12 to 18 years

Degree(s) of burns: (< 10 years old)

First degree: Superficial. Damage is limited to the epidermis. Erythema appears. Between 10 and 20 % total body surface area-minor burn.

Second degree: Deep partial thickness burns of the eyes, ears, face, hands, feet or perineum; or burns complicated by fractures or respiratory damage; electrical burns; and all burns in poor-risk patients.

- ✓ Involvement of less than 10% total body surface area-minor burn.
- ✓ Involvement of 10% - 20% total body surface area-moderate burn.

- ✓ Involvement of more than 20% total body surface area-major burn.

Third degree: Full thickness burns covering 2% of the body, excluding the eyes, ears, face, hands, feet or perineum = major burn.

OR

Full thickness burns of the eyes, ears, face, hands, feet or perineum covering > 1% and < 10% total body surface area = major burn.

Revenue Code

Narrative Description

207

Admissions for burns. One (1) unit = one (1) day.

405 IAC 5-17-2 (a)

Indicators

The admission may be approved without referral for physician review if at least ONE of the following is present: (recent onset)

1. Electrical burns with devitalized skin, fat, or muscle
2. 1st degree burns covering 40% of TBS
3. 2nd degree burns covering 15% of TBS
4. 2nd degree burns covering face, genitalia, hands, or feet
5. 3rd degree burns covering 5% or more of TBS

AND at least ONE of the following treatments is being provided at least daily:

1. Post surgery or procedure care \leq 2 days
2. IV electrolytes
3. Burn therapy with at least TWO of the following:
 - IV fluids \geq 30 mL/kg/24h
 - IV plasma expanders

- $O_2 \geq 28\%$ (4L)

OR at least THREE of the following treatments are being provided:

1. Blood or blood products
2. Complex burn, graft, or wound care
3. Physical therapy
4. IV fluids ≥ 30 mL/kg/24h
5. IV plasma expanders
6. TPN or Enteral feeding
7. IV or IM corticosteroids at least 3x/24h
8. IV diuretics at least 2x/24h
9. IV or IM analgesics at least 4x/24h
10. IV or IM antiemetics at least 4x/24h
11. IV or IM anti-infectives at least 3x/24h

References

Information obtained from the Medicare MDC Criteria Manual.

INPATIENT DENTAL ADMISSIONS**Revenue Code****Narrative Description****120****Inpatient days (Appropriate procedure code for dental procedure must also be authorized.)****405 IAC 5-14-18****Indicators****ONE of the following:**

1. Mental incapacitation such that the recipient's ability to cooperate with procedures is impaired, including mental retardation, organic brain disease and behavioral problems associated with uncooperative, but otherwise healthy, children.
2. Severe physical disorders affecting the tongue, or jaw movements.
3. Seizure disorders.
4. Significant psychiatric disorders resulting in impairment of the recipient's ability to cooperate with procedures.
5. Previously demonstrated idiosyncratic or severe reactions to IV sedation medication.
6. The need for oral surgery, listed in 405 IAC 5-19-17 or in extreme cases of facial trauma, pathology, or deformity.
7. Periodontal surgery only in cases of drug-induced periodontal hyperplasia.
8. Elective oral surgery when recipient is unable to cooperate with or tolerate the procedure.

**HOSPITAL INPATIENT
FACT SHEET
ADDENDUM A**

Note: This addendum contains provider notifications that have been published since the review of the Hospital Inpatient Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200509 **Publication Date:** 03/01/2005

Subject: Hospital Stays <24 hours

Date Added to Manual: 04/29/2005

Text of Publication

As a result of changes to 405 IAC 1-10.5-3 (y), effective for admissions on or after November 1, 2004, providers are required to bill an inpatient stay of less than 24 hours as an outpatient service. Claims that group to diagnosis-related grouping (DRG) 637 - *Neonate, died w/in one day of birth, born here* and DRG 638 - *Neonate, died w/in one day of birth, not born here* are exempt from this policy because they are specific to one-day stays. The Office of Medicaid Policy and Planning (OMPP) has received inquiries about potential medical record compliance issues with this rule. Specifically, providers have questioned whether billing for outpatient services when a patient has been admitted as an inpatient will be viewed by the OMPP as non-compliance with program policies concerning internal records and billing requirements. The OMPP will not take action against a provider for adhering to the agency's billing requirements for inpatient stays of less than 24 hours, because this is in compliance with the Indiana regulation and billing requirements. In addition, providers have questioned whether their medical records, which originally indicated an inpatient stay of less than 24 hours, should be amended to show that outpatient services were performed. Providers do not need to amend their medical record keeping to comply with the changes that became effective on November 1, 2004.

MEDICAL POLICY FACT SHEET

**TITLE: HOSPITAL INPATIENT--READMISSIONS GENERAL/
SAME PROVIDER**

DESCRIPTION:

Readmission is the term used when patients are admitted to the hospital, acute care or other, with the same diagnosis.

SUMMARY OF CURRENT POLICY:

Readmissions are subject to medical review [currently performed by the Surveillance, Utilization and Review Department of Health Care Excel] to determine if previous discharge was premature. Reviews are conducted based on statistical data sets for readmissions. If the discharge was premature and payment made, the readmission or discharge may be subject to recoupment [currently performed by the Surveillance, Utilization and Review Department of Health Care Excel]. Readmissions will be treated as separate stays for payment purposes.

MEDICAL TOPICS CROSS-REFERENCES:

Hospital Inpatient

Nursing Facilities

Mental Health/Behavioral Health – Inpatient Services

Mental Health/Behavioral Health – Outpatient Services

RULES, CITATIONS, AND SOURCES:

405 IAC 1-10.5-3 Reimbursement for Inpatient Hospital Services
Indiana Health Coverage Programs Provider Manual 1999

Initial Policy	Issue	Effective Date	Implementation Date	Retroactive Date
470 IAC 5-9-15, 5-9-38 Transferred	Hospital Services	7/1/91		
405 IAC 1-7-15, 1-7-36 Repealed 8/24/97	Hospital Services	1/1/92		
Revisions:				
405 IAC 1-10.5-3	Prospective Reimbursement Methodology	12/27/96		
405 IAC 5-17	Hospital Services	8/24/97		

APPLICABLE INDIANA A/M EDITS AND AUDITS:

6508

6509

MEDICAL POLICY FACT SHEET

TITLE: HOSPITAL OUTPATIENT

DESCRIPTION

Outpatient hospital services refer to disease prevention and diagnosis and/or therapeutic and rehabilitative services including, but not limited to, surgery, therapy, laboratory, radiology, chemotherapy, renal dialysis, clinic, treatment room, and emergency department care. Services must be provided by or under the direction of a physician.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding these services. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

The IHCP will reimburse for outpatient services provided to a member who is not registered as an inpatient in an acute care, psychiatric, or rehabilitation hospital. Outpatient hospital services are covered when such services are provided or prescribed by a physician. Documentation must support medical necessity for the diagnosis and treatment of the condition. There are four categories of service within the defined outpatient hospital prospective payment system.

- Outpatient surgery services
- Treatment room visit services
- Standalone services
- Add-on services

Observation Room Services

Outpatient services that occur within three days preceding an inpatient admission to the same facility for the same or related diagnosis will be considered part of the corresponding inpatient admission.

Outpatient services within three days preceding a less than 24-hour inpatient stay should continue to be billed as an outpatient service. Because the inpatient service was less than 24 hours, it should be billed as an outpatient service.

Emergency Room Services

Payments for non-emergent care that do not include surgery and that are provided in an emergency department, treatment room, observation room, or clinic will be based on the statewide fee schedule amount that went into effect during state fiscal year 2003.

Noncovered Services

Reimbursement shall not be made for any hospital services not covered under the IHCP. In addition, if a service requires prior authorization (PA), which was either not obtained or denied, reimbursement for any associated services may be denied. Separately reimbursable DME devices may not be covered if they are not prior authorized.

PRIOR AUTHORIZATION

Surgical procedures that are usually provided on an outpatient basis, but are performed as an inpatient service must be prior authorized (i.e., medical difficulties during the outpatient procedure, prolonged pre- or post-operative observation, and simultaneous procedure requiring hospitalization).

The following services require PA.

- Stress electrocardiograms except for medical conditions
- All out-of-state services
- Separately reimbursable implantable DME items

MANAGED CARE

For members enrolled in Risk-Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the IHCP Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and RBMC delivery systems.

IHCP members enrolled in *Medicaid Select* receive the same benefit coverage, and are subject to the same limitations as Traditional Medicaid FFS. Refer to the *Medicaid Select* Provider Manual for Primary Care Providers and Office Staff for further information.

BILLING REQUIREMENTS**Outpatient Surgeries**

Outpatient surgeries provided in either a hospital or an ambulatory surgical center (ASC) are reimbursed an all-inclusive flat fee that includes all related procedures.

Reimbursement is available for outpatient surgeries provided in a number of settings including an operating room, treatment room, emergency department, or clinic.

Reimbursement is based on the assignment of the Current Procedural Terminology® (CPT) code to one of the ASC groups. Reimbursement rates have been established for each ASC group that is reflective of the average cost for procedures within the group. The IHCP will reimburse a maximum of two units of service regardless of the number of incisions. The procedure with the highest ASC rate is reimbursed at 100 percent of that rate. The procedure with the second highest ASC rate or bilateral procedure is reimbursed at 50 percent of the respective ASC rate. All other procedures are denied. To denote multiple surgeries, the appropriate revenue code and CPT code must be listed as two separate detail line items on the claim form.

Surgical Revenue Codes

Surgical revenue codes are generally defined as 36X and 49X. The revenue codes for treatment rooms, such as 45X, 51X, 52X, 70X, 71X, 72X, and 76X, are defined as surgical revenue codes when accompanied by a surgical Healthcare Common Procedure Coding System (HCPCS) code. These revenue codes are paid at the appropriate ASC rate. If no surgical procedure is performed, the revenue code must be submitted without a CPT or HCPCS code. These services are then priced at the treatment room rate. Component billing of any related services is not appropriate and will be denied. Add-on or standalone services are not allowed with any surgical revenue codes.

Any details billed on the claim form, not among the approved surgical revenue codes, will be denied as services included in the ASC procedure reimbursement rate. To denote multiple surgeries, the appropriate revenue code must be listed as two separate detail line items on the Uniform Billing (UB-92) claim form with the applicable HCPCS surgical procedure code.

- The primary surgical procedure is reimbursed at 100 percent of the IHCP allowable rate.
- The second procedure is reimbursed at 50 percent of the IHCP allowable rate.
- Bilateral procedures are reimbursed at 150 percent of the IHCP allowable rate.
- Because only two procedure codes are allowed, other procedure codes will be denied.

All outpatient services provided on the day of the surgery must be included on a single claim. Charges for any other services provided on the day of the surgery must be included with the charge for the surgery, as described above. Add-on or standalone services are not separately reimbursable and will be denied.

Durable Medical Equipment

The cost of certain *implantable* durable medical equipment is separately reimbursable. Some of these items require prior authorization and/or a manufacturer's cost invoice showing the purchase price. Claims for these items should be submitted on the CMS-

1500 billing form or 837P electronic transaction. The IHCP permits only these items to have separate reimbursement.

- Cardiac Pacemakers Single-chamber
- Cardiac Pacemakers Dual-chamber
- Implantable Loop Recorders
- Phrenic Nerve Stimulators
- New Technology Intraocular Lenses
- Vagal Nerve Stimulators
- Implantable Infusion Pumps-Non-programmable
- Implantable Infusion Pumps-Programmable

Outpatient Corneal Tissue Transplant Procedures

The cost associated with corneal tissue acquisition, HCPCS code V2785–*Processing, preserving, and transporting corneal tissue*, is separately reimbursable from the ASC rate for outpatient corneal transplant procedures. Claims for this item should be submitted on the CMS-1500 claim form or through the 837P electronic transaction. A copy of the invoice from the eye bank or organ procurement organization showing the actual cost of acquiring the tissue must be attached to the claim form. Providers must follow current policy for submitting paper attachments with the 837P electronic transaction. For additional information about corneal tissue transplant services, please refer to the Surgery–Transplants Medical Policy Fact Sheet.

Treatment Room Services

For purposes of the IHCP's outpatient prospective payment system, treatment rooms include emergency department, clinics, cast room, labor and delivery room, recovery room, and observation room.

When surgeries are performed in a treatment room, the appropriate CPT code should accompany the revenue code and reimbursement is based on the ASC methodology. Otherwise, facilities should not use a surgical CPT code in addition to the treatment room revenue code.

Treatment room services are reimbursed at a flat rate that includes most drugs and supplies. Reimbursement is limited to one unit per day, per patient, per provider. Services must be billed on the UB-92 claim form using the appropriate revenue code.

Standalone services may be billed in conjunction with treatment room services. Standalone services include therapies, dialysis, radiology, and laboratory services. Certain add-on services are allowed if billed in conjunction with a treatment room. All other add-on services are denied if billed in conjunction with a treatment room service.

Emergency Room Services

Reimbursable emergency room services are for the treatment of ill and injured members requiring immediate, unscheduled medical or surgical services. These claims may be suspended for review to determine whether medical necessity, for an emergency medical

condition, is met. Reimbursement is denied if services are not medically necessary. A comprehensive list of all diagnosis codes considered emergency for outpatient reimbursement is located in Chapter 8 of the IHCP Provider Manual. Please refer to the Medical Policy Emergency Medicine-Emergency Services Fact Sheet for specific coverage and billing information.

Observation Room Services

Reimbursable observation room services are furnished on the hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing staff. These services are reasonable and necessary to evaluate a patient's condition or to determine the need for an inpatient admission. Services are covered only when ordered by a physician or other individual authorized by state licensure law and hospital bylaws to admit patients or order outpatient tests.

Standalone Services

Standalone services include therapies, diagnostic testing, dialysis, laboratory, and radiology procedures performed in an outpatient setting. Standalone services may be billed separately, or in conjunction with treatment room visits. Standalone services are not separately reimbursable with outpatient surgeries or on the same day as an outpatient surgery.

Standalone services are reimbursed at an established flat statewide rate. Laboratory and radiology services are reimbursed at the lower of the submitted charge or the fee schedule amount. A maximum of one unit of service, per revenue code, for each date of service is allowed, except for lab and radiology. Services must be billed on the UB-92 claim form. Table 8.15 of Chapter 8 in the IHCP Provider Manual provides a list of revenue codes for standalone services.

Add-on Services

Add-on services are separately reimbursable in conjunction with a standalone procedure. Certain revenue codes for add-on services are separately reimbursable if billed in conjunction with a treatment room. These are 255 (Drugs Incident to Radiology), 258 (IV Solutions), 29X (DME), 370 (anesthesia), 38X (Blood), 39X (Blood Storage and Processing), and 62X (Diagnostic Supplies). All other add-on services are denied if billed in conjunction with a treatment room visit.

Add-on services are not separately reimbursable if billed with a surgery or provided on the same day as an outpatient surgery. Refer to table 8.14 of Chapter 8 in the IHCP Provider Manual for specific information regarding billing add-on services.

Add-on services are complementary outpatient services provided either in a treatment room or with a standalone service. Add-on services are reimbursed at a flat rate.

RELATED MEDICAL TOPICS

Anesthesia Services
Consultations – Second Opinion Services
Diagnostic Services
Emergency and Evaluation Management Services
Emergency Room Services
Federally Qualified Health Centers/Rural Health Centers
Home Health Services
Inpatient Hospital Services
Laboratory Services
Managed Care Organization Services
Mental/Behavioral Health Services
Nursing Services
Observation Services
Pharmacy Services
Radiology Services
Surgery Services
Treatment Room Services

RULES, CITATIONS, AND SOURCES

Code of Federal Regulation (CFR)
 42 CFR 440.20–Outpatient hospital services
Indiana Administrative Code (IAC)
 405 IAC 5-1-5–Global Fee Billing
 405 IAC 5-5-2–Prior authorization requirements for out-of-state services
 405 IAC 5-3-13–Services requiring prior authorization
 405 IAC 5-17-2–Hospital Services
 405 IAC 5-28-1–Medical and Surgical Services; Reimbursement limitations
 405 IAC 5-28-2–Medical and Surgical Services; Medical diagnostic procedures
 405 IAC 5-29-1–Services Not Covered by Medicaid; Noncovered services
Indiana Health Coverage Programs Provider Manual
 1994
 1999
 2005, Version 5.1
Indiana Health Coverage Programs Provider Bulletin (BT)
 BT200420-Changes in DRG/LOC Inpatient and Outpatient Reimbursement
 BT200114-Implantable Loop Recorders
 BT200108-Phrenic Nerve Stimulators
 BT200106-New Technology Intraocular Lenses
 BT200032-Vagal Nerve Stimulators
Indiana Health Coverage Programs Provider Banner (BR)
 BR200314-Vagal Nerve Stimulators

Origination Date: 08/24/1997

Revisions and Reviews	Reason	Effective Date
Revision	405 IAC 5-17-2 Hospital Services-Prior Authorization, outpatient versus Inpatient Procedures/Surgery	08/24/1997
Revision	405 IAC 5-3-13 Prior Authorization; Procedures Requiring Prior Authorization	08/24/1997
Revision	405 IAC 5-16-6 Free-standing clinics and surgical centers; limitations	08/24/1997
Review	Scheduled	01/31/2007

APPLICABLE INDIANA A/M EDITS AND AUDITS

3010-Out of state provider requires prior authorization
3011-Out of state provider requires prior authorization
4000-More than two surgical units on the claim
4081-Invalid Service-Per Diem
4089-Missing or invalid HCPCS code for surgery revenue code
4095-Nonsurgical services are not reimbursed individually if performed in conjunction with an outpatient surgery
4099-DRG not on file
4116-Diagnosis is not valid for DRG pricing
4108-No ASC on file
6514-No more than one emergency room visit per day
6515-Inpatient admit date within three days after DOS of paid outpatient claim
6516-Outpatient service rendered within three days prior to admit date of paid inpatient claim

MEDICAL POLICY FACT SHEET

TITLE: HYPERBARIC OXYGEN THERAPY

DESCRIPTION

Hyperbaric Oxygen Therapy (HBO) is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure, increasing vascular flow and improved oxygenation of body tissue. Originally developed for the treatment of decompression sickness, hyperbaric oxygen is adjunctive treatment for the management of select non-healing wounds, treatment of carbon monoxide poisoning, and other conditions as noted on pages 2 and 3, in the section entitled, "Coverage Criteria."

RELATED MEDICAL TOPICS

Physician Services

RULES, CITATIONS, AND SOURCES

405 IAC 5-28-11

Origination Date: 1/31/05

Reviews and Revision	Reason	Date

APPLICABLE INDIANA A/M EDITS AND AUDITS

4104 – HBO Therapy Restricted by Diagnosis Code
6096 – CPT Code Billed is Not Payable According to PPS Reimbursement Methodology
6652 – Multiple Surgeries Must Be Billed on Same Claim
6751 – Hyperbaric Oxygen Therapy Greater than Two Months
6754 – Hyperbaric Oxygen Therapy

PRIOR AUTHORIZATION

Prior authorization is not required for HBO

COVERAGE CRITERIA

Reimbursement for HCPCS code C1300, *Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval* and CPT code 99183, *Physician attendance and supervision of hyperbaric oxygen therapy, per session* is available for the following conditions.

Table 1. – Diagnosis Codes for HBO Therapy

Diagnosis	ICD 9 Codes	Limitations
Acute carbon monoxide intoxication	986	
Decompression illness	993.2, 993.3	
Gas embolism	958.0, 999.1	
Gas gangrene	040.0	
Acute traumatic peripheral ischemia	902.53, 903.1, 903.01, 903.4, 904.0, 904.41, 996.9	Adjunctive treatment to be used in combination with accepted standards and therapeutic measures.
Crush injuries and suturing of severed limbs	902.53, 925.1, 925.2, 926.0, 926.1, 926.11, 926.12, 926.19, 926.8, 926.9, 927.0, 927.00, 927.01, 927.02, 927.03, 927.09, 927.10, 927.11, 927.20, 927.21, 927.3, 927.8, 927.9, 928.0, 928.00, 928.01, 928.1, 928.10, 928.11, 928.2, 928.20, 928.21, 928.3, 928.8, 928.9, 929.0, 929.9, 903.1, 903.01, 903.4, 904.0, 904.41	Adjunctive treatment to be used in combination with accepted standards and therapeutic measures.
(Meleney Ulcers) Progressive necrotizing infections	686.0, 686.09, 728.86	Other types of cutaneous ulcers are not covered.
Acute peripheral arterial insufficiency	444.21, 444.22, 444.81	
Compromised skin grafts	996.52	Preparation and preservation.
Chronic Refractory Osteomyelitis	730.10-730.19	Use when unresponsive to conventional medical and

Diagnosis	ICD 9 Codes	Limitations
		surgical management.
Osteoradionecrosis	526.89	Adjunct to conventional treatment.
Soft tissue radionecrosis	990	Adjunct to conventional treatment.
Cyanide poisoning	987.7, 989.0	
Actinomycosis	039.0-039.4, 039.8, 039.9	Use when unresponsive to conventional medical and surgical management.
Acute Cerebral Edema	348.5	

Reimbursement is **not** available for HBO for the following conditions or services.

- ◆ Topical application of oxygen
- ◆ Cutaneous, decubitus, and stasis ulcers
- ◆ Chronic peripheral vascular insufficiency
- ◆ Anaerobic septicemia and infection other than clostridial
- ◆ Thermal skin burns
- ◆ Senility
- ◆ Myocardial Infarction
- ◆ Cardiogenic shock
- ◆ Sickle cell crisis
- ◆ Acute thermal and chemical pulmonary damage including smoke inhalation with pulmonary insufficiency
- ◆ Acute or chronic cerebral vascular insufficiency
- ◆ Hepatitis necrosis
- ◆ Aerobic septicemia
- ◆ Nonvascular causes of chronic brain syndrome, including Picks, Alzheimers, and Korsakoff's disease
- ◆ Tetanus
- ◆ Systemic aerobic infection
- ◆ Organ Transplantation
- ◆ Organ storage
- ◆ Pulmonary emphysema
- ◆ Exceptional blood loss anemia
- ◆ Multiple sclerosis
- ◆ Arthritic diseases

Treatment may include multiple HBO sessions that may be administered over a duration ranging from less than one week to two months, the average being two to four weeks. Claims submitted for treatment sessions lasting more than a two-month period will be suspended to Location 22 for submission of documentation to support medical necessity of continued therapy.

405 IAC 5-11(c) cites “Hyperbaric therapy shall be clinically practical and shall not be a replacement for other standard successful therapeutic measures”

BILLING REQUIREMENTS

Providers may use HCPCS code 99183 or C1300, with revenue code 413 for reimbursement of hyperbaric oxygen therapy services as a hospital outpatient service. An appropriate diagnosis code (see **Table 1. Diagnosis codes for HBO Therapy**) must be included on claims.

Note: The evaluation and management services and/or procedures (such as wound debridement) provided in a hyperbaric oxygen treatment should be reported separately from CPT code 99183.

MEDICAL POLICY FACT SHEET

TITLE: IMMUNIZATIONS AND VACCINES

DESCRIPTION

Immunization is the process by which a person becomes protected against a disease. This term is often used interchangeably with vaccination or inoculation. It is defined as the injection of a killed or weakened infectious organism in order to prevent disease.

COVERAGE CRITERIA

Vaccinations and immunizations are covered through the Vaccines for Children (VFC) program and the Indiana Health Coverage Programs (IHCP). The VFC program provides a variety of free vaccines to children 18 years of age and younger. The IHCP also reimburses for vaccines not covered by the VFC program or for administration of the vaccines to IHCP members 19 years of age and over.

Vaccines Not Available Through the Vaccines for Children Program or Administered to Members 19 Years of Age and Older

Vaccines not available through the VFC program or vaccines administered to members 19 years of age and older are reimbursed the lesser of the provider's usual and customary charge, or the IHCP allowed amount for the vaccine supply. A \$2.90 administration fee is included in the reimbursement of the vaccine supply code. Influenza vaccine instructions are revised frequently, therefore providers are to monitor program publications for special instructions.

Vaccines for Children Program

The VFC program is a federally funded program intended to help raise childhood immunization levels in the United States by supplying health care providers with free vaccines to administer to children 18 years of age and younger. Recipients must meet one or more of the following criteria.

- Be enrolled in the IHCP
- Have no health insurance
- Be identified by parent or guardian as American Indian or Alaskan native

- Be underinsured. For example, children with health insurance that does not cover immunizations (administered in federally qualified health care centers or rural health clinics only)

The VFC Program makes vaccines available at no cost to providers for members 18 years of age and younger (including those 18 years of age and younger enrolled in Hoosier Healthwise Package C). Providers are reimbursed either the lower of their submitted charge or \$8 for the administration of each vaccine. Providers are not required to physically separate vaccine stock for children in the VFC program from the vaccine stock for Hoosier Healthwise Package C children. No additional storage rules apply. Currently, the VFC program offers free vaccines against the following diseases.

- Diphtheria
- Hemophilus influenza type B
- Hepatitis B
- Measles
- Mumps
- Rubella
- Pertussis
- Poliomyelitis
- Pneumococcal disease
- Tetanus
- Varicella

All vaccine ordering, distribution, and accountability processes are administered through the Indiana State Department of Health's (ISDH) Indiana Immunization Program. The federal VFC program includes private and public practitioners across Indiana. Providers should contact the ISDH to enroll in the VFC program. Under an arrangement, the ISDH performs the VFC program administration functions, including provider enrollment, education, and vaccine ordering and distribution. To participate in the VFC program providers must complete the following.

1. Call the ISDH office and request VFC provider enrollment forms
2. Complete and mail the provider enrollment forms
3. Receive appropriate training and technical assistance
4. Order vaccines periodically, as needed, and maintain appropriate vaccine supply records

Providers who choose not to participate in the VFC program must provide appropriate vaccine referrals for the member, follow-up with the member, and document the immunization history of the member. Hoosier Healthwise Primary Medical Providers (PMP) who choose not to participate in the VFC program must have a procedure in place, such as a Memorandum of Collaboration (MOC), to ensure that children are adequately and appropriately immunized. For more information about the MOC and collaborative agreements, contact the Hoosier Healthwise Primary Care Case Management Helpline.

BILLING GUIDELINES

Billing Guidelines for Vaccines Not Available Through the Vaccines for Children Program or Administered to Members 19 Years of Age and Older

Vaccines not available through the VFC program or administered to members 19 years of age and older have an all-inclusive fee attached to the vaccine code. The IHCP calculates the maximum allowable reimbursement based on the current average wholesale price for the procedure code, plus \$2.90 for vaccine administration to cover the costs of supplies and staff time associated with giving the injection. The \$2.90 is included in the reimbursement for the vaccine product, and is not to be billed as a separate charge on the claim form. The provider is reimbursed the lesser of their usual and customary charge or the IHCP allowed amount.

Billing Guidelines in the Vaccines for Children Program

Vaccines through the VFC program are supplied to providers at no cost, and providers are reimbursed only for the administration of the vaccine. Providers are to report the appropriate vaccine product code, and will be reimbursed the lesser of their usual and customary charge for administration or an \$8 administration fee. In addition, providers are to report a principal diagnosis of V20.2, *Routine infant or child health check*. The IHCP permits only one administration fee per VFC vaccine injection administered. For combined vaccines, the correct code for the combined vaccine with only one vaccine administration fee should be billed. However, if no combination vaccine is available and the provider must administer more than one injection, each injection is to be listed with the appropriate CPT code and a vaccine administration fee is allowed for each. When a specific vaccine has been removed from VFC pricing, providers are to submit claims with charges reflective of whether the vaccine was from VFC or private stock (\$8 for VFC stock or the provider's usual and customary charge for private stock). If the only service performed is vaccine administration, providers must not submit a bill for an office visit. Providers can bill an office visit in conjunction with vaccine administration only when other services are performed during the same visit.

PRIOR AUTHORIZATION

Prior authorization is required for Synagis and Respigam for the treatment of respiratory syncytial virus. Refer to the Synagis and Respigam fact sheet for additional information.

MANAGED CARE

Coverage and billing guidelines for PrimeStep/PCCM is the same as Traditional Medicaid fee for service. For Risk Based Managed Care, vaccines are administered to

VFC-eligible children and billed directly to the appropriate MCO with the principal diagnosis of V20.2, *Routine infant or child health check*. Managed care providers who are not the PMP or do not have an authorization from the PMP may charge the member for the service. The member must sign a waiver acknowledging they would not otherwise be required to pay for the vaccination from an in-network provider. Contact the appropriate MCO for details about reimbursement under the RBMC delivery system.

Since vaccines are provided by different funding sources, the ISDH must report the number of doses administered to VFC members and Hoosier Healthwise Package C members separately. Providers must indicate vaccines administered to Hoosier Healthwise Package C members on the *Patient Eligibility Screening Record* and the *Vaccine Accountability Tally Sheet*. Providers are to submit the forms to the ISDH by the 10th day of the following month in which the vaccines were administered. This change standardizes the reporting time frame for all providers.

RELATED MEDICAL TOPICS

EPSDT – HealthWatch

RULES, CITATIONS, AND SOURCES:

405 IAC 5-15-3 EPSDT

Indiana Health Coverage Programs Provider Bulletins

E98-11 – Vaccines For Children Program Rate Increase

E98-21 – Vaccines For Children Program Administration Fee

BT200007 – Vaccine for Children Update

BT200151 – Revised Policy for Billing of Office-Administered Injectable Drugs and Infusions

Indiana Health Coverage Programs Provider Banners

BR200045 – Prevnar Available Through Vaccines For Children Program

BR200144 – Influenza Vaccines

BR200233 – Administration Fee in the Vaccines For Children Program

BR200442 – Administration Fee

Indiana Health Coverage Programs Provider Newsletter

NL200404 – Vaccines for Children and Injectibles

Indiana Health Coverage Programs Provider Manual 2004

Origination Date: July 1, 1991

Revisions and Reviews	Reason	Date
Revision	EPSDT Services	1/1/92
Revision	EPSDT Periodic Screening	8/24/97
Revision	Vaccines For Children (VFC) Program	1/1/98
Review	Immunizations and Screenings	February 2002

Revisions and Reviews	Reason	Date
Revision	Vaccines for Children	April 2002
Review	Expansion of Vaccinations Not Reimbursed for the Vaccines for Children Program	April 30, 2005

APPLICABLE INDIANA AIM EDITS AND AUDITS:

6018-Global Fee- Immunizations

6031-Global Immunization Not Payable When Component Paid

6096-The CPT/HCPCS code is not payable according to the PPS payment methodology

IMMUNIZATIONS AND VACCINES FACT SHEET ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Immunizations and Vaccines Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BT200511 **Publication Date:** 06/01/2005
Subject: Submission of Miscellaneous Drug Injection Codes
Date Added to Manual: 07/29/2005

Text of Publication

The provider should indicate the National Drug Code (NDC) code for the drug dispensed in the claim notes segment.

Provider Notification: NL200506 **Publication Date:** 06/2005
Subject: Vaccines for Children and Injectables
Date Added to Manual: 07/29/2005

Text of Publication

Provider-Purchased Vaccine

When a provider administers immunizations using the provider's private stock, refer to IHCP provider bulletin, *BT200151*, for use of the administration code 90788, as appropriate, for the additional \$2.75 rate.

Administration Fee

Separate reimbursement is allowed when the administration of the drug is the only service billed by the practitioner. In addition, if more than one injection is given on the same date of service and no E/M code is billed, providers may bill a separate administration fee for each injection using 90788. When billing for privately purchased vaccine, bill an administration code in addition to the CPT code to obtain reimbursement for both vaccine and its administration. Do not bill an administration CPT code when billing for VFC vaccine. VFC vaccines must be billed with the CPT code for the vaccine and the provider's charge (not to exceed \$8) for VFC vaccine administration. Medicaid maximum fee information can be found on the www.indianamedicaid.com Web site. Be aware of the member's primary medical provider assignment, managed care delivery system assignment, and third party liability resource(s).

RHCs and FQHCs

Note: RHC- and FQHC-specific encounter rates already include payment for immunizations.

When submitting RHC and FQHC claims to track encounters (such claims will be denied), bill no more than the \$8 VFC administration fee for use of VFC influenza vaccine **or** bill the usual and customary rate for the influenza vaccine CPT® plus the administration CPT 90782 for use of providerpurchased meningococcal vaccine. All immunization dollars should be included and totaled on the line specific for immunizations in cost reports submitted to Myers & Stauffer.

IMMUNIZATIONS AND VACCINES ADDENDUM B

Note: This addendum contains provider notifications that have been published since the review of the Immunizations and Vaccines Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200542 **Publication Date:** 10/18/2005

Subject: TdaP and MCV4 Vaccines

Date Added to Manual: 01/31/2006

Text of Publication

Currently, the Vaccines For Children (VFC) program cannot distribute a sufficient supply of TdaP and MCV4 vaccines to all VFC-participating providers. Due to this shortage crisis, the Indiana Health Coverage Programs (IHCP) is not limiting reimbursement for TdaP, Tetanus diphtheria toxoids and acellular pertussis vaccine (CPT 90715 – Adecel and Boostrix) and MCV4, meningococcal conjugate vaccine, tetavalent (CPT 90734 – Menactra) to the VFC Vaccine Administration Fee of \$8.00 or less. This policy allows providers to obtain reimbursement for using privately purchased TdaP or meningococcal vaccines if they cannot obtain a VFC vaccine. When administering privately purchased TdaP or meningococcal vaccines, providers may bill for the cost of the vaccine plus its administration, and the IHCP-allowable reimbursement will include payment for both.

Note: If a provider administers a free VFC vaccine, the provider should bill the appropriate TdaP or meningococcal vaccine procedure code but not charge more than the \$8.00 VFC vaccine administration fee, and not bill the separate administration CPT code.

When a provider administers immunizations using the provider's private stock, refer to IHCP provider bulletin BT200151 for use of the administration code 90782, as appropriate, for the additional \$3.00 rate.

- To address an immediate need for immunizations and a shortage of available influenza vaccines, the IHCP is not limiting reimbursement for any influenza vaccines, regardless of availability from the VFC program. This policy will allow providers to obtain reimbursement for using a privately purchased influenza vaccine if they do not have a VFC vaccine due to the shortage crisis. When administering a privately purchased influenza vaccine, providers may bill for both the cost of the vaccine plus its administration, and the IHCP-allowable reimbursement will include payment for both. Refer to banner page BR200442, published October 19, 2004, regarding detailed billing instructions when administering private stock.

IMMUNIZATIONS AND VACCINES ADDENDUM C

Note: This addendum contains provider notifications that have been published since the review of the Immunizations and Vaccines Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200627 **Publication Date:** 07/04/2006

Subject: Vaccines for Children

Date Added to Manual: 10/31/2006

Text of Publication

Effective July 17, 2006, the Indiana State Department of Health (ISDH) announces that the vaccine for Hepatitis A pediatric/adolescent dosage will be available through the Vaccines for Children program. Therefore, for dates of service on or after July 17, 2006, reimbursement for Health Care Procedure Coding System (HCPCS) codes 90633 – *Hepatitis A vaccine, pediatric/adolescent dosage – 2-dose schedule, for intramuscular use* and 90634 – *Hepatitis A vaccine, pediatric/adolescent dosage – 3-dose schedule, for intramuscular use*, is the lesser of the \$8 administration fee or the billed amount.

IMMUNIZATIONS AND VACCINES ADDENDUM D

Note: This addendum contains provider notifications that have been published since the review of the Immunization and Vaccines Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200639 **Publication Date:** 09/26/2006

Subject: Vaccines for Children

Date Added to Manual: 10/31/2006

Text of Publication

Effective September 25, 2006, the Indiana State Health Department (ISDH) announces that the vaccine CPT code 90715 - Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) for use in individuals 7 years or older, for intramuscular use (Boostrix and Adacel), is available through the Vaccines for Children (VFC) Program. Therefore, for dates of service on or after September 25, 2006, reimbursement for CPT code 90715 is the lesser of the \$8 administration fee or the billed amount.

MEDICAL POLICY FACT SHEET

TITLE: INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

DESCRIPTION

Intermediate Care Facilities for the Mentally Retarded (ICF/MR) provide health care and rehabilitative services to individuals who do not require acute treatment interventions; however, as a result of mental retardation and/or a disability, these individuals do require consistent, daily interventions to improve daily functioning.

An ICF/MR interdisciplinary team must develop a plan of care for each individual to identify developmental strengths, functional and adaptive abilities, and deficient areas of development. As appropriate, goals include developing appropriate interpersonal skills, daily living skills, vocational skills, rehabilitative skills, behavior management, and other services deemed medically necessary for the functioning of an individual. Interventions and services are provided with sufficient intensity and frequency to achieve treatment goals. Ongoing evaluations and revisions of the treatment plan are conducted to prevent regression and/or loss of functional abilities.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code, or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

ICF/MR services are a specific level of care (LOC) to be provided to a member who is mentally retarded or has certain other conditions that meet medical necessity in an institution that meets the certification standards to participate as a Medicaid provider. ICF/MR services and/or treatment programs are delivered on an inpatient basis and under the direction and supervision of the required professional staff. Admissions to ICF/MR must be based upon a determination of the need for such care by an interdisciplinary professional team. Approval by the Indiana Family and Social Services Administration – Division of Disability, Aging, and Rehabilitative Services (DDARS)/Bureau of Developmental Disabilities Services (BDDS) must be received by the ICF/MR institution prior to admission, or in cases of those individuals who make application while in the institution, prior to payment for that service. The interdisciplinary professional team completes a comprehensive evaluation that covers physical, emotional, social, and cognitive factors.

ICF/MR reimbursement will be provided by the Medicaid program, for eligible members who meet all of the following criteria.

- Diagnosis of mental retardation or related conditions of epilepsy, cerebral palsy, or other developmental disability found to be closely related to mental retardation or that require treatment similar to services required for mentally retarded individuals.
 - Severely or profoundly retarded, moderately retarded, severely physically handicapped, aggressive, assaultive, security risk, or manifesting severe hyperactive or psychotic-like behavior.
 - Moderately retarded and may require habit training, training and guidance in the activities of daily living, and development of self-help skills for maximum independence, and as needed by the member.
 - Participate in vocational training programs or adults who work in sheltered workshops.

Categories of ICF/MR

There are three different categories of ICF/MR available to IHCP members. The three categories are listed below.

- 1) Large private ICF/MR—greater than eight beds
- 2) Small ICF/MR (commonly referred to as community residential facilities for the developmentally disabled (CRF/DD))—four to eight beds
 - Basic developmental services
 - Child rearing residences with specialized programs
 - Developmental training
 - Intensive training
 - Sheltered living
 - Behavioral management residences for children
 - Extensive needs for adults
- 3) State operated facilities—greater than eight beds

Admission and Readmission Criteria for Large Private and Small ICF/MR

IHCP covers services provided by certified ICF/MR when such services are rendered to a Medicaid member. Admissions to large private and small ICF/MR are based upon a determination of the need for such care by the DDARS/BDDS. The interdisciplinary professional team from the proposed placement facility reviews a comprehensive evaluation including physical, emotional, social, and cognitive factors to ensure the facility can meet the needs of the member. The interdisciplinary professional team includes a physician, certified social worker, Qualified Mental Retardation Professional (QMRP) (See 42 CFR 483.430 for further information about this professional), and other professionals.

IHCP payment must be authorized for each member in the large private and small ICF/MR. This process must be completed prior to the first IHCP payment. Determination of appropriate reimbursement is based on documentation outlined by the following guidelines that are applicable for admission and readmission of a member to a large private or small ICF/MR.

- Diagnostic evaluation including social and psychological components.
- A Form 450B, *Physician Certification for Long-Term Care Services*, completed by the physician must be submitted to DDARS/BDDS or its designee. The payment period will not be approved for any period of time that precedes the date the physician signs the Form 450B certifying the need for ICF/MR services.
- Both member and provider must be eligible during any period for which IHCP reimbursement is requested.
- A physician must certify the member's need for ICF/MR care at the time of admission. The first recertification must take place within 12 months from the date of admission certification. Subsequent recertifications must occur annually thereafter, or more often, as determined by the interdisciplinary team.
- The certification must specify the level of care required by the member, and the recertification must clearly indicate the need for care to continue at this level. The certification must be signed by the physician and dated at the time of signature. Subsequent recertifications must be signed by a physician, a physician assistant, or a nurse practitioner and dated at the time of signature. **(A stamped signature will not be accepted.)**
- The admission certification and the three latest recertifications must be kept in the member's active medical record. All other recertification must be kept on file in the facility and be available for review purposes.
- The interdisciplinary professional team must, within 30 days after admission, review and update the preadmission evaluation.
- The individual program plan must be reviewed by the physician or the QMRP (Refer to 42 CFR 483.430 for further description) and revised as necessary.
- At least annually, the comprehensive functional assessment of each member must be reviewed by the interdisciplinary team for relevancy and updated as needed.

Admission to Large State ICF/MR

Admissions to large state operated ICF/MR facilities are based upon a determination of the need for such care by the DDARS/BDDS. The interdisciplinary professional team from the proposed placement facility reviews the comprehensive evaluation covering physical, emotional, social, and cognitive factors to ensure the member's needs are met. A physician must complete a Form 450B, *Physician Certification for Long-Term Care Services*, prior to receiving the first IHCP payment.

Transfer to Another ICF/MR

A current Form 450B must be submitted for any transfer to another ICF/MR. Diagnosis and evaluation documentation completed within the last year must be submitted as well. For large state ICFs/MR, if the member is transferred to a noncertified unit, the admission procedure must be followed for any readmission to the large state ICF/MR facility for determination of appropriate reimbursement.

Covered Services

Multiple services are provided to IHCP members once enrolled in an ICF/MR. Facilities provide all-inclusive per diem programs to ICF/MR enrolled members. The following services are included in the programs.

- **Room and board services**
Room accommodations, all dietary services (including routine, special dietary, and school lunches), and laundry services
- **Dental services** (Large state operated facilities only)
- **DME services**
DME, except customized items and associated repair costs, include, but not limited, to the following items.
 - Ice bags
 - Bed rails
 - Canes
 - Walkers
 - Crutches
 - Wheelchairs
 - Traction equipment
- **Medical and Non-medical supplies services**
Medical and non-medical supplies and equipment, including items generally required to provide adequate medical care and personal hygiene for members
- **Mental health services**
Behavior management, consultation, psychiatric, and psychological services
- **Nursing care services** (Large private and small facilities only)
Nursing services and supervision of health services
- **Optometry services** (Large state operated facilities only)
- **Therapy services**
Physical therapy, occupational therapy, speech therapy, respiratory therapy, and audiological therapy services
- **Transportation services**
Transportation to vocational and habilitation services
- **Vocational and habilitation services**
 - Training in activities of daily living
 - Training in the development of self-help and social skills
 - Development of program and evaluation plans
 - Development and execution of activity schedulesVocational and habilitation services must be provided in a Family and Social Services Administration approved setting. Reimbursement is not available for services for remediation of learning disabilities.

MANAGED CARE

Managed care members must be disenrolled from their managed care plan prior to becoming eligible for level of care (LOC) services. Once disenrolled, IHCP coverage continues under the fee-for-service Traditional Medicaid program.

In unusual circumstances, a RBMC member may be placed in a facility on a short-term basis. If a short-term placement becomes a long-term placement, the member is disenrolled from the RBMC when LOC is approved and entered into IndianaAIM. ICF/MR providers must verify eligibility upon admission of a new member, and on the first and 15th of every month for existing members, to confirm IHCP eligibility. It is the responsibility of the facility to verify healthcare coverage.

- If the ICF/MR facility determines, upon checking eligibility on date of admission (the first or 15th of each month) that the member is enrolled in RBMC, the facility must notify the RBMC within 72 hours after admission.
- If the ICF/MR facility notifies the RBMC within 72 hours, the RBMC is responsible for charges up to 60 calendar days from the date of admission.
- If the ICF/MR facility fails to verify a member's coverage in RBMC within 72 hours of admission, the facility may be responsible for charges incurred until the facility has notified the RBMC of the member's status.
- In the case of notification past the 72-hour deadline, the RBMC is liable for charges incurred in the ICF/MR from the date of notification and up to 60 calendar days, beginning on the date of notification.
- If, after 60 calendar days, the member is still in the ICF/MR facility, LOC determination has not been implemented, and the member is still enrolled in RBMC, then the ICF/MR facility is liable for any costs associated with the member until LOC has been implemented.

The 60 calendar day coverage requirement for RBMC is an extension of the current managed care continuity of care policy that requires the health plan that receives the member to honor authorizations of the previous health plan for the first 30 days. This period is intended to allow for proper notifications and reviews to take place without interrupting the care being delivered to the member. The overall period of 60 calendar days is to allow sufficient time, not only for notifications and reviews, but also preadmission screening, LOC determination, disenrollment from managed care, and to ensure appropriate reimbursement to the facility for services rendered.

BILLING REQUIREMENTS

All ICF/MR services are covered in the per diem rate and are not to be billed separately to the IHCP. There are reimbursement exceptions for specific services rendered to members in large state ICF/MR facilities. The following information explains these exceptions.

- Medical services, rendered by health care providers outside a large state ICF/MR, require prior authorization. Prior authorization will not be given for medical services included in the per diem rate. Written evidence of physician involvement and personal member evaluation in the progress notes and attached to the prior authorization form is required to document the medical necessity of the service. Documentation for prior authorization must include medical necessity of the service, explanation of why the service cannot be rendered at the facility, and review of criteria for the specific medical service requested.
- Hospital services rendered due to an acute illness or injury may be billed to the IHCP directly by the hospital.

- Necessary dental services that cannot be provided on-site by the dental staff require prior authorization. These prior authorized dental services must be billed directly to the IHCP by the outside dental provider. Admission of a member to a hospital for the purpose of performing dental services requires prior authorization. Refer to the IHCP Provider Manual, Chapter 8, for further dental information.
- Emergency transportation is billable outside the per diem rate. The transportation provider must bill the IHCP directly.
- Nonstandard DME services require prior authorization. The DME provider must bill the IHCP program for reimbursement. Facilities cannot require IHCP members to purchase or rent DME items with their personal funds.

Pharmacy Services

As a result of frequent member admissions, discharges, and readmissions, the IHCP allows a pharmacy servicing facility residents to indicate the member's location code in the National Council for Prescription Drug Programs field number 307-C7. Entering 03 in this field, indicates to the claims processing system that the member resides in an IHCP certified facility.

Personal Care Items

Routine personal care items (soap, shampoo, deodorant, and other personal hygiene items) will be included in the per diem reimbursement. Routine personal care items do not include personal items such as make-up, cigarettes, etc.

Client Clothing

The IHCP will not provide reimbursement for clothing items purchased by a provider for a member.

Transportation

Transportation services furnished to members who are in ICF/MR are exempt from co-payment requirements.

Respite Care

Respite care is not available for members residing in ICF/MR.

Reservation of Beds

IHCP reimbursement is available for reserving beds in a large private, small, or state operated ICF/MR for IHCP members, at one-half the regular per diem rate, when one of the following conditions is present.

- **Hospitalization**
 - Hospitalization must be ordered by the physician for treatment of an acute condition that cannot be treated in the facility.

- The length of time allowed for payment of a reserved bed for a single hospital stay is 15 days.
- If the member requires hospitalization longer than 15 consecutive days, the member must be discharged from the facility.
- If the member is discharged from the ICF/MR following a hospitalization in excess of 15 consecutive days, the ICF/MR is responsible for appropriate discharge planning if the ICF/MR does not intend to provide ongoing services following the hospitalization. Discharge planning is provided for those members who continue to require ICF/MR level of services.
- A physician's order for hospitalization must be maintained in the member's medical record at the ICF/MR facility. ICF/MR providers must use revenue code 185 when billing for bed reservations for hospitalization.

- **Therapeutic leave of absence**

- A leave of absence must be for therapeutic reasons, as prescribed by the attending physician and indicated in the member's plan of care. The length of time allotted for a therapeutic leave in any calendar year is 60 days per member residing in an ICF/MR. Leave days need not be consecutive. If the member is absent for more than 60 days per year, no further IHCP reimbursement will be available for reserving a bed for that member in that year. A physician's order for the therapeutic leave must be maintained in the member's medical record at the ICF/MR facility. Providers must use the revenue code 183 when billing for this service.

When filing a claim for a hospital or therapeutic bed hold, do not use a discharge code on the claim form. The discharge status code closes the member's level of care segment and all future claims are denied. Providers should use the status code 30 when billing a hospital or therapeutic bed hold.

RELATED MEDICAL TOPICS

Dental Services
Emergency Room Services
Inpatient Hospital Services
Long-term Care Services
Mental Health Services
Mental Rehabilitation Services
Nursing Facility Services
Ophthalmological Services
Outpatient Hospital Services
Pharmacy Services
Physician Services
Surgery Services
Transportation Services
Waiver Services

RULES, CITATIONS, AND SOURCES**Code of Federal Regulations (CFR)**

42 CFR 483.400-483.480 – Intermediate Care Facilities for the Mentally Retarded

Indiana Administrative Code (IAC)

405 IAC 1-1-10 – Intermediate care for the mentally retarded; governing provisions

405 IAC 1-1-11 – Intermediate care for the mentally retarded; eligibility

405 IAC 1-12 – Rate Setting Criteria for State-Owned Intermediate Care Facilities for the Mentally Retarded and Community Residential Facilities for the Developmentally Disabled

405 IAC 1-17 – Rate Setting Criteria for State-Owned Intermediate Care Facilities for the Mentally Retarded

405 IAC 5-13 – Intermediate Care Facilities for the Mentally Retarded

Indiana Code (IC)

IC 12-15-39.6 – Long Term Care Program

IC 12-15-32 – Community Residential Facilities for the Developmentally Disabled

Indiana Health Coverage Programs Provider Banner (BR)

BR200441 – Pharmacy & LTC update

BR200433 – LTC Adjustments made to CMI & MDS Field Audit

BR200429 – LTC Provider Specialty 030 update

BR200340 – Nursing ICF/MR

BR200312 – LTC Billing Errors

BR200309 – LTC Wheelchairs

BR200110 – Nursing Facilities and ICF/MR Claims Denying for Edit 4219

BR200107 – ICF/MR

BR199945 – LTC Forms 450B and 450B SA/DEBR

BR199812 – LTC Claim Payment Logic

Indiana Health Coverage Programs Provider Banner (BR) (cont.)

BR199805 – LTC Facilities Mass Adjustment

Indiana Health Coverage Programs Provider Bulletin (BT)

BT200412 – Waiver Audit Process

BT200371 – Documentation Standards for Home and Community-Based Services Waiver Programs

BT200347 – Appropriate Billing Practice for IHCP Residents Discharged from a LTC facility.

BT200343 – HCBS Waiver for Aged and Disabled and Target Case Management for the Elderly and Disabled

BT200315 – Targeted Case Management and Requirements for Respite Care

BT200305 – Changes to the Home and Community-Based Services Waiver Review Process

BT200252 – Home and Community Based Services Waiver Claims Information for the Developmental Disabilities Waiver Targeted Case

Management for Individuals with Developmental Disabilities and
Related Home and Community-Based Services Waiver Changes
BT200123 – Initial Assessments and Annual Functional Assessments Currently
Conducted by the D&E Teams for Individuals with Developmental
Disabilities

BT200113 – New Information for Case Managers and Waiver Providers
Available on the Web

Indiana Health Coverage Programs Provider Manual – Version 5.1

Revision date: 1/31/06

Revisions and Review	Reason	Date
470 IAC 5-8-10 Transferred	ICF/MR	7/1/91
405 IAC 1-6-10 Repealed 8/24/97	ICF/MR	1/1/92
IC 12-15-32	Community Residential Facilities for the Developmentally Disabled	2/14/92
Indiana Medicaid Update Bulletin 95-60	Cost Reporting Issue	7/1/94
405 IAC 5-13	ICF/MR	8/24/97
405 IAC 5-13-3	ICF/MR	10/27/99
405 IAC 5-13-4 Amended	ICF/MR	10/27/99
405 IAC 5-13-7	ICF/MR	10/27/99
405 IAC 5-13-8	ICF/MR	10/27/99
405 IAC 5-13-9	ICF/MR	10/27/99
Routine Review	Scheduled	1/31/06

APPLICABLE INDIANA A/M EDITS AND AUDITS

282 – Covered Days Missing
283 – Covered Days Invalid
546 – Type of Bill Invalid for Recipient Level of Care
548 – Therapeutic Leave Billed Without Accommodation Code
549 – Invalid Type of Provider to Bill for Ancillary Service
581 – Cannot Bill NDC on Home Health or Long-term Care
1018 – No Rate Segment for Level of Care
1019 – Multiple Levels of Care Per Diem on File
1023 – Level of Care Billed Not on File for This Provider
1024 – Billing Provider Is Not Member's Listed LTC Provider, Verify Provider Number
and Resubmit
1025 – Billing Provider Not Enrolled For the Date of Service
2008 – Member Ineligible for Level of Care Billed

2011 – Medical and Non-Medical Supplies and Routine DME
2013 – Recipient Ineligible for Level of Care
4219 – Units Billed Exceed Days Covered
6047 – Excessive Therapeutic Leave Days
6067 – Excessive Therapeutic Leave Days (ICF)
6068 – Excessive Therapeutic Leave Days (ICF/MR or CRF/DD)
6081 – DME Not Payable When Patient in ICF/SNF
6511 – One Dispensing Fee Per Month for LTC Recipients

MEDICAL POLICY FACT SHEET

TITLE: LABORATORY SERVICES

DESCRIPTION

A clinical laboratory is a place where materials derived from the human body are tested, measured, or examined in order to provide information on diagnosis, monitoring, prevention, or treatment of disease.

SUMMARY OF CURRENT POLICY

Indiana Health Coverage Programs (IHCP) reimbursement is available for most clinical diagnostic laboratory procedures, performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients. Laboratory procedures are subject to the Clinical Laboratories Improvement Act (CLIA) rules and regulations.

IHCP reimbursement is available for the drawing of or collection of, specimens provided by physicians, independent laboratories, or hospital laboratories. These services are covered only in circumstances in which a blood sample is drawn through venipuncture or a urine sample is collected by catheterization.

RELATED MEDICAL TOPICS

Chiropractic Services
EPSDT - HealthWatch
Hematology
Laboratory Services – Group A Beta Hemolytic Streptococcal Pharyngitis Tests
Laboratory Services – HIV Testing
Laboratory Services – Microquantative Sweat Test
Podiatry
Screening Services – Newborn Screening

RULES, CITATIONS, AND SOURCES

42 CFR § 441.16 Laboratory services.
42 CFR § 440.30 Other laboratory and X-ray services.
405 IAC 5-18 Laboratory Services
Indiana State Department of Public Welfare Medical Policy Manual 1991

Indiana Medicaid Update Bulletin 95-21-- Conveyance of a Specimen to a Laboratory--
date of bulletin 05/02/95

Indiana Medical Assistance Programs Provider Manual 1994

Indiana Medicaid Update Bulletin 98-16--Clinical Laboratory Improvement Amendment
(CLIA) Requirements 06/10/98

405 IAC 5-12-4 Chiropractic Services—Laboratory Services

405 IAC 5-26-4 Podiatric Services—Laboratory or X-ray Services

405 IAC 5-18-2c Reimbursement Restrictions

IHCP 2003 Provider Manual, Chapter 7, Section 8

IHCP 2003 Provider Manual, Chapter 8, Section 3

ORIGINATION, REVISIONS, AND REVIEWS

Origination Date: 12/31/00

Reviews and Revisions	Reason	Date
Indiana Medicaid Update Bulletin 95-21	Conveyance of a Specimen to a Laboratory	6/1/95
405 IAC 5-18	Laboratory services	8/24/97
405 IAC 5-17	Hospital services	8/24/97
405 IAC 5-12-4	Chiropractor ordered Lab Services	8/24/97
405 IAC 5-26-4	Podiatry-Lab or X-ray services	8/24/97
Indiana Medicaid Update Bulletin 98-16	Clinical Laboratory Improvement Amendment (CLIA) Requirements	7/1/98
Review and Update	Scheduled Review	4/30/04

APPLICABLE INDIANA A/M EDITS AND AUDITS:

4110

4112

4207

4208

6001

6007

6500

6501

6502

6503

6504

6506

6507

COVERAGE CRITERIA

Laboratory services are reimbursable only when such services are necessitated by a condition-related diagnosis.

Clinical Diagnostic Laboratory Procedure

Introduction

The pathology and laboratory guidelines noted in the Current Procedural Terminology (CPT) and HCFA Common Procedure Coding System (HCPCS) Level II Codes should be used to bill lab services.

Reimbursement Methodology

Most clinical diagnostic laboratory procedures, performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients, will be reimbursed on the basis of the lower of the submitted charge, based on either the Medicare Clinical Lab Fee Schedule, or the RBRVS IHCP Fee Schedule. For purposes of this fee schedule, clinical diagnostic laboratory services include all laboratory tests listed in codes 80002 – 89399 of the CPT book except for the following categories: Blood, Blood Products, Blood Testing, and Tests involving Physician interpretation. Providers must have a valid Clinical Laboratory Improvement Amendment (CLIA) number on file with the IHCP in order to be reimbursed for clinical laboratory services under CLIA regulations.

Exceptions

The following codes may be classified as clinical diagnostic laboratory procedures only in certain circumstances. When submitted on the same claim form with codes corresponding to blood or blood products, these codes are not subject to pricing by Medicare fee schedules. If submitted on a claim with no charge for blood or blood products, these services are classified as clinical diagnostic lab tests, subject to pricing by Medicare fee schedules:

86021

86022

86880

86885

86886

86900-86911

86970-86972

86975-86978

60% Versus 62% Defined

Laboratory tests performed by a physician's office or by an independent laboratory will be reimbursed at 60% of the prevailing charge. Laboratory tests performed in a hospital outpatient setting will be reimbursed at 62% of the prevailing charge when the tests are performed by a qualified hospital laboratory of a sole community hospital. A qualified laboratory is one that provides some clinical laboratory tests 24 hours a day, seven days a week, in order to serve a hospital's emergency room that is available to provide services 24 hours, seven days a week. A hospital with physicians and laboratory technicians on call to handle emergencies meets the requirement. In situations where a hospital laboratory is acting as an independent laboratory (i.e., performing tests for persons who are non-hospital patients), the services will be reimbursed at 60% of the prevailing charge. Additionally, laboratory tests performed by a non-qualified laboratory, or by a qualified hospital laboratory not located in a sole community hospital, will be reimbursed at 60% of the prevailing charge.

Hospital Outpatient Defined

A hospital outpatient is a person who has not been admitted by the hospital as an inpatient, but is registered on the hospital records as an outpatient and receives services directly from the hospital. If a tissue sample, blood sample, or specimen is taken by personnel not employed by the hospital and is sent to the hospital for performance of tests, these tests are classified as non-patient hospital services (rather than outpatient) since the member did not directly receive services from the hospital.

Billing Procedures

When billing for clinical diagnostic tests, the appropriate CPT or HCPCS code must be indicated on the claim form. If the procedure is administered more than one time in the same day, it should be billed as only one line item, with an indication of the number of units of service given in that day. Laboratories performing services must bill the IHCP directly unless otherwise specified by the CMS.

Specimen Collection

A minimal fee will be allowed for separate charges made by physicians, independent laboratories, or hospital laboratories for the drawing of or collection of specimens. These services are covered only in circumstances when a blood sample is drawn through venipuncture or where a urine sample is collected by catheterization. Specimen collection fees must be itemized when billed. Only one charge per day for each member will be allowed for venipuncture. A charge for catheterization will be allowed for each patient encounter; i.e., there is no per day or per claim limitation.

Handling/Conveyance

IHCP reimburses for handling and conveyance of a specimen to a laboratory if services are billed by a physician, chiropractor, or podiatrist [405 IAC 5-18-2(c).] Providers will be reimbursed for no more than two conveyance fees (CPT Procedure codes 99000 and 99001) on the same date of service.

Consultative Laboratory Services

Consultative laboratory services are covered for clinical laboratory tests if the following conditions are met:

- ◆ services were requested by the member's attending physician;
- ◆ service relates to a test result that lies outside the clinically significant normal or expected range in view of the condition of the member;
- ◆ service results in a written narrative report included in the member's medical record; and
- ◆ service requires the exercise of medical judgement by the consultant physician.

Clinical Laboratory Improvement Amendments (CLIA)**General Information**

Providers rendering laboratory services must obtain a Clinical Laboratory Improvement Amendments (CLIA) number. Information regarding CLIA can be obtained at www.cms.hhs.gov.

The CLIA program is intended to ensure that providers who perform laboratory procedures do so in accordance with Federal regulations. Laboratory procedures are defined as any procedure for the examination of materials derived from the human body.

CLIA certification types are as follows

- Certificate of Waiver—This certificate is issued to a laboratory to perform only waived tests.
- Certificate for Provider-Performed Microscopy (PPM) Procedures—This certificate is issued to a laboratory in which a physician, midlevel practitioner or dentist performs no test other than the PPM procedures. This certificate permits the laboratory to also perform waived tests.

- **Certificate of Registration**—This certificate is issued to a laboratory that enables the entity to conduct moderate or high complexity laboratory testing or both until the entity is determined by survey to be in compliance with the CLIA regulations.
- **Certificate of Compliance**—This certificate is issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.
- **Certificate of Accreditation**—This is a certificate that is issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by HCFA.

Information regarding the procedure codes allowed to be billed by specific certificate type can be obtained at www.cms.hhs.gov.

Edit Codes Indicating A Denied Laboratory Procedure Code

Claims for laboratory services that have been denied will post edit codes 4207 or 4208. Edit 4207 states: CLIA Number Not On File For Date Of Service Billed. Once the provider receives written confirmation from EDS that a CLIA Number and its effective date have been entered into the IndianaAIM System, previously denied claims may be resubmitted.

Edit 4208 states: Invalid CLIA Certification/Procedure Code Combination. This means the provider billed a laboratory procedure code outside of the provider's CLIA certificate type and will not be reimbursed for this service.

LABORATORY SERVICES ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Laboratory Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200537 **Publication Date:** 09/13/2005

Subject: Lab Codes That Allow Interpretation

Date Added to Manual: 10/31/2005

Text of Publication

The IHCP reimburses the following Current Procedural Terminology (CPT®) clinical lab codes that allow interpretation, retroactive to July 1, 2002, (retroactive to January 1, 2005, for CPT codes 84166 and 86335). The IHCP follows Medicare guidelines for the CPT clinical lab codes that allow interpretation.

83020	83912	84165	84166	84181
84182	85390	85576	86255	86256
86320	86325	86327	86334	86335
87164	87207	88371	88372	89060

Both the technical and professional components are reported separately to ensure proper reimbursement. Providers bill the IHCP for the technical component of the clinical lab procedure reporting the base code only, without modifier TC. If the modifier TC is billed at the claim detail the claim will be denied. The interpretation service is reported with the CPT code and modifier 26. For example, providers performing both the technical component and interpretation of CPT code 84165 report CPT code 84165 for the technical component and the CPT code modifier combination 84165-26 for the interpretation.

The IHCP will mass void and replace the affected claims with dates of service July 1, 2002, through August 17, 2005. The mass void and replacement of claims will begin appearing on providers' September 27, 2005, remittance advice statements. For any claim that has not been submitted to the IHCP for reimbursement or may need to be voided or replaced after the mass void or replacement of claims has been completed, providers may use a copy of this banner page article as documentation to waive the one year filing limit.

MEDICAL POLICY FACT SHEET

**TITLE: LABORATORY SERVICES--GROUP A BETA
 HEMOLYTIC STREPTOCOCCAL PHARYNGITIS
 TESTS**

DESCRIPTION

Group A Beta Hemolytic Streptococcus is a bacteria that causes sore throat, pharyngitis, upper respiratory infection, and may cause scarlet fever. Several microbiological tests are used to identify this organism. Infectious agents can be detected using antigen detection, direct fluorescence microscopy, or nucleic acid probe techniques.

SUMMARY OF CURRENT POLICY

Medicaid reimbursement is available for approved laboratory tests used for the detection of Group A Beta Streptococcus.

RELATED MEDICAL TOPICS

Laboratory Services

RULES, CITATIONS, AND SOURCES

Indiana Medicaid Update Bulletin 98-45 dated 12/01/98
Indiana Health Coverage Programs Provider Manual 1999
470 IAC 5-9-26

ORIGINATION, REVISIONS AND REVIEWS

Origination Date: 12/31/00

Revisions and Reviews	Reason	Date
405 IAC 5-18	Laboratory services	8/24/97
Bulletin 98-45	Laboratory Services	12/1/98
Reviewed Without Revision	Scheduled Review	4/30/04

APPLICABLE INDIANA AIM EDITS AND AUDITS:

MEDICAL POLICY FACT SHEET

**TITLE: LABORATORY SERVICES - HER-2/NEU GENE
 DETECTION TEST AND HER-2 PROTEIN
 EXPRESSION TEST**

DESCRIPTION

Many advances have been made in the treatment of breast cancer. The human HER-2/neu gene (also known as c-erbB-2, ERBB2 or neu) encodes a protein called HER-2 protein or p185^{HER-2}. This protein receptor plays a role in controlling cell growth and division. In 25 to 30 percent of patients with breast cancer, the HER-2 protein is overexpressed as part of the malignant transformation and tumor progression. Overexpression of HER-2 protein has been shown to contribute to the progression of the cancer and is associated with poor clinical outcome. Targeted antibody therapy to HER-2 has played a significant role in the treatment of metastatic breast cancer. Clinical trial results show that the HER-2 protein on breast cancer cells is an important target for cancer therapies and that trastuzumab (HERCEPTIN[®]) can be an effective treatment, whether used by itself or in combination with other chemotherapy drugs.

Several types of HER-2 overexpression tests are available. One type is a semiquantitative immunohistochemical assay that measures the overexpression of HER-2 protein (for example, the HercepTest[®]). Another type is a gene probe assay, which detects the qualitative presence of the gene amplification in human breast tissue (for example, Oncor's INFORM[®] HER-2/neu Gene Detection Test). This test is a DNA probe assay known as fluorescent *in situ* hybridization (FISH).

RELATED MEDICAL TOPICS

Oncology
Pathology
Laboratory

RULES, CITATIONS, AND SOURCES

BT20005 - HER-2/neu Gene Detection Test and HER-2 Protein Expression Test

Origination Date: 1/14/2000

Reviews and Revisions	Reason	Effective Date
BT200005	Fact Sheet Implementation	1/14/2000
BT200005	Review, HER-2 Test – no policy changes	7/30/04

APPLICABLE INDIANA A/M EDITS AND AUDITS

6001

6011

COVERAGE CRITERIA

Prior authorization is not required.

The FDA-approved indications for HER-2 protein overexpression and gene detection tests are:

For HER-2 protein overexpression tests (HercepTest[®]), as an aid in assessment of patients for whom trastuzumab (HERCEPTIN[®]) is being considered.

For HER-2/neu gene detection tests, as an adjunct to existing clinical and pathological information and as an aid to stratify breast cancer patients with a primary, invasive, localized breast carcinoma, and who are lymph node negative, for risk for recurrence or disease-related death. This test is used as a prognostic indicator for these patients.

The ICD-9-CM Diagnosis Codes that support the medical necessity of HER-2 protein overexpression and gene detection tests are as follows:

174.0–174.9 Malignant neoplasm of the female breast

175.0–175.9 Malignant neoplasm of the male breast

The ordering physician must have documentation in the member's medical records to support the medical necessity of the test(s) ordered. Laboratories performing the test must have documentation that laboratory personnel education has been completed in the proper performance of the test and reporting of the test results. Reimbursement will be provided only to Clinical Laboratory Improvement Amendments (CLIA) certified laboratories.

BILLING INFORMATION

A HER-2 protein overexpression test (for example, HercepTest[®]) is billed using the following codes:

88342 Immunocytochemistry (including tissue immunoperoxidase), each antibody

88365 Tissue *in situ* hybridization, interpretation and report

The HER-2/neu Gene Detection Test (for example, Oncor's INFORM[®]) is billed using the following codes:

83892 Enzymatic digestion

88271 Molecular cytogenetics; DNA probe, each (for example, FISH)

88274 or 88275 Interphase *in situ* hybridization, analyze 25-99 cells (88274) or 100-300 cells (88275). Only one (1) of these two (2) codes should be billed.

88291 Cytogenetics and molecular cytogenetics, interpretation and report

MEDICAL POLICY FACT SHEET

**TITLE: LABORATORY SERVICES--HUMAN
 IMMUNODEFICIENCY VIRUS (HIV) TESTING**

DESCRIPTION

The human immunodeficiency virus is the virus that causes acquired immunodeficiency syndrome (AIDS). HIV progressively damages and kills cells of the body's immune system, destroying the body's ability fight infections and certain cancers. HIV can be transmitted when blood, semen, vaginal fluid, or breast milk is internally passed from an infected person to an uninfected person. HIV is most commonly transmitted in three ways: (1) unprotected sexual activity with an infected partner; (2) contact with infected blood; or (3) and from mother to child during pregnancy, birth, or breast feeding. According to the Centers for Disease Control a diagnosis of AIDS is appropriate when an individual with HIV has a T4 lymphocyte (CD4) cell count below 200. The presence of various opportunistic infections can also indicate the onset of AIDS.

Early HIV infection often causes no symptoms and requires a blood test to detect the presence of HIV antibodies. HIV antibodies are often not detectable in the blood for one to three months following infection, and can take up to six months following infection to be detected in standard blood tests. In babies born to mothers with HIV, a definitive diagnosis of HIV infection cannot be made using standard antibody tests until after 15 months of age.

The enzyme-linked immunoassay (EIA or ELISA) test is the standard test to detect the presence of antibodies to HIV. If the ELISA is positive, a second test, the Western Blot, is necessary to confirm if an individual is HIV positive. A second test may be warranted as there are other conditions that may inaccurately produce a positive ELISA test result.

SUMMARY OF CURRENT POLICY

Testing for HIV is covered by the Indiana Health Care Programs (IHCP) when medically necessary for establishing an HIV diagnosis. HIV testing is only covered in circumstances when a blood sample is drawn through venipuncture or when a urine sample is collected by catheterization. Oral HIV testing methods are not covered by the IHCP. Testing for HIV is also covered in conjunction with family planning services and EPSDT.

Reimbursement for HIV testing, when medically necessary for establishing an HIV diagnosis, is available using the following codes.

- 86701 – HIV-1
- 86702 – HIV-2
- 86703 – HIV-1 and HIV-2, single assay
- 86689 – HLTV or HIV antibody, confirmatory test (e.g. Western Blot)

HIV Testing of Pregnant Women and Newborns

The Indiana Code (IC) 16-41-6-8 requires that, as a routine component of prenatal care, physicians or advanced practice nurses explain the purpose, risks, and benefits of HIV testing and order a HIV test for pregnant women. The results of this test are confidential. Pregnant women have the right to refuse this test. A signed statement acknowledging that the pregnant woman was counseled and provided the information necessary to make an informed decision regarding whether or not to be tested must be maintained in the medical records.

If the woman provides her consent to an HIV test and the test is positive for HIV infection, the provider must inform the pregnant woman of the test results and provide treatment and/or referral options available to her for HIV prevention, health care, and psychosocial services. The physician must also discuss risk reduction activities, including methods to reduce the risk of perinatal HIV transmission and HIV transmission through breast milk.

A physician overseeing the care of a newborn infant may offer the parent the option of a confidential HIV test for the newborn within the first 48 hours after birth under the following circumstances, as required in IC 16-41-6-4.

- The mother of the newborn has not been previously tested for HIV
- The mother of the newborn has refused an HIV test for the newborn
- If the physician believes that testing the newborn is medically necessary for reasons other than those listed above.

If the parent objects to testing the newborn in writing for religious reasons, the newborn is exempt from the testing requirement.

The results of the HIV test must be released to the mother of the newborn. If the test results are positive, the individual who provides the test results must provide the mother with treatment and/or referral options available to the newborn infant.

EPSDT

Reimbursement for HIV testing is available for at-risk children and youth ages 0-20.

RELATED MEDICAL TOPICS

HIV-AIDS Care Coordination

Laboratory Services

Screening Services—Newborn Screening

RULES, CITATIONS, AND SOURCES:

405 IAC 5-18 Laboratory Services

Indiana State Department of Public Welfare Medical Policy Manual 1991--Human Immunodeficiency Virus Testing (86311-86314, 86687-86689)

IHCP Provider Manual, Chapter 8, Section 3, Family Planning Services

HealthWatch EPSDT Provider Manual, Section 3, Immunizations and Screenings

IndianaAIM

2004 CPT Expert

ORIGINATION, REVISIONS AND REVIEWS

Origination Date: 07/01/91

Initial Policy Revisions and Reviews	Reason	Effective Date
Indiana State Department of Public Welfare Medical Policy Manual 1991	HIV testing	7/1/91
470 IAC 5-9-26 Transferred	Laboratory services	7/1/91
405 IAC 1-7-25 Repealed 8/24/97	Laboratory services	1/1/92
405 IAC 5-18	Laboratory services	8/24/97
IHCP Provider Manual, Chapter 8, Section 3, Family Planning Services	Review of HIV testing policies and procedures	7/30/04
HealthWatch EPSDT Provider Manual, Section 3, Immunizations and Screenings	Review of HIV testing policies and procedures	7/30/04
IndianaAIM	Review of applicable HIV testing codes	7/30/04

APPLICABLE INDIANA AIM EDITS AND AUDITS:

The following edits and audits are attached to CPT codes 86701, 86702, 86703, 86689.

6001 – Complete Radiology or Pathology Procedure Payable at Reduced Amount When Professional/Technical Component is Already Paid

6011 – Professional/Technical Component for Radiology or Pathology Not Payable When Complete Procedure is Already Paid

6096 – CPT/HCPCS Code Billed Not Payable According to PPS Reimbursement Methodology

MEDICAL POLICY FACT SHEET

TITLE: LABORATORY SERVICES-- SWEAT CHLORIDE TEST

DESCRIPTION

The sweat chloride test (sweat test), is used to diagnose Cystic Fibrosis (CF). According to the Merk Manual and the Cystic Fibrosis Foundation, the iontophoresis sweat test is the only reliable test for confirming the diagnosis of CF. CF is a generalized, autosomal recessive disorder of infants, children, and young adults, in which there is widespread dysfunction of the exocrine glands. The disease causes excess mucus production in the respiratory tract, signs of chronic pulmonary disease, pancreatic enzyme deficiency resulting in steatorrhea and azotorrhea, abnormally high levels of electrolytes in the sweat, and occasionally biliary cirrhosis.

The sweat test is ordered when an individual, usually an infant, displays symptoms of CF, such as noticeably salty sweat, or has a close relative who has been diagnosed with CF. It is also used to help confirm or rule out a diagnosis of CF in individuals who have tested positive or indeterminate with other tests. The sweat test measures the amount of salt in the sweat. A high level of salt indicates CF.

SUMMARY OF CURRENT POLICY

The sweat test is covered by the Indiana Health Care Programs (IHCP) when used to confirm a diagnosis of CF. Reimbursement is available using the following CPT code:

- 89230 – Sweat collection by iontophoresis

RELATED MEDICAL TOPICS

Laboratory Services

Medical Supplies and Equipment (for ThAIRpy vest for C.F.)

Pediatrics

RULES, CITATIONS, AND SOURCES

Indiana Health Coverage Programs Manual 1999

405 IAC 5-18 Laboratory Services

ORIGINATION, REVISIONS, AND REVIEWS

Origination Date 07/01/91

Initial Policy, Revisions, and Reviews	Reason	Effective Date
470 IAC 5-9-26 Transferred	Laboratory services	7/1/91
405 IAC 1-7-25 Repealed 08/24/97	Laboratory services	1/1/92
405 IAC 5-18	Laboratory services	8/24/97
Policy Review	MP Manual update	7/31/04

APPLICABLE INDIANA AIM EDITS AND AUDITS:

6001

6011

6096

MEDICAL POLICY FACT SHEET

**TITLE: LABORATORY SERVICES - SALIVARY ESTRIOL
TEST FOR PRETERM LABOR RISK ASSESSMENT**

DESCRIPTION

Preterm labor, which is defined as labor before 37 weeks gestation, occurs in eight to 10 percent of all births and accounts for more than 85 percent of perinatal complications and death. Several tests using either biochemical markers or endocrine assay methods are available to predict preterm labor risk. One endocrine assay test detects and measures salivary estriol. Estriol is most detectable in a pregnant woman's saliva, and increases before parturition.

The salivary estriol test is a series of tests conducted weekly or biweekly on pregnant women between weeks 22 and 35 of gestation. Research on the salivary estriol test indicates that it provides clinical benefits for its ability identify women at both low and high risk for preterm birth. In the conducting serial testing on women with labor-like symptoms, the test may ease concerns for the patient and allows the provider to use more clinically appropriate interventions based on the member's risk level.

SUMMARY OF CURRENT POLICY

The Indiana Health Coverage Programs (IHCP) reimburses for salivary estriol test using CPT S3652. This test is limited to the following ICD-9-CM codes that support the medical necessity of this test. Documentation in the member's medical record must support the medical necessity of the test(s) ordered.

ICD-9-CM Code	Descriptions
V23.2	Pregnancy with history of abortion
V23.4	Pregnancy with other poor obstetric history
V23.8	Other high risk pregnancy
658.9	Other problems associated with amniotic cavity and membranes (with V23.8)
640.9	Unspecified hemorrhage in early pregnancy (with V23.8)
644.0	Early or threatened labor
644.03	Threatened premature labor, antepartum condition, or complication
644.13	Other threatened labor, antepartum condition, or complication

ICD-9-CM Code	Descriptions
654.50	Cervical incompetence
654.53	Cervical incompetence, antepartum condition, or complication
654.60	Other congenital or acquired abnormality of cervix; unspecified as to episode of care, or
654.63	Other congenital or acquired abnormality of cervix; antepartum condition or complication
621.0	Disorders of uterus not elsewhere classified through
621.9	Unspecified disorder of uterus

Reimbursement is available for CPT S3652, one unit per test, between gestational ages 22 to 35 weeks, every one to two weeks. Modifier U2, second trimester, or Modifier U3, third trimester, must be indicated on the physician's test order and on the claim. Reimbursement for CPT S3652 will be denied when home tocolytic therapy is being provided using CPT S9349 or 99553. Although prior authorization is not required, use of the salivary estriol test is closely monitored for appropriateness of use.

RELATED MEDICAL TOPICS

Laboratory

Obstetrics and Gynecology

RULES, CITATIONS, AND SOURCES

Indiana Medicaid Bulletin BT200353

Indiana Medicaid Bulletin BT200014

IHCP Provider Manual, April 2003

Indiana Administrative Code 405 IAC 5-18

ORIGINATION, REVISIONS, AND REVIEWS

Origination Date – 10/1/99

Initial Policy, Revisions, and Reviews	Reason	Effective Date
405 IAC 5-18	Laboratory services	07/25/1997
BT200014	Original salivary estriol policy	10/01/1999
IHCP Provider Manual	Billing instructions	04/2003
BT200353	CPT Code changes	08/15/2003
MP Manual	Scheduled review	07/30/2004

APPLICABLE INDIANA A/M EDITS AND AUDITS

6077

6078

MEDICAL POLICY FACT SHEET

TITLE: LOCUM TENENS AND SUBSTITUTE PHYSICIAN

DESCRIPTION

Locum tenens and *substitute physician* are terms used to describe the relationship of a physician who is acting as a fill-in for a member's regular physician. The regular physician may be the member's primary care physician, or primary medical care provider, (PMP). The regular physician could also be a specialist the member sees regularly for a specific problem or chronic condition.

According to the *Social Security Act 42 USC §1395x(r)*, the term physician includes a doctor of medicine, osteopathy, dental surgery, dental medicine, podiatry, optometry, or chiropractic medicine. A *locum tenens* or substitute physician arrangement may be used in any one of the above disciplines; however, the *locum tenens* or the *substitute physician* must be of the same discipline as the regular physician.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

Locum Tenens Physicians

A *locum tenens* arrangement is made when the regular physician must leave a practice due to an illness, vacation, or medical education opportunity. This arrangement is to ensure services continue and are available to members. The *locum tenens* arrangement may be used in a single practice or group practice, but the *locum tenens* physician cannot be a member of the practice group where the patient's regular physician is a member. The *locum tenens* physician usually has no permanent practice and provides services in various locations as needed. Often, this physician is reimbursed a fixed amount per diem and is identified as an independent contractor, not an employee. The *locum tenens* physician must meet all requirements for the practice of medicine in the State of Indiana and hospital or other institutional credentialing requirements prior to providing IHCP member services. For provision of *locum tenens* physician services as defined above, the *locum tenens* physician is not required to be an IHCP provider. The regular physician's

office must maintain documentation of the *locum tenens* arrangement to include the *locum tenens* services provided and dates of service.

Substitute Physicians

A *substitute physician* is requested by the regular physician to see a member in a reciprocal arrangement. This occurs when the regular physician is unavailable to see the member. In these instances, the IHCP member must agree to the *substitute physician* providing the service. In a *substitute physician* arrangement, the regular physician reciprocates the substitute physician by one of the following.

- Reimbursing the *substitute* the amount received for the service rendered
- Serving in the same capacity in return (in which the regular physician might cover for the *substitute* in a similar situation)

For example, when an IHCP member seeks unscheduled care, a *substitute physician* may be asked to see the member if the regular physician is neither available nor on-call. If a regular physician has the member scheduled for an examination, but is called away, a *substitute physician* may be asked to see the member.

PRIOR AUTHORIZATION

Prior authorization of services performed by a locum tenens or a substitute physician is the same as for the member's regular physician.

MANAGED CARE

For members enrolled in Risk-Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and RBMC delivery systems.

IHCP members enrolled in *Medicaid Select* PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the *Medicaid Select* Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

Locum Tenens

The regular physician's office personnel submit claims for *locum tenens* services using the regular physician's provider number. Modifier Q6, *Service furnished by a locum tenens physician*, is placed on the CMS-1500 claim form or 837P electronic transaction to indicate services were rendered by a *locum tenens* physician. The payment amount is the

lesser of the billed amount or the IHCP allowed amount for the service rendered. When the regular physician is enrolled in IHCP as a PMP in the PCCM program, the *locum tenens* physician may use the regular physician's certification code when authorizing services by other providers. *Locum tenens* arrangements should not exceed 90 consecutive days. If a physician is away from his or her office for more than 90 days, additional *locum tenens* can be used to fill in during that physician absence. This means that various physicians would be required to fill in for different 90-day periods of time. *Locum tenens* should not be used to fill physician vacancies in the office. If it becomes necessary for the same *locum tenens* physician to remain longer than 90 days in the same practice for which he or she has been a temporary replacement, then he or she must enroll as an IHCP provider.

Substitute Physician

For provision of *substitute physician* services as defined in this document, both the regular physician and the *substitute physician* are required to be IHCP providers. The regular physician's office submits the claim and receives payment using the regular physician's IHCP provider number. The payment amount will be the lesser of the billed amount or the IHCP allowed amount for the service rendered. If the regular physician is enrolled in the IHCP as a primary medical provider (PMP) in PCCM, the *substitute physician* may use the regular PMP's certification code when authorizing services for PMP members. The modifier, Q5, *Services furnished by a substitute physician under a reciprocal billing arrangement*, must be reported on the CMS-1500 claim form or 837P electronic transaction to indicate services were rendered by a *substitute physician*. The *substitute physician* arrangement should not exceed 14 consecutive days. The *substitute physician* arrangement does not apply to substitution arrangements for physicians in the same medical group with claims submitted in the name of the medical group. For situations in which one group member substitutes for another, the substitution is noted by listing the substitute group member number as the rendering provider on the CMS-1500 claim form or the 837P electronic transaction and the Q5 modifier is not used. The group number is listed as the billing provider. **Table 1** compares the requirements for substitute and *locum tenens* physicians.

Table 1 – Requirements for Substitute and Locum Tenens Physicians

Requirement	Substitute Physician	Locum Tenens Physician
Must be enrolled as an IHCP Provider	Yes	No
May be employed by the same group as the regular physician	No	No
Claims are submitted by the regular physician's office and that office receives payment	Yes	Yes
Modifier required to identify the arrangement	Yes, Q5	Yes, Q6
May use the regular physician's certification code for PCCM PMP authorizations	Yes	Yes
Maximum time frame allowed	14 days	90 days

RELATED MEDICAL TOPICS

Physician Services
Dental Services
Chiropractic Services
Vision Care Services

RULES, CITATIONS, AND SOURCES

Social Security Act Amendments of 1994, Section 125
Omnibus Budget Reconciliation Act of 1990, Section 4110
Indiana Health Coverage Programs Provider Bulletins
 BT200201
 BT200115
 BT200125
Indiana Health Coverage Programs Provider Manual
 March 2005, Version 5.1

Origination Date: 12/31/2002

Review/Revision	Reason	Date
BT200201	Locum Tenens and Substitute Physician Policy	3/5/2002
Review	Scheduled	7/31/2006

APPLICABLE INDIANA AIM EDITS AND AUDITS

0231 – Rendering Provider Number Is Missing
0232 – Rendering Physician Number Not In Valid Format
0381 – Attending Physician License Number Missing
0382 – Attending Physician ID Invalid
0399 – Referring Provider I.D.# Is Not In a Valid Format
1000 – Billing Provider I.D. Number Not On File
1001 – Billing Provider Not Enrolled at SVC Location for Program Billed
1002 – Rendering Provider Not Enrolled at SVC Location for DOS
1003 – Billing Provider Not Enrolled at SVC Location on DOS
1004 – Rendering Provider Not Eligible to Render SVS on DOS
1007 – Rendering Provider Not On Provider Database
1008 – Rendering Provider Must Have an Individual Number
1010 – Rendering Provider Not Member of Group or Rendering Not Equal Billing
1028 – Rendering Provider Specialty Not Eligible to Render This Modifier
1029 – Prescribing Provider Not Eligible to Prescribe This NDC

- 1033 – Rendering Provider Eligible Without Specialty
- 1036 – Rendering Provider Not Eligible
- 1039 – Service Rendered by Out-Of-Network Provider
- 1996 – IMMIS Rendering Provider ID Number Not Enrolled
- 1998 – IMMIS Billing Provider ID Number Not Enrolled

MEDICAL POLICY FACT SHEET

TITLE: LONG-TERM ACUTE CARE HOSPITALS

DESCRIPTION:

Long-Term Acute Care (LTAC) hospitals are designed to provide specialized acute care for patients that require an especially long recovery period. These patients usually are in an acute care facility, their medical condition has stabilized, but they continue to require an acute level of care. A lesser level of care such as a skilled nursing facility (SNF) or subacute care facility is not appropriate. Federal regulations for LTAC hospitals require an average inpatient length of stay greater than 25 days, using Medicare program criteria to qualify a facility as a LTAC hospital. Patients are generally discharged to home with or without home care services, to acute inpatient rehabilitation hospitals, subacute rehabilitation programs, or to SNFs. LTAC hospitals are licensed by state acute care licensing standards and are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

MEDICAL TOPICS CROSS-REFERENCES:

Hospital Inpatient

RULES, CITATIONS, AND SOURCES:

405 IAC 1-10.5-2 (s)

405 IAC 1-10.5-3

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
405 IAC 1-10.5-2 (s)		08/31/2001		
BT200360	Changes in Diagnosis-Related Group Relative weights and New Long-Term Acute Care Hospital Level-of-Care Reimbursement Methodology	09/16/2003	11/01/2003	
Revisions:				

APPLICABLE INDIANA AIM EDITS AND AUDITS:**Coverage Criteria:**

Prior authorization (PA) is required for LTAC hospital admissions covered by the Indiana Health Coverage Programs (IHCP) and reimbursed under the level of care methodology described in the Indiana Administrative Code (IAC) *405 IAC 1-10.5*. Before admission to a LTAC hospital, assessment of the patient's current medical status and discharge goals must be provided to Health Care Excel (HCE) for PA purposes. This information should also be documented in the medical record. Each PA request is reviewed for medical necessity on an individual, case-by-case basis. LTAC facilities are designated as provider specialty type *013*. LTAC facilities are paid a daily rate (per diem) for each day of care provided. The per diem is all-inclusive. No other payments are permitted in addition to the LTAC level-of-care (LOC) per diem. The LTAC LOC per diem payments are in lieu of diagnosis-related group (DRG) and outlier payments. Per diem billing is permitted on a weekly basis. LTAC LOC per diem rates are hospital specific and implemented as budget neutral for the IHCP. LTAC LOC payments will resemble the payments that each facility currently receives. Claims noted as statistical outliers for each facility were not included in the development of each LTAC hospital's LOC per diem.

Admission Criteria

The proposed admission needs to be to a facility that meets the definition of a LTAC hospital in *405 IAC 1-10-2(s)* which states, "Long term care hospital means a freestanding general acute care hospital licensed under Indiana Code *IC 16-21* that:

(1) is designated by the Medicare program as a long term hospital; or

(2) has an average inpatient length of stay greater than twenty-five (25) days as determined using the same criteria used by the Medicare program to determine whether a hospital's average length of stay is greater than twenty-five (25) days.”

“Freestanding does not mean a wing or specialized unit within a general acute care hospital.” However, they may be licensed hospitals that operate as separate entities within a host hospital.

The patient must be admitted directly from an acute care facility, or be a readmission from a nursing facility or rehabilitation facility. No PA will be approved for requests for initial admission directly from a nursing facility, physician office, or from home.

The following documentation must be included with requests for admission to a LTAC hospital and must be available for review by HCE's Prior Authorization Department or Surveillance and Utilization Review (SUR) Department, as applicable:

- A signed statement from the referring physician indicating medical necessity for transfer to a LTAC hospital.
- The following information must accompany a request for approval and an evaluation by the requesting facility:
 - diagnosis and premorbid condition(s). If the patient is currently in an acute care hospital, the diagnosis at discharge should be included if it has changed from the time of admission.
 - information about where the patient is being admitted from, if not hospitalized.
 - neurological assessment.
 - complete listing of long and short-term goals.
 - discharge plan with two options, dependent on the member's condition
 - potential date of admission.
 - projected date of discharge.
 - history of any previous rehabilitation therapies.
 - prognosis and documentation that there is a reasonable expectation the member's functional and medical status will improve.
 - history, physical, and discharge or case summary, if the member is currently hospitalized.
 - completed IHCP LTAC hospital pre-admission form available from the PA contractor by contacting Health Care Excel PA Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.

Note: The provider is responsible for compiling and submitting the necessary documentation for the PA request in a timely manner.

All of the following situations apply to the patient's status and current requirements before admission to the LTAC hospital.

- The patient is medically stable.
- The initial diagnostic work up is completed.
- There are no major surgical procedures planned.
- The patient has a prognosis requiring a prolonged stay in an acute setting and there is a reasonable expectation for an improvement in the status of his or her medical condition.
- The patient requires interactive physician direction with daily on-site assessment.
- The patient requires significant ancillary services dictated by complex, acute medical needs, for example, full service and STAT laboratory, radiology, respiratory care services.
- There is a patient-centered, outcome-focused, interdisciplinary approach requiring a physician directed professional team, including intensive case management, to move the patient efficiently through the continuum of care.
- Education for the patient and family must be provided to manage the patient's present and future health care needs.

Physician consultants are used during the PA process if assistance is needed to determine the medical necessity of the admission. Admissions requested for categories not specified in the following sections will be reviewed for medical necessity and intensity of service on a case-by-case basis.

Respiratory

The patient must meet **two or more** of the following requirements for admission and continued stay.

1. Requires ventilator assistance, and has failed attempts to be extubated or maintain adequate ventilation, oxygenation, or functional level after extubation.
2. Requires one or more of the following intravenous medications daily.

Bronchodilators	Corticosteroids
Diuretics	Antiviral agents
Anti-tuberculosis agents	Antiprotozoal agents
Chemotherapy	Antibiotics
Antifungal agents	Anticoagulation medications

3. Requires frequent monitoring of tissue oxygenation (for example, pulse oximetry), frequent respiratory therapy treatments, suctioning or inhalation medications.

Impaired Skin Integrity

Impaired skin integrity means the patient has stage three or four decubitus wounds, infected necrotic skin conditions, surgical wounds, or burns. **The patient must meet each of the following requirements for admission or continued stay:**

1. The patient has non-healing wounds that have failed to improve while receiving home care, SNF, or acute hospital care.
2. The patient requires complex dressing changes using daily whirlpool, debridement, frequent intramuscular or intravenous analgesics or antifungals, frequent positioning, or hyperbaric treatments.
3. The patient requires more than one of the following intravenous medications at least daily:

Antiviral agents	Antibiotics
Antifungal agent	Intravenous plasma expanders
Intravenous electrolytes	Total parenteral nutrition (TPN)

Cardiac

Cardiac care is required if the member is unable to maintain adequate circulation related to mechanical or electrical dysfunction of the cardiovascular system. **The patient must meet each of the following requirements for admission or continued stay:**

1. The patient requires frequent monitoring of tissue oxygenation (for example, pulse oximetry) and continuous telemetry.
2. The patient requires management of hemodynamic instability, cardioversion or valsalva maneuver, temporary pacemaker, or monitoring of a functional permanent pacemaker, monitoring for drug toxicity, defibrillation, pulmonary artery catheterization and arterial monitoring, and monitoring of electrolyte imbalance.
3. The patient requires **two or more** of the following medications intravenously to maintain cardiovascular integrity:

Anticoagulants	Antianginal agents
Antiarrhythmics	Antibiotics
Anticoagulants	Antihypertensives
Alpha/beta-adrenoreceptor blocking agents	Betablockers
Calcium Channel blockers	Cardiac glycosides
Class mucarinic receptor antagonists	Corticosteroids
Diuretics	Inotropic agents

Sodium channel blockers	Tissue plasminogen activators
Thrombolytic enzymes	Vasodilators
Vasopressors	

Continued Stay Criteria

All of the following are required to be documented for review of a continued stay in the LTAC hospital.

- Multidisciplinary team evaluation at least weekly.
- Evidence of participation in a rehabilitation therapy program.
- Continued daily on-site direction of a qualified physician.
- Continued skilled nursing care or supervision required.
- Continued need for acute level of care as evidenced by continuing to meet the admission criteria category requirements.

Documentation Requirements for Continued Stay

Concurrent review for approval of additional days, must be received by the PA department at least 48 hours before the last approved day, including:

Completed IHCP LTAC hospital pre-admission form available from the PA contractor by contacting the Health Care Excel PA Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.

- A summary of the current discharge plans.
- Documentation of family or friend participation in the discharge planning process.
- A neurological assessment update, if appropriate.
- Documentation of the member's cooperation, participation, or progress.

Note: For review purposes, the PA contractor can request additional or updated information at any time.

Discharge Criteria

Continued length of stay will not be authorized without the physician consultant review when any of the following conditions occur:

- Evidence in the patient record that the patient has achieved stated goals.
- Medical complications require readmission to inpatient acute facility.
- Multidisciplinary services are no longer needed.

- No additional improvement is anticipated.
- Patient's progress towards goals has remained unchanged for seven days.

Billing Guidelines

Long-term acute care facilities must submit charges on a UB-92 claim form. The revenue code *101 –All-inclusive room and board* will be utilized for the PA process and should be reflected on the UB-92 claim form by the billing provider.

The discharging hospital must enter the patient status code 63 in Field Locator (FL) 22 on the UB-92 claim form. This indicates the status of the patient as of the ending service date was “discharged” or “transferred to a long-term care hospital.”

MEDICAL POLICY FACT SHEET

TITLE: MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT (DME) OVERVIEW

DESCRIPTION

This document is intended to serve as a general summary of the IHCP policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

Medical supplies are described in the Indiana Administrative Code (IAC) 405 IAC 5-19-1 as the following.

- (1) Disposable items that are not reusable and must be replaced on a frequent basis;
- (2) Used primarily and customarily to serve a medical purpose;
- (3) Generally not useful to a person in the absence of an illness or injury; and
- (4) Covered only for the treatment of a medical condition.

405 IAC 5-19-2 defines DME as equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to a recipient in the absence of illness or injury.

Coverage of specific medical supplies and DME will be addressed in individual fact sheets.

MEDICAL SUPPLIES**Coverage Criteria**

Medical supplies are items that are generally disposable and must be replaced on a frequent basis. Medical supplies that are reimbursable by the IHCP include, but are not limited to the following supplies.

- Antiseptics and solutions
- Bandages and dressing supplies
- Gauze
- Catheters

- Incontinence supplies
- Irrigation supplies
- Diabetic supplies
- Ostomy supplies
- Respiratory supplies
- Tracheotomy supplies
- Needles and syringes

The IHCP does not cover the following supplies.

- Sanitary napkins
- Cosmetics
- Dentifrice items
- Tissue
- Items generally used for personal hygiene, including but not limited to, non-ostomy deodorizing products, soap, disposable wipes, and shampoo

Prior Authorization

Prior authorization (PA) is not required for the reimbursement of medical supplies unless requested by an out-of-state supplier.

Billing Information

- Reimbursement is not available for medical supplies dispensed in quantities greater than a one month supply for each calendar month, except when packaged by the manufacturer only in larger quantities or the recipient is a Medicare beneficiary and Medicare allows reimbursement for a larger quantity.

The IHCP does not currently define a one month quantity limitation for individual medical supplies. The physician must determine the appropriate one month quantity for the prescribed supply based on the member's medical needs.

The IHCP will accept crossover claims for diabetic testing supplies with dates of service that span 90 days. Banner BR200449 lists the procedure codes that may be billed with a span date of 90 days, as well as the billing instructions for these services.

- The cost of all medical and non-medical supplies, which includes those items generally required to assure adequate medical care and personal hygiene of patients, is included in the per diem rate for long term care (LTC) facilities. LTC facilities include skilled nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), and community residential facilities for the developmentally disabled (CRFS/DD).

- Medical supplies that are included as part of reimbursement for a medical or surgical procedure are not separately reimbursable to any party.
- All traditional Medicaid claims for medical supplies are reimbursed as purchase only items. No modifier is required to be billed with the HCPCS code. HCPCS codes A4254 – *Replacement battery, any type, for use with medically necessary home glucose monitor owed by patient, each*, A4638 – *Replacement battery for patient-owned ear pulse generator, each*, and A7017 – *Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen*, may be billed as rental items for crossover claims only. The RR modifier must be billed with the HCPCS code for these rental claims to be reimbursed.

DURABLE MEDICAL EQUIPMENT (DME)

Coverage Criteria

Durable medical equipment includes equipment that can withstand repeated use, is primarily used to serve a medical purpose, and is not useful to the recipient in the absence of illness or injury. All DME must be ordered in writing by a physician. The written order must be kept on file by the physician and the rendering provider for audit purposes.

DME equipment is reimbursable by the IHCP within one of the following classifications listed in **Table 1**.

Table 1 - DME Classification Codes

DME Classification Number	DME Classification Name
1	Capped rental items
2	Inexpensive or other routinely purchased items
3	Items requiring frequent or substantial servicing
4	Customized items
5	Prosthetic and orthotic devices
6	Oxygen and oxygen equipment

Capped Rental Items

Certain procedure codes are limited to 15 months of continuous rental. Continuous rental is defined as rental without interruption for a period of more than 60 days. A change in provider does not cause an interruption in the rental period. Claims submitted for capped rental items are reimbursed in the following manner.

- Claims are paid until the number of rental payments made to date reaches the capped rental number of 15 months.

- Claims submitted for rental in excess of 15 total months will be denied for audit 6080, *DME rentals limited to 15 months*.
- Requests for approval of DME capped rental items are evaluated for documentation of long term need. In long term situations, a decision may be made to purchase the item.

The use of a piece of equipment during a rental period may be interrupted; however, if the patient resumes use of the equipment within 60 days of the last payment, the original 15-month period remains active. If the interruption period exceeds the 60 day period, and the interruption reasons are justified, a new PA request must be submitted to begin a new 15-month rental period. The supplier must document the reason for the greater-than-60-day break in the rental period on the *Indiana Prior Review and Authorization Request* form. Justification for a break in the rental period more than 60 days may include the following.

- Change in medical necessity
- Hospitalization
- Nursing facility stay

Unless a new PA is received requesting a new rental period, the original 15-month period remains active. If a member becomes inactive for a period of more than 60 days, a new PA is required to resume services.

Capped rental items are also subject to replacement or servicing when certain criteria are met. Replacement of capped rental items is not authorized more often than once every five years per member, unless there is a change in the member's medical needs, documented in writing, significant enough to warrant a different type of equipment.

During the 15-month capped rental period, the supplier must supply and service the item at no additional charge to the IHCP or the member. However, subject to prior approval parameters, reimbursement for repair not covered by warranty is not reimbursed more frequently than six months after the 15th month and every six months thereafter, for as long as the equipment is medically necessary.

Capped rental items are subject to prior authorization. Providers should refer to Chapter 8, Section 3 of the Provider Manual to view the list of the capped rental codes.

Inexpensive or other routinely purchased items

Inexpensive or routinely purchased DME is defined as equipment whose purchase price does not exceed \$150, or equipment that is acquired at least 75% of the time by purchase. Equipment in this category may be purchased or rented. The decision to rent or purchase DME is based on the least expensive option available for the anticipated period of need. DME items purchased with IHCP funds become the property of the OMPP.

Purchases are reimbursed in a lump sum, minus any previous rental payments. If the equipment is rented, the IHCP will allow monthly rental payments until the rental price

equals the purchase price. Any claims billed for rental payments exceeding the purchase price will deny for audit 6065, *DME total rental amount not to exceed fee for purchase*.

Items requiring frequent or substantial servicing

For items requiring frequent or substantial servicing, the IHCP reimburses providers for rental payments only, as long as the equipment is deemed medically necessary. Claims for the purchase of these items are denied. As noted in *405 IAC 5-19-4* repair of rental items is the responsibility of the rental provider. Providers should refer to Chapter 8, Section 3 of the Provider Manual to view the list of items considered to require frequent or substantial servicing.

Customized Items

Custom equipment is defined as equipment uniquely constructed or substantially modified to meet the specific needs of an individual patient according to the description and orders of the member's treating physician. Due to the unique aspects, these items cannot be grouped with similar items for purposes of payment.

Suppliers must submit documentation of the costs of the item, including the cost of labor and types of materials used in customizing the item. A materials and labor itemization and a manufacturer's cost invoice must be attached to the claim when submitted for payment. Each item on the invoice is reviewed when calculating the reimbursement amount for all customized items.

Customized items must be billed using HCPCS code E1399 for the materials and E1340 for the labor. HCPCS code E1399 for customized equipment requires prior authorization.

The following are examples of items that are **not** considered customized items.

- Items that are individually constructed, but that have standard costs and charges, and that can be billed using a national HCPCS code.
- A wheelchair that is ordered in individual parts from one or multiple manufacturers and assembled by the supplier.
- A wheelchair that is ordered from a manufacturer that makes available special features, modifications, or components cannot be considered a customized wheelchair.

Prosthetic and Orthotic Devices

All prosthetic and orthotic devices billed under the HCPCS L codes are paid in a lump sum amount, and may not be rented. Prosthetic and orthotic devices billed with HCPCS L codes do not require prior authorization.

Oxygen and Oxygen Equipment

The IHCP reimburses liquid and gaseous oxygen systems as rental only items, subject to prior authorization. Reimbursement for oxygen contents is included in the reimbursement of the oxygen system, and is not separately reimbursable for rented systems. Oxygen contents are separately reimbursable when a third party has purchased an oxygen system, or the IHCP or third party has rented or purchased a portable oxygen system. Accessories, including but not limited to, cannulas, masks, and tubing, are also included in the allowance for rented systems and are not separately reimbursable unless used with a purchased system. See the Oxygen and Oxygen Equipment Fact Sheet for further details.

Manually Priced Items

Reimbursement for DME services, equipment, and supplies that are billed with a nonspecific HCPCS code with a description such as unspecified, unclassified, or miscellaneous, is based on manual pricing. Examples of manually priced HCPCS codes are A4649, *surgical supply-miscellaneous* and E1399, *durable medical equipment-miscellaneous*.

Payment for manually priced HCPCS codes, related to DME services, is specific to the item being billed. Providers must submit documentation supporting the cost of the item, including a listing of all materials. Reimbursement is determined using the following guidelines.

- If the provider submits an itemized sale invoice from the manufacturer listing all materials or supplies purchased and showing the price paid for individual items, the claim is reimbursed at the billed amount, up to 30 percent above the invoice amount. The IHCP will not accept a manufacturer's price list as proof of purchase price for this level of reimbursement.
- If a provider submits retail price lists from the manufacturer, the claim is reimbursed at 90 percent of the price on the manufacturer's retail price list, but will not exceed the billed amount.
- If the provider submits a copy of the provider's own retail price list or an invoice from their own company, which indicates the price that a provider charges the general public for products or supplies, the claim is reimbursed at 90 percent of the invoice or price list, not to exceed the billed amount.

A provider must not bill more than their usual and customary charge for any item. When requesting prior authorization for miscellaneous services, an itemized list of materials must be included in the PA request. Any item that is identified under a miscellaneous code on the PA form must have a specific number of units identified for billing purposes and claim adjudication.

Repair of DME

The IHCP reimburses for labor costs associated with the repair and servicing of DME. Repair of DME must be billed using HCPCS code E1340, *Repair or non-routine service for DME requiring the skill of a technician, labor component, per 15 minutes*. Repairs of prosthetic and orthotic devices, hearing aids, and augmentative communication devices should be billed using the appropriate repair codes for those devices.

The IHCP will not pay for labor for the repair of DME under the following circumstances.

- IHCP does not pay for repair of equipment still under warranty
- No payment is authorized for repair necessitated by member misuse or abuse, whether intentional or unintentional
- Repairs for rental equipment are the responsibility of the rental provider
- Payment for maintenance charges of properly functioning equipment is not covered
- Repair costs for DME included in an long-term care (LTC) facility's per diem rate is also included in the per diem rate

In addition, the IHCP will only reimburse E1340 for tasks considered to be labor or non-routine servicing of DME. The IHCP will not reimburse E1340 for the following types of services.

- Evaluation of a member for a wheelchair or seating system
- Patient education in the use and care of DME
- Measurement of recipient for DME
- Initial assembly of DME

Replacement of DME

The IHCP will reimburse for the replacement of medically necessary DME under the following circumstances.

Loss of the item due to theft or fire

- If the equipment being replaced does not require PA and does not have a limit restriction, the provider may directly bill for the item. The provider should maintain documentation in their records to support the reason for replacement. This documentation would be subject to post payment review.
- If the item requires PA, the provider must submit a new PA request for the item, including an explanation that the item was lost due to theft or fire. The provider should maintain documentation in their records to support the reason for replacement. This documentation would be subject to post payment review.
- If the item has a limit restriction, whether or not the DME item requires PA, the provider should submit a PA request for a replacement item with an

explanation that the original item was lost due to fire or theft. The provider should maintain documentation in their records to support the reason for replacement. This documentation would be subject to post payment review.

Irreparable damage or wear

- Replacement of large DME items is not authorized more than once every five years per member. More frequent replacement is allowed only if there is a change in the member's medical needs.

Change in the member's condition that requires a change in equipment.

- These changes must be documented by the member's physician, and a request must be sent to the prior authorization department demonstrating a significant change warranting new equipment.

Modifications to DME

The IHCP may make additional payment for modifications to DME. Examples of some modifications are attachments to convert a wheelchair to a one-arm drive, or the addition of brake extensions, wheelchair hand rims, or anti-tipping devices to a wheelchair after the initial assembly.

Routine Maintenance

Payment for routine maintenance of properly functioning equipment is not covered by the IHCP. Routine maintenance includes services such as testing, cleaning, regulating, and checking of equipment that does not require the skill of a technician.

DME in Long Term Care (LTC) Facilities

DME utilized for the usual care and treatment of members in LTC facilities are reimbursed by the IHCP in the facility's per diem rate and may not be billed to Medicaid by the facility, pharmacy, or other provider. Repair costs necessary to maintain equipment reimbursed in the facility's per diem rate is also the responsibility of the facility. LTC facilities include skilled nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), and community residential facilities for the developmentally disabled (CRFS/DD).

Nonstandard or custom/special equipment and their associated repair costs may be billed separately to the IHCP for LTC facility members, subject to prior authorization. PA requests for separate reimbursement of this DME for LTC facility members will be considered on a case-by-case basis. Providers should refer to BR200307 to view specific information regarding the prior authorization criteria for separate reimbursement of custom wheelchairs for LTC facility members.

Package C

Package C coverage is available to certain members 19 years of age and younger. Coverage of medical supplies and DME is included under Package C with a maximum benefit of \$2,000 per calendar year, or \$5,000 per lifetime.

PRIOR AUTHORIZATION

PA is required for capped rental items, selected inexpensive or other routinely purchased items, and oxygen equipment. Providers should refer to Chapter 8, Section 3 of the IHCP Provider Manual for a list of items that do not require PA. PA requests for DME shall be reviewed on a case-by-case basis by the contractor, using all of the following criteria.

1. The item must be medically reasonable and necessary, as defined at 405 IAC 5-2-17, for the treatment of an illness or injury or to improve the functioning of a body member.
2. The item must be adequate for the medical need; however, items with unnecessary convenience or luxury features will not be authorized.
3. The anticipated period of need, plus the cost of the item will be considered in determining whether the item shall be rented or purchased. This decision shall be made by the contractor based on the least expensive option available to meet the recipient's needs.

The following items are examples of DME that require prior authorization.

- Hospital beds
- Wheelchairs
- Ventilators
- Heated and non-heated humidifiers
- Oxygen and oxygen equipment
- Patient lifts
- Stenders
- Power seating systems
- Cranial orthosis molding helmet
- Bone growth stimulators
- Enteral nutrition

Certain DME also requires a certificate of medical necessity (CMN) to be submitted with the prior authorization request. DME that require a CMN are listed below.

- Augmentative Communication Devices
- Oxygen Equipment
- Enteral Nutrition and Parenteral and Enteral Nutrition Pumps
- Hearing Aids
- Hospital Beds
- Motorized and Nonmotorized Wheelchairs
- Negative Pressure Wound Therapy Devices
- Stenders
- TENS Units

Out-of-State DME Providers

405 IAC 5-5-3 states that in order to be treated as an in-state provider for purposes of the prior authorization rule, any out-of-state supplier of medical equipment must comply with the following criteria.

- a. Maintain an Indiana business office, staffed during regular business hours, with telephone service.
- b. Provide service, maintenance, and replacements for Indiana Medicaid recipients whose equipment has malfunctioned.
- c. Qualify with the Indiana Secretary of State as a foreign corporation.

Out-of-state providers who do not meet these requirements must obtain PA prior to providing any DME or medical supplies. DME and medical supplies may not be obtained by out-of-state or in-state providers without prior authorization by use of an emergency indicator. If DME or medical supplies are needed in an emergency situation, PA may be obtained by telephone.

Telephone PA

PA may be obtained by telephone for DME services under the following circumstances.

- a. For medically reasonable and necessary supplies to facilitate discharge from or prevent admission to a general hospital
- b. For repair of DME when the equipment repair is necessary for life support or safe mobility of the patient.

The DME provider must subsequently submit a properly completed prior authorization request form signed by the ordering physician in order for the service to be approved for reimbursement. Refer to 405 IAC 5-3-2 (b) for further instructions.

DME PROVIDER CODE SET

On November 1, 2004, the IHCP implemented the provider code set for DME providers. The DME provider code set identifies procedure codes that are appropriate for reimbursement by DME providers. Claims submitted by DME providers for codes not listed on the DME code set will deny edit *1012 – Rendering provider specialty not eligible to render procedure code*. Providers must ensure that they are enrolled under the correct provider specialty with the IHCP.

The DME code set is available on the IHCP Web site at www.indianamedicaid.com. This code set is subject to change and will be updated accordingly based on annual and quarterly HCPCS updates and policy changes. Providers should monitor the Web site for changes to the DME provider code set.

MANAGED CARE

Primary Care Case Management (PCCM) services are subject to the same policies and restrictions as Traditional Medicaid services. Questions regarding coverage of services in Risk Based Managed Care (RBMC) should be directed to the appropriate Managed Care Organization (MCO).

RELATED MEDICAL TOPICS:

Medical Supplies and Equipment - Automatic External Defibrillators
Medical Supplies and Equipment - Beds
Medical Supplies and Equipment - Gloves
Medical Supplies and Equipment - Implantable Infusion Pumps
Medical Supplies and Equipment - Incontinence Supplies
Medical Supplies and Equipment - Left Ventricular Assist Device (LVAD)
Medical Supplies and Equipment - Monitoring Devices
Medical Supplies and Equipment - Neurocybernetic Prosthesis (NCP)
Medical Supplies and Equipment - Negative Pressure Wound Therapy
Medical Supplies and Equipment - Non-Invasive Respiratory Assist Devices
Medical Supplies and Equipment - Patient-Activated Event Recorder - Implantable Loop Recorder (ILR)
Medical Supplies and Equipment - Phrenic Nerve Stimulator
Medical Supplies and Equipment - Power Wheelchairs
Medical Supplies and Equipment - Programmable Hearing Aids
Medical Supplies and Equipment - Prothrombin Time
Medical Supplies and Equipment - Standers
Medical Supplies and Equipment - Standing Wheelchair
Medical Supplies and Equipment - ThAIRapy Vest

RULES, CITATIONS, AND SOURCES:

Indiana Administrative Code 405 IAC 5-19-1
Indiana Administrative Code 405 IAC 5-19-2
Indiana Administrative Code 405 IAC 5-19-3
Indiana Administrative Code 405 IAC 5-19-4
Indiana Administrative Code 405 IAC 5-19-5
Indiana Administrative Code 405 IAC 5-19-7
Indiana Health Coverage Program Provider Manual Chapter 8, Medical Supplies
Indiana Health Coverage Program Provider Manual Chapter 8, Oxygen and Durable Medical Equipment
Indiana Health Coverage Program Provider Banner BR200449
Indiana Health Coverage Program Provider Banner BR200307
Indiana Health Coverage Program Website, DME Provider Code Sets
Indiana Health Coverage Program Website, DME Per Diem Table

Origination Date: 7/31/05

Revisions and Reviews	Reason	Date
405 IAC 5-19-1	Definition Medical Supplies and Equipment	7/31/05
405 IAC 5-19-2	Definition DME	7/31/05
405 IAC 5-19-3	Reimbursement for DME	7/31/05
405 IAC 5-19-4	Repair of Purchased DME	7/31/05
405 IAC 5-19-5	Reimbursement for Replacement of DME	7/31/05
405 IAC 5-19-7	Prior Authorization for DME	7/31/05
405 IAC 5-5-3	Out-of-State DME Services	7/31/05
405 IAC 5-3-2	Telephone Prior Authorization	7/31/05
IHCP Provider Manual Chapter 8, Section III	Medical Supply and DME policy	7/31/05
Banner BR200449	Diabetic Test Strip Update	7/31/05
Banner BR200307	LTC Wheelchairs	7/31/05

APPLICABLE INDIANA A/M EDITS AND AUDITS:

- 6065 - DME total rental amount not to exceed fee for purchase
- 6080 - DME rentals limited to 15 months
- 6113 - DME limited to \$2,000 per recipient per calendar year
- 6114 - DME limited to \$5,000 per recipient per lifetime
- 2034 - Medical and non-medical supplies and routine DME included in the per diem
- 6250 - Oxygen maximum fee cut back to 1 unit/28 days
- 6252 - Oxygen/pound vs. oxygen maximum fee reimbursement

MEDICAL SUPPLIES AND EQUIPMENT – (DME) OVERVIEW FACT SHEET ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the (_add title of fact sheet_) Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200539 **Publication Date:** 09/27/2005

Subject: DME Billing Changes

Date Added to Manual: 10/31/2005

Text of Publication

This article notifies providers of new HCPCS code changes. Based on a recent analysis to identify potential duplicates among temporary and permanent codes (such as, items potentially billable under more than one HCPCS code), the OMPP has determined that durable medical equipment (DME) codes E0953, E1000, and A4632 will no longer be reimbursed effective November 11, 2005. Instead, the corresponding K codes (as listed below) and their Medicare fee will be adopted.

Adopting the K codes with established Medicare fees will expedite crossover claims processing. Direct questions about these HCPCS code changes to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

HCPCS Code	Description	Corresponding HCPCS Code	Description	Max Fee
E0953	Pneumatic Tire, EA	K0067	Pneumatic Tire, Any Size, EA	\$34.77-NU \$3.41-RR
E1000	Tire, Pneumatic Caster	K0074	Pneumatic Caster Tire, Any Size	\$36.00-NU \$3.96-RR
A4632	Repl Batt For External Infusion Pump, Any Type	K0601	Replacement Batt For Ext Inf Pump, Silver Oxide, 1.5 V	\$1.10
A4632	Repl Batt For External Infusion Pump, Any Type	K0602	Replacement Batt For Ext Inf Pump, Silver Oxide, 3.0 V	\$6.36
A4632	Repl Batt For External Infusion Pump, Any Type	K0603	Replacement Batt For Ext Inf Pump, Alkaline, 1.5	\$0.57

HCPCS Code	Description	Corresponding HCPCS Code	Description	Max Fee
			V	
A4632	Repl Batt For External Infusion Pump, Any Type	K0604	Replacement Batt For Ext Inf Pump, Lithium, 3.6 V	\$6.09
A4632	Repl Batt For External Infusion Pump, Any Type	K0605	Replacement Batt For Ext Inf Pump, Lithium, 4.5 V	\$14.60

MEDICAL POLICY FACT SHEET

**TITLE: MEDICAL SUPPLIES AND EQUIPMENT,
 AUTOMATIC EXTERNAL DEFIBRILLATORS (AED)**

DESCRIPTION

The IHCP covers two types of automatic external defibrillators for individual use. The first is a stand-alone model referred to as an AED. The Food and Drug Administration (FDA) approved the AED for individual use in the home November 2003. An AED is similar to a manual defibrillator except an AED detects and analyzes heart rhythms automatically. A microprocessor inside the AED analyzes the victim's heart rhythm through adhesive electrodes and makes a determination on the need for defibrillation to restore normal cardiac rhythm. The AED is programmed to recognize different shockable heart rhythms such as ventricular fibrillation or ventricular tachycardia, and to perform the defibrillation as quickly as possible. This automation reduces the amount of training needed for effective use of the AED, and allows for people with minimal training to perform defibrillation in emergency situations with little risk of additional injury to the member.

To use an AED, members must have a live-in companion/spouse available to apply the electrode pads at the time of a cardiac event and then follow the AED's instructions. The live-in companion or spouse needs some training with this device, as well as instruction in CPR and access to the local Emergency Medical Service.

The second type of automatic external defibrillator is the wearable cardioverter defibrillator (WCD). The FDA approved the WCD December 18, 2001. The equipment is a vest-like or garment-like device worn under the member's clothing that holds a cardiac monitor, electrodes, and a small alarm module. The device works by monitoring the member's heart rhythm through the electrodes and treating abnormal heart rhythms identified, such as ventricular fibrillation, by delivering the appropriate electrical shock to the member. The WCD also records the member's ECG. The alarm module alerts the member of impending defibrillation. This allows the member to prevent unneeded electrical shock by responding to the alarm and deactivating the device. Non-wearable components include a battery charger, a computer modem, a modem cable, a computer cable, WCDNET, and the diagnostic tester. WCDNET is a secure web-based data storage and retrieval system that allows the physician to access the member's ECG data stored on the Member Database.

RELATED MEDICAL TOPICS

Durable Medical Equipment

Hospital Outmember

Emergency Medicine – Cardiopulmonary Resuscitation (CPR)

RULES, CITATIONS, AND SOURCES

405 IAC 5-19-2

405 IAC 5-19-3

ORIGINATION, REVIEWS, AND REVISIONS**Origination Date:** 4/30/04

Review or Revision	Reason	Date
Revision	ICD-9-CM Diagnosis Code update, October 2005	01/27/05

APPLICABLE INDIANA A/M EDITS AND AUDITS:

6065 (K0606)

COVERAGE CRITERIA

The AED and the WCD are indicated for members who normally are candidates for an implanted cardioverter defibrillator (ICD), but for whom an ICD is contraindicated, or needs to be removed. These defibrillators are most often used for members who are awaiting heart transplants, who have recently had a heart attack, or who have had their ICD removed due to an ICD pocket infection. The average time of use is approximately 2-3 months, although some members awaiting transplant have used the device for over one year.

Members who are not able to use the WCD vest due to obesity other medical conditions, or who cannot tolerate wearing electrodes 24-hours a day, are able to utilize an AED because the electrodes are only placed at the time of a cardiac event. Members with limited mobility or who are confined to bed may also be unable to use the vest. The WCD is an option for members do not have a spouse/live-in companion able and/or available to use the device, or for members who must frequently be away from home.

The WCD has the capability to monitor and store ECG data as well as provide defibrillation. The member must download the ECG data from the WCD to a computer for their physician to access the information. The physician can obtain the data using WCDNET, a secure web-based data storage and retrieval system. When the ECG monitoring afforded by the WCD is not needed, or able to be utilized, the AED would be an alternative to the WCD.

If a defibrillator is indicated, the decision to prescribe the AED vs. WCD should be the physician's, in consultation with the member. The option of either the AED or the WCD is a clinical decision, influenced by the practical matters discussed above.

The IHCP covers AED and WCD and their accessories, with prior authorization, under the following codes.

Table 1 – Wearable Cardioverter Defibrillator

HCP CODE	DESCRIPTION
K0606	AED with integrated electrocardiogram analysis, garment type
K0607	Replacement battery for AED, each
K0608	Replacement garment for use with AED, each
K0609	Replacement electrodes for use with AED, each

Table 2 – Automatic External Defibrillator

HCP CODE	DESCRIPTION
E0617	Automatic External Defibrillator
K0607	Replacement battery for AED, each
K0609	Replacement electrodes for use with AED, each

PRIOR AUTHORIZATION CRITERIA FOR AUTOMATIC EXTERNAL DEFIBRILLATORS (E0617) AND WEARABLE CARDIOVERTER DEFIBRILLATORS (K0606)

The IHCP covers the AED (E0617) and the WCD (K0606) under the same PA criteria. The AED or the WCD is covered for members in two circumstances below.

Members must meet either (1) **BOTH** criteria A and B; **OR**
(2) Criterion C.

A. The member has **ONE** of the following conditions (**1-5**)

1. A documented episode of cardiac arrest due to ventricular fibrillation, not due to a transient or reversible cause ¹ (ICD-9 427.41, 427.42, 427.5);
2. A sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia, either spontaneous or induced during an electrophysiologic (EP) study, not

associated with acute myocardial infarction², and not due to a transient or reversible cause (ICD-9 427.1);

3. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmias such as long QT syndrome (ICD-9 426.82) or hypertrophic cardiomyopathy (ICD-9 425.1);
4. Coronary artery disease with a documented prior myocardial infarction, (ICD-9 410.0-410.92) with a measured left ventricular ejection fraction² less than or equal to 0.35, and inducible, sustained ventricular tachycardia (VT) or ventricular fibrillation (VF) during an EP study. To meet this criterion **BOTH (a) AND (b) BELOW MUST OCCUR.**
 - a) The myocardial infarction must have occurred more than 4 weeks prior to the external defibrillator prescription; **AND**,
 - b) The EP test must have been performed more than 4 weeks after the qualifying myocardial infarction.
5. Documented prior myocardial infarction (ICD-9 410.00-410.92) and a measured left ventricular ejection fraction less than or equal to 0.30 and a QRS duration of greater than 120 milliseconds. **PATIENTS MUST NOT HAVE:**
 - a) New York Heart Association classification IV; **OR**
 - b) Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm; **OR**
 - c) Had a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) within the past three months; **OR**
 - d) Had an enzyme-positive MI within past month; **OR**
 - e) Clinical symptoms or findings that would make them a candidate for coronary revascularization; **OR**
 - f) Irreversible brain damage from preexisting cerebral disease; **OR**
 - g) Any disease, other than cardiac disease (e.g., cancer, uremia, liver failure), associated with a likelihood of survival less than one year.

B. Implantation surgery is contraindicated.

C. A previously implanted defibrillator now requires removal.

¹ Transient or reversible causes include conditions such as drug toxicity, severe hypoxia, acidosis, hypocalcemia, hyperkalemia, systemic infections, and myocarditis (not all-inclusive).

² Myocardial infarctions must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram. Ejection fractions must be measured by angiography, radionuclide scanning or electrocardiography.

Claims for defibrillators for other indications will be denied as not medically necessary. The IHCP will not purchase both an AED and WCD for one member, nor rent an AED and a WCD simultaneously for one member.

PRIOR AUTHORIZATION CRITERIA FOR ACCESSORIES K0607 – K0609

Prior authorization criteria for the accessories is based on the estimated average life expectancies of the accessories. The accessories replacement batteries, K0607, and replacement electrodes, K0609, are used for both the AED (E0617) and WCD (K0606).

K0607 – Replacement Battery

1. The member must currently be renting or have purchased an AED (E0617) or WCD (K0606 with integrated electrocardiogram analysis, garment type).
2. The battery being replaced must be at least 11 months old or completely discharged.

K0608 – Replacement Garment (only for WCD)

1. The member must currently be renting or have purchased a WCD with integrated electrocardiogram analysis, garment type, K0606.
2. The garment must be damaged or worn beyond repair and have been in use at least 5 months.

K0609 – Replacement Electrodes

1. The member must currently be renting or have purchased an AED (E0617) or the WCD with integrated electrocardiogram analysis, garment type (K0606).
2. The electrodes being replaced must have been used for at least 22 months, or it must be proven that the equipment is broken or damaged beyond repair.

MEDICAL POLICY FACT SHEET

TITLE: MEDICAL SUPPLIES AND EQUIPMENT—HOSPITAL BEDS/SPECIALTY BEDS

Description:

Indiana Health Coverage Programs will provide coverage for hospital beds and specialty beds when they are medically necessary in a non-institutional setting, there is a written physician's order, and they have been prior authorized. The purpose for the policy is to decrease variation in utilization management by providing a guide for determining the medical necessity of hospital beds and specialty beds.

- For purposes of the Indiana Health Coverage Programs, “hospital beds” refers to adjustable heights, semi-electric, and total electric beds. “Specialty beds” refers to enclosed beds, or pediatric hospital beds.

Definition of Terms:**Hospital beds:**

A fixed-height hospital bed is one with manual head and leg elevation adjustments.

A variable-height hospital bed is one that has manual adjustment elevation for the head, height, and legs.

A semi-electric hospital bed is one that has a manual height adjustment with electric elevation for the leg and head adjustments.

A total-electric hospital bed is one that has electric adjustments for height, head, and leg elevation.

Specialty beds:

An enclosed bed is one that is one piece of equipment, e.g., bed and mesh canopy or a bed with padded walls and a mattress especially designed for patients with traumatic brain injury (TBI).

A pediatric hospital bed has higher side rails that are close together to prevent injury from falling through the rails and usually has a protective covering.

MEDICAL TOPICS CROSS-REFERENCES:

Home Health Services

Medical Supplies and Equipment

Physical Rehabilitation Services

RULES, CITATIONS, AND SOURCES:

405 IAC 5-19-2

Indiana Health Coverage Programs Provider Manual

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
405 IAC 5-19-2	Medical Supplies and Equipment	8/25/97		
Provider Bulletin 200026	Hospital Beds and Specialty Beds	8/01/00	8/10/00	
Revisions:				
405 IAC 5-19	Medical Supplies and Equipment	10/27/99	10/27/99	

APPLICABLE INDIANA AIM EDITS AND AUDITS:

6080

COVERAGE CRITERIA:

A hospital bed is considered medically necessary if one or more of the following conditions are met:

- Positioning of the body that is ordered by the physician, in ways not feasible with an ordinary bed due to a medical condition, which is expected to last at least one month. Elevation of the head and upper body greater than 30 degrees.
- Positioning of the body that is ordered by the physician in ways to alleviate pain that are not possible in an ordinary bed.
- Positioning of the body ordered by the physician that requires head elevation greater than 30 degrees most of the time related to medical condition, such as congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed.
- A physician orders traction that requires traction equipment, which can only be attached to a hospital bed.

A variable height hospital bed is covered if, in addition to meeting one (1) or more of the criteria for a hospital bed, the following condition is met:

- The physician orders a bed height different than a fixed-height hospital bed to accommodate transfers to a chair, wheelchair, or standing position.

A semi-electric hospital bed is covered if, in addition to meeting one (1) or more of the criteria for a hospital bed, the following condition is met:

- The physician orders frequent changes in body positioning and/or the patient has an immediate need for a change in body position.

An enclosed bed or cubicle bed is considered medically necessary when all the following criteria are met:

- a) The patient has an appropriate diagnosis which could include, but is not limited to, the following:
 - 343.8 Other specified infantile cerebral palsy
 - 343.9 Infantile cerebral palsy
 - 318.1 Severe mental retardation
 - 318.2 Profound mental retardation
 - 780.3 Convulsions
 - 345.1 Generalized convulsive epilepsy
 - 345.3 Grand mal status
 - 330.0 Leukodystrophy

- 331.1 Picks disease
 - 331.4 Obstructive hydrocephalus
 - 348.1 Anoxic brain damage
 - 854 Intracranial injury of other and unspecified nature
- b) Documentation of medical necessity must include **at least one (1)** of the following:
- Daily seizure activity
 - Uncontrolled perpetual movement related to diagnosis
 - Self-injurious behavior, such as uncontrolled head banging activity
- c) Documentation of safety factors tried and failed including, but not limited to, the following:
- Chest restraints
 - Side rails
 - A mattress on the floor
 - Protective helmet
- d) Supporting documentation must include secondary diagnoses and pertinent history:
- History of injuries or falls
 - High risk for fractures due to osteoporosis
 - At risk for hemorrhage due to thrombocytopenia
 - Frequent upper respiratory infections and or other complications related to aspiration
 - Respiratory complications related to positioning. Requires elevation of the head and upper body greater than 30 degrees
 - Requires frequent positional changes
- e) A signed physician's order for enclosed bed or cubicle bed.
- f) A Medical Clearance Form completed and signed by the physician.
- g) Verification that the primary caregiver is willing and able to clean and maintain the mesh canopy per the manufacturer recommendations. Indiana Health Coverage Programs will not pay for laundering of the mesh canopy.

Pediatric hospital beds are considered medically necessary when all the following criteria are met:

- a) Has a medically necessary diagnosis. Diagnoses could include, but are not limited to, the following:
- V55.0 Tracheostomy

- V55.1 Gastrostomy
- 428.0 Heart Failure
- 511.8 Other specified forms of effusion, except tuberculosis
- 511.9 Unspecified pleural effusion
- 518.81 Respiratory failure
- 518.82 Other pulmonary insufficiency, not elsewhere classified
- 518.89 Other disease of the lung, not elsewhere classified
- 519.1 Other disease of trachea and bronchus, not elsewhere classified
- 769.0 Respiratory distress syndrome
- 770.8 Other respiratory problems after birth
- 786.9 Other

b) Mandatory criteria for prior authorization (1-4)

1. A physician's order for a multi-positional bed related to frequent positioning changes that are required.
2. Elevation of upper body and head greater than 30 degrees is required.
3. Written documentation of why a standard crib is not appropriate and what alternative methods have been tried and failed is required.
4. A Medical Clearance Form completed and signed by the physician.

Recommended criteria (patient must meet at least one of the following criteria)

5. Documentation that indicates there is a risk for aspiration pneumonitis and/or gastric reflux related to disease processes is present.
6. Documentation of a history of aspiration pneumonitis is present.

HCPCS Codes:

Fixed height beds
E0250 - Hospital bed, fixed height, with any type side rails, with mattress.
E0251 - Hospital bed, fixed height, with any type side rails, without mattress.
E0290 - Hospital bed, fixed height, without side rails, with mattress.
E0291 - Hospital bed, fixed height, without side rails, without mattress.

Variable height
• E0255 - Hospital bed variable height, (hi-lo), with any type side rails, with mattress.
E0256 - Hospital bed variable height, (hi-lo), with any type side rails, without mattress.
E0292 - Hospital bed variable height, (hi-lo), without side rails, with mattress.
E0293 - Hospital bed variable height, (hi-lo), without side rails, without mattress.

Semi-electric beds
E0260 - Hospital bed, semi- electric (head and foot adjustments), with any type side rails, with mattress.
E0261 - Hospital bed, semi- electric (head and foot adjustments), with any type side rails, without mattress.
E0294 - Hospital bed, semi- electric (head and foot adjustments), without side rails, with mattress.
E0295 - Hospital bed, semi- electric (head and foot adjustments), without side rails, without mattress.

Total electric beds
E0265 - Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress.
E0266 - Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress.
E0296 - Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress.
E0297 - Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress.

Specialty beds
Z5101 Enclosed bed/with mattress/all accessories included
Z5102 Cubicle bed/with mattress/all accessories included
Z5103 Pediatric hospital bed/with mattress/all accessories included

Trapeze bars and other bed accessories	
E0271 - Mattress, innerspring	
E0272 - Mattress, foam rubber	
E0273 - Bed board	
E0274 - Over-bed table	
E0280 - Bed cradle, any type	
E0305 - Bedside rails, half length	
E0310 - Bedside rails full length	
E0315 - Bed accessories: boards or tables, any type	
E0910 - Trapeze bars, patient helper, attached to bed, with grab bar	
E0940 - Trapeze bar, free standing, Complete with grab bar	

MEDICAL POLICY FACT SHEET

TITLE: MEDICAL SUPPLIES AND EQUIPMENT—GLOVES

DESCRIPTION:

The Indiana Health Coverage Programs (IHCP) provides coverage for sterile and non-sterile gloves for use in the home by the member, family, or other non-paid caregiver. Universal precautions are required to protect members and caregivers from exposure to blood, body fluids, and other potentially infectious materials. Gloves, whether sterile or non-sterile, are used as personal protective equipment (PPE), to prevent exposure. The purpose of PPE is to prevent blood and body fluids from reaching the skin, mucous membranes, or personal clothing. The type of glove utilized should be based on the task to be performed, conditions present, duration of use, and the potential hazards identified. The two main indications for the use of gloves include the following.

- To protect hands from contamination with organic matter and microorganisms
- To reduce the risks of transmission of microorganisms to both the member and caregiver

Gloves should be worn as single use items and discarded after each care activity to prevent transmission of microorganisms to other sites. Gloves should be worn for contact with sterile sites, non-intact skin, mucous membranes, invasive procedures, and all activities carrying a risk of exposure to blood, body fluids, secretions, and excretions. In addition, they should be worn when handling contaminated instruments. The decision to wear sterile or non-sterile gloves should be based on contact with susceptible sites or clinical devices. Gloves should fit properly to ensure that all exposed skin is covered. The user should inspect gloves to ensure they are not worn or torn and free of holes that could lead to exposure.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

Gloves must be ordered in writing by a physician and be used only for administration of medical treatment. Documentation of medical need will be required for all gloves, sterile and non-sterile. The supplier should maintain a signed physician's order in the patient record with a start and stop date, frequency of treatment, and type of treatment for which gloves will be used.

Documentation should indicate the reason the gloves have been ordered by the physician. The physician order must be renewed at least every six months to ensure ongoing need for gloves. The order should reflect any changes in the plan of care in the home treatment setting. Providers must maintain records of the quantities supplied. If these supplies are delivered or mailed, a record showing proof of delivery must be maintained.

Medical necessity for non-sterile gloves includes, but is not limited to, the following.

- Bowel program requiring manual evacuation
- Ostomy care program
- Wound care program
- Exposure to blood and body fluids

Sterile gloves are covered when ordered by a physician for a medically necessary treatment. Sterile gloves are not separately reimbursed when included in sterile procedure kits. Such kits include, but are not limited to the following.

- Catheter insertion kits
- Suture removal kits

Reasons for non-coverage

Sterile and non-sterile gloves would be non-covered for the following indications.

- If used in the home by a paid caregiver
- Not used for a medically necessary treatment
- For members who reside in a nursing facility, gloves are included in the per diem reimbursement
- For End-Stage Renal Disease (ESRD)/dialysis services, gloves are included in the composite reimbursement

PRIOR AUTHORIZATION

Prior Authorization (PA) is not required for sterile or non-sterile gloves.

MANAGED CARE

For members enrolled in a Risk-Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the IHCP Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and RBMC delivery systems.

IHCP members enrolled in Medicaid Select PCCM receive the same benefit coverage and are subject to the same limitations as traditional Medicaid FFS. Refer to the Medicaid Select Manual for Primary Care Providers and Office Staff for further information.

BILLING REQUIREMENTS

The following Healthcare Common Procedure Coding System (HCPCS) codes are used to report the use of sterile and non-sterile gloves.

A4927, *Gloves, non-sterile, per 100*

A4930, *Gloves, sterile, per pair*

In accordance with the provider agreement and the regulations governing this program, providers may not bill the IHCP any amount that exceeds their usual and customary charge to the general public.

RELATED MEDICAL TOPICS

Home Health Services

Hospital Outpatient

Medical Supplies and Equipment

Nursing Facilities

Pharmacy

ESRD/Dialysis Services

RULES, CITATIONS, AND SOURCES

405 IAC 5-2-17, *Medically Reasonable and Necessary Service*

405 IAC 5-19-1, *Medical Supplies*

405 IAC 5-29-1, *Noncovered services*

405 IAC 5-31-4, *Per diem services*

Indiana Health Coverage Programs Provider Banners

BR200138

BR200139

BR200322

Indiana Health Coverage Programs Provider Bulletins

BT200031-New Local Codes for Sterile and Non-Sterile Gloves

BT200353-HIPAA-Mandated Elimination of Local Codes and Local Code Modifiers

Origination Date: 09/08/2000

Revisions and Review	Reason	Date
Revision	Changes in Coding Requirements	08/15/2003
Review	Scheduled	01/31/2007

APPLICABLE INDIANA AIM EDITS AND AUDITS

6096-The CPT/HCPCS Code Billed Is Not Payable According to the PPS Reimbursement Methodology

6260-Parenteral/Enteral Kit or Supplies Denied or Payment Reduced

6261-Parenteral/Enteral Kits (Maximum Fee) Versus Supplies

6916-Global-Home Uterine Monitoring (Tocolytic Therapy)

6917-Global-Home Uterine Monitoring (Tocolytic Therapy)

6652-Multiple Surgeries Must Be Billed on Same Claim

6768-Services Not Covered for Telemedicine

MEDICAL POLICY FACT SHEET

TITLE: MEDICAL SUPPLIES AND EQUIPMENT- IMPLANTABLE INFUSION PUMPS

DESCRIPTION:

Implantable infusion pumps (IIPs) are intended to provide long-term continuous or intermittent infusion of a drug, and are designed to deliver therapeutic levels of a drug directly to the target compartment or organ for prolonged periods of time. IIPs are supplied as a complete system with all the necessary components; are implanted in a subcutaneous pocket then connected to the intra-arterial, epidural, or intrathecal catheter; and may be programmable or nonprogrammable. The pumps are labeled by the FDA for specified drugs and routes of administration and are usually implanted in the abdominal area.

Non-programmable pumps deliver a predetermined constant rate of infusate, and are limited in their ability to provide bolus or modulated patterns of delivery. Programmable pumps have a variable delivery rate that is adjusted by radio frequency control, and have the ability to provide bolus or modulated patterns of delivery. The reservoir volume of an implantable infusion pump varies between 10 and 50 cc. The reservoir can be refilled as needed through the use of specially designed needles that are inserted transcutaneously into a self-sealing rubber septum that covers the reservoir.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

The IHCP provides coverage for services considered medically necessary and reasonable and are provided by a doctor of medicine or doctor of osteopathy related to implantable infusion pumps provided within the scope of practice of medicine as set forth in 405 IAC 5-25-1. Prior authorization is not required for IIP services.

Test dosing or placement of a temporary catheter for trial screening can be conducted in the outpatient setting, but is usually administered in the hospital setting. In the case of Baclofen®, one to two intrathecal (by lumbar puncture) or epidural boluses can produce

effects over a 36-hour period and the patient will need monitoring for respiratory depression, confusion, light-headedness, vision changes, nausea and vomiting, somnolence, urinary retention, hypotension, and coma. The same or similar technique is utilized for other medications to be administered by implanted infusion pump.

Usually, hospitalization associated with the pump implantation is required for up to three days, to monitor for a cerebral spinal fluid (CSF) leak, to protect the surgical wound, and to monitor the pump. The pump is activated at the time of implantation. The pump chambers allow for approximately 30-90 days of medication administration and are refilled at intervals dependent on pump delivery rate, usually every 25-50 days. Members may utilize their physician, hospital, or home health agency (if they are home bound) to have their pumps reprogrammed and filled using the appropriate coding and billing guidelines.

The medical record should fully document the refilling of the implantable pump or reservoir and the appropriate time, dosage, medications, and solution. The medical record should fully document the medical history of drugs used in the pump, including adverse reactions. IHCP reimbursement may be made for drugs necessary for the effective use of an implantable infusion pump as long as the drug being used with the pump is itself reasonable and necessary for the patient's treatment.

Prior Authorization is not required for the implantable device or services. Implantable devices for intra-arterial, epidural, and intrathecal infusions are considered medically appropriate based on the following criteria.

1. Chemotherapy for liver cancer

The implantable infusion pump is covered for intra-arterial infusion of 5-FUDR (Floxuridine) for the treatment of liver cancer for members with primary hepatocellular carcinoma or Duke's Class D colorectal cancer, in whom the metastases are limited to the liver, and the disease is unresectable or the member refuses surgical excision of the tumor.

2. Anti-spasmodic drugs

To administer anti-spasmodic drugs intrathecally e.g., baclofen, to treat chronic intractable spasticity in members who have proven unresponsive to less invasive medical therapy as determined by the following criteria.

- ♦ Documented history of at least a six-week trial period on oral anti-spasmodics that has failed to adequately control the spasticity or has produced intolerable side effects.
- ♦ Prior to pump implantation, the patient must have had a favorable response to a trial epidural or intrathecal dose of an anti-spasmodic drug.

3. Opioid drugs

To administer opioid drugs e.g., morphine, intrathecally for treatment of severe chronic intractable non-malignant pain and malignant pain for members who have

proven unresponsive to less invasive medical therapy, the medical record must reflect the following criteria.

- ♦ An appropriate ICD-9-CM diagnosis
- ♦ The member, and/or the person responsible for the member, must be fully aware of the risks and benefits of the surgery, including the mortality and morbidity experience of the providers
- ♦ A documented medical history of less invasive medical therapy that was tried and failed
- ♦ A preliminary trial of placebo and opioid intraspinal therapy with a temporary catheter that demonstrated adequate acceptable pain relief, degree of side effects, and patient acceptance

4. Other uses

Coverage for other uses of implanted infusion pumps may be approved if the practitioner has documentation maintained in the member's medical record that indicates all of the following.

- ♦ the drug is reasonable and necessary for the treatment of the individual
- ♦ it is medically necessary that the drug be administered by an implanted infusion pump
- ♦ the FDA approved labeling for the pump specifies the drug being administered and the purpose for which it is administered is an indicated use for the IIP

NOTE: Reimbursement may also be available for drugs necessary for the effective use of an implantable infusion pump as long as the drug being used with the pump is itself reasonable and medically necessary for the member's treatment.

Contraindications for use of implantable infusion pump

The implantation of an infusion pump is contraindicated in the following situations.

- ♦ Known allergy or hypersensitivity to the drug being used (e.g., oral baclofen, morphine, etc)
 - ♦ An infection affecting the area of implantation
- ♦ Body size is insufficient to support the weight and bulk of the device
- ♦ Other implanted programmable devices, since crosstalk between devices may inadvertently change the prescribed settings

Table 1, on the following page, details the procedure codes, corresponding ambulatory surgical center (ASC) groups for each code, and IHCP coverage for IIPs. Providers should report one of the codes detailed in **Table 2**, on the following page, for the device.

**Table 1 – Implantable Infusion Pumps Procedure Codes,
Corresponding ASC Groups, and IHCP Coverage**

CPT Code	Description	ASC Group	IHCP Coverage
36260	Insertion of implantable intra-arterial infusion pump	4	Yes
36261	Revision of implantable intra-arterial infusion pump	2	Yes
36262	Removal of implantable intra-arterial infusion pump	1	Yes
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy	2	Yes
62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy	2	Yes
62355	Removal of previously implanted intrathecal or epidural catheter	3	Yes
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir	2	Yes
62361	Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump	2	Yes
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	2	Yes
62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	2	Yes
62367	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming	2	Yes
62368	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	2	Yes

Table 2 – Implantable Infusion Pump Durable Medical Equipment Codes

HCPCS Code	Description	Prior Authorization	Coverage
E0782	Infusion pump, implantable, non-programmable (includes all components, e.g., pump, catheter, connectors, etc.)	No	Yes
E0783	Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)	No	Yes

PRIOR AUTHORIZATION

Prior authorization is not required for the implantation or the implantable infusion pump device.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in *Medicaid Select* PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the *Medicaid Select* Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

The IHCP will provide reimbursement for implantable pump services reported with standard billing practices.

RELATED MEDICAL TOPICS

Hospital Inpatient
Hospital Outpatient
Medical Supplies and Equipment
Pharmacy Services
Surgery

RULES, CITATIONS, AND SOURCES:

405 IAC 5-17-1
405 IAC 5-19-1
405 IAC 5-25
Indiana Health Coverage Programs Provider Manual, Version 5.1, March, 2005

Origination Date: 12/31/2003

Initial Policy	Issues	Date
405 IAC 5-19-1	Medical Supplies	10/27/1999
Medical Policy Committee Meeting	Implantable Infusion Pumps	10/10/2001
Review	Scheduled	10/31/2006

APPLICABLE INDIANA A/M EDITS AND AUDITS:

- 6002 – Any Two Anesthesiology Providers Same Procedure Requires Review
- 6003 – Manual Pricing for Split Care Billing
- 6034 – Global Surgery Payable at Reduced Amount When Components of Surgical Care Paid
- 6035 – Components of Surgical Care Not Payable When Global Surgery Paid
- 6037 – Only One Assistant Surgeon Allowed for Select Surgeries
- 6039 – Assistant Surgeon Not Payable When Co-Surgeon Paid
- 6040 – Co-Surgeon Not Payable When Assistant Surgeon Paid
- 6096 – The CPT/HCPCS Code Billed is Not Payable According to the PPS
Reimbursement Methodology
- 6152 – Surgery Payable at Reduced When Consultation Paid Days Before or After Surgery
- 6652 – Multiple Surgeries Must be Billed on Same Claim
- 6768 – Services not Covered for Telemedicine
- 6666 – Anesthesia Services Not Allowed by Provider Billing for Surgery

MEDICAL POLICY FACT SHEET

**TITLE: MEDICAL SUPPLIES AND EQUIPMENT—
INCONTINENCE SUPPLIES**

DESCRIPTION

The Indiana Health Coverage Programs (IHCP) covers medically necessary disposable and reusable incontinence supplies for members three years of age or older. Disposable incontinence supplies include diapers, briefs, protective underwear, pull-ons, liners, shields, and underpads. Reusable products include protective underwear, pull-ons, and underpads.

This document is intended to serve as a general summary of the IHCP policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

The IHCP covers incontinence supplies for members three years of age and older based on medical necessity. A member may receive a maximum of \$1,950 of incontinence supplies per rolling calendar year. Claims billed for purchases over \$1,950 per rolling calendar year will deny for audit 6085, *Incontinence supplies limited \$1,950/rolling year*. Providers may review the amount of money applied toward a member’s incontinence supply cap on the Web interChange.

Incontinence supplies must be ordered in writing by a physician. The clinical documentation must include a diagnosis of incontinence. The incontinence diagnosis must also be documented on the CMS-1500 claim form, with information about the specific quantity and description of the supplies provided. The physician’s order must be renewed annually at minimum.

Incontinence supplies may only be provided to members in one month increments. The supplier must maintain documentation in the members medical record of the specific quantity and description (such as brand, type, size, and so forth) of the supplies provided.

In addition to the signed physician’s order, the supplier must maintain documentation of proof of delivery. Documentation must include the date of delivery, address of delivery,

and signature of the IHCP member, caregiver, or family member who received the supplies.

Incontinence supplies are included in the per diem rate for long term care (LTC) facilities and may not be billed to Medicaid by the facility, pharmacy, or other provider. LTC facilities include skilled nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), and community residential facilities for the developmentally disabled (CRFS/DD).

NONCOVERED ITEMS

According to 405 IAC 5-29-1(5) personal comfort or convenience items are noncovered by the IHCP. Therefore, products such as peri-wash spray, wet-wipes or baby wipes, and soap or cleansers used for incontinence care are non-covered by the IHCP.

PRIOR AUTHORIZATION

Prior authorization is not required for the reimbursement of incontinence supplies unless supplied by an out-of-state provider.

CODING

The IHCP adopted HCPCS T codes (T4521-T4542) for the reimbursement of incontinence supplies effective January 1, 2005. HCPCS codes A4521-A4538 (with the exception of A4534) were deleted December 31, 2004, as part of the annual 2005 HCPCS update. **Table 1** below lists the covered T codes for incontinence supplies. Providers should refer to the IHCP newsletter 200504 for a crosswalk of the incontinence supply codes.

Table 1 – Incontinence Supply Codes

Code	Description
T4521	Adult sized disposable incontinence product, brief/diaper, small each
T4522	Adult sized disposable incontinence product, brief/diaper, medium each
T4523	Adult sized disposable incontinence product, brief/diaper, large, each
T4524	Adult sized disposable incontinence product, brief/diaper, extra large, each
T4525	Adult sized disposable incontinence product, protective underwear/pull-on, small size, each
T4526	Adult sized disposable incontinence product, protective underwear/pull-on, medium size, each
T4527	Adult sized disposable incontinence product, protective underwear/pull-on, large size, each
T4528	Adult sized disposable incontinence product, protective underwear/pull-on, extra large size, each
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each

Table 1 – Incontinence Supply Codes

Code	Description
T4531	Pediatric sized disposable incontinence product protective underwear/pull-ons, small/medium size, each
T4532	Pediatric sized disposable incontinence product protective underwear/pull-ons, large size, each
T4533	Youth sized disposable incontinence product, brief/diaper, each
T4534	Youth sized disposable incontinence product, protective underwear/pull-ons, each
T4535	Disposable liner/shield/guard/pad/ undergarment, for incontinence, each
T4536	Incontinence product, protective underwear/pull on reusable, any size, each
T4537	Incontinence product, protective underpad, reusable, bed size, each
T4539	Incontinence product, diaper/brief, reusable, any size, each
T4540	Incontinence product, protective underpad, reusable, chair size

CMS implemented HCPCS code A4520 – *Incontinence garment, any type, (e.g. brief, diaper), each*, during the annual 2005 HCPCS update. HCPCS code A4520 is used by third party payers for reimbursement of all incontinence supplies; however, A4520 is not covered by the IHCP because more specific T codes are available. In addition, CMS continued coverage of HCPCS codes A4534 – *Youth-sized incontinence product, brief, each*, and A4554, *Disposable underpads, all sizes (e.g., Chux's)*. These A codes are non-reimbursable by the IHCP, effective January 1, 2005.

Code A4335 may be used to obtain reimbursement for miscellaneous medically necessary items for incontinence care that are not specifically reimbursable using the HCPCS T codes. An example of a miscellaneous incontinence supply is a skin barrier used to treat excoriated or reddened tissue resulting from incontinence. Only A4335 can be used for miscellaneous supplies related to incontinence. Use of other codes may result in claim denials or recoupment.

BILLING

Crossover claims for members with primary insurance that have been billed using A4520 must be billed to the IHCP using the appropriate T codes for the incontinence supplies on a CMS-1500 claim form. The provider must indicate the primary payment received in Field 29 of the CMS-1500 or 837P claim forms. All TPL claims are subject to post-payment review.

MANAGED CARE

PrimeStep services are subject to the same policies and restrictions as Traditional Medicaid services. Questions regarding coverage of services in Risk Based Managed Care (RBMC) should be directed to the appropriate Managed Care Organization (MCO).

RELATED MEDICAL TOPICS

Medical Supplies and Durable Medical Equipment (DME) Overview

RULES, CITATIONS, AND SOURCES

Indiana Administrative Code 405 IAC 5-19-1

Indiana Health Coverage Program Provider Manual Chapter 8 Section 3

Indiana Health Coverage Program Provider Bulletin BT200430

Origination Date: 8/25/97

Revisions and Reviews	Reason	Date
405 IAC 5-19-1	Medical Supplies – Incontinence Supplies policy	8/25/97
BT200130	Incontinence Supplies Update	9/17/01
BR200139	Incontinence Supplies Update	9/25/01
BT200430	Incontinence Supplies Update	7/31/05

APPLICABLE INDIANA A/M EDITS AND AUDITS:

6065 - Incontinence supplies limited \$1950/rolling year

MEDICAL POLICY FACT SHEET

TITLE: MEDICAL SUPPLIES AND EQUIPMENT --- MONITORING DEVICES (APNEA MONITORS, NONINVASIVE PULSE OXIMETRY, PNEUMOGRAMS, AND TREND EVENT MONITORING)

DESCRIPTION

Cardiorespiratory monitoring is the observation of cardiac and respiratory activities by a device that displays and/or records specific data. Trend event and apnea monitors are used to monitor for apnea episodes or absences of respiration. Noninvasive pulse oximetry is the measurement of oxygen saturation by variations of light absorption through well-vascularized tissue during systole and diastole. A pneumogram is an overnight recording of breathing effort, heart rate, oxygen saturation, and air flow to the lungs during sleep.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding these services. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

Trend Event Monitoring and Apnea Monitors

Trend event monitoring is performed with an apnea monitor that has recording features. The appropriate Current Procedural Terminology (CPT) code for monitoring, recording, transmission, and interpretation must be used to bill for these services. Current coding options are illustrated in **Table 1**. When an apnea monitor without a recording feature is required, Healthcare Common Procedure Coding System (HCPCS) code E0618, *Apnea monitor, without recording feature* must be used.

Table 1–Coding Options for Trend Event Monitoring and Apnea Monitors

Procedure Code	Description
E0618 RR (Rental)	Apnea monitor, without recording feature
E0618 NU (Purchase)	Apnea monitor, without recording feature

Table 1–Coding Options for Trend Event Monitoring and Apnea Monitors

E0619 RR (Rental)	Apnea monitor, with recording features
Procedure Code	Description
E0619 NU (Purchase)	Apnea monitor, with recording features
93268	Patient demand single or multiple event recording with pre-symptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission, physician review and interpretation
93270	Patient demand single or multiple event recording with pre-symptom memory loop, per 30 day period of time; recording (includes hook-up, recording, and disconnection)
93271	Patient demand single or multiple event recording with pre-symptom memory loop, per 30 day period of time; monitoring, receipt of transmissions, and analysis
93272	Patient demand single or multiple event recording with pre-symptom memory loop, per 30 day period of time; physician review and interpretation only

Pneumograms

Pneumograms should be billed using CPT code 94772, *Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour continuous recording, infant*. This code includes both technical (modifier TC) and professional (modifier 26) components of service. Prior authorization (PA) for pneumograms is not required. One pneumogram, with any number of channels, is considered one unit. Oximetry is not separately reimbursable during a pneumogram because it is included in the pneumogram reimbursement.

Noninvasive Pulse Oximetry

Oximetry for oxygen saturation is performed with an oximeter device that can be appropriately billed with HCPCS code E0445, *Oximeter device for measuring blood oxygen levels noninvasively*. Oximetry determination should be billed using the appropriate CPT code. Current coding options are illustrated in **Table 3**, on the next page. Noninvasive pulse oximetry reimbursement is available using the CPT codes, 94760, *Noninvasive ear or pulse oximetry for oxygen saturation; single determination*, 94761, *Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations*, and 94762, *Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring*. PA is not required for noninvasive pulse oximetry reimbursement. Reimbursement of codes 94760, 94761, and 94762 includes the physician interpretation of the oximetry results and any related equipment. Noninvasive pulse oximetry is not separately reimbursable during a pneumogram.

Noninvasive pulse oximeters are classified as capped rental items under the IHCP. The device is available for rental using the RR modifier or purchase using the NU modifier. Rental of noninvasive pulse oximeters with HCPCS code E0445 includes all cords, batteries, alarms, sensors, probes, printers, and all supplies.

Table 3–Coding Options for Oximeters

Procedure Code	Description
E0445 RR (Rental)	Oximeter device for measuring blood oxygen levels noninvasively
E0445 NU (Purchase)	Oximeter device for measuring blood oxygen levels noninvasively
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761	Noninvasive ear or pulse oximetry for oxygen saturation; multiple determination (e.g., during exercise)
94762	Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)

PRIOR AUTHORIZATION

Prior Authorization (PA) is not required for apnea or trend event monitors, noninvasive pulse oximetry or pneumograms. Please refer to the Fact Sheet that corresponds with each additional service provided, when available, for more information on PA.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the IHCP Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in *Medicaid Select* PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the *Medicaid Select* Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

Providers are responsible for determining if Home Medical Equipment (HME) licensure is required to submit claims for particular products or services. Information is available on the IHCP website under *Provider Code Sets*.

RELATED MEDICAL TOPICS

Home Health Services

Medical Supplies and Durable Medical Equipment (DME) Overview

RULES, CITATIONS, AND SOURCES

405 Indiana Administrative Code (IAC) Rule 19 Medical Supplies and Equipment
Indiana Health Coverage Programs (IHCP) Provider Manual 2005

Origination Date: 12/31/2000

Revisions and Review	Reason	Date
Indiana Health Coverage Programs Provider Bulletin – BT200334	Procedure Code Crosswalks	06/30/2003
Review	Scheduled	10/31/2006

APPLICABLE INDIANA A/M EDITS AND AUDITS

6008-Select Critical Care/Neonatal Intensive Care Components Not Payable Same Date of Service as Global Codes

6030-Critical Care/Neonatal Intensive Care Visit Codes Payable at Reduced Amount

6065-DME Total Rental Amount Not to Exceed Fee for Purchase

6080-DME Rentals Limited to 15 Months

6096-The CPT/HCPCS Code Billed is Not Payable

6104-DME Rental From Chiropractor of More Than One Month Requires PA

6113-DME Limited to \$2,000 Per Member Per Calendar Year

6114-DME Limited to \$5,000 Per Member Per Lifetime

6255-Trend Event Monitor Components Not Reimbursable When Billed in Conjunction With Trend Event Monitor

6256-Trend Event Max Fee Reimbursed at Reduced Amount When Component Services Previously Paid

6257-Maximum Reimbursement for Oximetry

6652-Multiple Surgeries Must be Billed on Same Claim

6768-Services Not Covered for Telemedicine Services

MEDICAL POLICY FACT SHEET

**TITLE: MEDICAL SUPPLIES AND EQUIPMENT—
NEGATIVE PRESSURE WOUND THERAPY (NPWT)**

DESCRIPTION:

NPWT is a controlled application of subatmospheric pressure to a wound. NPWT is achieved using an electrical pump to convey, intermittently or continuously, subatmospheric pressure through a connecting tube to a specialized wound dressing. This specialized dressing includes a resilient open cell foam surface dressing, sealed with an occlusive dressing that is meant to contain the subatmospheric pressure at the wound site and promote wound healing.

Indiana Health Coverage Programs (IHCP) will provide coverage for negative pressure wound therapy (NPWT) in a home-care setting or a long-term care setting based on the criteria described in this policy.

MEDICAL TOPICS CROSS-REFERENCES:

Medical Supplies and Equipment
Prior Authorization

RULES, CITATIONS, AND SOURCES:

405 IAC 5-19

405 IAC 5-13

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
BT200122	Negative Pressure Wound Therapy	07/07/2001		
Revisions:				
Policy update	Pricing	04/02/2002		

APPLICABLE INDIANA AIM EDITS AND AUDITS:

COVERAGE CRITERIA:

- ◆ The member must be enrolled in the Indiana Health Coverage Programs.
- ◆ The member must have a physician's order.
- ◆ The NPWT must be reasonable and medically necessary.
- ◆ The member must have a stage III or IV pressure ulcer, neuropathic ulcer, venous or arterial insufficiency ulcer, or chronic (being present for at least 60 days) ulcer of mixed etiology. A complete wound program described in the criteria listed below, as applicable depending on the type of wound, must have been tried and failed prior to application of the NPWT.

Prior Authorization

Prior authorization is required for reimbursement of NPWT. The provider must submit a completed prior authorization form and a completed medical clearance form signed by the physician to the HCE Prior Authorization Unit for review of medical necessity. To be considered medically necessary, the member must have a stage III or IV pressure ulcer, neuropathic ulcer, venous or arterial insufficiency ulcer, or chronic (present for at least 60 days) ulcer of mixed etiology. A complete wound program described in the criteria listed below, as applicable depending on the type of wound, must have been tried and failed prior to application of the NPWT. Prior authorization is required, and the service will be reimbursed as a capped rental item.

The NPWT is only authorized for four weeks at a time. Each new request requires a statement from the treating physician describing the initial condition of the wound including measurements, efforts taken to address wound care, and the changes in the wound therapy being applied to affect wound healing.

- ◆ Each new physician's order for continued use of NPWT requires a new prior authorization period. If a prior authorization is modified and authorized for less time than the physician's order had requested initially, a new prior authorization form and updated physician's orders must be obtained before the current authorization expires.
- ◆ Authorization for coverage beyond four months in a home care setting will be given individual consideration based on additional documentation that sets out the reason for continuing use of NPWT.

Criteria:

1. For all ulcers or wounds, all of the following minimum general measures of a wound therapy program must be addressed or applied prior to application of NPWT:
 - Documentation in a patient's medical record of evaluation, care, and wound measurements by a licensed medical professional.
 - Application of dressings to maintain a moist wound environment.
 - Debridement of necrotic tissue if present.
 - Evaluation of and provision for adequate nutritional status.
2. In addition to criterion one, stage III or IV pressure ulcers must also be evaluated for all of the following components:
 - The patient has been appropriately turned and positioned and has a current turning and positioning plan in place.
 - If the wound is on the trunk or the pelvis, the patient has used a group 2 or 3 support surface.
 - The patient's moisture and incontinence has been appropriately managed.
3. In addition to criterion one, neuropathic ulcers must also be evaluated for all of the following components:
 - The patient has been on a comprehensive diabetic or other applicable disease management program.
 - Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
4. In addition to criterion one, venous stasis ulcers must also be evaluated for all of the following components:
 - Compression bandages or garments have been consistently applied.
 - Leg elevation and ambulation have been encouraged.

Continued Coverage:

To obtain prior authorization for continued service after the initial prior authorization of NPWT, documentation of the following must be included with the request:

- ◆ Indication that a licensed medical professional has directly performed or supervised the performance of the dressing changes.
- ◆ Progress and changes in the ulcer. (If there is no progress in one month, or from month to month, the approval for the NPWT will be discontinued.)
- ◆ A completed NPWT medical clearance form signed and dated by the ordering physician.

Supplies

Supplies for the NPWT must be prior authorized. Dressing sets are packaged five or ten to a case. Each dressing set equals one unit and includes, but is not limited to, a resilient open cell foam surface dressing, drainage tubing, and an occlusive dressing that creates a seal around the wound site to maintain subatmospheric pressure at the wound. No more

than 15 units for dressing sets, any size, will be authorized per wound, per month. No more than ten canisters, any size, per wound, per month, will be authorized unless documentation is submitted with the request to identify proof of an increased amount of supplies.

Submitting Claims

Claims must be submitted on a HCFA-1500 form using the appropriate K-codes. Health Care Financing Administration Common Procedure Coding System (HCPCS) codes K0538, K0539, and K0540 are described in Table 1.1 with maximum fees and monthly allowable amounts listed.

Table 1.1 – HCPCS Codes for NPWT

HCPCS Code	Description of Code	Maximum Fee	Maximum Monthly Allowable Units
K0538	Stationary portable electrical pump that provides controlled subatmospheric pressure	\$1707.97 per month	A maximum of one unit will be authorized per month. If more than one wound exists, use a Y-connector for the additional wound site.
K0539	Dressing set includes, but is not limited to, the following: resilient open cell foam dressing, drainage tubing, and occlusive dressing	\$27.28 per dressing set	15 per month, all sizes; per wound
K0540	Wound drainage canister	\$24.41 per canister	Ten per month, any size; per wound

Hospital Reimbursement

When the NPWT is used in a hospital, reimbursement for the NPWT is included in the hospital diagnosis-related groups (DRG) rate.

MEDICAL POLICY FACT SHEET

**TITLE: MEDICAL SUPPLIES AND EQUIPMENT:
NON-INVASIVE RESPIRATORY ASSIST DEVICES
(CPAP AND BI-PAP)**

DESCRIPTION

Non-invasive positive pressure respiratory assist devices administer positive pressure, using a nasal and/or oral mask interface, which creates a seal, avoiding the use of more invasive airway access (e.g., tracheostomy). These devices are sometimes applied to assist insufficient respiratory efforts in the treatment of conditions that may involve sleep-associated hypoventilation. It is to be distinguished from the invasive ventilation administered via a securely intubated airway, in a member for whom interruption or failure of ventilatory support would lead to the demise of the member. These devices are referred to as Respiratory Assist Devices (RAD) in this document. The three types of RAD's are continuous positive airway pressure (CPAP) devices, bi-level positive airway pressure (BiPAP) with a backup rate feature, and BiPAP without a backup rate feature.

MEDICAL TOPICS CROSS-REFERENCES

Medical Supplies and Equipment

RULES, CITATIONS, AND SOURCES

405 IAC 5-2-17 Medically Reasonable and Necessary Service Defined

405 IAC 5-19 Medical Supplies and Equipment

Indiana Health Coverage Programs 1999 Provider Manual

Indiana Health Coverage Programs Provider Bulletin BT 200042

Region B DMERC Supplier Manual Rev. 2, March 1995; Continuous Positive Airway Pressure System

Region B DMERC Supplier Manual Rev. 20, December 1999; Respiratory Assist Devices

Region B DMERC Supplier Bulletin, June 2000, 00-02; Continuous Positive Airway Pressure Devices

Indiana Health Coverage Programs Provider Bulletin BT200401

Indiana Health Coverage Programs Provider Newsletter NL200405

ORIGINATION, REVISIONS, AND REVIEWS

Origination Date: 12/31/00

Revisions and Reviews	Reason	Date
Revision	BT200401	4/30/04
Revision	NL200405	5/15/04

APPLICABLE INDIANA A1M EDITS AND AUDITS:

6080

COVERAGE CRITERIA:**Continuous Positive Airway Pressure System (CPAP) Coverage Criteria**

CPAP is covered for members with a diagnosis of obstructive sleep apnea with documentation of at least 30 episodes of apnea, each lasting a minimum of 10 seconds, during 6 to 7 hours of recorded sleep (i.e., a polysomnogram).

If 30 or more episodes of apnea are documented during less than six hours of sleep (e.g., 35 episodes in four hours), that would also meet coverage criteria. However, it is not possible to extrapolate results if fewer than 30 episodes are observed over a shorter period. For example, if 20 episodes of apnea are observed during three hours of sleep, coverage criteria would not be met (i.e., it cannot be assumed that in this situation 40 episodes would have occurred if testing had been conducted during six hours of sleep).

CPAP is covered when used in members with a diagnosis of moderate or severe obstructive sleep apnea, for whom surgery is a likely alternative to CPAP.

Copies of the member's sleep lab evaluation, including a polysomnogram, must be retained in the physician's record.

The current rental maximum fee for CPAP rental is \$122.25 per month. Accessories (except humidifiers, which will be billed separately) will be included in the rental reimbursement rate.

K0532 and K0533 Coverage Criteria**Initial Coverage Criteria for K0532 and K0533 (First Three Months of Rental)**

1. Non-Invasive Positive Pressure Respiratory Assist (NPPRA) devices will be covered only if medical necessity is documented.
2. Coverage will be considered when the physician's documentation includes a statement that the member is experiencing symptoms of sleep associated

hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.

A respiratory assist device (K0532 and K0533), used to administer NPPRA therapy is covered for those members with clinical disorder groups characterized as: (a) restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities), (b) severe chronic obstructive pulmonary disease (COPD), (c) central sleep apnea (CSA), or (d) obstructive sleep apnea (OSA) (K0532 only), and who meet the following criteria:

(a) Restrictive Thoracic Disorders:

- 1) There is documentation in the member's medical record of a progressive neuromuscular disease (for example, amyotrophic lateral sclerosis), or a severe thoracic cage abnormality (for example, post-thoracoplasty for tuberculosis), **AND**
- 2) An arterial blood gas PaCO₂, done while awake and breathing the member's usual FIO₂, is greater than or equal to 45 mm Hg, **OR**

Sleep oximetry demonstrates oxygen saturation of less than or equal to 88%, done while breathing the member's usual FIO₂, **OR**

For a progressive neuromuscular disease only, maximal inspiratory pressure is less than 60 cm H₂O or forced vital capacity is less than 50% predicted, **AND**

- 3) Chronic pulmonary disease does not contribute significantly to the member's pulmonary limitation.

If all of the above criteria are met, either a K0532 or K0533 device (based upon the judgment of the treating physician) will be covered for members within this group of conditions for the first three months of NPPRA therapy.

(See below for continued coverage after the initial three months.) If all of the above criteria are not met, then K0532 and K0533 will be denied as not medically necessary.

(b) Severe COPD:

- 1) An arterial blood gas PaCO₂, done while awake and breathing the member's usual FIO₂, is greater than or equal to 52 mm Hg, **AND**

Sleep oximetry demonstrates oxygen saturation less than or equal to 88%, done while breathing oxygen at 2 LPM or the member's usual FIO₂ (whichever is higher), **AND**

- 2) Prior to initiating therapy, obstructive sleep apnea (OSA) and treatment with CPAP has been considered and ruled out.

If all of the above criteria for members with COPD are met, a K0532 device will be covered for the first three months of NPPRA therapy. (See below for continued coverage after the initial three months.)

A K0533 device will usually not be covered for a member with COPD during the first two months, because therapy with a K0532 device with proper adjustment of the device's settings and member accommodation to its use will usually result in sufficient improvement without the need of a back up rate. (See below for coverage of a K0533 device for COPD after two months use of a K0532 device.)

If all of the above criteria are not met, K0532 and related accessories will be denied as not medically necessary.

(c) Central Sleep Apnea (i.e., apnea not due to airway obstruction):

Prior to initiating therapy, a complete facility-based, attended polysomnogram must be performed documenting the following:

- 1) The diagnosis of central sleep apnea (CSA), **AND**
- 2) The exclusion of obstructive sleep apnea (OSA) as the predominant cause of the sleep-associated hypoventilation, **AND**
- 3) The ruling out of CPAP as effective therapy if OSA is a component of the sleep-associated hypoventilation, **AND**
- 4) Oxygen saturation less than or equal to 88%, done while breathing the member's usual FIO₂, **AND**
- 5) Significant improvement of the sleep-associated hypoventilation with the use of a K0532 or K0533 device on the settings that will be prescribed for initial use at home, while breathing the member's usual FIO₂.

If all of the above criteria are met, either a K0532 or K0533 device (based upon the judgment of the treating physician) will be covered for members with documented CSA conditions for the first three months of NPPRA therapy. (See below for continued coverage after the initial three months.) If all of the above criteria are not met, then K0532 and K0533 and related accessories will be denied as not medically necessary.

(d) Obstructive Sleep Apnea:

- 1) A complete facility-based, attended polysomnogram has established the diagnosis of obstructive sleep apnea, **AND**

A single level device (E0601 = CPAP) has been tried and proven ineffective.

If the above criteria are met, a K0532 device will be covered for the first three months of NPPRA therapy. (See below for continued coverage after the initial three months.) If all of the above criteria are not met, K0532 and related accessories will be denied as not medically necessary.

A K0533 device is not medically necessary if the primary diagnosis is OSA.

Continued Coverage beyond the First Three Months of Therapy

Members covered for the first three months of a K0532 or K0533 device must be re-evaluated to establish the medical necessity of continued coverage by Indiana Health Coverage Programs (IHCP). While the member may need to be evaluated at earlier intervals after the initiation of therapy, the re-evaluation upon which IHCP will base a decision to continue coverage beyond this time must occur within 61 to 90 days of initiating therapy. There must be documentation in the member's medical record about the progress of relevant symptoms and member usage of the device up to that time. Failure of the member to consistently use the K0532 or K0533 device for an average of four hours per 24-hour period by the time of the 61 to 90 day re-evaluation would represent non-compliant utilization for the intended purposes and expectations of benefit of this therapy. This would constitute reason for IHCP to deny continued service as not medically necessary.

Aside from the above documentation in the member's medical record, the following must be obtained by the device supplier for continuation of coverage (beyond the initial three months):

Documentation signed and dated by the treating physician no sooner than 61 days after initiating use of the device, declaring that the member is compliantly using the device (an average of four hours per 24-hour period) and that the member is benefiting from its use.

The required documentation must be submitted with the request for prior authorization for continued service.

Criteria for Coverage of a K0533 Device for Severe COPD after Two Months Use of a K0532 Device

1. Arterial blood gas PaCO₂ repeated no sooner than 61 days after initiation of compliant use of K0532, done while awake and breathing the member's usual FIO₂, still remains greater than or equal to 52 mm Hg, **AND**

2. Sleep oximetry repeated no sooner than 61 days after initiation of compliant use of K0532 device, and while breathing with the K0532 device, demonstrates oxygen saturation less than or equal to 88%, done while breathing oxygen at 2 LPM or the member's usual FIO₂ (whichever is higher), **AND**

A signed and dated statement from the treating physician, completed no sooner than 61 days after the initiation of the K0532 device, declaring that the member has been compliantly using the K0532 device [an average of four hours per 24-hour period] but the member is **NOT** benefiting from its use, **AND** stating that the physician feels that the member meets the listed criteria for a K0533 device.

If the above criteria for the K0533 device are not met, it will be denied as not medically necessary.

Criteria for Coverage of E0561 and E0562 for Humidifiers

This coverage criteria is effective 5/15/04.

1. E0561 and E0562 for use with a non-invasive respiratory assistive device (RAD) will be considered for coverage only when physician documentation supports the medical necessity of the humidifier. Documentation must indicate that the member is suffering from nosebleeds, extreme dryness of the upper airways, or other conditions that interfere with compliance or use of the RAD, and that the humidifier could improve this condition. Prior authorization is required.
2. A non-heated (E0561) or a heated (E0562) humidifier will be covered for use with a RAD (codes E0601, K0532, and K0533), when ordered by a physician, based on medical necessity, subject to prior authorization.
3. E0561 and E0562 are inexpensive and routinely purchased items available for purchase only. They are single-patient use items. A rental trial is no longer required before purchase of non-heated or heated humidifiers.

Definitions

Non-Invasive Positive Pressure Respiratory Assist (NPPRA) devices administer positive air pressure, using a nasal and/or oral mask interface, which creates a seal, avoiding the use of more invasive airway access (e.g., tracheostomy). It may sometimes be applied to assist insufficient respiratory efforts in the treatment of conditions that may involve sleep-associated hypoventilation. It is to be distinguished from the invasive ventilation administered via a securely intubated airway, in a member for whom interruption or failure of ventilatory support would lead to imminent demise of the member. These devices are also referred to as Respiratory Assist Devices (RAD) in this document. Three types of RAD's include CPAP, BiPAP with the backup rate feature, and BiPAP without the backup rate feature.

A continuous positive airway pressure device (CPAP) provides air pressure by means of a nose mask and flow generator system to prevent collapse of the oropharyngeal walls during sleep. Code E0601 is used for a device with a single delivered pressure. Code K0183 describes (a) a nasal mask and exhalation port or (b) nasal pillow / seal system.

A respiratory assist device (RAD) without backup rate (K0532), also known as BiPAP, delivers adjustable, variable levels (within a single respiratory cycle) of positive airway pressure by way of tubing and a non-invasive interface (such as a nasal or oral facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs (i.e., NPPRA).

A respiratory assist device (RAD) with backup rate (K0533), also known as BiPAP, delivers adjustable, variable levels (within a single respiratory cycle) of positive air pressure by way of tubing and a non-invasive interface (such as a nasal or oral facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs (i.e., NPPRA). In addition, it has a timed backup feature to deliver this air pressure whenever spontaneous inspiratory efforts fail to occur.

Polysomnography is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six or more hours with physician review, interpretation, and report. It must include sleep staging which is defined to include a one- to four-lead electroencephalogram (EEG), and electro-oculogram (EOG), and submental electromyogram (EMG). It must also include at least the following parameters of sleep: airflow, respiratory effort, and oxygen saturation by oximetry. For the purpose of this policy, polysomnographic studies must be performed in a sleep study laboratory, and not in the home or in a mobile facility. Testing must comply with all applicable state regulatory requirements.

FIO₂ is the fractional concentration of oxygen delivered to the member for inspiration. For the purpose of this policy, the member's "usual FIO₂" refers to the oxygen concentration the member normally breathes when *not* undergoing testing to qualify for coverage of NPPRA therapy. That is, if the member does not normally use supplemental oxygen, their usual FIO₂ is that found in room air. For the purpose of this policy, a DME supplier may not perform arterial blood gas, sleep oximetry, and polysomnographic studies.

Reasons for Noncoverage

Respiratory assist devices are non-covered if the member does not meet the criteria for coverage if the member is not eligible at the time of service, or if prior authorization has not been obtained prior to the provision of service when prior authorization is required.

HCPCS Codes

K0183-K0189 are RAD (CPAP or BiPAP) accessories and will be reimbursed according to the limitations outlined below when the RAD is member owned. Otherwise, the cost

of the accessories is included in the rental reimbursement rate. K0532 and K0533 will be rented on a frequent and substantial servicing basis, i.e., ongoing rental. E0561 and E0562 are inexpensive and routinely purchased items available for purchase only.

K0183-Nasal application device; maximum of one unit per three months

K0184-Nasal pillows/seals, replacement for nasal application device, per pair; maximum of two units per one month

K0185-Headgear, used with positive pressure RAD; maximum of one unit per six months

K0186-Chin strap; maximum of one unit per six months

K0187-Tubing; maximum of one unit per one month

K0188-Filter, disposable; maximum of two units per one month

K0189-Filter, non-disposable; maximum of one unit per six months

E0561-Humidifier, non-heated, used with positive pressure airway device

E0562-Humidifier, heated, used with a positive pressure airway device

K0532-Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)—BiPAP without backup rate

K0533-Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)—BiPAP with backup rate

E0601-Continuous positive airway pressure (CPAP) device

Approved 1/24/01

MEDICAL POLICY FACT SHEET

**TITLE: MEDICAL SUPPLIES AND EQUIPMENT—
PATIENT-ACTIVATED EVENT RECORDER—
IMPLANTABLE LOOP RECORDER (ILR)**

DESCRIPTION:

The insertable loop recorder (ILR) is a fully implantable patient-activated event recorder used to record the heart's rate and rhythm at the time of a syncopal event. The information provided by the device, in the form of an electrocardiogram (EKG), can be used by physicians to identify, or rule out, an irregular heartbeat as the cause of such events.

The Indiana Health Coverage Programs (IHCP) covers the patient-activated event recorder—ILR for use after a syncopal event. The device may be implanted at any of three places of service including inpatient, outpatient, or physician's office. The device may not be implanted in the same member more often than every two years or 24 months. The recorder activator is furnished with the system and is not separately reimbursed.

COVERAGE CRITERIA

The following information includes coverage criteria for an ILR:

- The ILR device is covered only if a definitive diagnosis has not been made after meeting **all** of the following conditions.
 - Complete history and physical examination
 - Electrocardiogram (ECG)
 - Two negative or non-diagnostic 30-day pre-symptom memory loop patient demand recordings (may be either single or multiple event recordings, with or without 24-hour attended monitoring)
 - Negative or non-diagnostic tilt table testing
 - Negative or non-diagnostic electrophysiological testing
- The patient must be capable of activating the hand-held telemetry unit
- The ILR device is not covered for the following.
 - Patients with presyncopal episodes
 - Patients failing to fulfill the indications for coverage in this policy
 - Patients for whom compliance or lifestyle make use of the external monitoring systems inappropriate

- Removal of an ILR on the same day as the insertion of a cardiac pacemaker is considered to be part of the pacemaker insertion procedure and is not reimbursed separately.
- The ILR is only covered for a given patient in any two-year time period (24 months).
- ECG analyses obtained during device insertion for signal quality and amplification purposes are considered part of the implant procedure and are not reimbursed separately.

Device Monitoring

The Current Procedure Terminology CPT code for analysis of information collected by the recorder is 93727, *Electronic analysis of implantable loop recorder (ILR) system (includes retrieval of recorded and stored ECG data, physician review and interpretation of retrieved ECG data and reprogramming)*, and should be billed only subsequent to the date of insertion. Initial analysis and monitoring is included in the fee for insertion; therefore, CPT code 93727 may not be billed on the date of insertion. The programmer used to program the ILR, retrieve, display, and print stored data is furnished to the physician, but remains the property of the manufacturer.

PRIOR AUTHORIZATION

Neither the implantation of the device nor the patient-activated event recorder—ILR requires prior authorization (PA), but will be subject to retrospective review according to IHCP criteria. If a replacement recorder activator is needed, PA is required.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in Medicaid Select PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the Medicaid Select Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

These procedure codes have a 90-day global postoperative care designation for which care related to the surgical procedure is not separately reimbursable unless such care is non-routine (e.g. treatment of complications).

- CPT code 33282, *Implantation of patient-activated cardiac event recorder*, is used for the implantation of an ILR.
- CPT code 33284, *Removal of an implantable, patient-activated cardiac event recorder*, is used for the removal of this device.

If the procedure is performed when the patient is an inpatient for a related problem, submit a UB-92 using the International Classification of Diagnoses Ninth Edition (ICD 9-CM) code 780.2, *Syncope and collapse*, as one of the diagnosis codes on the claim form. If the procedure is performed as an outpatient, submit a UB-92 using revenue code 360, *Operating Room Services* and the CPT code 33282 for implantation. The device itself should be billed on a CMS-1500 using code E0616, *Implantable cardiac event recorder with memory, activator and programmer* and 780.2, *Syncope and collapse* as the primary diagnosis code. Use CPT code 33284 with revenue code 360 to bill for removal of the device. Physician's charges for the surgery should be billed on a HCFA-1500.

If the procedure is performed in a physician's office, the physician should bill 33282 for implantation and E0616 for the device on the HCFA-1500. **Table 1.1, Place of Service Codes** illustrates coding for each place of service:

Table 1.1 – Place of Service Codes

	Inpatient	Outpatient	Physician's Office
Type of Claim	UB-92	UB-92 (and HCFA-1500 if billing for device)	HCFA-1500
ICD-9-CM Diagnosis Code	780.2 – Syncope and Collapse	780.2 – Syncope and Collapse	780.2 – Syncope and Collapse
Revenue and CPT Codes	Revenue code-360 CPT code not necessary	Revenue code-360 CPT code-33282 for insertion CPT code-33284 for removal	Revenue code not needed CPT code-33282 for insertion CPT code-33284 for removal
HCPCS Code	Not needed	On HCFA-1500 – E0616	E0616

Table 1.2, Loop Recorder System Implantation Codes illustrates the codes for implantation and the device. Providers must bill their usual and customary charges on the claim form. Insertion of the device carries a 90-day global surgery designation with no assistant surgeon required.

Table 1.2 – Loop Recorder System Implantation Codes	
Code	Description
33282	Implantation of patient-activated cardiac event recorder
33284	Removal of an implantable, patient-activated cardiac event recorder
93727	Electronic analysis of ILR system (includes retrieval of recorded and stored ECG data, physician review, and interpretation of retrieved ECG data and reprogramming)
E0616	Implantable cardiac event recorder memory, activator, and programmer. (The programmer is furnished by the manufacturer, to the physician, for use in the office for reading saved information in the recorder.)
E1399	Recorder activator (replacement)

RELATED MEDICAL TOPICS

Cardiology
 Hospital Inpatient
 Hospital Outpatient
 Medical Supplies and Equipment
 Physician Services
 Surgery

RULES, CITATIONS, AND SOURCES

405 IAC 5-17-1, Reimbursement; limitations
 405 IAC 5-28-1, Reimbursement; limitations

Origination Date: 10/10/01

Revisions and Review	Reason	Date
BT200114	Patient-activated Event Recorder	10/26/00
Review	Scheduled	10/31/06

APPLICABLE INDIANA AIM EDITS AND AUDITS

6124-Implantable loop recorder limited to one (1) every two years
 6152-Surgery payable at reduced amount when consultation paid days before or after surgery
 6649-Surgery payable at reduced amount when related postoperative care paid
 6653-Postoperative care within zero to 90 days of surgery
 6654-Preoperative care within one day of surgery

6655-Surgery payable at reduced amount when preoperative care paid

6656-Postoperative care within 10 days of select surgery

6657-Preoperative care on day of surgery

6658-Surgery payable at reduced amount when preoperative care paid same day of service

6659-Surgery payable at reduced amount when related postoperative care paid

MEDICAL POLICY FACT SHEET

**TITLE: MEDICAL SUPPLIES AND EQUIPMENT—
PHRENIC NERVE STIMULATOR
(BREATHING PACEMAKER)**

DESCRIPTION:

This device is an electrophrenic pacemaker for pacing of the diaphragm. It consists of an external radio frequency transmitter, an antenna, a subcutaneous radio receiver, and a bipolar platinum nerve electrode. Diaphragmatic pacing (intermittent electrical stimulation of the phrenic nerves) offers patients who need long-term ventilation, and have a functionally intact phrenic nerve and chest wall stability, freedom from mechanical ventilation.

MEDICAL TOPICS CROSS-REFERENCES:

Home Health Services
Hospital Outpatient
Hospital Inpatient
Medical Supplies and Equipment
Nursing Facilities
Physical Rehabilitation Services
Surgery

RULES, CITATIONS, AND SOURCES:

405 IAC 5-17-1 Reimbursement; limitations
405 IAC 5-17-2 Prior authorization; generally
405 IAC 5-19-8 “Durable medical equipment” or “DME” defined

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
BT200108	Phrenic Nerve Stimulator	10/26/00	10/26/00	
Revisions:				

APPLICABLE INDIANA AIM EDITS AND AUDITS:

6026
6027
6152
6653
6654
6655
6656
6657
6658
6659
6649

COVERAGE CRITERIA:**Patient Selection**

The primary objective of implanting the phrenic nerve stimulator is to allow the member to return to a home environment from a skilled nursing facility and be more independent. Therefore the following criteria are mandatory for prospective candidates requesting this device:

Functional lungs and diaphragm muscle

Absence of infection

A clear and adequate upper airway (including nasopharynx, pharynx, larynx)

Family support that includes an unpaid, physical care giver of adequate quality and the availability of nursing and medical care

Medical Review Documentation

Prior authorization for medical necessity is required for this device and its implantation. The equipment is costly and requires preoperative testing of the components and thorough education of the member and his or her caregivers concerning its use.

Medical Policy Criteria

1. Members who qualify for this device will demonstrate life-threatening oxygen depletion when respiration is unassisted.
2. For stable, non-acute quadriplegics and other spinal cord or brain stem injured members [ICD-9-CM 344(00-09) diagnosis codes] all of the following criteria must be met:
 - Patient is oriented to name, date, and place.
 - Patient's mobility will be improved. Patient will be able to be out of bed and be mobile per wheelchair, which may include employment or attending school.

- Increased mobility will allow the patient to function without interference of large equipment.
- Patient's skin integrity will be better maintained because of increased mobility.
 - Patient has capacity to be productive. He or she will more easily perform cognitive tasks within physical limitations.
 - Patient will be better able to eat and swallow.
3. For nonobstructive (or central) sleep apnea (ICD-9-CM 780.51, 780.53 diagnosis codes) only when other treatments have failed, and the following criteria must be met:
- The requesting physician will present sleep studies demonstrating life-threatening respiratory cycles when the patient is asleep.
 - The member must have a diagnosis of central sleep apnea and have failed to maintain an appropriate PO₂ level (oxygen partial pressure) with continuous positive air pressure (CPAP) and bi-level continuous positive airway pressure (BiPAP) treatments.
 - Documentation by a specialist in otolaryngology or pulmonology of treatment attempts will accompany the prior authorization request.
 - The breathing pacemaker should **never** be recommended for treatment of obstructive sleep apnea.
4. Documentation indicating medical necessity for the appropriate diagnosis will be submitted **prior to** surgical implantation of the stimulator wires.

Device Monitoring

Medical device tracking regulations of the U.S. Food and Drug Administration require that the manufacturer of the device be notified when the following occurs:

Diaphragm pacing system is implanted,

Diaphragm pacing receiver or electrode is explanted, (date, name, mailing address, and telephone number of the explanting physician are to be included)

Diaphragm pacing patient dies,

Diaphragm pacing device is returned

Diaphragm pacing device is permanently retired from use or otherwise permanently discarded.

Coding and Billing Instructions

For inpatient billing of the **implantation of the device**, the appropriate diagnosis-related grouping (DRG) will be used. The claim for the **device** must be submitted as a durable medical equipment (DME) item on a HCFA-1500 claim form. When the device is implanted as an outpatient procedure, the **revenue code 360** with **CPT code 33282** should be used on the UB-92 claim form and the device billed as a DME item on a HCFA-1500 claim form. The decision for either outpatient or inpatient status is made by

the physician and determined by the assessment of complicating factors and their severity at the time the procedure is planned. The hospital providing the equipment for implantation must have a DME provider number.

Table 1.1 provides the CPT codes and description information to use when submitting claims either as an inpatient or outpatient.

Table 1.1 – CPT Codes for Inpatient and Outpatient Claims

CPT/HCPCS Code	Description	Current Pricing
64577	Incision for implantation of neurostimulator electrodes; autonomic nerve	RBRVS- \$207.72 ASC 1- \$337.08
64585	Revision or removal of peripheral neurostimulator electrodes	RBRVS- \$83.62 ASC A- \$348.20
95970	Initial programming	Included in initial fee
95974	Intraoperative or subsequent programming, first hour	Included in initial fee, provided by manufacturer at the time of implant then per telephone for life of the power source at no cost to the member.
Z5108	Implantable neurostimulator pulse generator	Max Fee \$58,299
Z5109	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	Max Fee \$37,967

Prior Authorization

Prior authorization (PA) is required for this device and its implantation whether implanted as an inpatient or an outpatient. One or more of the following *ICD-9-CM* diagnosis codes must be used when submitting requests for PA. Members with these diagnoses who are ventilator dependent and have a tracheostomy due to partial or complete respiratory insufficiency are considered candidates for this device subject to review.

- 344.0-344.9 includes quadriplegia and quadraparesis of all types
- 780.51 and 780.53—nonobstructive sleep apnea
- 786.09—congenital respiratory abnormalities, other

MEDICAL POLICY FACT SHEET

TITLE	MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT – MANUAL WHEELCHAIRS, MOTORIZED/POWER WHEELCHAIRS, AND POWER OPERATED VEHICLES
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DESCRIPTION

The Indiana Health Coverage Programs (IHCP) will provide reimbursement for a manual wheelchair, motorized/power wheelchair, or power operated vehicle (POV) when medically necessary for IHCP members with prior authorization (PA). Certain medical criteria must be met for the approval of each piece of equipment. The IHCP will only reimburse for one wheelchair or POV per member, per five year period.

This document is intended to serve as a general summary of the IHCP policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

Manual Wheelchairs

The IHCP will reimburse a manual wheelchair, when medically necessary, subject to PA. Requests for manual wheelchairs require that a completed medical clearance form be submitted with the PA request.

Motorized/Power Wheelchairs

According to the Indiana Administrative Code (IAC) 405 IAC 5-19-9, “motorized vehicles are covered only when the recipient is enrolled in a school, sheltered workshop, or work setting, or if the recipient is left alone for significant periods of time. It must be documented that the recipient can safely operate the vehicle and that the recipient does not have the upper extremity function necessary to operate a manual wheelchair.”

A member who requires a motorized/power wheelchair is usually nonambulatory and has severe weakness of the upper extremities due to a neurologic or muscular disease or condition and would otherwise be confined to a bed or chair without the use of the power wheelchair. A power wheelchair is covered if the member’s condition is such that the requirement for a power wheelchair is long term (at least six months).

POVs

The IHCP will reimburse a POV, such as a scooter, subject to PA, for members who are unable to operate a manual wheelchair and who have adequate trunk stability to safely operate the vehicle. A POV should be considered when the member does not require the full support or features that are provided by a power wheelchair. POVs are not covered by the IHCP when needed for use outside the home only, or to allow the member to perform leisure or recreational activities. Therefore, POVs that are designed, by size and features, primarily for outdoor use, will be denied as not medically necessary.

Reimbursement for manual and motorized/power wheelchairs includes all labor charges involved in the assembly of the wheelchair. Reimbursement of manual and power/motorized wheelchairs and POVs also includes emergency services, delivery, setup, and items covered under a warranty. See the Medical Supplies and Durable Medical Equipment Overview fact sheet for further information regarding reimbursement of labor, repairs, and replacement of durable medical equipment for wheelchairs. The IHCP will provide reimbursement for one manual wheelchair, motorized/power wheelchair, or POV per five year period. Any wheelchair designated for use as a backup will be denied as not medically necessary.

PRIOR AUTHORIZATION**Manual Wheelchairs**

- Providers must submit a PA request and an IHCP Non-Motorized Wheelchair Medical Clearance form signed by a physician that documents the member's condition, mobility needs, and/or prognosis to support the medical necessity for a manual wheelchair. Documentation of medical necessity must be maintained in the member's medical records.

Motorized/Power Wheelchairs

- For a motorized/power wheelchair to be considered for coverage, the information submitted with the PA must be supported by documentation in the member's medical record that medical necessity has been met.
- A completed IHCP Motorized Wheelchair Purchase Medical Clearance Form must be submitted with the PA request for rental or purchase of a motorized/power wheelchair. The medical clearance form must be reviewed and signed by a physiatrist.
- The member's physician may prescribe a motorized/power wheelchair. However, the medical necessity must be reviewed and the medical clearance form must be approved and signed by a physiatrist prior to the form being submitted to the PA department. A member is only required to see the physiatrist if the physiatrist requests to see the member after a review of the documentation. If a physiatrist requests to see a member after reviewing the documentation, the member would

then be required to visit the physiatrist. Providers should note that if the physiatrist does not choose to see the member for an evaluation, the IHCP will not provide reimbursement to the physiatrist for the chart review.

POVs

- A completed IHCP Motorized Wheelchair Purchase Medical Clearance Form signed by a physician must be submitted with the PA request form that documents the member's condition, mobility needs, and/or prognosis to support the medical necessity for a POV.
- Documentation must indicate the member's condition that renders them unable to operate a manual wheelchair.
- Documentation must also indicate the member is capable of safely operating a POV, can transfer in and out of a POV, and has adequate trunk stability to safely ride in and operate the POV.

CODING

Manual Wheelchairs

The IHCP will reimburse for both standard and nonstandard manual adult wheelchairs and for manual pediatric wheelchairs. Manual pediatric wheelchairs are billed using HCPCS codes E1229 and E1231-E1238.

A standard adult wheelchair is defined as a wheelchair with a base that weighs greater than 36 lbs, with seat dimensions of 16"-18" wide, 16" deep, and greater than 19" and less than 21" in height. A standard wheelchair includes a non-adjustable back height of 16"-17", fixed or detachable arm rests, fixed or detachable foot rests, and footplate extensions of 16"-21".

A nonstandard adult wheelchair is a wheelchair base other than a standard wheelchair or custom wheelchair. Nonstandard wheelchair bases include, but are not limited to the following; fully-reclining, hemi, lightweight, ultra lightweight, high strength lightweight, semi-reclining, amputee, heavy duty, wide heavy duty, extra heavy duty, tilt-in-space, and motorized/power wheelchairs. **Table 1** lists the range of HCPCS codes available for reporting standard and nonstandard manual wheelchairs.

Table 1 – Manual Wheelchair Codes

Code Range	Description
E1130-E1160 & E1221-E1224	Standard Manual Wheelchairs
E1031-E1039	Rollabout and Transport Chairs
E1050-E1070	Fully Reclining Wheelchairs
E1083-E1086	Hemi-Wheelchairs
E1087-E1090	High Strength Lightweight Wheelchairs

Table 1 – Manual Wheelchair Codes

Code Range	Description
E1092-E1093	Wide Heavy-Duty Wheelchairs
E1100-E1110	Semi-Reclining Wheelchairs
E1161	Tilt-in-Space Wheelchair
E1170-E1200	Amputee Wheelchairs
E1240-E1270	Lightweight Wheelchairs
E1280-E1295	Heavy-Duty Wheelchairs

Motorized/Power Wheelchairs

The IHCP will reimburse claims for adult sized motorized/power wheelchairs using HCPCS codes K0010 through K0014 and pediatric-sized power wheelchairs using HCPCS code E1239. See **Table 2** below for a description of the “K” codes for adult-sized motorized/power wheelchairs.

Table 2 – Codes for Motorized/Power Wheelchairs

Code	Description
E1220	Wheelchair; specially sized or constructed (indicate brand name, model number, if any, and justification)
E1239	Power wheelchair, pediatric size, not otherwise specified
K0010	Standard-weight frame motorized/power wheelchair
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control, and braking
K0012	Lightweight portable motorized/power wheelchair
K0014	Other motorized/power wheelchair base

POVs

POVs should be billed using HCPCS code E1230, *Power operated vehicle (three or four wheel nonhighway)*, specify brand name and model number. E1230 is reimbursed at the IHCP’s allowable rate. Specially constructed POV’s for members greater than 300 pounds is to be billed using HCPCS code E1220. Providers should submit their usual and customary charge on the CMS 1500 or 837P electronic claim.

BILLING**Manual and Motorized/Power Wheelchairs**

Providers should determine which HCPCS code listed in **Tables 1 and 2** is most appropriate to use, based on the *Wheelchair Product Classification List*, published by Medicare’s Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC). Providers are encouraged to periodically review this list for updates. If a specific wheelchair base is not shown on the *Wheelchair Product Classification List*, providers are advised to select the most appropriate code that describes the product provided. Providers should bill the wheelchair base code and any reimbursable modifications or upgrades on the CMS-1500 and/or 837P electronic claim.

PER DIEM

Standard wheelchairs are included in the per diem for facilities that are reimbursed on a per diem basis. Standard wheelchairs with custom features require prior authorization and will be reviewed on a case-by-case basis for payment outside the facility per diem. Nonstandard wheelchairs, motorized/power wheelchair, and POVs are not included in the facility per diem rate and are separately reimbursable by the IHCP.

MANAGED CARE

Primary Care Case Management (PCCM) services are subject to the same policies and restrictions as Traditional Medicaid services. Questions regarding coverage of services in Risk Based Managed Care (RBMC) should be directed to the appropriate Managed Care Organization (MCO).

RELATED MEDICAL TOPICS

Medical Supplies and Durable Medical Equipment - Overview

Medical Supplies and Durable Medical Equipment - Wheelchair Accessories

RULES, CITATIONS, AND SOURCES

405 IAC 5-19-9

Indiana Health Coverage Programs Provider Manual 2003

Indiana Health Coverage Programs Provider Manual 2005

Indiana Health Coverage Programs Newsletter NL200402

Indiana Health Coverage Programs Bulletin BT200335

Origination Date 7/25/97

Revision and Review	Reason	Date
405 IAC 5-19-9	Wheelchairs and similar motorized vehicles	07/25/1997
BT200335	Motorized/Power Wheelchairs and Programmable Electronics Bulletin	07/18/2003
2005 Provider Manual	Manual Wheelchair and Motorized/Power Wheelchair Revisions	10/30/2005
NL200402	Physiatrist Review of the Motorized/Power Wheelchair Medical Clearance Form	

APPLICABLE INDIANA AIM EDITS AND AUDITS

- 6065 – DME total rental amount not to exceed fee for purchase
- 6082 – Nursing facility visits vs DME services
- 6080 – DME rentals limited to 15 months
- 6096 – The CPT/HCPCS code billed is not payable
- 6104 – DME rental from chiropractor of more than 1 month
- 6113 – DME limited to \$2,000 per recipient per calendar year
- 6114 – DME limited to \$5,000 per recipient per lifetime

MEDICAL SUPPLIES AND EQUIPMENT - POWER WHEELCHAIRS ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Medical Supplies and Equipment – Power Wheelchairs Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200533 **Publication Date:** 08/16/2005

Subject: Adjustable and Nonadjustable Seat Cushions

Date Added to Manual: 10/31/2005

Text of Publication

Currently, providers bill both adjustable and nonadjustable seat cushions using the same HCPCS codes. Adjustable cushions have all of the characteristics of a skin protection seat cushion (E2603 and E2604) or skin protection and positioning seat cushion (E2607 and E2608); however, they are also adjustable. Adjustments are made by adding or removing significant quantities of air, liquid, gel, or other fluid medium in physiologically appropriate areas of the cushion to promote pressure reduction.

New, more descriptive, procedure code and modifier combinations (PICS) have been developed for billing adjustable seat cushions. Medicare currently utilizes 4 definitions for adjustable seat cushions, each billed with procedure code K0108. The IHCP has mirrored this policy by creating 4 PICS with unique definitions for each type of adjustable seat cushion. The new coding and pricing information for adjustable seat cushions is listed in Table 1 below, and will be effective September 30, 2005. The coding and fee schedule for all other wheelchair seat cushions will remain the same.

Table 1 – Adjustable Seat Cushion Codes Effective September 30, 2005

Adjustable cushions are purchase only items. Providers must attach the NU modifier when billing adjustable seat cushions. The adjustable cushions do not have to be listed on the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) classification list in order to be reimbursed by the IHCP.

Code	Description	Pricing
K0108 U1 NU	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches	\$330.81
K0108 U2 NU	Skin protection wheelchair seat cushion, adjustable, width greater than or equal to 22 inches	\$389.54
K0108 U3 NU	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches	\$378.68
K0108 U4 NU	Skin protection and positioning wheelchair seat cushion, adjustable, greater than or equal to 22 inches	\$435.56

MEDICAL POLICY FACT SHEET

**TITLE: MEDICAL SUPPLIES AND EQUIPMENT—
PROGRAMMABLE HEARING AIDS**

DESCRIPTION:

Programmable hearing aids are hearing aids that are pre-programmed specifically based upon the member's hearing loss. Most programmable aids can accommodate from one to seven pre-programmed settings at a time. The device easily adjusts to the type of noise, when a member enters into a different sound environment. It can also be re-programmed to make adjustments to the sound quality. In addition, programmable hearing aids offer advantages over conventional devices such as, better sound quality, flexibility, and better clarity of speech because they are custom programmed specifically to a member's hearing loss. Programmable hearing aids usually would be considered a comfort/convenience and not medically reasonable or necessary. However, in certain circumstances, the devices are supported by medical necessity. Programmable hearing aids require prior authorization (PA).

Indiana Health Coverage Programs (IHCP) provides coverage for programmable hearing aids based on the criteria described in this policy. The device would be classified as a customized item with the IHCP. Customized equipment is defined as equipment uniquely constructed or substantially modified to meet the specific needs of an individual member. The IHCP Provider Manual, Chapter 8, section 3 provides information regarding durable medical equipment and hearing aids coverage and billing procedures.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

Programmable hearing aids will only be prior authorized when medically necessary. Documentation must include the significant, objective benefit to the member. Coverage may be considered for the specific instances noted on the following page.

- Fluctuating hearing loss (Meniere's disease, autoimmune sensorineural hearing loss, otogenic syphilis, large vestibular aqueduct syndrome and other entities resulting in fluctuant hearing loss)
- Progressive hearing loss (Meniere's disease, Alport's syndrome, and other entities resulting in progressive hearing loss. A retrocochlear hearing loss must be excluded, particularly when the loss is asymmetrical)
- Severe recruitment or very narrow dynamic range
- Very young children who are hard to test or hard to fit
- Member's with hearing loss with unusual audiometric configurations

Documentation Requirements

The PA request must be accompanied with the following documentation.

- A completed IHCP Medical Clearance and Audiometric Test (IHCP MCAT) form. The MCAT form reflects current policy for all types of hearing aids and can be located on the IHCP website at www.indianamedicaid.com. Medical necessity for programmable hearing aids must be clearly documented in the sections entitled, "Recommendation Information" and/or "Special Conditions" on page two of the IHCP MCAT form
- A record of the audiogram obtained not more than three months from the date of the request
- An otological examination report, signed by the physician, that includes the medical etiology and diagnosis for the hearing loss
- A diagnosis that supports the medical necessity must be included on the PA request and on the claim form for programmable hearing aids
- A documented case history should include at least the following information regarding the member's needs and life style
 - a. The past history of hearing aid use
 - b. The reason programmable hearing aid(s), rather than conventional hearing aid(s), would be medically necessary
 - c. A description of the hearing environment(s) in which the member has trouble hearing and to which the member is subjected. The frequency and duration of exposure to these environments should also be included
 - d. Documentation of any other factors, such as lack of normal dexterity, should be included
 - e. Documentation must be provided that supports medical necessity of the programmable hearing aids outside of vocational needs

Programmable hearing aids may be authorized for monaural amplification (one ear) or for binaural amplification (two ears). The Indiana Administrative Code (IAC) 405 IAC 5-19-13 (5), *Hearing aids; purchase* mandates, binaural aids and CROS-type aids will be authorized only when significant, objective benefit to the recipient can be documented. Hearing aids come in a variety of models and styles, therefore, prices vary depending upon not only the hearing aid model and style, but also upon the degree of hearing loss

and the special options chosen to personalize the instrument. Documentation should support the number of pre-programmed settings requested. Only the least costly alternative to meet the member's medically necessary hearing aid needs will be approved. Any PA request that does not or questionably meets criteria must be referred to a consultant for review.

Additionally, some programmable aids may also be digital programmable aids. Digital aids are typically much higher in cost than aids with analog sound. Research indicates that digital aids improve sound quality over an analog aid much like a compact disc (CD) improves the sound quality of a recording compared to a cassette tape. This would not likely be medically necessary and should be denied as a comfort item as mandated in 405 IAC 5-29-1(5). The medical necessity requirement may be attained utilizing a more basic hearing aid, whether conventional or programmable.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in Medicaid Select PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the Medicaid Select Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

Coding and Reimbursement

Programmable hearing aids should only be approved using Healthcare Common Procedure Coding System (HCPCS) code V5299, *Hearing service, miscellaneous*. Utilizing the miscellaneous code for programmable hearing aids will allow the aid to be manually priced, since the cost for the aids may vary greatly. Conventional hearing aids should only be approved using the following HCPCS codes.

- V5050, *Hearing aid, monaural, in the ear*
- V5060, *Hearing aid, monaural, behind the ear*
- V5130, *Binaural, in the ear*
- V5140, *Binaural, behind the ear*

Unlike HCPCS codes V5130 and V5140 in which one unit is equal to two aids, one unit of V5299 is equal to one programmable aid. However, if medical necessity is met for binaural aids, two units may be approved.

Reimbursement is made at the lesser of 130% of the manufacturer's cost invoice amount or the provider's usual and customary fee. A manufacturer's cost invoice is required for reimbursement. HCPCS code V5299 does not specifically describe programmable hearing aids; therefore, other items may occasionally be requested under this code. Providers should report the most appropriate code that describes the service provided, but on an infrequent basis, it may be necessary to approve other services under this miscellaneous code. All IHCP providers are responsible for verifying if a product or service requires additional licensure under Home Medical Equipment (HME).

RELATED MEDICAL TOPICS

Medical Supplies and Equipment
Prior Authorization

RULES, CITATIONS, AND SOURCES

405 IAC 5-3, *Prior Authorization*
405 IAC 5-19, *Medical Supplies and Equipment*
405 IAC 5-29, *Services Not Covered by Medicaid*
Indiana Health Coverage Programs Provider Bulletin
BT200105-Programmable Hearing Aids
Indiana Health Coverage Programs Provider Newsletter
NL200409

Origination Date: 02/02/2001

Revisions and Review	Reason	Date
Review	Scheduled	08/08/2006

APPLICABLE INDIANA A/M EDITS AND AUDITS

6000-Manual Pricing Required
6096-The CPT/HCPCS code billed is not payable
6768-Services not covered for telemedicine

MEDICAL POLICY FACT SHEET

**TITLE: MEDICAL SUPPLIES AND EQUIPMENT—
PROTHROMBIN TIME SELF-MANAGEMENT
MONITORS**

DESCRIPTION:

Anticoagulants are increasingly being prescribed for a number of chronic and life-long conditions. For patients who require long term anticoagulant therapy, the problems of compliance, the use of drugs that interact with the anticoagulants, and fluctuations in sensitivity to anticoagulants make periodic measurement of the prothrombin time (PT) or International Normalized Ratio (INR) necessary. Studies have shown patients using home prothrombin time monitors can achieve a degree of therapeutic effectiveness at least comparable to patients in an anti-coagulation clinic.

MEDICAL TOPICS CROSS-REFERENCES:

Laboratory
Medical Supplies and Equipment

RULES, CITATIONS, AND SOURCES:

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
BT200017	8/21/2000	10/5/2000	10/5/2000	
405 IAC 5-18	7/25/1997	7/25/1997	7/25/1997	
405 IAC 5-19	7/25/1997	7/25/1997	7/25/1997	
Revisions:				

APPLICABLE INDIANA A/M EDITS AND AUDITS:

6076 Limit of 4 units of strips or cuvettes per month

COVERAGE CRITERIA:

Prior authorization must be obtained to purchase a home prothrombin time monitor. Prior authorization will be granted when the physician has submitted documentation supporting all of the following criteria, along with the appropriate medical diagnosis code(s) listed in this bulletin. A copy of the physician's order must accompany the request for prior authorization.

The patient must have a medical condition requiring lifetime warfarin therapy and monitoring of prothrombin time activity.

The patient must need to have frequent prothrombin time testing once a week or multiple times per month.

The patient (or patient's resident caregiver) must have the ability to use the prothrombin time monitoring device after obtaining education on its proper use from the physician, nurse, or appropriate health care professional. A certificate of completion of education or training must be obtained and kept in the patient's medical records.

The patient (or patient's resident caregiver) must have a telephone in the home.

The patient (or patient's resident caregiver) must agree to use the home monitoring system in lieu of office or laboratory testing except when requested by the ordering physician.

The patient (or patient's resident caregiver) must **not** have any contraindications to or inability to comply with anticoagulation therapy, such as:

A history of noncompliance during outpatient care;

Chronic alcoholism or other substance abuse; or

Memory impairment.

The use of self-management of oral anticoagulation can be used for, but is **not** limited to, the medical conditions listed in Table 1.1.

Table 1.1 – Medical Conditions

Code(s)	Description
V42.1, V42.2, and V43.3	Prosthetic valve replacements (for example, mitral or aortic valve replacements) or heart transplant
V42.0-V42.9	Organ or tissue replaced by transplant
V43.0-V43.89	Organ or tissue replaced by mechanical or prosthetic means
V53.31	Cardiac pacemaker
394.0-394.9	Mitral valve disease
395.0-395.9	Aortic valve disease
396-396.3, 396.8, 396.9	Mitral and aortic valve disease
401.9	HTN-hypertension
410.9	Post myocardial infarction

Table 1.1 – Medical Conditions

Code(s)	Description
411.1	Angina
414.9	Chronic ischemic heart disease (coronary artery disease)
415.1-415.19	Pulmonary embolisms and infarction
427.31	Atrial fibrillation
425.4	Cardiovascular collagenosis (primarily cardiomyopathies)
427.9	Dysrhythmias
436	Acute cerebrovascular disease (includes CVA)
438	Late effects of cerebrovascular disease (old CVA)
443.9	Peripheral vascular disease, unspecified
453.0-453.9	Other venous embolism and thrombosis

Some underlying conditions that may cause venous embolism and/or thrombosis are as follows:

Antiphospholipid antibodies

Anticardiolipin antibody

Congenital antithrombin deficiency

Hyperhomocysteinemia

Prothrombin 20210

Protein S deficiency

Systemic lupus erythematosus

Kawasaki disease with giant coronary aneurysms

Nephrotic syndrome

Cancer

Myelomeningocele

Factor V Leiden or activated protein C-resistance

Homozygous protein C deficiency

Hereditary thrombophilia

BILLING INSTRUCTIONS AND REIMBURSEMENT

Durable medical equipment providers or pharmacists supplying the monitors and testing materials must bill only on the HCFA-1500 claim form. Only one home prothrombin monitor per member is allowed. If multiple family members living in the same household require use of the monitor, only one monitor will be allowed per household. Practitioners and providers are to bill their usual and customary fee for the monitor and associated testing supplies. The items listed in Table 1.2 are reimbursable.

Note: Rate of reimbursement may be different for risk-based managed care members.

Table 1.2 – Reimbursable Items

Code	Description	Maximum Allowed Charges Per Unit
Z5093	Home Protime monitor, 1 unit = 1 monitor	\$1177
Z5094	Home Protime reagent (test) strips, 1 unit = 15 strips	\$75
Z5095	Home prothrombin time cuvettes, 1 unit = 6 cuvettes	\$48
Z5096	Batteries, standard AA, 1 unit = 1 battery	\$2.25
Z5097	Home Protime controls for strips, 1 unit = 1 box of controls	\$20
Z5098	Battery charger 110V, 1 unit = 1 charger	\$40

Codes A4258, lancet device, and A4259, lancets per box, can also be billed for blood collecting devices when these are not included in the monitor kit or testing strips.

MEDICAL POLICY FACT SHEET

TITLE: MEDICAL SUPPLIES AND EQUIPMENT—STANDERS

DESCRIPTION

“Standers” refers to a mechanical standing device that provides support and positioning, and aids in decreasing postural instability by targeting specific muscle groups with isokinetic exercises (a type of exercise that maintains constant torque and tension as muscles contract).

This document is intended to serve as a general summary of the Indiana Health Coverage Programs’ (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

IHCP will provide reimbursement for standers considered medically necessary in a non-institutional setting. A written physician's order is required and prior authorization (PA) is required. The purpose of this policy is to provide a guide for determining the medical necessity of standers.

Types of Standers

Prone Standers

Prone standers support the front of the body. They lean the member forward at varying angles to keep the member upright. Supports and straps are commonly placed at the sides, feet, knees, buttocks, and trunk to hold the member in position. The supports can be adjusted to accommodate growth. There are two types of prone standers, freestanding units and lean-to units. Freestanding units have stable bases and stand independently anywhere in the room. Lean-to units are dependent standers that lean against a stable piece of furniture as support.

Supine Standers

Supine standers support the posterior surface of the body. The angle of most supine standers can be adjusted from horizontal to vertical. The supine stander provides assistance to a member who cannot stand fully upright to achieve a passive standing position. Supine standers are usually equipped with lateral supports and anterior straps

positioned at the feet, knees, and trunk. Three types of supine standers include supine frames, tables, and boards.

Vertical Standers

Vertical standers are recommended for members with good balance and trunk control. Vertical standers provide the least amount of support of all standers and position members in a fully upright position. Supports are placed at the knees, hips, and lower torso. Three types of vertical standers include a vertical frame, a standing box, and a standing table.

Multi-Positional Standers

Multi-positional standers have a full range of standing angle adjustments to supply optimum standing positioning with the capability to convert to a prone, supine, and/or vertical stander. Multi-positional standers typically come equipped with lateral, trunk, and hip supports, as well as knee, foot, and body straps.

Sit-to-Stand Standers

Sit-to-stand standers allow the member to change positions from sitting to standing and back. The stander assists the member to move to the standing position using manual power, a hydraulic lift, or an electric lift. If the member lifts themselves manually, a sling is commonly hooked behind the member and a foot positioner and knee block is used to assist the member to extend their knees and hips to the standing position. The hydraulic lift uses a gas-spring system with a push handle to assist in lifting the member's weight. Common sit-to stand standers are Easy Stand and Ovation products (with the exception of the Easy Stand 6000 Glider).

PRIOR AUTHORIZATION

All initial requests for standers require PA and a completed medical clearance form signed by the physician. A copy of a physical therapy (PT) and/or occupational therapy (OT) evaluation within the last two months, which shows the patient's functional and cognitive baseline and ability to progress with therapy, will be required for the initial prior authorization. The request for initial prior authorization must also include documentation of medical necessity and a plan of care signed by the ordering physician. Subsequent requests for prior authorization will require ongoing documentation indicating progress towards goals up through the 15th month, and a completed medical clearance form signed by a physician.

Plan of Care

The plan of care must include the following documentation.

1. Measurable goals for therapy and training
Therapy necessary to obtain a stander may be performed by a PT, OT, or family member who has been properly trained to perform the necessary exercises.

2. Estimated amount of time the member is expected to stand
The member should be able to stand one hour a day or have the potential goal of standing one hour a day. The member is not required to stand for one hour continuously.
3. List expected benefits from utilizing the stander as an adjunctive therapy. Examples of the benefits of passive standing include, but are not limited to, the benefits as follows.
 - Aids in the prevention of atrophy in the trunk and leg muscles
 - Improves circulation to the trunk and lower extremities
 - Prevents formation of decubiti (pressure sores) with changeable positions
 - Helps maintain bone integrity
 - Reduces swelling in the lower extremities
 - Improves range of motion
 - Improves kidney and bladder function
 - Decreases muscle spasms
 - Strengthens the cardiovascular system and builds endurance
 - Improves strength of the trunk and lower extremities
 - Prevents or decreases muscle contractures
 - Lessens or prevents progressive scoliosis
 - Aids normal skeletal development
 - Improves bowel function

General Diagnosis

The PA request must include an appropriate diagnosis demonstrating the medical necessity for a stander. Diagnoses may include, but are not limited to, the following.

- 318.1 Severe mental retardation
- 318.2 Profound mental retardation
- 335.20 Amyotrophic lateral sclerosis
- 336.9 Unspecified disease of the spinal cord
- 340 Multiple sclerosis
- 341.9 Demyelinating disease of the central nervous system, unspecified
- 342.xx Hemiplegia and hemiparalysis
- 343.0 Diplegia
- 343.2 Quadriplegia
- 343.9 Infantile cerebral palsy, unspecified
- 344.0x Quadriplegia
- 344.1 Paraplegia
- 348.3x Encephalopathy, not elsewhere classified
- 359.x Muscular dystrophies and other myopathies
- 741.9x Spina bifida, without mention of hydrocephalus
- 742.4 Other specified anomalies of brain

- 783.4x Lack of expected normal physiological development in childhood
- 952.xx Spinal cord injury
- 995.55 Shaken infant syndrome

Multi-positional Stander PA criteria

When a multi-positional stander is requested, the provider must indicate the secondary complications that justify the need for a multi-positional stander. Secondary complications include, but are not limited to, the examples as follows.

- The member requires postural drainage
- The member requires suctioning while in the stander related to excessive secretions
- The member has a history of postural hypotension

Additional documentation that must be included in the PA request for a multi-positional stander includes the following.

- Specific muscle groups to be targeted for stretching and strengthening in the stander and expected outcomes
- Specific orders indicating the proper positioning of the member in the stander

Sit-to-Stand PA Criteria

All requests for sit-to-stand standers will be considered on a case-by-case basis. All diagnoses listed previously will be considered for sit-to-stand standers. The member must be able to perform the following.

- Maneuver from the sitting to standing position without assistance
- Stand vertically or have the medical potential to stand vertically in the near future

Documentation of medical justification for a sit-to-stand stander must be included in the PA request. Some examples of secondary conditions that may justify the need for a sit-to-stand stander are as follows.

- Children who are not ready to stand fully upright, but are actively in transition between sitting and standing
- Highly independent youth and adults who can stand vertically and safely transfer alone
- Members who cannot stand for long periods of time due to contractures or muscle weakness
- Members with orthostatic hypotension

Certain sit-to-stand standers, such as standers manufactured by Easy Stand, have a mobility option. The mobility option is identified by two medium sized all-terrain tires on the front of the stander and casters in the rear of the stander. Two maneuvering wheels are placed at waist level and attached to a pulley system which allows the member limited mobility in a small area. The IHCP will cover the mobility option as a

reimbursable accessory, included under the max fee for code E0637, *Combination sit to stand system, any size including pediatric, with seat lift feature, with or without wheels*, on a case-by-case basis. The mobility option will only be approved for members with independent capabilities, and bilateral upper-body strength and coordination to maneuver themselves.

Children are not required to be independent to meet the criteria for a sit-to-stand stander. Decisions regarding approval for children will be made on a case by case basis.

NON-COVERED ITEMS

Some standers are categorized as mobile standers. These standers allow self-propulsion in the standing position throughout large areas. Mobile standers are identified as having large pneumatic wheels similar or identical to manual wheelchairs. Some mobile standers are electrically powered. The IHCP will not provide reimbursement for mobile standers. The following is a list of some mobile standers. This list is not all-inclusive.

- Rifton Mobile Stander (Rifton)
- Rifton Dynamic Stander (Rifton)
- Chameleon (Sammons Presto)
- Power Drive Stand Aid (Stand Aid of Iowa)
- Standing Dani Wheelstand (Standing Dani)
- Sprout Wheelstand (Standing Dani)

BILLING REQUIREMENTS

Suppliers should specify the brand name, model number, type of stander, and base price of the stander on the PA request. Trays are included in the base price of a stander. Upgraded trays will not be reimbursed. Certain supports and straps are included in the base price of the stander, as noted previously in this document. Upgraded supports and straps are considered on a case-by-case basis. An itemized list of any additional attachments and accessories with the individual prices must be included with the PA request.

The sit-to-stand stander should be billed with HCPCS code E0637. (Wheels in this definition are considered casters by the IHCP.) Sit-to-stand standers will be suspended for correct coding if requested with L1510. HCPCS code E0637 requires PA, and is reimbursed at a max fee.

IHCP reimbursement is available with PA for HCPCS code E0638, *Standing frame system, one position (e.g., upright, supine or prone stander), any size, including pediatric, with or without wheels*. E0638 is a max fee priced code. Providers are to bill their usual and customary charge for the equipment and will be reimbursed the lesser of the submitted or max fee price.

The IHCP will provide reimbursement for thigh, hip, knee, ankle orthosis (THKAO) reported with HCPCS code L1510, *THKAO, standing frame, with or without tray and accessories*, for supine, prone, vertical, or multi-positional standers with PA. L1510 is a manually priced code with a maximum cap. Providers are to bill their usual and customary charge for the equipment and will be reimbursed the lesser of 90% of the manufacturer's invoice price or the manual price cap. Attachments and accessories must be included on the claim for the stander and will not be separately reimbursed.

Repairs and maintenance of standers are billed using E1399, *Durable medical equipment, miscellaneous*, for replacement parts and E1340, *Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes*, for labor charges as appropriate.

RELATED TOPICS

Medical Supplies and Equipment

RULES, CITATIONS, AND SOURCES

405 IAC 5-19-2 Medical Supplies and Equipment
Indiana Health Coverage Programs Provider Bulletins
BT200027 Standers
BT200401 New 2004 HCPCS Codes
Indiana Health Coverage Programs Provider Manual Version 5.1

Origination Date: 8/10/2000

Revisions and Reviews	Reason	Date
405 IAC 5-19-2	Medical Supplies and Equipment	8/25/97
Provider Bulletin 200027	Standers	8/10/00
405 IAC 5-19-2	Medical Supplies and Equipment	10/27/99
Provider Bulletin 200401	New 2004 HCPCS Codes	10/29/04
Review	Update of pediatric requirements	07/31/06

APPLICABLE INDIANA AIM EDITS AND AUDITS

6065 – DME Total Rental Amount Not to Exceed Fee for Purchase
6080 – DME Rentals Limited to 15 Months

6096 – The CPT/HCPCS Code Billed is Not Payable According to the PPS
Reimbursement Methodology

6113 – DME Limited to \$2000 Per Recipient per Calendar Year

6114 – DME Limited to \$5000 Per Recipient per Lifetime

6652 – Multiple Surgeries Must be Billed on Same Claim

6768 – Services Not Covered for Telemedicine

MEDICAL POLICY FACT SHEET

TITLE: MEDICAL SUPPLIES AND EQUIPMENT – STANDING WHEELCHAIR

DESCRIPTION:**Half Power/Half Manual Standing Wheelchair**

A half power/half manual standing wheelchair has a manual standing mechanism. The manual standing mechanism functions to move the person in the chair from the sitting to standing position. A lever is pushed to release the lift by gas cylinders while a rotation handle is used on both sides of the chair to get to the standing position. While transitioning to the standing position, the flip up armrests rotate inward to the chest to provide chest support and prevent falling. Once the standing position is achieved, the chair is stationary.

Another type of half power/half manual standing wheelchair is a manual rigid base wheelchair that has an electric component for the standing position. The chair has the functions as the electric/power wheelchair that has a manual standing mechanism. This type of standing wheelchair also comes as a heavy-duty wheelchair for individuals weighing 210 pounds or more. It is used primarily for individuals who have a high level of quadriplegia, advanced cerebral palsy, muscular dystrophy, or multiple sclerosis. The individual must have strong upper body strength to operate the standing mechanism. Upper body strength is determined by evaluating if a patient can lift a 10-pound bar. An individual must be diagnosed with a high level of paraplegia or low quadriplegia, advanced cerebral palsy, advanced muscular dystrophy, or multiple sclerosis to qualify for the wheelchair. In addition to significant upper body strength to operate the manual portion of the chair, the individual must have the ability to move fingers to operate the joystick that controls the power standing feature or the manual base of the chair.

Full Power Standing Wheelchair

A full power standing wheelchair is operated entirely by power. The standing mechanism is controlled through the joystick. The joystick moves upward with the chair to the standing position. Depending on the manufacturer, once the standing position is achieved, an individual may drive the machine while in the standing position or be stationary.

These types of wheelchairs are used primarily for individual's who have a high level of quadriplegia, advanced cerebral palsy, muscular dystrophy, or multiple sclerosis, have little to no upper body strength, but do have some arm and hand control for joystick operation.

MEDICAL TOPICS CROSS-REFERENCES:

Medical supplies and equipment

Medical supplies and equipment –standers

Medical supplies and equipment--wheelchairs

RULES, CITATIONS, AND SOURCES:

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
Revisions:				

APPLICABLE INDIANA AIM EDITS AND AUDITS:

Not Applicable

COVERAGE DECISION:

The Indiana Health Coverage Programs (IHCP) does not cover standing wheelchairs because there is insufficient clinical data to support the benefits of this equipment.

The manufacturers use criteria for an individual to qualify for a standing wheelchair based upon coordination efforts with physical and occupational therapists and physician providers.

Health Care Excel also sought the opinion of three Physical Medicine and Rehabilitation specialists to formulate its recommendation to the IHCP, one of whom ambulates by means of an electric wheelchair. These consultants agreed that there is insufficient clinical research conducted on the benefits of standing wheelchairs to warrant coverage by the IHCP.

MEDICAL POLICY FACT SHEET

**TITLE: MEDICAL SUPPLIES AND EQUIPMENT –
THAIRAPY™ VEST**

DESCRIPTION:

The ThAIRapy™ Vest is a mechanical device that utilizes a vest and a generator to loosen bronchial secretions and clear the airway. All requests for this durable medical equipment device will continue to require prior authorization with an appropriate clinical summary and physician prescription.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

The following criteria must be met for the ThAIRapy™ Vest to be approved and covered by the IHCP.

- A physician order
- The physician determines that the patient requires airway clearance therapy at least once a day
- Recent pulmonary function study demonstrates
 - a Forced Expiratory Volume (FEV1), 80% of predicted,
 - a Forced Vital Capacity (FVC) 50% of predicted, and
 - 25% decrease on small airway score (Forced Expiratory Flow [FEF] 25-75) over one year
- Documentation supports that chest physiotherapy and/or flutter devices used twice a day have been ineffective in managing bronchial secretions
- Documentation supports that family members and caregivers have been unable to provide effective chest therapy
- The patient is at risk for continued hospitalization
- The patient does not have a cardiac condition

Limitations and Restrictions

Rental of the ThAIRapy™ Vest for three months is required before purchase of the equipment is covered or reimbursable. At the end of three months, documentation is required that the ThAIRapy™ Vest has been used at least 67% of the prescribed time. Medical records must indicate patient compliance and tolerance before purchase will be approved.

PRIOR AUTHORIZATION

Prior Authorization (PA) is required for the ThAIRapy vest. Please refer to the Fact Sheet that corresponds with each additional service provided if applicable, for more information on PA.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in *Medicaid Select* PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the *Medicaid Select* Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

As of January 1, 2003, codes for the ThAIRapy vest were crosswalked from Health Care Common Procedural Coding System national codes S8200, *Chest compression vest* and S8205, *Chest compression system generator and hoses (for use with chest compression vest)* to permanent code E0483, *High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each*.

Providers are responsible for determining if Home Medical Equipment (HME) licensure is required to submit claims for particular products. Resources are available on the IHCP website under *Provider Code Sets*.

RELATED MEDICAL TOPICS

Home Health Services
Medical Supplies and Equipment

RULES, CITATIONS, AND SOURCES:

405 Indiana Administrative Code (IAC) 5-19-1
405 Indiana Administrative Code (IAC) 5-25
Indiana Health Coverage Programs (IHCP) Provider Manual 2005

Origination Date: 12-31-2002

Revisions and Review	Reason	Date
IHCP Bulletin BT200205	Policy Revision for Coverage of the ThAIRapy™ Vest	02/01/2002
Review	Scheduled	10/31/2006

APPLICABLE INDIANA AIM EDITS AND AUDITS:

6096–The CPT/HCPCS Code billed is not payable according to the PPS Reimbursement Methodology
6065–DME total rental amount not to exceed fee for purchase
6080–DME rentals limited to 15 months
6104–DME rental from chiropractor of more than one month requires PA
6113–DME limited to \$2,000 per member per calendar year
6114–DME limited to \$5,000 per member per lifetime
6652–Multiple surgeries must be billed on the same claim
6768–Services not covered for telemedicine services

MEDICAL POLICY FACT SHEET

TITLE: MEDICAL SUPPLIES AND EQUIPMENT—VAGUS NERVE STIMULATOR FOR EPILEPSY

DESCRIPTION:

A vagus nerve stimulator is a small programmable device implanted under the skin. This system works as a pacemaker for the brain. A wire lead under the skin connects the device to the vagus nerve in the neck. The device produces weak electrical signals at regular programmed intervals which help prevent the bursts of electrical activity in the brain that cause seizures. The battery powered device can have the programming adjusted by a physician as required without further surgical intervention. The vagus nerve stimulator is indicated as an adjunctive therapy in reducing the frequency of seizures in adults and adolescents older than 12 years old who have partial onset seizures that are refractory to anti-epileptic medications and for which surgery has failed or is not recommended.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC), or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

IHCP reimbursement for implantation, revision, programming and reprogramming, and removal of the vagus nerve stimulator is available for members older than 12 years of age with medically intractable partial onset seizures and who are not otherwise surgical candidates. Providers are required to perform this procedure on an outpatient basis whenever medically possible. Implantation procedures and equipment require prior authorization (PA) with documentation of medical necessity.

In situations where complicating factors require this procedure to be performed on an inpatient basis, medical history and records should support the need for the inpatient admission. PA is not required for the hospital admission or the device (reimbursement for the device is included in the DRG payment). The device cannot be billed separately for inpatients.

Members with an ominous prognosis or other limiting factors would not be considered appropriate candidates for implantation of the vagus nerve stimulator (for example,

members with an absent left vagus nerve, severe mental retardation, cerebral palsy, stroke, progressive fatal neurologic disease, or progressive fatal medical disease).

Diagnosis and Procedure Codes

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis and procedure codes listed in **Tables 1** and **2** and the CPT procedure codes noted in **Table 3** are appropriate for reporting implantation, revision, programming and reprogramming, and removal of a vagus nerve stimulator. Providers are advised to utilize the most appropriate code for the service provided.

Table 1 – ICD-9-CM Diagnosis Codes for Reporting Vagus Nerve Stimulator Services

Code	Description
345.41	Partial epilepsy, with impairment of consciousness, with intractable epilepsy
345.51	Partial epilepsy, without mention of impairment of consciousness, with intractable epilepsy

Table 2 – ICD-9-CM Procedure Codes for Reporting Vagus Nerve Stimulator Services

Code	Description
04.92	Implantation or replacement of peripheral neurostimulator lead(s)
04.93	Removal of peripheral neurostimulator lead(s)
86.94*	Insertion or replacement of single array neurostimulator pulse generator, not specified as rechargeable
86.95*	Insertion or replacement of dual array neurostimulator pulse generator, not specified as rechargeable
86.96*	Insertion or replacement of other neurostimulator pulse generator
86.97*	Insertion or replacement of single array rechargeable neurostimulator pulse generator
86.98*	Insertion or replacement of dual array rechargeable neurostimulator pulse generator

*These codes were part of the ICD-9-CM annual update effective October 1, 2005

Table 3 – CPT Procedure Codes for Reporting Vagus Nerve Stimulator Services

Code	Description
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to a single electrode array
61888	Revision or removal of cranial neurostimulator pulse generator or receiver
64553	Percutaneous implantation of neurostimulator electrodes; cranial nerve
64573	Incision for implantation of neurostimulator electrodes; cranial nerve
64585	Revision or removal of peripheral neurostimulator electrodes

Table 3 – CPT Procedure Codes for Reporting Vagus Nerve Stimulator Services (Cont'd)

Code	Description
95970	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
95975	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)
95975	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour

PRIOR AUTHORIZATION

PA must be obtained by the physician for the implantation procedures regardless of setting. The following documentation must be maintained in the medical record and submitted with the request for PA.

- Documentation that an evaluation has been made by a neurologist
- Documentation of the member's type of epilepsy
- Documentation that the member's seizures are medically intractable (member continues with an unacceptable number of seizures with adequate treatment consisting of two or more anti-epileptic drugs (AEDs) for a period of at least 12 months)
- Documentation that the member is not a surgical candidate or that surgery has been unsuccessful (for example, the member is not a surgical candidate due to multiple epileptic foci)

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and RBMC delivery systems.

IHCP members enrolled in *Medicaid Select* PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the *Medicaid Select* Manual for Primary Medical Providers and Office Staff for further information.

BILLING GUIDELINES

Table 4, indicates the procedure codes to be used when billing for the incision, implantation, revision, or removal of the vagus nerve stimulator. The CPT code must be billed in conjunction with the appropriate revenue code on the UB-92 claim form. Also included in the table are the corresponding ambulatory surgical center (ASC) groups and the PA requirement. Claims for services provided by hospital outpatient and ambulatory surgical centers must be billed with revenue codes 360 (Operating Room Services) or 490 (Ambulatory Surgical Care) on the UB-92 claim form.

Table 4 – Procedure Codes and Corresponding ASC Groups and Rates

Category	CPT Code	Description	ASC Group	PA Required
Implantation	64573	Incision for implantation of neurostimulator electrodes; cranial nerve	1	Yes
	64553	Percutaneous implantation of neurostimulator electrodes; cranial nerve		Yes
	61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to a single electrode array	2	Yes
Revision/ Removal	64585	Revision or removal of peripheral neurostimulator electrodes	A	No
	61888	Revision or removal of cranial neurostimulator pulse generator or receiver	1	No

The surgical procedure involves two separate incisions. Therefore, both CPT codes 64573 and 61885, or 64553 and 61885 should be used. Reimbursement is based on 100 percent of the highest ASC group and 50 percent for the second highest ASC group (no additional reimbursement is available for three or more procedures).

Additional reimbursement, separate from the ASC rate for the implantation procedure performed in an outpatient setting, will be allowed for the cost of the device. Providers are to report their usual and customary charge for this device and will be reimbursed the lesser of the submitted charges for the device or the maximum fee allowed. The device must be billed on a CMS-1500 claim form using a DME provider number and prior authorization must be obtained.

The appropriate HCPCS codes listed in **Table 5** should be used when billing the device and services related to the vagus nerve stimulator.

Table 5 – Codes for Additional Reimbursement for Vagus Nerve Stimulator Devices

Code	Description	PA Requirement
L8680	Implantable neurostimulator electrode, each	Yes
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator	Yes
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension	Yes
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension	Yes
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension	Yes
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension	Yes
L8689	External recharging system for implanted neurostimulator, replacement only	Yes

Hospital Inpatient

In situations where a complicating factor is present and the patient requires admission to the hospital for the procedure, the procedure and equipment will be reimbursed according to the appropriate diagnosis related group (DRG) payment. PA is not required for the admission or the device, which is included in the DRG reimbursement. However, the physician must obtain PA for the surgical procedure. The hospital stay must be billed on the UB-92 claim form and must include a secondary diagnosis indicating a complicating factor that necessitated inpatient admission. Hospitals cannot receive additional

reimbursement outside the DRG payment for the cost of the device. DRG payments for inpatient procedures with complicating factors include reimbursement for the device.

Physician Billing Instructions

Physicians will bill the professional services on the CMS-1500 claim form (see Chapter 8 of the *Indiana Health Coverage Programs Provider Manual*), using the appropriate procedure codes in the following tables.

Table 6 – Surgeon CPT Procedure Codes

Category	CPT Code	Description	PA Required
Implanting	64573	Incision for implantation of neurostimulator electrodes; cranial nerve	Yes
	64553	Percutaneous implantation of neurostimulator electrodes; cranial nerve	Yes
	61885	Incision and subcutaneous placement of cranial neurostimulator pulse generator and or receiver, direct or indirect coupling with connection to a single electrode array	Yes
Revision/ Removal	64585	Revision or removal of peripheral neurostimulator electrodes	No
	61888	Revision or removal of cranial neurostimulator pulse generator or receiver	No

The following codes in **Table 7** should be used by the physician to report interrogation and programming services provided for members with implants.

Table 7 – Neurologist CPT Procedure Codes for Implanted Devices

Code	Description	PA Required
95970	Electronic analysis of implanted neurostimulator pulse generator system (for example, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex neurostimulator pulse generator, without programming	No
95974	Complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour	No

Table 7 – Neurologist CPT Procedure Codes for Implanted Devices

Code	Description	PA Required
95975	Complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, each additional 30 minutes after first hour (list separately in addition to code for primary procedure)	No

RELATED MEDICAL TOPICS

Hospital Inpatient
Hospital Outpatient
Medical Supplies and Equipment
Surgical Services

RULES, CITATIONS, AND SOURCES

405 IAC 5-19 Medical Supplies and Equipment
405 IAC 5-28 Medical and Surgical Services
Indiana Health Coverage Programs Provider Bulletin (BT)
BT200032 – Coverage of NCP System-Vagus Nerve Stimulator
Indiana Health Coverage Programs Provider Banner (BR)
BR200537– Annual Update-ICD-9-CM
Indiana Health Coverage Programs Provider Manual
March, 2005, Version 5.1
Origination date: 04/30/2001

Reviews and Revisions	Reason	Date
BT200032	Coverage of NCP System-Vagus Nerve Stimulator	10/23/2000
405 IAC 5-19	Medical Supplies and Equipment	8/25/1997
405 IAC 5-19	Medical Supplies and Equipment	10/27/1999
Review	Scheduled	01/31/2007

APPLICABLE INDIANA A/M EDITS AND AUDITS

3003 – Procedure Code Requires Prior Authorization
6002 – Any Two Anesthesiology Providers Same Procedure Requires Review
6003 – Manual Pricing for Split Care Billing
6034 – Global Surgery Payable at Reduced Amount When Components of Surgical Care Paid
6035 – Components of Surgical Care Not Payable When Global Surgery Paid

- 6037 – One Assistant Surgeon Allowed For Select Surgeries
- 6039 – Assistant Surgeon Not Payable When Co-Surgeon Paid
- 6040 – Co-Surgeon Not Payable When Assistant Surgeon Paid
- 6079 – Unbundling Audit for Vagus Nerve Stimulator
- 6096 – The CPT/HCPCS Code Billed Is Not Payable
- 6113 – DME Limited to \$2,000 Per Recipient Per Calendar Year
- 6114 – DME Limited to \$5,000 Per Recipient Per Calendar Year
- 6152 – Surgery Payable at Reduced Amount when Consultation Paid Days Before or After Surgery
- 6652 – Multiple Surgeries Must Be Billed on Same Claim
- 6661 – Duramorph Cannot Be Billed on Same Day as Surgery
- 6666 – Anesthesia Services Not Allowed By Provider Billing for Surgery
- 6768 – Services Not Covered for Telemedicine

MEDICAL POLICY FACT SHEET

**TITLE: MEDICAL SUPPLIES AND EQUIPMENT —
VENTRICULAR ASSIST DEVICE (VAD) SYSTEMS**

DESCRIPTION

Ventricular Assist Devices (VADs) are mechanical circulatory assistive devices that assist the heart in performing its pumping function. VADs can be used for short-term, intermediate-term, and long-term support as a bridge-to-recovery, bridge-to-transplant, and destination therapy.

VADs may be designed for use in the left ventricle (LVAD), the right ventricle (RVAD), or for both ventricles (Bi-VAD). VADs are either pneumatic or electromechanical pulsatile pumps that can operate in a synchronous mode (triggered by an EKG) or an asynchronous mode. The electromechanical pumps are primarily battery operated, and include a power hookup for battery recharging and for other necessary events.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

SUMMARY

Heart failure affects an estimated 5 million American, resulting in approximately 300,000 deaths annually. Of an estimated 16,500 Americans who would benefit from a heart transplant each year, only 13% typically receive the surgery due to lack of available transplant candidates. This lack of resources has increased the necessity of VADs for qualified candidates.

VADs are used to assist the ventricles of the heart in pumping blood and therefore reduce the heart's workload. Due to this mechanism, VAD therapy has been shown to improve heart function by allowing the heart to repair endocrine function and reverse remodeling. Studies show that VAD therapy in conjunction with aggressive medical therapy may provide increased medical benefits to cardiac patients following extended VAD use at the time of cardiac transplantation.

VADs have been available for implantation since April 1993. The first Food and Drug Administration (FDA) approved VAD was manufactured by Abiomed (the Abiomed BVS 5000), and was indicated for postcardiotomy cardiogenic shock. Other VADs indicated for cardiogenic shock include the Thoratec VAD and the TandemHeart percutaneous transseptal ventricular assist (PTVA) device. VADs became covered by Medicare October 18, 1993 for post-cardiotomy cardiogenic shock.

In 1994, the FDA approved VADs for bridge-to-transplant. Bridge-to-transplant is the term used to describe an intermediate-term support by a VAD while awaiting a heart transplant. Bridge-to-transplant is indicated for transplant candidates whose hemodynamic status deteriorates despite maximal pharmacologic therapy or intra-aortic balloon pump (IABP) assistance. On January 22, 1996 Medicare approved bridge-to-transplant procedures. The Abiomed BVS 5000 may be used for bridge-to-transplant, although its primary indication is for post-cardiotomy cardiogenic shock. Other VADs indicated for bridge-to-transplant include the following.

- Thoratec Ventricular Assist Device System
- Novacor Ventricular Assist System
- HeartMate Left Ventricular Assistive Device (LVAD)
- HeartMate Vented-Electric VE-LVAD
- HeartMate “Sutures Not Applied” SNAP-VE
- HeartMate Implantable Pneumatic IP-VAD
- DeBakey VAD Child Left Ventricular Assist System

Initially bridge-to-transplant patients were confined to the hospital during treatment with a VAD. In 1998, the FDA approved the VAD for use outside the hospital, and patients were allowed to return to work during treatment with a VAD.

In July 2003, the FDA approved the HeartMate (extra long drive line) XVE-LVAD for destination therapy based on substantial improvement in patient quality of life and survival compared to pharmaceutical therapy. Destination therapy is permanent cardiac support by a VAD for members who have chronic end-stage heart failure and are not candidates for heart transplantation. Medicare approved coverage of VADs for destination therapy October 1, 2003. The SNAP-VE, VE-LVAD, and XVE-LVAD are approved for destination therapy.

USES OF VADS

Short-Term Support

VADs can be used for short-term support as a bridge-to-recovery (the term used to describe a patient supported by a VAD until the heart recovers from temporary heart failure) for patients who are experiencing postcardiotomy cardiogenic shock. Postcardiotomy cardiogenic shock is heart failure following cardiac surgery. Conditions that may necessitate heart surgery and ultimately lead to postcardiotomy cardiogenic shock include myocarditis, myocardial infection, cardiomyopathy, arrhythmias, and acute

myocardial infarction (MI). Postoperatively, temporary mechanical circulation with a VAD may be necessary to lead the patient to recovery. Patients who are placed on cardiopulmonary bypass during surgery may also need a VAD in order to wean from cardiopulmonary bypass.

Intermediate-Term Support

VADs are most commonly used as a bridge-to-transplant. Bridge-to-transplant is indicated for candidates with end-stage heart failure (New York Heart Association Class III or IV) whose hemodynamic status deteriorates despite maximal pharmacologic therapy or intra-aortic balloon pump (IABP) assistance. The FDA lists hemodynamic instability as noted on the next page.

- Pulmonary capillary wedge pressure less than 20mmHg
- Cardiac index less than or equal to 2L/minute/m²
- Systolic BP less than or equal to 80mmHg

Contraindications to heart transplant, and therefore implantation of a VAD for bridge-to-transplant, include, but are not limited to, elevated, fixed pulmonary hypertension or severe pulmonary disease, respiratory failure, sepsis, renal failure, and severe neurological deficit.

Improved cardiac function with extended VAD support has been reported due to decreased demands on the heart. This creates a positive impact on mortality and the rehabilitation potential for the transplant candidate. Reported benefits of VAD treatment include increased cardiac output, improved cardiac index, decreased peripheral vascular resistance, increased right ventricular ejection fraction, decreased LV diameter, improved hemodynamic status, normalized of fluid load, improved renal and hepatic function, and reversed passive pulmonary hypertension. Many patients will decrease from New York Heart Association Class III or IV to Class I heart failure within three to four weeks.

Long-Term Support

LVADs are FDA approved for long-term support as destination therapy. Destination therapy is defined as permanent mechanical cardiac support for individuals who are not candidates for heart transplant. The individual must have New York Heart Association Class IV, chronic end stage-heart failure, for at least 90 days, and have a life expectancy of less than two years. The individual must have also failed to respond to medical therapy.

The Randomized Evaluation, of Mechanical Assistance for the Treatment of Congestive Heart Failure (REMATCH) study, comparing the use of an LVAD for destination therapy to medical management, showed an increased one year and two year survival rate, decreased mortality rate, and improved quality of life in the LVAD group. The LVAD group also had a higher rate of side effects such as infection and bleeding. Members

receiving destination therapy can be treated at home and return to normal, or near normal living, and working activities.

TYPES OF VADS

VADs can be used as left ventricular devices (LVADs), right ventricular devices (RVADs) or biventricular devices (BI-VADS). VADs can either be pneumatic or electromechanical. Pneumatic devices require that the patient be tethered to a large console and remain in the hospital for the duration of treatment. Electrically powered devices are operated by a battery pack the majority of use, and are plugged into a power base unit during hospital stays, showering and battery recharging. Electromechanical devices can be used in the hospital or home settings. VADs are pulsatile pumps that can be synchronous or asynchronous. Asynchronous pumps operate independently of cardiac rhythm and can be advantageous during potentially fatal arrhythmias.

The VAD pump is placed outside the heart while a cannula is inserted in the appropriate ventricle(s) to pull the blood from the heart into the pump and circulate it to the body. The VAD pump can be implanted in the body (intracorporeal) or sit outside the body (extracorporeal).

A new type of VAD, called a percutaneous transseptal ventricular assist (PTVA), allows implementation of mechanical support through a noninvasive technique that can be performed in a catheterization lab. The heart is accessed percutaneously by inserting a cannula into the femoral vein, through the right atrium, into the left atrium, through a transseptal puncture. The cannula pulls the blood from the left atrium into the VAD pump which is externally attached to the thigh. A second cannula is placed in the femoral artery and returns the blood for circulation throughout the body.

FDA APPROVED VADS

Abiomed Biventricular (BVS) 5000

The Abiomed BVS 5000 is a biventricular, extracorporeal, pneumatic VAD that can be used as a LVAD, RVAD, or BI-VAD. The Abiomed BVS can be used in an asynchronous mode for patients with arrhythmias. The Abiomed BVS is FDA approved primarily for postcardiotomy cardiogenic shock, but is also approved for right ventricular support for members currently using an intermediate-term LVAD. If cardiac recovery no longer becomes possible following placement of the Abiomed BVS, the system may be exchanged for a more permanent VAD.

Thoratec Ventricular Assist Device

The Thoratec VAD is an extracorporeal, pneumatic VAD that can be used as a LVAD, RVAD, or Bi-VAD. The Thoratec VAD is limited to use in the hospital setting and is FDA approved for bridge-to-recovery in postcardiotomy cardiogenic shock and also for bridge-to-transplant.

Novacor Ventricular Assist System

The Novacor Ventricular Assist System is a pulsatile, intracorporeal, electromechanical VAD. The Novacor system is used as an LVAD for members who are candidates for bridge-to-transplant. The Novacor system can be powered by rechargeable batteries or an external power base unit and can be used in the hospital or home settings.

HeartMate Vented Electric Left Ventricular Systems (VE-LVAD, XVE-LVAD, and SNAP-VE)

The HeartMate vented electric LVADs are pulsatile, intracorporeal, electromechanical VADs. The devices have an implanted electric motor connected to a lightweight battery pack. The vented electric LVADs can be used inside and outside the hospital setting, and are FDA approved for bridge-to-transplant and destination therapy.

HeartMate Implantable Pneumatic Left Ventricular Assist Device (IP-LVAD)

The IP-LVAD is an implantable pump connected by a percutaneous air driveline to an external, electrically driven air pump. The IP-LVAD is indicated for use in the hospital setting and is FDA approved for bridge-to-transplant.

DeBakey VAD Child Left Ventricular Assist System

The DeBakey VAD has received a Humanitarian Device Exemption (February 2004) for treatment of children ages 5-16 for bridge-to-transplant. The DeBakey VAD can be used in the hospital or home setting.

TandemHeart Percutaneous Transseptal Ventricular Assist (PTVA) Device

The TandemHeart PTVA is an LVAD that can be implanted percutaneously in a catheterization lab. A cannula is advanced into the femoral vein, through the right atrium, and into the left atrium. The external pump pulls the blood from the atrium back to the pump, then circulates the blood throughout the body through a second cannula in the femoral artery. The TandemHeart PTVA is used in the hospital and is FDA approved for bridge-to-recovery in postcardiotomy cardiogenic shock.

COVERAGE CRITERIA

VADs, including LVADs, RVADs, and BI-VADs, are considered medically necessary by the IHCP under the following conditions.

1. Treatment of **postcardiotomy cardiogenic shock** is covered by the IHCP when ventricular dysfunction continues after maximum medical therapy or as a means of myocardial recovery support for individuals who are unable to be weaned off cardiopulmonary bypass with maximal inotropic support and use of an intraaortic balloon pump.
2. **Bridge-to-transplant** is covered by the IHCP for members who meet the following criteria.

- a) The member must be at risk of imminent death from nonreversible left ventricular failure (NYHA Class III or IV).
 - b) The member has been prior authorized for a heart transplant (excluding dual eligible members).
 - c) The member is listed as a candidate for heart transplantation by a Medicare/Medicaid approved heart transplant center.
 - d) If the VAD is implanted at a different site than the Medicare/Medicaid approved transplant center, the implanting site must receive written permission from the Medicare/Medicaid approved center under which the patient is listed prior to implantation of the VAD.
3. **Destination therapy** is covered by the IHCP for members who meet the following criteria.
- a) The member must not be a candidate for heart transplant.
 - b) The member must have chronic end-stage heart failure (NYHA Class IV) for at least 90 days, and have a life expectancy of less than 2 years.
 - c) The member's Class IV heart failure symptoms must have failed to respond to optimal medical therapy for at least 60 of the last 90 days. Medical therapy must include the treatments as listed.
 - Salt restriction
 - Diuretics
 - Digitalis
 - Beta-blockers
 - ACE inhibitors (if tolerated)
 - d) Left ventricular ejection fraction (LVEF) must be less than 25%.
 - e) The member has demonstrated functional limitation with a peak oxygen consumption of less than 12ml/kg/min; or continued need for IV inotropic therapy due to symptomatic hypotension, decreasing renal function, or worsening pulmonary congestion.
 - f) The member has the appropriate body size (greater than or equal to 1.5m²) to support the LVAD implantation.
 - g) VAD implantation must occur at a Medicare/Medicaid approved heart transplant center.

A VAD is a covered service for postcardiotomy cardiogenic shock or bridge-to-transplant only if it has received approval from the FDA for the intended purpose, and only if it is used according to the FDA-approved labeling instructions for that intended purpose.

A VAD is a covered service for destination therapy only if it has received approval from the FDA for destination therapy or as a bridge-to-transplant, or has been implanted as part of an FDA investigational device exemption trial for one of these two indications.

NONCOVERED SERVICES

1. VADs are noncovered for all other conditions not listed above.
2. Use of a non-FDA approved VAD is considered investigational and is a noncovered service.
3. The artificial heart (i.e. AbioCor, CardioWest) as a replacement heart for a diseased heart is noncovered by the IHCP.

PRIOR AUTHORIZATION CRITERIA

VADs, including LVADs, RVADs, and BI-VADs, and their surgical implantation do not require prior authorization. Members who receive bridge-to-transplant or destination therapy, and who can continue therapy on an outpatient basis, will require accessory equipment for use with the VAD. The patient supply and replacement equipment, listed in **Table 1**, on the following page, require prior authorization.

Stationary Power Base and Display Module

- The power base is the electrical supply unit for the VAD. It provides tethered functioning of the VAD by powering the VAD and simultaneously recharging the batteries. The display module provides pump functioning information for the physician in order to evaluate patient status.
- The power base is purchased by the hospital or DME provider as a capital expense and loaned to the member. The hospital or DME provider is reimbursed a rental payment while the equipment is being used on an outpatient basis by the member.
- The physician must submit a prior authorization request for HCPCS code L9900 and the RR modifier.

Patient Supplies and Replacement Equipment

- Includes system controller, rechargeable batteries, a travel case, a shower kit, and other miscellaneous supplies.
- The hospital or DME provider must supply the patient supplies and replacement equipment.

Table 1 – VAD HCPCS Codes Requiring Prior Authorization

Code	Description	Effective Date
Q0480	Drive for use with pneumatic ventricular assist device, replacement only	2005/10/01
Q0481	Microprocessor control unit for use with electric ventricular assist device, replacement only	2005/10/01
Q0482	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only	2005/10/01
Q0483	Monitor/display module for use with electric ventricular assist	2005/10/01

Table 1 – VAD HCPCS Codes Requiring Prior Authorization

Code	Description	Effective Date
	device, replacement only	
Q0484	Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0485	Monitor control cable for use with electric ventricular assist device, replacement only	2005/10/01
Q0486	Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0487	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0488	Power pack base for use with electric ventricular assist device, replacement only	2005/10/01
Q0489	Power pack base for use with electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0490	Emergency power source for use with electric ventricular assist device, replacement only	2005/10/01
Q0491	Emergency power source for use with electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0492	Emergency power supply cable for use with electric ventricular assist device, replacement only	2005/10/01
Q0493	Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0494	Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0495	Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0496	Battery for use with electric or electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0497	Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0498	Holster for use with electric or electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0499	Belt/vest for use with electric or electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0500	Filters for use with electric or electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0501	Shower cover for use with electric or electric/pneumatic ventricular assist device, replacement only	2005/10/01
Q0502	Mobility cart for pneumatic ventricular assist device, replacement only	2005/10/01
Q0503	Battery for pneumatic ventricular assist device, replacement only	2005/10/01
Q0503	Battery for pneumatic ventricular assist device, replacement only, each	2005/10/01

Table 1 – VAD HCPCS Codes Requiring Prior Authorization

Code	Description	Effective Date
Q0504	Power adapter for pneumatic ventricular assist device, replacement only, vehicle type	2005/10/01
Q0505	Miscellaneous supply or accessory for use with ventricular assist device	2005/10/01

POST PAYMENT REVIEW

IHCP covered services for implantation of VADs for postcardiotomy cardiogenic shock, bridge-to-transplant, and destination therapy are subject to post payment review. Providers must maintain documentation in the member's medical record that indicates that **all criteria** listed under the IHCP "Coverage Criteria" have been met for implantation of a VAD. If all of the criteria for implantation are not satisfied, reimbursement of funds may be recouped, including surgical fees, professional fees, and equipment costs.

MANAGED CARE

Questions regarding coverage of services to Risk Based Managed Care (RBMC) members should be directed to the appropriate Managed Care Organization (MCO).

CODING AND BILLING INSTRUCTIONS

Tables 2-4 list the appropriate codes for billing implantation and removal of the VADs. **Table 2**, on the next page, lists the diagnosis codes appropriate for implantation of a VAD. The diagnosis code is to be billed on the UB-92 claim form with the corresponding ICD-9-CM procedure code.

Table 2 – ICD-9-CM Diagnosis Codes

Code	Description
410.xx	Acute myocardial infarction
411.1	Intermediate coronary syndrome
411.81	Acute coronary occlusion without myocardial infarction
414.9	Chronic ischemic heart disease, unspecified
422.xx	Acute myocarditis in disease classified elsewhere
425.x	Cardiomyopathy
426.xx	Conduction disorders
427.xx	Cardiac dysrhythmias
428.xx	Heart Failure

Table 2 – ICD-9-CM Diagnosis Codes

Code	Description
429.4	Functional disturbances following cardiac surgery
785.51	Cardiogenic shock
997.1	Cardiac complications

* xx represents diagnosis code placeholders. For example, 410.xx means all diagnoses in the 410 series are applicable.

Table 3 lists the applicable ICD-9-CM Procedure codes for implantation, repair and removal of a VAD. The ICD-9-CM code must be billed on the UB-92 claim form and will be incorporated into the DRG payment.

Table 3 – ICD-9 Procedure Codes

Code	Description
37.63	Repair of heart assist system Replacement of parts of an existing VAD
37.64	Removal of heart assist system
37.65	Implant of external heart assist system Device (outside the body but connected to heart) with external circulation and pump Includes: open chest procedure for cannula attachments
37.66	Implant of implantable heart assist system Device directly connected to the heart and implanted in the upper left quadrant of peritoneal cavity Includes: LVAD Pulsatile heart assist system RVAD Rotary pump heart assist system Transportable, implantable heart assist system VAD, not otherwise specified

Table 4 lists the applicable CPT codes for the physician component of the implantation and removal of a VAD. The CPT code should be billed on a CMS-1500 claim form or 837P electronic transaction.

Table 4 – CPT Procedure Codes

Code	Description
33975	Insertion of ventricular assist device; extracorporeal, single ventricle
33976	Insertion of ventricular assist device; extracorporeal, biventricular
33977	Removal of ventricular assist device; extracorporeal, single ventricle
33978	Removal of ventricular assist device; extracorporeal, biventricular
33979	Insertion of ventricular assist device, implantable, intracorporeal, single ventricle
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle
0048T	Implantation of a ventricular assist device, extracorporeal, percutaneous transseptal access, single or dual cannulation
0049T	Prolonged extracorporeal percutaneous transseptal ventricular assist device,

Table 4 – CPT Procedure Codes

Code	Description
	greater than 24 hours, each subsequent 24 hours period
0050T	Removal of a ventricular assist device, extracorporeal, percutaneous transseptal access, single or dual cannulation

Items Included in the DRG for Hospital Inpatients Utilizing the VAD System

1. ICD-9-CM Diagnoses (Primary, Secondary, Tertiary, as needed)
2. ICD-9-CM Procedures
3. VAD (included in the ICD-9-CM Procedure code)
4. Stationary Power Base and Display Module (capital purchase by the hospital)
5. Rechargeable batteries and harness (for untethered systems)
6. Miscellaneous Supplies

Billing Instructions for Outpatient Equipment Utilizing the CMS-1500 Claim Form

1. Prior authorization must be obtained for LVAD equipment.
2. The description of the Power Unit and Display Module should be entered on a detail line with HCPCS code L9900 placed in locator 24d of the CMS-1500 claim form. The total rental price may not exceed the purchase price.
3. The description of the accessories should be placed on a second detail line with the appropriate HCPCS code in locator 24d of the CMS-1500 claim form.
4. An invoice for each detail must accompany the CMS-1500 claim form when submitted.

RELATED MEDICAL TOPICS

Hospital Inpatient
Hospital Outpatient
Medical Supplies and Equipment
Physician Services
Surgery
Surgery - Transplants

Origination Date: 7/31/2001

Reviews and Revisions	Reason	Date
Revision	Addition of new CPT Codes and ICD-9-CM procedure codes	10/29/2004
Revision	Addition of coverage of postcardiotomy cardiogenic shock, destination therapy, and a summary of types and uses of VADS, addition of HCPCS code for reporting replacement parts.	01/31/06

RULES, CITATIONS, AND SOURCES

405 IAC 5-28

405 IAC 5-19

APPLICABLE INDIANA AIM EDITS AND AUDITS

- 6649 – Surgery payable at reduced amount when related post-operative care paid
- 6653 – Post-operative care within 0-90 days of surgery
- 6654 – Pre-operative care within one day of surgery
- 6655 – Surgery payable at reduced amount when pre-operative care paid
- 6002 – Any two anesthesiology provider same procedure
- 6003 – Manual pricing for split care billing
- 6034 – Global surgery payable at reduced amount when components of surgical care paid
- 6035 – Components of surgical care not payable when global surgery paid
- 6039 – Assistant surgeon not payable when co-surgeon paid
- 6040 – Co-surgeon paid at reduced amount when assistant surgeon paid
- 6661 – Duramorph can not be billed on same day as surgery
- 6666 – Anesthesia services not allowed by provider billing for surgery
- 6037 – Only one assistant surgeon allowed for select surgeries
- 6652 – Multiple surgeries must be billed on same claim
- 6152 – Surgery payable at reduced amount when consult paid

MEDICAL POLICY FACT SHEET

TITLE: MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT – WHEELCHAIR ACCESSORIES

DESCRIPTION

This fact sheet describes the different wheelchair accessories covered by the Indiana Health Coverage Programs (IHCP). The following is a list of the wheelchair accessories included in this fact sheet.

- Programmable electronic parts
- Wheelchair cushions
- Wheelchair positioning accessories
- Mounting hardware
- Universal headrest plates
- Power seating systems
- Matrix Seating System

This document is intended to serve as a general summary of the IHCP policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

I. PROGRAMMABLE ELECTRONIC PARTS

A. Coverage Criteria

The IHCP covers programmable electronic parts for motorized/power wheelchair bases with PA under the following circumstances.

1. The IHCP will provide separate reimbursement for medically necessary programmable electronic system *upgrades* to a system that comes standard on a specific wheelchair model for motorized/power wheelchair bases.
2. The IHCP covers adaptive switch controls, such as a sip and puff, or additional drive controls and programming not available on the basic one-drive electronic system for patients with degenerative diseases.

Programmable electronic systems that come standard on a specific motorized/power wheelchair model cannot be billed separately because total reimbursement for a motorized/power wheelchair with programmable electronics, coded as K0011, includes the programmable electronic system.

Programmable electronic upgrades include items such as MKIV electronics. MKIV electronics offers at least three functions over that of standard electronics, and may be deemed medically necessary for select patients. The elements of MKIV electronics include: smoother driving over a variety of terrain, increased speed of the chair with quick performance selections, and the ability to program for special finger control operation for patients who cannot effectively operate a joystick due to spasticity of limbs or other muscular conditions.

B. Prior Authorization

The following PA criteria must be met for approval of programmable electronic parts.

- Providers must submit documentation that the member's condition, mobility needs, and/or prognosis supports the medical necessity for a programmable electronic system upgrade, such as an upgrade from an Invacare MKIV RII system, to an Invacare MKIV A system, or for an adaptive control, such as sip and puff.
- A completed IHCP medical clearance form, to be submitted with the PA request, for rental or purchase of the upgraded programmable electronic parts or adaptive controls. The medical clearance form must be reviewed and signed by a physiatrist.
- The member's physician may prescribe a motorized/power wheelchair. However, the medical necessity must be reviewed and the medical clearance form must be approved and signed by a physiatrist prior to the form being submitted to the PA department. A member is only required to see the physiatrist if the physiatrist requests to see the member after a review of the documentation. If a physiatrist requests to see a member after reviewing the documentation, the member would then be required to travel to the nearest physiatrist. Providers should note that if the physiatrist does not choose to see the member for an evaluation, the IHCP will not provide reimbursement to the physiatrist for a chart review.
- When submitting a request for K0014, *other motorized/power wheelchair base*, the PA must include documentation indicating the model, brand name, model number and a statement documenting the medical necessity of the base for the particular member including why customization is needed.

C. Coding and Billing

Upgrades of programmable electronic systems are to be billed using HCPCS code K0108, *Wheelchair component or accessory not otherwise specified*, with the KA modifier, *add-on option accessory*. The cost of the upgraded electronics must not already be included in the base wheelchair code. K0108 will be covered for purchase only and will be reimbursed at the maximum fee of \$1,950.

Providers must bill their usual and customary charge for the particular programmable electronic system or joystick upgrade installed on the wheelchair base and must attach either a provider's cost invoice or retail price invoice to document the cost or price of the upgraded electronic system. The invoice must include, at a minimum, supporting information such as the item or part number, the description of the item, the quantity provided, and the manufacturer's name. In addition to the invoice, providers should include supporting documentation that details the difference in the cost or price between the electronic system that came standard on the wheelchair base and the upgraded electronic system.

When billing K0108 for a programmable electronic system upgrade, the wheelchair base must be billed using HCPCS code K0014. K0014 is a manually priced code. By using K0014, the IHCP reimburses for the wheelchair base only, without the electronics. Billing in this manner allows the IHCP to make accurate payment decisions for medically necessary electronic system upgrades. The wheelchair base and electronic system upgrade should be billed on the same CMS-1500 or 837 electronic transaction. Providers may refer to IHCP bulletin BT200335 for examples of IHCP coding and reimbursement for programmable electronic system upgrades.

Programmable adaptive controls, such as sip and puff, must be billed using the appropriate HCPCS E code shown in **Table 1**. The adaptive controls are reimbursed at the IHCP max fee on file. The wheelchair base must be billed using K0014.

Table 1 – Coding for Adaptive Controls

Code	Definition
E2310	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware
E2311	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware
E2320	Power wheelchair accessory, hand or chin control interface, remote joystick or touchpad, proportional, including all related electronics, and fixed mounting hardware
E2321	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and

Code	Definition
	fixed mounting hardware
E2322	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated
E2324	Power wheelchair accessory, chin cup for chin control interface
E2325	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware
E2326	Power wheelchair accessory, breath tube kit for sip and puff interface
E2327	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware
E2328	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware
E2329	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware
E2330	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware
E2331	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware
E2399	Power wheelchair accessory, not otherwise classified interface, including all related electronics and any type mounting hardware

II. WHEELCHAIR CUSHIONS

A. Coverage Criteria

The IHCP reimburses wheelchair seat and back cushions for members with either a manual or motorized/power wheelchair, when medically necessary. Reimbursable cushions include general seat and back cushions, nonadjustable skin protection seat cushions, adjustable skin protection seat cushions, positioning seat and back cushions, nonadjustable skin protection and positioning seat cushions, and adjustable skin protection and positioning seat cushions. Certain cushions require PA.

B. Prior Authorization

General use seat cushions (E2601 and E2602) and general use back cushions (E2611 and E2612) are covered for any member who has a wheelchair, regardless of their diagnosis. General use cushions do not require PA.

PA is required for all other wheelchair seat and back cushions. The PA criteria for these cushions are listed on the next page.

Nonadjustable skin protection seat cushions (E2603 and E2604) and adjustable skin protection seat cushions (K0108 U1 and K0108 U2) are covered under the following conditions.

1. The member must have a wheelchair.
2. The patient has **either** of the following conditions.
 - a) Current pressure ulcer of the lower back, hip, or buttock (707.03-707.05) or past history of a pressure ulcer on one of the same areas; **or**
 - b) Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one or more of the following diagnoses:
 - Spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1)
 - Other spinal cord disease (336.0-336.3)
 - Multiple sclerosis (340)
 - Other demyelinating disease (341.0-341.9)
 - Cerebral palsy (343.0-343.9)
 - Anterior horn cell disease including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9)
 - Post polio paralysis (138)
 - Traumatic brain injury resulting in quadriplegia (344.09)
 - Spina bifida (741.00-741.93)
 - Childhood cerebral degeneration (330.0-330.9)
 - Alzheimer's disease (331.0)
 - Parkinson's disease (332.0)

Positioning seat cushions (E2605 and E2606) and positioning back cushions (E2613-E2616, E2620) are covered under the following conditions.

1. The member must have a wheelchair.

2. The member has significant postural asymmetries that are due to one or more of the diagnoses listed in 2b above, or of the following diagnoses:
 - a) Monoplegia of the lower limb (344.30-344.32, 438.40-438.42)
 - b) Hemiplegia due to stroke, TBI or other injury (342.00-342.92, 438.20-438.22)
 - c) Muscular dystrophy (359.0, 359.1)
 - d) Torsion dystonias (333.4, 333.6, 333.7)
 - e) Spinocerebellar disease (334.0-334.9)

Nonadjustable skin protection and positioning seat cushions (E2607 and E2608) and adjustable skin protection and positioning seat cushions (K0108 U3 and K0108 U4) are covered under the following conditions.

1. The member must have a wheelchair
2. The member must meet the criteria for coverage of both a skin protection seat cushion and a positioning seat cushion.

A custom fabricated seat cushion (E2609) and a custom fabricated back cushion (E2617) are covered under the following conditions.

1. The member must have a wheelchair.
2. The cushion must meet the IHCP guidelines for custom DME.
3. The prescribing physician must submit comprehensive documentation that explains what other prefabricated seat or back cushions have been tried, and why these items have not been sufficient to meet the patients needs.
4. The member must meet all criteria necessary for the approval of a prefabricated seat or back cushion.

C. Coding and Billing

Table 2 lists the codes available for reporting wheelchair seat and back cushions. The provider should choose the most appropriate code for billing on the CMS-1500 and/or the 837P electronic claim. Providers may refer to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) as a guideline for coding wheelchair cushions. The IHCP does not limit reimbursement of seat or back cushions to the cushions listed in the SADMERC classification list. If a provider chooses to supply a cushion that is not listed on the SADMERC classification list, it is the provider's responsibility to submit the HCPCS code that most appropriately represents the type of cushion being supplied.

Table 2 – Wheelchair Cushion Codes

Code	Description
E2601	General use wheelchair seat cushion, width less than 22 inches, any depth
E2602	General use wheelchair seat cushion, width 22 inches or greater, any depth
E2603	Skin protection wheelchair seat cushion, nonadjustable, width less than 22 inches, any depth
K0108 U1	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches
E2604	Skin protection wheelchair seat cushion, nonadjustable, width 22 inches or greater, any depth
K0108 U2	Skin protection wheelchair seat cushion, adjustable, width greater than or equal to 22 inches
E2605	Positioning wheelchair seat cushion, width less than 22 inches, any depth
E2606	Positioning wheelchair seat cushion, width 22 inches or greater, any depth
E2607	Skin protection and positioning wheelchair seat cushion, nonadjustable, width less than 22 inches, any depth
K0108 U3	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches
E2608	Skin protection and positioning wheelchair seat cushion, nonadjustable, width 22 inches or greater, any depth
K0108 U4	Skin protection and positioning wheelchair seat cushion, adjustable, width greater than or equal to 22 inches
E2609	Custom fabricated wheelchair seat cushion, any size
E2611	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware
E2612	General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware
E2613	Positioning wheelchair back cushion, posterior width less than 22 inches, any height, including any type mounting hardware
E2614	Positioning wheelchair back cushion, posterior width 22 inches or greater, any height, including any type mounting hardware
E2615	Positioning wheelchair back cushion, posterior-lateral width less than 22 inches, any height, including any type mounting hardware
E2616	Positioning wheelchair back cushion, posterior-lateral width 22 inches or greater, any height, including any type mounting hardware
E2617	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware
E2620	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware
E2621	Positioning wheelchair back cushion, planar back with lateral supports, 22 inches or greater, any height, including any type mounting hardware

III. WHEELCHAIR POSITIONING ACCESSORY

A. Coverage Criteria

Positioning accessories include cushioned headrests, lateral trunk or hip supports, medial and lateral thigh supports, and shoulder harnesses or chest straps. The IHCP covers wheelchair positioning accessories (HCPCS codes E0955-E0957, and E0960) when medically necessary for IHCP members with postural disorders. The cushioned headrests, lateral trunk or hip supports, and medial and lateral thigh supports require PA. Shoulder harnesses and chest straps (E0960) do not require PA.

B. Prior Authorization

Positioning accessories E0955-E0957 will be approved if the member has

- 1) A wheelchair; and
- 2) Significant postural asymmetries that are due to one or more of the following diagnoses.
 - Spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1)
 - Other spinal cord disease (336.0-336.3)
 - Multiple sclerosis (340)
 - Other demyelinating disease (341.0-341.9)
 - Cerebral palsy (343.0-343.9)
 - Anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9)
 - Post polio paralysis (138)
 - Traumatic brain injury resulting in quadriplegia (344.09)
 - Spina bifida (741.00-741.93)
 - Childhood cerebral degeneration (330.0-330.9)
 - Alzheimer's disease (331.0)
 - Parkinson's disease (332.0)
 - Monoplegia of the lower limb (344.30-344.32, 438.40-438.42)
 - Hemiplegia due to stroke, TBI or other injury (342.00-342.92, 438.20-438.22)
 - Muscular dystrophy (359.0, 359.1)
 - Torsion dystonias (333.4, 333.6, 333.7)
 - Spinocerebellar disease (334.0-334.9)

C. Coding and Billing

Providers must report the codes listed in **Table 3** for positioning accessories. Positioning accessories E0955-E0957 include fixed mounting hardware in the cost of the equipment. If adjustable or swingaway mounting hardware is medically necessary for these accessories, providers may bill for the hardware separately using HCPCS code E1028

(See IHCP policy for Mounting Hardware on the following page). Providers may bill for lateral thigh supports utilizing HCPCS code K0108.

Table 3 – Codes for Positioning Accessories

Code	Description
E0955	Wheelchair accessory, headrest, cushioned, any types, including fixed mounting hardware
E0956	Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware
E0957	Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware
E0960	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware
K0108	Wheelchair component or accessory not otherwise specified

IV. MOUNTING HARDWARE

A. Coverage Criteria

The IHCP allows reimbursement of swingaway or retractable mounting hardware, when fixed mounting hardware is not adequate to meet the member's medical needs, using HCPCS code E1028, *Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory*. E1028 may only be reimbursed under the circumstances on the following page.

- May be reimbursed in addition to positioning accessories (E0955-E0957) when swingaway, or removable type adjustable hardware is required.
- Reimbursable with lateral pediatric supports (E1025-E1027) when swingaway and removable hardware are required.
- For swingaway hardware used with hand and chin control interfaces (E2320 and E2321), swingaway or flip-down hardware for head control interfaces (E2327-E2330) and swingaway hardware for an indicator display box that is related to the multi-motor electronic connection (E2310 or E2311).
- HCPCS Code E1028 is not to be used for swing away hardware used with sip and puff interface (E2325) because swingaway hardware is included in the allowance for that code.

B. Prior Authorization

PA is required for mounting hardware. Providers must indicate the mounting hardware that is required, including the brand name, model name and number, and the type of equipment the mounting hardware is being used with. Documentation of medical

necessity for the swingaway, retractable, or removable mounting hardware must be included with the PA request.

C. Coding and Billing

Providers must use HCPCS code E1028 to bill mounting hardware. Requests for mounting hardware using HCPCS code E1399 will be denied. Requests for swingaway, retractable, or removable mounting hardware for use with equipment other than those specified in this policy will be denied.

V. UNIVERSAL HEADREST PLATES

A. Coverage Criteria

The IHCP will reimburse a universal headrest plate when the initial headrest ordered for a new wheelchair does not meet the member's needs upon the first or subsequent fittings, and a replacement headrest is required. The universal headrest plate is necessary to fit a headrest from one manufacturer to the wheelchair back from a different manufacturer.

Universal headrest plates will not be covered for the initial headrest ordered for use on a new wheelchair. The wheelchair back should be pre-drilled to accommodate the headrest initially ordered with the wheelchair.

B. Prior Authorization

Reimbursement of the universal headrest plates will be subject to the PA criteria on the next page.

1. Universal headrest plates will be covered when the initial headrest ordered for a new wheelchair does not meet the member's medical needs and a replacement headrest is required. The provider must document on the PA request, the brand name and model of the original headrest and include an explanation of why the headrest did not meet the member's needs. In addition, the provider must indicate the brand name and model of the subsequent headrest that will be used on the wheelchair.
2. Universal headrest plates will be covered for a used wheelchair if the member's condition changes and the wheelchair back is not pre-drilled for the headrest. The provider must provide documentation of the medical necessity for the headrest.
3. Replacement universal headrest plates will be covered with documentation of an explanation for the replacement (i.e. plate is damaged due to high tone/spasticity of the patient).

C. Coding and Billing

HCPCS code E1028, *Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory*, must be used for PA and billing. Requests for approval of the universal headrest plate using HCPCS code E1399, *Durable medical equipment, miscellaneous*; will be denied for appropriate coding. Providers should submit their usual and customary charge using HCPCS code E1028.

VI. POWER SEATING SYSTEMS

A. Coverage Criteria

The IHCP covers power seating systems including power tilt only, power recline only with or without shear reduction, and the combination of power tilt and recline with or without shear reduction. In addition, the IHCP will reimburse for power leg elevation systems to be used with power seating systems. The IHCP does not provide reimbursement for a power seat elevator, as this equipment is not considered medically necessary.

B. Prior Authorization

Power seating systems require PA. Providers must submit documentation of medical necessity detailing the member's condition that requires tilt and/or recline. Documentation must also be submitted that indicates the member requires assistance to use a manual tilt and/or recline and is left unattended for extended periods of time, or would be otherwise able to independently care for themselves with the power system.

Power tilt-in-space seating systems may be considered for the following medical conditions.

- History of skin breakdown or current indication of skin breakdown that cannot be controlled by less costly modalities such as pressure relief cushions or manual pressure relief techniques
- Excessive extensor or flexor muscle tone that requires a constant seat-to-back angle, when automatic position changes are necessary for the member
- Upper body instability that causes dependent sitting balance requiring gravity assisting positioning
- Orthostatic hypotension

Power recline seating systems may be considered for the following medical conditions.

- History of skin breakdown or current indication of skin breakdown that cannot be controlled by less costly modalities such as pressure relief cushions or manual pressure relief techniques
- Hip extension contractures that do not require a constant seat-to-back angle, when automatic position changes are necessary for the member
- Orthostatic hypotension
- Bladder management, such as intermittent catheterization

Shear reduction may be approved when documentation indicates the level of possible skin breakdown justifies sheer reduction.

C. Coding and Billing

Table 4 lists the codes available for reporting power seating systems. Providers should bill the appropriate code on the CMS-1500 or 837P electronic transaction.

Table 4 – Power Seating System Codes

Code	Description
E1002	Wheelchair accessory, power seating system, tilt only
E1003	Wheelchair accessory, power seating system, recline only, without shear reduction
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction
E1005	Wheelchair accessory, power seating system, recline only, with power shear reduction
E1006	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction
E1007	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction
E1009	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each
E1010	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, each

VII. MATRIX SEATING SYSTEM

A. Coverage Criteria

The IHCP will provide reimbursement for the purchase of, any medically necessary revisions to, and repairs of the Matrix seating system, with PA. Coverage of the Matrix seating system includes coverage of the Matrix TMX Composite Shell, the Matrix Extra Rigid Support Frame, the Matrix TMX Seat Cover, the Matrix Mobility Base, the TMX Quik Release Interface, or other Matrix accessories.

B. Prior Authorization

PA requests for the Matrix TMX Composite Shell and the Matrix Extra Rigid Support Frame will be considered for approval if medical necessity for custom seating is established by a physiatrist or orthopedic surgeon and all criteria listed below are met.

1. The member has tried multiple seating systems in the past three years (replacement every 6-12 months) showing unsuccessful seating attempts by other means, or it is expected that the member will have frequent change of seating needs (every 6-12 months) due to growth or anticipated surgeries.
2. The TMX is prescribed for the treatment of severe musculoskeletal deformity, severe weakness of the trunk muscles, or severe spasticity/extremely high tone.
3. The member must weigh less than 300 pounds with room for growth (should only be given prior approval on a case-by-case basis if weight could reasonably exceed 300 pounds within next three years).
4. The member is in the wheelchair six to eight hours daily, or is expected to be, with use of the TMX seating system.
5. The TMX must be the most cost-effective of the available options (documentation must be provided that identifies all seating options that would meet medical necessity, including cost, and address why each was not selected).

A photograph showing current seating may be required with the PA request. Members must meet the above PA criteria to be approved for other Matrix accessories or the Matrix Mobility Base. In addition, providers requesting the Matrix Mobility Base must document that the Matrix TMX system has an expected use of a minimum of 10 years. Providers requesting the TMX Quik Release Interface must meet the above criteria and include documentation of the need for portability.

D. Coding and Billing

The Matrix TMX Composite Shell is billed with HCPCS code E1399 U1, *Matrix Composite Shell*, and includes the reimbursement of a custom contoured insert, rigid support frame, wheelchair interface mounting kit, all hardware needed for the seat/back, and all refitting/readjustments needed within six months (unless necessitated by a significant change in medical condition). Reimbursement for the composite shell does not include reimbursement of an extra rigid support frame, seat covers, headrests, armrests, footrests, leg troughs, footboxes, covers for these special items, or a mobility base. The Matrix Extra Rigid Support Frame is billed with HCPCS code E1399 U2, *Matrix Extra Rigid Support Frame*, when medically necessary for increased stability, and includes reimbursement of the frame and necessary hardware.

Revisions to the Matrix Composite Shell are accomplished with simple hand tools, such as an electric screwdriver. A revision may involve minor adjustments to relieve specific pressure points or to add more support in specific areas by changing the shape of the Matrix TMX fabric at that site. In other cases, a revision may entail complete disassembly of the seat and reshaping to the current needs of the member. A complete disassembly and refitting is usually done for growth or significant posture changes (such as with Herrington rod placement for scoliosis). Often, with a complete disassembly and refitting, extra parts are needed to enlarge the seat. This is usually accomplished by inserting extra TMX fabric into the center of the seat. These extra parts do not represent an additional cost to the provider since many parts are left over from the initial fitting. The manufacturer has indicated that any extra parts needed as part of a revision should not receive reimbursement. Therefore, no reimbursement will be made for extra fabric, hardware, or framing components necessary to make such modifications.

Revisions (regardless of the intensity or degree of modification required) are reimbursed only as labor by a technician using code E1340, *Repair or non-routine service, requiring the skill of a technician, per 15 minutes*. Units billed for labor must reflect actual time spent and a log of time spent must be maintained in the member's record, which is subject to post-payment review. The term "revision" applies only to the reshaping of the Matrix TMX shell to meet current medical needs of the member. For addition of any ancillary accessories, these items should be coded using the most appropriate HCPCS code.

Matrix TMX seat covers (whether provided with a new system or as replacement covers) are billed using HCPCS code E2605, *Positioning wheelchair cushion, width less than 22 in, any depth*. Only half-covers will be covered by the IHCP since full covers are aesthetic in nature and not medically necessary. With normal wear and tear, new covers will rarely be approved more often than every 18 months. Replacement of covers at an interval less than 18 months may be considered in cases such as theft, fire, or irreparable damage from an auto accident or similar circumstances. Cases of extreme wear may be considered on a case by case basis for replacement more frequently than the specified time frame (pictures may be required along with a detailed explanation of the excessive wear and the care for the items). Two covers may be allowed in cases of incontinence because the covers must be air-dried when washed, which would cause the entire chair to be non-usable for 24 to 72 hours.

The TMX Mobility Base is billed using HCPCS code E1220, *Wheelchair; specially sized or constructed*, and includes all refitting and readjustments needed within six months (unless necessitated by a significant change in medical condition). Claims submitted for the TMX Mobility Base must reflect the provider's usual and customary charge. The mobility base can be adapted to fit the changing needs of the patient. Parts needed for growth will receive no additional reimbursement if "left-over" parts from previous fittings are available for use. Labor for growth modifications may be billed using E1340.

As all components of the TMX are supported by a lifetime warranty, replacement of an entire Matrix TMX Mobility Base will rarely be approved. An entire mobility base may be considered for replacement only in cases of unusual or unavoidable circumstances, such as theft, fire, or irreparable damage from an auto accident or similar circumstance. No additional reimbursement will be made for TMX Mobility Base framing components or any component under warranty. Additional reimbursement is made for parts not under lifetime warranty, such as tires or casters.

The Matrix Quik Release Interface is billed using HCPCS code E1399. Additional Matrix accessories such as headrests, armrests, footrests, etc. should be billed using the most appropriate HCPCS code. Only if no code is available for the accessory should E1399 be used for PA requests or billing.

VIII. MANAGED CARE

Primary Care Case Management (PCCM) services are subject to the same policies and restrictions as Traditional Medicaid services. Questions regarding coverage of services in Risk Based Managed Care (RBMC) should be directed to the appropriate Managed Care Organization (MCO).

RELATED MEDICAL TOPICS

Medical Supplies and Equipment – Manual Wheelchairs and Motorized/Power Wheelchairs

RULES, CITATIONS, AND SOURCES

IHCP Provider Bulletin
 BT200335 – Motorized Wheelchairs
 BT200401 – HCPCS Updates
 IHCP Provider Banner
 BR200509 – Matrix Seating System
 BR200525 – Universal Headrests

Origination Date: 01/31/06

Revisions and Review	Reason	Date

APPLICABLE INDIANA A/M EDITS AND AUDITS

6065 - DME total rental amount not to exceed fee for purchase

6080 - DME rentals limited to 15 months

6113 - DME limited to \$2,000 per recipient per calendar year

6114 - DME limited to \$5,000 per recipient per lifetime

MEDICAL SUPPLIES AND EQUIPMENT – WHEELCHAIR ACCESSORIES ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Medical Supplies and Equipment-Wheelchair Accessories Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200627 **Publication Date:** 07/04/2006

Subject: July 2006, Quarterly HCPCS Codes Update

Date Added to Manual: 10/31/2006

Text of Publication

HCPCS codes K0734 through K0737 are new codes to report adjustable skin protection and positioning seat cushions currently reported with HCPCS code K0108 and modifier U1, U2, U3, or U4. The IHCP created the procedure code to modifier combinations in order to mirror Medicare policy for the use of HCPCS code K0108 for adjustable seat cushions as published in provider banner [BR200536](#). Adjustable cushions are purchase-only items by the IHCP, and providers must attach the NU modifier when billing to the IHCP. Pricing established for adjustable and positioning seat cushions as published in *BR200536* is applied to HCPCS codes K0734 through K0737, effective for dates of service on or after September 1, 2006. Providers are allowed to report procedure code K0108 and modifier U1, U2, U3, or U4 for skin protection and positioning seat cushions for dates of service through August 31, 2006.

MEDICAL POLICY FACT SHEET

**TITLE: MENTAL HEALTH/BEHAVIORAL HEALTH—
INPATIENT SERVICES**

DESCRIPTION

Acute psychiatric and substance abuse inpatient services are mental health interventions used to stabilize and manage people with severe symptoms and behaviors that have or may result in harm to self and/or others. The following information describes presenting factors that may meet medical necessity for inpatient services.

- Current and/or recent serious suicide ideation with plan and potential means with lethal intent
- Current and/or recent serious, violent, impulsive, and unpredictably dangerous homicidal ideation with plan and potential means with lethal intent
- Current and or recent harm to self or others with plan and potential means with lethal intent
- Unable to care for self due to a psychiatric condition so that imminent life-threatening deterioration has occurred
- Acute psychotic symptoms, severely bizarre thinking and/or psychomotor agitation/retardation that cannot be safely treated in a less restrictive level-of-care

Depending on the needs of the patient, acute psychiatric and substance abuse inpatient services often include, but are not limited to, 24-hour psychiatric and medical services, continuous monitoring, medication management, treatment planning, individual therapy, family therapy, and group therapy.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code, or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

PRIOR AUTHORIZATION

Prior authorization (PA) is required for all acute inpatient admissions, emergency and non-emergency. The facility is responsible for initiating the PA review process. Providers should contact the Health Care Excel (HCE) PA department for the initial pre-certification and concurrent review. For IHCP members enrolled in Managed Care, refer

to the Managed Care section for PA requirements. PA is not a guarantee of payment for services rendered.

Reimbursement is available for inpatient care provided on the psychiatric unit of an acute care hospital only when the need for admission has been certified. The Division of Family and Children State Form *1261A, Certification Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*, fulfills the written certification of need requirements.

The HCE PA department reviews each *1261A* form and determines whether the requested acute inpatient services meet medical necessity. Reimbursement is denied for any days the facility cannot justify a need for inpatient care. If the provider fails to complete a telephone PA pre-certification, reimbursement will be denied for the period of time from the admission to the actual date of notification.

Emergency Admissions

- A telephone PA must be completed within 48 hours of the admission date, not including Saturdays, Sundays, and legal holidays
- A completed *1261A* form must be received, via U.S. mail, within 14 working days of the admission date, not including Saturdays, Sundays, and legal holidays

Non-Emergency Admissions

- A telephone PA must be completed prior to admission
- A completed *1261A* form, via U.S. mail, must be received within ten working days of the admission date, not including Saturdays, Sundays, and legal holidays

When an individual applies to become an IHCP member after admission to a facility, providers must notify HCE in writing within ten days of receiving a notification of IHCP eligibility. At that time, providers may request coverage for the entire period of service for which reimbursement is being sought.

COVERAGE CRITERIA

Admission Criteria

Members must meet medical necessity to be eligible for acute IP psychiatric and substance abuse inpatient services. Members must present with the following criteria at the time of admission.

- Acute psychiatric inpatient admissions are available for members with a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one or more of the following.

- Danger to the individual
 - Danger to others
 - Death of the individual
- Substance abuse inpatient admissions must be to a psychiatric facility or unit. Admissions to a general hospital floor are only appropriate when medical services are required for life-support and cannot be rendered in a substance abuse treatment facility or unit. These inpatient detoxification, rehabilitation, and aftercare admissions are available for members when the following criteria have been determined.
 - Evaluation, treatment, and detoxification are based on the stated medical condition and/or primary diagnosis for inpatient admission
 - Need for safe withdrawal from alcohol and/or other drugs is indicated
 - Reasonable evidence that detoxification and aftercare cannot be accomplished in an outpatient setting
 - History of recent convulsions or poorly controlled convulsive disorder

Plan of Care

Each Medicaid member admitted to an acute psychiatric facility or unit must have an individually developed plan of care. For members between 22 and 65 years of age in a psychiatric facility of 16 beds or less, plans of care must be developed by the attending or staff physician. For members under 21 years of age, plans of care must be developed by a physician and interdisciplinary team. All plans of care must be developed within 14 days of the admission date regardless of the age of the member. The following components must be documented in each member's plan of care.

- Treatment objectives and goals including an integrated program of appropriate therapies, activities, and experiences designed to meet these objectives
- Discharge and coordination plans for inpatient services with partial discharge plans including appropriate services in the community to ensure continuity of care (i.e., family and school)

The plan of care is developed as a result of a diagnostic evaluation that includes an examination of the medical, psychological, social, and behavioral aspects of the member's presenting problem and previous treatment interventions. The plan of care must be reviewed and updated at least every 90 days for members between 22 and 65 years old by the attending or staff physician to ensure appropriate services being provided continue to be medically necessary. An interdisciplinary team is required to develop and direct the plan of care for all members 21 years and younger. This team is responsible for developing and updating plans of care at least every 30 days. One of the following professionals or combination of professionals must be active in the treatment planning process.

- A board certified or eligible psychiatrist
- A psychologist endorsed as a health service provider in psychology (HSPP) and a physician licensed to practice medicine or osteopathy

- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist endorsed as an HSPP or licensed psychologist

A professional, who is qualified to make determinations regarding mental health conditions and treatments, must be part of the interdisciplinary team as well. At least one of the following professionals must be active in the treatment planning and implementation process.

- A licensed clinical social worker, licensed marital and family therapist, licensed mental health counselor, or a person holding a master's degree in social work, marital and family therapy, or mental health counseling
- An advanced practice nurse or registered nurse who has specialized training or one year experience in treating people with mental illnesses
- An occupational therapist registered with the National Association of Occupational Therapists who has specialized training or one year of experience treating people with mental illnesses
- A psychologist endorsed as an HSPP or a licensed psychologist

Package C Members

Inpatient mental health and substance abuse services are covered when the services are medically necessary for the diagnosis or treatment of the member's condition except when provided in a mental health institution with more than 16 beds.

Restricted Card Program Members

Mental and behavioral health services are included in the carved-out Medicaid services; therefore, a written referral is not required for members of the Restricted Card Program to access these services.

REIMBURSEMENT

Inpatient Services

Reimbursement will be denied for any days during which the acute psychiatric inpatient hospitalization is found to lack medical necessity. Telephone certifications of medical necessity provide a basis for reimbursement and must be supported by the written certification of need. If the required written documentation is not submitted within the specified time frame and/or does not support medical necessity, reimbursement will be denied.

Acute inpatient care is reimbursed based on a level of care (LOC) and a diagnosis related group (DRG) methodology. The following information describes reimbursement for psychiatric and substance abuse inpatient services.

- Acute psychiatric inpatient services are reimbursed on a LOC reimbursement methodology; therefore, these services are paid on a per diem basis. The per diem rate includes routine, ancillary, and capital costs. Direct care physicians services are excluded from the per diem rate and are separately billable. All other supplies and services provided to members, including services provided by health service providers in psychology (HSPP) and clinical psychologists, salaried, contracted, and independent providers, are included in the per diem rate and cannot be billed separately.
- Substance abuse inpatient services are reimbursed on a DRG reimbursement methodology; therefore, this service is paid on a per case basis.

OTHER INPATIENT SERVICES

Readmission

A readmission is defined as a hospital admission within three days following a previous hospital admission and discharge for the same or related condition. Same or related condition refers to the primary diagnosis code which is based on the first three digits of the ICD-9-CM code. Readmissions are treated as separate stays for payment purposes, but are subject to medical review. Providers should bill one inpatient claim when a patient is readmitted to their facility within three days of a previous inpatient discharge (the stays should be consolidated on one claim) for the same or related diagnosis. If it is determined that a discharge is premature, payment made as a result of the discharge or readmission may be subject to recoupment. Additionally, post-payment review of readmissions will be conducted to ensure providers are appropriately following the readmission policies and guidelines.

Observation Stays

Psychiatric and substance/chemical abuse observation stays in acute care hospitals and freestanding psychiatric hospitals are reimbursable. The observation period must last no more than three days (72 hours). If the member meets the criteria for inpatient admission prior to the end of the observation period, the member's status may be changed to inpatient at that time. IHCP members may qualify for observation status meeting both of the following criteria.

- The criteria for inpatient admission have not been met
- The treating physician or mental health provider has determined that allowing the member to leave the facility would likely put the member at serious risk

Observation stays are reimbursed according to outpatient mental health services. Refer to the IHCP Provider Manual Outpatient services for more information regarding these services.

Less Than 24-Hour Stays

Providers should bill any inpatient stay that is less than 24 hours as an outpatient service. Inpatient stays less than 24 hours that are billed as an inpatient service will be denied, or will be subject to retrospective review.

Outpatient Service Within Three Days of an Inpatient Stay

Outpatient services that occur within three days preceding an inpatient admission to the same facility for the same or related diagnosis are considered part of the corresponding inpatient admission. Providers are required to submit an inpatient claim only when both of the services, outpatient and inpatient, occur at same facility.

If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim will deny with an explanation of benefits code indicating that the provider should bill services on the inpatient claim. The provider should adjust the outpatient claim (complete adjustment) and resubmit one inpatient claim.

Reserving Beds

Reimbursement is available for reserving beds in psychiatric hospitals; it is not available in general acute care hospitals. Hospitalization must be ordered by a physician for the treatment of an acute condition that cannot be treated in a psychiatric facility. Physician orders must be maintained in the member's file at the facility. The total length of time reimbursable per inpatient stay is 15 days. If a member requires more than 15 days consecutively, the member must be discharged from the psychiatric facility. Facilities are reimbursed at one-half the regular per diem rate.

Therapeutic Leave of Absence

Reimbursement is available for therapeutic leave of absence from psychiatric hospitals; it is not available from general acute hospitals. Leaves of absence must be for therapeutic reasons and ordered by a physician as indicated in the member's plan of care. Physician orders must be maintained in the member's file at the facility. The total length of time available for therapeutic leaves of absence is 60 days per calendar year per member. If a member is absent from a psychiatric hospital for more than 60 days per year, no further reimbursement will be available for reserving a bed for that member in that year. Facilities are reimbursed at one-half the regular per diem rate.

MANAGED CARE

While the MCO retains responsibility for the delivery and payment of most care for its members, certain services are not paid by the MCO. These services remain the financial

responsibility of the State and reimbursed on a fee-for-service basis. These carve-out services include most mental health and substance abuse services from IHCP enrolled providers with a mental health specialty. The following information describes who providers should notify when a RBMC member is admitted for acute psychiatric or substance abuse inpatient services.

- Mental health care provided to an MCO-enrolled member in an acute care facility is the responsibility of the MCO and is authorized and reimbursed by the MCO.
- Mental health services provided to an MCO-enrolled member in a freestanding mental health facility or by mental health specialties are not the MCO's responsibility and are subject to all PA and reimbursement criteria established for IHCP fee-for-service billing.

RELATED MEDICAL TOPICS

Assertive Community Treatment Services
Community Mental Health Centers Services
Developmental, Neurological, and Psychological Testing Services
Emergency Medicine—Emergency Room
Emergency Medicine—Emergency Services
Evaluation and Management Services
Intermediate Care Facility for the Mentally Retarded
Inpatient Hospital Services
Outpatient Hospital Services
Outpatient Mental Health Services
Managed Care Services
Mental Health Rehabilitation Services
Pharmacy Services
Physician Services
Psychiatric Residential Treatment Facility Services
Smoking Cessation Services
Waiver Services

RULES, CITATIONS, AND SOURCES

Indiana Administrative Code (IAC)

- 405 IAC 1-8-2 – Hospital and ambulatory surgical center reimbursement for outpatient services
- 405 IAC 1-10.5-3 – Perspective reimbursement methodology
- 405 IAC 5-2-19 – “Outpatient services” defined
- 405 IAC 5-3 – Prior authorization
- 405 IAC 5-2-17 – “Medically reasonable and necessary service” defined
- 405 IAC 5-20-8 – Outpatient mental health services
- 405 IAC 5-21 – Community mental health rehabilitation services

- 405 IAC 5-25 – Physician services
- 405 IAC 5-29 – Services not covered by Medicaid
- 405 IAC 5-37 – Smoking cessation treatment policy
- 440 IAC 5.2-2-3 – Assertive community treatment services

Indiana Code (IC)

- IC 12-15-12 – Managed care
- IC 25-23-1-1(b)(3) – Advance practice nurses credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center

Indiana Health Coverage Programs Provider Banner (BR)

- BR200532 – Supervision of Mental Health or Managed Care Organization Services
 - BR200523 – Assertive Community Treatment Community Mental Health Centers
H0040 – ACT Services, Per Diem
 - BR200514 – Hoosier Healthwise Mandatory Risk-based Managed Care (RBMC) Enrollment
 - BR200451 – Mental Health Cross Walked Local Codes
 - BR200430 – EDS Made Changes to HCPCS Code H0040–Assertive Community Treatment Program, Per Diem
 - BR200424 – Explanation of benefits (EOB) code 5007
 - BR200439 – CPT Codes 90805, 90807, 90809, 90810, 90813, and 90815 for Psychotherapy with Medical Evaluation and Management, and CPT Code 90862 for Pharmacological Management
 - BR200244 – System Modification Affecting Medicare Part B Crossover Claims Billed by a Health Service Provider in Psychology (HSPP) with an AH Modifier
 - BR200421 – Mid-level Practitioner Modifiers
 - BR200240 – Explanation of Benefit (EOB) Code 4116–Diagnosis Code is Not Valid for DRG Pricing.
 - BR199952 – Supervision Requirements
 - BR199950 – Risked-based Managed Care Inpatient Psychiatric Services
 - BR199946 – Implementation of Smoking Cessation Treatment Services
 - BR199920 – Changes in Diagnostic Related Groups/Level of Care Inpatient and Outpatient Methodologies
 - BR199810 – Modifications to the Computer System to Allow Psychiatric Medicare Part B Crossover Claims
- Indiana Health Coverage Programs Provider Bulletin (BT)
- BT200506 – State-wide Hoosier Healthwise Mandatory Managed Care Organization Transition
 - BT200432 – Annual Notice for Hoosier Healthwise Managed Care Members
 - BT200429 – Psychiatric Residential Treatment Facility Services for Patients Younger than Six Years Old
 - BT200415 – Clarification of Mental Health Modifiers, Mental Health Clinics, and Community Mental Health Centers
 - BT200413 – Assertive Community Treatment Service Coverage, Standards, and Requirements

- BT200404 – Acute Care Hospitals, Psychiatric Hospitals, Psychiatrists, Health Services Providers in Psychology, Mental Health Clinics, Physicians, Primary Medical Providers for Primary Care Case Management and Community Mental Health Centers
 - BT200360 – Changes in Diagnosis-Related Group Relative Weights and New Long-Term Acute Care Hospital Level-of-care Reimbursement Methodology
 - BT200362 – Prior Authorization for Hoosier Healthwise Managed Care Organizations
 - BT200340 – Hoosier Healthwise Mandatory Managed Care Organization Transition
 - BT200262 – Hoosier Healthwise Managed Care Certification Code Requirements
 - BT200240 – MDwise Managed Care Organization Service Area Expansion
 - BT200231 – Managed Care Carve-out and Self-referral Education
 - BT200208 – Changes to the Medicaid Medical Policy Rule Regarding Outpatient Mental Health Services (405 IAC 5-20 and 405 IAC 5-21)
 - BT200206 – Medicaid Rehabilitation Option Issues
 - BT200145 – Community Mental Health Centers Third Party Liability Edits
 - BT200140 – Mandatory Managed Care Organization Enrollment Update
 - BT200129 – Changes in Diagnostic-Related Groups/Level-of-care Inpatient and Outpatient Reimbursement Methodologies
 - BT200124 – Acute Care and Freestanding Psychiatric Hospitals Reimbursement for Child Abuse and Neglect Cases
 - BT200121 – Important Information about Hoosier Healthwise Managed Care Entity Contact Information
 - BT200049 – Procurement of Hoosier Healthwise MCO Contract
 - BT200028 – Changes to the Medicaid Medical Policy Rule Regarding Outpatient Mental Health Services (405 IAC 5-20 and 405 IAC 5-21)
 - BT199951 – House Enrolled Act (HEA) 1396, OMPP is Amending the Mental Health Services Sections of the Covered Services Rule (405 IAC 5-20 and 405 IAC 5-21)
 - BT199950 – Free-Standing Psychiatric Hospitals Are Carved-out of Risk-based Managed Care (RBMC) and Paid on a Fee-for-service Basis
 - BT199946 – Implementation of Smoking Cessation Treatment Services
 - BT199930 – Participation in the Indiana Medicaid Hospital Care for the Indigent (HCI) Payment, Municipal County Hospital Indiana Medicaid Shortfall Payment and Indiana Medicaid Disproportionate Share Hospital (DSH) Payment Programs
 - BT199917 – Acute Care and Freestanding Psychiatric Hospitals Child Abuse and Neglect Cases
 - BT199902 – Changes in Diagnostic-Related Groups/Level-of-care Inpatient and Outpatient Reimbursement Methodologies
 - BT199822 – Mental Health Crossover Claims
 - BT199819 – New Mental Health Rehabilitation Option Procedure Code–Z5025
- Indiana Health Coverage Programs Provider Newsletter (NL)

NL200506 – Psychiatric Residential Treatment Facility Update PRTF
 NL200501 – Cross Walked Local Codes
 NL200405 – Cognitive Therapy Services
 NL200406 – Mental Health Billing Modifiers
 NL200410 – Medicaid Behavioral/Physical Health Coordination Form
 Indiana Health Coverage Programs Provider Manual
 1999
 2005 Version 5.1

Revision: December 15, 2005

Revision and Review	Reason	Date
Indiana State Department of Public Welfare Medical Policy Manual 1991	Inpatient Psychiatric Reimbursement	7/01/91
470 IAC 5-9-22 Transferred	Mental Health Services	7/01/91
405 IAC 1-6-13;1-7-20 Repealed	Mental Health Services	1/01/92
405 IAC 5-20	Mental Health Services	8/24/97
Routine Review	Scheduled	1/31/06

APPLICABLE INDIANA A/M EDITS AND AUDITS

0437 – Psych Adjustment Amount Invalid
 0636 – Enrolled in the RBMC of the Hoosier Health Program
 2028 – Non-IHCP Member Ineligible for Dates of Services
 2032 – Therapy and Hospital are Only Leave Days Valid on Psychiatric Unit
 2033 – Package C Recipients Not Eligible for Clone Dates
 3000 – Units Exceed Prior Authorization Master
 3001 – Dates of Service Not on Prior Authorization Database
 3007 – No Prior Authorization Segment for Level of Care
 3008 – Prior Authorization Units Equal Zero
 4082 – Bed Reservation in Psychiatric Hospital
 4083 – Inpatient Mental Health Facility
 4085 – Inpatient Care in a Psychiatric Hospital for Members Ages 22-64
 4086 – Therapies After More than 30 Days from Hospital
 4204 – Invalid Diagnosis for Procedure Code/ Modifier
 5000 – Possible Duplication
 5001 – Exact Duplication
 5009 – Suspect Duplication Different Provider Allowed
 6120 – Outpatient Mental Health/ Substance Abuse Services Office Visits, Maximum 30 Per Calendar Year Without Prior Authorization
 6121 – Outpatient Mental Health/ Substance Abuse Services Office Visits, Maximum 50 Per Calendar Year Without Prior Authorization
 6125 – Cognitive Rehabilitation is Limited to Procedure and Diagnosis
 6258 – Inpatient Psych Leave Days Only Allowed 60 Per Year
 6270 – Smoking Cessation Counseling Limited to Ten 15-minute Units Per Calendar Year
 6508 – Same Day Discharge
 6515 – Inpatient Admit Date Within Three Days After DOS of Paid Outpatient Claim

- 6516 – Outpatient Services Rendered Within Three Days Prior to Admit Date of Paid Inpatient Claim
- 6517 – Inpatient Claim Discharge Date Within Three Days Prior to Admit Date Paid Inpatient Claim
- 6518 – Inpatient Claim Admit Date Within Three Days After Discharge Date of Paid Inpatient Claim
- 6615 – Assertive Community Treatment Is Limited One Per Day
- 6631 – Medical Leave cannot Exceed Four Consecutive Days
- 6632 – T2048 Is Only Reimbursable for Provider Specialty 033
- 6633 – 25180 and T2048 Limited to One Psychiatric Treatment Per Day
- 6635 – Treatment Leave Days Exceed 14 Per Year
- 6636 – Mid-level Services Not Reimbursable the Same Day a Paid PRTF Service
- 6673 – Psychiatric Per Diem Medical Leave Days Cannot Exceed Four Consecutive Days
- 6900 – Outpatient Mental health Services More Than 20/Year Without Prior Authorization
- 6901 – Outpatient Psychiatric Testing Exceeds Two Units Per Year
- 6902 – Outpatient Therapies Over 80 Units Requires Prior Authorization
- 6921 – One Diagnostic Evaluation Per Recipient Every Six Months

MEDICAL POLICY FACT SHEET

**TITLE: MENTAL HEALTH/BEHAVIORAL HEALTH—
OUTPATIENT SERVICES**

DESCRIPTION

Outpatient mental health services are interventions intending to reduce and/or alleviate symptoms, improve the level of functioning, and prevent further and/or recurrent deterioration. After clients are assessed, a determination is made as to what forms of therapy will most likely be beneficial. Common interventions of outpatient treatment include individual, family, couple, and group counseling.

Therapy is a collaborative process; therefore, the client is expected to be active and cooperative with establishing the treatment plan. Treatment plans include specific goals, methods to accomplish goals, and methods to measure the progress of treatment goals. Measurable goals are also necessary to determine when improvement or deterioration of a client's functioning has occurred. Treatment plans must be reviewed and updated on a regular basis to reflect continued needs and identify new goals of the client.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code, or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

The IHCP covers outpatient (OP) mental health services provided by a licensed medical doctor, doctor of osteopathy, psychologist endorsed as a Health service provider in psychology (HSPP), psychiatric hospitals, psychiatric wings of acute care hospitals, and OP mental health facilities. Reimbursement is also available for services provided by mid-level practitioners when services are supervised by a physician or a HSPP. Mid-level practitioners who are eligible to provide OP mental health services must have obtained one of the following credentials.

- Academy of Certified Social Workers
- Advanced Practice Nurses credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Certified Clinical Social Worker

- Certified Psychologist
- Independent Practice School Psychologist
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Mental Health Counselor
- Licensed Psychiatric and Mental Health Clinical Nurse Specialist
- Licensed Psychologist
- Psychologist with a basic certificate
- Registered Nurse with a master's degree in nursing with a major in psychiatric and mental health nursing from an accredited school of nursing
- Master's degree in social work, marital and family therapy, or mental health counseling

The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and supervising the plan of treatment. They are responsible for seeing the member during the intake process or reviewing the medical information obtained by the mid-level practitioner within seven days of the intake process. Also, the physician, psychiatrist, or HSPP must see the member or review the medical information and certify medical necessity on the basis of medical information provided by the mid-level practitioner at intervals not to exceed 90 days. Both reviews must be documented in writing; co-signatures alone are not sufficient.

I. Outpatient Services

Medicaid reimbursement is available for one psychiatric diagnostic interview examination without prior authorization (PA) per member, per provider, per rolling calendar year (Refer to Chapter 2 of the IHCP Provider Manual for an explanation of rolling calendar year). A maximum of two diagnostic interview examinations per member, per rolling calendar year is allowed without PA when one examination is provided by a physician or HSPP and one examination is provided by a mid-level practitioner. All additional examinations require PA.

Prior authorization is required for mental health services provided in an OP facility or office setting that exceed 20 units per member, per provider, per rolling calendar year. A current treatment plan and progress notes, outlining the necessity and effectiveness of therapy, must be attached to the PA form and available for audit purposes. The following CPT codes are subject to the 20 units per member, per provider, per rolling calendar year.

- 90801–90802
- 90804–90815
- 90845–90857

Noncovered Services

- Day care
- Hypnosis

- Biofeedback
- Missed appointments
- Experimental drugs, treatments, procedures, and all related services
- Services for the remediation of learning disabilities
- Treatments or therapies of an educational nature
- Acupuncture
- Hyperthermia
- Hypnotherapy
- Day care or partial day care or partial hospitalization
- Cognitive rehabilitation, except for treatment of traumatic brain injury

Package C Members

Package C members are eligible for outpatient mental health services. Reimbursement is available for 30 visits per member, per rolling calendar year. An additional 20 visits may be covered with PA for a maximum of 50 visits per year.

Reimbursement

All rendered outpatient services must be identified and itemized on the *CMS-1500*. The medical record documentation must identify the services and the length of time of each therapy session. This information must be available for audit purposes. Mid-level services should be billed using the rendering provider number of the supervising practitioner (physician or HSPP), following by the appropriate modifier, and the billing provider number of the outpatient mental health clinic or facility. **Table 1** lists mid-level practitioners and the appropriate corresponding modifiers for billing purposes.

Table 1 – Outpatient Mental Health Modifiers for Mid-level Practitioners

Mid-level Practitioner	Modifier
Clinical Psychologist	AH
Clinical Social Worker	AJ
Nurse Practitioner or Clinical Nurse Specialist	HE/ SA
Nurse Practitioner or Clinical Nurse Specialist in a non-mental health arena	SA
Any other mid-level practitioner	HE

Claims billed for services provided by mid-level practitioners and billed with the appropriate modifier will reimburse 75% of the IHCP allowed amount. HSPPs do not use modifiers.

II. Mental Health Rehabilitation Option Services

Mental Health Rehabilitation Option (MRO) services are restricted to providers enrolled as Community Mental Health Centers (CMHC). These services are provided to individuals, families, or groups living in the community who need aid intermittently for emotional disturbances or mental illnesses. MRO services include

traditional IHCP outpatient mental health services, partial hospitalization services, and case management services. Outpatient mental health services may include, but not limited to, services provided in the member's home, workplace, mental health facility, or emergency department. These services must be rendered by a qualified mental health professional. Reimbursement is available for the following MRO outpatient mental health services.

- Case management services
- Conjoint counseling or psychotherapy
- Crisis intervention
- Diagnostic assessment and pre-hospitalization screening
- Family counseling or psychotherapy
- Group counseling or psychotherapy
- Individual counseling or psychotherapy
- Medication or somatic treatment
- Partial hospitalization
- Training in activities in daily living

Partial Hospitalization

Partial hospitalization is a series of structured group activities with components of two or more hours in duration, but less than full-time hospitalization. For billing purposes, one unit of service is equal to 15-minutes. Actual time per day is to be totaled and rounded up to the closest one-quarter hour.

Reimbursement

Community Mental Health Centers must continue to use the *HW* modifier to denote MRO services in addition to the modifiers that identify the qualifications or the individual rendering the service. Community Mental Health Center providers are to bill using the CPT code *H0031 HW, Mental health assessment, by non-physician (one unit equals one-quarter hour)*, for physicians performing mental health assessments. Mid-level practitioners should bill using the CPT code *H0031 HW* with the appropriate mid-level practitioner modifier.

Services Not Reimbursable

- Case management services will not be provided as a means for enrollment in the Medicaid program or verification of IHCP benefits
- Case management services will not be reimbursed for activities which are vocational in nature or job skill oriented
- MRO services are not covered for Package C members

III. Assertive Community Treatment Service

Assertive Community Treatment (ACT) is an intensive mental health service for members discharged from a hospital after multiple or extended stays, or who are difficult to engage in treatment. ACT services are provided by an interdisciplinary staff team and must be ordered by a physician. Services are provided through intensive community supports. The goal of ACT services is to decrease the frequency of hospitalizations, length of hospitalizations, and/or need of crisis services. ACT services must be available 24-hours a day, seven days a week, with emergency response coverage, including availability of a psychiatrist. The ACT team must meet and discuss the services rendered, schedule services, and progress of ACT members on a daily basis during the five-day work week to meet program review standards. ACT teams should have a procedure in place to track daily team meeting attendance and client therapy participation.

Prior authorization (PA) is required for ACT services covered by the IHCP. It is not necessary to submit PA requests to HCE. The Division of Mental Health and Addiction reviews random samples of ACT medical records for appropriateness and ensures that the required services and documentation are maintained. The provider is responsible for compiling and maintaining the necessary documentation for PA.

ACT services are only reimbursable for members who meet the criteria for ACT services and for whom the ACT team psychiatrist has documented medical necessity.

Eligibility for ACT services is determined from the current medical status, psychiatric history, and status at time of consideration for ACT services. Treatment plan goals must be documented and reviewed by the ACT team psychiatrist. The following illustrates additional information which must be documented in the medical record and is required for the PA process.

- Member's level of functioning factor score at the date of most recent assessment and the date of that assessment
- Clinical summary including documentation of any institutionalizations and hospital visits related to the member's condition in the past two years
- Documentation supporting the member's severe limitations with activities of daily living, a current treatment plan, and documentation supporting how the member meets the CMHC requirements for ACT participation
- Individual treatment plans, which need to be reviewed and updated every 90 days, must be developed and include the following documentation: medication administering and monitoring; self-medication monitoring; crisis assessment and intervention; symptom assessment, management and individual supportive therapy; substance abuse training and counseling; psychosocial rehabilitation and skill development; personal, social, and interpersonal skill training; and coordination with case management, consultation, and psycho-educational support for individuals and their families
- Signature of the ACT team psychiatrist is considered the clinical review required for PA

Reimbursement

ACT services must be billed using procedure code *H0040, ACT Program, per diem*, and modifier *HW, Funded by state mental health agency*. One unit of ACT service equals one 24-hour day. The ACT team psychiatrist or a health service provider in psychology (HSPP) who is an ACT team member must be present at the daily team meetings for the service code to be reimbursed at 100% of the Medicaid allowable amount. Additional mid-level practitioner modifiers are necessary, when the ACT team psychiatrist or HSPP is not in attendance at the daily team meeting, to obtain reimbursement at 75% of the allowed rate.

IV. Waiver Services

Waiver members may receive MRO services; however, services may not be duplicated. The waiver case manager and the CMHC must coordinate services to ensure duplication does not occur.

V. Other Outpatient Mental Health Services

Testing Services

PA is required for all units of testing which includes codes CPT 96101, *Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour*; 96110, *Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report*; 96111, *Developmental testing; extended (includes assessment of motor language, social, adaptive, and/ or cognitive functioning by standardized developmental instruments) with interpretation and report*; and 96116, *Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour*, and 96118, *Neuropsychological testing battery (eg, Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour*. A physician or an HSPP must provide all testing services, as well as, interpretation and reporting.

Medication Management Services

During the initial assessment with the member, there must be face-to-face contact with a physician; however, at the three-month review, the face-to-face contact may be made with the physician or an advanced practice nurse with prescription authority providing services within the scope of practice. **Table 2** includes covered medication management services that are reimbursable only when rendered by a physician or an advanced practice nurse with prescription authority.

Table 2 – Medication Management Services

CPT Code	Description
90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90807	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90809	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
90811	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90813	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90815	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy

RELATED MEDICAL TOPICS

Assertive Community Treatment Services
 Community Mental Health Centers Services
 Developmental, Neurological, and Psychological Testing Services
 Evaluation and Management Services
 Intermediate Intensive Care Facility for the Mentally Retarded
 Inpatient Hospital Services
 Managed Care Services
 Mental Health Rehabilitation Services
 Outpatient Services
 Pharmacy Services
 Physician Services

Psychiatric Residential Treatment Facility Services
Smoking Cessation Services
Waiver Services

RULES, CITATIONS, AND SOURCES

Indiana Administrative Code (IAC)

- 405 IAC 1-8-2 – Hospital and ambulatory surgical center reimbursement for outpatient services
- 405 IAC 1-10.5-3 – Perspective reimbursement methodology
- 405 IAC 5-2-19 – “Outpatient services” defined
- 405 IAC 5-3 – Prior authorization
- 405 IAC 5-2-17 – “Medically reasonable and necessary service” defined
- 405 IAC 5-20-8 – Outpatient mental health services
- 405 IAC 5-21 – Community mental health rehabilitation services
- 405 IAC 5-25 – Physician services
- 405 IAC 5-29 – Services not covered by Medicaid
- 405 IAC 5-37 – Smoking cessation treatment policy
- 440 IAC 5.2-2-3 – Assertive community treatment services

Indiana Code (IC)

- IC 12-15-12 – Managed care
- IC 25-23-1-1(b) (3) – Advance practice nurses credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center

Indiana Health Coverage Programs Banner (BR)

- BR200532 – Supervision of mental health or managed care organization services
- BR200523 – Assertive community treatment community mental health centers
H0040–ACT services, per diem
- BR200514 – Hoosier Healthwise mandatory risk-based managed care (RBMC) enrollment
- BR200451 – Mental health cross walked local codes
- BR200439 – CPT codes 90805, 90807, 90809, 90811, 90813, and 90815 for psychotherapy with medical evaluation and management, and CPT code 90862 for pharmacological management
- BR200430 – EDS made changes to HCPCS code H0040–Assertive community treatment program, per diem
- BR200424 – Explanation of benefits (EOB) code 5007
- BR200244 – System modification affecting Medicare Part B crossover claims billed by a health service provider in psychology (HSPP) with an *AH* modifier
- BR200421 – Mid-level practitioner modifiers
- BR200240 – Explanation of benefit (EOB) code 4116–diagnosis code is not valid for DRG pricing.
- BR199952 – Supervision requirements
- BR199950 – Risked based managed care inpatient psychiatric services
- BR199946 – Implementation of smoking cessation treatment services

BR199920 – Changes in diagnostic related groups/level of care inpatient and outpatient methodologies

Indiana Health Coverage Programs Provider Bulletin (BT)

- BT200506 – State-wide Hoosier Healthwise mandatory managed care organization transition
- BT200432 – Annual notice for Hoosier Healthwise managed care members
- BT200429 – Psychiatric residential treatment facility services for patients younger than six years old
- BT200415 – Clarification of mental health modifiers, mental health clinics, and community mental health centers
- BT200413 – Assertive community treatment service coverage, standards, and requirements
- BT200404 – Acute care hospitals, psychiatric hospitals, psychiatrists, health services providers in psychology, mental health clinics, physicians, primary medical providers for primary care case management, and community mental health centers
- BT200362 – Prior authorization for Hoosier Healthwise managed care organizations
- BT200360 – Changes in diagnosis-related group relative weights and new long-term acute care hospital level-of-care reimbursement methodology
- BT200340 – Hoosier Healthwise mandatory managed care organization transition
- BT200262 – Hoosier Healthwise managed care certification code requirements
- BT200240 – MDwise managed care organization service area expansion
- BT200231 – Managed care carve-out and self-referral education
- BT200208 – Modifications to prior authorization requirement
- BT200206 – Medicaid rehabilitation option issues
- BT200145 – Community mental health centers third party liability edits
- BT200140 – Mandatory managed care organization enrollment update
- BT200129 – Changes in diagnostic-related groups/level-of-care inpatient and outpatient reimbursement methodologies
- BT200124 – Acute care and freestanding psychiatric hospitals reimbursement for child abuse and neglect cases
- BT200121 – Important information about Hoosier Healthwise managed care entity contact information
- BT200049 – Procurement of Hoosier Healthwise MCO contract
- BT200028 – Changes to the Medicaid medical policy rule regarding outpatient mental health services (405 IAC 5-20 and 405 IAC 5-21)
- BT199946 – Implementation of smoking cessation treatment services
- BT199930 – Participation in the Indiana Medicaid hospital care for the indigent (HCI) payment, Municipal County Hospital Indiana Medicaid shortfall payment and Indiana Medicaid disproportionate share hospital (DSH) payment programs
- BT199917 – Acute care and freestanding psychiatric hospitals child abuse and neglect cases

BT199902 – Changes in diagnostic-related groups/level-of-care inpatient and outpatient reimbursement methodologies

Indiana Health Coverage Programs Provider Newsletter (NL)

NL200506 – Psychiatric residential treatment facility update PRTF

NL200501 – Crosswalked local codes

NL200410 – Medicaid behavioral/physical health coordination form

NL200406 – Mental health billing modifiers

NL200405 – Cognitive therapy services

Indiana Health Coverage Programs Manual

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2005 Version 5.1

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Revision and Review	Reason	Date
470 IAC 5-9-22	Mental Health Services	7/01/91
405 IAC 1-6-13; 1-6-13.1; & 1-7-20	Mental Health Services (Repealed)	1/01/92
405 IAC 5-20-8	Outpatient Mental Health Services	8/24/97
405 IAC 5-21-1	Community Mental Health Rehabilitation Services	8/24/97
Indiana Medicaid Update Bulletin	Mental Health Rehabilitation Option	7/01/98
Indiana Health Coverage Programs	Mental Health Providers, Physicians, and Psychologists	12/28/99
Indiana Medicaid Update Bulletin	Psychiatrists, Physicians, Health Service Providers in Psychology, and Mental Health Facilities Clinics	8/04/00
Routine Review	Scheduled	1/31/06

APPLICABLE INDIANA A/M EDITS AND AUDITS

1040 – MRO Services Can Only be Billed On a HCFA 1500 Form By A CMHC

2202 – Recipient Not Enrolled With Billing MCO

4203 – Denial Modifier for Non Covered MRO Service- Y8

4204 – Invalid Diagnosis for Procedure Code/Modifier Combination

6120 – Outpatient Mental Health/ Substance Abuse Services Office Visits, Maximum 30 Per Calendar Year Without Prior Authorization

6121 – Outpatient Mental Health/ Substance Abuse Services Office Visits, Maximum 50 Per Calendar Year Without Prior Authorization

6125 – Cognitive Rehabilitation is Limited to Procedure and Diagnosis

6270 – Smoking Cessation Counseling Limited to 10 15-minute Units Per Calendar Year

6515 – Inpatient Services Performed 3 Days After DOS of Paid Outpatient Claim

6516 – Outpatient Services Rendered Within 3 Days Prior to Admit

- 6517 – Inpatient Claim Discharge Date Within 3 Days Prior to Admit Date of Paid Inpatient Claim
- 6518 – Inpatient Claim Admit Date Within 3 Days After Discharge Date of Paid Inpatient Claim
- 6615 – Assertive Community Treatment Is Limited One Per Day
- 6632 – T2048 Is Only Reimbursable for Provider Specialty 033
- 6633 – Z5180 and T2048 Limited to One Psychiatric Treatment Per Day
- 6636 – Mid-level Services Not Reimbursable the Same Day a Paid PRTF Service
- 6673 – Psychiatric Per Diem Medical Leave Days Cannot Exceed Four Consecutive Days
- 6900 – Outpatient Mental health Services More Than 20/Year Without Prior Authorization
- 6902 – Outpatient Therapies Over 80 Units Requires Prior Authorization
- 6921 – One Diagnostic Evaluation Per Recipient Every 6 Months

MEDICAL POLICY FACT SHEET

TITLE: NURSING FACILITIES

DESCRIPTION:

A nursing facility [long-term care facility (LTC)] is an extended-care facility for persons who require medical attention of the type and complexity that does not require hospitalization. Nursing facilities provide 24-hour nursing supervision, rehabilitation services, activity and social services, a restraint-appropriate environment, careful attention to nutritional needs, and measures to prevent complications of decreased mobility. (Taber's Cyclopedic Medical Dictionary, Edition 18, Copyright © 1997 by F.A. Davis Co., Philadelphia, PA).

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

Services and products furnished by a nursing facility for the usual care and treatment of IHCP members are reimbursed in the per diem rate. The per diem rate for nursing facilities includes room and board, nursing care, the cost of all medical and nonmedical supplies and equipment, medically necessary and reasonable therapy services, which include physical, occupational, respiratory, and speech pathology services, and transportation to vocational/habilitation service programs. Routine nursing services must be provided by a registered nurse, a licensed practical nurse, or a nurse's aide.

IHCP reimbursement is not available for personal care or comfort items. The IHCP member receives a personal needs allowance to be used at the member's discretion for items such as clothing, makeup, or other personal items. Providers may not utilize these funds without the member's expressed consent.

Hospice Services

Providers are advised to consult the Medical Policy Fact Sheet regarding Hospice Services and the IHCP Hospice Provider Manual for information regarding hospice services provided to an IHCP member that is residing in a nursing facility.

Transportation Services

Providers are advised to consult the Medical Policy Fact Sheet/Transportation Services for further information.

Pharmacy Services

The IHCP does not provide reimbursement for pharmacy services provided to a dually eligible IHCP member in a nursing facility during a Medicare covered post-hospitalization period. Drug products dispensed for these members should be billed to the nursing facility only. Providers are advised to consult the Medical Policy Fact Sheet/Pharmacy Services for further information.

Case Mix Reimbursement

Under the case mix reimbursement system, each nursing facility has one nursing facility level of care designation in IndianaAIM and one per diem rate calculated on resource usage for residents within the facility. The per diem rate changes quarterly and is calculated by IHCP's rate setting contractor.

**INDIANA PRE-ADMISSION SCREENING
PRE-ADMISSION SCREENING AND RESIDENT REVIEW**

Indiana pre-admission screening (IPAS) refers to the assessment and determination of a member's eligibility **prior** to admission to a nursing facility. Resident review (RR) refers to the annual evaluation used to determine the necessity to continue services due to a change in condition. Initial medical information is submitted for all nursing facility admissions utilizing the Form 450B, described on the following page.

All individuals applying for admission to Medicaid-certified nursing facilities, regardless of their source of payment, must be pre-screened through a two level screening process, Pre-Admission Screening and Resident Review (PASRR)⁵. Level I identifies individuals who may be mentally ill (MI) or Mentally Retarded/Developmentally Disabled (MR/DD). A PASRR Level II assessment is conducted by the Community Mental Health Centers (CMHCs) for nursing facility residents who may be MI. Nursing facility residents who may be MR/DD receive the PASRR Level II assessment by the Diagnostic and Evaluation (D&E) Team. Nursing facility residents may also require assessment under the Resident Review (RR) Level II process if they are identified as possibly being MI or MR/DD under one of the following circumstances.

- The resident was not assessed through the PASRR program prior to admission
- The resident has a substantial change in condition related to their MI or MR/DD condition, which may require a change in services or placement

Diagnostic and Evaluation Teams

Diagnostic and Evaluation (D&E) Teams must be contracted and approved by the Division of Disability, Rehabilitative Services (DDARS), and the Bureau of Developmental Disabilities

⁵ PASRR is a Federally required administrative program that requires all individuals with mental illness (MI) and/or mental retardation/developmental disabilities (MR/DD), who make application for Level II placement, must be admitted to a Medicaid-certified nursing facility.

Services (BDDS) to conduct the PASRR Level II MR/DD assessments and be enrolled with the IHCP to be eligible to submit Level II MR/DD claims. Providers may obtain a list of contracted and authorized D&E Teams from DDARS.

Community Mental Health Centers

CMHCs are contracted and approved by the Division of Mental Health and Addiction (DMHA) to conduct the PASRR Level II MR/DD assessments and are enrolled with the IHCP to be eligible to submit Level II MR/DD claims. Providers may obtain a list of contracted and authorized CMHCs from the DMHA.

Form 450B/Nursing Facility Level of Care

The *Form 450B*, Physician Certification for Long Term Care Services, must be submitted by the nursing facility to gain State authorization for admissions, transfers between levels of care, re-admissions, Medicare-to-Medicaid transfers, and new Medicaid eligibility. This form is submitted by the nursing facility to the Office of Medicaid Policy and Planning (OMPP). There are currently three variations of *Form 450B*. Facilities can order *Form 450B* and *OMPP 450B SA/DE (State Form 49120)* from the Department of Administration, Forms Distribution Center.

Table 2 in Appendix A describes the use of the forms listed below.

- *Form 450B (State Form 38143)* is used for physician certification for LTC services.
- *OMPP 450B SA/DE (State Form 49120)* is used for nursing facility level of services, State authorization, and data entry.
- *OMPP 450B SA/DE (computer-generated) (State Form 49210)* is used for nursing facility level of service, State authorization, and data entry. This computer-generated *OMPP 450B SA/DE* includes an Indiana Family Social Services Administration signature and is considered to be the official *Form 450B* and must be maintained in the resident's medical records.

Form 450B is not required for any readmission following a hospitalization exceeding the bed-hold policy, as long as the resident was approved for nursing facility care prior to the hospitalization. This applies to readmissions from a hospital to the same or another nursing facility; however, there must be no break in medical care. Nursing facilities are required to submit the *OMPP 450B SA/DE (computer-generated)* to the OMPP in place of the paper *Form 450B*, for purposes of data entry of the resident's readmission date and the appropriate facility provider number in *IndianaAIM* to reinstate nursing facility reimbursement. If the facility intends to reflect other changes, such as new Medicaid eligibility, readmission, or a transfer from another nursing facility, this information should not be entered in the "Level of Care Transfer Date" box.

Resident Level of Care Information on the IndianaAIM System

Under case mix, the reimbursement rate is based on the information submitted on the Minimum Data Set (MDS) 2.0 form⁶ for each resident. This information is then to be used to compute a facility-average case mix index and rate. Therefore, residents certified for nursing facility

⁶ MDS is a comprehensive assessment for all residents of LTC facilities certified to participate in the Medicaid program.

placement by the Office of Medicaid Policy and Planning (OMPP) will be denoted with the ‘N’ level of care indicator.

Billing Requirements for PASRR

All PASRR claims are reviewed with the State PASRR database prior to reimbursement. CMHCs and D&E Teams may submit claims for PASRR Level II assessments conducted as a result of a Level I referral. Providers should terminate a PASRR Level II assessment immediately if it is determined that the Level I referral was not appropriate, such as, applicant is not DD or has a primary diagnosis of dementia. The submitted claim should reflect a reduced fee as appropriate for the individual assessment. PASRR claims use normal claim processing billing procedures, with the following minor differences.

- D&E Teams and CMHCs are only approved to conduct PASRR Level II assessments through contractual arrangements with DDARS and DMHA. PASRR providers must be enrolled as IHCP providers.
- PASRR applicant(s) or member(s) may be dually-eligible in the IHCP.
- Providers are advised to submit claims for the member using the PASRR member identification number that begins with **800** and the member’s social security number. If an applicant does not have or refuses to provide a social security number, providers may contact the EDS Customer Assistance Unit.
- Providers may not bill members for a PASRR Level II assessment.
- Services cannot be combined with other non-PASRR service type(s), even if the service(s) are rendered on the same day, or same visit. For example, a claim for PASRR services cannot be combined with a claim for other IHCP services.
- PASRR claims are subject to all edits and audits not excluded by PASRR program requirements. If a claim encounters an edit or audit for missing or invalid information, the claim suspends or denies.
- Provider reimbursement for rendered services is determined by the procedure codes, modifiers as defined in **Table 1**, and the associated maximum (max) fee rate. Procedure code(s), modifier(s), and max fee rate(s) must accompany all PASRR claim submissions.
- Providers may void or replace PASRR claims.
- PASRR financial information is available on the 835 Remittance Advice transaction.

Table 1 – CPT Codes for Reporting PASRR Services

CPT Code	Description
T2011 U1 UA	T2011 , Preadmission screening and resident review (PASRR) level II evaluation, per evaluation U1 , PAS (Preadmission screening) UA , Mental retardation/developmental disability
T2011 U1 UA HI	T2011 , Preadmission screening and resident review (PASRR) level II evaluation, per evaluation U1 , PAS (Preadmission screening) UA , Mental retardation/developmental disability HI , Integrated mental health and mental retardation/developmental disabilities program

Table 1 – CPT Codes for Reporting PASRR Services

CPT Code	Description
T2011 U2 UA	T2011 , Preadmission screening and resident review (PASRR) level II evaluation, per evaluation U2 , RR (Resident review) UA , Mental retardation/developmental disability
T2011 U2 UA HI	T2011 , Preadmission screening and resident review (PASRR) level II evaluation, per evaluation U2 , RR (Resident review) UA , Mental retardation/developmental disability HI , Integrated mental health and mental retardation/developmental disabilities program
T2011 U1 UB	T2011 , Preadmission screening and resident review (PASRR) level II evaluation, per evaluation U1 , PAS (Preadmission screening) UB , Mental illness
T2011 U1 UB TS	T2011 , Preadmission screening and resident review (PASRR) level II evaluation, per evaluation U1 , PAS (Preadmission screening) UB , Mental illness
T2011 U2 UB	T2011 , Preadmission screening and resident review (PASRR) level II evaluation, per evaluation U2 , RR, (Resident review) UB , Mental illness

BILLING REQUIREMENTS

The IHCP does not provide separate reimbursement for medical supplies, non-medical supplies, and routine durable medical equipment (DME) items for members residing in LTC facilities. LTC facilities include nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), and community residential facilities for the developmentally disabled (CRFs/DD). The costs for these services are included in the facility per diem rate, and the medical supplier, or DME supplier should bill the long-term care facility directly for such services.

Therapeutic Leave Days/Hospital Leave Days

The revenue code specific to the leave must be utilized for billing purposes. Revenue code 183 must be used for a therapeutic leave of absence, and revenue code 185 must be used for the hospitalization bed hold. A supporting physician's order for all leave of absences must be maintained in the member's medical record.

Ancillary Charges

The IHCP does not provide separate reimbursement for medical, nonmedical supplies, and routine medical equipment. These items are included in the nursing facility per diem rate. Food supplements, nutritional supplements, and infant formulas are also excluded from separate billing and reimbursement.

Therapy Services

All therapy services provided to IHCP members by nursing facilities are included in the established per diem rate. Therefore, a provider may not bill the IHCP for therapies in addition to the established per diem rate.

NURSING FACILITY AUDITS

The IHCP conducts on-site audits in nursing facilities to review the continuing need for IHCP reimbursement and to ensure that PASRR requirements are met. The on-site audit process includes a verification of the MDS 2.0 responses transmitted to the IHCP rate setting contractor, through a review of documentation in the member's medical record. A sample of all residents in the nursing facility is reviewed, including those residents whose care is not directly funded by the Indiana Medicaid program.

MANAGED CARE

The IHCP pays for room and board under the IHCP hospice benefit for dually-eligible Medicare/Medicaid nursing facility residents and Medicaid-only nursing facility residents who elect the hospice benefit. Each provider group must complete their respective responsibilities to disenroll the member from managed care to ensure that the hospice provider may successfully bill the IHCP for room and board under the hospice benefit. Each provider group must comply with the IHCP Provider Agreement and regularly verify IHCP eligibility.

Nursing facilities and the Area Agency on Aging must notify the specific managed care organization (MCO) immediately when an MCO member is admitted to a facility or undergoes IPAS/PASRR. The MCO is financially responsible for all care provided to its members until enrollment termination is effective. IHCP fee-for-service is financially responsible for nursing facility reimbursement when the member is approved for intermediate level of care (LOC), skilled LOC, or general case mix and the member is disenrolled from the MCO.

Nursing facilities must coordinate with the MCO to allow members to use appropriate in-network service during the period when the member is assigned to the MCO. Providers are advised to contact the individual MCO for further information.

RELATED MEDICAL TOPICS

Evaluation and Management Services

Hospice

Hospital, Inpatient

Hospital, Outpatient

Intermediate Care Facilities for the Mentally Retarded

Nursing Services

Physical Rehabilitation Services

Transportation Services

RULES, CITATIONS, AND SOURCES

405 IAC 1-12.2 Rate setting

405 IAC 1-12-5 New provider; interim rate setting

405 IAC 1-12-7 Request for rate review

405 IAC 1-14.5 Rate setting criteria for HIV nursing facilities

405 IAC 1-14.6 Rate setting criteria for nursing facilities

405 IAC 1-17 Rate setting criteria for state-owned intermediate facilities for the mentally retarded

405 IAC 5-13-3 Services included in the per diem for large private and small ICFs/MR

405 IAC 5-31 Nursing Facility Services

405 IAC 5-5-2 Out-of-State Services

405 IAC 5-30-1 Transportation Services

Indiana Medical Assistance Program Provider Manual 1994

Indiana Medicaid Update Bulletin

95-81 Transportation

98-06 Utilization Review Update

98-26 Case Mix

98-29 Verification

98-30 Hospice Benefit

98-40 450B SA/DE

99-21 Personal Needs Allowance

Indiana Health Coverage Programs Banners

BR200302 – Pharmacy services during Medicare Post-Hospitalization Period

BR200506 – Billing

BR200524 – PASRR and Medical Review Team

Indiana Health Coverage Programs Bulletins

BT200002 – Use of Forms 450B and OMPP 450B SA/DE

BT200501 – Excessive Nursing Home Visits or More Than One per 27 Days, Pre-Admission Screening and Resident Review

BT200513 – Pre-Admission Screening and Resident Review Level II Claims Processing Change

Indiana Health Coverage Programs Provider Newsletters

NL200503 – Disenrolling a Member from an IHCP Managed Care Program

Origination Date: 12/31/2000

Revisions and Review	Reason	Date
Indiana Medicaid Update Bulletin 95-81	Transportation Trip Limit Policy	12/20/1995
405 IAC 5-31, 5-5-2, 5-24-7, 5-30-1	Nursing Facility Services, Out-of-State Services, Pharmacy Services, Transportation Services	08/24/1997

Revisions and Review	Reason	Date
Indiana Medicaid Update Bulletin 98-40	Form 450B SA/DE, Case Mix Reimbursement, Verification of Eligibility for Medicaid Member in Residing in Nursing Facilities	10/01/1998
Indiana Medicaid Update Bulletin 99-21	Personal Needs Allowance (PNA)	07/01/1999
405 IAC 1-12-5 and 405 IAC 1-12-7	ICF/MR and Nursing Facility Services	10/01/1999
405 IAC 5-5-2, and 5-30-1, 5-31-1, 5-31-5, 5-31-8, Amended; 405 IAC 5-31-1.1, Added; 405 IAC 5-31-2, 5-31-3, Repealed	Out of State Services, Transportation Services, and Nursing Facility Services	10/27/1999
Review/Revision	Scheduled Review and Update	10/31/2006

APPLICABLE INDIANA A/M EDITS AND AUDITS

- 1017 – No Rate Segment for Level of Care (Case Mix)
- 1018 – No Rate Segment for Level of Care
- 1019 – Multiple Levels of Care Per Diem on File
- 1023 – Level of Care Billed Not On File for This Provider
- 1030 – Ancillary Service Not Covered
- 2008 – Recipient Ineligible for Level of Care Billed
- 3015 – Out of State Noncovered Services – LTC
- 3016 – Out of State Home Health Services are Non Covered
- 4015 – PASRR Assessments
- 4113 – Unit Dose Packaging Covered for Residents of Long Term Care
- 6047 – Excessive Therapeutic Days
- 6067 – Excessive Therapeutic Leave Day (ICF)
- 6068 – Excessive Therapeutic Leave Days (ICF/MRO or CFR)

Appendix A
Table 2 – Use of Forms 450B, 450B SA/DE (Paper or Computer Generated) for IHCP Members

Scenario	Qualifier	Form Required	Accompanied Information	Official Form for Medical Record
Initial Admission to NF ⁷ (IPAS and PASRR)	All cases of IPAS/PASRR	Entire 450B (Sections I and II) completed	Complete IPAS/PASRR packet	Computer generated OMPP 450B SA/DE or Form 450B with Section III completed
NF to hospital and return same NF (with existing effective Medicaid reimbursement date)	Not exceeding bed hold policy	None	None	Existing 450B with effective Medicaid reimbursement date
NF to hospital and return same NF (with existing effective Medicaid reimbursement date)	Exceeding bed hold policy	450B (Section I only) or 450B SA/DE	None	Returned 450B with effective Medicaid reimbursement date
NF to hospital and return to another NF (with effective Medicaid reimbursement date)	Following any length of hospitalization	450B (Section I only) or 450B SA/DE	None	Returned 450B with effective Medicaid reimbursement date
Transfer from NF to NF (no intervening hospitalization)	None	Entire 450B (Section I and II) completed or 450B Sa/DE with fully completed MDS ⁸	Copy of PAS 4B from the previous NF	Returned 450B with effective Medicaid reimbursement date
Resident change from private pay to Medicaid member	Including changes in eligibility status from Medicaid MCO to regular Medicaid	Entire 450B (Section I and II) completed or 450B Sa/DE with fully completed MDS ³ or computer-generated OMPP 450B SA/DE*** ⁹	Copy of PAS 4B	Returned 450B with effective Medicaid reimbursement date or computer-generated OMPP 450B SA/DE.

⁷ NF-Nursing Facility

⁸ The fully completed MDS for the period under review should be submitted with the Form 450B SA/DE only. The day of the MDS observation period must be within 90 days of Medicaid effective date or requested start date.

⁹ Resubmit an updated (RID, dates, provider number) State-generated OMPP 450B SA/DE if a resident became Medicaid eligible and the requested effective date for Medicaid reimbursement is within 90 days of the state-authorized signature on the OMPP 450B SA/DE.

Scenario	Qualifier	Form Required	Accompanied Information	Official Form for Medical Record
Change from Medicare primary payer to Medicaid primary payer (without existing effective Medicaid reimbursement date)	When Medicare coverage ends	Entire <i>450B</i> (Section I and II) completed or <i>450B SA/DE</i> with fully completed MDS ³	Copy of PAS 4B	Returned <i>450B</i> with effective Medicaid reimbursement date or computer-generated <i>OMPP 450B SA/DE</i>
Change from Medicare payer to Medicaid primary payer (with existing effective Medicaid reimbursement date)	When Medicare coverage ends	<i>450B</i> (Section I only) or <i>450B SA/DE</i>	None	Returned <i>450B</i> with effective Medicaid reimbursement date or computer-generated <i>OMPP 450B SA/DE</i>

MEDICAL POLICY FACT SHEET

TITLE: NURSING SERVICES

DESCRIPTION:

General nursing services for this policy include those services rendered by registered nurses (RN) and licensed practical nurses (LPN), in an office setting, in-patient or out-patient hospital setting, clinic, or home health setting. Other nursing services included in this policy are services rendered by advance practice nurses.

SUMMARY OF CURRENT POLICY

Medicaid reimbursement is available for nursing services rendered by registered nurses, licensed practical nurses, and home health agencies who are Medicaid providers, subject to the following limitations.

- The nurse must possess a current and active license from the Health Professions Bureau.
- Services must be rendered under the supervision and orders of a physician.
- The IHCP no longer enrolls RNs and LPNs in the IHCP program as rendering providers. However, RNs and LPNs are allowed to be the rendering provider of appropriate services in settings including but not limited to the physician office, in-patient or out-patient hospital setting, clinic, and home health settings.
- The IHCP will reimburse nursing services to the billing provider supervising the nursing services (e.g. physician, home health agency).
- Nursing services provided by a home health agency require prior authorization subject to the Indiana Administrative Code (IAC) 405 IAC 5-22-2. For further information, see the Home Health Fact Sheet.

IHCP reimbursement is available for appropriately licensed and certified advanced practice nurses enrolled in the IHCP, according to the scope of the applicable license and certification. The Indiana Code (IC) IC 25-23-1-1 lists three categories of advanced practice nurses, including nurse practitioners, nurse midwives, and clinical nurse specialists. Other types of nurse practitioners enrolled in the IHCP include: certified registered nurse anesthetists, family practice nurse practitioners, pediatric nurse practitioners, and obstetric nurse practitioners.

RELATED MEDICAL TOPICS

Anesthesia Services
Home Health Services
Mental Health

RULES, CITATIONS, AND SOURCES

405 IAC 5-22 Nursing and Therapy Services
405 IAC 5-10 Anesthesia Services
Indiana Medical Assistance Program Provider Manual 1994
Indiana Health Coverage Programs Provider Manual, Version 5.0, 2004
Indiana Health Coverage Programs Banner, BN200351
848 IAC 2-2
848 IAC 2-3
IC 25-23-1-1.1
IC 25-23-1-1.2
IC 25-23-1-1.3
848 IAC 4-1-3
848 IAC 5-1
IC 25-23-1.19.6
848 IAC 4-2-1
848 IAC 4-3-1
848 IAC 3-1-2
IC 25-23-1-30
NL200406

Origination Date: 12/31/00

Review and Revisions	Reason	Date
407 IAC 5-8-19-Nursing and Therapy Services	Transferred	7/1/91
405 IAC 1-6-20; 1-7-21 Nursing and Therapy Services	Repealed 8/24/97	1/1/92
405 IAC 5-22	Nursing and Therapy Services	8/24/97
405 IAC 5-22-2	Nursing and Therapy Services	10/27/99
405 IAC 5-22-2	Nursing and Therapy Services Revision	1/30/05
Provider Enrollment Provider Specialty Matrix	Provider Specialties Revision	1/30/05
848 IAC 2-2	Registered Nursing	1/30/05
848 IAC 2-3	Licensed Practical Nursing	1/30/05
IC 25-23-1-1.1	Registered Nurse	1/30/05

Review and Revisions	Reason	Date
IC 25-23-1-1.2	Licensed Practical Nurse Defined	1/30/05
IC 25-23-1-1.3	Practical Nursing Defined	1/30/05
848 IAC 4-1-3	Advanced Practice Nurse Defined	1/30/05
848 IAC 5-1 and IC 25-23-1.19.6.	Prescriptive Authorities of Advanced Practice Nurses	1/30/05
848 IAC 4-2-1.	Nurse Practitioner Scope of Practice	1/30/05
848 IAC 4-3-1	Clinical Nurse Specialist Scope of Practice	1/30/05
848 IAC 3-1-2	Nurse-Midwife Defined	1/30/05
IC 25-23-1-30	CRNAs	1/30/05
2004 Provider Manual Ch. 8 Section 3	Nurse Practitioner Billing	1/30/05
BN200351	CRNA Billing	1/30/05
NL200406	Mid-Level Practitioner Billing in Mental Health	1/30/05

APPLICABLE INDIANA A/M EDITS AND AUDITS

None

PROVIDER TYPE AND SPECIALTY

Provider Type	Provider Specialty
09 Advance practice nurse	092 Pediatric nurse practitioner
	091 Obstetric nurse practitioner
	092 Family nurse practitioner
	093 Nurse practitioner, other (Clinical nurse specialist)
	094 Certified registered nurse anesthetist (CRNA)
	095 Certified nurse midwife

COVERAGE CRITERIA

Registered Nurse

The IHCP will provide coverage of services performed by an RN in accordance with the criteria set in IC 25-23-1-1.1 provided below. An RN is not enrolled as a billing provider in the IHCP and may not directly bill the IHCP for any services provided. An RN does not have medical diagnostic or prescriptive privileges and may not sign prescriptions or member records on behalf of the physician.

- Sec. 1.1. (a) As used in this chapter, "registered nurse" means a person who holds a valid license issued:
- (1) under this chapter; or
 - (2) by a party state (as defined in IC 25-23.2-1-11); and who bears primary responsibility and accountability for nursing practices based on specialized knowledge, judgment, and skill derived from the principles of biological, physical, and behavioral sciences.
- (b) As used in this chapter, "registered nursing" means performance of services which include but are not limited to:
- (1) assessing health conditions;
 - (2) deriving a nursing diagnosis;
 - (3) executing a nursing regimen through the selection, performance, and management of nursing actions based on nursing diagnoses;
 - (4) advocating the provision of health care services through collaboration with or referral to other health professionals
 - (5) executing regimens delegated by a physician with an unlimited license to practice medicine or osteopathic medicine, a licensed dentist, a licensed chiropractor, a licensed optometrist, or a licensed podiatrist;
 - (6) teaching, administering, supervising, delegating, and evaluating nursing practice;
 - (7) delegating tasks which assist in implementing the nursing, medical, or dental regimen; or
 - (8) performing acts which are approved by the board or by the board in collaboration with the medical licensing board of Indiana.

As stated in the IC, an RN may derive a nursing diagnosis. A nursing diagnosis consists of identifying needs that may be performed by an RN including appropriate preventative, restorative, maintenance, and promotional activities. These activities may be performed by meeting or assisting with self-care needs, counseling and teaching. For further information on the responsibilities of an RN, refer to 848 IAC 2-2.

Licensed Practical Nurse

The IHCP will provide coverage of services performed by an LPN in accordance with the criteria set in IC 25-23-1-1.2 and IC 25-23-1-1.3 provided below. An LPN is not enrolled as a billing provider in the IHCP and may not directly bill the IHCP for any services provided. An LPN does not have medical diagnostic or prescriptive privileges and may not sign prescriptions or member records on behalf of the physician.

- Sec. 1.2. As used in this chapter, "licensed practical nurse" means a person who holds a valid license issued under this chapter or by a party state (as defined in IC 25-23.2-1-11) and who functions at the direction of:
- (1) a registered nurse;
 - (2) a physician with an unlimited license to practice medicine or osteopathic medicine;
 - (3) a licensed dentist;

- (4) a licensed chiropractor;
 - (5) a licensed optometrist; or
 - (6) a licensed podiatrist;
- in the performance of activities commonly performed by practical nurses and requiring special knowledge or skill.

Sec. 1.3. As used in this chapter, "practical nursing" means the performance of services commonly performed by practical nurses, including:

- (1) contributing to the assessment of the health status of individuals or groups;
- (2) participating in the development and modification of the strategy of care;
- (3) implementing the appropriate aspects of the strategy of care;
- (4) maintaining safe and effective nursing care; and
- (5) participating in the evaluation of responses to the strategy of care.

For further information on the responsibilities of a LPN, refer to 848 IAC 2-3.

Advanced Practice Nurse

The IHCP will provide coverage of services performed by an advanced practice nurse in accordance with the criteria set in 848 IAC 4-1-3 provided below. An advanced practice nurse can enroll as a billing provider. See the billing section of this document for specific details. An advanced practice nurse has prescriptive authorities as described in 848 IAC 5-1 and IC 25-23-1.19.6. The advanced practice nurse must include their signature, credentials, and identification number on each prescription in order for the prescription to be valid.

Sec. 3. (a) "Advanced practice nurse" means a registered nurse holding a current license in Indiana who:

- (1) has obtained additional knowledge and skill through a formal, organized program of study and clinical experience, or its equivalent, as determined by the board;
- (2) functions in an expanded role of nursing at a specialized level through the application of advanced knowledge and skills to provide healthcare to individuals, families, or groups in a variety of settings, including, but not limited to:
 - (A) homes;
 - (B) institutions;
 - (C) offices;
 - (D) industries;
 - (E) schools;
 - (F) community agencies;
 - (G) private practice;
 - (H) hospital outpatient clinics; and
 - (I) health maintenance organizations; and
- (3) makes independent decisions about the nursing needs of clients.

Nurse Practitioner

One type of advanced practice nurse is a nurse practitioner. The IHCP will provide coverage of services performed by a nurse practitioner under the same criteria as advanced practice nurses as provided in 848 IAC 4-1-3. The scope of practice of a nurse practitioner is outlined in 848 IAC 4-2-1 below.

- Sec. 1. A nurse practitioner shall perform as an independent and interdependent member of the health team as defined in 848 IAC 2-1-3. The following are standards for each nurse practitioner:
- (1) Assess clients by using advanced knowledge and skills to:
 - (A) identify abnormal conditions;
 - (B) diagnose health problems;
 - (C) develop and implement nursing treatment plans;
 - (D) evaluate patient outcomes; and
 - (E) collaborate with or refer to a practitioner, as defined in IC 25-23-1-19.4, in managing the plan of care.
 - (2) Use advanced knowledge and skills in teaching and guiding clients and other health team members.
 - (3) Use appropriate critical thinking skills to make independent decisions, commensurate with the autonomy, authority, and responsibility of a nurse practitioner.
 - (4) Function within the legal boundaries of their advanced practice area and shall have and utilize knowledge of the statutes and rules governing their advanced practice area, including the following:
 - (A) State and federal drug laws and regulations.
 - (B) State and federal confidentiality laws and regulations.
 - (C) State and federal medical records access laws.
 - (5) Consult and collaborate with other members of the health team as appropriate to provide reasonable client care, both acute and ongoing.
 - (6) Recognize the limits of individual knowledge and experience, and consult with or refer clients to other health care providers as appropriate.
 - (7) Retain professional accountability for any delegated intervention, and delegate interventions only as authorized by IC 25-23-1 and this title.
 - (8) Maintain current knowledge and skills in the nurse practitioner area.
 - (9) Conduct an assessment of clients and families which may include health history, family history, physical examination, and evaluation of health risk factors.
 - (10) Assess normal and abnormal findings obtained from the history, physical examination, and laboratory results.
 - (11) Evaluate clients and families regarding development, coping ability, and emotional and social well-being.
 - (12) Plan, implement, and evaluate care.
 - (13) Develop individualized teaching plans with each client based on health needs.
 - (14) Counsel individuals, families, and groups about health and illness and

- promote attention to wellness.
- (15) Participate in periodic or joint evaluations of service rendered, including, but not limited to, the following:
 - (A) Chart reviews.
 - (B) Client evaluations.
 - (C) Outcome statistics.
- (16) Conduct and apply research findings appropriate to the area of practice.
- (17) Participate, when appropriate, in the joint review of the plan of care.

Clinical Nurse Specialist

A second type of advanced practice nurse is a clinical nurse specialist. The IHCP will enroll a clinical nurse specialist under specialty type 093, *nurse practitioner, other*. The IHCP will provide coverage of services performed by a clinical nurse specialist under the same criteria as advanced practice nurses as provided in 848 IAC 4-1-3. The scope of practice of a clinical nurse specialist is outlined in 848 IAC 4-3-1 below.

- Sec. 1. A clinical nurse specialist shall perform as an independent and interdependent member of the health care team as defined in 848 IAC 2-1-3. The following are standards for each clinical nurse specialist:
- (1) Assess clients by using advanced knowledge and skills to:
 - (A) identify abnormal conditions;
 - (B) diagnose health problems;
 - (C) develop and implement nursing treatment plans;
 - (D) evaluate patient outcomes
 - (2) Use advanced knowledge and skills in teaching and guiding clients and other health team members.
 - (3) Use appropriate critical thinking skills to make independent decisions, commensurate with the autonomy, authority, and responsibility of the clinical nurse specialist
 - (4) Function within the legal boundaries of their advanced practice area and shall have and utilize knowledge of the statutes and rules governing their advanced practice area, including the following:
 - (A) State and federal drug laws and regulations.
 - (B) State and federal confidentiality laws and regulations.
 - (C) State and federal medical records access laws.
 - (5) Consult and collaborate with other members of the health team as appropriate to provide reasonable client care.
 - (6) Recognize the limits of individual knowledge and experience, and consult with or refer clients to other health care providers as appropriate.
 - (7) Retain professional accountability for any delegated intervention, and delegate interventions only as authorized by IC 25-23-1 and this title.
 - (8) Maintain current knowledge and skills in the nurse practitioner area.
 - (9) Provide direct nursing care utilizing advanced scientific knowledge, nursing theory, and nursing skills in the assessment, planning, implementation, and evaluation of health and nursing care of individual clients.

- (10) Provide indirect nursing care through planning, guiding, evaluating, and directing nursing care delivered by nursing and ancillary personnel as authorized by IC 25-23-1 and this title.
- (11) Conduct nursing research, including methods of nursing intervention and healthcare in the area of specialization, and apply research findings appropriate to the area of practice.
- (12) Teach and counsel individuals or groups by utilizing communication skills and teaching or learning theories to increase knowledge or functioning of individuals or groups, nursing personnel, students, and other members of the health care team.
- (13) Serve as a consultant and as a resource, utilizing advanced health knowledge and skills, to those who are directly and indirectly involved in patient care.
- (14) Participate in periodic or joint evaluations of service rendered, including, but not limited to, the following:
 - (A) Chart reviews.
 - (B) Client evaluations.
 - (C) Outcome statistics.

Nurse-Midwife

A nurse-midwife is another type of advanced practice nurse. Medicaid reimbursement is available for services rendered by a certified nurse-midwife under the same criteria as advanced practice nurses as provided in 848 IAC 4-1-3. 848 IAC 3-1-2 states that the practice of nurse-midwifery means the practice of nursing and the extension of that practice, including well-woman gynecological healthcare, family planning, and care to the normal and expanding family throughout pregnancy, labor, delivery, and post - delivery. For further details on the scope of practice for nurse-midwives, see 848 IAC 3-3-1.

Certified Registered Nurse Anesthetist (CRNA)

A CRNA is a type of nurse practitioner. Like nurse practitioners, Medicaid reimbursement is available for services rendered by a CRNA under the same criteria as advanced practice nurses as provided in 848 IAC 4-1-3. A CRNA must graduate from an accredited Nurse Anesthesia Educational program and be properly licensed and certified to practice to be reimbursed by the IHCP. IC 25-23-1-30 notes that CRNAs do not have to obtain prescriptive authority to administer anesthesia. See the billing section of this document entitled "Billing Requirements" for billing instructions and reimbursement information for CRNAs.

BILLING REQUIREMENTS

Nurse Practitioners

Reimbursement is available for medically necessary services or preventative health care services provided by a nurse practitioner enrolled either as a billing, group or dual provider.

The Provider Manual Chapter 8, Section 3 lists the IHCP instructions for proper billing of nurse practitioner procedures as follows. The term nurse practitioner, as indicated in the billing section of the provider manual, refers to all advanced practice nurses (family practice nurse practitioners, pediatric nurse practitioners, obstetric nurse practitioners, nurse midwives, clinical nurse specialists) except certified registered nurse anesthetists.

- Independently practicing nurse practitioners are reimbursed at 75 percent of the rate on file. The nurse practitioner provider number is included in Locators 24K and 33 of the *CMS-1500 Claim Form*.
- Nurse practitioners, not individually enrolled in the IHCP, and clinical nurse specialists employed by physicians, in a physician directed group or clinic, bill services with the SA modifier and the physician number in locators 24K and 33 and are reimbursed at 100 percent of the Medicaid allowed amount.
- Nurse practitioners, with an individual provider number, and employed by a physician(s) should bill using their own provider number in locator 24K and the billing group number in locator 33 and are reimbursed at 100 percent of the Medicaid allowed amount.
- Nurse practitioner services in outpatient hospital settings are not separately billable and are included in the hospital outpatient reimbursement rate.

Further information for billing nurse practitioner services are found in the IHCP Provider Manual, Chapter 8, Section 3.

Certified Registered Nurse Anesthetists

CRNAs must use anesthesia CPT codes (00100-01999) and bill with the appropriate modifier. The table below lists the only modifiers that can be used by CRNAs. The AD modifier may not be used. One of the anesthesia procedure code modifiers listed in the table below must be reported to identify services rendered by the CRNA and the anesthesiologist providing medical direction. CRNAs use the same physical status modifiers that apply to the anesthesiologist. Anesthesia details submitted by a CRNA are reimbursed at 60 percent of the allowed amount. Further instructions for billing services of CRNAs can be found in the Provider Manual Chapter 8.

Modifier	Description
QS	Monitored anesthesia care service
QX	CRNA service: with medical direction by a physician
QZ	CRNA service: without medical direction by a physician
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals

Nurse Practitioners and Clinical Nurse Specialists in Mental Health

Mental health services provided by a nurse practitioner or clinical nurse specialist under the supervision of a physician, psychiatrist, or HSPP must be billed with the HE modifier in conjunction with the SA modifier, as indicated in field 24K of the CMS-1500 claim form. Claims billed for nurse practitioner and clinical nurse specialist mental health

services will reimburse 75 percent of the IHCP allowed amount for the procedure code identified.

MEDICAL POLICY FACT SHEET

TITLE: OBSTETRIC CARE

DESCRIPTION

Obstetric care includes the care of and services provided to a member during pregnancy and childbirth (including the immediate postpartum period).

This document is intended to serve as a general summary of the IHCP policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

SUMMARY OF CURRENT POLICY

The Indiana Health Coverage Programs (IHCP) provide reimbursement for various services for obstetric care, which may include, but are not limited to the following.

- Pregnancy care coordination services are available for eligible Medicaid members. All eligible pregnant women may receive initial assessment services.
- IHCP reimbursement is available for sonography procedures performed during pregnancy with the restrictions noted in 405 IAC 5-27-6.
- Home tocolytic infusion therapy utilizing a home uterine monitoring device is covered with limitations.
- IHCP reimbursement is available for anesthesia services provided during labor and delivery.

The IHCP covers HIV testing for pregnant members and newborns. Please refer to the Medical Policy fact sheet for Lab Services, Human Immunodeficiency Virus (HIV) testing for additional information.

COVERAGE CRITERIA

Pharmacy Services

The IHCP does not require a copayment for drugs dispensed to a pregnant member. Family planning services and supplies furnished to individuals of a child bearing age do not require a copayment.

Transportation Services

No copayment is required for transportation provided to pregnant members; however, transportation exceeding the 20-mile one-way trip limitation is subject to prior authorization. Refer to the Medical Policy fact sheet for Transportation Services for additional information.

Antepartum Services

The IHCP follows the guidelines of the American College of Obstetricians and Gynecologists (ACOG) which separates antepartum care from delivery and postpartum care. This enables the Indiana Medicaid Program to more effectively encourage antepartum care and track its impact on reducing poor pregnancy outcomes.

Recommended Visit Schedule

The IHCP reimburses up to 14 visits for normal antepartum care, one visit more than the 13 visits recommended by the American College of Obstetricians and Gynecologists (ACOG). Providers are reimbursed for the following number of visits in a normal pregnancy:

- Three visits in trimester one
- Three visits in trimester two
- Eight visits in trimester three

Additional antepartum care visits are allowed for members considered to have a medically high-risk pregnancy. See this fact sheet's section entitled "Medically High-Risk Pregnancies" for additional information.

Other Outpatient Office Visits

CPT procedure codes 99211-99215 or 99241-99245 may be billed for outpatient office visits rendered to pregnant members if related to a concurrent medical condition requiring medical care or consultative referral. The concurrent condition must be identified as either a primary or secondary condition by a valid ICD-9-CM diagnosis code and the appropriate diagnosis reference number (1, 2, 3, or 4) must be indicated in form Locator 24E of the CMS-1500 claim form.

Billing for Antepartum Visits

The last menstrual period (LMP) date, indicated in a MM/YY/DD format, must be indicated in form locator 14, on the CMS-1500 claim form or field 28 of the 837P electronic transaction. Claims submitted without the LMP will not be processed for payment. The provider's charge for each antepartum visit must be entered in form Locator 24F. The expected date of delivery (EDD) must be indicated in form Locator 14, and the appropriate diagnosis codes entered in form Locator 21 and referred to in form Locator 24E on the CMS-1500 claim form or the 837P transaction for pregnancy-related services.

Antepartum care for pregnant members must be billed separately from the delivery and postpartum visits. Each antepartum visit must be individually listed on the CMS-1500 claim form or the 837P transaction. **Table 1 – Antepartum Trimester Billing Requirements** describes billing requirements specific to each trimester.

Table 1 – Antepartum Trimester Billing Requirements

Trimester	Visit No.	CPT codes	Modifier required for all codes visit codes.	Comments
First Trimester	1	59425 or 99201 through 99215	*U1, Trimester one (0 through 14 weeks 0 days)	Providers may use a new or established patient E/M code, 99201–99215, for the first antepartum visit to reflect the initial assessment, testing, counseling, and other services typically performed during this time. Claims may be submitted after each visit or at the end of the respective trimester. Required antepartum tests and screenings for the first trimester should be billed along with the first trimester visits. Services within the first trimester should be billed within 30 days of the end of the trimester.
	2 – 3	59425	*U1, Trimester one (0 through 14 weeks 0 days)	Claims may be submitted after each visit or at the end of the respective trimester. Required antepartum tests and screenings for the first trimester should be billed

Table 1 – Antepartum Trimester Billing Requirements

Trimester	Visit No.	CPT codes	Modifier required for all codes visit codes.	Comments
				along with each visit. Services provided within the trimester should be billed within 30 days of the end of the trimester.
Second Trimester	4-6	59425	*U2, Trimester Two (14 weeks 1 day through 28 weeks 0 days)	Claims may be submitted after each individual visit or at the end of the respective trimester. Required antepartum tests and screenings for the second trimester should be billed along with each visit. Services provided within the second trimester should be billed within 30 days of the end of the trimester.
Third Trimester	7-12 (Up to eight antepartum visits during the third trimester are allowed for a normal pregnancy.)	59426	*U3, Trimester Three (28 weeks 1 day through delivery)	Third trimester antepartum visits can be billed with the delivery and postpartum services on the same CMS 1500 claim form or the 837P transaction. Required antepartum tests and screenings for the third trimester should be billed along with each visit.

*The modifier is placed in the modifier space following the CPT code in form Locator 24D of the *CMS-1500*.

Antepartum Tests and Screenings Schedule

In addition to the schedule for antepartum visits, the OMPP has developed a schedule of tests and screenings highly recommended to be provided to pregnant members within each respective trimester. Other tests and screenings, such as those defined as optional, should be rendered only when the provider determines the procedure is medically necessary. The tests and screenings in **Table 2**, on the following pages, may be billed with the appropriate antepartum care visit code on the same CMS-1500 claim form or 837P transaction. The trimester schedules are uniform with the standards established by the ACOG and the American Academy of Pediatrics (AAP).

Table 2 – Antepartum Tests and Screenings Schedule

Trimester One (three total visits)	
HCP Code	Procedure
59425*	First trimester visits = 3
59426* - U1	
59015	Chorionic Villa Sampling (CVS), optional for women older than 35
81000 (includes microscopy for suspected urinary tract infection) OR 81002 (without microscopy) OR 81001 (Urinalysis, automated with microscopy) OR 81003 (Urinalysis, automated without microscopy)	Urinalysis, by dipstick, performed each visit The use of the automated urinalysis is to be based on medical necessity as determined by the physician.
86644	CMV antibody titer
86694	Herpes simplex test
86701	HIV test (optional)
86777	Toxoplasma antibody titer
88150, 88152 - 88155	Cervical cytology (Pap smear)
80055	Total obstetrical panel includes: <ul style="list-style-type: none"> • <i>CBC with complete differential</i> • <i>Hepatitis B surface antigen</i> • <i>Rubella antibody titer</i> • <i>Syphilis test</i> • <i>Antibody screen, RBC</i> • <i>Blood typing (ABO)</i> • <i>Blood typing (RhD)</i>
or instead of 80055 use the following:	
85025	CBC with complete differential
87340	Hepatitis B surface antigen
86762	Rubella antibody titer
86592	Syphilis Test; Qualitative (eg, VDRL, RPR, ART)
86850	Antibody screen, RBC
86900	Blood typing (ABO)
86901	Blood typing (RhD)

* Use the appropriate CPT code for the number of antepartum visits:	
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only, 7 or more visits

**Table 2 – Antepartum Tests and Screenings Schedule
(continued)**

Trimester Two (three total visits)	
HCP Code	Procedure
59425*	Second trimester visits = 3
59426* - U2	
59000	Amniocentesis, optional for women older than 35
81000 (includes microscopy for suspected urinary tract infection) OR 81002 (without microscopy) OR 81001 (Urinalysis, automated with microscopy) OR 81003 (Urinalysis, automated without microscopy)	Urinalysis, by dipstick, performed each visit The use of the automated urinalysis is to be based on medical necessity as determined by the physician.
82105	Serum alpha-fetoprotein
82947	Diabetic screening
82951	Glucose tolerance test
86644	CMV antibody titer
86694	Herpes simplex test
86777	Toxoplasma antibody titer
80055	Total obstetrical panel includes: <ul style="list-style-type: none"> • <i>CBC with complete differential</i> • <i>Hepatitis B surface antigen</i> • <i>Rubella antibody titer</i> • <i>Syphilis test</i> • <i>Antibody screen, RBC</i> • <i>Blood typing (ABO)</i> • <i>Blood typing (RhD)</i>
Or instead of 80055, use the following (if not done in first trimester due to late entry into prenatal care)	
85025	CBC with differential
87340	Hepatitis B surface antigen
86762	Rubella antibody titer
86592	Syphilis test: Qualitative (eg, VDRL, RPR, ART)
86850	Antibody Screen (RBC)
86900	Blood Typing (ABO)
86901	Blood Typing (RhD)

* Use the appropriate CPT code for the number of antepartum visits:	
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only, 7 or more visits

**Table 2 – Antepartum Tests and Screenings Schedule
(Continued)**

Trimester Three (eight total visits)	
HCPCS Code	Procedure
59425*	Third trimester visit = 8
59426* - U3	
81000 (includes microscopy for suspected urinary tract infection) OR 81002 (without microscopy) OR 81001 (Urinalysis, automated with microscopy) OR 81003 (Urinalysis, automated without microscopy)	Urinalysis, by dipstick, performed each visit The use of the automated urinalysis is to be based on medical necessity as determined by the physician.
85025	CBC with differential
86592	Syphilis test, repeat test for patients who tested positive in first trimester
86850	Antibody Screen (RBC) - repeat for patients who tested negative in first trimester
86644	CMV antibody titer
86694	Herpes simplex test
86777	Toxoplasma antibody titer
80055	Total obstetrical panel includes: <ul style="list-style-type: none"> • <i>CBC with complete differential</i> • <i>Hepatitis B surface antigen</i> • <i>Rubella antibody titer</i> • <i>Syphilis test</i> • <i>Antibody screen, RBC</i> • <i>Blood typing (ABO)</i> • <i>Blood typing (RhD)</i>
Or instead of 80055, use the following (if not done in first trimester due to late entry into prenatal care)	
85025	CBC with differential
87340	Hepatitis B surface antigen

86850	Antibody Screen (RBC)
86900	Blood Typing (ABO)
86901	Blood Typing (RhD)
* Use the appropriate CPT code for the number of antepartum visits:	
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only, 7 or more visits

Normal Pregnancies

A normal pregnancy is one in which the physician determines that the pregnant member is not at risk of a preterm birth or poor pregnancy outcome due to medical or psychosocial reasons. The following diagnosis codes indicate a normal, low-risk pregnancy:

- ◆ V22.0 – Supervision of normal first pregnancy
- ◆ V22.1 – Supervision of other normal pregnancy

Psychosocially High-Risk Pregnancies

High-risk pregnancies identified for psychosocial reasons are limited to the IHCP standard maximum of 14 antepartum care visits. Psychosocial high-risk pregnancies do not automatically qualify for higher reimbursement unless another medical complication exists that is listed under the ICD-9-CM codes for a high-risk pregnancy. Pregnant women with psychosocial factors identified that may affect the pregnancy may require care coordination. Prenatal Care Coordination services are described on page 11 of this fact sheet. ICD-9-CM diagnosis codes V15.82, V23.7, V60.0 through V62.9, 305.1, 648.33, 995.80, and 995.81 are typically used to indicate a high-risk pregnancy for psychosocial reasons.

Medically High-Risk Pregnancies

Some pregnant members have medical complications that may adversely affect the outcome of the pregnancy if not adequately addressed. These complications, usually identified during the prenatal assessment, may place the member and the fetus in a high-risk pregnancy category that requires additional primary care management. Only physicians (MDs or DOs) may be reimbursed for medically high-risk pregnancy care. Providers may refer members identified as having medically high-risk pregnancies only to appropriate physicians. Referrals to non-physicians for high-risk pregnancy-related services are not permitted. Providers in the PrimeStep PCCM delivery system participating in a Memorandum of Collaboration agreement may provide care for patients as defined in the agreement.

A pregnant woman may be considered high-risk if at least one medical condition is identified in her current pregnancy or obstetrical history that places her at risk for a preterm birth or poor pregnancy outcome. Further information regarding the Prenatal Risk Assessment Form is located in Chapter 8, of the Indiana Health Coverage Programs Provider Manual. The form can be printed from the Forms section of the IHCP website, www.indianamedicaid.com, and is to be used by the provider as a tool for identifying

pregnant members at risk of a preterm birth or poor pregnancy outcomes due to medical or psychosocial reasons.

Reimbursement for Medically High-Risk Pregnancies

Members identified as having a medically high-risk pregnancy may receive additional antepartum care visits, beyond the maximum of 14 allowed for a normal pregnancy. The IHCP recognizes that the care of pregnant women in the medically high-risk category requires greater physician management. Higher reimbursement is available when providers bill with prenatal office visit procedure codes (CPT codes 59425 and 59426) and an ICD-9-CM diagnosis code that is listed in **Table 3 – ICD-9-CM Diagnosis Codes for Medically High-Risk Pregnancy**. Each trimester should be billed on a separate claim form. To receive additional reimbursement, the provider must document the specific medical high-risk factors in the medical record and indicate the high-risk diagnosis when submitting claims. This information must be easily identifiable on the medical record for audit purposes. This requirement may be met if the provider completes a Prenatal Risk Assessment form, and retains a copy of the form in the member's medical record.

The IHCP does not determine conditions that may or may not complicate a pregnancy. Therefore, if a physician determines that an illness or injury could complicate a pregnancy or have an adverse effect on the outcome of the pregnancy, the IHCP allows billing for covered services provided to treat that illness or injury. Physicians must use one of the diagnosis codes listed in **Table 3** as the primary diagnosis on the claim. If none of the diagnosis codes are appropriate for the situation, a pregnancy diagnosis code should be listed as the primary diagnosis code, and the illness or injury being treated should be identified as the secondary diagnosis code.

Table 3 - ICD-9-CM Diagnosis Codes for Medically High-Risk Pregnancy

Medical Factor	Code	Medical Factor	Code
Anemias, Acquired and Hereditary	282.0 – 282.9, 283.1X – 283.9, 284.0, 284.9, 285.0 – 285.9, 287X, 288X, 648.20, 648.23	Other (for medical high-risk-pregnancy)	Examples include V23.1, V23.4X, V23.8X, and V23.9
Current Drug or Alcohol Abuse	304.00 – 304.93, 648.30, 648.33	Other Specified Complications of Pregnancy	646.80, 646.83
Current Malignancy or Leukemia	140.0 – 174.9, 176.0 – 184.9, 188.0 – 214.3, 214.8 – 221.9, 223.0 – 233.3, 233.7 – 236.3, 236.7 – 239.9	Pregnancy with History of Abortion	646.30, 646.33, V23.2

Table 3 - ICD-9-CM Diagnosis Codes for Medically High-Risk Pregnancy

Medical Factor	Code	Medical Factor	Code
Diabetes	648.00, 648.03, 648.80, 648.83	Preterm Complications, History of or with Current Pregnancy	640.00, 640.03, 640.80, 640.83, 640.90, 640.93, 641.00, 641.03, 641.10, 641.13, 641.20, 641.23, 641.30, 641.33, 641.80, 641.83, 641.90, 641.93, 658.10, 658.13, 671.30, 671.33, 760.5
Excessive Vomiting in Pregnancy	643.00, 643.03, 643.10, 643.13, 643.20, 643.23, 643.80, 643.83, 643.90, 643.93	Preterm Labor in Current Pregnancy or Previous Pregnancy	644.00, 644.03, 644.10, 644.13, 644.20, 654.50, 654.53, V13.21
History of a Previous Pregnancy Resulting in a Congenital Anomaly or Complication to Infant	286.0 – 286.4, 317, 318.X, 319, V19.5, V21.30 – V21.35, V23.41	Potential Structural Complications of Pregnancy or Delivery	629.23, 648.70, 648.73, 654.00, 654.03, 654.10, 654.13, 654.20, 654.23, 654.50, 654.53, 654.60, 654.63, 657.00, 657.03, 658.00, 658.03, V67.00
Infections Affecting Pregnancy	041.02, 042, 079.5X, 090.X – 099.X, 616.10, 647.33, 647.53, 655.33, 795.71, V08, V01.6	Primigravida, less than 17 years or more than 35 years	659.50, 659.53, 659.80, 659.83, V23.81 – V23.84
Hypertension and Related Disorders in Current or Previous Pregnancy	642.00, 642.03, 642.10, 642.13, 642.20, 642.23, 642.30, 642.33, 642.40, 642.43, 642.50, 642.53, 642.60, 642.63, 642.70, 642.73, 642.90, 642.93	Renal Complications and Infections	580.0 – 593.9, 639.3, 646.20, 646.23, 646.60, 646.63

Table 3 - ICD-9-CM Diagnosis Codes for Medically High-Risk Pregnancy

Medical Factor	Code	Medical Factor	Code
Maternal Diseases or History Affecting Pregnancy	345.00 – 345.91, 523.0 – 523.9, 646.13, 646.70, 646.73, 646.80, 646.83, 648.10, 648.13, 648.50, 648.53, 648.60, 648.63, 656.23, V23.82, V23.84, V42.0 – V42.9	Respiratory Disease, History of or Acquired	480.0 – 487.0, 491.0 – 491.9, 493.0X – 493.9X, V46.1X
Multiple Gestation/Grand Multipara	651.00, 651.03, 651.10, 651.13, 651.20, 651.23, 651.30, 651.33, 651.40, 651.43, 651.50, 651.53, 651.60, 651.63, 651.80, 651.83, 651.90, 651.93, 659.40, 659.43, 659.60, 659.63 V23.3	Smoking, more than 10 cigarettes per day	305.11, 648.33, V15.82

POSTPARTUM SERVICES

Postpartum Reimbursement

Up to two postpartum visits are allowed within 60 days post delivery. The provider may be reimbursed for up to two postpartum visits using CPT code 59430, *Postpartum care only (separate procedure)*. Services are subject to post payment review. If CPT codes 59410, *Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care* or 59515, *Cesarean delivery only; including post partum care* are used when billing, only one additional postpartum visit may be billed using procedure code 59430, *Postpartum care only (separate procedure)*.

PRENATAL CARE COORDINATION

Care coordination for pregnant women is an active, ongoing process of assisting the individual to identify, access, and utilize community resources, and coordinating the services to meet individual needs. This includes locating service sources, making appointments for services, and following up to verify or reschedule appointments for eligible women whose pregnancies are at risk for low birth weight or poor pregnancy outcomes. Members identified by the *Prenatal Risk Assessment* form (see Appendix A)

as having a high-risk pregnancy due to medical or psychosocial conditions, may also receive pregnancy care coordination services through the Indiana Health Coverage Programs (IHCP).

After an initial evaluation by the obstetrician, IHCP members may be referred to a Prenatal Care Coordinator that conducts an assessment to determine the necessary services. The Prenatal Risk Assessment form must be used by Prenatal Care Coordinators during the initial visit to assess for potential high-risk pregnancy issues. Prenatal care coordination services are designed to combat preterm or poor pregnancy outcomes by linking the pregnant member to all necessary services, including medical, health promotion, and social services. These services, available on a trimester basis, may be provided by physicians, registered nurses, social workers, and registered dietitians with certified training in pregnancy case management to combat poor pregnancy outcomes, and include:

- ◆ Home visits, including the initial and postpartum home visit,
- ◆ Referral to social service agencies,
- ◆ Follow-up activities to ensure services were received.

If the initial prenatal risk assessment indicates a high-risk condition that could result in a poor pregnancy outcome, the pregnancy care coordinators should provide intensive intervention services including up to two additional prenatal reassessments, a postpartum assessment, and the required home visit following delivery, to gather vital information about the pregnancy outcome and assess the newborn's care needs.

Additional information regarding Care Coordination Services for pregnant women can be found in Indiana Health Coverage Programs Provider Manual, Chapter 8, and in the Medical Policy fact sheet for Case Management – Pregnant Women.

EMERGENCY LABOR AND DELIVERY SERVICES

Certain undocumented persons and persons living in Indiana legally but not meeting Medicaid citizenship eligibility criteria are entitled to IHCP coverage of treatment for medical emergency conditions. Hoosier Healthwise Package E provides services defined by the Omnibus Budget Reconciliation Act of 1986 as “a medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the patient's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any organ or part.” In the case of pregnant women eligible for such emergency coverage, reimbursement is available for labor and delivery services up to the time the mother is stable. A child born in Indiana is eligible at birth for full IHCP coverage, regardless of the mother's immigration status, if all other Medicaid eligibility criteria are met.

ECHOGRAPHY

The IHCP does not reimburse for routine echographies. The diagnosis of a normal pregnancy does not substantiate an echography. Documentation in the patient's medical record must substantiate the medical need for an echography. Echographies performed to detect fetal malformations or intrauterine growth retardation should have an *ICD-9-CM* code from the V22 series, *Normal pregnancy* as the primary diagnosis and an *ICD-9-CM* diagnosis code from the V28 series, *antenatal screening*, listed as the secondary diagnosis. Pregnancy-related echographies billed without a secondary diagnosis to support medical necessity of the echography are subject to payment recovery. The secondary codes are as follows:

- V28.3 – Screening for malformation using ultrasonics
- V28.4 – Screening for fetal growth retardation using ultrasonics

The IHCP does not provide reimbursement for echographies performed for gender determination.

SONOGRAPHY

Reimbursement is available for sonography services performed during pregnancy when indicated by one or more of the following conditions.

- Early diagnosis of ectopic or molar pregnancy
- Fetal age determination if necessitated by the following.
 - Discrepancy in size versus fetal age
 - Lack of fetal growth or suspected fetal death
 - Fetal postmaturity syndrome
 - Guide for amniocentesis
 - Placental localization associated with abnormal bleeding
 - Polyhydramnios or oligohydramnios
 - Suspected multiple births
 - Suspected congenital anomaly

Reimbursement is available for sonography for fetal age determination prior to therapeutic, non-elective, abortions when the age of a fetus cannot be determined by the patient's history and physical examination in the case of fetal demise, or for a missed abortion (miscarriage). The information may also be essential for the selection of an abortion method when a procedure is being considered and the conditions meet the requirements of *IC 16-10-3-3* for an elective abortion.

Reimbursement is also available for ultrasound guidance to perform a procedure that improves fetal status. Reimbursement is not available for CPT code 59072, *Fetal*

umbilical cord occlusion, including ultrasound guidance because this procedure is designed to terminate a fetus.

HOME TOCOLYTIC INFUSION THERAPY

The IHCP provides reimbursement for home tocolytic infusion therapy utilizing a home uterine monitoring device. Refer to the Medical Policy fact sheet for Home Health Care for further information, including prior authorization requirements.

To qualify for this therapy, the member must meet the following criteria.

- Be at least 24 to 34 weeks gestation
- Be in current preterm labor. Preterm labor is defined as greater than or equal to six contractions per hour
- Have a cervical dilation of greater than or equal to one centimeter, or an effacement of greater than or equal to 75 percent
- Have direct home telephone access to providers, which means having a working telephone
- Have experienced secondary failure to wean from infused tocolytics, or have failed oral therapy and require continued infusion therapy
- Have an obstetrician or gynecologist (OB/GYN) as the referring physician, or have had a consultation with an OB/GYN

Cases of premature labor treated with oral medication only, or requests for home uterine monitoring devices alone for the purpose of screening high-risk pregnancies will not be approved. Members who receive only oral medications or who only require home uterine monitoring devices do not qualify for tocolytic infusion therapy.

SALIVARY ESTRIOL

One of the endocrine assay tests developed to predict preterm labor risk is a test that detects and measures salivary estriol (for example, the SalEst™ test). The Indiana Health Coverage Programs (IHCP) covers salivary estriol testing using CPT code S3652, *saliva test, hormone level; to assess preterm labor risk*. However, reimbursement is limited to one unit per test, between gestational ages 22 to 35 weeks, every one to two weeks. This test gives the physician/practitioner additional information to assess the risk for preterm delivery and identify high-risk members, even when the patient does not appear to be high-risk by traditional assessment methods. Refer to the Medical Policy fact sheet for Laboratory Services – Salivary Estriol Test for further information.

ANESTHESIA FOR VAGINAL OR CESAREAN DELIVERY

The IHCP does provide reimbursement for anesthesia services for a vaginal or cesarean delivery. Refer to the Medical Policy fact sheet for Anesthesia Services for further information.

General, regional or epidural anesthesia administered by the same provider who performs the surgical or obstetrical delivery procedure will be denied because it is included in the surgical delivery fee.

PRIOR AUTHORIZATION

Prior authorization (PA) is required for a pregnant member's transportation services exceeding the 20-mile one-way trip limitation.

PA is required by the IHCP for CPT code 59897, *Unlisted fetal invasive procedure, including ultrasound guidance*. The PA request must document the ultrasound guided procedure being performed, the purpose or goal of the procedure, and the medical necessity of the procedure. This information must also be documented in the medical record. Each request will be reviewed on a case-by-case basis. PA will be approved for procedures that are medically necessary and have the goal of preserving or improving fetal status. Procedures with the goal of fetal demise will be denied. Prior authorization can be received for this procedure up to six months after the ultrasound guided procedure is performed.

MANAGED CARE

IHCP members enrolled in Hoosier Healthwise PrimeStep (PCCM) must select primary medical provider (PMP). If the member does not select a PMP, one is assigned to the member. An OB/GYN may choose to be a PMP for pregnant women only, or for all women. The PMP is responsible for providing or authorizing most primary and preventive services, and for reviewing and authorizing necessary specialty care and hospital admissions. Members enrolled in PrimeStep receive the same benefit coverage and are subject to the same limitations as traditional Medicaid Fee-for-Service. Refer to the Hoosier Healthwise Manual for Primary Medical Providers and Office Staff for further information.

Hoosier Healthwise Package B provides medically necessary services to pregnant women to meet the health needs of the pregnancy. In addition to drug coverage, transportation, family planning, routine prenatal, delivery, and postpartum care, the IHCP reimburses providers for a condition that may complicate the pregnancy. A condition that may complicate the pregnancy is defined as a condition manifesting itself by symptoms of sufficient severity that the absence of medical attention could reasonably be expected to result in a deterioration of the patient's condition or a need for a higher level of care. As with all claims, Hoosier Healthwise Package B members' benefits are reimbursed in accordance with the IAC.

Services for Hoosier Healthwise Package B members must comply with the following restrictions.

- Reimbursement is not available for any service other than pregnancy-related services.
- The IHCP pays for drugs prescribed for indications directly related to the pregnancy in accordance with IAC restrictions
- Drugs or services necessary to prevent complications related to the pregnancy.

Chiropractors may receive reimbursement for services provided to Package B members. Claims must be submitted with one of the diagnosis codes in **Table 4** and the appropriate chiropractic diagnosis code and chiropractic procedure code.

Table 4
ICD-9-CM Diagnosis Codes – Chiropractic Services for Package B Members

Diagnosis Codes	Description
646.93	Unspecified complication of pregnancy – antepartum condition or complication
648.73	Bone and joint disorders of the back, pelvis, and lower limbs – antepartum condition or complication
648.93	Other current conditions classified elsewhere – antepartum condition or complication

Following termination or loss of the pregnancy or following delivery, a Package B member is eligible solely for transportation, family planning, and postpartum care services. Urgent care services unrelated to complications of the puerperium are not reimbursed. Eligibility for these services begins on the last day of pregnancy and extends through the end of the month in which the last day of the 60-day period ends.

All children born to mothers covered by Hoosier Healthwise Package B are covered under Fee-For-Service, PrimeStep, or Risk Based Managed Care (RBMC) for at least the first year of life. Pregnant Hoosier Healthwise members are encouraged to select, prior to delivery, a pediatric provider to serve as the PMP for the newborn.

When billing for urgent care services for Hoosier Healthwise Package B, claims must be appropriately marked and coded as an emergency. The primary diagnosis code must be pregnancy related, or the claim will be denied. If a pregnancy and urgent care only member receives a sterilization procedure following delivery, the primary diagnosis code should be pregnancy with voluntary sterilization as a secondary diagnosis. The appropriate consent forms must be completed and sent with the claim.

Questions regarding coverage of services to RBMC members should be directed to the appropriate Managed Care Organization (MCO).

RELATED MEDICAL TOPICS

Abortion
Anesthesia Services
Case Management-Pregnant Women
Chiropractic Services
Family Planning
Gynecology-Laminaria
Gynecology-Pelvic Exam Under Anesthesia
HIV Care Coordination
Home Health Services
Lab Services – Human Immunodeficiency Virus (HIV) testing
Lab Services-Salivary Estriol
Screening Services-Newborn Screening
Transportation

RULES, CITATIONS, AND SOURCES

405 IAC 5-22-3 Nursing and Therapy Services--Certified nurse midwife services
405 IAC 5-11 Case Management Services for Pregnant Women
405 IAC 5-24-7 Obstetric Services--Copayment for legend and nonlegend drugs
405 IAC 5-27-2 Radiology Services--Utilization criteria
405 IAC 5-27-6 Sonography
Indiana Code 16-41-6 Communicable Disease: Mandatory Testing of Individuals with
Communicable or Dangerous Diseases
Indiana Medical Assistance Program Provider Manual 1994
Indiana State Department of Public Welfare Medical Policy Manual 1991
Indiana Medicaid Update Bulletins 97-14 and 95-21
Indiana State Medicaid Plan 01/01/92 Nurse-Midwife Services
Indiana Health Coverage Programs Provider Bulletins
BT2000014 – Salivary Estriol Test
BT200137 – Care Coordination Outcome Report Form
Indiana Health Coverage Programs Provider Newsletters
NL200402 – Prenatal Risk Assessment
NL200405 – Home Tocolytic Infusion Therapy and Sonography
NL200409 – Chiropractic Services for Package B members
Indiana Health Coverage Programs Provider Manual, Version 5.0, July 2004

Origination Date: 12/31/00

Revisions and Reviews	Reason	Date
405 IAC 5-22-3	Nursing and Therapy Services-Certified nurse midwife services	08/24/97
405 IAC 5-27	Obstetric Services-Copayment for legend and nonlegend drugs	8/24/97
Indiana Medicaid Bulletin BT200353 (dated 8/15/03)	Radiology Services	8/24/97
405 IAC 5-11-1 Amended	Case Management Services for Pregnant Women	8/24/97
405 IAC 5-11-7 Amended	Case Management Services for Pregnant Women	10/27/99
Amended	Case Management Services for Pregnant Women	10/27/99
Indiana Health Coverage Programs Newsletter 200405	Home Tocolytic Infusion Therapy and Sonography	1/1/04
Review	Scheduled Review	4/29/05

APPLICABLE INDIANA A/M EDITS AND AUDITS

504 – Expected Delivery Date Missing
 535 – Invalid Expected Date of Delivery/Trimester Combination
 1031 – High-risk Prenatal Care May Only Be Rendered by a Physician
 2005 – SOBRA Pregnant Women (Detail)
 2012 – Pregnant and Urgent Care Only
 6002 – Any Two Anesthesiology Providers Same Procedure
 6003 – Manual Pricing for Split Care Billing
 6034 – Global Surgery Payable at Reduced Amount When Component Paid
 6035 – Component of Surgical Care Not Payable When Global Paid
 6037 – Only One Assistant at Surgery Allowed for Select Surgeries
 6039 – Assistant at Surgery Not Payable When Co-Surgeon Paid
 6040 – Co-Surgeon Not Payable When Assistant Surgeon Paid
 6041 – E&M Codes Not Reimbursable with Prenatal Codes
 6042 – Prenatal Codes Not Reimbursable with E&M Codes
 6043 – Prenatal Visits Limited to 14 in a 10 Month Period
 6044 – Prenatal Visits Limited to Three in Second Trimester
 6045 – Prenatal Visits Limited to Eight
 6050 – Care Coordinator - Reassessment
 6051 – Care Coordinator – Initial Assessment
 6052 – Care Coordination Post-Partum Assessment/Outcome
 6064 – Components Not Payable when Global Paid – Medical System

- 6070 – Prenatal Visits Limited to Four in the First Trimester
- 6096 – CPT/HCPCS Code Billed is Not Payable According to the PPS Reimbursement Methodology
- 6660 – Preoperative and Postoperative Care Billed with Unlisted Surgeries Requires Review
- 6666 – Anesthesia Service Not allowed by Provider Billing for Surgery
- 6702 – Newborn Screening Limited to One per Lifetime
- 6703 – Maternity/One Within Nine Month Period
- 6704 – Family Planning Service/One Every 12 Months
- 6800 – Care Coordination Transportation for Home Visit
- 6801 – Care Coordination – Transportation for Home Visit
- 6802 – Care Coordination – Transportation (Postpartum)
- 6916 – Global – Home Uterine Monitoring
- 6917 – Components-Home Uterine Monitoring

APPENDIX A**Indiana Health Coverage Programs****P R E N A T A L R I S K A S S E S S M E N T F O R M**

Patient Name	RID Number	LMP
Provider Name	Medicaid Provider ID Number	EDD
Provider Telephone Number	Plan (check one) <input type="checkbox"/> FFS <input type="checkbox"/> PCCM <input type="checkbox"/> MCO Name _____	
*At Risk of Preterm Birth or Poor Pregnancy Outcome Medical Factors (Please check all that apply)		
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> 1. Anemias, Acquired and Hereditary <input type="checkbox"/> 2. Current Drug or Alcohol Abuse <input type="checkbox"/> 3. Current Malignancy or Leukemia <input type="checkbox"/> 4. Diabetes <input type="checkbox"/> 5. Excessive Vomiting in Pregnancy <input type="checkbox"/> 6. History of a Previous Pregnancy Resulting in a Congenital Anomaly or Complication to Infant <input type="checkbox"/> 7. Infections Affecting Pregnancy <input type="checkbox"/> 8. Hypertension and Related Disorders in Current or Previous Pregnancy <input type="checkbox"/> 9. Maternal Diseases or History Affecting Pregnancy <input type="checkbox"/> 10. Multiple Gestation/Grand Multipara </div> <div style="width: 50%;"> <input type="checkbox"/> 11. Other (for medical high risk – pregnancy) <input type="checkbox"/> 12. Other Specified Complications of Pregnancy <input type="checkbox"/> 13. Pregnancy with History of Abortion <input type="checkbox"/> 14. Preterm Complications, History of or with Current Pregnancy <input type="checkbox"/> 15. Preterm Labor in Current Pregnancy or Previous Pregnancy <input type="checkbox"/> 16. Potential Structural Complications of Pregnancy or Delivery <input type="checkbox"/> 17. Primigravida, less than 17 years or more than 35 years <input type="checkbox"/> 18. Renal Complications and Infections <input type="checkbox"/> 19. Respiratory Disease, History of or Acquired <input type="checkbox"/> 20. Smoking, more than 10 cigarettes per day </div> </div>		
Psychosocial Factors That May Affect Current Pregnancy Outcome Please check all that apply		
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> 21. Acute Reaction to Stress <input type="checkbox"/> 22. Domestic Violence <input type="checkbox"/> 23. High Risk Sexual Behavior <input type="checkbox"/> 24. Lack of Housing Resources <input type="checkbox"/> 25. Late Initial Visit, after 14 weeks of pregnancy <input type="checkbox"/> 26. Lead Exposure </div> <div style="width: 50%;"> <input type="checkbox"/> 27. Missed Prenatal Appointment s, consecutive <input type="checkbox"/> 28. Other and Unspecified Disorders of Eating <input type="checkbox"/> 29. Other Personal History Presenting Hazards to Health <input type="checkbox"/> 30. Other Psychosocial Circumstances <input type="checkbox"/> 31. Prenatal Care Non-compliance, most recent pregnancy <input type="checkbox"/> 32. Unwanted Pregnancy </div> </div>		
Other Risk Factors Affecting Medical or Psychosocial Condition Not Described in Any Above Listing (Include ICD-9 Diagnosis Codes)		
Provider Signature	Date	

*NOTE: Refer to provider notifications for update information.

OBSTETRIC SERVICES ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Obstetric Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: NL200606 **Publication Date:** 06/2006

Subject: Appropriate Billing of Professional Services for Multiple Births

Date Added to Manual: 10/31/2006

Text of Publication

This article outlines the appropriate billing of professional services for multiple births.

Multiple birth deliveries are subject to multiple surgery reimbursement. The current reimbursement policy indicated in *405 IAC 5-28-1 (g)* for pricing multiple surgical procedures states that 100 percent of the global fee is reimbursed for the most expensive procedure. The second most expensive procedure is reimbursed at 50 percent of the global fee and remaining procedures are reimbursed at 25 percent of the global fee. The IHCP only reimburses for one cesarean procedure regardless of the number of babies delivered during the cesarean section. Therefore, only one detail line with one unit of service is billed for cesarean delivery procedures codes. The IHCP only reimburses for one delivery procedure code that includes postpartum care. If there are multiple births during one delivery, the first delivery code can include postpartum care; however, any subsequent deliveries are billed with a procedure code that does not include postpartum care.

If billing for multiple births when all births are vaginal deliveries, providers bill the first birth using procedure code *59409 – Vaginal delivery only (with or without episiotomy and/or forceps)*; *59410 – Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care*; *59612 – Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)*, or *59614 – Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care*. The second birth and any subsequent births are billed using procedure codes 59409 or 59612 with modifier *51 – Multiple procedures*.

When billing for one vaginal birth and one or more births by cesarean section; the cesarean birth is billed with procedure code *59514 – Cesarean delivery only* or *59515 – Cesarean delivery only; including postpartum care* and the vaginal birth is billed using procedure code 59409 or 59612 with modifier 51.

When billing for two or more vaginal births and one or more births by cesarean; the cesarean birth(s) are billed on one detail line with one unit of service using procedure

code 59514 or 59515. The vaginal birth(s) are billed as separate details using procedure code 59409 or 59612 with modifier 51.

If all births are delivered by cesarean; the cesarean birth(s) are billed using the appropriate procedure code 59514, 59515, 59620, or 59622 and one unit of service.

If an assistant surgeon aids in the cesarean delivery the service is billed using modifiers 80 and 82 to indicate the service was performed by an assistant surgeon. The reimbursement for the assistant surgeon's services is 20 percent of the allowed amount for the cesarean delivery. Providers cannot bill the same rendering provider number for both the surgeon and assistant surgeon details when billing for a cesarean delivery. If billing for assistant surgery services provided by a physician assistant, providers can bill the same rendering provider number for both the surgeon and physician assistant surgery details. The detail for the physician assistant is billed with the AS modifier to indicate the service was provided by the physician assistant. The reimbursement for the physician assistant's services is 20 percent of the allowed amount for the cesarean delivery.

MEDICAL POLICY FACT SHEET

TITLE: ONCOLOGY

DESCRIPTION:

As defined in Dorland's Medical Dictionary, 1994-Edition 28, oncology is the study of tumors; a tumor is a morbid enlargement or a new growth of tissue in which the multiplication of cells is uncontrolled and progressive; also called *neoplasm*.

SUMMARY OF CURRENT POLICY:

Oncology services are covered if the services are medically necessary and reasonable services and are provided by a doctor of medicine or doctor of osteopathy for diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided within the scope of the practice of medicine as set forth in 405 IAC 5-25-1. Prior authorization is required for bone marrow or stem cell transplants. Per 405 IAC 5-28-10, outpatient administration of chemotherapy and costs related to this therapy, including catheterization, physician's visits, cost of drug and solutions, pump regulators, and servicing, will be covered and do not require prior authorization. . Chemotherapy services provided by a home health agency are subject to the prior authorization criteria. Prior authorization is not required for parenteral infusion pumps when used in conjunction with parenteral hyperalimentation, including central venous catheters.

MEDICAL TOPICS CROSS-REFERENCES:

Hematology
Hospital Outpatient
Laboratory Services
Laboratory Services-HER-2/neu Gene Detection Test and HER2 Protein Expression Test
Pathology
Pharmacy

RULES, CITATIONS, AND SOURCES:

405 IAC 5-25 Physician Services
 405 IAC 5-3 Prior Authorization-exceptions
 405 IAC 5-29-1 Noncovered services
 405 IAC 5-28-10 Chemotherapy
 405 IAC 5-19-6 Durable Medical Equipment subject to prior authorization

Indiana Medicaid Update Bulletin 96-25—Billing procedures for chemotherapy
 Indiana Health Coverage Programs Provider Manual 1999

Initial Policy	Issue	Effective Date	Implementation Date	Retroactive Date
405 IAC 1-7-12 Repealed 07/25/97	Medical Services	1/1/92		
Indiana Medicaid Update Bulletin 96-25	Billing Procedures For Chemotherapy		7/18/96	
405 IAC 5-3	Prior Authorization Exceptions	8/24/97		
405 IAC 5-29-1	Noncovered Services	8/24/97		
405 IAC 5-28-10	Chemotherapy	8/24/97		
405 IAC 5-19-6	Durable Medical Equipment subject to Prior Authorization	8/24/98		
Revisions:				
405 IAC 5-3-12 Amended	Prior Authorizations Exceptions	10/27/99		
405 IAC 5-25	Physician Services	8/24/97		
405 IAC 5-29-1 Amended	Noncovered Services	10/27/99		

APPLICABLE INDIANA AIM EDITS AND AUDITS:

4090

4091

COVERAGE CRITERIA:**Billing Procedures for Chemotherapy and Radiation Treatment Services****Chemotherapy**

All outpatient hospital chemotherapy and radiation treatment services are billed on the UB-92 claim form.

Chemotherapy services consist of four components: treatment room services, administration of chemotherapy agent, chemotherapy agent, and intravenous (IV) solution and IV equipment. Each of these four components can be separately billed when chemotherapy is administered. In order to bill for chemotherapy services, providers should adhere to the following guidelines:

Treatment room services--Bill using revenue codes 45X, 51X or 76X.

Administration of chemotherapy agent--Bill using revenue codes 331, (Description Chemotherapy--Oral is not listed in Indiana AIM as attached to any of the CPT chemotherapy administration codes listed below) or 335. The appropriate CPT chemotherapy administration codes (96400-96549) should be listed along with revenue codes. Preparation of chemotherapy agents is included in the service for administration of the agent. [American Medical Association (AMA) Current Procedural Terminology (CPT) 2002]

Chemotherapy agent--Bill using revenue code 636 (Drugs requiring detailed coding) along with the appropriate HCPCS J code(s) (J9000-J9390).

Intravenous solution and IV equipment--Bill using revenue code 258 for the IV solution and revenue code 261 for IV equipment. No reimbursement will be made for other revenue codes associated with supplies.

Radiation Treatment

Radiation Treatment services consist of two components: Treatment room services and administration of radiation treatment. In order to bill for radiation treatment services, providers should adhere to the following guidelines: Treatment room services—Bill using revenue codes 45X, 51X, or 76X.

Administration of radiation treatment—Bill using revenue codes 330, 333, or 339 along with the appropriate CPT radiation treatment code(s) (77261-77799). When chemotherapy and radiation treatment services are rendered on the same day, all applicable components may be billed to Medicaid.

MEDICAL POLICY FACT SHEET

TITLE: ONCOLOGY—BREAST AND CERVICAL CANCER PROGRAM

DESCRIPTION:

United States Code Title 42, Chapter 6A, Subchapter XIII, Section 300k makes grants available to states to screen women for breast and cervical cancer as a preventative health measure. The State Department of Health is responsible for implementing the Indiana Breast and Cervical Cancer Program. Effective July 1, 2001, patients diagnosed with breast or cervical cancer, including pre-cancerous lesions, through the Indiana Breast and Cervical Cancer Program of the State Department of Health, are eligible for Medicaid during the course of their treatment if they meet the eligibility requirements in Indiana Code 12-15-2-13.5.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

In order to be eligible for Medicaid while receiving treatment for breast or cervical cancer, a woman must meet the following criteria.

1. A woman may not be eligible for Medicaid under any other section of IC 12-15.
2. A woman must be under 65 years of age.
3. A woman has been screened for breast or cervical cancer through the breast and cervical cancer screening program under the Federal Breast and Cervical Cancer Mortality Prevention Act of 1990 (42 U.S.C. 300k) and determined to need treatment for breast or cervical cancer.
4. A woman is not otherwise covered under credible coverage as defined in 42 U.S.C. 300gg(c).
5. A woman's family income does not exceed 200% of the federal income poverty level for the same size family.

A woman eligible for Medicaid under this provision is limited to coverage for the duration of treatment required for breast or cervical cancer. The woman is entitled to full Medicaid coverage as specified in the State Plan.

PRIOR AUTHORIZATION

Requirements for prior authorization (PA) are contingent upon each service rendered to participants of the Breast and Cervical Cancer Program. Please refer to the Fact Sheet that corresponds with each service rendered, when available, for more information on PA.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in *Medicaid Select* PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the *Medicaid Select* Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

IHCP providers are responsible for following correct coding procedures in accordance with standard billing practices. Please refer to the Fact Sheet that corresponds with each service rendered, when available, for more information on billing requirements.

RELATED MEDICAL TOPICS

Genetic Testing-BRCA1 and BRCA2 for Breast and Ovarian Cancer

Gynecology-Hysterectomy

Hospice

Hospital Inpatient Hospital Outpatient

Laboratory Services

Laboratory Services-HER-2-/Neu Gene Detection and HER2 Protein Expression Tests

Medical Supplies and Equipment

Oncology

Pathology

Pharmacy

Transportation

RULES, CITATIONS, AND SOURCES

Indiana Code 12-15-2-13.5

Indiana Code 12-15-2.3

Indiana Health Coverage Programs Provider Banner

BR200134 - Eligibility

Indiana Health Coverage Programs Provider Bulletin

BT200605 – Billing Requirements and Prior Authorization Criteria for Genetic Testing for Breast and Ovarian Cancer

Indiana Health Coverage Programs Provider Manual Version 5.1, March, 2005

Origination Date: 07/01/2001

Revisions and Review	Reason	Date
Indiana Code 12-15-2-13.5 12-15-2.3	Eligibility Presumptive Eligibility for Women with Breast or Cervical Cancer	07/01/2001
42 USC 1396r-1b	Presumptive Eligibility for Certain Breast or Cervical Cancer Patients	10/01/2000
Review	Scheduled	10/31/2006

APPLICABLE INDIANA*AIM* EDITS AND AUDITS

Indiana*AIM* Edits and Audits are dependent on procedure codes corresponding to services rendered to Breast and Cervical Cancer Program participants. Please refer to the Fact Sheet that corresponds with each service rendered, when available, for more information on applicable Indiana*AIM* edits and audits.

MEDICAL POLICY FACT SHEET

TITLE: OPHTHALMOLOGIC SERVICES

DESCRIPTION

Ophthalmology is the branch of medicine pertaining to the eye that includes anatomy, physiology, and pathology. Ophthalmologists are licensed medical physicians or osteopathic physicians who have the ability and credentials to perform surgical procedures on the eye and related structures.

Optometry is the professional practice concerned with the eye and related structures to determine the presence of vision problems and eye disorders. (Stedman Electronic Medical Dictionary v. 5.0, 2005). Other vision related services such as pharmaceutical, surgeries, and diabetes self management training (DSMT) are covered services when determined to be medically necessary.

This document is intended to serve as a general summary of the IHCP policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC), or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

Ophthalmology services must be provided by an ophthalmologist or an optometrist within the scope of their licensure. The IHCP provides reimbursement for vision care services subject to the following restrictions.

- One routine vision care examination and refraction is covered for members 18 years old and younger, per rolling calendar year
- One routine vision care examination and refraction is covered for members 19 years old and older every two years
- For eyeglasses, including frame and lenses, documentation of medical necessity must include the following.
 - A change of 0.75 diopters for members six to 42 years old
 - A change of 0.50 diopters prescription or change for members more than 42 years old
 - An axis change of at least 15 degrees

- Replacement frames and lenses are only covered when medical necessity guidelines are met or when necessitated by loss, theft, or damage beyond repair

PRIOR AUTHORIZATION

Most vision care services do not require prior authorization; however, prior authorization is required for the following services.

- Blepharoplasty for a significant obstructive vision problem
- Prosthetic device, except eyeglasses
- Reconstructive or plastic surgery

*Prior authorization is required for all vision services provided to 590 members when an amount greater than \$500.00 per procedure is billed.

INITIAL EXAMINATIONS

IHCP coverage for vision examinations is limited to specific criteria. Documentation of medical necessity must be maintained in the provider's office and is subject to post payment review and audit. Initial examinations may include the following.

- Eye examination, including history
- Visual acuity determination
- External eye examination
- Biocular measure
- Routine ophthalmoscopy
- Tonometry and gross visual field testing, including color vision, depth perception, or stereopsis
- Any additional examination must be medically necessary

DIAGNOSTIC SERVICES

Diagnostic services, if medically necessary, may be submitted for reimbursement in addition to the eye examination. These services may include the following.

- Supplemental evaluation
- Multiple pattern fields, including Roberts, Harrington, or Flods
- Central field study
- Peripheral field study
- Tangent screen study
- Color field study
- Binocular ophthalmoscope
- Other supplemental testing

- Visual skills study
- Clinical photography
- Bifocal determination
- Trifocal determination
- Definitive fundus evaluation
- Electrophysiology
- Gonioscopy
- Neutralization of lens or lenses
- Extended ophthalmoscopy
- Serial tonometry
- Refractions
- Office visit
- Consultation
- Visual skills testing

The Medicare program does not cover refractions because the service is considered statutorily excluded. For dually-eligible members, this service may be billed directly to the IHCP for consideration on the CMS-1500 or 837P. Providers are not required to submit refraction claims to Medicare first.

Lenses

The prescription of lenses, when required, is included in the HCPCS code 92015—*Determination of refractive state*. It includes specification of lens type, monofocal, bifocal, lens power, axis, prism, absorptive factor, impact resistance, and other factors. The IHCP does not provide coverage for all lenses. If a member chooses to upgrade to non-covered lenses, the basic lens V code can be billed to the IHCP. The upgrade portion can be billed to the member, only if the member was given an appropriate advance notification of the non-covered service and a separate procedure code for the service exists. Safety lenses are covered only for corneal lacerations and other severe intractable ocular or ocular adnexal diseases. **Table 1** lists non-covered lens CPT codes.

TABLE 1—Non-covered Vision Codes

CPT Code	Code Description
V2702	Deluxe lens feature
V2744	Tint, photochromatic, per lens
V2745	Additions to lens, tint, any color, solid, gradient or equal, excluded photochromatic, any lens material, per lens
V2750	Antireflective coating, per lens
V2760*	Scratch resistant coating, per lens
V2781	Progressive lens, per lens
V2782*	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens
V2783*	Lens, index greater than or equal to 1.66 plastic, or greater than or equal to 1.80 glass, excludes polycarbonate, per lens
V2786*	Specialty occupational multifocal lens, per lens

*These codes are non-covered effective December 1, 2004.

Polycarbonate Lenses

The IHCP has developed specific criteria for polycarbonate lenses to ensure that they are used only for medically necessary conditions that require additional ocular protection for members. HCPCS code V2784—*Lens, polycarbonate or equal, any index, per lens* may be billed when a corrective lens is medically necessary and if one or more of the following criteria is met.

- Member has carcinoma in one eye and the healthy eye requires a corrective lens
- Member has only one eye which requires a corrective lens
- Member has had eye surgery and still requires the use of a corrective lens
- Member has retinal detachment or is post-surgery for retinal detachment and requires a lens to correct a refractive error of one or both eyes
- Member has a cataract in one eye or is post-cataract surgery and requires a lens to correct a refractive error of one or both eyes
- Member has low vision or legal blindness in one eye with normal or near normal vision in the other eye
- Other conditions deemed medically necessary by the optometrist or ophthalmologist. These conditions must be such that one eye is affected by an intractable ocular condition and the polycarbonate lens is being used to protect the remaining vision of the healthy eye.

Frames

Reimbursement is available for frames, including but not limited to, plastic or metal. Providers should bill for frames using V2020—*Frames, purchase*. Providers who receive payment from the IHCP for the frames, may not bill the member for any additional cost above the IHCP reimbursement, except in circumstances where a member requests an upgrade that has a separately billable code or for non-covered services, instances where the member signed a waiver.

The IHCP does not cover any portion of a deluxe or fancy frame purchase, except when medically necessary. Charges for medically necessary deluxe frames must be submitted with procedure code V2025—*Deluxe frame*. All Medicaid claim forms submitted for a more expensive frame must be accompanied by documentation supporting medical necessity. Situations where medical necessity for a more expensive frame may be indicated include, but are not limited to, the following.

- Frames to accommodate facial deformity or anomaly
- Allergy to standard frame materials
- Infant or child frames

If a member chooses to upgrade to a deluxe frame without medical necessity, the entire frame is considered to be non-covered and may be billed to the member, if proper advance notice of non-coverage was provided and signed by the member. In these situations, only the claim for the lenses should be submitted to the IHCP for reimbursement.

Replacement Eyeglasses

Repair or replacement services refer to the part of the eyeglasses that is broken or damaged. Members are not entitled to a new pair of eyeglasses if the lenses and/or frames can be repaired. The following information describes instances that support medical necessity for the replacement of the eyeglasses.

- Members 19 years of age and older that have met the medical necessity for the replacement of the eyeglasses may be eligible for a new pair of eyeglasses two years from the date the replacement eyeglasses were provided.
- If a member needs replacement eyeglasses due to loss, theft, or damage beyond repair, prior to the established limitations, the modifier RP—*Replacement or repair*, must be used to bill for this service.
- If a member needs replacement eyeglasses due to a change in the prescription and it is prior to the established limitations, the modifier SC—*Medically necessary service or supply*, must be used to bill for this service.
- Documentation must be present in the member's medical record to substantiate the need for replacement frames or lenses. Documentation that eyeglasses have been lost, stolen, or damaged beyond repair must include a signed statement by the member detailing how the eyeglasses were lost, stolen, or damaged beyond repair.

* The modifiers are only needed on claims for replacement of frames or lenses within the one or two year period, based on the member's age at the time of service. However, all eyeglasses dispensed must meet the minimum prescription requirements for the initial dispensing and each subsequent dispensing of eyeglasses.

Contact Lenses

Contact lenses are covered when medically necessary. Documentation is not required with the claim, but must be maintained in the member's medical record for post-payment review. Medical necessity for contact lenses include, but is not limited to, members with a severe facial deformity who are physically unable to wear eyeglasses or members who have a severe allergy to all frame materials. The prescription of contact lenses includes the specification and physical characteristics such as power, size, curvature, flexibility, and gas permeability. Fitting contact lenses includes instruction, training, and incidental revision of the lenses during the training period. Follow-up and documentation of successful fitting of the extended wear lenses is necessary as well.

OPHTHALMOLOGIC SURGERIES

Documentation must be maintained in their member's medical records to support medical necessity for all ophthalmologic surgeries, including Argon and Krypton LASER Beam therapy, YAG LASER, Intraocular Lenses (IOLs), New Technology Intraocular Lenses (NTIOLs) and Vitrectomy. If performed in the office, the submitted billing code should reflect the location. If performed in another location, the global surgery billing/payment fee will apply. Other related information regarding these surgeries may be found in the Surgery and Transplant Fact Sheets.

Argon and Krypton LASER Beam Therapy

Argon and Krypton LASER beam therapy uses a variety of gases to produce light beams to provide therapy for multiple conditions. Argon and Krypton LASER Beam treatment may be used to weld the retina to the back of the eye in the case of small retinal detachment or may be used to incise tissue to provide a new avenue for the aqueous humor to drain as part of the treatment of glaucoma.

Intraocular Lenses (IOLs) and New Technology Intraocular Lenses (NTIOLs)

IOLs and NTIOLs are intraocular lenses that are implanted to replace the natural lenses following procedures such as cataract surgery. Other diagnoses that support medical necessity of NTIOLs include, but are not limited to, the following.

- Glaucoma
- Iris melanoma
- Ciliary body melanoma
- Choroids melanoma

Any facility reimbursed at an ASC rate should submit claims for surgical insertions of IOLs using the CPT code 66983, 66984, 66985, or 66986 and the appropriate revenue code on a UB-92 claim form. The NTIOLs claim must be submitted on a separate HCFA-1500 claim form using the facility's durable medical equipment (DME) provider number. The appropriate Q-Code will be reimbursed at an allowed rate of \$50 for each implanted NTIOLs lens.

Vitrectomy

A vitrectomy is the removal of the vitreous humor when it is diseased or damaged. Diagnoses that may support medical necessity of vitrectomy as a sight-saving procedure include, but are not limited to, the following.

- Vitreal hemorrhage
- Retinal detachment
- Scarring or fibrosis of vitreous
- Proliferative retinopathy

Documentation must be maintained in the member's medical record. The operative report should be reviewed and the claim paid as follows.

- If the vitrectomy is performed through the pars plana, the vitrectomy and the appropriate cataract extraction code will be paid according to the multiple surgical procedure payment guidelines.
- If the claim states "restorations of anterior chamber," the cataract extraction will be paid, and the vitrectomy is included in the procedure and will not be reimbursed separately.

- If an open sky vitrectomy is performed with the cataract extraction, the vitrectomy and the cataract extraction will be paid according to the multiple surgical procedure payment guidelines.

Vitrectomy services billed with corneal transplant on the same eye should be denied if the service is to restore the anterior chamber. Vitrectomy through the pars plana or the open sky technique with the corneal transplant should be paid according to the guidelines for vitrectomy with cataract surgery. A pars plana vitrectomy and photocoagulation billed separately should be combined and coded appropriately.

YAG LASER

The YAG LASER treatment is the laser separation of the posterior capsule that is used when there is a blockage between the lens and the vitreous humor of the eye. This treatment allows the passage of light through the media to the retina which was initially retracted and obstructed. The YAG LASER may be used for the surgical removal of pathological tissue, i.e. brain tumors, hemorrhoids, and chondylmata. When used in conjunction with a surgery other than specific to ophthalmological treatments, it should be included in the global fee billing schedule when filing a claim.

BILLING INFORMATION

Vision care reimbursement is not available for more than one unit for eye exams and other ophthalmologic procedures. IHCP providers may only bill one unit, per member, per day for the procedures indicated in **Table 2**. Claims that have more than one unit per day for these codes will automatically pay for one unit. Examinations where counseling and coordination of care are the dominant services may be coded with the appropriate evaluation and management (E/M) code using the time factor associated with the code. Documentation in the member's record must include the total time of the encounter, synopsis of the counseling topics, and information regarding the coordination of care efforts. The following services are included in the eye examination and are not separately billable.

- Biocular measurement
- Routine ophthalmoscopy and external eye examination
- Gross visual field testing including color vision, depth perception, or stereopsis
- Tonometry
- Visual acuity determination

Table 2—Ophthalmologic Services

CPT Code	Description
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient

Table 2—Ophthalmologic Services

CPT Code	Description
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits
92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete
92019	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; limited
92020	Gonioscopy (separate procedure)
92060	Sensorimotor examination with multiple measurements of ocular deviation (i.e., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (i.e., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (i.e., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (i.e., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus programs G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
92100	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (i.e., diurnal curve or medical treatment of acute elevation of intraocular pressure)
92120	Tonography with interpretation and report, recording indentation tonometer method or perilimbal suction method
92130	Tonography with water provocation
92140	Provocative tests for glaucoma, with interpretation and report, without tonography
92250	Fundus photography with interpretation and report

Table 2—Ophthalmologic Services

CPT Code	Description
92260	Ophthalmodynamometry
92265	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report
92270	Electro-oculography with interpretation and report
92275	Electroretinography with interpretation and report
92284	Dark adaptation examination, with interpretation and report
92285	External ocular photography with interpretation and report for documentation of medical progress (i.e., close-up photography, slit lamp photography, gonioscopy, stereophotography)
92286	Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count
92287	Special anterior segment photography with interpretation and report; with fluorescein angiography
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens
92315	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, one eye
92316	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, both eyes

ORTHOPTIC OR PLEOPTIC TRAINING, VISION TRAINING, AND THERAPIES

All vision training therapies are covered under CPT code 92065—*Orthoptic and/ or pleoptic training, with continuing medical direction and evaluation*. The medical record must be maintained to support medical necessity and include the following coverage criteria for these services.

- CPT code 92065—*Orthoptic and /or pleoptic training, with continuing medical direction and evaluation* is limited to one unit or visit per day
- Vision therapy services must be ordered by a physician or an optometrist
- The physician or optometrist must document a diagnosis, treatment plan, and the need for continued treatment in the medical record

- Vision therapy services can be performed by an optometrist, a physician, or supervised staff. Staff must be trained or certified to provide these vision services
- Staff trained or certified in vision training may perform orthoptic and pleoptic training only under the direct supervision of an optometrist or physician. Direct supervision requires that the supervising physician or optometrist must be physically available at the time and the location of where the vision therapy services are rendered
- All documentation of directly supervised vision therapy services rendered by staff must be cosigned by the supervising optometrist or physician in the medical record

VISION CARE FOR MANAGED CARE ORGANIZATIONS

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in Hoosier Healthwise PrimeStep (PCCM) receive the same benefit coverage, and are subject to the same limitations, as traditional Medicaid FFS. Refer to the Hoosier Healthwise Manual for Primary Medical Providers and Office Staff for further information.

Ophthalmologic Surgeries

Providers furnishing optical or ophthalmology services to members enrolled in MCO delivery systems must contact the appropriate organization and refer the appropriate manual for specific guidelines for surgical services.

RELATED MEDICAL TOPICS:

Anesthesia Services
Clinic Services—FQHC and Rural Health Clinic Services
Diabetes Self Management Treatment (DSMT)
Hoosier Healthwise Managed Care Organizations
Hospital Inpatient Services
Hospital Outpatient Services
Physician Services
Prior Authorization
Podiatry Services
Surgery Services
Transplant Services

RULES, CITATIONS, AND SOURCES:**Code of Federal Regulations**

42 CFR 440.120 Subpart A—Definitions

42 CFR 441.30 Subpart A—General Provisions—Optometric services

Indiana Administration Code

405 IAC 5-9-1—Evaluation Management (E/M) services

405 IAC 1-6-14 Repealed 8/24/97—Optometrist and Optician services

405 IAC 1-7-1 Repealed 8/24/97—Global Fee Billing

405 IAC 5-3-13—Prior Authorization

405 IAC 5-16-6—Home Health Agency and Clinic Services

405 IAC 5-19-11—Prosthetic Devices

405 IAC 5-23—Vision Care Services

405 IAC 5-28-1(a), (g)—Medical and Surgical Services

405 IAC 5-36-1—Diabetes Self Management Treatment

470 IAC 5-8-14 Transferred—Optometrist and Optician Services

470 IAC 5-9-1 Transferred—Global Fee Billing

Indiana Health Coverage Programs Bulletin

E96-01—Indiana Medicaid Ophthalmologists, Optometrists, and Opticians

E96-20—Prior Authorization Rule Changes

E96-26—Coverage Issues: Metal Frames for Eyeglasses

E96-37—Vision Services in Hoosier Healthwise

E98-05—Vision Coverage

E98-09—Vision Training

BT199909—Removal of Services from Prior Authorization

BT199916—Changes in Policy and Billing of Vision Services

BT200103—New Technology Intraocular Lenses

BT200217—Orthoptic and Pleoptic Training, Vision Training, and Therapy Changes

BT200427—Hoosier Healthwise Mandatory Managed Care Organization Transition

BT200506—State-wide Hoosier Healthwise Managed Care Organization Transition

BT200507—New 2005 Quarterly HCPCS Codes

Indiana Health Coverage Programs Banner (continued)

BR199952—Coverage

BR200237—Limits for replacement eyeglasses

BR200238—Replacement eyeglasses

BR200433—Provider code sets

BR200434—Provider code sets

BR200435—Billing and claims

Indiana Health Coverage Programs Provider Manual

1999

Version 5.1, March 2005

Indiana Health Coverage Programs Provider Monthly Newsletter

NL200505—Vision Services

Indiana State Department of Public Welfare Medical Policy Manual 1991**Origination Date: 1/31/2000**

Revisions and Reviews	Reason	Date
470 IAC 5-8-14 Transferred	Optometrist and Optician Services	7/1/91
470 IAC 5-9-1 Transferred 1/1/92	Global fee billing	7/1/91
405 IAC 1-6-14 Repealed 8/24/97	Optometrist and Optician Services	1/1/92
405 IAC 1-7-1 Repealed	Global Fee Billing	1/1/92
Indiana Medicaid Update Bulletin 96-01	Indiana Medicaid Ophthalmologists, Optometrists, and Opticians	1996
Indiana Medicaid Update Bulletin 96-20	Prior Authorization	7/22/96
Indiana Medicaid Update Bulletin 96-26	Coverage Issues	7/26/96
Indiana Medicaid Update Bulletin 96-37	Vision Services in Hoosier Healthwise	1/1/97
405 IAC 5-3-13	Services Requiring Prior Authorization	8/24/97
405 IAC 5-23	Vision Care Services	8/24/97
42 CFR 440.120	Subpart A–Definitions	10/1/97
42 CFR 441.30	Subpart A–General Provisions–Optometric services	10/1/97
Indiana Medicaid Update Bulletin 98-09	Vision Training	3/27/98

Origination Date: 1/31/2000 (continued)

Revisions and Reviews	Reason	Date
Indiana Medicaid Update Bulletin BT199909	Removal of Services from Prior Authorization	4/19/99
405 IAC 5-23-3 Amended	Vision Care Services – Reimbursement limitations	10/27/99
405 IAC 5-16-6	Home Health Agency and Clinic Services	11/1/99
Vision Services Code Set Optician (180)	Changes in Policy and Billing of Vision Services	10/1/04
Vision Services Code Set Optometrist (190)	Changes in Policy and Billing of Vision Services	10/1/04
Revision	Ophthalmological Service Fact Sheet: Vision care, Surgeries, Vision training, and Managed care organizations	7/29/05

APPLICABLE INDIANA A/M EDITS AND AUDITS:

6006—Only One New Patient Visit per 3 Years

6012—Medical Services 20 per Year

6014—Global Payable at a Reduced Fee When Components Paid- Medical Services

6017—Global Payable at a Reduced Fee When Components Paid- Endocrine/Nervous/ Eye/Ear

6048—Components Not Payable When Global Paid- Endocrine/ Nervous/ Eye/ Ear

6069—Office Visits 30 per Year

6096—CPT/ HCPCS Code Billed is not Payable According to the PPS Reimbursement Methodology

6600—Frames Initial or Replacement- Member 18 years or younger

6601—Lenses Initial or Replacement- Member 18 years or younger

6602—Postoperative Cataract Lens Replacement/ One per Year

6603—Frames Initial or Repair/Replacement – Member Over 18 years

6604—Lenses Initial or Repair/Replacement – Member Over 18 years

6605—Frames Replacement Versus Frame Repair on Same Date of Service

6606—Frame Replacements Parts in Excess of \$20

6607—Frames Repair Versus Frame Replacement

6608—Frame- One Replacement Allowed per Day

6610—Routine Vision Exam Limited to One Exam Per Twelve (12) Months for Ages 1 to 18 Years

6611—Routine Vision Exam Limited to One Exam per Twenty-four (24) Months for Ages 19 to 99 Years

6649—Surgery Payable at Reduced Amount When Related Postoperative Care Paid

6651—Surgical Cutback Procedures are Limited to One per Lifetime

6652—Multiple Surgeries Must be Billed on Same Claim

- 6653—Postoperative Care Within Zero to 90 Days of Surgery
- 6654—Postoperative Care Within One Day of Surgery
- 6655—Surgery Payable at Reduced Amount When Preoperative Care Paid
- 6656—Postoperative Care Within 10 Days of Select Surgery
- 6657—Postoperative Care on Day of Surgery
- 6658—Surgery Payable at Reduced Amount When Preoperative Care Paid Same Date of Service
- 6659—Surgery Payable at Reduced Amount When Related Postoperative Care Paid
- 6660—Preoperative and Postoperative are Billed with Unlisted Surgeries Requires Review
- 6665—Bilateral Versus Unilateral Surgeries
- 6920—Diabetes Management Limited to 8 Units in 12 months

MEDICAL POLICY FACT SHEET

TITLE: OSTEOGENIC BONE GROWTH STIMULATOR

DESCRIPTION

Electrical stimulation produces calcification and mineralization of the fibrocartilage repair tissue (bone growth) at a fracture site and helps to increase vascularity. Electrical stimulators are used for nonhealing or hard to heal fractures, usually of the long bones, and also for spinal fusions.

There are several types of bone growth stimulators available to deliver therapy by different methods.

- Implantable direct current stimulators are most commonly used in spinal fusions, at the time of the surgical procedure, but can be implanted surgically for bone grafting of nonunion and stress fractures. Invasive electric stimulators can be either fully or partially implantable. A second surgical procedure is necessary at the end of treatment to remove the device. The advantages of the implantable stimulators are constant current treatment and patient compliance. Disadvantages are the high cost and the requirement of two surgical procedures.
- One type of non-invasive external device uses electrodes that are applied to the skin at the fracture site. The electrodes can be placed under a cast when necessary. The device operates on an external battery pack and eliminates the need for surgical procedures to initiate treatment. The unit may be operated up to 24 hours per day, but the 9-volt battery must be changed daily. Disadvantages of this device are possible skin irritation from the electrodes and frequent battery replacement.
- A second type of external device is a coil that is placed under the cast or on the outside of the cast. The coil attaches to a battery pack and a control unit that is worn externally. This device is recommended for treatment no more than 10 hours per day. Patient compliance is a concern with this device because the unit is heavy and larger than most other options.
- The newest option is an ultrasonic osteogenic stimulator, a noninvasive unit that may be applied directly to the skin. This OBGS produces pulsed ultrasound, which increases vascularity to speed healing. The ultrasound signal, comparable to that used in conventional fetal monitoring, is transmitted to the skin via a conductive coupling

gel, which coats the skin. In the event a cast is present, a hole is made in the cast so the device can be applied to the skin. Overlaying the fracture site or through a window in the cast, this device is used for only 20 minutes per day. The disadvantage of the ultrasound OBGS is it is larger than all other options.

The IHCP covers osteogenic stimulators with prior authorization under the following codes:

Table 1 – Osteogenic Bone Stimulators

HCP CODE	DESCRIPTION
E0747	Osteogenesis Stimulator, noninvasive
E0748	Osteogenesis Stimulator, noninvasive, spinal applications
E0749	Osteogenesis Stimulator, surgically implanted
E0760	Osteogenesis Stimulator, low intensity ultrasound

RELATED MEDICAL TOPICS

Physician Services
Durable Medical Equipment
Surgery
Hospital Inpatient
Hospital Outpatient

RULES, CITATIONS, AND SOURCES

405 IAC 5-3-5	405 IAC 5-19-3
405 IAC 5-17-1	405 IAC 5-19-6
405 IAC 5-17-2	405 IAC 5-19-7
405 IAC 5-19-1	405 IAC 5-19-8
405 IAC 5-19-2	

ORIGINATION, REVIEWS AND REVISIONS

Origination date: 7/30/04

Review and Revisions	Reason	Date

APPLICABLE INDIANA A/M EDITS AND AUDITS

6002
6003
6034
6035
6039
6040
6065
6080
6096
6104
6152
6162
6661
6666

COVERAGE CRITERIA

The PA criteria are as follows.

Noninvasive Stimulators (E0747 and E0748) The noninvasive stimulator devices are covered only for the following indications.

- Nonunion of long bone fractures;
- Congenital pseudoarthroses; and
- As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. A multiple level fusion involves three (3) or more vertebrae (e.g. L3-L5, L4-S1, etc.)

Invasive (Implantable) Stimulator (E0749) The implantable invasive stimulator is covered only for the following indications.

- Nonunion of long bone fractures; and
- As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusion. A multiple level fusion involves three (3) or more vertebrae (e.g. L3-L5, L4-S1, etc.)

Ultrasound Stimulator (E0760) The ultrasound stimulator is covered for the following indications.

- Nonunion of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the ultrasound stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.
- The member must have documented failure of at least one surgical intervention for the treatment of the fracture.
- The ultrasonic osteogenic stimulator may not be used concurrently with other non-invasive osteogenic devices.

The above policy relates to nonunion fractures as defined below. The diagnosis for nonunion of a fracture must meet the following criteria.

1. Serial radiographs must have confirmed that fracture healing has ceased for three or more months prior to starting treatment with an osteogenic stimulator.
2. Serial radiographs must include a minimum of two sets of radiographs, each including multiple views of the fracture site separated by a minimum of 90 days.

Non-unions of the skull, vertebrae, and those that are tumor-related are excluded from coverage. Treatment for fresh fractures and non-union associated with osteomyelitis is not covered.

MEDICAL POLICY FACT SHEET

TITLE: OUT-OF-STATE SERVICES

DESCRIPTION:

Recipients of Indiana Medicaid may require healthcare services when they are outside the state of Indiana. Out-of-state healthcare providers can enroll in the Indiana Medicaid Program. If an Indiana Medicaid member requires healthcare services, he/she should inquire prior to receipt of service if the service organization is enrolled as an Indiana Medicaid provider, if possible.

MEDICAL TOPICS CROSS-REFERENCES:

Potentially All Medical Policies

RULES, CITATIONS, AND SOURCES:

405 IAC 5-5 Out-of-State Services
405 IAC 5-13-5 Prior authorization for services rendered outside of the large state
ICF/MR
Provider Bulletin 96-12
Provider Bulletin 95-79
HCFA 10-1-97, 42 CFR 431.52
Indiana Health Coverage Programs Provider Manual 1999

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
470 IAC 5-9-4 Transferred	Out-of-state medical services	7/1/91		
405 IAC 1-7-4 Repealed 8/24/97	Out-of-state medical services	1/1/92		
Bulletin 95-79	Out-of-state Prescriptions		1995	
Bulletin 96-12	Out-of-state Prescriptions		1996	
Revisions:				
405 IAC 5-5	Out-of-state Services	8/24/97		
405 IAC 5-5-1 Amended	Out-of-state Services	4/10/98		
405 IAC 5-5-2 Amended	Out-of-state Services	10/27/99		
405 IAC 5-13-5	PA for services rendered outside of large state ICFMR	8/24/97		
BT200317	Pharmacy Processor Change Reminders	3/23/03		

APPLICABLE INDIANA A/M EDITS AND AUDITS:

3010

3011

3015

3016

COVERAGE CRITERIA:

IHCP reimbursement is available for the following services provided outside the state of Indiana.

- Acute general hospital care
- Physician services
- Dental services
- Pharmacy services
- Transportation services
- Therapy services
- Podiatry services
- Chiropractic services
- Durable medical equipment and supplies
- Hospice services, subject to the conditions in 405 IAC 5-34-3

PRIOR AUTHORIZATION

Prior authorization may be granted for any time period from one day to one year for out-of-state medical services listed above if the service meets criteria for medical necessity and any one of the following criteria is met.

- The service is not available in Indiana. Care provided by out-of-state Veteran's Administration and Shrine hospitals is an exception to this requirement.
- The member has received services from the provider previously.
- Transportation to an appropriate Indiana facility would cause undue exposure or hardship to the recipient or the Medicaid program.
- The out-of-state provider is a regional treatment center or distributor.
- The out-of-state provider is significantly less expensive than the Indiana providers, for example, large laboratories versus an individual pathologist.

All out-of-state service provided to IHCP members require prior authorization (PA) with the following exceptions.

- Emergency services. Continuation of inpatient treatment and hospitalization is subject to IHCP prior authorization requirements.
- Recipients of the adoption assistance program placed outside of Indiana will receive approval for all routine medical and dental care provided out-of-state.

The following out-of-state cities are designated as having the same PA requirements as in-state service providers.

Designated Areas for In-state PA Requirements

State	City
Illinois	Danville
	Watseka
Kentucky	Louisville
	Owensboro
Michigan	Sturgis
Ohio	Cincinnati
	Hamilton
	Harrison
	Oxford

Members can receive services in Chicago, Illinois, subject to all of the following conditions.

- The member's physician determines the service is medically necessary.
- Transportation to an appropriate Indiana facility would cause undue hardship to the patient or the patient's family.
- The service is not available in the immediate area.
- The member's physician complies with all of the criteria set forth in this article, in accordance with the state plan and 42 CFR 456.3.

Prior authorization of the following will not be approved and the services are not covered when by any out-of-state provider or a designated out-of-state service provider.

- Nursing facilities or Intermediate care facilities for the mentally retarded (ICFs/MR).
- Any other long-term care facility, including facilities directly associated with, or part of, an acute general hospital.
- Any provider type that is not eligible for enrollment in the IHCP.

OUT-OF-STATE SUPPLIERS OF MEDICAL EQUIPMENT

In order to be treated as an in-state provider, any out-of-state supplier of medical equipment must comply with the following.

1. Maintain an Indiana business office, staffed during regular business hours, with telephone service.
2. Provide service, maintenance, and replacements for Indiana Medicaid members whose equipment has malfunctioned.
3. Qualify with the Indiana Secretary of State as a foreign corporation.

REIMBURSEMENT

Enrolled out-of-state hospital providers are reimbursed for inpatient acute care services at diagnosis related group (DRG) in-state rates or the established reimbursement methodology for Medicaid members in the provider's state. All other out-of-state hospital procedures and reimbursement methodologies are the same as for enrolled in-state hospital providers. Providers are reimbursed according to the IHCP reimbursement policy.

Provider Bulletin BT200317 announced that ACS Healthcare, the Pharmacy Benefits Manager (PBM) would assume processing of the IHCP pharmacy claims. As part of this information, ASC provided notification of the requirements on the IHCP Pharmacy Claim-NCPCP 3.2(3C). Field number 411 (prescribe ID) is keyed with the following numbers for out-of-state prescribers.

91111111-Illinois
92222222-Kentucky
93333333- Ohio
94444444- Michigan
95555555- all other states

The bulletin also provides information regarding claims that are denied for a restricted or lock-in member with an out-of-state prescriber number that has denied for an invalid lock-in prescriber. If the member indicates an out-of-state prescriber is a valid referral, the pharmacy must call HCE to receive an override for payment of the claim.

MEDICAL POLICY FACT SHEET

TITLE: PHARMACY

DESCRIPTION:

Pharmacy is the practice of preparing and preserving drugs, and of compounding and dispensing medicines according to prescriptions of physicians or other professionals as authorized by State and Federal laws.

SUMMARY OF CURRENT POLICY

Pharmacy policies cover prescribed drugs for the cure, mitigation, prevention of disease, or health maintenance and are prescribed by a physician, dispensed by licensed pharmacists after receipt of a written prescription. Pharmacy, in this instance, may be considered a collection of services that are covered by Medicaid, with some restrictions.

The Indiana Health Coverage Programs (IHCP) has developed a Preferred Drug List (PDL). This listing is reviewed and updated quarterly based upon recommendations submitted by the Therapeutics Committee to the Drug Utilization Review Board. Non-preferred drugs require prior authorization.

RELATED MEDICAL TOPICS

Diabetes Self-Management Training
EPSDT – HealthWatch
Family Planning
Home Health Services
Hospital Inpatient
Hospice
Immunizations
Intermediate Care Facilities for the Mentally Retarded
Medical Supplies and Equipment
Nursing Facilities
Oncology
Smoking Cessation Treatment

RULES, CITATIONS, AND SOURCES

405 IAC 5-24 Pharmacy Services
405 IAC 5-25-3 Physician Services
405 IAC 5-28-10 Medical and Surgical Services
405 IAC 5-31-5 Nursing Facility Services
405 IAC 5-36 Diabetes Self Management Training Policy
405 IAC 5-37 Smoking Cessation Treatment Policy
405 IAC 5-34 Hospice
42 CFR 440.120
Indiana Medicaid Update Bulletin 96-04
Indiana Medicaid Update Bulletin 98-08
BT200132 Brand Medically Necessary PA
BT200148 Indiana Rational Drug Program
BT200151 Revised Policy for Office-Administered Injectable Drugs and Infusions
BT200210 Indiana Rational Drug Program Phase 2
BT200221 ProDUR Alerts
BT200225 Indiana Rational Drug Program Phase 3
BT200235 Preferred Drug List Phase 1
BT200243 Preferred Drug List Phase 2
BT200247 Preferred Drug List Phase 3
BT200255 Preferred Drug List Phase 4 and 5
BT200261 Preferred Drug List Phase 6
BT200307 Preferred Drug List Phase 7
BT200319 Preferred Drug List Phase 8
BT200333 Preferred Drug List Phase 9
BT200342 Preferred Drug List Phase 10
BT200351 PDL Re-Review
BT200359 PDL Re-Review
BT200365 ProDUR Alerts
BT200403 PDL Changes to BT200359
BT200406 Updated Pharmacy Copayment Information
BT200407 PDL Changes
BT200411 PDL Changes
BT200422 PDL Changes
Indiana Health Coverage Programs Provider Manual 2004

Origination Date : 12/31/2000

Revisions and Reviews	Reason	Date
470 IAC 5-8-20 Transferred	Pharmacy Services	7/1/91
405 IAC 1-6-21 Repealed 8/24/97	Pharmacy Services	1/1/92
405 IAC 5-24	Pharmacy Services	8/24/97
405 IAC 5-25-3	Injections administered by physician	8/24/97
405 IAC 5-28-10	Chemotherapy	8/24/97
405 IAC 5-31-5	Nursing Facility Services: Legend and prescription items	8/24/97
405 IAC 5-24-3 Amended	Pharmacy Services	10/27/99
405 IAC 5-24-5 Amended	Pharmacy Services	10/27/99
405 IAC 5-24-8 Amended	Pharmacy Services	10/27/99
405 IAC 5-31-5 Amended	Nursing Facility Services: Legend and prescription items	10/27/99
405 IAC 5-24-8.5	Prior authorization; other drugs	01/07/02
405 IAC 5-24-11	Limitations on quantities dispensed and frequency of refills	01/07/02
405 IAC 5-24-12	Risk Based Managed Care	01/07/02
405 IAC 5-24-8.6	Prior authorization limitations and other; antianxiety, antidepressant, or antipsychotic agents	02/14/02
405 IAC 5-24-4 Amended	Reimbursement of Legend Drugs	04/30/02
405 IAC 5-24-5 Amended	Reimbursement of Non-Legend Drugs	04/30/02
405 IAC 5-24-6 Amended	Dispensing Fee	04/30/02
405 IAC 5-31-4 Amended	Nursing Facility Services; Per Diem Services	06/05/03
405 IAC 5-24-7 Amended	Copayment for legend and non-legend drugs	02/24/04

APPLICABLE INDIANA AIM EDITS AND AUDITS

Effective March 23, 2003, ACS State Healthcare assumed the responsibility for pharmacy claims processing. IndianaAIM edits and audits for pharmacy claims are effectively no longer active; however, shadow pharmacy claims are shared by ACS and IndianaAIM edits and audits 'post and pay' on these shadow claims. In 2005, the pharmacy processor is subject to change.

COVERAGE CRITERIA

Drug Utilization Review Board

The Drug Utilization Review Board was originated in the *Omnibus Reconciliation Act (OBRA) of 1990*, coincident and ancillary to federal rebate provisions that require each state to have a Drug Utilization Review (DUR) program. The Indiana DUR program is comprised of two components. Prospective DUR (Pro-DUR) is enabled by the Medicaid contractor's point-of-sale (POS) system and performed by the pharmacist at the service location. Retroactive DUR (Retro-DUR) is based on paid claims data that is reviewed by the state DUR board or by Medicaid contractor(s). The Indiana DUR board is required to file an annual report of Pro-DUR and Retro-DUR activities with the Centers for Medicare and Medicaid Services (CMS). Copies of this report are available upon request from CMS.

Medicaid Therapeutics Committee and Preferred Drug List

Senate Enrolled Act No. 228 of the 2002 General Assembly created a requirement for a preferred drug list (PDL) under Indiana Medicaid. In accordance with law, drugs that are included on the Indiana Medicaid PDL **do not** require prior authorization, and drugs that are not included on the PDL **do** require prior authorization. Basic criteria for prior authorization requests for drugs not included on the PDL are therapeutic failure or adverse reaction with the preferred drug.

In accordance with the new law, a Medicaid Therapeutics Committee, which is a subcommittee of the state's Medicaid Drug Utilization Review (DUR) Board, was selected. The Therapeutics Committee, which is comprised of five physicians and two pharmacists, has the responsibility of assisting the DUR Board in the Board's development and recommendation of a PDL to the Office of Medicaid Policy and Planning.

The Therapeutics Committee makes recommendations to the DUR Board for changes to the PDL quarterly. Changes to the PDL are published in provider newsletters, bulletins, banners, and the website for pharmacy services, www.indianapbm.com.

Prior Authorization

Prior authorization is required for the following pharmacy services.

- (1) Brand name drugs that are subject to the generic substitution per IC 16-22-42-4.
- (2) Drugs not included in the Indiana Medicaid PDL (non-preferred drugs).
- (3) Other drugs that the Indiana Medicaid DUR Board places on prior authorization, include, but are not limited to, the following.
 - Cox-II Inhibitors for patients less than 70 years of age
 - Cytotec
 - Toradol (if greater than 20 tablets for 5 days per month)
 - Growth Hormone
 - Synagis and Respigam
 - Actiq
 - Forteo

Limitations to prior authorization are identified by 405 IAC 5-24-8.6. The following drugs are exempt from prior authorization requirements.

- (1) Central nervous system drugs classified by Drugs Facts and Comparisons as any of the following.
 - (a) antianxiety
 - (b) antidepressant
 - (c) antipsychotic
 - (d) any drugs "cross-indicated" to classifications (a) through (c) and used for the purpose generally held to be reasonable, appropriate, and within community standards of practice
- (2) Brand name drugs where the physician has written in his own hand-writing , "Brand Medically Necessary."

Pro-DUR

The purpose of Pro-DUR is to improve the quality and cost-effectiveness of drug use by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical reactions. In addition to the *OBRA '90* requirements for program agencies, the act required pharmacy providers to perform the following activities for all patients.

- (1) Prospective Drug Utilization Review (Pro-DUR)
- (2) Patient counseling
- (3) Proper patient records maintenance
- (4) Evaluation of the following drug therapy problems before filling prescriptions
 - (a) therapeutic duplication
 - (b) drug-disease contraindications
 - (c) drug-drug interactions
 - (d) incorrect drug dosage or duration of drug treatment
 - (e) drug-allergy interactions
 - (f) evidence of clinical abuse or misuse

In addition, therapeutic screening takes place through computer based software programs set up by the IHCP. The IHCP therapeutic screening system alerts pharmacists when the member's claims profile detects the following potential conflicts.

- (1) drug-drug interaction
- (2) drug age precaution
- (3) drug disease alert
- (4) drug pregnancy alert
- (5) high and low dosage alerts
- (6) overuse and underuse precaution
- (7) therapeutic duplication

The claims processing software sends an alert to the pharmacist including the following information with the rejected claim response.

- (1) Drug conflict code
- (2) Clinical significance code, or severity
- (3) Other pharmacy indicator
- (4) Previous fill date
- (5) Quantity of previous fill
- (6) Database indicator
- (7) Other prescriber indicator
- (8) Free text for drug-drug and therapeutic duplication that contains the name of the drug in the related claim history
- (9) DUR overflow

DESI (LTE) Drugs

The Federal Food, Drug, and Cosmetics Act of 1938 established the requirement that a manufacturer prove the safety of a drug before it could be marketed in the United States. In 1962, this act was amended to require that drugs sold in the United States be regulated more closely. All new drugs must demonstrate, via adequate studies, both safety and efficacy before introduction into the market. Federal law prohibits payment under the Indiana Medicaid Program for any drug that is considered "less than effective" (LTE) or "identical, related, or similar" (IRS) to an LTE drug. Comprehensive listings of updated and revised DESI listings are published regularly and available from the Medicaid pharmacy benefit management contractor.

Mandatory Generic Substitution and "Brand Medically Necessary"

Generic substitution under the Medicaid program is mandatory per IC 16-42-22-10. Pharmacy providers must dispense in accordance with the law, and failure to do so can result in a risk of recoupment.

In addition, pharmacy providers must be aware of and dispense in accordance to the provisions in 405 IAC 5-24-8. Prior authorization is required for a brand name drug that is subject to generic substitution under IC 16-42-22-10. The prescriber must indicate "brand medically necessary" on the written prescription drug order and substantiate the medical necessity of the brand name drug to the PBM.

The following drugs are exempt from the brand medically necessary prior authorization requirement; however, the prescription must indicate “brand medically necessary” in the prescriber’s own handwriting.

- Dilantin
- Coumadin
- Lanoxin
- Premarin
- Tegretol
- Provera
- Synthroid

Non-Legend or Over-the-Counter (OTC) Drugs

The IHCP provides for coverage and reimbursement of OTC drugs in accordance with 405 IAC 5-24-3. The IHCP has an OTC drug formulary that is updated regularly and published for providers.

Usual and Customary Charge

Providers are to bill the program for covered services with only the provider’s usual and customary charge to the general public for the covered service. The provider’s usual and customary charge includes any dispensing fee that the provider may charge to the general public.

Drug Copayment

Indiana Medicaid drug copayment is set out in 405 IAC 5-24-7. Under IC 12-15-6, a copayment is required for legend and nonlegend drugs and insulin in accordance with the following.

- (1) The copayment amount is deducted from the Medicaid reimbursement to the provider.
- (2) In accordance with 42 CFR 447.15, the provider may not deny services to an eligible member due to the member’s inability to pay. This service guarantee does not apply to an individual who is able to pay nor does this eliminate the individual’s liability for the copayment.
- (3) The amount of the copayment is \$3.00 for each covered drug dispensed and is collected by the pharmacy provider.
- (4) Individuals enrolled in the Children’s Health Insurance Program (CHIP), or Hoosier Healthwise Package C, are responsible for a copayment of \$3.00 for generic, compound, single source legend drugs, and \$10.00 for brand name drugs.

The following pharmacy services are exempt from the copayment requirement.

- (1) Emergency services provided in a hospital, clinic, office, or other facility equipped to furnish emergency care.

- (2) Services furnished to individuals less than eighteen years of age.
- (3) Services furnished to pregnant women, if such services are related to the pregnancy or any other medical condition that may complicate the pregnancy.
- (4) Services furnished to individuals who are inpatient in hospitals, nursing facilities, intermediate care facilities for the mental retarded, or other medical institutions.
- (5) Family planning services and supplies furnished to individuals of child bearing age.
- (6) Health maintenance organization (HMO) pharmacy services.

Long Term Care Facilities and Pharmacy Services

Pharmacy providers are not entitled to separate reimbursement for any Medicaid covered service that is reimbursed through per diem reimbursement. Medical and non-medical supplies and legend and non-legend water products are included in the per diem rate for nursing facilities. These supplies and water products when dispensed to the nursing facility residents are not separately billable to Medicaid.

Covered, manufacturer packaged, unit dose medications are covered by Medicaid for long term care facility residents only. However, the program does not provide reimbursement for costs associated with unit dose packaging when the pharmacy provider packages or repackages medications. In addition, FMAC and SMAC rates apply to manufacturer packaged unit dose medications.

State laws IC 25-26-13-25 (h) and 856 IAC 1-21-1 allow for the return of medications from long term care facilities to the dispensing pharmacy under certain circumstances. Medications returned to the dispensing pharmacy that are put back in stock for re-dispensing must be credited to the program within 30 days of being returned to the pharmacy.

Hospice

Pharmacy services, for conditions related to the patient's terminal illness are included the hospice per diem rate. In addition, pharmacy services not related to the patient's terminal condition are covered outside the hospice per diem rate. All pharmacy services not related to the patient's terminal condition are subject to PDL limitations and PA is required for hospice patients in instances where a non-preferred drug is prescribed or PDL limitations have been exceeded.

Reimbursement Methodology

Pharmacy services are reimbursed at the lowest of the following.

1. Estimated Acquisition Cost (EAC),
2. Federal Upper Limit (FUL, FMAC),
3. State Maximum Allowable Cost (SMAC), or
4. the provider's usual and customary (U&C) charge.

PHARMACY SERVICES ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Pharmacy Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200532 **Publication Date:** 08/09/2005

Subject: HEA 1325 and Medicare Part D Drug Prescription

Date Added to Manual: 10/31/2005

Text of Publication

The passage of *House Enrolled Act (HEA) 1325* has created some confusion. Some advocates and industry representatives have been disseminating information that Prior Authorizations and other clinical edits on behavioral health drugs covered through the Hoosier Healthwise Managed Care Organizations (MCO) are invalid as of July 1, 2005. However, that information is inaccurate.

HEA 1325 confers upon the Mental Health Quality Assurance Committee the responsibility to make recommendations to the Office of Medicaid Policy and Planning (OMPP) regarding access to behavioral health drugs through the Indiana Medicaid program. The OMPP has the ultimate responsibility for implementing any restrictions with the advice of the Committee. The Mental Health Quality Assurance Committee is currently being assembled in accordance with the guidelines set forth in *HEA 1325*.

Until the committee is formed and the OMPP issues guidance regarding access to behavioral health drugs by Hoosier Healthwise members in the Risk-Based Managed Care program, all MCO preferred drug lists (PDL) clinical edits will remain in effect.

- Effective January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) is implementing the new Medicare prescription drug coverage. This coverage, also known as Medicare Part D, is a new benefit to help Medicare members pay for prescription drugs.

The IHCP will provide information as it becomes available with banner pages, the IHCP provider newsletter, bulletins, and the IHCP Web site. The annual IHCP Seminar and fourth quarter provider workshops will include materials and training about the new Medicare Prescription Drug Benefit.

For more information about the Medicare Prescription Drug Benefit visit the CMS Web site at <http://www.cms.gov/medicarereform/>

Provider Notification: 200531**Publication Date:** 08/02/2005**Subject:** State Maximum Allowable Cost**Date Added to Manual:** 10/31/2005**Text of Publication**

Effective September 9, 2005, the following drug groups will be added to the State Maximum Allowable Cost (State MAC) for legend drugs rate list.

Drug Name	State MAC Rate
CILOSTAZOL 100 MG TABLET	0.70570
GABAPENTIN 800 MG TABLET	1.52230
MOMETASONE FUROATE 0.1% CREAM	1.1577
QUINAPRIL HCL 20 MG TABLET	0.78670
QUINAPRIL HCL 40 MG TABLET	0.93950

Effective July 15, 2005, State MAC rates for the following drugs will be increased as listed below.

Drug Name	State MAC Rate
CYCLOSPORINE 100 MG SOFTGEL	4.25370
PAROXETINE HCL 10 MG TABLET	0.99107
PAROXETINE HCL 20 MG TABLET	0.76272
PAROXETINE HCL 30 MG TABLET	1.00320
PAROXETINE HCL 40 MG TABLET	0.88560
PROMETHAZINE 25 MG TABLET	0.38430
TRETINOIN 0.01% GEL	1.50720

Effective September 9, 2005, State MAC rates for the following drugs will be decreased as listed below.

Drug Name	State MAC Rate
CLINDAMYCIN PHOS 1% GEL	0.41748
PROMETHAZINE W/COD SYRUP	0.02316
TRIAMCINOLONE 0.1% CREAM	0.03528
OXYCODONE/APAP 7.5/325 MG TABLET	0.92724

PROMETHAZINE 25 MG SUPPOSITORY	0.69876
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Effective June 24, 2005, the State MAC rate for Bupropion SR 150mg Tab - AB2 (Zyban) will be removed. The State MAC rate for Bupropion SR 150mg Tab - AB1 (Wellbutrin) will remain active. Please direct any questions regarding the State MAC for legend drugs to the Myers and Stauffer pharmacy unit at (317) 816-4136 or 1-800-591-1183, or e-mail at pharmacy@mslc.com

Effective January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) is implementing a Medicare prescription drug benefit. This coverage, also known as Medicare Part D, is a new benefit to help Medicare members pay for prescription drugs. The IHCP will provide information as it becomes available with banner pages, the IHCP provider newsletter, bulletins, and the IHCP Web site. The annual IHCP Seminar and fourth quarter provider workshops will include materials and training about the new Medicare Prescription Drug Benefit.

For more information about the Medicare Prescription Drug Benefit visit the CMS Web site at <http://www.cms.gov/medicarereform/>

This is to advise providers that the new drug Revatio® (sildenafil citrate—Pfizer) will require prior authorization under the Traditional Indiana Medicaid pharmacy benefit. Criteria for approval of prior authorization requests is limited to the labeled indication, diagnosed pulmonary arterial hypertension to improve exercise ability. While the drug is on the Preferred Drug List, prior authorization is being required in order to prevent fraud, abuse, waste, overutilization, or inappropriate utilization, specifically due to its similarity to Viagra®, which is also a sildenafil citrate product. Please call ACS for prior authorization questions at 1-866-879-0106.

Provider Notification: BT200515 **Publication Date:** 07/25/2005

Subject: Post Payment Auditing

Date Added to Manual: 10/31/2005

Text of Publication

Post-payment auditing of pharmacy claims identifies instances where providers have incorrectly billed the Indiana Health Coverage Programs (IHCP), resulting in overpayments. Sometimes the incorrectly billed claim can be corrected by adjusting the claim. In other instances, Prudent Rx cannot adjust the fields containing incorrect information.

For example, a provider submitted a claim for 75 cc of albuterol solution, 5 mg/cc that is available in a 20 cc bottle. The prescription, however, was written and dispensed for a total of 75 cc, or 25 vials of the 3 cc premixed vials. Because these are entirely different products and the submitted NDC is incorrect, the claim cannot be adjusted by Prudent

Rx. The claim must be reversed via the audit process and subsequently a replacement claim must be submitted by the provider to accurately reflect what was dispensed.

To resolve an audit, a provider must repay the incorrectly billed claim and then submit a new claim that will replace the incorrectly billed claim. If the audited claim is **less than one year old** at the time that the provider agrees to the overpayment, the provider may submit the replacement claim with the correct information via POS, **after** repayment has been made via the audit process.

For those claims with dates of service **more than one year old**, the following procedure has been established that will allow providers to submit a replacement claim for payment:

1. Prepare the paper claim for the rendered service with the correct billing information.
2. Sign the overpayment acceptance form, return it and indicate acceptance of the recovery of the inappropriately billed claim.
3. Send the new replacement claim and the overpayment acceptance form to Prudent Rx as instructed in the audit letter.
4. Clearly indicate on all new replacement claims the Transaction Control Number (TCN) of the audited claim that is being replaced.

Prudent Rx will send the audited claim to ACS to be reversed. After the overpayment has been collected and the audited claim reversed, Prudent Rx will send the replacement claim to ACS to be paid.

It is important the providers remember the following:

- This process must be followed in this order to prevent the replacement claims from being denied as duplicates.
- Replacement claims will not be processed unless the provider has agreed to recovery of the overpayment.
- Providers must correct the error identified on the audited claim. Submitting the replacement claim exactly as it was originally billed will result in the claim being re-audited.
- Prudent Rx will only accept replacement paper claims that are:
 - More than one year old
 - Subject to the audit and recovery process
- Prudent Rx will not accept claims for services that are more than one year old and were not subject to the audit process. Prudent Rx will return these claims to the provider. **Error Code RD (Missing/Invalid Date on the Prescription)**
- Prudent Rx will no longer be recovering funds for claims found to have an error code of RD (missing/invalid date on prescription) during the audit process. Instead, these errors will be referred to the Indiana Board of Pharmacy.

Provider Notification: BT200515 **Publication Date:** 07/25/2005

Subject: Post Payment Auditing

Date Added to Manual: 10/31/2005

Text of Publication

This notice advises providers that, in response to rapidly escalating expenditures for Medicaid-covered drugs, and in order to stay within available appropriations while maintaining beneficiary access to services, the office will be adopting an emergency rule that amends pharmacy reimbursement for Medicaid and HoosierRx. Specifically, estimated acquisition cost (EAC) for brand name legend drugs will change from Average Wholesale Price (AWP) minus 13.5 percent to AWP minus 19 percent. At the same time, to bring consistency to reimbursement policy for insulins, OTC insulins will commence being paid in accordance with applicable legend drug EAC methodology. These changes will be effective October 1, 2005.

- Effective January 1, 2006, the CMS is implementing the new Medicare prescription drug coverage. This coverage, also known as Medicare Part D, is a new benefit to help Medicare members pay for prescription drugs. The IHCP Web site now includes a new section titled *Medicare Prescription Drug Coverage*. Providers should visit this section periodically at <http://www.indianamedicaid.com/ihcp/ProviderServices/medicareD.asp> for the latest information.

The annual IHCP Seminar and fourth quarter provider workshops will include materials and training about the new Medicare prescription drug benefit.

For more information about the Medicare prescription drug benefit visit the CMS Web site at <http://www.cms.gov/medicarereform/>

PHARMACY SERVICES ADDENDUM B

Note: This addendum contains provider notifications that have been published since the review of the Pharmacy Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BT200531 **Publication Date:** 12/21/2005

Subject: Medicaid Prescription Drug Coverage Changes Due to the New
Medicare Prescription Drug Coverage

Date Added to Manual: 01/31/2006

Text of Publication

Beginning Sunday, January 1, 2006, Medicaid can no longer pay for prescription drugs for people who have both Medicare and Medicaid, commonly referred to as dual eligibles.

Medicaid Prescription Drug Coverage Changes for Medicare Beneficiaries

Instead, your prescription drugs will be covered by a Medicare prescription drug plan (PDP). This plan is sometimes called Medicare Part D. If you continue to be eligible for Medicaid, Medicaid will continue to pay for other Medicaid-covered health care for which you are eligible that Medicare does not cover.

What This Change Means For You

Because Medicaid can no longer cover your prescription drugs, you must enroll in a Medicare PDP to continue getting prescription drug coverage. Medicare is working with companies that offer these PDPs. You can choose from 13 plans available in your area and not have a premium. Some drug plans may not cover all the drugs you take, some may limit what pharmacies you can use, or they may require small co-payments. For these reasons, you must pick a plan that best meets your needs. You can get help choosing a Medicare PDP by contacting Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 or visit the Medicare Web site at www.medicare.gov

If you do not enroll yourself in a Medicare PDP by December 31, 2005, Medicare will automatically enroll you in a low-cost PDP in your area. This guarantees that you will still have prescription drug coverage on January 1, 2006. You can choose another Medicare PDP at any time. The change will take effect the first day of the month following the receipt of the change.

Extra Help with Medicare Prescription Drug Plan Costs

Because you get full Medicaid benefits, Medicare will give you extra help paying for your PDP costs. The extra help you get from Medicare will pay no more than \$35.69 toward your monthly premium for prescription drug coverage. If you choose a Medicare

PDP with a higher premium, you will have to pay out of pocket the difference between the higher premium amount and \$35.69. Please note that some members will have no premium to pay at all. Depending on the drug plan you choose, you will pay:

- No monthly premium or a low monthly premium
- No yearly deductible
- \$0 to \$5 co-payments for your prescription drugs

If you are in a long-term care facility (nursing facility), Intermediate Care Facility for the Mentally Retarded, or Community Residential Facility for the Developmentally Disabled (group home) you will have no co-payment while you are in the facility. If you are in an assisted living facility or adult living facility you will have a small co-payment.

Choose a Prescription Drug Plan by December 31, 2005

The *Medicare & You 2006* handbook issued in October 2005, has information about Medicare PDPs, and it lists the plans in your area and how to enroll. You can enroll in a Medicare PDP on your own or you can stay with the plan that Medicare chose for you. If you do not enroll yourself in a Medicare PDP by December 31, 2005, you will remain with the plan chosen for you by Medicare. This guarantees that you still have prescription drug coverage on January 1, 2006.

Prescription Drug Coverage through an Employer or Union

If you already have prescription drug coverage through your past or current employer or union, you may not need to enroll in a Medicare PDP. Some retirement plans may discount retiree coverage if you join a Medicare PDP. Talk with your employer or union benefits administrator to see if your current prescription drug coverage is at least as good as the Medicare drug plan. If your current prescription drug coverage is not better, then choose a Medicare plan that meets your needs. You can get help choosing a Medicare PDP that meets your needs by contacting Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 or visit the Medicare Web site at www.medicare.gov

Effects of Coverage Change for People with Medicare and Medicaid

It is important for you to know that, beginning January 1, 2006, Indiana Medicaid will no longer cover your prescription drugs, except for a few types of prescription drugs that are excluded from the new Medicare prescription drug benefit and are covered by Indiana Medicaid. Although Medicare will cover most prescription drugs for people who have both Medicaid and Medicare, Indiana Medicaid will still pay for benzodiazepines (examples include Xanax, Ativan, Klonopin and Valium), barbiturates (examples include Seconal and phenobarbital), and over-the-counter (OTC) drugs that are on the *State of Indiana Over-the-Counter Drug Formulary*.

Medicaid will continue to pay for all your other Medicaid-covered health care, such as hospital, physician, and home health care services. When appropriate, Medicaid will also continue to pay your monthly premiums for Medicare Part A (hospital) and Medicare Part B (medical) coverage.

These coverage changes are necessary due to the passage of the Medicare Modernization Act (MMA) and federal rules supporting the MMA. This change in law affects all people who are eligible for both Medicare and Medicaid. You are eligible for both Medicare and Medicaid. You have the right to request an appeal, but because you are eligible for Medicare and Medicaid, your appeal will be considered without a hearing. Full Medicaid drug benefits can only continue for those not eligible to enroll in Medicare. You will continue to receive Medicaid coverage, but most of your drugs will now be covered by Medicare.

Provider Notification: BT200532 **Publication Date:** 12/29/2005

Subject: Updated Notice Of Program Change Due To The New Medicare Prescription Drug Coverage

Date Added to Manual: 01/31/2006

Text of Publication

Note: The information in this bulletin is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system. The information in this bulletin is directed to the service delivery and billing staff of all fee-for-service and pharmacy providers. Please distribute appropriately. We also request that the associations distribute this information to their members and/or place this information in the materials that they publish.

This bulletin provides additional information and clarification concerning Provider Bulletin [BT200526](#) released on November 15, 2005. Effective January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) is implementing the new Medicare prescription drug coverage, also known as Medicare Part D. With the implementation of this new coverage, Medicaid can no longer pay for Medicare-covered prescription drugs for members who also have Medicare.

Members entitled to receive traditional Medicare, and who receive full Medicaid benefits, are eligible for Medicare Part D. People who receive Medicare benefits and full Medicaid benefits were automatically enrolled in Medicare prescription drug coverage in October 2005. These members can choose a Medicare prescription drug plan (PDP) on their own prior to December 31, 2005, or remain with the PDP chosen for them by Medicare. Medicare will pay for the majority of prescription drugs for these members.

CMS Solution For People Not Auto-Enrolled

CMS is contracting with a single national plan, Wellpoint, to manage payment of prescription drug claims for people who may not have been auto-enrolled. This single national plan is for the very limited number of dual eligible beneficiaries who have not yet been auto-enrolled into a Medicare Part D plan. CMS will provide additional information to pharmacies about this process.

E1 Eligibility Function Testing

CMS advised pharmacy providers to begin testing the new E1 eligibility function that will be available to pharmacies for the implementation of the new Medicare Part D plan. Testing may help to eliminate many of the pharmacy insurance and billing issues concerning third party liability. Free test transactions are available at:

http://medifacd.ndchealth.com/Pharmacies/MediFacD_Pharmacies_Testing.htm

http://medifacd.ndchealth.com/home/MediFacd_home.htm

CMS Fax Procedures for Multiple LTC Resident PDP Enrollment Information

Long-term care (LTC) facilities may need PDP enrollment information for residents of their facility. Nursing homes without Internet access or who need Medicare PDP enrollment information for multiple residents can now use a special CMS fax-based procedure. Nursing home representatives must provide the required authentication information for each of their Medicare residents using the appropriate authentication form. Nursing homes are required to fax the completed form, along with the appropriate cover sheet including the name and telephone number of a voice contact, to Medicare at (785) 830-2593. Providers must use these forms to expedite fax requests for PDP information to CMS. Failure to follow these procedures will result in a delay in response time. The Medicare customer service representatives will process the requests and fax them back to the nursing home. To access these forms, cover sheets, and instructions, refer to:

http://www.indianamedicaid.com/ihcp/Forms/LTC_Nursing_Home_Administrators_FA_X_Procedures.doc

or call 1-800-MEDICARE to request the forms.

Medicare Part D Coverage and Exclusions

This section provides coverage and exclusion information for Medicare Part D. Some Medicare-excluded drugs are also excluded from coverage by Medicaid. Certain drugs, including but not limited to over-the counter drugs excluded by Medicare, may be covered by Medicaid, if the drug is part of the member's covered Medicaid benefits.

Medicare Part D Coverage

Medicare drug plans will cover brand name and generic drugs as follows:

- Prescription drugs
- Biological products
- Insulin as described in specified paragraphs of *section 1927(K)* of the *Medicare Modernization Act*
- Medical supplies for injection of insulin such as syringes, needles, alcohol swabs, and gauze
- Vaccines licensed under *section 351* of the *Public Health Service Act*. Vaccines not covered by Medicare Part B that are determined to be medically necessary are covered under Medicare Part D.

Note: PDPs are not required to cover all Medicare Part D covered drugs. Refer to the PDP specific drug formulary for coverage information.

Home Infusion Therapy

Medicare Part D drugs that are a component of home infusion therapy are not to be billed to Indiana Medicaid for dual eligibles. Provider adherence to this policy will be monitored via post payment review and recoupment will follow in cases of violation of this directive.

Medicare Part D Exclusions

After December 31, 2005, Medicaid cannot pay for Medicare-covered prescription drugs for people with Medicare and Medicaid, the Medicare PDP deductibles, or co-payments. Medicare Part D coverage excludes the following drugs:

- Drugs for anorexia, weight loss, or weight gain
- Drugs used to promote fertility
- Drugs used for cosmetic purposes or for hair growth
- Drugs from a manufacturer who requires that any associated tests and monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee
- Benzodiazepines
- Barbiturates
- Drugs used for symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparation products
- Any drug covered through Medicare Part A or Medicare Part B
- Supplies, equipment, and services involved in the delivery of home infusion

Indiana Medicaid Coverage of Medicare Part D Excluded Drugs

Indiana Medicaid will pay for Medicare Part D - excluded drugs to the extent that they are a covered Indiana Medicaid benefit. Any OTC drug covered by Indiana Medicaid must be on the *State of Indiana OTC Drug Formulary*. Medicare Part D - excluded prescription drugs are subject to the preferred drug list (PDL), existing PDL limits, and any other applicable pharmacy program restrictions. The Medicaid-covered, Medicare Part D - excluded drug listing can be viewed at:

<http://www.indianamedicaid.com/ihcp/ProviderServices/medicareD.asp>. This listing is subject to change based on changes to program policy. The OTC Drug Formulary and PDL can be viewed at <http://www.indianapbm.com/>. Pharmacists and prescribing practitioners should contact ACS with any questions related to the PDL or OTC Drug Formulary by calling 1-866-879-0106.

Medicaid Spenddown and Medicare Part D

Indiana Medicaid members with a spenddown must still satisfy their monthly spenddown obligation before providers will be reimbursed for Medicaid. Medicare Part D co-payments and out-of-pocket expenses for Medicare-excluded drugs covered by Medicaid will apply to spenddown, in addition to other Medicaid covered medical expenses. Pharmacists will be notified of the amount the member owes for his or her remaining spenddown balance at the time the POS claim adjudicates. Pharmacists may collect payment from the member at the point of dispensing. Members will be responsible for retaining bills or receipts for Medicare Part D out-of-pocket expenses that count toward

their monthly Medicaid spenddown. Members must take the receipts or bills to their local Office of Family Resources to apply to their spenddown. For general information about spenddown, providers should refer to the provider manual, bulletins, newsletter articles, and banners. For additional information about spenddown, refer to *BT200527* available on the IHCP Web site at:

<http://www.indianamedicaid.com/ihcp/Bulletins/BT200527.pdf>.

Medicare Part D and Medicaid Eligibility Verification

An upgrade to the IHCP Eligibility Verification System (EVS) will be implemented along with Medicare Part D. A new Medicare indicator of 'D' will display on the eligibility verification response if a member is eligible for Medicare Part D. All forms of IHCP eligibility verification – Web interChange, Automated Voice Response (AVR), and the Omni swipe card system – are included in this upgrade.

Providers who use OMNI for eligibility verification must download the new version of OMNI software on or after January 1, 2006, to display the Part D indicator. There is no cost associated with this download. The IHCP provider bulletin, *BT200303*, published January 31, 2003, provides complete download instructions. The bulletin is available from the IHCP Web site at www.indianamedicaid.com. Direct questions about the OMNI device download to the OMNI Help Desk at (317) 488-5051 in the Indianapolis local area or 1-800-284-3548. The OMNI Help Desk telephone lines are available from 8 a.m. to 5 p.m. Monday through Friday, excluding State holidays.

Additional Information

Medicare Part D is a federal program implemented by CMS. The information in this bulletin is meant to address changes to the Indiana Medicaid program as a result of implementation of the Medicare Part D benefit. The following are additional sources of information about Medicare Part D:

- *Medicare & You 2006* handbook
- Medicare Web site at www.medicare.gov
- 1-800-MEDICARE (1-800-633-4227) or 1-877-486-2048 for TTY users
- Medicare Part B versus Part D Information at <http://www.cms.hhs.gov/pdps/PartbandPartDdoc-revised7-27-05.pdf>

PHARMACY SERVICES ADDENDUM C

Note: This addendum contains provider notifications that have been published since the review of the Pharmacy Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: NL200602 **Publication Date:** 02/2006

Subject: New Pharmacy Reimbursement Rule

Date Added to Manual: 04/28/2006

Text of Publication

This notice is to advise providers that, in response to rapidly escalating expenditures for Medicaid-covered drugs, and in order to stay within available appropriations while maintaining beneficiary access to services, the office will be adopting an emergency rule that amends pharmacy reimbursement for Medicaid and HoosierRx. Specifically, EAC for brand name legend drugs will change from AWP minus 13.5 percent to AWP minus 16 percent with a dispensing fee of \$4.90. (This change also applies to HoosierRx.) At the same time, to bring consistency to reimbursement policy for insulins, OTC insulins are now paid in accordance with applicable legend drug EAC methodology. These changes are effective for dates of service on or after October 1, 2005.

PHARMACY SERVICES ADDENDUM D

Note: This addendum contains provider notifications that have been published since the review of the Pharmacy Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BT200613 **Publication Date:** 04/28/2006

Subject: Billing and Policy Reminders: Emergency Supply,
Third Party Liability Codes

Date Added to Manual: 10/31/2006

Text of Publication

Emergency Supply

The purpose of the Emergency Supply Policy is to comply with federal emergency supply provisions, and ensure that patients do not go without covered outpatient drugs in emergency situations. Emergency situations are being construed as including instances when it is not possible to obtain prior authorization (PA) due to PA offices being closed. It is not the intent to allow pharmacy providers to circumvent otherwise applicable program parameters, such as PDL status, “brand medically necessary” requirements, PDL step therapy edits, or early refill edits. It has been determined from the recent review, that some providers are misusing the emergency supply provisions for such purposes and perhaps in other inappropriate situations.

EDS intends to make compliance with the emergency supply provisions of the Medicaid program a primary focus of review by the pharmacy audit contractor, Prudent Rx. Those providers found to be violating the Emergency Supply Billing Policy face possible recoupment of funds associated with the misbillings, as well as other applicable sanctions.

Third Party Liability Codes

Some pharmacy providers are misusing third party liability (TPL) codes, in particular, TPL Override Code 2. This code is intended to: (1.) be utilized by a pharmacy to indicate that they have billed the primary payer, and (2.) reflect the actual dollar amount that the primary payer has paid towards the claim. In particular, when using TPL Override Code 2, the pharmacy provider must report a non-zero amount in National Council for Prescription Drug Programs (NCPDP) field 431-DV – Other Payer Amount Paid. If the primary payer has been billed and has not paid any amount, a TPL Override Code 2 should never be used. There are more appropriate codes to report the situation. Attachment 1 of this bulletin is a quick reference of all TPL Override Codes available for use with the NCPDP versions 5.1 and 1.1 transaction sets. For the full descriptions of these override codes and the corresponding NCPDP field numbers for all TPL

information, refer to the Companion Guide: NCPDP Versions 1.1 and 5.1 Transaction Payer Sheet available on the IHCP Web site at <http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/payersheet.pdf>. Review your utilization of the TPL Override Codes to ensure that in all instances the codes are being used solely as specified.

Third Party Liability (TPL) Override Codes Quick Reference

Code and Description	Explanation
TPL Override Code 2 – Other payment exists-payment collected	This code should be used when other insurance exists and payment is collected. The other payer amount collected [National Council for Prescription Drug Programs (NCPDP) field 431-DV] and other payer date (NCPDP field 443-E8) must be populated with a non-zero amount.
TPL Override Code 3 – Other coverage exists-this claim not covered	This code should be used when the primary insurance does not cover any portion of the claim. Examples of this include over-the-counter (OTC) items and any other item that is covered by the Indiana Health Coverage Programs (IHCP) that is not covered by the primary insurance.
TPL Override Code 4 – Other coverage exists-payment not collected	This code should only be used in cases in which a patient has active TPL coverage, but the claim is not paid. Deductibles and exhausted benefits are examples of such situations.
TPL Override Code 5 – Managed Care plan denial	This code should not be used for risk-based managed care (RBMC) IHCP denials; rather, it is to be used when the primary insurance is a managed care organization that denies the claim.
TPL Override Code 6 – Other coverage exists, not a participating provider	This code should be used when the dispensing pharmacy or prescribing physician is not a participating provider in the primary insurance company's network.
TPL Override Code 7 – Other coverage exists, not in effect at time of service	The dispensing pharmacy should use this code only if a denial has been received from the primary insurance company stating the coverage for the participant has been terminated or if it has been otherwise verified that there is no other existing third party coverage.
TPL Override Code 8- Claim is billing for a copay	This code should be used when the pharmacy is billing the IHCP for a fixed copayment required by another insurer. The copay amount should be submitted in the Gross Amount Due and Other Amount Claimed submitted fields (NCPDP fields 430-DU and 480-H9, respectively)

MEDICAL POLICY FACT SHEET

TITLE: PHARMACY – BOTULINUM TOXIN INJECTIONS

DESCRIPTION

The United States Food & Drug Administration (FDA) has approved two types of botulinum toxin injections; botulinum toxin type A, (Botox) and botulinum toxin type B (Myobloc). These injections are approved for symptomatic treatment of certain neuromuscular conditions. Botox and Myobloc are neurotoxins that interfere with neuromuscular transmission. They are injected directly into the affected muscle, through a procedure called chemodenervation, to temporarily paralyze the muscle by blocking the nerve for the affected muscle. Each treatment lasts approximately three months. The affected muscle is identified by electrode stimulation of the muscle, manual examination of the affected area, or by electromyography (EMG). Botox and Myobloc provide symptomatic treatment of focal dystonias, such as blepharospasm, cervical dystonia, hemifacial spasms, and other neurological conditions that cause excessive muscle contractions. In addition, research has shown these drugs to be successful in improving neuromuscular function, relieving pain, improving range of motion, and enhancing the effectiveness of physical therapy.

SUMMARY OF CURRENT POLICY

The Indiana Health Coverage Programs (IHCP) provides reimbursement for chemodenervation using Botox and Myobloc for the treatment of certain neuromuscular conditions including cervical dystonia, cerebral palsy, multiple sclerosis and other muscular and neurological conditions that cause excessive muscle contractions. Reimbursement is only available when administered in a physician's office, consistent with IHCP policy concerning reimbursement for injectable pharmaceutical products. Prior authorization (PA) is not required for this service. The IHCP does not provide reimbursement for Botox and Myobloc for cosmetic purposes, as indicated in 405 IAC 5-24-3.

COVERAGE CRITERIA

Botox and Myobloc are neurotoxins that interfere with neuromuscular transmission. IHCP reimbursement is available for Botox and Myobloc injections when determined medically necessary. Botox and Myobloc are not covered by the IHCP and for cosmetic purposes. Reimbursement is limited to one injection every three months. **TABLE 1**, on the next page, shows the HCPCS codes that are available for billing Botox and Myobloc.

TABLE 1
HCPCS Coding for Botox and Myobloc Injections

HCPCS Code	Definition
J0585	Botulinum toxin type A, per unit (Botox)
J0587	Botulinum toxin type B, per 100 units (Myobloc)

Botox and Myobloc are injected directly into the affected muscle, through a procedure called chemodenervation, to temporarily paralyze the muscle by blocking the release of acetylcholine to the nerve of the affected muscle. The affected muscle is identified by electrode stimulation of the muscle, manual examination of the affected area, or by electromyography (EMG). IHCP reimbursement for Botox and Myobloc must include one of the following CPT codes available for billing chemodenervation, listed in **TABLE 2**.

TABLE 2
CPT Codes for Chemodenervation for Use with Botox and Myobloc Injections

CPT Code	Definition
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)
64613	Chemodenervation of muscle(s); cervical spinal muscles(s) (e.g. for spasmodic torticollis)
64614	Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis)
64640	Destruction by neurolytic agent; other peripheral nerve or branch
95860	Needle electromyography; one extremity with or without related paraspinal areas
95861	Needle electromyography; two extremities with or without related paraspinal areas
95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral
95868	Needle electromyography; cranial nerve supplied muscle(s), bilateral
95869	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)
95870	Needle electromyography; limited study of muscles in on extremity non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles or sphincters

Treatment with botulinum toxin injections provides temporary relief of symptoms associated with these conditions and is indicated for use when conventional treatment has failed and/or in conjunction with physical therapy or other therapeutic techniques. Botox and Myobloc have been shown to be medically necessary in the treatment of the following conditions.

- Blepharospasm
- Cervical Dystonia

- Hyperhidrosis
- Strabismus
- Oromandibular Dystonia
- Lingual Dystonia
- Hemifacial Spasms
- Myofascial Pain Syndrome
- Spasticity related to stroke, cerebral palsy, multiple sclerosis, and spinal cord injury
- Paraplegia, hemiplegia, quadriplegia, or monoplegia

IHCP reimbursement for Botox and Myobloc injections is limited to specific diagnosis codes to ensure that injections are medically necessary. **TABLE 2** shows the ICD-9-CM codes that are available for reimbursement of Botox and Myobloc injections.

TABLE 2
ICD-9-CM Codes Available for
Reimbursement of Botox and Myobloc Injections

ICD-9-CM Code	Definition
333.6	Idiopathic torsion dystonia
333.7	Symptomatic torsion dystonia
333.81	Blepharospasm
333.82	Orofacial dyskinesia
333.83	Spasmodic torticollis
333.84	Organic writers' cramp
333.89	Other fragments of torsion dystonia
334.1	Hereditary spastic paraplegia
340	Multiple sclerosis
341.0	Neuromyelitis optica
341.1	Schilder's disease
341.8	Other demyelinating diseases of central nervous system
341.9	Demyelinating disease of central nervous system, unspecified
342	Hemiplegia and hemiparesis
342.10	Spastic hemiplegia and hemiparesis affecting unspecified side
342.11	Spastic hemiplegia and hemiparesis affecting dominant side
342.12	Spastic hemiplegia and hemiparesis affecting nondominant side
343.0	Diplegic
343.1	Hemiplegia
343.2	Quadriplegic
343.3	Monoplegic
343.4	Infantile hemiplegia
343.8	Other specified infantile cerebral palsy
343.9	Infantile cerebral palsy, unspecified
351.8	Other facial nerve disorders
378.00	Esotropia, unspecified

TABLE 2
ICD-9-CM Codes Available for
Reimbursement of Botox and Myobloc Injections

ICD-9-CM Code	Definition
378.01	Monocular estropia
378.02	Monocular esotropia with A pattern
378.03	Monocular esotropia with V pattern
378.04	Monocular estropia with other noncomitances
378.05	Alternating esotropia
378.06	Alternating estropia with A pattern
378.07	Alternating estropia with V pattern
378.08	Alternating esotropia with other noncomitances
378.10	Exotropia, unspecified
378.11	Monocular exotropia
378.12	Monocular exotropia with A pattern
378.13	Monocular exotropia with V pattern
378.14	Monocular exotropia with other noncomitances
378.15	Alternating exotropia
378.16	Alternating exotropia with A pattern
378.17	Alternating exotropia with V pattern
378.18	Alternating exotropia with other noncomitances
378.20	Intermittent heterotropia, unspecified
378.21	Intermittent esotropia, monocular
378.22	Intermittent esotropia, alternating
378.23	Intermittent exotropia, monocular
378.24	Intermittent exotropia, alternating
378.30	Heterotropia, unspecified
378.31	Hypertropia
378.32	Hypotropia
378.33	Cyclotropia
378.34	Monofixation syndrome
378.35	Accommodative component in esotropia
378.40	Heterophoria, unspecified
378.41	Esophoria
378.42	Exophoria
378.43	Vertical heterophoria
378.45	Alternating hyperphoria
378.50	Paralytic strabismus, unspecified
378.51	Third or oculomotor nerve palsy, partial
378.52	Third or oculomotor nerve palsy, total
378.53	Fourth or trochlear nerve palsy
378.54	Sixth or abducens nerve palsy
378.55	External ophthalmoplegia
378.56	Total ophthalmoplegia

TABLE 2
ICD-9-CM Codes Available for
Reimbursement of Botox and Myobloc Injections

ICD-9-CM Code	Definition
378.6	Mechanical strabismus
378.60	Mechanical strabismus, unspecified
378.61	Brown's (tendon) sheath syndrome
378.62	Mechanical strabismus from other musculofascial disorders
378.63	Limited duction associated with other conditions
378.71	Duane's syndrome
378.72	Progressive external ophthalmoplegia
378.73	Strabismus in other neuromuscular disorders
378.81	Palsy of conjugate gaze
378.82	Spasm of conjugate gaze
378.83	Convergence insufficiency or palsy
378.84	Convergence excess or spasm
378.85	Anomalies of divergence
378.86	Internuclear ophthalmoplegia
378.87	Other dissociated deviation of eye movements
378.9	Unspecified disorder of eye movements
478.29	Other diseases of pharynx or nasopharynx
478.75	Laryngeal spasm
478.79	Other diseases of larynx
530.0	Achalasia and cardiospasm
565.0	Anal fissure
705.21	Primary focal hyperhidrosis
723.5	Torticollis, unspecified
729.1	Myalgia and myositis, unspecified
754.1	Certain congenital musculoskeletal deformities of sternocleidomastoid muscle

Billing Partial Units

The IHCP recognizes that Botox is distributed in single-dose vials of 100 units. Botox has an extremely short shelf life, once reconstituted, and because of this short shelf life, some wastage of the product may be unavoidable. The IHCP has adopted the following Medicare carrier's policy for billing unused units of Botox.

IHCP providers may bill the entire 100 units to the IHCP in cases in which less than 100 units are injected in a single treatment session AND the balance of the product is discarded. If more than 100 units are injected in a single treatment session, and the remainder is not used for another member, the billed amount on the claim should be rounded up to the nearest 100 units. Whenever unused Botox is billed, both the amount

of the agent actually administered and the amount discarded are to be documented in the member's medical record.

Similarly, Myobloc has a short shelf life, and wastage of the product may be unavoidable. The IHCP has adopted the following Medicare carrier's policy for billing unused units of Myobloc.

Myobloc is supplied in 2,500, 5,000, and 10,000 units. Billing for Myobloc must show the number of units given on the claim form. If a vial is split between two or more members, the amount of the Myobloc used for each member is billed and the unused can be billed as wastage on the claim for the last member injected. If the vial is not split between two or more members, the discarded portion may be billed to the IHCP. Whenever unused Myobloc is billed, both the amount of agent actually administered and the amount discarded are to be documented in the member's medical record.

RELATED MEDICAL TOPICS

Pharmacy
Injectables

RULES, CITATIONS, AND SOURCES

405 IAC 5-24 Pharmacy Services
BR199935 – Botox injection billing
BT200207 – 2002 New HCPCS Codes
IHCP Provider Manual, July 2004 - Injections

ORIGINATION, REVISIONS, AND REVIEWS

Origination date: 5/25/97

Revisions and Reviews	Reason	Date
405 IAC 5-24	Pharmacy Services	7/25/1997
BR199935	Appropriate Billing Guidelines	8/19/1999
BT200207	New HCPCS Codes –Cover New HCPCS Code J0587 (Myobloc)	2/15/2002
IHCP Provider Manual	Injections	July 2004
Medical Policy Manual	4 th Quarter 2004 Update	1/31/05

APPLICABLE INDIANA AIM EDITS AND AUDITS

6096 – The CPT/HCPCS code billed is not payable in PPS

MEDICAL POLICY FACT SHEET

TITLE: PHARMACY - SYNAGIS® AND RESPIGAM®

DESCRIPTION

Respiratory syncytial virus (RSV) is a cause of serious respiratory tract infections in infants and children under four years of age. The symptoms are similar to the common cold, although they may lead to more serious infections such as bronchiolitis, pneumonia, and severe lower respiratory tract disease. Synagis® (palivizumab) and RespiGam® (RSV-IGIV) are prophylactic treatment options for people at risk for RSV. Synagis® is a monoclonal antibody given as a monthly intramuscular injection. RespiGam® is a blood product given as a monthly infusion.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

Synagis® and RespiGam® are reimbursed by the IHCP for prophylactic treatment of RSV. A member will not be approved for Synagis® or RespiGam® if he or she is currently receiving immunoglobulin infusions. Immunity should be acquired through those infusions. Synagis® is the preferred product for prophylaxis; however, Synagis® or RespiGam® will be reimbursed if prior authorization (PA) criteria are met.

PRIOR AUTHORIZATION

Synagis® and RespiGam® require PA. The following criteria reflect the conditions under which Synagis® and RespiGam® will be prior authorized.

PA Submission

Non-pharmacy providers submit PA requests for Synagis® (90378) or RespiGam® (90379 or J1565) to the Health Care Excel (HCE) PA Department. The HCE PA Department may be contacted by calling 1-800-457-4518 or (317) 345-4511. It is recommended that providers submitting PA requests attach the *Synagis Prior*

Authorization Form for Synagis® or RespiGam® available for download at www.indianamedicaid.com. In addition, providers solely enrolled as durable medical equipment (DME) providers are not eligible for the reimbursement of pharmaceuticals.

Approval Period and Quantity

The approval period for Synagis® and RespiGam® is October 1 through April 30, the RSV season. Approval consists of a total of six doses of Synagis® or RespiGam®. The administration of a seventh dose requires a separate PA.

Location of Service

Synagis® may be administered in any setting where intramuscular injections are appropriate, including home administration. RespiGam® may be administered in a clinic, physician's office, or hospital. RespiGam® is not approved for home administration.

PA Criteria

Synagis® and RespiGam® may be administered to members at risk for RSV. At least one of the following criteria must be met before the patient is considered at risk for RSV.

1. The member is less than 24 months old at the start of therapy and has chronic lung disease, especially if on oxygen chronically or off oxygen less than three to six months.
2. The member is younger than one year old and has a history of accompanying medical problems, for example, caffeine administration for respiratory stimulation within the last year.
3. The member is younger than six months old at the start of therapy with a gestational age of 29 to 32 weeks.
4. The member is less than three months old at the start of therapy with a gestational age of 33 to 36 weeks and accompanying medical problems.
5. The member is six months old at the start of therapy with a gestational age of 33 to 36 weeks and has one of the following risk factors; school age siblings, crowding in the home, daycare attendance, exposure to tobacco smoke in the home, multiple births, neurological disease, anticipated cardiac surgery, distance to or availability of hospital care.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the

IHCP Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), PrimeStep, and RBMC delivery systems.

IHCP members enrolled in PrimeStep receive the same benefit coverage, and are subject to the same limitations, as traditional Medicaid FFS. Refer to the Hoosier Healthwise Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

Physicians, hospitals, and clinics that provide Synagis® or RespiGam® in an office, home, or outpatient setting must bill the appropriate claim format with CPT code 90378 for Synagis®, or CPT code 90379 or HCPCS code J1565 for RespiGam®. Providers must report the most specific code that represents the immune globulin product. The administration of the immune globulin product is separately billable. A pharmacy, or a provider dually enrolled as a pharmacy, must submit claims for Synagis® or RespiGam® with the NDC on the pharmacy claim form.

Table 1 - Codes for Reporting Immune Globulin Product for Synagis or RespiGam		
Drug	Code	Description
Synagis®	90378	Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use, 50 mg, each
RespiGam®	90379	Respiratory syncytial virus immune globulin (RSV-IgIV), human, for intravenous use
RespiGam®	J1565	Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg

RELATED MEDICAL TOPICS

Immunizations and Vaccines
Pharmacy

RULES, CITATIONS, AND SOURCES

Indiana Code

15 IC 12-15-21-3 Subjects for Which Rules to Be Adopted

Indiana Administrative Code

405 IAC 5-2-17 Medically Reasonable and Necessary Service Defined

405 IAC 5-3 Prior Authorization

405 IAC 5-24-8.5 Prior Authorization; Other Drugs

Indiana Health Coverage Programs Provider Newsletters

NL200410 Prior Authorization Instructions

Indiana Health Coverage Programs Provider Bulletins

BT200210 Prior Authorization Changes

Indiana Health Coverage Programs Provider Banners

BR200240	Prior Authorization Changes
BR200239	Prior Authorization Changes
BR200238	Prior Authorization Changes
BR199919	Billing Instructions
BR199918	Billing Instructions

Origination Date: 07/31/05

Revisions and Review	Reason	Date

APPLICABLE INDIANA AIM EDITS AND AUDITS

3000	Units Exceed PA Master
3001	Dates of Service Not On PA Database
3003	Procedure Code Requires PA
3008	Prior Authorized Units Equals Zero
6096	The CPT/HCPCS Code Billed Is Not Payable According to the PPS Reimbursement Methodology

MEDICAL POLICY FACT SHEET

TITLE: PLASMAPHERESIS

DESCRIPTION

Plasmapheresis is the most common type of apheresis procedure, and involves the removal of a prescribed amount of plasma from the circulating blood. A plasmapheresis treatment takes several hours, and an average course is six to ten treatments over a two to ten week period. Plasmapheresis can also involve plasma exchange. During plasma exchange, plasma is removed and discarded, and replaced with allogenic (genetically different) plasma or another substitution fluid, such as albumin.

Plasmapheresis is prescribed for patients with acute, self-limited diseases, where plasma exchange is used to acutely lower the circulating pathogenic substances; or for patients with chronic diseases that produce an overabundance of pathogenic autoantibodies, such as systemic lupus erythematosus (SLE).

COVERAGE CRITERIA

Plasmapheresis is covered when performed in a hospital setting (either inpatient or outpatient); or in a nonhospital setting (e.g. a physician directed clinic), when the following conditions are met.

- A physician is available to perform medical services and to respond to medical emergencies at all times during patient care hours
- The member is under the care of a physician
- All nonphysician services are furnished under the direct responsibility of a physician

Plasmapheresis is considered medically necessary for the following indications.

- Plasma exchange for acquired myasthenia gravis
- Plasmapheresis in the treatment of primary macroglobulinemia (Waldenstrom)
- Plasmapheresis and plasma exchange for the treatment of hyperglobulinemias, including (but not limited to) multiple myelomas, cryoglobulinemia and hyperviscosity syndromes

- Plasmapheresis or plasma exchange as a last resort treatment of thrombotic thrombocytopenic purpura (TTP)
- Plasmapheresis or plasma exchange as the last resort treatment of life threatening rheumatoid vasculitis
- Plasma exchange in the treatment of Goodpasture's Syndrome
- Plasma exchange in the treatment of glomerulonephritis, associated with antiglomerular basement membrane antibodies and advancing renal failure, or pulmonary hemorrhage
- Plasmapheresis, with plasma exchange, for treatment of chronic relapsing polyneuropathy for members with severe or life threatening symptoms, who have failed to respond to conventional therapy
- Plasmapheresis, with plasma exchange, for treatment of life threatening scleroderma and polymyositis that is unresponsive to conventional therapy
- Plasmapheresis for treatment of Guillain-Barre Syndrome
- Plasmapheresis, as a last resort, for life threatening systemic lupus erythematosus (SLE), when conventional therapy has failed to prevent clinical deterioration

PRIOR AUTHORIZATION

Plasmapheresis does not require prior authorization.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in Hoosier Healthwise PrimeStep (PCCM) receive the same benefit coverage, and are subject to the same limitations, as traditional Medicaid FFS. Refer to the Hoosier Healthwise Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

The IHCP reimburses plasmapheresis services when IHCP providers bill with CPT code 36514, *Therapeutic apheresis; for plasmapheresis*. The appropriate ICD-9-CM procedure code is 99.71, *Therapeutic plasmapheresis*. Prior authorization is not required. Plasmapheresis services are subject to post payment review. Providers must maintain documentation in the member's medical record that indicates the IHCP coverage criteria has been met.

RELATED MEDICAL TOPICS

Physician Services
Hospital Services – Outpatient
Hospital Services – Inpatient

RULES, CITATIONS, AND SOURCES

405 IAC 5-3-13 – Services Requiring Prior Authorization
Indiana Health Coverage Programs Provider Manual, July 2004, Version 5.0

Origination Date: 4/29/05

Revisions and Review	Reason	Date

APPLICABLE INDIANA A/M EDITS AND AUDITS

6002 – Any Two Anesthesiology Providers
6003 – Manual Pricing for Split Care Billing
6034 – Global Surgery Payable at Reduced Amount
6035 – Components of Surgical Care Not Payable When Global Surgery Paid
6039 – Assistant Surgeon Not Payable when Co-Surgeon Paid
6040 – Co-Surgeon Not Payable When Assistant Surgeon Paid

6096 – The CPT/HCPCS Code Billed Is Not Payable

MEDICAL POLICY FACT SHEET

TITLE: PODIATRY

DESCRIPTION

Podiatry is a specialized practice focusing on the study and care of the foot and related structures, including its anatomy, pathology, and medical and surgical treatment.

SUMMARY OF CURRENT POLICY

The Indiana Health Coverage Programs (IHCP) covers services and procedures associated with the diagnosis of foot disorders and mechanical, medical, or surgical treatment of such disorders, subject to restrictions and limitations set in the Indiana Administrative Code (IAC), 405 IAC 5-26.

RELATED MEDICAL TOPICS

Consultations – Second Opinion
Diagnostic Studies
Hospital Outpatient
Nursing Facilities
Surgery – Surgical Services

RULES, CITATIONS, AND SOURCES

405 IAC 5-5 Out of State Services
405 IAC 5-17 Hospital Services
405 IAC 5-26 Podiatric Services
Indiana State Department of Public Welfare Medical Policy Manual 1991
Indiana Medical Assistance Program Provider Manual 1994
Indiana Medicaid Update Bulletins, 95-21; 96-38
Indiana Medicaid Bulletin, 091598
Indiana Health Coverage Programs Provider Manual 1999
IHCP Provider Manual, July 2004

ORIGINATION, REVISIONS, AND REVIEWS

Origination date: 12/31/04 Revisions and Reviews	Reason	Date
Indiana State Department of Public Welfare Medical Policy Manual, 1991	Podiatric Services	7/1/91
470 IAC 5-8-16; 470 IAC 5-9-13 Transferred	Podiatric Services	7/1/91
405 IAC 1-7-13; 405 IAC 1-6-16 <i>Repealed 8/24/97</i>	Podiatric Services	1/1/92
405 IAC 5-26	Podiatric Services	8/24/97
Indian Medicaid Update Bulletin	Prior Authorization Rule Changes	6/3/96
Indiana Medicaid Update Bulletin, 96-38	Hoosier Healthwise Changes	11/16/96
Indiana Medicaid Update Bulletin, 091598	Podiatry Coding for Routine Foot Care	4/1/98
Indiana Medicaid Bulletin, BT199909	Removal of Services from Prior Authorization	3/15/98
Indiana Medicaid Bulletin, BT200208	Modifications to Prior Authorization Requirement	2/19/02
IHCP Provider Manual	Manual Update	7/2004

APPLICABLE INDIANA A/M EDITS AND AUDITS

- 6049 – Components not payable when global paid
- 6090 – Office visits limited to one per year – podiatrist
- 6091 – One initial office visit per recipient – podiatrist
- 6651 – Surgical cutback procedure – 50%
- 6664 – Global vs. Components – Integumentary/neuromuscular
- 6665 – Bilateral vs. Unilateral surgery
- 6855 – More than 6 routine foot care treatments per year
- 6857 – Preoperative Doppler studies payable to podiatrist

COVERAGE CRITERIA

General Restrictions

As indicated in 405 IAC 5-26-2, podiatric services are subject to the following general restrictions:

1. In an emergency situation, when services require prior authorization (PA), the authorization must be obtained within 48 hours of the time the service was provided, not including Saturdays, Sundays, and legal holidays.
2. Any podiatrist services rendered during inpatient days that do not receive appropriate PA, or are subsequently found not to be medically necessary will not be reimbursed. PA is required for hospital stays as outlined in 405 IAC 5-17 (b).
3. Any podiatrist services rendered during an outpatient visit that do not receive appropriate PA, or are subsequently found not to be medically necessary will not be reimbursed.
4. Consultation services rendered by a podiatrist in a nursing facility are not covered when performed on members on a routine basis for screening purposes, except in those cases where a specific foot ailment is involved.

Prior Authorization (PA)

PA is required for the following services:

- Orthotics and related devices for the foot as outlined in 405 IAC 5-19.
- Palliative or hygienic care for the removal or trimming of corns, calluses, and nails covered for members with painful keratosis, diseased nails, or deformed nails. PA is provided for six treatments per year.
- Routine foot care in excess of six services per year for members with diabetes mellitus, peripheral vascular disease, or peripheral neuropathy

Routine Foot Care

Routine foot care, as described in the IHCP Provider Manual, includes the following.

- Cutting or removal of corns, calluses or warts, including plantar warts
- Trimming of nails, including mycotic nails
- Treatment of fungal, mycotic infection of the toenail with clinical evidence toenail infection and compelling medical evidence that the member has a marked limitation of ambulation requiring active treatment of the foot or will result in significant medical complications.

Routine foot care is only reimbursable by IHCP if the member is being treated by a medical doctor or doctor of osteopathy for treatment and evaluation of a systemic disease during the six months prior to rendering routine foot care services. A maximum of six routine foot care services per rolling 12-month period are covered only when: (1) a member has a diagnosis of systemic disease of sufficient severity that treatment of the disease may pose a hazard when performed by a non professional such procedure would be hazardous, and (2) the condition has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet. Routine foot care, when performed in these situations does not require PA. **Table 1** shows the ICD-9 codes that represent conditions that justify IHCP coverage for routine foot care.

Table 1: ICD-9 Codes for Routine Foot Care

ICD-9 Code(s)	Description
250.00 – 250.91	Diabetes mellitus
440.20 – 440.29	Arteriosclerotic vascular disease of the lower extremities
443.1	Thromboangiitis obliterans
459.1	Post-phlebitis syndrome
357.1 – 357.7	Peripheral neuropathies of the feet

Podiatric Office Visits

The IHCP covers one podiatric office visit per year, using the following evaluation and management (E/M) codes: 99211, 99212, and 99213. The IHCP does not reimburse for the following types of extended or comprehensive office visits: (1) new patient comprehensive, CPT codes 99204 and 99205; (2) established patient detailed, CPT code 99214; and, (3) established patient comprehensive, CPT code 99215.

New patient podiatric office visits are limited to one visit, per provider, within a three year period. A new patient is, “one who has not receive professional services from the provider or another provider of the same specialty who belongs to the same practice within the last three years,” per 405 IAC 5-26-7. Reimbursement for subsequent office visits is included in the procedure performed on that date and is not billed separately. However, if a significant problem is addressed on a subsequent visit, the visit code may be reported with the -25 modifier.

Laboratory Services, X-Rays and Doppler Evaluations

The IHCP reimburses a podiatrist for laboratory or X-ray services only when rendered by or under the personal supervision of a podiatrist. Services ordered by a podiatrist, but performed by a laboratory or x-ray facility can be directly billed by the laboratory or x-ray facility. Comparative foot x-rays are only reimbursed when prior authorization is obtained under Reimbursement is available for the following lab and x-ray services.

- Cultures of foot infections and mycotic fungal nails for diagnostic purposes.
- Medically necessary presurgical testing.
- Sensitivity studies for treatment of infection processes.

The IHCP will reimburse one ultrasonic measurement of blood flow (Doppler evaluation) per year, when prior authorized for the proposed medical procedure. Coverage is available, subject to the following limitations.

- A preoperative diagnosis of diabetes mellitus, peripheral vascular disease or peripheral neuropathy.
- The ultrasonic measurement is for preoperative podiatric evaluation.
- The ultrasonic measurement cannot be used for routine screening purposes.
- The ultrasonic measurement cannot be used as an evaluation of routine foot care procedures, including such services as removal or trimming of corns, calluses, and nails.

Surgical Procedures

The IHCP will reimburse for the following podiatric surgical procedures without prior authorization.

- Drainage of skin abscesses of the foot
- Drainage or injections of a joint or bursa of the foot
- Surgical cleansing of the skin
- Trimming of skin lesions of the foot, other than those identified as included in routine foot care services

Podiatrists may be required to obtain a confirmatory consultation, in accordance with the guidelines for consultations and second opinions at 405 IAC 5-8-4, in order to establish medical necessity for the following podiatric surgical procedures.

- Bunionectomy procedures
- All surgical procedures involving the foot

A confirmatory consultation is required regardless of the setting in which the surgery is performed, including ambulatory surgical centers, hospitals, clinics, or in the office.

All services provided by the podiatrist must be performed within the scope of practice for podiatric medicine. Reimbursement for other surgical procedures performed within the scope of the podiatrist's license is available subject to the prior authorization requirements of 405 IAC 5-3.

Surgical procedures on one or both feet performed on the same date are paid at 100% of the IHCP allowance for the major procedure and 50 percent of the IHCP allowance for subsequent procedures. If surgery is performed on both feet and the surgery for the second foot is performed at least five days after the first, 100% allowance is payable for the second surgery.

If the major surgical procedure is performed on one toe, a period of five days must pass before subsequent surgery on the same toe would again be paid at 100% of the IHCP allowable reimbursement. Surgery performed sooner than five days is paid at 50% of the IHCP allowable reimbursement.

If the major surgical procedure is performed on one toe, a period of 30 days must elapse before a subsequent surgery on the same toe would again be paid at 100% of the IHCP allowable reimbursement. Surgery performed sooner than 30 days is reimbursed at 50% of the IHCP allowable reimbursement.

Podiatric surgical procedures, including diagnostic surgical procedures, cannot be fragmented and billed separately, as they are included in the major procedure.

The following surgical procedures are generally included in major surgical procedures:

- Arthroscopy or arthrotomy procedures in the same area as a major joint procedure unless the claim documents a second incision was made
- Local anesthesia administered to perform the surgical or diagnostic procedure
- Scope procedures used for the surgical procedure approach

PODIATRY SERVICES ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Podiatry Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200544 **Publication Date:** 11/01/2005

Subject: Podiatry Multiple Unit Billing

Date Added to Manual: 01/31/2006

Text of Publication

The Health Care Excel Surveillance and Utilization Review (SUR) Department identified utilization issues related to podiatrists inappropriately billing multiple units of Current Procedural Terminology (CPT®) codes 99201-99203) for new patient visits and CPT codes 99211-99213 for established patient visits.

Office visits for podiatry services are limited to the following:

- New patient office visits – Limited to one visit per member, per provider, every three years, using CPT codes 99201, 99202, or 99203.
- Office visits – Limited to one visit per member, per 12 months, without obtaining PA, using CPT codes 99211, 99212 or 99213.

This information can be found in the *IHCP Provider Manual, Chapter 8, Section 3*, and in the Indiana Administrative Code (IAC), *405 IAC 5-26-7*.

SUR is advising all providers to carefully review claims submitted to the IHCP to ensure proper billing of units for these services. The SUR Department is conducting a review of claims to determine any inappropriate reimbursement and recoup overpayments. If a provider identifies overpayments related to these errors, the provider should file an adjustment or contact the SUR Department to arrange for repayment.

MEDICAL POLICY FACT SHEET

TITLE: RADIOIMMUNOTHERAPY

DESCRIPTION

The Indiana Health Coverage Programs (IHCP) provides reimbursement for radioimmunotherapy for the treatment of refractory low-grade B-cell non-Hodgkin's lymphoma utilizing Zevalin®, effective May 1, 2003, and Bexxar®, effective January 1, 2004. The IHCP will provide reimbursement for additional radioimmunotherapy regimens as approved by the Food and Drug Administration (FDA).

This document is intended to serve as a general summary of the IHCP policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

Radioimmunotherapy is utilized for the treatment of low-grade B-cell non-Hodgkin's lymphoma in patients that have not responded to or failed other chemotherapy treatments, and should not be used for the first line of treatment. The patient's medical record must support the medical necessity of the radioimmunotherapy regimen. Zevalin® and Bexxar® are monoclonal antibodies that target lymphocytes, including malignant B-cells involved in the disease. Radiation-carrying antibodies infused into a patient circulate throughout the body, bind to specific cells, and deliver cytotoxic radiation directly to cancerous cells. This treatment methodology may result in significant tumor shrinkage and avoidance of larger full body treatment doses of radiation.

The radioimmunotherapy regimen is administered in two separate steps. The first step is diagnostic to determine the radiopharmaceutical biodistribution of radiolabeled antibodies. The second step is the therapeutic administration of targeted radiolabeled antibodies. The published criteria for determining appropriate biodistribution involve making a qualitative comparison of isotope uptake in several organ systems between at least two nuclear medicine scans. Therefore, these scans cannot be read in isolation and should be reported once regardless of the number of scans performed during the treatment regimen. Rituximab® and its infusion prior to the administration of Zevalin®

and the infusion of tositumomab prior to the administration of Bexxar® are separately reimbursable.

Currently radioimmunotherapy is not a procedure typically performed more than once. Codes specific to the radioimmunotherapy procedure are limited to one unit per lifetime. The IHCP will re-examine the issue if future research determines that the coverage and reimbursement of additional radioimmunotherapy services would be appropriate.

PRIOR AUTHORIZATION

Radioimmunotherapy services do not require prior authorization (PA).

MANAGED CARE

For PrimeStep, the same policies apply as those applicable to the Traditional Fee-For-Service (FFS) program. For Risk-Based Managed Care (RBMC) specific policies, please consult the appropriate Managed Care Organization (MCO).

BILLING REQUIREMENTS

Billing for Outpatient Facility Setting – Effective January 1, 2004

Table 1.1 provides information regarding billing radioimmunotherapy services provided in an outpatient facility utilizing Zevalin® or Bexxar® for dates of service on or after January 1, 2004. Billing instructions changed in 2004, and the radiopharmaceutical is separately reimbursable from the nuclear medicine scanning procedure. Specific codes were developed to represent the diagnostic and therapeutic supply of Bexxar® and the infusion and supply of tositumomab in the Bexxar® regimen. New codes are used to report the scanning procedure, and HCPCS codes G0273 and G0274 are not reimbursable on or after January 1, 2004. HCPCS code G0273 has been replaced by CPT code 78804 for the diagnostic portion, and HCPCS code G0274 has been replaced by CPT code 79403 for the therapeutic portion of the scanning procedure. The outpatient facility will bill the technical component of the procedure using CPT code 78804 or 79403, the radiopharmaceutical using HCPCS code C1080, C1081, C1082, or C1083, and the appropriate revenue code on the UB-92 claim form or 837I transaction. Rituximab® (J9310) and its infusion (Q0084), prior to the administration of Zevalin®, or the supply and infusion of tositumomab (G3001), prior to the administration of Bexxar®, are separately reimbursable to the facility. Effective January 1, 2005, providers may report the appropriate code(s) for the infusion of Rituximab® - Q0084, 96410, 96414, 96422, and 96425. The physician will bill the professional component with the code-modifier combination 78804-26 or 79403-26 on a CMS-1500 claim form or 837P transaction.

Table 1.1 - Zevalin® and Bexxar® Therapy Provided in an Outpatient Facility (effective 1/1/04)		
Code	Revenue Code	Description
78804* (outpatient facility)	341	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging
79403* (outpatient facility)	340, 342	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion
78804-26* (physician)	N/A	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging
79403-26* (physician)	N/A	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion
C1080* (Bexxar®) or C1082* (Zevalin®)	343, 636	Supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per dose Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose
C1081* (Bexxar®) or C1083* (Zevalin®)	343, 344, 636 344, 636	Supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per dose Supply of radiopharmaceutical therapeutic imaging agent, yttrium 90 ibritumomab tiuxetan, per dose

*Limited to one unit per lifetime

Table 1.1 - Zevalin® and Bexxar® Therapy Provided in an Outpatient Facility (effective 1/1/04) <i>continued</i>		
Code	Revenue Code	Description
J9310 and as appropriate	636	Rituximab, 100 mg
Q0084	335	Chemotherapy administration by infusion technique only, per visit
96410 (as of 1/1/05)	335	Chemotherapy administration, intravenous; infusion technique, up to one hour
96414 (as of 1/1/05)	335	; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
96422 (as of 1/1/05)	335	Chemotherapy administration, intra-arterial; infusion technique, up to one hour
96425 (as of 1/1/05) (Zevalin® regimen)	335	; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
G3001 (Bexxar® regimen)	333, 34x	Administration and supply of tositumomab, 450 mg

Billing for Physician Office Setting – Effective January 1, 2004

Table 1.2 provides information regarding billing radioimmunotherapy services provided in a physician office setting utilizing Zevalin® or Bexxar® for dates of service on or after January 1, 2004. Billing instructions have changed for 2004, and new codes are used to report the radiopharmaceutical and nuclear medicine scanning procedures. HCPCS code G0273 has been replaced by CPT code 78804 for the diagnostic portion, and HCPCS code G0274 has been replaced by CPT code 79403 for the therapeutic portion of the scanning procedure. HCPCS code A9522 has been replaced by code C1082 for the supply of the diagnostic imaging agent, and HCPCS code A9523 has been replaced by HCPCS code C1083 for the supply of the therapeutic imaging agent in the Zevalin® regimen. Specific codes have also been developed to represent the diagnostic and

therapeutic supply of Bexxar® and the infusion and supply of tositumomab in the Bexxar® regimen. The physician office provider will bill the global scanning procedure with CPT code 78804 or 79403 and the radiopharmaceutical with HCPCS code C1080, C1081, C1082, or C1083 on a CMS-1500 claim form or 837P transaction. Rituximab® (J9310) and its infusion (Q0084) prior to the administration of Zevalin® and the supply and infusion of tositumomab (G3001) prior to the administration of Bexxar® are separately reimbursable. Effective January 1, 2005, providers may report the appropriate code(s) for the infusion of Rituximab® - Q0084, 96410, 96414, 96422, and 96425.

Table 1.2 - Zevalin® and Bexxar® Therapy Provided in a Physician Office (effective 1/1/04)	
Code	Description
78804*	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging
79403*	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion
C1080* (Bexxar®) or C1082* (Zevalin®)	Supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per dose Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose
C1081* (Bexxar®) or C1083* (Zevalin®)	Supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per dose Supply of radiopharmaceutical therapeutic imaging agent, yttrium 90 ibritumomab tiuxetan, per dose

*Limited to one unit per lifetime

Table 1.2 - Zevalin® and Bexxar® Therapy Provided in a Physician Office (effective 1/1/04) <i>continued</i>	
Code	Description
J9310 and as appropriate	Rituximab, 100 mg
Q0084	Chemotherapy administration by infusion technique only, per visit
96410 (as of 1/1/05)	Chemotherapy administration, intravenous; infusion technique, up to one hour
96414 (as of 1/1/05)	; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
96422 (as of 1/1/05)	Chemotherapy administration, intra-arterial; infusion technique, up to one hour
96425 (as of 1/1/05) (Zevalin® regimen)	; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
G3001 (Bexxar® regimen)	Administration and supply of tositumomab, 450 mg

Billing for Outpatient Facility Setting – May 1, 2003 through December 31, 2003

Table 2.1 provides information regarding billing for outpatient facility treatment utilizing Zevalin® for dates of service May 1, 2003 through December 31, 2003. The outpatient facility will bill HCPCS code G0273 for the diagnostic portion or HCPCS code G0274 for the therapeutic portion of the procedure with revenue code 333 on a UB-92 claim form or 837I transaction. Reimbursement for the radiopharmaceutical is included in the reimbursement for the procedure when performed by an outpatient facility. Rituxumab® (J9310) and its infusion (Q0084) prior to the administration of Zevalin® are separately reimbursable to the facility. The physician will bill the professional component with HCPCS code G0273-26 or G0274-26 on a CMS-1500 claim form or 837P transaction.

Table 2.1- Zevalin® Therapy Provided in an Outpatient Facility (effective 5/1/2003-12/31/2003)		
Code	Revenue Code	Description
G0273* (outpatient facility)	333	Radiopharmaceutical biodistribution, single or multiple scans on one or more days, pre-treatment planning for radiopharmaceutical therapy of non-hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)
G0274* (outpatient facility)	333	Radiopharmaceutical therapy, non-hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)
G0273-26* (physician)	N/A	Radiopharmaceutical biodistribution, single or multiple scans on one or more days, pre-treatment planning for radiopharmaceutical therapy of non-hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)
G0274-26* (physician)	N/A	Radiopharmaceutical therapy, non-hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)
J9310 and Q0084	636 335	Rituximab, 100 mg Chemotherapy administration by infusion technique only, per visit

*Limited to one unit per lifetime

Billing for Physician Office Setting - May 1, 2003 through December 31, 2003

Table 2.2 provides information regarding billing for radiopharmaceutical therapy services performed in the physician office setting utilizing Zevalin® for dates of service May 1, 2003 through December 31, 2003. The radiopharmaceutical is separately reimbursable from the procedure when performed in a physician office setting. The supply of the radiopharmaceutical, HCPCS codes A9522 and A9523, is to be reported once during the treatment regimen, regardless of the dosage administered, as reimbursement is based on the supply required for the procedure and not the per millicurie rate. The physician office provider will bill HCPCS codes G0273 and A9522 for the diagnostic portion or HCPCS codes G0274 and A9523 for the therapeutic portion on a CMS-1500 claim form or 837P transaction. Rituxumab® (J9310) and its infusion (Q0084) prior to the administration of Zevalin® are separately reimbursable.

Table 2.2- Zevalin® Therapy Provided in a Physician Office (effective 5/1/2003-12/31/2003)	
Code	Description
G0273*	Radiopharmaceutical biodistribution, single or multiple scans on one or more days, pre-treatment planning for radiopharmaceutical therapy of non-hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)
G0274*	Radiopharmaceutical therapy, non-hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)
A9522*	Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per mci
A9523*	Supply of radiopharmaceutical therapeutic imaging agent, yttrium 90 ibritumomab tiuxetan, per mci
J9310 and Q0084	Rituximab, 100 mg Chemotherapy administration by infusion technique only, per visit

*Limited to one unit per lifetime

RULES, CITATIONS, AND SOURCES

Indiana Health Coverage Programs Provider Newsletters

NL200408 Radioimmunotherapy billing for Zevalin®, effective May 1, 2003-December 31, 2003

NL200411 Radioimmunotherapy billing for Zevalin® and Bexxar®, effective January 1, 2004

NL200505 Revisions to Radioimmunotherapy Services

Indiana Health Coverage Programs Provider Banners

BR200446 Pricing for CPT code 78804

BR200513 Addition of revenue codes 343 and 344, and new codes for the administration of Rituximab®

Origination date 1/31/05

Revisions and Reviews	Reason	Date
Revision	Changes in Billing Requirements	7/31/05

APPLICABLE INDIANA AIM EDITS AND AUDITS

- 6140 Radioimmunotherapy service (78804) is limited to one unit per lifetime
- 6141 Radioimmunotherapy service (79403) is limited to one unit per lifetime
- 6142 Radioimmunotherapy service (C1080) is limited to one unit per lifetime
- 6143 Radioimmunotherapy service (C1081) is limited to one unit per lifetime
- 6144 Radioimmunotherapy service (C1082) is limited to one unit per lifetime
- 6145 Radioimmunotherapy service (C1083) is limited to one unit per lifetime
- 6146* Radioimmunotherapy service (A9523) is limited to one unit per 14 days
- 6147* Radioimmunotherapy service (G0274) is limited to one unit per 14 days
- 6148* Radioimmunotherapy service (G0273) is limited to one unit per 14 days
- 6149* Radioimmunotherapy service (A9522) is limited to one unit per 14 days

*Audits 6146, 6147, 6148, and 6149 are effective 2003/05/01 and end dated 2003/12/31. The audits were established in IndianaAIM for one unit per fourteen days to correspond to the timeframe of the radioimmunotherapy regimen; however provider publications state one unit per lifetime.

MEDICAL POLICY FACT SHEET

TITLE: RADIOLOGY

DESCRIPTION:

Radiology is the branch of medicine concerned with the diagnosis and treatment of disease by using ionizing radiation, radionuclides, nuclear magnetic resonance, and ultrasound.

SUMMARY OF CURRENT POLICY

Medicaid reimbursement is available to radiology inpatient and outpatient facilities, freestanding clinics, and surgical centers for services provided to IHCP members. Radiological services must be ordered in writing by a physician or other practitioner authorized to do so under state law. The Indiana Administrative Code 405 IAC 5-27-1 allows for prior authorization (PA) of radiological services that exceed utilization parameters set forth by the IHCP; however, there are no PA restrictions in place.

RELATED MEDICAL TOPICS

Diagnostic Studies
Laboratory Services
Oncology
Physician Services
CT scans
Radionuclide Bone Scans
Hospice

RULES, CITATIONS, AND SOURCES

405 IAC 5-27 Radiology Services
 405 IAC 5-8-2 "Consultation" defined
 405 IAC 5-12-3 Chiropractic x-ray services
 405 IAC 5-26-4 Laboratory or x-ray services [Podiatric Services]
 Indiana Medical Assistance Program Provider Manual 1994
 Indiana State Medicaid Plan--Other Laboratory and X-ray Services
 Indiana State Department of Public Welfare Medical Policy Manual 1991
 Indiana Health Coverage Programs Provider Manual 1999
 IHCP Bulletin BT199925
 IHCP Bulletin BT200127
 IHCP Bulletin BT200144

Origination Date: 7/1/91

Reviews and Revisions	Reason	Date
405 IAC 5-9-21, Transferred to 470 IAC 5-9-21	Radiology Services	7/1/91
470 IAC 5-8-16, 5-9-13	Podiatric Services	7/1/91
IHCP Provider Manual 1991	Laboratory and X-Ray Services, Radiology Services, and Radiation Therapy	7/1/91
470 IAC 5-8-9	Hospital Services	7/1/91
405 IAC 5-27	Radiology Services Revision	8/24/97
405 IAC 5-26-4	Podiatric Services Revision	8/24/97
405 IAC 5-12-3	Chiropractic Services Revision	8/24/97
IHCP Provider Manual 2004	Radiology Services Revision (chiropractic services removed)	10/29/04

APPLICABLE INDIANA A/M EDITS AND AUDITS:

- 6001 – Complete Radiology And Pathology Procedures Payable At Reduced Amount When Profesional/Technical Components Already Paid
- 6011 – Professional/Technical Components Not Payable When Complete Procedure Already Paid
- 6110 – Component Procedures Not Payable When Global Procedure Paid - Radiology Services

COVERAGE CRITERIA

Provider Type and Specialty Type

Table 1 lists the provider types and specialties that are authorized to bill radiology services to the IHCP. Radiology clinics can be enrolled as a billing provider or as a group with members. A radiology group with rendering members are enrolled with provider type 31 – Physician, with provider speciality 341 (radiologist). Radiology clinics can either be enrolled as a freestanding clinic or a mobile X-ray clinic.

Table 1

Provider Type	Provider Specialty
29 Radiology Provider	290 Freestanding x-ray clinic 291 Mobile x-ray clinic
31 Physician	341 Radiologist

Radiology providers are required to submit a copy of their Registration Certificate, ISDH Notice of Compliance, and operator certificates for all employee operators except PET CT scanner operators. Please note that PET and MRI services do not require certification or a Notice of Compliance.

Out-of-state mobile radiology providers performing services in Indiana must be certified in Indiana and possess a Notice of Compliance in Indiana. All operators must be certified in the state of Indiana.

Coverage Limitations

Reimbursement is available to radiology inpatient and outpatient facilities, freestanding clinics, and surgical centers for services provided to members subject to the following limitations.

- ◆ A radiological service must be ordered in writing by a physician or other practitioner authorized to do so under state law.
- ◆ The radiological service facility must bill the IHCP directly for components provided by the facility. When two practitioners each provide a portion of the radiology service, each practitioner may bill the IHCP separately for the component provided. The IHCP reimburses a physician or other practitioner for radiological services only when such services are performed by or under direct supervision of the physician or practitioner.
- ◆ A physician is reimbursed for the professional component of a radiological service by billing the appropriate CPT code along with Modifier 26, *Professional component*. When billing only the technical component, Modifier TC, *Technical*

component, must be used with the appropriate CPT code. When billing for both professional and technical components of service, modifiers should not be used. CPT codes billed using these modifiers are listed in the Federal Register under RVUs and related information.

- ◆ Radiology procedures cannot be unbundled and billed separately. Such circumstances may include, but are not limited to the following:
 - CPT codes for supervision and interpretation procedures are not reimbursed when the same provider bills for the complete procedure CPT code.
 - If two provider specialties are performing a radiology procedure, the radiologist bills for the supervision and interpretation procedure and the second physician bills the appropriate injection, aspiration, or biopsy procedure.
 - Angiographic procedures, when performed as an integral component of a surgical procedure by the operating physician, are not reimbursed separately. Such procedures include, but are not limited to the following:
 - Angiographic injection procedures during coronary artery bypass graft
 - Peripheral, percutaneous transluminal angioplasty procedures

Radiology services are available to PCCM and RBMC members on a self-referral basis. RBMC member claims should be submitted to the member's MCO for payment. Services that require PA furnished to members enrolled in RBMC must be prior authorized by the member's MCO in accordance with the MCO's guidelines.

Utilization Criteria for General Radiological Services

Criteria for the use of radiological services include consideration of the following.

- ◆ Evidence that this radiologic procedure is necessary for the appropriate treatment of illness or injury.
- ◆ X-rays of the spinal column limited to cases of acute documented injury or a medical condition in which interpretation of X-rays would make a direct impact on the medical/surgical treatments.
- ◆ Reimbursement is available for X-rays of the extremities and spine for the study of neuromusculoskeletal conditions.
- ◆ Reimbursement is not available for radiology examinations of any body part taken as a routine study not necessary for the diagnosis or treatment of a medical condition. Situations generally not needing radiology services include, but are not limited to the following:

- Fluoroscopy without films
- Pregnancy
- Premarital examinations
- Research studies
- Routine physical examinations or check-ups
- Screening, pre-operative chest X-ray

Radiation Treatment Services Revenue Codes

Radiation Treatment Services consist of two components which are separately reimbursable using the following code combinations.

- ◆ Administration of radiation treatment
 - Bill using revenue codes 330, 333, or 339 along with the appropriate CPT radiation treatment code, 77261 through 77799.
- ◆ Treatment room services
 - Bill using revenue codes 45X, 51X, 52X, or 76X.

When chemotherapy and radiation treatment services are rendered on the same day, all applicable components are billed to the IHCP.

Computerized Tomography Scans

Reimbursement may be available for diagnostic examination of the head and of other parts of the body, head scans, and body scans, performed by computerized tomography (CT) scanners, subject to the following restrictions:

- ◆ The scan should be reasonable and necessary for the individual patient.
- ◆ The use of a CT scan must be found to be medically appropriate considering the patient's symptoms and preliminary diagnosis.
- ◆ Reimbursement is made only for CT scans performed with equipment certified by the FDA.
- ◆ Whole abdomen, or whole pelvis scans on greater than 20 cuts is not reimbursed, except in staging cancer for treatment evaluation.
- ◆ PA is not required for CT scans.

Radionuclide Bone Scans

Reimbursement is available for radionuclide bone scans when performed for the detection and evaluation of suspected or documented bone disease.

Gastrointestinal Studies

Reimbursement is available for upper gastrointestinal (GI) studies when performed for detection and evaluation of diseases of the esophagus, stomach, and duodenum. An upper GI study is not a covered service for a patient with a history of duodenal or gastric ulcer disease unless recently symptomatic. An upper GI study is not a covered service in the preoperative cholecystectomy patient unless symptoms indicate an upper GI abnormality in addition to cholelithiasis, or if the etiology of the abdominal pain is uncertain.

X-ray Services While in Hospice

Costs for services such as X-rays and laboratory are not included on the attending physician's billed charges. These costs are included in the daily hospice care rates paid and are expressly the responsibility of the hospice provider. However, if the Medicaid hospice member requires radiological services not related to the terminal illness, the hospice provider is not responsible for these radiological services. IHCP will allow for separate reimbursement of the non-hospice related radiological treatment in these circumstances. The Medicaid provider billing for the treatment of the non-terminal condition is reminded that they are responsible for obtaining Medicaid prior authorization for any non-hospice services that are subject to prior authorization.

RADIOLOGY FACT SHEET ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Radiology Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200509 **Publication Date:** 03/01/2005

Subject: Transportation of Portable EKG or X-ray Machine

Date Added to Manual: 04/29/2005

Text of Publication

As of April 15, 2005, HCPCS code R0076 - *Transportation of portable EKG to facility or location, per patient*, is a non-covered service for the IHCP. Providers will no longer be reimbursed for this service. HCPCS code R0070 - *Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen*, is reported for one patient served. HCPCS code R0070 must not be reported with modifiers UN, UP, UQ, UR, or US. One unit must be reported for the trip. When more than one patient is served, providers should report HCPCS code R0075 - *Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen*, with the appropriate modifier representing the number of patients served. One unit must be reported for the trip. The service must be reported on each member's claim with the appropriate modifier. Reimbursement will be prorated according to how many patients are served, as represented by modifiers UN, UP, UQ, UR, and US. The table below lists the percentage of the fee schedule amount that each modifier will reimburse when reported with HCPCS code R0075.

Modifier	Description	Fee Schedule Percentage
UN	Two patients served	50%
UP	Three patients served	33%
UQ	Four patients served	25%
UR	Five patients served	20%
US	Six or more patients served	16%

RADIOLOGY SERVICES ADDENDUM B

Note: This addendum contains provider notifications that have been published since the review of the Radiology Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200544 **Publication Date:** 11/01/2005

Subject: Stereotactic Radiosurgery

Date Added to Manual: 01/31/2006

Text of Publication

The Indiana Health Coverage Programs (IHCP) currently covers three types of stereotactic radiosurgery (SRS) as represented by Healthcare Common Procedure Coding System (HCPCS) codes G0173, G0242, and G0251. In addition, the IHCP covers pre-operative planning under HCPCS code G0243 or G0338. Reimbursement for physician services is bundled into the pre-operative planning service.

Currently, all SRS procedures are manually priced by the IHCP. In order to more closely align IHCP pricing with Medicare, the IHCP will amend pricing for SRS procedures as reflected in **Table 1** below, effective December 15, 2005. Providers must bill SRS therapy and pre-operative planning with revenue code 333 on the UB-92 claim form or 837I transaction.

Table 1 – New IHCP SRS Reimbursement Rates, Effective December 15, 2005

Code	Description	Reimbursement
G0173	Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session	\$5,250
G0242	Multi-source photon stereotactic radiosurgery (cobalt 60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment	\$1,450
G0243	Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions	\$5,250
G0251	Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment	\$1,150
G0338	LINAC based stereotactic radiosurgery plan, including dose	\$1,450

Code	Description	Reimbursement
	volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment	

RADIOLOGY SERVICES ADDENDUM C

Note: This addendum contains provider notifications that have been published since the review of the Radiology Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200606

Publication Date: 02/07/2006

Subject: Changes to Billing Requirements for Stereotactic Radiosurgery

Date Added to Manual: 04/28/2006

Text of Publication

The purpose of this article is to advise IHCP providers of changes to billing requirements for physician's services for stereotactic radiosurgery (SRS). IHCP bulletin [BT200528](#) advises providers to report the physician's professional services that had previously been billed with HCPCS codes G0242 and G0338, with Common Procedural Terminology (CPT[®]) code 77301; however, services previously billed with these two codes should be billed with procedure identification code 77301 U5. The HCPCS codes listed in Table 2 are end-dated December 31, 2005. Effective for dates of service on and after January 1, 2006, providers are advised to bill the SRS services as reflected in Table 3. All other billing requirements for SRS therapy remain unchanged.

Table 1 – HCPCS Codes Non-Covered by Medicare, Effective
February 7, 2006

92630	92633	A6530	A6533	A6534	A6535	A6536
A6537	A6538	A6539	A6540	A6541	A6542	A6543
A6544	A6549	E0172	E0641	J7306	S2078	S2079

Table 2 – SRS HCPCS Codes End-Dated December 31, 2005

Code	Description
G0242	Multi-source photon stereotactic radiosurgery (cobalt 60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment
G0338	LINAC-based stereotactic radiosurgery plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification; all lesions treated, per course of treatment

Table 3 – SRS CPT Codes Effective January 1, 2006

Code	Description	Reimbursement
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	\$1,014.63
77301 U5	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications; multi-source photon or linear accelerator based stereotactic radiosurgery plan optimization for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment	\$1,450.00

RADIOLOGY SERVICES ADDENDUM D

Note: This addendum contains provider notifications that have been published since the review of the Radiology Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200639 **Publication Date:** 09/26/2006

Subject: Proton Treatment Billing

Date Added to Manual: 10/31/2006

Text of Publication

The purpose of this article is to inform providers that the Indiana Health Coverage Programs (IHCP) has determined that it is appropriate for providers to use the Current Procedural Terminology (CPT®) codes listed in Table 1 to report the technical component only of the CPT codes noted in Table 1 for reporting proton treatment delivery. Therefore, effective for dates of service on or after December 1, 2006, the IHCP will not reimburse providers services reported using the CPT codes listed in Table 1 and billed with modifiers *26 – Professional component*, and *TC – Technical component*. Providers are advised to bill CPT codes 77520, 77522, and 77525 for the technical component only. Additionally, providers are advised to report the professional services using an appropriate CPT procedure code.

Table 1 – CPT Codes Reporting Proton Treatment Delivery

CPT Code	Description
77520	Proton treatment; simple, without compensation
77522	Proton treatment; simple, with compensation
77525	Proton treatment delivery; complex

MEDICAL POLICY FACT SHEET

TITLE	RADIOLOGY - POSITRON EMISSION TOMOGRAPHY (PET) SCANS
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DESCRIPTION

Positron Emission Tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting, radioactive tracer substances (radiopharmaceuticals) that are administered intravenously to the patient.

COVERAGE CRITERIA

The Indiana Health Coverage Programs (IHCP) reimbursement policy currently uses the same criteria and coding methodology as Medicare. Providers must bill ICD-9-CM codes supporting medical necessity and the appropriate HCPCS codes. Appropriate ICD-9-CM diagnoses for billing purposes are included in **TABLE 1 – ICD-9-CM CODES SUPPORTING MEDICAL NECESSITY**. Professional and technical components are billable for PET scans.

TABLE 1 – ICD-9-CM CODES SUPPORTING MEDICAL NECESSITY

PET SCAN IMAGING	CPT CODE	ICD-9-CM CODE
Breast Cancer	78811, 78812, 78814, 78815	174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 147.9, 175.0, 175.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1
Myocardial perfusion imaging	78459, 78491, 78492	411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.8, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05

TABLE 1 – ICD-9-CM CODES SUPPORTING MEDICAL NECESSITY

PET SCAN IMAGING	CPT CODE	ICD-9-CM CODE
Refractory seizures	78608, 78609	345.01, 345.11, 345.2, 345.3, 345.41, 345.51, 345.61, 345.71, 345.81, 345.91
Regional or whole body, for single pulmonary nodule	78811, 78812, 78813, 78814, 78815, 78816	235.7, 239.1, 793.1, V71.1
Thyroid Cancer	78811, 78812, 78814, 78815	193
Whole body, for colorectal cancer	78813, 78816	153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 197.5, V10.05, V10.06, V71.1
Whole body, for esophageal cancer	78813, 78816	150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, V10.03, V71.1
Whole body, for melanoma	78813, 78816	172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82, V71.1
Whole body, for non-small cell lung carcinoma	78813, 78816	162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 196.1, V10.11, V71.1

TABLE 1 – ICD-9-CM CODES SUPPORTING MEDICAL NECESSITY

PET SCAN IMAGING	CPT CODE	ICD-9-CM CODE
Whole body, for lymphoma	78813, 78816	200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, V10.71, V10.72, V10.79, V71.1

TABLE 1 – ICD-9-CM CODES SUPPORTING MEDICAL NECESSITY

PET SCAN IMAGING	CPT CODE	ICD-9-CM CODE
Whole body, or regional, for head and neck cancer	78811, 78812, 78813, 78815, 78816	140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 170.0, 170.1, 171.0, 173.0, 173.1, 173.2, 173.3, 173.4, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 194.1, 194.3, 194.4, 194.5, 195.0, V10.01, V10.02, V10.12, V10.21, V10.22, V10.81, V10.83, V10.84, V10.89, V71.1

Prior Authorization Requirements

The IHCP does not require prior authorization for PET scans.

Managed Care

PET scan services are reimbursed and billed the same for Fee-for-Service and PrimeStep. Radiology services do not require a PMP's two digit certification code for payment. However, the eight-digit PMP license number continues to be required for claim reimbursement. For more information, see provider bulletin BT200262 or the IHCP Provider Manual.

For Risk Based Managed Care (RBMC), providers are to contact the individual MCO(s) to determine coverage, billing, and authorization requirements for PET scans.

Billing for PET Scans

If the member is an inpatient, the PET scan will be covered in the diagnosis-related grouping (DRG) payment to the hospital. The CPT codes for PET scans represent the global service. The provider performing just one component of the test should report the component performed.

If the member has services performed in the outpatient area of the hospital or a freestanding facility, the PET scan billing should be completed as follows.

- IHCP requires that providers bill specific ICD-9-CM diagnosis codes (**Table 1**) and the appropriate CPT codes when submitting claims. Claims for PET scans that do not include the appropriate ICD-9-CM diagnosis code will be denied.
- A radiologist should bill the professional services with the appropriate CPT codes and the 26 modifier on the CMS-1500 claim form or 837P electronic transaction.
- A facility should bill the technical component with the appropriate CPT Codes on the UB-92 claim form.

RELATED MEDICAL TOPICS

Radiology
Oncology
Oncology-Breast and Cervical Cancer

RULES, CITATIONS, AND SOURCES

Hoosier Healthwise Manual for Primary Medical Providers and Office Staff, January 2003

Indiana Administrative Code – 405 IAC 5-27-1

Indiana Health Coverage Programs Provider Bulletins

BT200339 – Criteria and Billing Information

BT200262 – PrimeStep PMP Certification Code Changes

BT200516 – PET Scan Changes

Indiana Health Coverage Programs Provider Banner BR200505 – ICD-9-CM Diagnosis Code Restriction

Indiana Health Coverage Programs –Provider Manual, Version 5.0, July, 2004

Origination Date: 10/30/03

Revisions and Reviews	Reason	Date
405-IAC-5-27-1	Radiology, Reimbursement Limitations	7/25/97
BT200339	Coverage Criteria and Billing Information	6/9/2003
BT200505	ICD-9-CM Diagnosis Code Restriction	3/1/05
Revision	Review Project Completion	4/29/05
Revision	Change from HCPCS G codes to CPT Codes	7/29/05

APPLICABLE INDIANA A/M EDITS AND AUDITS

- 6001 – Complete procedure payable at reduced rate
- 6011 – Radiology/technical component for radiology or pathology
 - Table 19- X-ray
- 6137 – Pet Scan Procedures Limited to Diagnosis
- 6138 – Procedure Code G0296 Limited to Diagnosis Codes
- 6139 – Pet Scan Procedures Limited to Diagnosis
- 6160 – Pet Scan Procedures Limited to Diagnosis
- 6161 – Pet Scan Procedures Limited to Diagnosis Codes
- 6162 – Pet Scans Limited to Diagnosis and Procedures
- 6163 – Pet Scans Limited to Certain Procedures Codes
- 6164 – Pet Scans Limited to Diagnosis Codes
- 6165 – Pet Scans Limited to Diagnosis Codes
- 6166 – Pet Scans Limited to Diagnosis Codes
- 6167 – Pet Scans Limited to Diagnosis Codes

RADIOLOGY PET SCANS ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Radiology PET Scans Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200602 **Publication Date:** 01/10/2006

Subject: PET Scan Coding

Date Added to Manual: 01/31/2006

Text of Publication

The IHCP bulletin *BT200516* provided billing guidelines for Positron Emission Tomography (PET) scans. *BT200516* advised providers to bill PET scans using an appropriate Common Procedural Terminology (CPT®) code and an appropriate International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code. Table 1 lists additional coding updates for PET scans. CPT codes 78811, 78812, and 78815 are added to PET scan imaging for non-small cell lung carcinoma. CPT code 78815 is added to PET scan imaging for colorectal and esophageal cancer. All other billing requirements remain unchanged.

Note: Reimbursement for PET scan services remains unchanged. Reimbursement for the appropriate CPT code, billed with the technical component (TC) and appropriate ICD-9-CM code, on a UB-92 claim form, is \$829.09. Reimbursement for professional services, reported with the appropriate CPT code, modifier 26 (professional services) and the appropriate ICD-9-CM code, and billed on a CMS-1500 or 837P electronic transaction, reimburses from the resource-based relative value scale (RBRVS) fee schedule.

Table 1 – ICD-9-CM Codes Supporting Medical Necessity

PET Scan Imaging	CPT Code	ICD-9-CM Code
Whole body, for non-small cell lung carcinoma	78811, 78812, 78813, 78815, 78816	162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 196.1, V10.11, V71.1
Whole body, for colorectal cancer	78813, 78815, 78816	153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 197.5, V10.05, V10.06, V71.1
Whole body, for esophageal cancer	78813, 78815, 78816	150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, V10.03, V71.1

MEDICAL POLICY FACT SHEET

TITLE: SCREENING SERVICES—NEWBORN SCREENING

DESCRIPTION:

Screening Services are various methods and procedures used to determine disease or the potential for developing an illness. Screening is usually done on a large number of persons who are thought to be at risk for disease. To screen is defined as “to examine, using physical and mental examinations and laboratory tests; to determine the presence of certain diseases or characteristics.”

MEDICAL TOPICS CROSS-REFERENCES:

EPSDT – HealthWatch

- A. HIV-AIDs Care Coordination
- B. Laboratory Services
- C. Obstetric Care

RULES, CITATIONS, AND SOURCES:

- D. Indiana Code 16-41-6 Communicable Disease: Mandatory Testing of Individuals with Communicable or Dangerous Diseases
- E. Indiana Medicaid Update Bulletin 95-21 dated May 2, 1995
- Indiana Health Coverage Programs Provider Manual 1999

Initial Policy	Issue	Effective Date	Implementation Date	Retroactive Date
Indiana Medicaid Update bulletin 95-21	Newborn Screening		5/2/95	5/1/95
410 IAC 3-3-3	Newborn Screening Log	11/7/86		
405 IAC 5-15	Early and Periodic Screening, Diagnostic, and Treatment Services	8/24/97		
IC16-41-17-2	Prevention and Treatment Programs: Examination of Infants for Phenylketonuria, Hypothyroidism, and Other Disorders	1993		
F. IC 16-41-6	Communicable Disease: Mandatory Testing of Individuals with Communicable or Dangerous Diseases	1993;1996; 1998		
Revisions:				
405 IAC 3-2 Amended	Prior Authorization	10/27/99		
405 IAC 3-3-3 Amended	Prior Authorization	10/27/99		
410 IAC 3-3-3 Amended	Newborn Screening Log	07/11/01		
IC 16-41-17-2	Prevention and Treatment Programs: Examination of Infants for Phenylketonuria, Hypothyroidism, and Other Disorders	1999;2001		

APPLICABLE INDIANA A/M EDITS AND AUDITS:

6028

6702

COVERAGE CRITERIA:

Medicaid reimbursement is available for services provided to eligible children under the EPSDT program. This program is set out in 405 IAC 5-15.

Indiana Code (IC), IC 16-41-17-2 and Indiana Administrative Code (IAC), 410-3-3-3 provides information regarding the screening examinations that are required for all newborn infants that are born in the state of Indiana.

- ◆ phenylketonuria (PKU)
- ◆ galactosemia
- ◆ hypothyroidism
- ◆ homocystinuria
- ◆ maple syrup urine disease
- ◆ hemoglobinopathies (which includes sickle cell anemia),
- ◆ congenital adrenal hyperplasia
- ◆ biotinidase deficiency
- ◆ disorders detected by tandem mass spectrometry or other technologies with the same or greater detection capabilities as tandem mass spectrometry if the state department determines that the technology is available for use by designated laboratory under section 7 of this chapter (IC 16-41-17-2).

This is a required procedure for every infant not earlier than forty-eight hours after birth and not before the infant has been on a protein diet for at least twenty-four hours, and no later than one hundred twenty hours after birth. This usually occurs before discharge from the hospital and the physician or midwife is responsible for making the referral to an appropriate facility to make sure that the blood specimen is obtained and submitted in accordance with the law. For preterm infants the specimen may be taken on the day of discharge or on the sixth day if the nursery stay is prolonged beyond six days. Medicaid pays for the newborn hospitalization, and therefore, the screening is already included in the DRG. Hospitals are not permitted to bill separately for newborn screening.

Every infant may receive a physiologic hearing screening examination at the earliest feasible time for detection of hearing impairments.

If a parent of an infant objects in writing for reasons pertaining to religious beliefs only, the infant is exempt from the examinations required by IC 16-41-17-2.

State law also provides that if a physician believes that testing the newborn infant is medically necessary; the physician may order a confidential test for the newborn infant in order to detect the human immunodeficiency virus (HIV) or the antibody or antigen to HIV. The test must be ordered at the earliest feasible time not exceeding 48 hours after the birth of the infant.

Newborn screening results must be recorded in the patient record for infants younger than one year old.

MEDICAL POLICY FACT SHEET

TITLE: SMOKING CESSATION

DESCRIPTION:

Smoking cessation refers to a course of treatment designed to assist individuals in decreasing or stopping the use of tobacco products.

MEDICAL TOPICS CROSS-REFERENCES:

Pharmacy

RULES, CITATIONS, AND SOURCES:

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
405 IAC 5-37	Smoking cessation treatment policy	10/27/99		
Revisions:				
405 IAC 5-37	Smoking cessation treatment policy	10/31/01		

APPLICABLE INDIANA A/M EDITS AND AUDITS:

6270
1040—on hold

COVERAGE CRITERIA:

Coverage of Smoking Cessation Treatment services is for dates of service on or after October 27, 1999.

Reimbursement for smoking cessation is available for one (1) twelve (12) week course of treatment per member per calendar year.

Treatment may include prescription of any combination of smoking cessation products and counseling. One (1) or more modalities of treatment may be prescribed. Counseling **must** be included in any combination of treatment.

Prior authorization is not required for reimbursement for smoking cessation products or counseling.

Hoosier Healthwise

Providers of smoking cessation treatment services must obtain the Primary Medical Provider (PMP) certification for Hoosier Healthwise enrollees.

Smoking Cessation Products

Reimbursement is available to pharmacy providers for smoking cessation products when *prescribed* by a licensed practitioner within the scope of his/her license under Indiana law.

Only patients who agree to participate in smoking cessation counseling are to receive prescriptions for smoking cessation products. The prescribing practitioner may want to have the patient sign a commitment to establish a “quit date” and to participate in counseling as the first step in smoking cessation treatment. A prescription for such products will serve as documentation that the prescribing practitioner has prescribed or obtained assurance from the patient that counseling will concomitantly occur with the receipt of smoking cessation products.

Products covered by Indiana Medicaid include, but are not limited to, the following:

- ◆ Sustained release bupropion products.
- ◆ Nicotine replacement drug products (patch, gum, inhaler).

Smoking Cessation Counseling

Counseling services must be *prescribed* by a licensed practitioner within the scope of his/her license under Indiana law. Reimbursement is available for smoking cessation counseling services *rendered* by the following licensed practitioners participating in the Indiana Medicaid Program.

- ◆ A physician
- ◆ A physician's assistant
- ◆ A nurse practitioner
- ◆ A registered nurse
- ◆ A psychologist
- ◆ A pharmacist
- ◆ A dentist

Counseling must be provided as follows: A minimum of thirty (30) minutes [two (2) units] and a maximum of one hundred fifty (150) minutes [ten (10) units] within the twelve (12) weeks. Counseling will be billed in fifteen (15) minute increments.

BILLING INSTRUCTIONS AND REIMBURSEMENT

Counseling Services

Providers/practitioners of counseling services must bill only on the CMS 1500 claim form (please see applicable provider manual section for full details), utilizing procedure code Z5064 (smoking cessation treatment counseling) with a primary diagnosis code of 305.1 (Tobacco use disorder). As previously noted herein, one unit of Z5064 will be considered as fifteen (15) minutes of service. Fractional units of service cannot be billed on the CMS1500, so providers/practitioners should accumulate billable time equivalent to whole units, before billing. Counseling must be provided within the twelve (12) week course of treatment and must be a minimum of thirty (30) minutes [two (2) units] with a maximum of one hundred fifty (150) minutes [ten (10) units].

The Indiana Medicaid maximum allowable rate for code Z5064, smoking cessation treatment counseling services is \$22.08 per unit, regardless of the type of practitioner rendering the service. PLEASE NOTE: Providers/practitioners are to bill their "usual and customary charge" for the units of service rendered, and Medicaid will calculate the final reimbursement amount.

Practitioners eligible to provide smoking cessation treatment counseling services, but not currently enrolled as an Indiana Medicaid provider, should contact the EDS Customer Assistance Unit for instructions on how to proceed. Eligible practitioners such as pharmacists, who work for or own Medicaid-enrolled pharmacies, will bill for counseling services they render through the enrolled entity in which they provide services. Physician's assistants, registered nurses, and psychologists who are not health service providers in psychology (HSPP) will bill for counseling services they render through the enrolled entity in which they provide services.

Providers/practitioners are reminded that they are NOT entitled to Medicaid reimbursement for a service which they provide to the general public at no charge, including smoking cessation counseling services. The Health Care Excel (HCE) Surveillance Utilization and Review (SUR) department will closely monitor adherence to this program limitation.

Both ordering and rendering practitioners should maintain sufficient documentation of their respective functions to substantiate the medical necessity of the service rendered, and the provision of the service itself; this requirement is consistent with existing Medicaid policies and regulations.

Smoking Cessation Products

Smoking cessation products, previously mentioned herein, will be covered under the Indiana Medicaid Program for products provided on October 27, 1999, and later.

Reimbursement is available to pharmacy providers for smoking cessation products when prescribed by a licensed practitioner within the scope of his/her license under Indiana law.

Over-the-counter smoking cessation products must still be prescribed by a licensed practitioner in order for the pharmacy to be reimbursed by Medicaid. All smoking cessation products must be prescribed by a licensed practitioner for use, along with counseling, within the twelve (12) week treatment timeframe.

Pharmacies will bill for reimbursement according to the normal procedures as outlined in the provider manual (please see applicable provider manual section for full details).

MEDICAL POLICY FACT SHEET

TITLE: SPEECH AND HEARING

DESCRIPTION

Speech and Hearing Services are provided for Indiana Health Coverage Programs (IHCP) members with speech, hearing, and/or language disorders. These services include diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

Medically necessary speech pathology and audiology services are available to IHCP members within the limitations set forth in the Indiana Administrative Code (IAC). IHCP reimbursement is available for therapy services provided outside the State, and are subject to the same limitations as in-state services. Refer to the Out-Of-State Services Medical Policy fact sheet.

SPEECH PATHOLOGY

Speech pathology services are allowed with the following restrictions.

- Evaluations and re-evaluations are limited to three hours of service per evaluation.
- Reevaluation will not be authorized more than one time yearly unless there is a significant change in the member’s condition. Documentation must be submitted.
- Group therapy is covered in conjunction with individual therapy only.
- Physician involvement and personal patient evaluation is required. Documentation in the member’s medical record must be maintained. Therapy must be ordered by a physician. A current plan of treatment and

progress notes, substantiating medical necessity and the effectiveness of the prescribed therapy, must be attached to the prior authorization request and is subject to post payment review.

- Therapy must be provided by a licensed therapist or qualified assistant under the direct supervision of the therapist as appropriate.
- Therapy must be of such a level of complexity and sophistication and the condition of the member must be such that the judgment, knowledge, and skills of a licensed therapist are required.
- IHCP reimbursement is available only for medically reasonable and necessary therapy.
- Therapy rendered for diversional, recreational, vocational, or avocational purposes, or for the remediation of learning disabilities or for developmental activities that can be conducted by nonmedical personnel, is not covered by the IHCP.
- Therapy for rehabilitative services will be covered for a member no longer than two (2) years from the initiation of the therapy unless there is significant change in medical condition. Documentation must be maintained in the medical record.
- Maintenance therapy is not a covered service.
- When an IHCP member is enrolled in therapy, ongoing evaluations to assess progress and redefine therapy goals are part of the therapy program. These ongoing evaluations are not separately reimbursed by the IHCP program.
- One hour of billed therapy service must include a minimum of forty-five minutes of direct patient care with the balance of the hour spent in related patient services.
- Therapy services will not be approved for more than one hour per day per type of therapy.
- A request for therapy services, which would duplicate other services provided to a patient, will not be prior authorized.
- Speech therapy is covered for a maximum of 50 visits per rolling 12 months per type of therapy (Package C only).

Prior Authorization for Speech Pathology

Requests for prior authorization (PA) are reviewed for medical necessity as well as the member's abilities and/or progress. A speech pathologist consultant is available to review documentation for medical necessity. Prior authorization is required for speech pathology services with the following exceptions.

- Initial evaluations.
- Any combination of therapy ordered in writing prior to a member's discharge from an inpatient hospital that may continue for a period not to exceed thirty (30) units in thirty (30) calendar days.
- Therapy services provided by a nursing facility or large private or small intermediate care facility for the mentally retarded (ICF/MR), which are included in the facility's per diem rate.

- Out-of-state services require prior authorization. (See 405 IAC 5-5-2). Refer to the Medical Policy fact sheet for Out-Of-State Services for further information.

AUDIOLOGY/HEARING TESTS

Audiology services are allowed with restrictions.

- The physician must certify in writing the need for an audiological assessment or evaluation.
- The audiology service must be rendered by a licensed audiologist or a person registered for his clinical fellowship year who is supervised by a licensed audiologist. A registered audiology aide can provide services under the direct on-site supervision of a licensed audiologist under 880 IAC.
- When a member is to be fitted with a hearing amplification device, by either the audiologist or a registered hearing aide specialist, a medical clearance and audiometric test form must be completed in accordance with instructions and submitted with the request for PA. This form must be complete and must include the proper signatures where indicated before the PA request will be reviewed.
- Initial audiological assessments are limited to one assessment every three years per member. If more frequent audiological assessments are necessary, PA is required.

Provisions of audiology services are subject to the following criteria.

- The member's history must be completed by any involved professional.
- The referring physician must complete Part 2 of the Medical Clearance and Audiometric Test Form no earlier than six months prior to the provision of the hearing aid. Children fourteen years of age and under must be examined by an otolaryngologist; members 14 years of age and older may be examined by a licensed physician if an otolaryngologist is not available.
- All testing must be conducted in a sound-free enclosure. If a member is institutionalized and his or her physical or medical condition precludes testing in a sound-free enclosure, the ordering physician must verify medical confinement in the initial order for audiological testing. The audiological assessment must be conducted by a licensed audiologist, clinical fellowship year audiologist, or otolaryngologist. Testing conducted by other professionals and cosigned by an audiologist or otolaryngologist will not be reimbursed by the IHCP. If the audiological evaluation reveals one or more of the following conditions, the member must be referred to an otolaryngologist for further evaluation.
 - Speech discrimination testing indicates a score of less than 60% in either ear.

- Pure tone testing indicates an air bone gap of fifteen decibels or more for two adjacent frequencies in the same ear.
- The hearing aid evaluation may be completed by the audiologist or registered hearing aid specialist.
- The hearing aid contract portion of the audiometric test form must be signed by a registered hearing aid specialist.
- Audiological assessments rendered more frequently than every three years will be assessed on a case-by-case basis, based upon documented otological disease.

Audiologic procedures cannot be fragmented and billed separately. Hearing tests, such as whispered voice and tuning fork, are considered part of the general otolaryngology services and cannot be reported separately.

- Basic comprehensive audiometry includes pure tone, air and bone threshold, and discrimination; testing provided for both ears.
- All other audiometric testing procedures will be reimbursed on an individual basis, based on the medical necessity for such test procedures.

Prior Authorization for Audiology/Hearing Tests

All requests for PA will be reviewed on a case-by-case basis. The following audiological services do not require PA.

- A screening test indicating the need for additional medical examination (screenings are not reimbursed separately under the IHCP).
- Initial assessment of hearing;
- Determination of suitability of amplification and the recommendation regarding a hearing aid;
- The determination of functional benefit to be gained by the use of a hearing aid;
- Audiology services provided by a nursing facility or large ICF/MR, which are included in the facility's established per diem rate.

Out-of-state services require prior authorization. (See 405 IAC 5-5-2). Refer to the MP fact sheet for Out-Of-States Services for further information.

Health Watch Early Periodic Screening Diagnosis, and Treatment (EPSDT)

Ensuring that all children in the IHCP receive age-appropriate, comprehensive, preventive services is the primary goal of the HealthWatch/EPSDT program. Components of screening examinations and the recommended frequency of screenings are listed in the EPSDT Provider Manual, *HealthWatch Periodicity and Screening Schedule* found in *Appendix A.*, 18-23 months, 24-35 months, and 3 years. Audiometric screening should be provided yearly for ages 4 through 14, and at 16, 18, and 20 years of age. Refer to the EPSDT Medical Policy fact sheet.

Hearing Aids Prior Authorization and Documentation Criteria

Hearing Aids

IHCP reimbursement is available for the purchase, repair, or replacement of hearing aids, including, air conduction or conventional hearing aids, bone anchored or bone conduction hearing aids (BAHA), and programmable hearing aids, under the following conditions.

- PA is required for hearing aids.
- A medical clearance form and audiometric test form must be completed and submitted with the PA request form.
- Any involved professional must complete a member history. The referring physician must complete Part 2 of the Medical Clearance and Audiometric Test Form no earlier than six months prior to the provision of the hearing aid.
- Hearing aid fitting may be provided by either the audiologist or a registered hearing aid specialist. Services must be performed in accordance with the appropriate provisions of 405 IAC 5-22.
- Hearing aids purchased by the IHCP become the property of the Office. All hearing aids purchased by the Office, which are no longer needed by a member, must be returned to the County Office of Family and Children.
- Hearing aids are not covered for members with a unilateral pure tone average loss (500, 1000, 2000, or 3000 hertz) equal to or less than thirty decibels.
- Binaural aids and CROS-type aids will be authorized only when significant, objective benefit to the member can be documented.
- Canal hearing aids are non-covered.

Air Conduction Hearing Aid

The air conduction hearing aid, or conventional hearing aid, amplifies and sends sound through the earmold, into the ear canal, through the middle ear and to the inner ear. This type of hearing aid is not appropriate for a child with Atresia, as the ear canal is blocked and the sound cannot get through. Conventional hearing aids will be authorized only if they are medically necessary and significant, and objective benefit to the member is documented.

Bone-Anchored Hearing Aids/BAHA

A bone conduction hearing aid is different from a conventional air conduction hearing aid. Unlike other hearing aids, BAHA hearing aids transmit sound through the bone of the skull rather than to the ear canal. This process is called direct bone conduction. Bone conduction hearing aids will be authorized only if they are medically necessary and significant, and objective benefit to the member is documented. Indications for BAHA's include the following.

- Chronic ear infection.
- Congenital hearing loss.
- Single-sided deafness (SSD).
- History of middle ear damage.

CROS/BICROS Hearing Aids

CROS is an acronym for Contralateral Routing of Signals. A CROS hearing aid is fit to a person who has normal hearing in one ear and one ear that is unaidable. The unaidable ear may be unaidable due to the severity of the loss, a physical malformation of the ear, a chronic medical condition that causes occlusion of the ear canal or any combination of the three. A CROS hearing aid consists of a microphone at the level of the unaidable ear which transmits via a wire or FM to a receiver in (or at) the normal hearing ear. BI CROS stands for bilateral-CROS. This refers to a hearing aid system which incorporates two microphones, one in (or at) each ear and a single amplifier and receiver. In this case, the BI CROS device is fit to an individual who has a hearing loss in both ears, but one ear is unaidable, allowing the individual to receive sounds from both sides of their head in their “good” ear.

Programmable Hearing Aids

Programmable hearing aids will be authorized only if they are medically necessary and objective evidence of significant benefit to the member is documented. Indications for programmable hearing aids include the following.

- Fluctuating hearing loss (Meniere’s disease, autoimmune sensorineural hearing loss, otogenic syphilis, large vestibular aqueduct syndrome, and other conditions resulting in fluctuant hearing loss).
- Progressive hearing loss (Meniere’s disease, Alport’s syndrome, and other conditions resulting in progressive hearing loss. A retrocochlear hearing loss must be excluded, particularly when the loss is asymmetrical).
- Severe recruitment or very narrow dynamic range.
- Very young children who are hard to test or hard to fit.
- Patients with hearing loss with unusual audiometric configurations.

Documentation Requirements for Programmable Hearing Aids

- An IHCP Medical Clearance and Audiometric Test (IHCP MCAT) form must be completed. Medical necessity for programmable hearing aids must be clearly documented in the sections entitled, “Recommendation Information” and/or “Special Conditions” on page two of the IHCP MCAT form.
- A record of the audiogram obtained not more than three months before the date of the request.
- An otological examination report signed by the physician that includes the medical etiology of or diagnosis for the hearing loss.
- A diagnosis that supports medical necessity must be included on the PA request and on the claim for programmable hearing aids.
- A documented case history of the member’s needs and lifestyle that include at the following:
 - Past history or hearing aid use.
 - Reason the programmable hearing aids(s) rather than a conventional hearing aid(s) is medically necessary.
 - Description of the hearing environment(s) in which the member has trouble hearing and to which he or she is subjected. The

frequency and duration of exposure to these environments should also be included.

- Documentation of any other factors, such as lack of normal dexterity, should be included.
- Documentation must be provided that supports medical necessity of the programmable hearing aids outside of vocational needs.

Hearing Aid Maintenance and Repair

The IHCP provides reimbursement for the maintenance or repair of hearing aids under the following conditions.

- Repairs for hearing aids and ear molds do not require PA; however, reimbursement for such repairs cannot be made more often than once every 12 months. Repairs may be prior authorized more frequently for members under 18 years of age if circumstances justifying need are documented.
- Batteries, sound hooks, tubing, and cords do not require PA.
- The IHCP will not reimburse for repair of hearing aids still under warranty.
- Routine servicing of functioning hearing aids is not covered by the IHCP.
- No payment shall be made for repair or replacement of hearing aids necessitated by member misuse or abuse whether intentional or unintentional.

Hearing Aid Replacement

IHCP reimbursement is available for the replacement of hearing aids under the following conditions.

- Replacement of hearing aids is subject to 405 IAC 5-19-14, Hearing aids; maintenance and repair.
- Requests for replacement of hearing aids must document a change in the member's hearing status and must state the purchase date and condition of the current hearing aid.
- Hearing aids shall not be replaced prior to five years from the purchase date. Replacements may be prior authorized more frequently for members under 18 years of age, if circumstances justifying medical necessity are documented.

Cochlear Implants

A cochlear implant device is an electronic instrument. Part of the device is implanted surgically to stimulate auditory nerve fibers, and the other part is worn or carried by the individual to capture, analyze, and code sound. Cochlear implant devices are available in single-channel and multi-channel models. The purpose of the implanted device is to provide awareness and identification of sounds to facilitate communication for persons who are moderately to profoundly hearing impaired.

Cochlear Implants will be authorized only if they are medically necessary and objective evidence of significant benefit to the member is documented. Indications for cochlear implants include the following.

- Cochlear implantation will be covered for treatment of bilateral pre-or-post-linguistic, sensorineural, moderate-to-profound hearing loss in individuals who demonstrate limited benefit from amplification.
- Post-linguistically deafened adults must demonstrate test scores of less than or equal to 40% on sentence recognition scores from tape recorded tests in the patient's best listening condition.
- Cochlear implants are covered for children between ages 2-17 where there is demonstrated by the ability to improve on age appropriate closed-set word identification tasks with amplification.

Coverage is provided only for those patients who meet all of the following selection guidelines.

- Diagnosis of bilateral moderate-to-profound sensorineural hearing impairment with limited benefit from appropriate hearing (or vibrotactile) aids;
- Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation;
- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system;
- No contraindications to surgery; and
- The device must be used in accordance with Food and Drug Administration (FDA)-approved labeling.

Individuals must have hearing test scores of greater than 40% and less than or equal to 60% only when the provider is participating in, and patients are enrolled in, either an FDA-approved category B investigational device exemption clinical trial as defined at 42 CFR 405.201, a trial under the Centers for Medicare & Medicaid (CMS) Clinical Trial Policy as defined at section 310.1 of the National Coverage Determinations Manual, or a prospective, controlled comparative trial approved by CMS as consistent with the evidentiary requirements for National Coverage Analyses and meeting specific quality standards. See the Medical Policy Fact Sheet for Clinical Trails for further information.

Cochlear Implant Maintenance and Repair

The IHCP provides reimbursement for the maintenance or repair of cochlear implants under the following conditions.

- Repairs for cochlear implants do not require PA; however, reimbursement for such repairs cannot be made more often than once every 12 months. Repairs may be prior authorized more frequently for members under 18 years of age if circumstances justifying need are documented.
- Batteries do not require PA.
- Headset/headpiece, microphone, and transmitting coil/cable do require PA.
- Payment is not available for repair of a cochlear implant device still under warranty.

- Routine servicing of a functioning cochlear implant is not covered under the IHCP.
- No payment shall be made for repair or replacement of hearing aids necessitated by member misuse or abuse whether intentional or unintentional.
- The device is in continuous use and still meets the medical necessity needs of the beneficiary.
- All charges for cochlear implant parts and repairs are to reflect no more than the usual and customary (U&C) charge to the public.

Cochlear Implant Replacement

The IHCP provides reimbursement for the replacement of cochlear implants under the following conditions.

- Replacement of a cochlear implant is subject to repair and maintenance criteria.
- Requests for replacement of cochlear implants must document a change in the member's status and must state the purchase date and condition of the current cochlear implant.
- Cochlear implants shall not be replaced prior to five years from the purchase date. Replacements may be prior authorized more frequently for members under 18 years of age, if circumstances justifying medical necessity are documented.
- For replacement of a cochlear implant with an upgraded model:
 - Documentation substantiates that the newer generation technology provides additional capacity.
 - The current implant has been worn for at least four years.

BILLING REQUIREMENTS

The IHCP provides reimbursement to IHCP enrolled providers for services billed with the appropriate HCPCS procedure code. Programmable hearing aids should be submitted for reimbursement using HCPCS procedure code V5299, Hearing Service, Miscellaneous. All other hearing aids will be submitted using the appropriate HCPCS V code.

A hearing services code set was implemented for audiologists, provider specialty 200, and hearing aid dealers, provider specialty 220. Audiologists and hearing aid dealers will be reimbursed from a designated list of procedure codes effective October 1, 2004. Codes billed by audiologists and hearing aid dealers that are not on the list will deny for edit 1012 - *Rendering provider specialty not eligible to render procedure code*. The code set is subject to change based on policy and coverage changes.

Programmable hearing aids are manually priced and require that an invoice accompany the claim. Providers should bill their usual and customary charge to the IHCP; however, reimbursement will be made at the lower of the provider's usual and customary charge or 130 percent of the manufacturer's invoice price.

MANAGED CARE

For PrimeStep, the same policies apply as those applicable to the Traditional Fee-For-Service program. For Risk-Based Managed Care (RBMC) specific policies, please consult the appropriate MCO.

RELATED MEDICAL TOPICS

EPSDT HealthWatch
Home Health Services
Intermediate Care Facilities for the Mentally Retarded
Medical Supplies and Equipment
Medical Supplies and Equipment – Programmable Hearing Aids
Nursing Facilities
Physician Services
Surgery Global Billing/Payment Guidelines
Therapies
Transportation Services
Out-Of-State Services

RULES, CITATIONS, AND SOURCES

42 CFR 405.201
42 CFR 440.110
IC 12-15-34 Home Health Services
IC 12-15-39 Long Term Care
405 IAC 5-3 Prior Authorization
405 IAC 5-4 Provider Enrollment
405 IAC 5-13 Intermediate Care Facilities for the Mentally Retarded
405 IAC 5-15 Early and Periodic Screening, Diagnostic, and Treatment Services
405 IAC 5-16 Home Health Agency and Clinic Services
405 IAC 5-19 Medical Supplies and Equipment
405 IAC 5-22 Nursing and Therapy Services
405 IAC 5-25 Physician Services
405 IAC 5-31 Nursing Facility Services
405 IAC 5-32 Rehabilitation Unit
405 IAC 5-33 Acute Care Hospital
405 IAC 5-34 Hospice Services
405 IAC 5-36 Diabetes Self Management Training
880 IAC Speech-Language Pathology and Audiology Board
Indiana Health Coverage Programs Provider Manual 2004
Indiana Health Coverage Programs Provider Bulletins
 BT200105 - Programmable Hearing Aids
Indiana Health Coverage Programs Provider Banners
 BR01-06-1998 – Hearing Aids PA Codes 96105, 96111

BR12-29-1998 – Hearing Test Audit Update
 BR200435 – Audiologist and Hearing Aid Dealers Code Set
 Indiana Health Coverage Programs Provider Newsletters
 NL200409 – Audiology and Hearing Aid Services
 Indiana Health Coverage Programs HealthWatch Early Periodic Screening, Diagnosis,
 and Treatment (EPSDT) Provider Manual, 2002

Origination Date: 12/31/02

Revisions and Review	Reason	Date
IHCP Web site	Hearing Services Provider Code Set	10/01/04
42 CFR 440.110	Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing, and Language Disorders	05/28/04
405 IAC 5-31-4	Nursing Facility Services	06/05/03
405 IAC 5-3-12	Prior Authorization	08/28/01
405 IAC 5-4-1	Provider Enrollment	06/27/01
405 IAC 5-13-3	Intermediate Care Facilities for the Mentally Retarded	06/27/01
405 IAC 5-15-3	Early and Periodic Screening, Diagnostic, and Treatment Services	06/27/01
405 IAC 5-16-2, 5-16-3.1	Home Health Agency and Clinic Services	06/27/01
405 IAC 5-19-13, 5-19-14, 5-19-15, 5-19-16, 5-19-17	Medical Supplies and Equipment	06/27/01
405 IAC 5-22-5, 5-22-6, 5-22-7, 5-22-9	Nursing and Therapy Services	06/27/01
405 IAC 5-25-3	Physician Services	06/27/01
405 IAC 5-32-2	Rehabilitation Unit	06/27/01
405 IAC 5-33-1, 5-33-2	Acute Care Hospital Admission	06/27/01
405 IAC 5-34-8	Hospice Services	06/27/01
405 IAC 5-36-1	Diabetes Self Management Training	06/27/01
IC 12-15-39.6-1	Long Term Care Defined	01/01/97
IC 12-15-34-2	Home Health Services Defined	1995
IC 12-15-34-4	Items and Services Included Under IC 12-15-34-2 Definition of Home Health Services	1992
Review	Scheduled	04/29/05
Review	Cochlear Implant Criteria Added	10/29/05

APPLICABLE INDIANA A/M EDITS AND AUDITS:

1012 – Rendering Provider Specialty Not Eligible to Render Procedure Code

6054 – Only One Hearing Test per 36 Months Without PA

6056 – Only One Hearing Aid Repair per 12 months Allowed for Members 18 and Older

6057 – Only One Hearing Aid Repair per 12 Months Allowed for Members Under 18 Years

Without PA

6058 – Hearing Aid Earmolds Repair per 12 Months – Members 18 Years or Older

6059 – Hearing Aid Earmolds Repair per 12 Months – Member Under 18 Years

6060 – Speech Therapy Evaluations – One per Year

6750 – Therapies Within 30 Days From Hospital Discharge Date Without Approved PA

MEDICAL POLICY FACT SHEET

TITLE: SUBSTANCE ABUSE

DESCRIPTION:

Substance abuse services covered by the IHCP include services for inpatient detoxification, rehabilitation, and after care for chemical dependency and outpatient services for individuals who have a substance-related disorder. Substance abuse, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV), is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substance. The terms substance abuse, chemical dependency, and substance-related disorder are used interchangeably in this document.

SUMMARY OF CURRENT POLICY

The Indiana Health Coverage Programs (IHCP) provides reimbursement for inpatient substance abuse services and outpatient substance abuse services to members who meet the criteria for services. Inpatient substance abuse treatment is available, subject to prior authorization (PA). Outpatient substance abuse services are available to members enrolled in the Medicaid Rehabilitation Option (MRO), who meet the substance-related disorder guidelines for case management services. Case management services under MRO are not subject to PA.

RELATED MEDICAL TOPICS

Emergency Medicine – Emergency Room
Mental Health/Behavioral Health – Inpatient Services
Mental Health/Behavioral Health – Outpatient Services
Community Mental Health Rehabilitation Services

RULES, CITATIONS, AND SOURCES

405 IAC 5-17 Hospital Services
405 IAC 5-20 Mental Health Services
405 IAC 5-21 Community Mental Rehabilitation Services
Indiana Health Coverage Programs Provider Manual 1999
Medicaid Rehabilitation Option Provider Manual, March 2004

ORIGINATION, REVIEWS AND REVISIONS

Origination Date: August 24, 1997

Revisions and Reviews	Reasons	Date
405 IAC 5-17-3	Emergency Admissions	8/24/97
405 IAC 5-17-5	Inpatient detoxification, rehabilitation, and after care for chemical dependency	8/24/97
405 IAC 5-20	Mental Health Services	7/25/97
405 IAC 5-21-5	Community Mental Health Rehabilitation Services Case Management Services	7/25/97
BT199923	Appropriate Procedures for Submitting the Certification of Ned (Form 1261A for Inpatient Psychiatric Services	8/24/99
BR199950	MCO Financial Responsibility	12/14/99
IHCP Provider Manual	Chapter 8 Inpatient Mental Health Services	7/04
IHCP Provider Manual	Chapter 6 Institutional Prior Authorization Policy Requirements	7/04
MRO Provider Manual	Section 4 Procedure Codes – Case Management	9/04
Medical Policy Manual	4 th Quarter 2004 Update	1/05

APPLICABLE INDIANA A/M EDITS AND AUDITS

6096 – The CPT/HCPCS Code Billed Not Payable In PPS

3014 – Substance Abuse DRG Requires Prior Authorization

COVERAGE CRITERIA

Inpatient Substance Abuse Services

The IHCP provides reimbursement for inpatient substance abuse and chemical dependency treatment, as outlined in 405 IAC 5-17-3. Substance abuse and chemical dependency admissions are reimbursed based on the DRG payment methodology. Admission must be to a psychiatric setting, unless medical services are required for life support and cannot be rendered in a substance abuse treatment unit or facility.

Inpatient substance abuse services are covered for Package C members when the services are medically necessary for the diagnosis or treatment of a member's condition. Managed care organizations (MCO) are financially responsible for all facility, ancillary, and professional services related to carved-out mental health services, including substance abuse related services, when rendered in an acute care hospital, by the primary medical provider, or any other specialty not enrolled as a psychiatrist, health services provider in psychology, or mental health services provider.

PA is considered for approval on a case-by-case basis for inpatient detoxification, rehabilitation, and aftercare under the following circumstances.

- Treatment, evaluation, and detoxification is necessary based on the stated medical condition
- Need for safe withdrawal from alcohol or other drugs
- History of recent convulsions or poorly controlled convulsive disorder
- Reasonable evidence that detoxification and aftercare cannot be accomplished in an outpatient setting.

A *Certification of Need, Form 1261A* is required for all mental health admissions, including admissions for substance abuse and chemical dependency, regardless of setting. For non-emergency admissions, this form must be received within ten working days of admissions. For emergency psychiatric admissions, as defined in 405 IAC 5-20-6, this form must be received within 14 days of admission. This form must include detailed information to document the necessity of the admission. In the event that the form does not meet the requirements, any claim(s) associated with the admission will be denied.

Detoxification is defined as treatment requiring physician assessment and supervision and skilled nursing care to restore physiological functioning impaired by prolonged and excessive use of alcohol and/or drugs. IHCP members must meet the following criteria for inpatient detoxification.

1. Evidence of symptoms of withdrawal that require close medical monitoring or continuous observation.
 - a. Three (3) or more of the following conditions.
 - Delirium tremens

- Hypertension of recent onset
 - Impaired or absence of gag reflex
 - Tachycardia
 - Elevated temperature
 - Diaphoresis
 - Piloerection (goose bumps)
- b. OR one (1) of the following conditions.
- Seizures
 - Hallucinations of recent onset
 - Disorientation or confusion
2. History of severe withdrawal reaction, such as seizures, delirium tremens or psychotic episode.
 3. Intoxicated with a history of recent, severe idiosyncratic intoxication, such as violence or blackouts while under the influence.
 4. In addition to alcohol/drug condition, member has a co-existing medical and/or psychiatric condition that requires medical and psychiatric services.
 5. Recent history of alcohol or other drug abuse and is currently unable to control abuse outside of a restrictive 24-hour care environment that is demonstrated by documented recent failed attempts.
 6. Dependency or abuse must be contributing to severe social and/or emotional dysfunction in one or more life spheres, e.g., vocational, familial, or social.

Outpatient Substance Abuse Services

Outpatient substance abuse services are covered under the case management service of the Medicaid Rehabilitation Option (MRO) program. PA is not required for MRO case management services. Case management services are available for IHCP members ages 18 to 64 years of age and 17 years of age and younger, who are determined to have a substance-related disorder, as defined in 405 IAC 5-21-5. In order to receive case management services for a substance-related disorder, IHCP members must meet all of the following criteria.

1. A substance-related disorder, as defined in the DSM-IV.
2. Significant functional impairments in two of the following areas.
 - a. Activities of daily living
 - b. Interpersonal functioning
 - c. Ability to live without recurrent use of chemicals
 - d. Psychological functioning

3. The duration of the addiction has been in excess of twelve months. However, members who have blackouts, convulsions, or other serious medical consequences of withdrawal from substance abuse and/or chemical dependency do not have to meet the durational requirement of these criteria.

MEDICAL POLICY FACT SHEET

**TITLE: SURGERY—MULTIPLE PROCEDURES/SAME
OPERATIVE SESSION**

DESCRIPTION:

Multiple surgical procedures may be performed on the same patient on the same day when it is determined a benefit to the surgeons and patient for the best outcome for the patient.

SUMMARY OF CURRENT POLICY:

Reimbursement for two or more surgeries performed during the same operative period will be subject to the rules set forth in 405 IAC 5-28-1(g). The most expensive procedure being paid at the full-allowed amount (100%), the second procedure at one-half (50%) of its allowed amount and the third procedure at twenty-five percent (25%) of its allowed amount. Documentation may be required to indicate medical necessity for the multiple procedures.

Many surgeries require prior authorization (see 405 IAC 5-3). Prior authorization for multiple surgeries on the same day does not override the restrictions of 405 IAC 5-28.

MEDICAL TOPICS CROSS-REFERENCES:

Gynecology -- Hysterectomy
Obstetric Care
Physician Services
Surgery-Global Billing/Payment Guidelines
Surgery-Office Visits
Surgery-Removal of Implants
Surgery-Services Requiring Prior Authorization
Surgery-Surgery and Anesthesia By the Same Provider
Surgery-Surgeon and Assistant Surgeon, Same Provider
Surgery-Surgical Services
Surgery-Suture of Wounds

RULES, CITATIONS, AND SOURCES:

405 IAC 5-28 Medical and Surgical Services

405 IAC 5-1-5 Global Fee Billing

Indiana Health Coverage Programs Provider Manual 1999

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
470 IAC 5-9-1 Transferred	Global fee billing	7/1/91		
405 IAC 1-7 Repealed 8/24/97	Global fee billing	1/1/92		
Revisions:				
405 IAC 5-28	Medical and surgical services	8/24/97		
405 IAC 5-1-5	Global fee billing	8/24/97		

APPLICABLE INDIANA A/M EDITS AND AUDITS:

6651

6665

COVERAGE CRITERIA:

MEDICAL POLICY FACT SHEET

TITLE: SURGERY—OFFICE VISITS

DESCRIPTION:

Prior to the performance of a surgical procedure, either inpatient or outpatient, the patient consults with the surgeon who will be performing the procedure. The visit can occur in the physician's office, in the emergency room, or in the out-patient surgery area.

SUMMARY OF CURRENT POLICY:

Office visits made with the surgeon prior to the scheduling of surgery are billed under the global surgery payment/billing rules. Certain modifiers may be used to distinguish a preoperative visit from a more in-depth visit at which time the decision was made for surgery, a significant, separately identifiable evaluation and management visit was made the same day of surgery, the surgeon served as a consultant for a second or third opinion, or an unrelated procedure or service by the same physician during the post-operative period. The appropriate modifier should be used to claim payment for these services.

MEDICAL TOPICS CROSS-REFERENCES:

Emergency Medicine

Surgery; Orthopedic, Otolaryngology, Ophthalmology, Thoracic, Urology, Vascular
Physician Office Services

RULES, CITATIONS, AND SOURCES:

405 IAC 5-25-1

405 IAC 5-25-2

IC 12-8-6-3

IC 12-8-6-5

IC 12-15-1-10

IC 12-15-21-2

IC 12-15-21-3

Indiana Health Coverage Programs Provider Manual 1999

Initial Policy	Issues	Date Approved By Authority	Date Applied To Program	Date Implemented In Program
405 IAC 5-9-1; 5-9-11 Transferred				01/01/92
Revisions:				
405 IAC 1-7-9 Repealed				01/01/92
405 IAC 5-25- 1;5-58-2				08/24/97

APPLICABLE INDIANA A/M EDITS AND AUDITS:

764

765

766

770

COVERAGE CRITERIA:

MEDICAL POLICY FACT SHEET

**TITLE: SURGERY - PLASTIC/RECONSTRUCTIVE
GENITOURINARY AND BREAST**

DESCRIPTION

Plastic or reconstructive surgery is intended to restore the normal appearance or function of tissues or body structures that are missing, defective, damaged, misshapen, or that have been significantly altered due to disease, trauma, surgery, or congenital anomalies. When a significant functional impairment is present, reconstructive services may be considered medically necessary; however, if significant functional impairment is not present, reconstructive services may not be considered medically necessary.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the “Rules, Citations, and Sources” section of this document for further information.

COVERAGE CRITERIA

The IHCP will provide reimbursement for reconstructive or plastic surgery for congenital defects, developmental anomalies, trauma, infection, tumors, or disease. Reconstructive or plastic surgery is generally performed to improve function, but may also be done to approximate a normal appearance. Prior authorization (PA) must be obtained.

Breast reconstruction is surgery performed to revise or change the configuration of the breast (male or female). Reduction mammoplasty is the surgical removal of a substantial portion of the breast(s), including the skin and underlying glandular tissue, until a clinically normal size is obtained. Bilateral surgery is usually performed; however, when there is significant hypertrophy of one breast, resulting in an abnormal appearance between the member's breasts, a unilateral breast reduction may be performed. Such a procedure may also be needed to achieve symmetry of the contralateral side when the opposite breast has been reconstructed after mastectomy.

IHCP reimbursement is not available for breast reconstruction to reshape the normal structure to improve appearance or self-esteem. IHCP reimbursement is not available for cosmetic symptoms including ptosis, poorly fitting clothing, unacceptable appearance, or

nipple-areolar distortion. In addition, the use of liposuction to perform breast reduction is considered investigational. Therefore, IHCP reimbursement is not available.

Reconstructive surgery is considered medically necessary for missing, defective, damaged, or misshapen structures of the genitourinary system. Additionally, the IHCP will provide reimbursement if a member has had significant alterations due to disease, trauma, surgery, or congenital anomalies. Prior authorization is required for reconstructive surgery.

The IHCP does not provide reimbursement for the following.

1. Scar removal or tattoo removals by excision or abrasion
2. Penile implants
3. Perineoplasty for sexual dysfunction
4. Tubal reanastomosis for the purpose of infertility

The IHCP defines intersex surgery as surgical intervention for members having congenital anomalies, resulting in both male and female characteristics. The IHCP considers intersex surgery medically necessary for congenital anomalies that result in a member having ambiguous genitalia. Documentation in the member's medical record is required to support medical necessity. All other intersex surgery is not covered. Intersex surgeries require prior authorization.

PRIOR AUTHORIZATION

Breast Reduction

The IHCP will provide reimbursement for breast reduction surgery in females. Documentation must be maintained in the member's medical record. Prior authorization criteria is as follows.

1. History of the member's symptoms for at least six months related to the large, pendulous breasts must include the following.
 - Neck and shoulder pain
 - Low back pain
 - Strap mark indentation
 - Restriction of physical activities
 - Poor posture
 - Skin irritation (submammary intertigo)

2. Asymmetry of the breasts will not be authorized unless it is done to achieve symmetry of the contralateral side when the opposite breast has been reconstructed after mastectomy for cancer.
3. Specific weight guidelines vary with the height and weight of the member. **Table 1**, on the following page, displays the height and weight categories with the minimum amount of breast tissue expected to be removed. Variances may occur which are not accommodated by this table; these variances will be reviewed on an individual basis.

Table 1. Expected Minimum Amount of Breast Tissue to be Removed

Height	Weight	Expected Amount of Breast Tissue to be Removed
Under 5'	Less than 140 lbs	300 Gm per breast
5' – 5'4"	Up to 180 lbs	350 Gm per breast
5'4" – 5'7"	Up to 220 lbs	400 Gm per breast
5'7" and up	211 lbs and greater	500 Gm per breast

The IHCP will provide reimbursement for breast reduction surgery in males that are over age 18 years of age or 18 months after the end of puberty, for gynecomastia, when medically necessary. PA criteria is as follows.

1. The tissue to be removed is glandular breast tissue and not the result of obesity, adolescence, or reversible effects of a drug treatment which can be discontinued. Documentation must be maintained in the medical record.
2. Documentation in the medical record indicates the conditions which may be associated with gynecomastia and includes, but is not limited, to the following.
 - Documented androgen deficiency
 - Chronic liver disease that causes decreased androgen availability
 - Klinefelter's syndrome (Chromosome 47XYY Syndrome)
 - Adrenal tumors that cause androgen deficiency or increased secretion of estrogen
 - Brain tumors that cause androgen deficiency
 - Testicular tumors causing androgen deficiency or tumor secretion of estrogen
 - Endocrine disorders, such as hyperthyroidism

Table 2 below lists the codes for reporting breast reduction and reconstruction surgeries. Additionally, **Table 2** reflects the PA requirement for the individual codes.

Table 2 - Codes for Reporting Breast Reduction and Reconstruction Surgeries

CPT Code	Description	PA Requirement
19140	Mastectomy for gynecomastia	Yes
19316	Mastopexy	No
19318	Reduction mammoplasty	Yes
19325	Mammoplasty, augmentation; with prosthetic implant	Yes

Table 2 - Codes for Reporting Breast Reduction and Reconstruction Surgeries

CPT Code	Description	PA Requirement
19328	Removal of intact mammary implant	No
19330	Removal of mammary implant material	No
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	Yes
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy, or in reconstruction	Yes
19350	Nipple/areola reconstruction	No
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	No
19361	Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant	No
19364	Breast reconstruction with free flap	No
19366	Breast reconstruction with other technique	No
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;	No
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM) single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)	No
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site	No
19370	Open periprosthetic capsulotomy, breast	No
19371	Periprosthetic capsulectomy, breast	No
19380	Revision of reconstructed breast	No

Genitourinary Surgery

The IHCP provides reimbursement for female reconstructive surgery with PA for one of the following conditions. Documentation supporting medical necessity must be maintained in the medical record.

1. Agenesis of the vagina
2. Post-trauma
3. Post cancer therapy

The IHCP provides reimbursement for male reconstructive surgery with PA in the following circumstances. Documentation supporting medical necessity must be maintained in the medical record.

1. Absence of testicle as a result of illness, injury, or congenital anomaly
2. No evidence of active infection, malignancy, or current treatment for malignancy

The IHCP provides reimbursement for intersex surgery with PA for congenital anomalies, resulting in a member having ambiguous genitalia. Documentation supporting medical necessity must be maintained in the medical record.

Table 3 below reflects the codes for reporting female and male reconstructive surgery and intersex surgeries. Additionally, **Table 3** reflects the PA requirement for each code.

Table 3 - CPT Codes for Reporting Reconstructive Genitourinary Surgery

CPT Code	Description	PA Requirement
54660	Insertion of testicular prosthesis (separate procedure)	Yes
54670	Suture or repair of testicular injury	No
55970	Intersex surgery; male to female	Yes
55980	Intersex surgery; female to male	Yes
56805	Clitoroplasty for intersex state	No
57291	Construction of artificial vagina; without graft	No
57292	Construction of artificial vagina; with graft	No
57335	Vaginoplasty for intersex state	No

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. IHCP members enrolled in Hoosier Healthwise PrimeStep [Primary Care Case Management (PCCM)] receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid Fee-For-Service (FFS). Refer to the Hoosier Healthwise Manual for Primary Medical Providers and Office Staff for further information.

Refer to the IHCP Provider Manual, Chapter 1, for detailed information about the FFS, PCCM, and RBMC delivery systems.

BILLING REQUIREMENTS

PA does not guarantee reimbursement for services. Documentation supporting medical necessity must be maintained in the medical records. Providers are advised to report the procedure code that best describes the services rendered.

Providers submitting claims for CPT codes 55970 and 55980, reporting intersex surgeries, must submit documentation to substantiate the procedure performed. The physician's notes or the operative notes are to be submitted with these submitted claims.

RELATED MEDICAL TOPICS

Consultations & Second Opinions

Hospital Inpatient

Hospital Outpatient

RULES, CITATIONS, AND SOURCES

Indiana Administrative Code

405 IAC 5-13 – Services requiring prior authorization

405 IAC 5-29-1 – Noncovered services

Indiana Health Coverage Program Provider Manual

Version 5.1, March, 2005

Indiana Health Coverage Programs Provider Newsletters

NL200501 – Physician Services

Indiana Health Coverage Programs Provider Bulletins

BT200208 – Modifications to Prior Authorization Requirements

Origination Date: 7/29/05

Revisions and Review	Reason	Date
Revision	Scheduled review and separation of the Global Surgery Fact Sheet into multiple fact sheets	07/29/05

APPLICABLE INDIANA A/M EDITS AND AUDITS

6002 – Any Two Anesthesiology Providers Same Procedure Requires Review

6003 – Manual Pricing for Split Care Billing

6034 – Global Surgery Payable at Reduced Amount When Components of Surgical Care Paid

6035 – Components of Surgical Care Not Payable When Global Surgery Paid

6037 – Only One Assistant Surgeon Allowed for Select Surgeries

6039 – Assistant Surgeon Not Payable When Co-Surgeon Paid

6040 – Co-Surgeon Not Payable When Assistant Surgeon Paid

6061 – Components Not Payable When Global Paid – Genital Urinary/Reproductive Systems

6096 – The CPT/HCPCS Code Billed Is Not Payable According to the PPS Reimbursement Methodology

6152 – Surgery Payable at Reduced Amount When Consultation Paid Days Before or After Surgery

6650 – Lifetime Procedures Are Limited to One Per Lifetime

6652 – Multiple Surgeries Must Be Billed on Same Claim

6661 – Duramorph Cannot Be Billed on the Same Day As Surgery

6665 – Bilateral Versus Unilateral Surgeries

6666 – Anesthesia Services Not Allowed By Provider Billing for Surgery

6706 – Global Payable at Reduced Fee When Components Paid – Genital Urinary/Reproductive Systems

MEDICAL POLICY FACT SHEET

**TITLE: SURGERY - PLASTIC AND RECONSTRUCTIVE SURGERY
FACIAL AND MAXILLOFACIAL**

DESCRIPTION

Facial plastic surgery is a general term for any surgery that proposes to alter the appearance of the face and includes the restoration of appearance after accidental injury or correction of a physical functional impairment caused by an accidental injury, a congenital anomaly, disease, or previous therapeutic process. Reconstructive surgery may require completion in staged procedures.

Maxillofacial surgery includes the diagnosis and surgical treatment of congenital or acquired diseases, dysfunction, defects, or injuries of the mouth, jaws, face, neck, and associated regions. Maxillofacial surgical services are provided by individuals licensed to practice dentistry that have completed an approved residency in oral surgery and eligible for certification by the Board of Oral and Maxillofacial Surgery or physicians who have completed residency training in plastic surgery and are eligible for certification by the American Board of Plastic Surgery.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding these services. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC), or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

I. FACIAL PLASTIC AND RECONSTRUCTIVE SURGERIES

The IHCP provides reimbursement for facial plastic or reconstructive surgery related to disease or trauma, specifically for surgery that alters the appearance of the lower face including the upper jaw, lower jaw, and chin. Surgery for these portions of the face may be considered cosmetic, or may be indicated when severe abnormalities result in functional impairment affecting the ability to eat, swallow, or breathe. Procedures may be indicated to correct or restore appearance following traumatic injuries or following medical or surgical treatments that result in anatomical changes.

The IHCP will provide reimbursement with prior authorization for surgical procedures to remove excess skin from the face and tighten the muscles of the face to correct a facial abnormality; for example, following burn injury or facial palsy from neurologic disease. IHCP reimbursement is

not available for surgical procedures to remove excess skin from the face and tighten the muscles of the face for members with no functional impairments, disease, or injury-related facial changes.

A. Craniofacial Deformities

Coverage Criteria for Craniofacial Deformities

Major mid-face craniofacial deformities of the facial bones or skull may require corrective reconstructive surgeries due to abnormal development in position, size, or shape. There are multiple diagnoses, such as Crouzon, Apert, Pfeiffer, Saethre-Chotzen, Carpenter, and Antley-Bixler that cause restricted growth of the midface. Members with these craniofacial midface diseases often require long-term monitoring of the ears, nose, and throat for occurrence of the following conditions that are frequently related to mid-face anomalies.

- Vision, hearing, speech, and language disabilities
- Learning disabilities
- Orthodontic problems due to abnormal shape and position of the jaw
- Abnormalities in the facial skeleton about the orbits, maxilla, and mandible
- Skull deformities, including a narrow width and an elongation from front to back
- Triangularly shaped skull, often with ridging in the midline of the forehead
- Flattening of the forehead on one side with bulging on the opposite side
- Proptosis (bulging eyes)
- Strabismus (wandering eye)
- Dry eyes
- Corneal ulcers
- Blindness (if corneal damage is untreated)
- Upper airway obstruction with sleep apnea (partial or complete cessation of respiration during sleep)

Nasal deformities may be congenital or acquired. Rhinoplasty is to change the shape or size of the nose is considered medically necessary when performed as a result of disease, structural abnormality, previous therapeutic process or reconstruction due to trauma. Septoplasty is the surgical procedure to correct defects or deformities of the nasal septum, often by alteration or partial removal of skeletal structures. Septoplasty is considered medically necessary when there is a functional impairment that does not respond to medical management treatment. Documentation must support failed conservative, medical interventions for severe airway obstruction.

Prior Authorization for Craniofacial Deformities

PA is required for most rhinoplasty and septoplasty services. However, PA is not required for members receiving rhinoplasty surgery related to a documented, primary diagnosis of cleft lip and/or cleft palate. Please refer to the section of this fact sheet that describes cleft lip and cleft palate services for additional information.

Congenital birth defects have a variety of presentations including cleft nasal deformity, which may be associated with cleft lip and/or cleft palate, characterized by distorted,

abnormally developed nasal structures. Deviations in the septum can alter normal airflow, which may result in mucosal changes. This interference in airflow may cause middle or inferior turbinate abnormalities. Additionally, sinus drainage may be compromised by deviation of the septum and can result in recurrent or chronic sinusitis. Surgical correction of congenital birth defects may involve staged procedures, flaps, or grafts. **Table 1**, on page 5, contains CPT codes utilized to report rhinoplasty services.

- Rhinoplasty is medically necessary when performed for correction or repair of the following conditions.
 - Nasal deformity secondary to a cleft lip/palate or other congenital craniofacial deformity causing functional impairment
 - Chronic, non-septal, nasal obstruction due to vestibular stenosis (collapsed internal valves) secondary to trauma, disease, or congenital defect, when both of the following criteria are met:
 - Documentation of the member's condition
 - Nasal airway obstruction unresponsive to a recent trial of conservative medical management that either has not resolved or would not be expected to resolve with septoplasty/turbinelectomy alone
- Septoplasty is medically necessary when performed for the following conditions.
 - Recurrent epistaxis related to septal deformity
 - Asymptomatic septal deformity that prevents access to other transnasal areas when such access is required to perform medically necessary procedures (e.g., ethmoidectomy)
 - In association with cleft lip or cleft palate repair
 - Obstructed nasal breathing due to septal deformity or deviation that is unresponsive to medical management and is interfering with the effective use of medically necessary continuous positive airway pressure (CPAP) for treatment of obstructive sleep disorder

B. External Ear Disorders

Coverage Criteria for External Ear Disorders

Microtia is a condition defined by an external ear that is not fully formed. Often, there is an associated malformation of the external auditory canal and the middle ear bones which transmit vibration of the eardrum to the cochlea. These anomalies occur as a part of many developmental anomalies of the head and neck. Conductive hearing loss may be associated with an abnormality of the external ear canal or middle ear. If hearing loss occurs in both ears, hearing aid devices may be considered to regain functional hearing ability.

Prior Authorization for External Ear Disorders

The IHCP will provide reimbursement for, but is not limited to, the CPT codes included in **Table 1**, on page 5, for members with repair and/or reconstruction of the external ear. The

codes in **Table 1** are not meant to be all inclusive. Prior authorization will be granted based on documentation of medical necessity maintained in the member's medical record.

- History of the etiology of the external ear deformity
- Any other medical documentation that supports the member's need of this service that will assist in the review process
- Absence of any additional medical condition jeopardizing the end result of the surgery or surgeries. These might include, for example, a suppressed immune system, a current infection that is unresponsive to medical management, or medical instability following illness or injury

C. Facial Nerve Disorders

Coverage Criteria for Facial Nerve Disorders

Facial nerve disorders often result from inflammation, infection, injury, or tumors in the nerve tissue. Common symptoms of facial nerve disorders include, but are not limited to, the conditions listed below.

- Numbness of the face
- Dryness of the eye secondary to reduced tear production
- Dryness of the mouth secondary to reduced saliva production
- Eyelid retraction and poor blinking mechanism
- Malpositioned eyelid and eyebrow
- Abnormal facial movement
- Facial twitching and/or spasms
- Disturbance of taste
- Restricted breathing
- Weakness of the arm, fingers, and hand on the same side as the facial weakness

Many types of nerve anomalies necessitate multiple operative procedures occurring at different stages of skeletal development. When facial nerve injury occurs, treatment may include repair or grafting of nerve tissue. The treatment of neurologic disorders may require surgery that includes the following procedures.

- Facial nerve decompression
- Nerve repair and grafting
- Reinnervation techniques
- Regional muscle transfers
- Free muscle transfers

Physical therapy will improve functional outcomes allowing surgical repair of facial nerves, especially for patients requiring tissue transfer. Physical therapy utilizes facial neuromuscular retraining to optimize the motor control of facial muscles. Refer to the Therapy Services fact sheet for physical therapy PA requirements.

PA Criteria for Facial Disorders

The IHCP will provide reimbursement for, but is not limited to, the CPT codes included in **Table 1**, on page five, for the members with midface disorders, nasal deformities, external ear disorders, and facial disorders. Providers are advised to report the most appropriate code for the procedure performed. The prior authorization requirement is indicated for each CPT code. The following information on the must be maintained in the member's medical record.

- History of the presenting problem
- Symptoms related to the facial disorder
- Previously attempted, less-invasive medical management treatment that has failed
- Any other medical documentation that supports the member's need of this service
- Absence of any additional medical condition jeopardizing the end result of the surgery. These might include; for example, a suppressed immune system, a current infection unresponsive to medical management, or medical instability following illness or injury.

**Table 1 – CPT Codes for Midface Disorders, Nasal Deformities,
External Ear Disorders, and Facial Disorders**

CPT Code	Description	PA Requirement
21137	Reduction forehead; contouring only	Yes
21138	Reduction forehead; contouring and application of prosthetic material or bone graft	Yes
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall	Yes
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	Yes
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	Yes
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)	Yes
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	Yes
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	Yes
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	Yes
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial	Yes
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete	Yes
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)	Yes

**Table 1 – CPT Codes for Midface Disorders, Nasal Deformities,
External Ear Disorders, and Facial Disorders**

CPT Code	Description	PA Requirement
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)	No
21270	Malar augmentation, prosthetic material	Yes
21295	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach	Yes
21296	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach	Yes
21299	Unlisted craniofacial and maxillofacial procedure	Yes
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	Yes
30410	Rhinoplasty complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	Yes
30420	Rhinoplasty complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip including major septal repair	Yes
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	Yes
30435	Rhinoplasty, intermediate revision (bony work with osteotomies)	Yes
30450	Rhinoplasty, major revision (nasal tip work and osteotomies)	Yes

D. Blepharoplasty

Coverage Criteria for Blepharoplasty

Blepharoplasty is a surgical procedure that removes excess skin and fatty tissue around the eyes. The IHCP provides reimbursement for blepharoplasties to improve abnormal function resulting in significant visual field loss or to reconstruct deformity due to trauma or a disease process. Reimbursement is not provided for blepharoplasties to enhance the appearance of the eyes.

PA Criteria for Blepharoplasty

PA is required for all blepharoplasties and documentation must support the medical necessity to improve abnormal function that has resulted in significant visual field loss or to reconstruct deformity due to trauma or a disease process as described on the next page. IHCP reimbursement for reporting services related to blepharoplasty includes, but is not limited to, the codes listed in **Table 2**.

Table 2 – Codes for Reporting Blepharoplasty

CPT Code	Description	PA Requirement
15820	Blepharoplasty, lower eyelid;	Yes
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	Yes
15822	Blepharoplasty, upper eyelid;	Yes
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	Yes
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	Yes
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material	Yes
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)	Yes
67903	Repair of blepharoptosis; (tarso)levator resection or advancement, internal approach	Yes
67904	Repair of blepharoptosis; (tarso)levator resection or advancement, external approach	Yes
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	No
67911	Correction of lid retraction	No
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)	Yes
67914	Repair of ectropion; suture	No

PA will be granted for blepharoplasty under the following indications.

- Upper eyelid blepharoplasty to relieve obstruction of central vision when **ALL** of the following criteria are met.
 - Visual field test without the eyelid or brow taped shows points of visual loss inside the 25° circle of the superior field **AND**
 - Visual field test with the eyelid or brow taped shows improvement in the superior field with no visual loss inside the 40° circle of the superior field; **AND**
 - A photograph of the patient looking straight ahead shows the eyelid at or below the upper edge of the pupil
- Upper eyelid blepharoplasty for upper eyelid position that is contributing to prosthesis difficulties in an anophthalmic (complete absence of the eye) socket
- Lower eyelid blepharoplasty to relieve excessive lower lid bulk secondary to systemic corticosteroid therapy, myxedema, Graves' disease, nephritic syndrome, or other metabolic or inflammatory disorders that precludes proper positioning of eyeglasses
- Upper or lower eyelid Blepharoplasty to treat chronic corneal exposure and/or recurrent corneal abrasions caused by conditions such as; ectropion (eyelid turning outward) or entropion (eyelid turning inward)

II. Maxillofacial Services

The IHCP provides coverage for maxillofacial surgery services. PA is required for certain maxillofacial surgeries as described elsewhere in this fact sheet. Providers may be required, based upon the facts of the case, to obtain a second or third opinion substantiating the medical necessity or approach for maxillofacial surgery related to disease and conditions of the jaw and contiguous structures, regardless of the setting in which the procedure is performed. The following maxillofacial services are covered by the IHCP.

- Orthognathic (jaw realignment) surgery with or without osteotomy
 - Treatment of temporomandibular joint (TMJ) syndrome
 - Removal of non-cancerous cysts, tumors, and growths of the oral and facial region
 - Surgical removal of impacted teeth
 - Treatment of facial fractures
 - Treatment of soft tissue trauma
 - Osseointegrated (bone anchored) implants, including dental and craniofacial implants
 - Adjunctive treatment of sleep apnea including mandibular advancement splints and jaw advancement surgery
 - Reconstructive surgery for disease or trauma
 - Salivary gland surgery
 - Radiology services for evaluation of maxillofacial anomalies
-
- Anesthesia services for maxillofacial surgery

A. Orthognathic (Jaw Realignment) Surgery

Orthognathic surgery is the revision of the upper jaw (maxilla) and/or the lower jaw (mandible) by ostectomy, osteotomy, or osteoplasty, and is intended to alter the relationship of the jaws and teeth. These surgical procedures are intended to correct jaw and cranio-facial deformities that are associated with significant functional impairment, or to reposition the jaws when conventional orthodontic therapy is unable to correct dental malocclusion.

Coverage Criteria for Orthognathic (Jaw Realignment) Surgery

The IHCP reimburses orthognathic surgery to correct jaw and craniofacial deformities causing significant functional impairment for members with congenital abnormality present at birth, or to treat a significant accidental injury, infection, or tumor when ONE OR MORE of the following clinical indications are met.

1. Anteroposterior discrepancies

- Maxillary/mandibular incisor relationship: overjet of 5 mm or more, or a value less than or equal to zero (norm 2 mm)
- Maxillary/mandibular anteroposterior molar relationship discrepancy of 4 mm or more (norm 0 to 1 mm)
- These values represent two or more standard deviations from published norms

2. Vertical discrepancies

- Presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks
- Open bite
 - No vertical overlap of anterior teeth
 - Unilateral or bilateral posterior open bite greater than 2 mm
- Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch
- Supraeruption of a dentoalveolar segment due to lack of occlusion

3. Transverse discrepancies

- Presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms
- Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth

4. Asymmetries

- Presence of anteroposterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry. ONE of the following symptoms must be present due to the malocclusion.
- Difficulty swallowing and/or choking, or ability to chew only soft or liquid food;
- Symptoms must be documented in the medical record, must be significant, and must persist for at least four months
- Other causes of swallowing/choking problems must have been ruled out by history, physical exam, and/or appropriate diagnostic study including, but not limited to, allergies, neurologic or metabolic diseases, and hypothyroidism
- Speech abnormalities have been determined by a speech pathologist or therapist to be due to the malocclusions and not improved by speech therapy or orthodontia
- Malnutrition must be related to the inability to masticate, significant weight loss must be documented over 4 months, and a low serum albumin exists that is related to malnutrition
- Presence of intra-oral trauma while chewing related to malocclusion or recurrent damage to the soft tissues of the mouth during mastication)
- Documentation of significant obstructive sleep apnea that is not responsive or treatable by conservative means

An oral surgeon or a plastic surgeon may provide orthognathic surgical services as the maxillofacial specialist performing the procedure. Other specialists, such as an orthodontist or otolaryngologist may be required to assist with the procedure. The procedure may be performed in an inpatient hospital, outpatient hospital, or ambulatory surgery center (ASC). Orthognathic services are considered medical/professional services, and providers bill these services using appropriate CPT codes on a CMS 1500 claim form or 837P electronic transaction.

Anesthesia for orthognathic surgery may be performed by an anesthesiologist or certified nurse anesthetist, as medically appropriate. The anesthesia service should be billed with the appropriate anesthesia CPT code for the head or neck (00100-00352) on the CMS 1500 claim form or 837P electronic transaction.

Prior Authorization for Orthognathic Surgery and Related Procedures

PA is required for certain maxillofacial procedures related to diseases or conditions of the jaw and contiguous structures, sliding mandibular osteotomies for prognathism (projected jaw) or micrognathism (protracted jaw), and for certain reconstructive or plastic surgeries, including genioplasty. The IHCP provides reimbursement for the codes listed in **Table 3** for orthognathic surgery and related procedures necessary for facial aesthetic surgery. The table indicates whether PA is required for each procedure.

Table 3 – Orthognathic Surgery Codes

CPT Code	Description	PA Requirement
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal	Yes
21125	Augmentation, mandibular body or angle; prosthetic material	Yes
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (include obtaining autograft)	Yes
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, Long Face syndrome), without bone graft	No
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft	No
21143	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, without bone graft	No
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	No
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	No
21147	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)	No
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)	No
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	No
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	No

Table 3 – Orthognathic Surgery Codes

CPT Code	Description	PA Requirement
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I	No
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	No
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining autograft)	No
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	No
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	No
21198	Osteotomy, mandible, segmental	No
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	Yes
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	No
21209	Osteoplasty, facial bones, reduction	Yes
21210	Graft, bone, nasal, maxillary, or malar areas (includes obtaining graft)	Yes
21215	Graft, bone, mandible (includes obtaining graft)	Yes
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	Yes

B. Temporomandibular Joint Syndrome

Temporomandibular joint syndrome or temporomandibular joint (TMJ) disorder is a condition resulting from macro-trauma or micro-trauma to the temporomandibular jaw joint and its surrounding muscles and tissues. Macro-trauma is usually a result of direct trauma to the TMJ. Micro-trauma is usually a chronic, indirect process that can be associated with conditions such as stress, anxiety, sleep disorders, dysfunctional occlusions, and myofascial disorders. Causes of TMJ include acute injury, clenching or grinding of the teeth, muscle spasms, dental occlusions, and degenerative joint disease. Common symptoms of TMJ include the following.

- Clicking, popping, grating, or grinding sounds when moving the jaw
- TMJ pain or stiffness while chewing, talking, or yawning
- Facial pain, especially in the ear region
- Jaw locking open or closed
- Difficulty in opening the jaw wide
- Uncomfortable bite
- Headache or earache

Coverage Criteria for Treatment of TMJ

The IHCP will cover both non-surgical and surgical treatments for TMJ. There are several approaches to treatment for TMJ based on the cause and severity of the disease; however, most members can be treated without surgery. IHCP members must receive a trial of conservative therapy before surgical treatment for TMJ will be prior authorized.

Nonsurgical Treatment of TMJ

Documentation in the member's medical records must indicate that at least two of the following forms of non-surgical interventions have been performed for a total of three to six months without adequate relief of symptoms prior to being evaluated for surgical treatment of TMJ.

1. Medical management may include non-opiate analgesics and non-steroidal anti-inflammatory drugs (NSAIDS) for mild-to-moderate inflammatory conditions and pain. Low-dosage tricyclic antidepressants may be prescribed for chronic pain, sleep disturbances, and nocturnal bruxism. Adjuvant pharmacologic therapies may include anticonvulsants, membrane stabilizers, and sympatholytic agents for unremitting pain, and opiate analgesics, corticosteroids, anxiolytics, and muscle relaxants for refractory pain. Osteopathic manipulative therapy may be included as part of the medical management prescribed. Medical management may be prescribed by a dentist, orthodontist, an ear nose and throat (ENT) specialist, psychiatrist, or oral surgeon.
2. Physical therapy (PT) for TMJ may include active and passive jaw exercises, thermal modalities, manipulation modalities, electrogalvanic stimulation, and transcutaneous electrical nerve stimulation (TENS). **Table 4**, on the next page, lists the appropriate codes to report PT for TMJ. Cranial manipulation, continuous passive motion, diathermy, infrared, and ultrasound treatment, hydrotherapy, myofunctional therapy, iontophoresis, and neuromuscular re-education are not considered medically necessary physical therapy treatments for TMJ. PA is required for physical therapy as designated below. Refer to the Medical Policy fact sheet entitled Therapy Services for further information regarding physical therapy services.

Table 4 – Physical Therapy Codes for TMJ

CPT Code	Description	PA Requirement
64550	Application of surface (transcutaneous) neurostimulator	No
97010	Application of a modality to one or more areas; hot or cold packs	Yes
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	No
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Yes
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	No

3. Psychiatric/psychological therapy may be initiated when TMJ is caused by a psychosomatic condition due to stress or anxiety. For example, bruxism, or teeth grinding, considered a psychophysiological disorder, is a common tension habit that can lead to TMJ. IHCP members without other obvious causative factors for TMJ symptoms (such as major trauma, arthritis, and jaw misalignment) should be evaluated for psychosomatic causes, and treated as appropriate. The IHCP will reimburse for the psychiatric codes listed in **Table 5**, in relation to treatment of TMJ.

Table 5 – Psychiatric Codes for TMJ Therapy

CPT Code Range	Description	PA Requirement
90801	Psychiatric diagnostic interview	No
90804-90809	Behavior modifying and/or supportive psychotherapy (office/outpatient)	No
90816-90822	Behavior modifying and/or supportive psychotherapy (inpatient, residential care)	No
90846-90853	Family and group psychotherapy	No

4. Mechanical therapy is provided through removable intra-oral appliances. Intra-oral appliances are used to treat members with dysfunctional occlusions. Treatment generally lasts for up to six months. The IHCP will provide reimbursement for intra-oral appliances, using HCPCS code E1700, *Jaw motion rehabilitation system*. No PA is required. Intra-oral appliances may be provided by a dentist, ENT specialist, orthodontist, or oral surgeon.

Surgical Treatment of TMJ

Treatment of TMJ by maxillofacial surgery will be covered if both of the following conditions are met.

1. A physical exam, diagnostic X-rays (70328-70330), arthrography (70332), or orthopantomogram (70355), and diagnostic imaging (CT, MRI, or arthroscopy) indicate an intra-articular cause of TMJ.
2. At least two non-surgical methods of treatment, as described previously, have been tried and have failed to adequately relieve the member's symptoms. Documentation in the medical record must establish that non-surgical treatment has been attempted for a period of three to six months prior to a request for prior authorization for surgery.

Prior Authorization for the Surgical Treatment of TMJ

PA is required for a diagnostic arthroscopy (29800) and an arthrotomy of the TMJ joint (21010). **Table 6**, on page 14, lists the radiology codes for evaluation of TMJ that are covered by the IHCP. **Table 7**, on page 14, lists the codes for reporting treatment of TMJ that are covered by the IHCP. PA requirements are noted in both tables.

Prior authorization will be granted for surgical treatment of TMJ under the following circumstances. Documentation must be maintained in the member's medical record and be submitted for prior authorization of these procedures.

1. Arthrocentesis is covered when the following conditions are met.
 - Persistent pain for more than three to six months that cannot be controlled by non-surgical treatment
 - Clinical examination and/or diagnostic imaging that indicates the presence of hypomobility of the TMJ joint
 - Medically necessary instillation of therapeutic drugs into the joint
2. Arthroscopy is covered when the following conditions are met.
 - Persistent pain for more than three to six months that cannot be controlled by non-surgical treatment
 - Clinical examination and/or diagnostic imaging indicates joint pathology such as internal derangement, hypomobility, or hypermobility that requires internal structural modification
3. Arthrotomy, disc plication, discectomy, and arthroplasty with or without autograft and allograft are covered when the following conditions are met.
 - Persistent pain for more than three to six months that cannot be controlled by non-surgical treatment
 - Severe, unremitting pain
 - Clinical examination and/or diagnostic imaging indicates joint pathology, such as internal derangement, hypomobility, or hypermobility that requires internal structural modification where minimally invasive surgery, such as arthrocentesis or arthroscopy, is not appropriate or has failed
4. Arthroplasty with total prosthetic joint replacement is covered when the following conditions are met.
 - Inflammatory arthritis involving the TMJ which is not responsive to other modalities of treatment
 - Recurrent fibrosis and/or bony ankylosis not responsive to other modalities of treatment
 - Failed tissue graft
 - Failed previous joint reconstruction
 - Loss of vertical mandibular condylar height due to bone reabsorption, trauma, developmental abnormality, or pathologic lesion

Table 6 – Radiology Codes for the Evaluation of TMJ

CPT Codes	Description	PA Requirement
70328	Radiology examination, temporomandibular joint, open and closed mouth; unilateral	No
70330	Radiology examination, temporomandibular joint, open and closed mouth; bilateral	No
70332	Temporomandibular joint arthrography, radiological supervision and interpretation	No
70336	Magnetic resonance (e.g., proton) imaging, temporomandibular joints	No
70450	Computed tomography, head or brain; without contrast material	No
70460	Computed tomography, head or brain; with contrast material(s)	No
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections	No
70486	Computed tomography, maxillofacial areas; without contrast material	No
70487	Computed tomography, maxillofacial areas; with contrast material(s)	No
70488	Computed tomography, maxillofacial areas; without contrast material, followed by contrast material(s) and further sections	No

Table 7 – Surgery Codes for the Treatment of TMJ

CPT Codes	Description	PA Requirement
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa)	No
21010	Arthrotomy, temporomandibular joint	Yes
21050	Condylectomy temporomandibular joint	No
21060	Menisectomy, partial or complete, temporomandibular joint (separate procedure)	No
21070	Coronoidectomy (separate procedure)	No
21116	Injection procedure for temporomandibular joint arthrography	No
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	No
21242	Arthroplasty, temporomandibular joint, with allograft	No
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	No
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	No
21485	Closed treatment of temporomandibular dislocation; complicated (e.g., recurrent requiring intermaxillary fixation or splinting), initial or subsequent	No
21490	Open treatment of temporomandibular dislocation	No
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	Yes
29804	Arthroscopy, temporomandibular joint, surgical	No

Anesthesia for the Surgical Treatment of TMJ

Local anesthesia is usually adequate arthrocentesis and arthroscopic TMJ procedures. The local anesthesia is included in the reimbursement for the procedure. General anesthesia may be necessary for other TMJ procedures. General anesthesia may be performed by an anesthesiologist or certified nurse anesthetist, as medically appropriate. IHCP providers are advised to report professional service for anesthesia with the appropriate anesthesia CPT code for the head or neck (00100-00352) on the CMS 1500 claim form or 837P electronic transaction.

Billing for the Surgical Treatment of TMJ

An oral surgeon or plastic surgeon may provide radiologic and surgical services as the maxillofacial specialist treating TMJ. Surgical treatments for TMJ are considered medical/professional services; therefore, providers must bill these services using the appropriate CPT code on a CMS 1500 or 837P electronic transaction. Arthrocentesis, arthroscopy, and uncomplicated, closed treatment of TMJ dislocation may be performed in an office setting, as well as an outpatient or ASC setting. The remaining procedures may be performed in an inpatient hospital, outpatient hospital, or ASC setting.

III. CLEFT LIP AND CLEFT PALATE

Cleft lip and cleft palate are congenital defects which occur during in-utero stages of development. Cleft lip is a separation of the two sides of the lip. This separation may include the bones of the upper jaw and/or upper tissue of the gum. Cleft palate is an opening in the roof of the mouth in which the two sides of the palate did not fuse or join together. Either defect may occur unilaterally or bilaterally.

Cleft palate and cleft lip may cause problems related to eating, speaking, and facial structure. The following findings are common problems resulting from these developmental defects.

- Swallowing difficulties
- Middle ear dysfunction
- Speech difficulties
- Poor facial muscle control
- Abnormal dentition

Coverage Criteria for Cleft Lip and Cleft Palate

The IHCP stipulates that the treatment of cleft lip and cleft palate must be provided by a craniofacial interdisciplinary team of health care professionals. According to the American Cleft Palate-Craniofacial Association, the following health disciplines may be included in the overall treatment process.

- Anesthesiology
- Audiology
- Dentistry
- Genetic counseling
- Neurology
- Ophthalmology

- Oral and maxillofacial surgery
- Orthodontics
- Otolaryngology
- Plastic surgery
- Prosthodontics
- Radiology
- Speech-language pathology
- Social services

The craniofacial team monitors the member's condition throughout treatment and provides any required interventions. Consultation with other professionals may be necessary depending on the member's needs. Specific aspects that are monitored may include, but not be limited to, the following.

- Height and weight
- Nutritional intake and feeding disorder symptoms
- Growth, motor, cognitive, and social development
- Speech and language development
- Hearing status
- Dentition
- Genetic diagnoses

Otolaryngologists, plastic surgeons, and oral surgeons usually recommend surgery to correct left lip and cleft palate deformities. Depending on condition of the member, secondary surgical procedures may be required involving the lip, nose, palate, and jaw. These procedures usually are staged over a period of several years.

Prior Authorization for Cleft Lip and Cleft Palate Services

PA is not needed for cleft lip and cleft palate services, except orthodontic services related to cleft palate. Orthodontic PA requests must be submitted on the Indiana Prior Review and Authorization Request Form, **not** the Indiana Prior Review and Authorization Dental Form. Documentation for services must be maintained in the member's dental or medical record and treatment plan. Members are expected to continue treatment with the same practitioner for the period of treatment time that is prior authorized. If the member must discontinue treatment with one practitioner and begin treatment with another practitioner, the practitioner continuing the treatment must submit a new PA request. The first practitioner must refund part of the reimbursement to the IHCP. Generally, one third of the reimbursement is for the evaluation and treatment plan, and two thirds of the reimbursement is for the actual treatment. Based upon the time remaining in the treatment rendered by a new practitioner, the first practitioner must prorate the amount to be refunded to the program.

Rhinoplasty may be required to treat a cleft lip or cleft palate. Appropriate HCPCS codes for these services include HCPCS code 30460, *Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only*, and HCPCS code 30462, *Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies*. All of the following criteria must be documented in the member's medical record to confirm the medical necessity for these services.

- Documentation of the extent of the deformity and associated symptoms
- Documentation of the plan for surgical correction
- Photographs to verify a plan that includes multiple surgeries
- History and physical including any problems/congenital deformities that could potentially affect the outcome of the requested procedure
- Documented evidence of family/caregiver education about the plan of care and special health care needs of the member, pre and post op
- The requested surgery is expected to correct a specified portion of the deformity
- The requested surgery is expected to improve the member's functional status

Prior Authorization of Orthodontic Services for Craniofacial Deformity or Cleft Palate

Orthodontic services are covered for members with documentation of diagnoses of craniofacial anomaly and malocclusion. All appliances, retainers, and repair or replacement of retainers are included in the fee for the comprehensive treatment and may not be billed separately if comprehensive treatment is rendered. **Table 8** below contains appropriate orthodontic HCPCS codes and descriptions for craniofacial services. All of the following criteria are required to meet medical necessity criteria.

- A member must be diagnosed by a practitioner of a recognized craniofacial team
- The member must be treated by a licensed practitioner, who accepts routine craniofacial members for orthodontic services
- A signed statement from the practitioner, who is a member of a hospital based craniofacial team, will certify the correct craniofacial diagnosis and malocclusion
- The diagnosis must include information a description of facial and soft tissue, skeletal, dental, occlusal, functional, and applicable medical conditions
- A step-wise treatment plan must be submitted with the treatment phase and an approximate length of time for treatment identified
- The PA request must be for the time period specified

Table 8 – Craniofacial Orthodontic HCPCS Codes

HCPCS Code	Description
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8210	Removable appliance therapy
D8220	Fixed appliance therapy

NONCOVERED SERVICES

The IHCP does not provide reimbursement for the following services.

- Blepharoplasties when not related to a significant obstructive vision problem
- Dermabrasion surgery for acne pitting or marsupialization
- Ear piercing
- Ear lobe reconstruction
- Otoplasty for protruding ears unless one of the following applies

- Multifaceted craniofacial abnormalities due to congenital malformation or maldevelopment, such as Pierre Robin Syndrome
 - A member has pending or actual employment where protruding ears would interfere with the wearing of required protective devices
- Removal of keloids caused from pierced ears unless one of the following is present
 - Keloids are larger than three centimeters
 - Obstruction of the ear canal is fifty percent or more
- Rhinoplasty or bridge repair of the nose in the absence of a significant obstructive breathing problem
- Rhytidectomy
- Scar removals or tattoo removals by excision or abrasion

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. IHCP members enrolled in Hoosier Healthwise PrimeStep primary care case management (PCCM) receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid fee-for-service (FFS) members. Refer to the Hoosier Healthwise Manual for Primary Medical Providers and Office Staff for further information. Additionally, refer to the IHCP Provider Manual, Chapter 1, for detailed information about the FFS, PCCM, and RBMC delivery systems.

BILLING REQUIREMENTS

PA does not guarantee reimbursement for services. Documentation supporting medical necessity must be maintained in the medical records. Providers are advised to report the procedure code that best describes the services rendered. Billing requirements for specific procedures are included in this fact sheet.

Reimbursement for cleft lip, cleft palate, and orthodontic services for craniofacial deformity is determined by diagnosis-related group (DRG) relative weights and average lengths of stay. Hospitals cannot bill IHCP members for the difference between payments and actual charges, except for those conditions stated in the IHCP Provider Manual, Chapter 4. Refer to the IHCP Provider Manual for specific information regarding reimbursement for these services.

RELATED MEDICAL TOPICS

Anesthesia Services
Dental Services

Mental Health Services
 Pharmacy – Botulinum Toxin A (BOTOX)
 Speech and Hearing Services
 Surgical Services
 Therapy Services

RULES, CITATIONS, AND SOURCES

Indiana Administrative Code

405 IAC 5-3-13 – Services Requiring Prior Authorization
 405 IAC 5-14-3 – Diagnostic Services
 405 IAC 5-14-21 – Maxillofacial Surgery
 405 IAC 5-28 – Medical and Surgical Services
 405 IAC 5-29-1 – Services Not Covered by Medicaid

IHCP Provider Banners

BR200519 – Flexible Base Dentures

IHCP Provider Bulletins

BT19909 – Removal of Services from Prior Authorization
 BT200109 – HCPCS Code Updates
 BT200208 – Modifications to Prior Authorization Requirement
 BT200230 – Criteria for Orthodontic Services
 BT200231 – Carve Out and Self-Referral Education
 BT200321 – Correct Codes for Billing of IHCP Dental Services
 BT200360 – Changes in DRG Relative Weights and New Long Term Acute Care
 Level- of-Care Reimbursement Methodology

BT200362 – Prior Authorization for Hoosier Healthwise Managed Care

Organizations

IHCP Provider Newsletters

NL200505 – RBMC Carve Out Dental Guidelines

IHCP Provider Manual – March 2005, Version 5.1

Origination Date: 01/31/06

Revisions and Review	Reason	Date
Revision	Scheduled review and separation of the Global Surgery Fact Sheet into multiple fact sheets	1/31/06

APPLICABLE INDIANA A/M EDITS AND AUDITS

6001 – Complete Radiology & Pathology Procedures Payable at Reduced Amt When Professional/Technical Components Already Paid

- 6002 – CRNA/AA and Anesthesiologist Same Procedure Requires Review
- 6003 – Manual Pricing with Split Care Billing
- 6011 – Professional/Technical Components for Radiology or Pathology Not Payable When Complete Procedure Already Paid
- 6034 – Global Surgery Payable at Reduced Amount When Components of Surgical Care Paid
- 6035 – Components of Surgical Care Not Payable When Global Surgery Paid
- 6037 – Only One Assistant Surgeon Allowed for Select Surgeries
- 6039 – Assistant Surgeon Not Payable When Co-Surgeon Paid
- 6040 – Co-Surgeon Not Payable When Assistant Surgeon Paid
- 6049 – Components Not Payable When Global Paid – Integumentary and Neuromuscular System
- 6096 – The CPT/HCPCS Code Billed Is Not Payable According to the PPS Reimbursement Methodology
- 6098 – Chiropractic Services Limited to Procedure and Diagnosis Codes Identified
- 6099 – Reimbursement is Limited to 50 Chiropractic Visits per Calendar Year
- 6100 – Maximum of 60 Chiropractic Therapeutic Physical Medicine Treatments per Calendar Year
- 6110 – Component Procedures Not Payable When Global Procedure Paid – Radiology Services
- 6112 – Maximum of 14 Chiropractic Therapeutic Physical Medicine Treatments per Calendar Year
- 6115 – Physical Therapy Services Limited to 50 Visits per Calendar Year
- 6118 – Occupational Therapy Services Limited to 50 Visits per Calendar Year
- 6120 – Outpatient Mental Health/Substance Abuse Services-Office Visits, Maximum 30 per Calendar Year W/Out Prior Authorization
- 6121 – Outpatient Mental Health/Substance Abuse Services-Office Visits, Maximum Fifty (50) per Calendar Year with Prior Authorization
- 6122 – Chiropractic Therapeutic Physical Medicine Treatments 15 through 50 Require Prior Authorization
- 6171 – One MRT Service per Lifetime
- 6403 – Respiratory Mutually Exclusive Codes CCI
- 6652 – Multiple Surgeries Must Be Billed on Same Claim
- 6661 – Duramorph Cannot Be Billed on Same Day as Surgery
- 6666 – Anesthesia Services Not Allowed By Provider Billing for Surgery
- 6900 – Outpatient Mental Health Services More Than 20 per 27 Days

MEDICAL POLICY FACT SHEET

**TITLE: SURGERY - PLASTIC AND RECONSTRUCTIVE -
PANNICULECTOMY**

DESCRIPTION

Dorlands Medical Dictionary defines a panniculectomy as the surgical removal of excessive skin, subcutaneous tissue and fat of the abdominal wall. While it is similar to abdominoplasty, which is typically used for cosmetic purposes, panniculectomy involves the removal of a hanging apron of excess skin, the pannus or panniculus, in a transverse or vertical wedge, but does not include muscle plication, neoumbilicoplasty or flap elevation.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs' (IHCP) policies regarding this service. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

All requests for panniculectomy will require prior authorization with an appropriate clinical summary and physician documentation of medical necessity. According to the IHCP Provider Manual, Version 5.1, "Morbid Obesity is a disorder associated with medical complications, and it, by itself, is considered a disease." The International Classification of Diseases 9th Edition Clinical Modification (ICD-9-CM) diagnosis codes for this disease are 278.01, *Morbid Obesity* or 278.00, *Obesity, unspecified*."

Massive weight loss, defined as loss of 50 percent of excess weight, often results in laxity and redundancy of the abdominal skin termed a panniculus. Patients with a large panniculus may experience functional and hygiene problems. At extremes, a panniculus may have recurrent infections, ulcerate and even become necrotic. Panniculectomy for medical necessity should be considered when ALL the following criteria are met.

- Pannus hangs at or below the level of the symphysis pubis, as demonstrated on pre-operative photographs.
- Pannus causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis, or skin ulcerations) that is refractory to at least six months of medical treatment in addition to good hygiene practices. Treatment

should include topical antifungals; topical and/or systemic corticosteroids; and/or local or systemic antibiotics.

- Pannus interferes with activities of daily living.

Current Procedural Terminology (CPT) code for panniculectomy may be found in **Table 1, Panniculectomy Procedure Code**.

Table 1 – Panniculectomy Procedure Code

CPT Code	Description
15831	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty)

The diagnosis codes which may be appropriate in determining medical necessity for panniculectomy may be found in **Table 2, Panniculectomy Diagnosis Codes**.

Table 2 – Panniculectomy Diagnosis Codes

Diagnosis Code	Description
278.1	Localized adiposity
682.2	Other cellulitis and abscess, trunk
692.9	Contact dermatitis and other eczema, unspecified
695.89	Unspecified erythematous condition
701.8	Other specified hypertrophic and atrophic conditions of skin
701.9	Unspecified hypertrophic and atrophic conditions of skin
707.8	Chronic ulcer of other specified site
707.9	Chronic ulcer of unspecified site
729.30	Panniculitis, unspecified site
729.39	Panniculitis, other sites

According to the Medical Policy (MP) Bariatric Surgery Fact Sheet, “Panniculectomy following gastric bypass procedures performed for **cosmetic** reasons, even if performed incidentally to a ventral herniorrhaphy, is a non-covered service.”

PRIOR AUTHORIZATION

Many surgeries require prior authorization, as required in the Indiana Administrative Code (IAC) citation 405 IAC 5-3. Prior authorization for multiple surgeries on the same day does not override the restrictions of 405 IAC 5-28. Prior authorization is required for panniculectomy. Information that should be included along with the request for prior authorization includes the following.

- The member’s diagnosis(es)
- The member’s current weight and height
- Preoperative photograph(s) front and lateral views

- History and physical including all previous surgeries and the member's weight loss history
- Medical documentation of medical conditions and complications of infections outlining all treatments, including duration and responses.
- Documentation of limitations on mobility and daily activities due to the pannus or resulting complications.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and Risk Based Managed Care (RBMC) delivery systems.

IHCP members enrolled in *Medicaid Select* PCCM receive the same benefit coverage, and are subject to the same limitations as traditional Medicaid FFS. Refer to the *Medicaid Select* Manual for Primary Medical Providers and Office Staff for further information.

BILLING REQUIREMENTS

Reimbursement requires compliance with all IHCP guidelines including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs. Physicians bill professional services on the CMS-1500 claim form. Providers must bill the ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity.

RELATED MEDICAL TOPICS

Surgical Services
Anesthesia Services
Gastroenterology
Consultations-Second Opinion

RULES, CITATIONS, AND SOURCES

405 IAC 5-3-13 Services requiring prior authorization
405 IAC 5-28-1 Reimbursement limitations
405 IAC 5-29-1 Services not covered by Medicaid
Provider Manual, Version 5.1

Origination Date: October 1, 2006

Revisions and Review	Reason	Date
Origination		10/01/ 2006

APPLICABLE INDIANA AIM EDITS AND AUDITS

6002- Any Two Anesthesiology Providers Same Procedure Required

6003- Manual Pricing for Split Care Billing

6034- Global Surgery Payable at Reduced Amount When Components of Surgical Care Paid

6035- Components of Surgical Care Not Payable When Global Surgery Paid

6039- Assistant Surgeon Not Payable When Co-Surgeon Paid

6040- Co-Surgeon Not Payable When Assistant Surgeon Paid

6661- Duramorph Can Not be Billed on Same Day as Surgery

6666- Anesthesia Services Not Allowed by Provider Billing for Surgery

MEDICAL POLICY FACT SHEET

TITLE: SURGERY—REMOVAL OF IMPLANTS

DESCRIPTION:

Medical implants, i.e. pins, screws, rods, plates, etc., many times will need to be removed when the fracture has healed or the symptoms that required implantation of the device abate. The implant may cause pain and restrict movement. The treatment is to remove the implant.

SUMMARY OF CURRENT POLICY:

Implant removals requiring an operating room are usually considered minor procedures and the rules governing minor procedures in 405 IAC 5-28-1 apply. Some implants may be removed in the physician's office and should be included in the office fee claim.

MEDICAL TOPICS CROSS-REFERENCES:

Anesthesia Services
Hospital Outpatient
Ophthalmology
Radiology
Physical Rehabilitation Services
Surgery-Global Billing/Payment Guidelines
Surgery-Multiple Procedures/Same Operative Session
Surgery-Office Visits
Surgery-Services Requiring Prior Authorization
Surgery-Surgery and Anesthesia By the Same Provider
Surgery-Surgeon and Assistant Surgeon, Same Provider
Surgery-Surgical Services
Surgery-Suture of Wounds
Urology

RULES, CITATIONS, AND SOURCES:

405 IAC 5-28 Medical and Surgical Services

Indiana State Department of Public Welfare Medical Policy Manual 1991

Indiana Health Coverage Programs Provider Manual 1999

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
Indiana State Department of Public Welfare Medical Policy Manual 1991	Removal of Implants		7/1/91	
470 5-9-1 Transferred	Global Fee Billing	7/1/91		
405 IAC 1-7-1 Repealed 8/24/97	Global Fee Billing	1/1/92		
Revisions:				
405 IAC 5-1-5	Global Fee Billing	8/24/97		
405 IAC 5-28	Medical and Surgical Services	8/24/97		

APPLICABLE INDIANA A/M EDITS AND AUDITS:

6014

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COVERAGE CRITERIA:

MEDICAL POLICY FACT SHEET

TITLE: SURGERY—SERVICES REQUIRING PRIOR AUTHORIZATION

DESCRIPTION:

Some specifically listed surgical procedures, according to guidelines in 405 IAC 5-3-13, require prior authorization. Criteria for coverage must be documented in the request for prior authorization and approval received before the service is provided in order to receive reimbursement for those specified surgical services.

SUMMARY OF CURRENT POLICY:

Medicaid reimbursement is available for certain surgeries, as listed in 405 IAC 5-3-13, when prior authorization is received in accordance with the prior authorization guidelines, as outlined below. Presently, the list includes, such surgical procedures as reduction mammoplasties, rhinoplasty or bridge repair of the nose when related to a significant obstructive breathing problem, intersex surgery, blepharoplasties for a significant obstructive vision problem, sliding mandibular osteotomies for prognathism or micrognathism, reconstructive or plastic surgery, bone marrow or stem cell transplants, all organ transplants covered by the Medicaid program, plasmapheresis, strabismus surgery for patients over ten (10) years of age, maxillofacial surgeries related to diseases and conditions of the jaws and contiguous structures, temporomandibular joint surgery, submucous resection of nasal septum and septoplasty when associated with significant obstruction, hysterectomy, tonsillectomy, adenoidectomy, cataract extraction, surgery to the foot, and all dental admissions.

MEDICAL TOPICS CROSS-REFERENCES:

Surgery-Global Billing/Payment Guidelines
Surgery-Multiple Procedures/Same Operative Session
Surgery-Office Visits
Surgery-Removal of Implants
Surgery-Surgery and Anesthesia By the Same Provider
Surgery-Surgeon and Assistant Surgeon, Same Provider
Surgery-Surgical Services
Surgery-Suture of Wounds

RULES, CITATIONS, AND SOURCES:

405 IAC 5-3 Prior Authorization

Indiana Health Coverage Programs Provider Manual 1999

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
470 5-9-3; 5-9-9; 5-9-14 Transferred	Prior Authorization	7/1/91		
405 IAC 1-7-3 Repealed 8/24/97	Prior Authorization	1/1/92		
Revisions:				
405 IAC 5-3	Prior Authorization	8/24/97		
405 IAC 5-3-2 Amended	Prior Authorization	10/27/99		
405 IAC 5-3-5 Amended	Prior Authorization	10/27/99		
405 IAC 5-3-6 Amended	Prior Authorization	10/27/99		
405 IAC 5-3-12 Amended	Prior Authorization	10/27/99		

APPLICABLE INDIANA A/M EDITS AND AUDITS:

3003

COVERAGE CRITERIA:

MEDICAL POLICY FACT SHEET

TITLE: SURGERY—SURGEON AND ASSISTANT SURGEON, SAME PROVIDER

DESCRIPTION:

A patient may have the need for two procedures coincidentally by two surgical specialists. One may serve as the assistant surgeon during the other specialist's procedure and then bill as the primary surgeon for the portion of which he/she is the specialist with the first surgeon remaining as an assistant.

SUMMARY OF CURRENT POLICY:

Another surgeon may be requested to assist the performing surgeon during a complex surgical procedure. Documentation explaining the need should accompany the claim and the modifier 80 should be used. The global fee rule will be used to assess appropriate payment.

MEDICAL TOPICS CROSS-REFERENCES:

Consultations – Second Opinion
Gynecology – Hysterectomy
Obstetric Care
Physician Services
Surgery-Global Billing/Payment Guidelines
Surgery-Multiple Procedures/Same Operative Session
Surgery-Removal of Implants
Surgery-Services Requiring Prior Authorization
Surgery-Surgery and Anesthesia By the Same Provider
Surgery-Surgical Services
Surgery-Suture of Wounds

RULES, CITATIONS, AND SOURCES:

405 IAC 5-25-2 Physician Services
Indiana State Department of Public Welfare Medical Policy Manual 1991

Indiana Health Coverage Programs Provider Manual 1999

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
Indiana State Department of Public Welfare Medical Policy Manual 1991	Assistant Surgeon		7/1/91	
470 IAC 5-8-15 Transferred	Surgeon and Assistant Surgeon by Same Physician	7/1/91		
405 IAC 1-6-15 Repealed 8/24/97	Physician Services	1/1/92		
Revisions:				
405 IAC 5-25-2	Physician Services	8/24/97		

APPLICABLE INDIANA A/M EDITS AND AUDITS:

6037

6038

COVERAGE CRITERIA:

MEDICAL POLICY FACT SHEET

TITLE: SURGERY—SURGERY AND ANESTHESIA BY THE SAME PROVIDER

DESCRIPTION:

The performing surgeon may provide local anesthesia or conscious sedation with and without local anesthesia to perform minor procedures and endoscopic examinations.

SUMMARY OF CURRENT POLICY:

Reimbursement for anesthesia administered by the surgeon in conjunction with a surgical procedure is included in the fee for the surgical procedure.

MEDICAL TOPICS CROSS-REFERENCES:

Anesthesia Services
Clinic Services—FQHC and Rural Health Clinic Services
Obstetric Care
Ophthalmology—Vitrectomy
Ophthalmology—YAG Laser
Surgery—Global Billing/Payment Guidelines
Surgery—Multiple Procedures/Same Day Operative Session
Surgery—Office Visits
Surgery—Removal of Implants
Surgery—Services Requiring Prior Authorization
Surgery—Surgeon and Assistant Surgeon, Same Provider
Surgery—Surgical Services
Surgery—Suture of Wounds
Urology

RULES, CITATIONS, AND SOURCES:

405 IAC 5-10 Anesthesia Services
Indiana State Department of Public Welfare Medical Policy Manual 1991
IC 12-15-1-10
IC 12-15-21-2
IC 12-15-21-3

Indiana Health Coverage Programs Provider Manual 1999

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
Indiana State Department of Public Welfare Medical Policy Manual 1991	Surgery and anesthesia by the same provider		7/1/91	
470 IAC 5-9-27 Transferred	Anesthesia Services	7/1/91		
405 IAC 1-7-26 Repealed	Anesthesia Services	1/1/92		
Revisions:				
405 IAC 5-10	Anesthesia Services	8/24/97		

APPLICABLE INDIANA A/M EDITS AND AUDITS:**COVERAGE CRITERIA:****Surgery and Anesthesia by the Same Provider****Indiana State Department of Public Welfare Medical Policy Manual 1991**

If a physician bills separate charges for anesthesia, whether local or regional (such as saddle block), and surgery on the same day, it should be combined and coded as the surgical procedure.

MEDICAL POLICY FACT SHEET

TITLE: SURGERY—SURGICAL SERVICES

DESCRIPTION:

Surgical services are services for a member requiring or seeking medically necessary perioperative care. These include, but are not limited to, the operating room, recovery room, outpatient admitting and discharge, and preoperative preparation. Prior to the performance of a surgical procedure, either inpatient or outpatient, the member consults with the surgeon who will be performing the procedure. The visit can occur in the physician's office, in the emergency room, in the outpatient surgery area, or an ambulatory surgery center (ASC).

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding surgical services. More specific information may be found in the IHCP Provider Manual, program notices, the Indiana Administrative Code (IAC), or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

The IHCP provides reimbursement for surgical services performed by IHCP enrolled providers when reported with the appropriate Current Procedural Terminology (CPT) or Health Care Common Procedure Coding System (HCPCS) procedure codes. Physician reimbursement for a surgical procedure generally includes the preoperative visits performed on the same day or the day prior to the surgery for major surgical procedures, and the day of the surgical procedure for minor surgical procedures.

Prior authorization (PA) is required for a scheduled inpatient surgical procedure if that procedure is usually performed on an outpatient basis. Reimbursement for the inpatient admission is determined by the appropriate Diagnostic Related Group (DRG), but may be subject to retrospective review of the medical necessity for the inpatient stay. The following criteria is used for determining the medical necessity for an inpatient admission.

- Technical or medical difficulty during the outpatient procedure as documented in the medical record
- Presence of physical or mental conditions which make prolonged preoperative or postoperative observations by a nurse or other skilled medical personnel medically necessary
- Performance of another procedure simultaneously, which itself requires hospitalization

- Anticipation of an additional procedure, which would require hospitalization following the initial procedure
- Documentation must be maintained in the medical record and clearly document any complications and services provided

Office Visits

Office visits made with the surgeon prior to the scheduling of surgery are billed under the global surgery payment/billing rules. Certain modifiers may be used to distinguish a preoperative visit from a more in-depth visit at which time the decision was made for surgery; a significant, separately identifiable evaluation and management visit was made the same day of surgery; the surgeon served as a consultant for a second or third opinion; or an unrelated procedure or service by the same physician during the postoperative period. The appropriate modifier should be used for claim payment of these services. Documentation must be maintained in the medical record.

Postoperative Care

Global postoperative care days for surgical procedures include a 90-day period following a major surgical procedure and a 10-day period following a minor surgical procedure. Separate reimbursement is available for care provided during these global postoperative periods that is unrelated to the surgical procedure, or for care given not considered routine and postoperative care for the surgical condition, such as complications. The medical visits are billed separately from the surgical fee. Complications may include, but are not limited to, the following examples.

- Cardiovascular complications
- Comatose conditions
- Elevated temperature above 38.4 degrees Celsius, or 101 degrees Fahrenheit, for two or more consecutive days
- Medical complications due to anesthesia, other than nausea and vomiting
- Post operative wound infection requiring specialized treatment
- Renal failure

Surgery and Anesthesia, Same Provider

Reimbursement for anesthesia administered by the surgeon in conjunction with a surgical procedure is included in the fee for the surgical procedure.

Multiple Procedures, Same Operative Session

Multiple surgical procedures may be performed on the same patient on the same day when it is determined to be beneficial for the surgeon(s) and patient, and provides the best outcome for the patient. Documentation is required to indicate the medical necessity for multiple procedures. When two or more surgeries are performed during the same operative period reimbursement will be subject to the following multiple surgery reductions.

- 100 percent of the global fee for the most expensive procedure
- 50 percent of the global fee for the second most expensive procedure
- 25 percent of the global fee for the remaining procedures

Removal of Implants

The IHCP provides reimbursement for removal of medical implants (i.e., pins, screws, rods, plates, etc.) when a fracture has healed or the symptoms that required implantation of the device abate. Implant removals requiring an operating room are usually considered minor procedures and the rules governing minor procedures in 405 IAC 5-28-1 apply. Some implants may be removed in the physician's office and should be included in the office fee claim.

Surgeon and Assistant Surgeon

A member may require two procedures coincidentally by two different surgical specialists. Each surgeon may serve as the assistant surgeon during the other surgeon's procedure. The surgeons may bill as primary surgeon for that portion of surgery for which he/she was responsible. Refer to the Billing Requirements section of this fact sheet for billing guidelines.

Wound Closure

There are times that it is not advisable to close an operative incision at the time of the initial surgical procedure, such as, infectious drainage or gangrenous bowel. The patient may remain in the hospital for observation and return to the operating room for secondary wound closure. When a dehiscence occurs in the immediate postoperative period, the patient may return to the operating room for suturing as an emergency procedure.

- Secondary closure after the initial surgical procedure may be considered part of the initial surgery and part of the global fee schedule
- Dehiscence of a wound is considered a complication of the primary procedure. As an emergency procedure, the rules pertaining to emergency procedures will apply

PRIOR AUTHORIZATION

IHCP reimbursement is available for certain surgeries, as listed in 405 IAC 5-3-13, when PA is received in accordance with the PA guidelines. Further information regarding PA criteria for the following services can be located in the corresponding Medical Policy fact sheets. Currently, PA is required for the following surgical procedures.

- Reduction mammoplasty
- Rhinoplasty or bridge repair of the nose when related to a significant obstructive breathing problem
- Intersex surgery
- Blepharoplasties for a significant obstructive vision problem
- Sliding mandibular osteotomies for prognathism or micrognathism
- Reconstructive or plastic surgery
- Bone marrow or stem cell transplant
- Organ transplants
- Maxillofacial surgeries related to diseases and conditions of the jaws and contiguous structures
- Temporomandibular joint surgery

- Submucous resection of nasal septum and septoplasty when associated with significant obstruction
- Weight reduction surgery, including gastroplasty and related gastrointestinal surgery
- Orthodontic procedures for members under 21 years of age for cases of craniofacial deformity or cleft palate
- All dental procedures requiring hospital admission
- Out-of-state procedures

PA is required for surgical procedures usually performed on an outpatient basis, when scheduled as an inpatient. Notification following emergency care must be done within 48 hours or the first working day following the weekend or holiday. If authorization is not received, the claim will be denied.

MANAGED CARE

For members enrolled in Risk Based Managed Care (RBMC), providers must contact the member's managed care organization (MCO) for more specific guidelines. Refer to the Provider Manual, Chapter 1, for detailed information about the fee-for-service (FFS), Primary Care Case Management (PCCM), and RBMC delivery systems.

IHCP members enrolled in *Medicaid Select* PCCM receive the same benefit coverage and are subject to the same limitations as traditional Medicaid FFS. Refer to the *Medicaid Select* Manual for Primary Care Providers and Office Staff for further information.

BILLING REQUIREMENTS

The following modifiers must be indicated on the CMS 1500 claim or the 837P electronic transaction when applicable to the procedure performed.

- Modifier 54, *Surgical care only*, indicates the physician performed only the surgical care
- Modifier 55, *Postoperative management only*, indicates the physician only performed on the postoperative care
- Modifier 56, *Preoperative management only*, indicates the physician only performed on the preoperative care
- Modifier 57, *Decision for surgery*, indicates the decision for surgery was made on the same day as the surgery

All surgical procedures performed on the same day, by the same rendering physician, must be billed on the same claim form; otherwise, the claim may be denied and the original claim will require adjustment for additional payment.

Providers submitting CMS 1500 claims or 837P electronic transaction using modifier 50, indicating a bilateral procedure, must report only one unit. The use of modifier 50 ensures that the procedure code is reimbursed at the lower of 150 percent of the billed charge or the rate on

file. Modifier 50 is not to be utilized if the CPT code description specifies the procedure as bilateral.

A surgeon may be requested to assist the performing surgeon as an assistant surgeon during a complex surgical procedure. Documentation explaining the need for an assistant should accompany the claim and modifier 80 should be used.

Additional Surgical Billing Requirements

The following perioperative encounters require additional/specific documentation.

- Surgery Payable at Reduced Amount When Related Post-Operative Care Paid
- Post-Operative Care Within 0-90 days of Surgery
- Pre-Operative Care on Day of Surgery
- Surgery Payable at Reduced Amount When Pre-Operative Care Paid Same Date of Service

To explain the above situations, the IHCP requires that the provider submit the following documentation.

- Medical reason and unusual circumstances for the separate evaluation and management (E/M) visit
- The medical necessity of visit occurring due to a complication, such as cardiovascular complications, comatose conditions, elevated temperature for two or more consecutive days, medical complications due to anesthesia other than nausea and vomiting, post-operative wound infection requiring specialized treatment, or renal failure

RELATED MEDICAL TOPICS

Anesthesia Services

Clinic Services—FQHC and Rural Health

Clinic Services

Consultations – Second Opinion

Emergency Medicine – Emergency Room

Emergency Medicine – Emergency Services

Emergency Services

Gastroenterology

Gynecological Services

Hospital Inpatient

Hospital Outpatient

Obstetric Care

Ophthalmology

Therapy Services

Radiology Services

RULES, CITATIONS, AND SOURCES

Indiana Administrative Code

405 IAC 5-1-5 Global Fee Billing

405 IAC 5-3 Prior Authorization

405 IAC 5-10 Anesthesia Services

405 IAC 5-25 Physician Services

405 IAC 5-28 Medical and Surgical Services

Indiana Code

IC 12-8-6-3 Administration of state program

IC 12-8-6-5 Rules

IC 12-15-1-10 Administrative actions and directions

IC 12-15-21-2 Acceptance by provider of Medicaid claim payment

Indiana Health Coverage Programs Provider Manual

1999

December, 2006 Version 6.0

Indiana State Department of Public Welfare Medical Policy Manual 1991

Indiana Health Coverage Programs Bulletins

BT200208 – Modifications to Prior Authorization Requirement

BT200216 – Split Billing of Global Surgery Postoperative Care Days

BT200511 – HIPAA Modifications

Origination date: 12/31/2000

Review or Revision	Reason	Date
470 IAC 5-9-1, 5-9-3, 5-9-9, 5-9-12, 5-9-14, 5-9-27 Transferred	Anesthesia Services, Global fee billing, Medical Services, Prior Authorization, Surgical Services	07/01/1991
Indiana State Department of Public Welfare Medical Policy Manual 1991	Removal of Implants, Suture of Wounds	
405 IAC 1-7, 1-7-3, 1-7-12; 1-7-14, 1-7-26 Repealed 8/24/97	Anesthesia Services, Global fee billing, Medical Services, Prior Authorization, Surgical Services	01/01/1992
405 IAC 5-1-5, 5-3, 5-10, 5-25, 5-28,	Anesthesia Services, Global fee billing, Medical Services, Prior Authorization, Surgical Services	08/24/1997
405 IAC 5-3-2, 5-3-5, 5-3-6, 5-3-12 Amended	Prior Authorization	10/27/1999

Review or Revision	Reason	Date
Revision	Scheduled review and consolidation of fact sheets <ul style="list-style-type: none"> • Surgery-Multiple Procedures/Same Operation • Surgery-Office Visits • Surgery-Removal of Implants • Surgery-Services Requiring PA • Surgery-Surgeon and Asst. Surgeon, Same Provider • Surgery-Surgical Services • Surgery-Suture of Wounds • Surgery/Anesthesia Same Provider 	01/31/07

APPLICABLE INDIANA4/M EDITS AND AUDIT

- 0764 – Missing or Invalid Compound Product ID Qualifier
- 0765 – Improper Order of Dispensing Status Code on Partial Fill Transaction
- 0766 – Missing or Invalid Associated Prescription or Service Reference Number on Completion Transaction
- 0770– Completion Transaction Not Permitted with Same Date of Service as Partial Transaction
- 3003 – Procedure Code Requires PA
- 4000 – More Than Two Surgical Units on the Claim
- 6014 – Global Payable at a Reduced Fee When Components Paid – Medical Services
- 6015 – Global Payable at a Reduced Fee When Components Paid – Respiratory Services
- 6017 – Global Payable at a Reduced Fee When Components Paid – Endocrine/Nervous /Eye/Ear
- 6022 – Components Not Payable When Global Paid – Digestive System
- 6023 – Global Payable at a Reduced Fee When Components Paid – Digestive System
- 6034 – Global Surgery Payable at Reduced Amount When Components of Surgical Care Paid
- 6035 – Components of Surgical Care Not Payable When Global Surgery Paid
- 6037 – Only One Assistant Surgeon Allowed for Select Surgeries
- 6038 – Two Assistant Surgeons Allowed Only for Select Surgeries
- 6039 – Assistant Surgeon Not Payable hen Co-Surgeon Paid
- 6040 – Co-Surgeon Not Payable When Assistant Surgeon Paid
- 6048 – Components Not Payable When Global Paid- Endocrine/Nervous/Eye/Ear
- 6049 – Components Not Payable When Global Paid – Endocrine/Nervous/Eye/Ear
- 6061– Components Not Payable When Global Paid – Genital Urinary/Reproductive Systems
- 6063 – Components Not Payable When Global Paid – Respiratory System
- 6064 – Components Not Payable When Global Paid – Medical System
- 6071 – Components Not Payable When Global Paid Cardiovascular/Lymphatic System

- 6072 – Global Payable at Reduced Fee When Components Paid – Cardiovascular/Lymphatic System
- 6630 – Professional/Technical Components for Cardiac Catheterization Versus the Complete Procedure
- 6634 – Complete Procedure for Cardiac Catheterization Versus Technical/Professional Components
- 6649 – Surgery Payable at Reduced Amount When Related Postoperative Care Paid
- 6650 – Lifetime Procedures are Limited to One Per Lifetime
- 6651 – Surgical Cutback Procedure 50 Percent
- 6652 – Multiple Surgeries Must be Billed on Same Claim
- 6653 – Postoperative Care Within Zero to 90 Days of Surgery
- 6654 – Preoperative Care Within One Day of Surgery
- 6655 – Surgery Payable at Reduced Amount When Preoperative Care Paid
- 6656 – Postoperative Care Within 10 Days of Select Surgery
- 6657 – Preoperative Care On Day of Surgery
- 6658 – Surgery Payable at Reduced Amount When Preoperative Care Paid Same Date of Service
- 6659 – Surgery Payable at Reduced Amount Related Care Paid
- 6660 – Preoperative and Postoperative Care Billed With Unlisted Surgeries Requires Review
- 6664 – Global Payable at a Reduced Fee When Components Paid–Integumentary and Neuromuscular
- 6665 – Bilateral Versus Unilateral Surgeries
- 6706 – Global Payable at a Reduced Fee When Components Paid–Genital Urinary/Reproductive Systems

MEDICAL POLICY FACT SHEET

TITLE: SURGERY—SUTURE OF WOUNDS

DESCRIPTION:

There are times that it is unadvisable to close an operative incision at the time of the initial surgical procedure, (i.e. infectious drainage, gangrenous bowel). The patient remains in the hospital for close observation and must return to the operating room for an intermediate closure. When a dehiscence occurs in the immediate postoperative period, the patient must return to the operating room for suturing as an emergency procedure.

SUMMARY OF CURRENT POLICY:

The suture of wounds is a covered Medicaid service under the following circumstances:

- 1) A secondary closure after the initial surgical procedure may be considered part of the initial surgery and part of the global fee schedule.

A dehiscence of a wound is considered a complication of the primary procedure. As an emergency procedure, the rules pertaining to emergency procedures will apply.

MEDICAL TOPICS CROSS-REFERENCES:

Emergency Medicine – Emergency Room
Emergency Medicine – Emergency Services
Gynecology -- Hysterectomy
Hospital Inpatient
Hospital Outpatient
Surgery – Global Billing/Payment Guidelines
Surgery – Services Requiring Prior Authorization
Surgery – Surgery and Anesthesia By the Same Provider

RULES, CITATIONS, AND SOURCES:

405 IAC 5-28-1
Indiana Health Coverage Programs Provider Manual 1999

Initial Policy	Issues	Effective Date	Implementation Date	Retroactive Date
Indiana State Department of Public Welfare Medical Policy Manual 1991	Suture of Wounds		7/1/91	
470 IAC 5-9-12; 5-9-14 Transferred	Medical Services; Surgical Services	7/1/91		
405 IAC 1-7-12; 1-7-14 Repealed 8/24/97	Medical Services; Surgical Services	1/1/92		
Revisions:				
405 IAC 5-28-1	Medical and Surgical Services	8/24/97		

APPLICABLE INDIANA AIM EDITS AND AUDITS:

4000
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COVERAGE CRITERIA:**Indiana State Department of Public Welfare Medical Policy Manual 1991**

1. Claims for intermediate repair of wounds should include the location and size of the wound repaired. If the size of the wound is not indicated, use the smallest code for the location of the wound.
2. Multiple wounds on the same day should be paid the full amount for the major (largest) wound and half for all other lacerations.
3. Claims for multiple complex repairs done on the same day should be routed to Medical Policy for review and pricing.

MEDICAL POLICY FACT SHEET

TITLE: SURGERY—TRANSPLANTS

DESCRIPTION

Stedman's Medical Dictionary defines a transplant as a transfer from one part to another, such as tissue or an organ, in grafting and transplantation. Autologous transplants involve tissue or organ transferred into a new position in the body of the same individual. Allogenic transplant pertains to transfer of human tissue or an organ from one person to another; allogenic indicates it is genetically different but still within the same species.

This document is intended to serve as a general summary of the Indiana Health Coverage Programs (IHCP) policies regarding this service. More specific information may be found in the IHCP provider manual, program notices, the Indiana Administrative Code (IAC) or other sources as appropriate. See the "Rules, Citations, and Sources" section of this document for further information.

COVERAGE CRITERIA

The IHCP provides reimbursement for the following transplants when medically necessary with prior authorization (PA). Reimbursement is also available for the cost of procuring the organs or tissue.

Bone Marrow and Stem Cell
Lung, cadaver and live donor
Heart
Heart/Lung
Liver, cadaver and live donor

Renal, cadaver and live donor
Pancreas, cadaver and live donor
Autologous Islet Cell
Intestinal, cadaver
Multi-visceral

The IHCP provides reimbursement for corneal tissue transplantation when medically necessary. Corneal tissue transplantation was removed from the Indiana Administrative Code (IAC) citation 405 IAC 5-3-13, Services Requiring Prior Authorization, in 2005.

Reimbursement for the transplant donor's hospital and surgical expenses for the removal of the donor tissue or organ during the inpatient admission will be provided when the recipient of the transplant is an IHCP member, the member meets criteria for the transplant, and the transplant is considered medically necessary.

Each type of transplantation has been included in separate sections of this document and includes specific information regarding prior authorization criteria, coding information, and documentation requirements. Additionally, information regarding the removal of transplanted tissue and transplantation billing in general is included in separate sections of this document.

A. Bone Marrow or Stem Cell Transplantations (Other than for Breast Cancer)

1. Coding for Bone Marrow or Stem Cell Transplantations, Autologous or Allogenic

The IHCP will provide reimbursement for autologous or allogenic bone marrow or stem cell transplants listed in **Table 1**. These codes should be used for bone marrow or stem cell transplants with or without the diagnosis of breast cancer.

Table 1 - CPT Codes for Bone Marrow or Stem Cell Transplantations

CPT CODE	DESCRIPTION
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic
38230	Bone marrow harvesting for transplantation
38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic
38241	Bone marrow or blood-derived peripheral stem cell transplantation; autologous
38242	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic donor lymphocyte infusions

2. Indications for Bone Marrow or Stem Cell Transplantations (Other Than Breast Cancer)

The IHCP will provide reimbursement for bone marrow transplants with prior authorization for **ONE of the following** indications other than for breast cancer.

- Adult or childhood acute myeloid leukemia (includes nonlymphocytic or nonlymphoblastic)
- Adult or high risk childhood lymphocytic (lymphoblastic) leukemia in remission
- Myelodysplastic syndromes
- Acute lymphocytic or non-lymphocytic leukemia in remission
- Non-Hodgkin's lymphoma of intermediate and high grade (stage 3 or 4) in remission or with evidence of chemotherapy responsive disease
- Hodgkin's Disease (lymphoma) in second remission or refractory to primary therapy
- Neuroblastoma: High risk disease by the International Neuroblastoma Staging System criteria with no evidence of disease progression at the time of transplant
- Congenital Marrow Failure Syndromes unresponsive to medical therapy
- Severe Aplastic Anemia
- Severe Combined Immunodeficiency Disease

- Multiple Myeloma (tandem stem cell transplants for treatment of Multiple Myeloma must receive PA as two separate procedures). Tandem stem cell transplants are considered medically necessary in patients who fail to achieve a complete remission or a good partial remission (at least 50% reduction in tumor cells) after the first transplant.
- Germ-cell Cancer: recurrent or refractory to primary therapy (tandem stem cell transplants should be considered for relapsed patients and must receive PA as two separate procedures)
- Ovarian cancer
- Hurler's Syndrome (other inherited metabolic diseases will be considered based on published literature)
- Ewing's Sarcoma limited to pulmonary relapse only
- Sickle cell anemia
- Thalassemia major or transfusion dependent thalassemia intermedia

AND when a member meets ALL of the following criteria.

- The life expectancy following the transplant can reasonably be expected to be one year or more, measured by current standards.
- The member, or his or her guardian, demonstrates a reasonable ability to comply with physician-directed postoperative treatment meant to reduce the chance of organ rejection.
- The adult member is competent and understands the risks and benefits of the transplant.
- The member has normal or treatable cardiovascular, pulmonary, hepatic, and renal function.

3. Contraindications to Bone Marrow or Stem Cell Transplantations (Other Than Breast Cancer)

Prior authorization will not be given for bone marrow transplants in the following circumstances.

- The member is a juvenile and has no identifiable caretaker or no adequate family support structure
- The member is septic or has an active infection
- The member has a frank relapse or progression of leukemia or disease
- The member has a condition preventing rehabilitation
- The member exceeds 175% of normal weight for height and age
- The member has an abnormal central nervous system (CNS) condition, e.g., CVA, Organic Brain Syndrome, or dementia. (CNS metastasis as a consequence of the primary diagnosis for which the transplant is being requested would be excluded from this restriction.)
- The member has another active malignancy or history of active malignancy within two years, excluding skin cancers cured by simple excision. Documentation will be required at the time of PA request.
- Transplant is contraindicated for acquired immune deficiency syndrome (AIDS) as defined by a CD4 count of less than 200 cells/mm³ unless the following are noted.
 - CD4 count greater than 200 cells/mm³
 - HIV-1 RNA undetectable

- Stable anti-retroviral therapy for more than 90 days
- No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, or antimicrobial resistant fungal infections, or Kaposi's sarcoma or other neoplasms)
- The member is moribund
- The member has an active illegal drug or alcohol dependence within the six months prior to the submission of the request
- The member has two or more significant abnormal lab or x-ray results, non-disease related

4. Documentation for Bone Marrow Transplantations (Other than Breast Cancer)

The following documentation must be maintained in the member's medical record.

- History and physical examination (H&P) signed by a physician and includes the member's height, weight and gender, completed within a medically reasonable timeframe prior to the submission of the request. Additionally, for members with a history of depression, suicide attempts or drug dependence, the H&P should include documentation of psychiatric or psychological evaluation signed by a psychiatrist or health services provider in psychology (HSPP).
- Clear documentation of the member's disease status including copies of all recent results of imaging studies, bone marrow testing, cytogenetics, and molecular studies when indicated
- CBC, UA, complete metabolic profile (CMP), and EKG within a medically reasonable timeframe prior to submission of the request.
- Urine or serum B-HCG (females only)
- Urine creatinine clearance or glomerular filtration rate (GFR)
- Chest X-ray within 90 days prior to submission of the request
- Urine drug screen within a medically reasonable timeframe prior to submission of the request for members > 18 years of age or based on physician discretion
- Appropriate screening for colon cancer, for members over 40 years of age
- Thallium stress test results, or suitable alternative per a cardiologist, for members with history of significant cardiac risk factors.
- HIV and hepatitis B virus (HBV), hepatitis C virus (HCV), cytomegalovirus (CMV), and any other serology testing, including toxoplasmosis, syphilis, and Epstein-Barr virus (EBV) results within a medically reasonable timeframe of the submission of the request. Positive results may be a relative contraindication.
- Results of arterial blood gases (ABGs) and pulmonary function tests if member was (is) a smoker or has a history of lung disease. Forced expired volume (FEV) less than 60% of normal and forced vital capacity (FVC) less than 50% of normal may be a contraindication to transplant. Pulmonary function studies in pediatric members may vary depending on testing capabilities.
- Dental evaluation with treatment of any significant dental disease

B. Bone Marrow and Stem Cell Transplantations for Breast Cancer

1. Coding for Bone Marrow and Stem Cell Transplantations for Breast Cancer

The IHCP advises providers to report the appropriate CPT code, as listed previously in this document in **Table 1** for bone marrow and stem cell transplants for breast cancer.

2. Indications for Bone Marrow and Stem Cell Transplantations for Breast Cancer

The IHCP will provide bone marrow transplants with prior authorization for confirmed cancer of the breast, Stage II with >10 positive axillary nodes, Stage III B, or Stage IV, with all of the following indications.

- Documentation of no other organ disease that interferes with his/her health
- Life expectancy of less than twelve months without procedure, documented by oncologist
- Life expectancy of 18 months or greater with procedure, documented by oncologist
- Breast cancer staging, overall physical status, and response to past therapy documented by the attending oncologist within three months of the procedure request
- Documentation of the completion of induction therapy without disease progression, within three months prior to the procedure request
- Documentation of a Karnofsky Performance status >70 (a measurement of rehabilitation potential) within three months prior to the procedure request
- No history of previous chemotherapy if Stage III B, or only adjuvant therapy if Stage IV
- Documentation of no history of a second active malignancy or > five years from initial diagnosis and treatment without evidence of recurrence
- Documentation of one failed hormonal therapy, if tumor estrogen receptor (ER) level is >10 femtomoles/mg and Stage IV
- Documentation of no brain metastases as evidenced by CT scan
- Documentation of no central nervous system involvement
- Documentation of a bone marrow aspirate and bilateral ischial bone biopsies with no evidence of marrow involvement with breast cancer

3. Contraindications for Bone Marrow and Stem Cell Transplantations for Breast Cancer

IHCP reimbursement for bone marrow and stem cell transplants will not be provided when any of the following clinical situations are present.

- An active malignancy, other than breast cancer
- Active illegal drug, tobacco, or alcohol dependence within the last six months
- Documentation of irreversible primary organ disease (e.g., heart, lung or kidney)
- Two or more documented abnormal lab or x-ray results not related to the breast cancer may be a relative contraindication

4. Documentation for Bone Marrow and Stem Cell Transplantations for Breast Cancer

The following studies are to be completed within a medically reasonable timeframe prior to the PA request and documentation must be maintained in the member's medical record.

- History and physical (H&P) examination signed by a physician that includes the member's height, weight and gender. Additionally, the H&P should include psychiatric or psychological evaluation in cases having a history of depression, suicide attempts or drug dependence signed by a psychiatrist or HSPP.
- Clear documentation of the member's disease status including copies of all recent results of imaging studies, bone marrow testing, cytogenetics, and molecular studies when indicated
- Abdominal and chest CT
- Bone scan
- Chest X-ray, posteroanterior view
- Bone marrow aspirate and bilateral ischial bone biopsy and cellularity (pathology reports)
- Pulmonary function, including DLCO > 60% predicted
- Thallium stress test results, or suitable alternative per a cardiologist, for members with history of significant cardiac risk factors
- Karnofsky Performance Status > 70
- Dental evaluation with treatment of any significant dental disease
- Urine drug screen within 90 days prior to submission of the request for members >18 years of age or based on physician discretion
- HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), syphilis and cytomegalovirus (CMV) serologies
- Laboratory values
 - CBC
 - CMT
 - Creatinine Clearance (CC)
 - Urinalysis
 - Carcinoembryonic antigen (CEA)
 - PT/INR, PTT
 - Creatine Kinase (CK)
 - Lactic Acid Dehydrogenase

C. Lung Transplantations

1. Coding for Lung Transplantations

The IHCP provides reimbursement for three components of lung transplantation, with PA as listed below. The IHCP provides reimbursement for the CPT codes for lung transplants listed in **Table 2** that follows on the next page.

- Harvesting of the lung includes cold preservation (see CPT code 32850).
- Backbench work consists of preparation of cadaver donor single lung or both lungs prior to transplantation. This includes dissection of the lung from tissue around it and preparation of the pulmonary venous/atrial cuff, pulmonary artery and bronchus bilaterally (see CPT codes 32855 and 32856).

- Recipient transplantation includes transplanting a single lung or both lungs into the patient (see CPT codes 32851-32854).

Table 2 - CPT Codes for Reporting Lung Transplantations

CPT Code	Description
32850	Donor pneumonectomy (including cold preservation), from cadaver donor
32851	Lung transplant, single; without cardiopulmonary bypass
32852	Lung transplant, single; with cardiopulmonary bypass
32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass
32854	Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass
32855	Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral
32856	Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; bilateral

2. Indications for Lung Transplantations

The IHCP considers lung transplants medically necessary with prior authorization for **ONE of the following** indications.

- Primary pulmonary hypertension
- Alpha-1 antitrypsin deficiency
- Pulmonary fibrosis (primary or secondary)
- Cystic fibrosis
- Surfactant deficiency
- Bronchopulmonary dysplasia
- Pulmonary berylliosis (with chronic interstitial granulomatous fibrosis)
- Atrioventricular canal
- Bronchiectasis
- Pulmonary vascular disease

3. Contraindications for Lung Transplantation

IHCP reimbursement for lung transplantation will not be provided when any of the following clinical situations are present.

- Active illegal drug, tobacco, or alcohol dependence within the last six months
- Active malignancy or other organ disease
- Acquired immune deficiency syndrome (AIDS) as defined by a CD4 count of less than 200 cells/mm³ unless the following are noted
 - CD4 count greater than 200 cells/mm³

- HIV-1 RNA undetectable
- Stable anti-retroviral therapy for more than 90 days
- No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, or Kaposi's sarcoma or other neoplasms)

4. Documentation for Lung Transplantation

Documentation must indicate the following information was obtained within a medically reasonable timeframe prior to the request.

- History and physical (H&P) examination signed by a physician that includes the member's height, weight and gender. Additionally, the H&P should include psychiatric or psychological evaluation in cases having a history of depression, suicide attempts or drug dependence signed by a psychiatrist or HSPP.
- Clear documentation of the disease status of the member including copies of all recent results of imaging studies, bone marrow testing (when indicated), cytogenetics, molecular studies, etc.
- No use of tobacco products for a period of six months prior to request or transplant
- Life expectancy without transplant is expected to be 18 months or less
- Life expectancy with transplant is expected to be 24 months or greater
- Ventilator dependency
- Current Prednisone use of less than 20 mg/day. Chronic high dose steroids for extrapulmonary disease are a contraindication. Prednisone dosage >5mg/day for a child with cystic fibrosis may be considered a contraindication.
- Karnofsky performance status > 70
- Chest X-ray, posteroanterior view
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- CT scans of lungs (other CT scans as applicable)
- Thallium stress test results, or suitable alternative per a cardiologist, for members with history of significant cardiac risk factors
- Results of arterial blood gases (ABGs) and carboxyhemoglobin, and pulmonary function, including forced expired volume (FEV) of 25% normal and decreasing forced volume capacity (FVC) of 40% normal or less.
- HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), syphilis, and cytomegalovirus (CMV) serologies
- Lab values within normal limits
 - CBC, urine, CEA, CMP
 - Plasma ammonia
 - Creatine Kinase (CK)
 - Serum magnesium
 - Lactic Acid Dehydrogenase
 - Serum phosphate
 - Platelet count

- Dental evaluation with treatment of any significant dental disease

D. Heart Transplantations

1. Coding for Heart Transplantations

The IHCP provides reimbursement for the following three components of heart transplantation with or without lung transplant. Providers are advised to report the appropriate CPT code from **Table 3** for reimbursement of heart transplants.

- Cadaver donor cardiectomy consists of harvesting and cold preservation of the graft prior to transport (see CPT code 33940).
- Backbench work consists of dissection of the donor heart from surrounding soft tissue prior to transplantation and preparation of aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for transplantation (see CPT code 33944).
- Recipient transplantation includes transplanting the heart/lungs into the patient (see CPT codes 33935 and 33945).

Repair or resection procedures of the donor heart should be reported using CPT codes 33300, 33310, 33320, 33400, 33463, 33464, 33510, 33641, 35216, 35276, and 35685 as appropriate. These procedures do not require prior authorization.

Table 3 - CPT Codes for Reporting Heart Transplantations

CPT Codes	Description
33940	Donor cardiectomy (including cold preservation)
33944	Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and pulmonary artery, and left atrium for implantation
33945	Heart transplant, with or without recipient cardiectomy

2. Indications for Heart Transplantation

The IHCP considers heart transplants medically necessary with prior authorization for **ONE of the following** indications.

- Eisenmenger's syndrome (ventricular septal defect - cardiac failure with significant right-to-left shunt producing cyanosis)
- Other complex congenital defects
- Myocardial failure unresponsive to medical management
- End-stage cardiomyopathy
- Inability to be weaned from temporary ventricular-assist devices after myocardial infarction or non-transplant cardiac surgery
- Valvular heart disease

AND meets ALL of the following criteria.

- Life expectancy with current medical management is expected to be 12 months or less
- Life expectancy after transplant expected to be two years
- The present degree of disability severely limits the member's activity. (New York Heart Association Classification III or IV)
- Member or guardian demonstrates a reasonable ability to comply with postoperative treatments meant to reduce the possibility of organ rejection, including medication administration and cardiac biopsies
- Adult member understands the risk and benefits of the transplant
- Member is one week of age or older and less than 70 years of age

3. Contraindications to Heart Transplantation

IHCP reimbursement for heart transplantation will not be provided when any of the following clinical situations are present.

- A juvenile with no identifiable caretaker or adequate family (social) support structure
- The member is moribund
- Fixed pulmonary hypertension or severe pulmonary disease (unless receiving combined heart/lung transplantation)
- Diabetes or uncontrolled hypertension
- Hepatic fibrosis or cirrhosis
- Hepatitis C with histological evidence of hepatic disease
- Uncorrected abdominal aneurysm greater than 4 centimeters
- The member exceeds 175% of normal weight for height and age
- Abnormal central nervous system (CNS) condition (e.g., CVA)
- Active malignancy or infection
- Active systemic disease that would not be alleviated by the requested transplant or that severely limits life expectancy or precludes adequate post-transplant rehabilitation such as autoimmune or collagen vascular disease
- Active gastrointestinal disease, such as bleeding peptic ulcer or diverticulitis
- Active illegal drug, tobacco, or alcohol dependence within the last six months
- Two or more documented, significant, abnormal lab or x-ray results
- Acquired immune deficiency syndrome (AIDS) as defined by a CD4 count of less than 200 cells/mm³ unless the following are noted
 - CD4 count greater than 200 cells/mm³
 - HIV-1 RNA undetectable
 - Stable anti-retroviral therapy for more than 90 days
 - No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, or Kaposi's sarcoma or other neoplasms).
- Uncontrolled or untreated psychiatric disorders that interfere with compliance to a strict treatment regimen

4. Documentation for Heart Transplantation

Documentation in the member's medical record must indicate the following information was obtained within a medically reasonable timeframe prior to the request for PA.

- History and physical (H&P) examination signed by a physician that includes the member's height, weight and gender: Additionally, the H&P should include psychiatric or psychological evaluation in cases having a history of depression, suicide attempts or drug dependence signed by a psychiatrist or HSPP.
- Clear documentation of the member's disease status including copies of all recent results of imaging studies, bone marrow testing, cytogenetics, and molecular studies when indicated
- CBC, UA, and CMP
- Chest X-ray, posteroanterior view
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- Appropriate screening for colon cancer, if member is greater than 40 years of age
- HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), syphilis, and cytomegalovirus (CMV) serologies
- Results of EKG, multigated-heart scan (MUGA scan), heart catheterization(s), or electrophysiological studies
- Results of arterial blood gases (ABGs) and pulmonary function tests if member was (is) a smoker or has a history of lung disease. Forced expired volume (FEV) less than 60% of normal, and forced vital capacity (FVC) less than 50% of normal may be a contraindication to transplant.
- Dental evaluation with treatment of any significant dental disease

E. Heart/Lung Transplantation

1. Coding for Heart/Lung Transplantation

The IHCP provides reimbursement for the following three components of a heart/lung transplantation, with PA. **Table 4**, on the next page, lists the codes to report for reimbursement of a heart/lung transplantation.

- Cadaver donor cardiectomy with pneumonectomy consists of harvesting and cold preservation of the graft prior to transport (see CPT code 33930).
- Backbench work includes dissection of the tissue around the heart and lungs and preparation of aorta, superior vena cava, inferior vena cava, and trachea for transplantation (see CPT code 33933).
- Recipient transplantation includes transplanting the heart/lungs into the patient (see CPT code 33935).

Repair or resection procedures of the donor heart should be reported using CPT codes 33300, 33310, 33320, 33400, 33463, 33464, 33510, 33641, 35216, 35276, and 35685 as appropriate. These procedures do not require prior authorization.

Table 4 - CPT Codes for Reporting Heart/Lung Transplantations

CPT Codes	Description
33930	Donor cardiectomy-pneumonectomy (including cold preservation)
33933	Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy

2. Indications for Heart/Lung Transplantation

The IHCP considers heart/lung transplants medically necessary with prior authorization if criteria for both heart and lung transplantation are met.

3. Contraindications for Heart/Lung Transplantation

IHCP reimbursement for heart/lung transplantation will not be provided when any of the contraindications for either a heart or lung transplantation, indicated previously in this document, are present.

4. Documentation for Heart/Lung Transplantation

The IHCP requires that documentation for heart lung transplantation meet the same criteria required for both heart and lung transplantation.

F. Hepatic (Liver) Transplantation

1. Coding for Liver Transplantation

The IHCP reimburses for three different components of liver transplantation as indicated below. **Table 5**, on the next page, lists the codes available for reporting liver transplantation.

- Cadaver or living donor hepatectomy consists of harvesting and cold preservation of the graft prior to transplantation and care of the donor, in the case of living donor hepatectomy (see CPT codes 47133, 47140-47142).
- Backbench work consists of preparation of donor liver prior to transplantation. This includes preparation of whole liver graft, including dissection and removal of surrounding tissue and soft tissue, preparation of the vena cava, portal vein, hepatic artery and common bile duct. Also included is preparation of the whole liver with splitting of the liver for partial grafts. Additional reconstruction of the liver graft including venous and arterial anastomosis(es) may also be performed (see CPT codes 47143-47147).
- Recipient transplantation includes transplanting the liver into the patient and care of the recipient (see CPT codes 47135-47136).

Table 5 - CPT Codes for Hepatic Transplantations

CPT Code	Description
47133	Donor hepatectomy (including cold preservation), from cadaver donor
47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age
47136	Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age
47140	Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)
47141	Donor hepatectomy (including cold preservation), from living donor; total left lobectomy (segments II, III and IV)
47142	Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII)
47143	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe split
47144	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of whole liver graft into two partial liver grafts (ie, left lateral segment (segments II and III) and right trisegment (segments I and IV through VIII))
47145	Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into two partial liver grafts (ie, left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII))
47146	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each
47147	Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each

2. Indications for Liver Transplantation

The IHCP considers liver transplants medically necessary with prior authorization for the **ONE of the following** indications.

- Acute liver failure due to viral hepatitis, drug reactions or toxins
- Chronic liver failure due to **ONE of the following**
 - primary biliary cirrhosis
 - chronic active hepatitis
 - autoimmune hepatitis
 - sclerosing cholangitis
 - biliary atresia
 - Budd-Chiari syndrome
 - alcoholic cirrhosis
 - cryptogenic cirrhosis
 - toxin induced cirrhosis

- Non-resectable, primary tumors of the liver, such as primary hepatomas and cholangiocarcinomas
- The development of life-threatening complications, such as variceal hemorrhage, encephalopathy, spontaneous bacterial peritonitis or intractable ascites
- Inborn errors of metabolism, such as Alpha-1 antitrypsin deficiency, Wilson's disease, primary hyperoxaluria, primary hypercholesterolemia, or tyrosinosis
- Traumatic or inflammatory, non-infectious conditions, other than metastatic cancer, which has resulted in the destruction of the liver or in the inability of the liver to function

AND meets ALL of the following criteria.

- Member, or guardian, demonstrates a reasonable ability to comply with post-operative treatments meant to reduce the possibility of organ rejection
- Life expectancy following transplant is expected to be two years
- Adult member is competent and understands the risks and benefits of the procedure
- Juveniles, or guardians, understand the likelihood of growth retardation as a result of the liver condition
- Member has normal or reversible cardiac, pulmonary, and renal function

3. Contraindications to Liver Transplantation

IHCP reimbursement will not be provided for liver transplantation when any of the following clinical situations are present.

- A juvenile with no identifiable caretaker or adequate family (social) support system
- Sepsis
- Age greater than 70 years of age and/or less than 90 days of age
- Any condition that would prevent rehabilitation
- Any severe, uncorrectable, pulmonary, cardiovascular, or renal dysfunction
- The member exceeds 175% of normal weight for height and age
- Active extrahepatic infection
- An abnormal central nervous system disorder, e.g., CVA
- An active extrahepatic malignancy
- Acquired immune deficiency syndrome (AIDS) as defined by a CD4 count of less than 200 cells/mm³ unless the following are noted.
 - CD4 count greater than 200 cells/mm³
 - HIV-1 RNA undetectable
 - Stable anti-retroviral therapy for more than 90 days
 - No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, or Kaposi's sarcoma or other neoplasms)

- Active systemic disease, other than diabetes, that would not be alleviated by the requested transplant or would limit life expectancy or compromise recovery, e.g., systemic vasculitis
- Active gastrointestinal disease, such as bleeding peptic ulcer or diverticulitis
- The member is moribund
- Active illegal drug or alcohol dependence within the previous six months
- Two or more significant, non-liver associated, abnormal lab or x-ray results
- Relative contraindications include, but are not limited to, previous extensive upper abdominal surgery, and thrombosis involving portal, superior mesenteric or splenic veins

4. Documentation for Liver Transplantation

Documentation in the member's medical record must indicate the following information was obtained within a medically reasonable timeframe prior to the request for PA.

- History and physical (H&P) examination signed by a physician that includes the member's height, weight and gender. Additionally, the H&P should include psychiatric or psychological evaluation in cases having a history of depression, suicide attempts or drug dependence signed by a psychiatrist or HSPP.
- Clearly document the disease status of the member including copies of all recent results of imaging studies, bone marrow testing (when indicated), cytogenetics, molecular studies, etc., if done, including CT scans or nuclear scans when appropriate for the work-up.
- CBC, UA, CMP, and EKG
- Chest X-ray, posteroanterior view
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- Appropriate screening for colon cancer if the member is over 50 years of age
- Thallium stress test results, or suitable alternative per a cardiologist, if the member has a history of significant cardiac risk factors.
- HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), syphilis, and cytomegalovirus (CMV) serologies
- Results of arterial blood gases (ABGs) and pulmonary function tests if member was (is) a smoker or has a history of lung disease. Forced expired volume (FEV) less than 60% of normal and forced vital capacity (FVC) less than 50% of normal may be a contraindication to transplant.
- Dental evaluation with treatment of any significant dental disease

G. Renal Transplantation

1. Coding for Renal Transplantation

The IHCP provides reimbursement for the following three different components of renal transplantation. **Table 6** lists the codes available for reporting renal transplantation.

- Cadaver or living donor nephrectomy consists of harvesting and cold preservation of the graft prior to transplantation and care of the donor (see CPT codes 50300, 50320, and 50547).
- Backbench work consists of preparation of the donor kidney prior to transplantation. This includes removal of perinephretic fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland; and preparation of ureter(s), renal vein(s), renal artery(s), and ligating branches as necessary. Other reconstruction procedures may involve venous, arterial, or ureteral anastomosis(es) necessary for the transplant (see CPT codes 50323, 50325, 50327-50329).
- Recipient transplantation includes transplanting the kidney into the patient (see CPT codes 50360, 50365).

Table 6 - CPT Codes Renal Transplantations

CPT Codes	Description
50300	Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral;
50320	Donor nephrectomy (including cold preservation); open, from living donor
50323	Back bench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland, and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary
50325	Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary
50327	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each
50328	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each
50329	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each
50340	Recipient nephrectomy (separate procedure)
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy;
50365	Renal allotransplantation, implantation of graft; with recipient nephrectomy
50380	Renal autotransplantation, reimplantation of kidney

2. Indications for Renal Transplantation

The IHCP considers kidney transplantations medically necessary with prior authorization for **ONE or more of the following** indications.

- Severe chronic renal failure with anticipated progression to end stage renal disease. Severe chronic renal failure is defined as a creatinine clearance of less than 30cc/min.
- Post-nephrectomy for pyonephrosis (infected hydronephrosis) due to chronic infection; infection must be resolved.
- Arteriovenous fistula with intractable hematuria not amenable to renal artery occlusive procedures
- Urothelial tumor of the renal pelvis
- Post-nephrectomy of atrophic kidney to treat uncontrolled hypertension
- Uncontrollable post transplant hypertension
- End-stage renal disease and availability of an acceptable donor kidney

AND meets ALL of the following criteria.

- Member has completed an evaluation and been accepted by the transplant committee at the kidney transplant center. Documentation must include a summary letter from the transplant center indicating acceptance and outlining the preoperative tests and their results.
- Absence of malignancy, or malignancy that has had curative therapy (e.g., surgical resection of non-invasive squamous cell or basal cell skin cancer), or the estimated risk of recurrence of the malignancy is less than 10% within the next two years. For example, renal cell carcinoma treated by nephrectomy with no evidence of metastatic disease two years after the nephrectomy, prostate cancer with negative prostate-specific antigen (PSA) levels after treatment, surgically treated colon cancer, thyroid cancer with normal thyroglobulin levels after therapy, and others. Women should have a negative Pap smear and mammography within the last year.
- The life expectancy following the transplant can reasonably be expected to be one year or more, measured by current standards.
- The member, or guardian, demonstrates a reasonable ability to comply with post-operative treatments meant to reduce the chance of organ rejection.
- The adult member is competent and understands the risks and benefits of the transplant.

3. Contraindications to Renal Transplantation

IHCP reimbursement will not be provided for renal transplantation when any of the following clinical situations are present.

- A juvenile with no identifiable caretaker or adequate family support structure

- Severe neurological or mental impairment in persons without adequate social support, such that the person is unable to adhere to the regimen necessary to preserve the transplant
- Oxalosis
- Recurrent uncorrectable lower urinary tract infections
- Any condition preventing rehabilitation
- Fixed pulmonary hypertension or severe pulmonary disease
- The member exceeds 175% of normal weight for height and age
- Progressive or deteriorating neurologic disease
- Persistent, uncontrolled coagulation disorder
- Active malignancy currently or within the past two years
- Active infection
- Active systemic disease other than renal, e.g., vasculitis, causing significant comorbidities
- Active gastrointestinal disease, such as bleeding peptic ulcer or diverticulitis
- The member is moribund
- Active illegal drug, or alcohol dependence within the last six months
- Two or more abnormal non-renal labs or x-rays without adequate explanation by the physician
- Acquired immune deficiency syndrome (AIDS) as defined by a CD4 count of less than 200 cells/mm³ unless the following are noted
 - CD4 count greater than 200 cells/mm³
 - HIV-1 RNA undetectable
 - Stable anti-retroviral therapy for more than 90 days
 - No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, or Kaposi's sarcoma or other neoplasms)

4. Documentation for Renal Transplantation

Documentation must indicate that the following information was obtained within a medically reasonable timeframe prior to the request.

- History and physical (H&P) examination signed by a physician that includes the member's height, weight and gender. Additionally, the H&P should include psychiatric or psychological evaluation signed by a psychiatrist or HSPP in cases having a history of depression, suicide attempts or drug dependence.
- CBC, UA, CMP, and EKG
- Chest X-ray, posteroanterior view
- CT scans or nuclear scan results when appropriate for the work-up
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- Appropriate screening for colon cancer, for members over 50 years of age
- Thallium stress test results, or suitable alternative per a cardiologist, for members with history of significant cardiac risk factors

- HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), syphilis, and cytomegalovirus (CMV) serologies
- Dental evaluation with treatment of any significant dental disease
- Results of arterial blood gases (ABGs) and pulmonary function tests if member was (is) a smoker or has a history of lung disease. Forced expired volume (FEV) less than 60% of normal and forced vital capacity (FVC) less than 50% of normal may be a contraindication to transplant.

H. Pancreatic Transplantation

1. Coding for Pancreatic Transplantation

IHCP provides reimbursement for three different components of pancreatic transplants with PA. Pancreatic transplantation that is performed at the same time as kidney transplantation is to be reported with the appropriate CPT code for each organ transplanted. **Table 7** lists the CPT codes that are available for reporting pancreatic transplantation.

- Cadaver pancreatectomy consists of harvesting and cold preservation of the graft prior to transplantation (see CPT code 48550).
- Backbench work consists of preparation of the donor pancreas prior to transplantation. This includes preparation of the pancreas by dissecting the soft tissues surrounding the pancreas, splenectomy, duodenotomy, ligation of the bile duct, ligation of the mesenteric vessels, and Y-graft arterial anastomosis from the iliac artery to the superior mesenteric artery and to the splenic artery. Venous anastomosis(es) may also be included in reconstruction of the donor pancreas. (See CPT codes 48551 and 48552).
- Recipient transplantation includes transplanting the pancreas into the patient (see CPT code 48554).

Table 7 - CPT Codes for Pancreatic Transplantation

CPT Codes	Description
48550	Donor pancreatectomy, (including cold preservation), with or without duodenal segment for transplantation
48551	Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomosis from iliac artery to superior mesenteric artery and to splenic artery
48552	Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation, venous anastomosis, each
48554	Transplantation of pancreatic allograft

2. Indications for Pancreatic Transplantation

The IHCP considers pancreatic transplantation medically necessary with PA when the following criteria are met.

ONE of the following.

- Type I diabetes mellitus
- Diabetic nephropathy with deteriorating or poor status
- Diabetic neuropathy
- Diabetic enteropathy
- Diabetic retinopathy, such as proliferative retinitis
- Diabetics who fail aggressive medical management of blood sugar
- Diabetics who demonstrate multiple episodes of ketoacidosis or hypoglycemia despite rigorous control and compliance
- Traumatic or inflammatory conditions, other than cancer, which has resulted in the destruction of the functional ability of the pancreas

AND meets ALL of the following criteria.

- Life expectancy following the transplant can reasonably be expected to be one year, measured by current standards and the transplant results of the institution doing the procedure
- Member, or guardian, demonstrates a reasonable ability to comply with the postoperative treatments meant to reduce the chance of organ rejection
- Adult member is competent and understands the risks and benefits of the transplant

4. Contraindications to Pancreas Transplantation

The IHCP will not provide reimbursement for pancreatic transplantation for the following clinical situations.

- Member is a juvenile with no identifiable caretaker or family support structure
- Type II diabetes
- The member is moribund
- Any condition preventing rehabilitation
- Severe, uncorrectable pulmonary, cardiac, renal, or hepatic dysfunction
- The member exceeds 175% of normal weight for height and age
- Abnormal CNS condition, e.g., CVA
- Active malignancy currently, or within past two years
- Active infection
- Active systemic disease other than diabetes, e.g., systemic vasculitis
- Active gastrointestinal disease, such as bleeding peptic ulcer or diverticulitis
- Active illegal drug, tobacco, or alcohol dependence within the last six months
- Two or more abnormal lab or x-ray reports, non-disease related

- Acquired immune deficiency syndrome (AIDS) as defined by a CD4 count of less than 200 cells/mm³ unless the following are noted
 - CD4 count greater than 200 cells/mm³
 - HIV-1 RNA undetectable
 - Stable anti-retroviral therapy for more than 90 days
 - No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, or Kaposi's sarcoma or other neoplasm)

5. Documentation for Pancreas Transplantation

Documentation must indicate the following information was obtained within a medically reasonable timeframe prior to the request.

- History and physical (H&P) examination signed by a physician that includes the member's height, weight and gender. Additionally, the H&P should include psychiatric or psychological evaluation signed by a psychiatrist or HSPP in cases having a history of depression, suicide attempts, or drug dependence.
- Clear documentation of the member's disease status including copies of all recent results of imaging studies, bone marrow testing, cytogenetics, and molecular studies when indicated
- CBC, UA, CMP, and EKG
- HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), syphilis, and cytomegalovirus (CMV) serologies
- Chest X-ray, posteroanterior and lateral views
- CT scans or nuclear scan results when appropriate for the work-up
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- Appropriate screening for colon cancer, results for members greater than 50 years of age
- Thallium stress test results, or suitable alternative per a cardiologist, for members with history of significant cardiac risk factors
- Results of arterial blood gases (ABGs) and pulmonary function tests if member was (is) a smoker or has a history of lung disease. Forced expired volume (FEV) less than 60% of normal and forced vital capacity (FVC) less than 50% of normal may be a contraindication to transplant.
- Dental evaluation with treatment of existing caries

I. Islet Cell Transplantation

1. Codes for Islet Cell Transplantation

The IHCP provides reimbursement for autologous islet cell transplantation with PA under CPT code 48160, *Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells*. Allogenic islet cell

transplantation, reported with HCPCS codes G0341, G0342, and G0343, are noncovered services, and are considered investigational.

2. Indications for Islet Cell Transplantation

An islet cell transplantation is indicated as an adjunct to a total or near total pancreatectomy in patients with chronic pancreatitis.

3. Contraindications for Islet Cell Transplantation

The IHCP will not provide reimbursement for pancreatic islet cell transplantation for the following clinical situations.

- Allogenic islet cell transplantation
- Treatment of type I diabetes
- Other applications for allogenic transplantation
- Active illegal drug, tobacco, or alcohol dependence within the last six months

4. Documentation for Islet Cell Transplantation

Documentation must indicate the following information was obtained within a medically reasonable timeframe prior to the request

- History and physical (H&P) examination signed by a physician that includes the member's height, weight and gender
- Clear documentation of the member's disease status including copies of all recent results of imaging studies, bone marrow testing, cytogenetics, and molecular studies when indicated
- HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), syphilis, and cytomegalovirus (CMV) serologies
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion

J. Intestinal (or Small Bowel) Transplantation

1. Codes for Intestinal Transplantation

The IHCP provides reimbursement for three different components of intestinal (or small bowel) transplantation with PA. **Table 8** lists the CPT codes available for reporting the transplantations.

- Cadaver or living donor enterectomy consists of harvesting and cold preservation of the graft prior to transplantation and care of the donor (see CPT codes 44132 and 44133).

- Backbench work consists of preparation of donor intestine prior to transplantation. This includes mobilizing and developing the superior mesenteric artery and vein (see CPT code 44715). Also included is any additional reconstruction of graft including venous and arterial anastomosis(es) (see CPT codes 44720-44721) prior to transplantation.
- Recipient transplantation includes transplanting the intestine into the patient (see CPT codes 44135 and 44136).

Table 8 - CPT Codes for Reporting Intestinal and Small Bowel Transplantation

CPT Code	Description
44132	Donor enterectomy (including cold preservation), open; from cadaver donor
44133	Donor enterectomy (including cold preservation), open; partial, from living donor
44135	Intestinal allotransplantation; from cadaver donor
44136	Intestinal allotransplantation; from living donor
44715	Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein
44720	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each
44721	Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; arterial anastomosis, each

2. Indications for Intestinal Transplantation

The IHCP considers intestinal transplant medically necessary with PA for members with irreversible intestinal failure who can no longer be maintained on total parenteral nutrition (TPN). PA may be given for small bowel or intestinal transplantation for the indications listed in **Table 9**, below. Clinical indications of TPN failure are listed in **Table 10**.

Members must meet both of the following criteria.

- The member must be capable of following a complex medical regimen post-transplantation.
- The member must be emotionally stable with a realistic attitude demonstrated during past and current illness.

Table 9 - Indications for Intestinal Transplantation

Pediatric	Adult
Aganglionosis (Hirschsprung's disease)	Crohn's disease
Congenital epithelial mucosal disease (microvillus inclusion disease, tufting enteropathy)	Desmoid tumors

Table 9 - Indications for Intestinal Transplantation (continued)

Pediatric	Adult
Gastroschisis	Gardner's syndrome/familial polyposis
Intestinal atresia	Ischemia
Necrotizing enterocolitis	Trauma
Pseudo-obstruction	Volvulus
Volvulus	Surgical adhesions
Radiation enteritis	Hollow visceral myopathy
Short gut syndrome	Inflammatory bowel disease
	Short Gut Syndrome

Table 10 - Clinical Indications of TPN Failure

Clinical Indications
Impending or overt liver failure due to TPN. Symptoms include: <ul style="list-style-type: none"> • Elevated bilirubin and/or liver enzymes • Gastroesophageal varices • Coagulopathy • Splenomegaly • Thrombocytopenia • Stomal bleeding • Hepatic fibrosis/cirrhosis
Central line access failure as evidenced by: <ul style="list-style-type: none"> • Thrombosis of two or more of the major central channels (jugular, subclavian, and femoral veins) • Pulmonary embolism • Superior vena cava syndrome • Chronic venous insufficiency
Two or more episodes of systemic sepsis due to line infection per year that requires hospitalization or a single episode of line-related fungemia, septic shock or acute respiratory distress syndrome
Frequent episodes of severe dehydration despite IV fluid supplementation

3. Contraindications for Intestinal Transplantation

The IHCP will not provide reimbursement for intestinal transplantation for the following clinical situations.

- **Absolute Contraindications**
Members with the following absolute contraindications will not be approved for intestinal transplantation.
 - Active malignancy, with the exception of squamous or basal cell carcinoma
 - Ongoing, recurring, or unsuccessfully treated infections
 - Serious cardiac insufficiencies that create an inability to tolerate transplantation
 - Active systemic illness

- Active illegal drug, tobacco, or alcohol dependence within the last six months
- Demonstrated patient noncompliance with medical recommendations
- Acquired immune deficiency syndrome (AIDS) as defined by a CD4 count of less than 200 cells/mm³ unless all of the following are noted
 - (1) CD4 count greater than 200 cells/mm³ for greater than 5 months
 - (2) HIV-1 RNA undetectable
 - (3) Stable anti-retroviral therapy for more than 90 days
 - (4) No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, Kaposi's sarcoma or other neoplasm)
- Relative Contraindications

Members meeting any **ONE of the following** general or disease specific relative contraindications must be evaluated carefully.

 - Potential complications from immunosuppressive medications
 - Cerebrovascular disease or accident, or progressive neuropathy or myopathy that is not amenable to rehabilitation
 - Malnutrition defined by a body mass index (BMI) of less than 17 or greater than 33
 - Uncontrolled co-morbid conditions such as diabetes mellitus, hypertension, autoimmune disease, or cytopenia
 - Untreated osteoporosis with a T-score greater than 2.5 standard deviations from mean or a Z-score greater than 2 standard deviations from mean
 - Uncorrected abdominal aortic aneurysm greater than four centimeters
 - Diabetes with end-organ damage such as neuropathy, nephropathy, and retinopathy
 - The member is greater than 70 years of age
 - Peripheral vascular disease not amenable to surgical or percutaneous therapy

4. Documentation for Intestinal Transplantation

Documentation must indicate that the following information was obtained within a medically reasonable timeframe prior to the request.

- History and physical (H&P) examination signed by a physician that includes the member's height, weight and gender. Additionally, the H&P should include psychiatric or psychological evaluation signed by a psychiatrist or HSPP in cases having a history of depression, suicide attempts or drug dependence.
- All current medication and treatment plans
- Clear documentation of the member's disease status including copies of all recent results of imaging studies, bone marrow testing, cytogenetics, and molecular studies when indicated
- Chemistries, including CBC, CMP, UA and creatinine clearance (if creatinine is greater than 2.0)
- Lipid and hepatic function panels

- HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), syphilis, and cytomegalovirus (CMV) serologies
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion.
- Recent electrocardiogram (EKG) and chest X-ray, posteroanterior view
- Psychosocial evaluation, performed at the transplant center
- Dental evaluation with treatment of any significant dental disease

K. Multi-Visceral Transplantation

1. Coding for Multi-Visceral Transplantation

Multi-visceral transplantation includes transplantation of the intestine, pancreas, and liver. Additional organs could include the stomach and colon. **Table 11** lists the codes available for reporting multi-visceral transplantation. Providers are advised to report the appropriate CPT code for the organs transplanted.

The IHCP reimburses for the three components (removal of donor organ, backbench work and recipient transplantation) for each organ included in the multi-visceral transplant.

- Cadaver or living donor enterectomy consists of harvesting and cold preservation of the organs prior to transplantation and care of the donor.
- Backbench work consists of preparation of donor organs prior to transplantation.
- Recipient transplantation includes transplanting the organs into the patient.

Table 11 -Codes for Reporting Multi-Visceral Transplantation

Codes	Description	Reference
44132-44133	Donor enterectomy (including cold preservation), open	See Table 8
44135-44136	Intestinal allotransplantation	
44715, 44720-44721	Backbench work – intestine allograft	
47133, 47140-47142	Donor hepatectomy	See Table 4
47135-47136	Liver transplantation	
47143-47147	Backbench work – liver graft	
48550	Donor pancreatectomy	See Table 7
48554	Pancreatic transplant	
48551-48552	Backbench work – pancreas allograft	

2. Indications for Multi-Visceral Transplantation

The IHCP considers multi-visceral transplant medically necessary with PA when **ONE of the following** criteria are met.

- Irreversible intestinal and multi-visceral organ failure that can no longer be maintained with TPN
- Total occlusion of the splanchnic circulation
- Extensive GI polyposis
- Myopathy or neuropathy of the hollow viscera
- Abdominal malignancy

NOTE:

1. Members must meet the PA criteria listed in this fact sheet for intestinal, liver and/or pancreatic transplantation in order to qualify for multi-visceral transplantation of these organs.
2. Providers should refer to the intestinal transplantation criteria for indications of intestinal failure and TPN failure.

AND both of the following criteria.

- The patient must be capable of following a complex medical regimen post-transplantation.
- Emotionally stable with realistic attitude demonstrated during past and current illness.

3. Contraindications to Multi-Visceral Transplantation

The IHCP will not provide reimbursement for multi-visceral transplantation for the following clinical situations.

- Absolute Contraindications

Members with the absolute contraindications as listed below will not be approved for multi-visceral transplantation.

- Active malignancy, with the exception of squamous or basal cell carcinoma
- Ongoing, recurring, or unsuccessfully treated infections
- Serious cardiac insufficiencies that create an inability to tolerate transplantation
- Active systemic illness
- Active illegal drug, tobacco, or alcohol dependence within the last six months
- Demonstrated patient noncompliance with medical recommendations
- Acquired immune deficiency syndrome (AIDS) as defined by a CD4 count of less than 200 cells/mm³ unless all of the following are noted
 - (1) CD4 count greater than 200 cells/mm³
 - (2) HIV-1 RNA undetectable
 - (3) Stable anti-retroviral therapy for more than 90 days

- (4) No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, Kaposi's sarcoma or other neoplasm)

- Relative Contraindications

Members meeting any **ONE of the following** general or disease specific relative contraindications must be evaluated carefully.

- Potential complications from immunosuppressive medications
- Cerebrovascular disease or accident, or progressive neuropathy or myopathy that is not amenable to rehabilitation
- Malnutrition defined by a BMI of less than 17 or greater than 33
- Uncontrolled co-morbid conditions such as diabetes mellitus, hypertension, autoimmune disease, or cytopenia
- Untreated osteoporosis with a T-score greater than 2.5 standard deviations from mean or a Z-score greater than 2 standard deviations from mean
- Uncorrected abdominal aortic aneurysm greater than four centimeters
- Diabetes with end-organ damage such as neuropathy, nephropathy, and retinopathy
- The member is greater than 70 years of age
- Peripheral vascular disease not amenable to surgical or percutaneous therapy

4. Documentation for Multi-Visceral Transplantation

Documentation in the member's medical record must indicate the following information was obtained within a medically reasonable timeframe prior to the request for PA.

- History and physical (H&P) examination signed by a physician that includes the member's height, weight and gender. Additionally, the H&P should include psychiatric or psychological evaluation signed by a psychiatrist or HSPP in cases having a history of depression, suicide attempts or drug dependence.
- All current medication and treatment plans
- Clear documentation of the member's disease status including copies of all recent results of imaging studies, bone marrow testing, cytogenetics, and molecular studies when indicated
- Chemistries, including CBC, CMP, UA, and creatinine clearance (if creatinine is greater than 2.0)
- Lipid and hepatic function panel
- HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), syphilis, and cytomegalovirus (CMV) serologies

- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- Recent electrocardiogram (EKG) and chest X-ray, posteroanterior view
- Psychosocial evaluation, performed at the transplant center
- Dental evaluation with treatment of any significant dental disease

REMOVAL OF TRANSPLANTED ORGANS

Certain organs may require removal following transplantation due to organ rejection. Removal of a transplanted organ does not require prior authorization. Transplantation of another organ does require a new PA request. The CPT codes available for reporting transplant removal are listed in **Table 12**.

Table 12 - CPT Codes for Reporting Removal of Transplanted Organs

CPT Code	Description
44137	Removal of transplanted intestinal allograft, complete
48556	Removal of transplanted pancreatic allograft
50370	Removal of transplanted renal allograft

BILLING REQUIREMENTS

The IHCP provides reimbursement for coverage of costs related to donor testing and harvesting. Additionally, the IHCP allows reimbursement for the donor's medications that are typically covered by the IHCP. The donor costs are billed under the IHCP member's name and recipient identification number (RID).

Transplantation of multiple organs at the same time is to be reported with the appropriate CPT code for each organ. Claims submitted for multiple organ transplantations will be subject to the multiple procedure reduction.

Transportation services for the member and caregiver to and from the transplant center are provided following guidelines for transportation services in the Medical Policy fact sheet for Transportation Services.

Routine post-operative surgical care during the first 90 days is included in the physician reimbursement for surgical procedures. Separate reimbursement is available for care provided that is not considered routine for the surgical condition, such as complications.

Organ transplants are not covered for Hoosier Healthwise Package C members. Inpatient claims submitted to the IHCP that group to experimental organ transplant DRGs are denied. Refer to the Medical Policy Fact Sheet for Clinical Trials for further information regarding any experimental or investigational procedure. DRGs for non-experimental organ transplants are 103, 302, 480, 795, 803, 804, and 805.

OUT-OF-STATE TRANSPLANTATIONS

The IHCP will provide for transplant surgeries in out-of-state facilities when the hospital specializes in the particular transplantation procedure, or if the hospital is one of a limited number of hospitals that can perform the procedure. All out-of-state services must be prior authorized. The requests for these procedures are reviewed on an individual basis. Refer to the Medical Policy Fact Sheet for Out-of-State Services for further information.

Out-of-state providers who receive approval from OMPP for transplantation will receive a written notification regarding how the claim will be reimbursed (either by the IHCP statewide rate or a percentage of the provider's usual and customary), and the coverage period (such as 365 days from transplant). The provider will be assigned a point of contact at EDS to assist with tracking expenditures, and processing of payment for services. Outpatient lab services are paid at the IHCP rate on file, with no additional payment unless specific approval is given by OMPP.

MANAGED CARE

Organ transplantations require the Primary Medical Providers (PMP) to obtain prior authorization for transplants. This should not be confused with PMP referral. Hoosier Healthwise managed care organizations (MCOs) have their own authorization requirements. Please contact the appropriate MCO for further information.

TRANSPLANTATIONS THAT DO NOT REQUIRE PRIOR AUTHORIZATION

A Corneal Tissue Transplantation

1. Coding for Corneal Tissue Transplantation

The IHCP provides reimbursement for corneal tissue transplants when medically necessary without prior authorization for services provided in-state. However, all procedures provided out-of-state must be prior authorized. Corneal tissue transplantation was removed from 405 IAC 5-3-13, services that require PA, in 2005. **Table 13** lists the covered CPT codes for the reimbursement of corneal tissue transplants.

Table 13 - CPT Codes for Reporting Corneal Transplantations

CPT Codes	Description
65710	Keratoplasty (corneal transplant); lamellar
65730	Keratoplasty (corneal transplant); penetrating (except in aphakia)
65750	Keratoplasty (corneal transplant); penetrating (in aphakia)

Table 13 - CPT Codes for Reporting Corneal Transplantations (continued)

CPT Codes	Description
65755	Keratoplasty (corneal transplant); penetrating (in pseudophakia)
65780	Ocular surface reconstruction; amniotic membrane transplantation
65781	Ocular surface reconstruction; limbal stem cell allograft (e.g. cadaveric or living donor)
65782	Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft)

2. Indications for Corneal Tissue Transplantation

IHCP provides reimbursement for corneal transplantation for **full thickness** corneal disease for the following medical conditions.

- Bullous keratopathy
- Corneal opacity
- Corneal thinning with potential for corneal perforation
- Keratoconus with ≥ 2 episodes of corneal hydrops
- Keratoconus (conical protrusion of cornea caused by thinning of the stroma) with potential for corneal perforation

Reimbursement is available for corneal transplantation for **partial thickness** corneal disease for **ONE of the following** medical conditions.

- Superficial stromal opacification
- Marginal corneal thinning or infiltration
- Localized corneal thinning or descemetocoele formation

The IHCP provides reimbursement for transplantation of **new tissue** to the cornea for the treatment of severe corneal surface disease, reported with CPT codes 65780, 65781, and 65782 for the following medical conditions.

- Corneal pannus or superficial corneal scarring
- Persistent corneal epithelial defects
- Corneal perforation
- Neurotrophic keratitis
- Persistent corneal epithelial defects
- Bullous keratopathy
- Corneal thinning
- Corneal ulcer
- Chemical burns of the ocular surface
- Erythema multiforme, including Stevens-Johnson syndrome

3. Billing for Corneal Tissue

The IHCP provides reimbursement for donated corneal tissue under HCPCS code V2785 – *processing, preserving, and transporting of corneal tissue*. The IHCP requires providers to bill HCPCS code V2785 on the CMS-1500 claim form or the 837P transaction for reimbursement separate from the Ambulatory Surgery Center (ASC) rate for outpatient corneal transplant procedures. A copy of the invoice from the eye bank or organ procurement organization showing the actual cost of acquiring the tissue must be attached to the claim form. When submitting paper attachments with an 837P transaction, providers must follow the instructions in the IHCP Provider Manual, Chapter 8, Section 1. The IHCP will reimburse providers 90% of the invoice amount.

RELATED MEDICAL TOPICS

Hospital Inpatient
Hospital Outpatient
Out of State Services
Transportation
Surgical Services

RULES, CITATIONS, AND SOURCES

Indiana Administrative Code
 405 IAC 5-3-13 – Services Requiring Prior Authorization
 405 IAC 5-29-1 – Services not Covered by Medicaid; Noncovered Services
Indiana Code
 IC 29-2-16-12 – Donation Costs
Indiana Health Coverage Programs Provider Bulletins
 BT199928 – Hoosier Healthwise Package C Overview
 BT200018 – Package C Claim Update
 BT200231 – Carve Out and Self-Referral Education
 BT200420 – Changes in Hospital Reimbursement Methodologies and Updated
 DRG/LOC Reimbursement Rates
Indiana Health Coverage Programs Provider Banners
 BR200506 – Corneal Tissue Reimbursement
Indiana Health Coverage Programs Provider Manual
 Version 5.1, March, 2005

Origination Date: 12/31/2000

Revisions and Review	Reason	Date
Revision	Revision of 405-IAC-5-3-13 Services requiring prior authorization, Revision of PA criteria	07/29/05

APPLICABLE INDIANA A/M EDITS AND AUDITS

4062—Organ Transplants are Non-covered for Package C.
 6002—Any Two Anesthesiology Providers Same Procedure Requires Review
 6003—Manual Pricing for Split Care Billing
 6015—Global Payable at a Reduced Fee When Components Paid – Respiratory System
 6034—Global Surgery Payable at Reduced Amount When Components of Surgical Care Paid
 6035—Components of Surgical Care not Payable When Global Surgery Paid
 6037—One Assistant Surgeon Allowed for Select Surgeries
 6038—Two Assistant Surgeons Allowed Only for Select Surgeries
 6039—Assistant Surgeon Not Payable When Co-Surgeon Paid
 6040—Co-Surgeon Paid at Reduced Amount when Assistant Surgeon Paid
 6063—Components Not Payable When Global Paid – Respiratory System
 6096—The CPT/HCPCS Code Billed is Not Payable According to the PPS Reimbursement Methodology
 6152—Surgery Payable at Reduced Amount When Consultation Paid Days Before or After Surgery
 6649—Surgery Payable at Reduced Amount When Related Postoperative Care Paid
 6652—Multiple Surgeries Must be Billed on Same Claim
 6661—Duramorph Can Not Be Billed on Same Day as Surgery
 6666—Anesthesia Services Not Allowed By Provider Billing for Surgery

MEDICAL POLICY FACT SHEET

TITLE: THERAPY SERVICES

DESCRIPTION

The Indiana Health Coverage Programs (IHCP) covers therapy services for its members. Therapy services, as described in this fact sheet, encompass occupational therapy, respiratory therapy, and physical therapy.

SUMMARY OF CURRENT POLICY

Reimbursement is available only for medically reasonable and necessary therapy services provided by professionally trained staff, within the scope of their professional license and/or credentials. Medically necessary therapy services, as defined in 405 IAC 5-22-1 are, “for the restoration of an impaired level of function caused by an acute change in medical condition.” Therapy services must be complex enough to require the judgment, knowledge, and skills of a qualified therapist. The IHCP will only cover rehabilitative services for up to two years from the initiation of the therapy unless there is a significant change in the medical condition. Therapy services may be provided in inpatient and outpatient settings such as the home, outpatient clinics, rehabilitation hospitals, inpatient hospitals, long term care facilities, and ICF/MR facilities.

RELATED MEDICAL TOPICS

Aged and Disabled – Waiver Services
Autism – Waiver Services
Consultations – Second Opinions
Emergency Medicine – Cardiopulmonary Resuscitation (CPR)
Emergency Medicine – Emergency Room
Emergency Medicine – Emergency Services
EPSDT - HealthWatch
Home Health Services
Hospital Inpatient
Intermediate Care Facilities for the Mentally Retarded
Medical Supplies and Equipment
Medically Fragile Children – Waiver Services

RULES, CITATIONS, AND SOURCES

IC 25-23.5-1-4
 IC 25-23.5-1-5
 IC 25-23.5-1-5.5
 IC 25-23.5-1-6
 IC 25-23.5-5-1
 IC 25-23.5-5-2
 IC 25-27-1-1
 IC 25-27-1-6
 IC 25-34.5-1-6
 IC 25-34.5-1-7
 IC 25-34.5-2-8
 IC 25-35.6-1-2
 IC 25-35.6-1-3
 IC 25-35.6-1-4
 IC 25-35.6-1-5
 405 IAC 5-3-12 Prior Authorization; exceptions
 405 IAC 5-5 Out of State Services
 405 IAC 5-16 Home Health Agency and Clinic Services
 405 IAC 5-16-4 Rehabilitation center services; limitations
 405 IAC 5-17 Hospital Services
 405 IAC 5-17-4 Physical rehabilitation services
 405 IAC 5-22 Nursing and Therapy Services
 405 IAC 5-32 Rehabilitation Unit
 Indiana Medicaid Update Bulletin 96-26
 Indiana Health Coverage Programs Provider Manual 1999
 Indiana Health Coverage Programs Provider Manual, July 2004

ORGANIZATION, REVISIONS, AND REVIEWS

Origination Date: July 1, 1991

Revisions and Reviews	Reason	Date
IC 25-23.5	Occupational Therapy	1989
IC 25-27	Physical Therapy	1989
IC 25-34.5	Respiratory Therapy	1989
470 IAC 5-8-19; 5-9-23, 24, 25, & 37 Transferred	Nursing and Therapy Services; Inpatient, Outpatient, and Allied Health Services; Rehabilitation Unit	7/1/91
405 IAC 1-6-20; 1-7-21; 1-7-22; 1-7-23; 1-7-35 <i>Repealed 8/24/97</i>	Nursing and Therapy Services; Inpatient Therapy, Outpatient Therapy, and Allied Health Services; Rehabilitation Unit	1/1/92

Revisions and Reviews	Reason	Date
Indiana Medicaid Update Bulletin	Bypassing of Occurrence Code “50” for OT and PT	7/29/96
405 IAC 5-3-12	Prior Authorization; exceptions	8/24/97
405 IAC 5-5-1	Out of State Services, Therapy Services	8/24/97
405 IAC 5-16	Home Health Agency Services Medicaid Reimbursement for OT, PT, and RT	8/24/97
405 IAC 5-16-4	Rehabilitation Center Services; Limitations	8/24/97
405 IAC 5-22-5	Occupational, Physical, and Respiratory Therapy and Speech Pathology; Reimbursement	8/24/97
405 IAC-5-22-6	Occupational, Physical, and Respiratory Therapy and Speech Pathology; Criteria for Prior Authorization	8/24/97
405 IAC 5-22-8	Physical Therapy Services	8/24/97
405 IAC 5-22-10	Respiratory Therapy Services	8/24/97
405 IAC 5-22-11	Occupational Therapy Services	8/24/97
405 IAC 5-29-1	Non-Covered Services	8/24/97
405 IAC 5-5-1	Out of State Services, Therapy Services	10/27/99
405 IAC 5-16-2	Home Health Agency Services Medicaid Reimbursement for OT, PT, and RT	10/27/99
405 IAC 5-16-3	Home Health Agency Services Medicaid Reimbursement for OT, PT, and RT	10/27/99
405 IAC 5-16-3.1	Home Health Agency Services; Limitations	10/27/99
405 IAC 5-22-6	Occupational, Physical, and Respiratory Therapy and Speech Pathology; Criteria for Prior Authorization	10/27/99
405 IAC 5-29-1	Non-Covered Services	10/27/99
Scheduled Review	IHCP Provider Manual, Chapter 8 Therapy Services	1/31/2005

APPLICABLE INDIANA A/M EDITS AND AUDITS

- 4086 – Therapies More Than 30 Days from Hospital Discharge
- 6750 – No More Than 30 Hours Within 30 Days from Hospital Discharge
- 6752 – Physical Therapy Evaluation Limited to One per 12 Month
- 6753 – Occupational Therapy Evaluation Limited to One per 12 Month
- 6755 – Outpatient Therapies Exceeded 80 Units per Year

COVERAGE CRITERIA

General Therapy Service Limitations

Prior authorization (PA) is required for all therapy services, as indicated in 405 IAC 5-22-6 and outlined in the IHCP Provider Manual. The following are exceptions to the PA requirement for occupational, physical, and respiratory therapy services.

- Initial evaluations
- Any combination of occupational, physical, and respiratory therapy ordered in writing prior to a recipient's discharge from inpatient hospital care, may continue for a period not to exceed 30 hours, sessions, visits in 30 calendar day with PA
- Deductible and copayment for services covered by Medicare Part B
- Oxygen equipment and supplies necessary for the delivery of oxygen with the exception of concentrators

Physical therapy and occupational therapy ordered in writing by a physician to treat an acute medical condition requires PA, except in the following instances, as required in 405 IAC 5-22-8, 10, and 11.

- Physical therapy services ordered in writing by a physician in an outpatient setting may continue for a period not to exceed 12 hours, sessions, or visits in 30 calendar days without PA. This includes the provision of splints, crutches, and canes. Additional services require PA.
- Occupational therapy services ordered in writing by a physician may continue for a period not exceeding 12 hours, sessions, or visits in 30 calendar days without PA. This includes the provision of splints, crutches, and canes.
- Respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis, and upper respiratory infection may be provided for a period not to exceed 14 hours or 14 calendar days without PA. Additional services require PA.

The following criteria must be met for PA of physical, respiratory, and occupational therapy, when provided outside of the exceptions previously stated.

- Written evidence of physician involvement and personal member evaluation will be required to document acute medical needs. Therapy must be ordered by a physician.
- A current plan of treatment, including clearly stated and measurable goals and progress.
- Once a member fails to progress or has reached his/her potential, services are discontinued.
- Therapies must be provided by a qualified therapist or qualified assistant under direct supervision of the therapist as appropriate.
- Therapy must be complex enough to require the judgment, knowledge and skills of a qualified therapist.

- Therapy for diversional, recreational, vocational, or avocational purpose or for the remediation of learning disabilities or for developmental activities that can be conducted by nonmedical personnel is non-covered.
- Therapy for rehabilitative services will be covered for a member no longer than two years from the initiation of the therapy unless there is a significant change in medical condition.
- Ongoing evaluations to assess progress and redefine therapy goals are part of the therapy program. Ongoing evaluations are not separately billable under the IHCP.
- One hour of therapy must include a minimum of 45 minutes of direct care with the member. Only one hour per day, per type of therapy will be approved.
- Therapies which duplicate other services provided to a patient will not be authorized (e.g., nursing services).

Therapy services provided by a nursing facility (NF) or large private or small intermediate care facility for the mentally retarded are included in the facility's per diem rate. Therapy services provided in these settings is not separately reimbursable. Occupational therapy psychiatric services are non-covered. In addition, general strengthening exercise programs for recuperative purposes and passive range of motion services as the only or primary modality are non-covered.

The initial evaluation does not require prior authorization; however, any additional re-evaluations require PA, unless it is conducted during the initial 30 days after a member has been discharged from the hospital and those orders include physical or occupational therapy. Re-evaluations will only be authorized one time per year, unless the provider submits documentation showing a significant change in the member's condition.

Therapy assistants may only perform the following activities. Reimbursement for these activities is included in the IHCP rate for the particular modality provided by the licensed therapist and may not be billed separately.

- Assisting member's in preparation for, as necessary during, and at the conclusion of the treatment
- Assembling and disassembling equipment
- Assisting the physical therapist in the performance of appropriate activities related to the treatment of the member
- Following established procedures pertaining to the care of equipment and supplies
- Preparing, maintaining, and cleaning treatment areas and maintaining supportive areas
- Transporting patients, records, equipment, and supplies in accordance with established policies and procedures
- Performing established clerical procedures

Occupational therapy

Occupational therapy, as defined in the Indiana Code (IC) 25.23-5-1-5, is the planning and directing exercises and programs to enhance sensory and motor skills to achieve and maintain an individual's optimal functional ability in activities of daily living and to further prevent disability.

Occupational therapy is reimbursed when performed by an occupational therapist or by a certified occupational therapy assistant under the direct, on-site supervision of a registered occupational therapist. Reimbursement for occupational therapy evaluations is only available when performed by a registered occupational therapist. Occupational therapy psychiatric services are non-covered.

Physical Therapy

Physical therapy, as defined in IC 25-27-1-1, is, "the evaluation of, treatment of, or instruction in physical rehabilitative and habilitative techniques and procedures to evaluate, prevent, correct, treat, alleviate, and limit physical disability; pathokinesiological function, bodily malfunction, pain from injury, disease, and any other physical disability or mental disorder."

Physical therapy is reimbursed in the IHCP when performed by a licensed physical therapist or certified therapy assistance under the direct, on-site supervision of a licensed physical therapist.

Respiratory Therapy

Respiratory care, as defined in IC 25-34.5-1-6 is an allied health specialty designed to assist the supervising physician or osteopath in the treatment, management, diagnostic testing, control, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system. A respiratory therapy practitioner is someone who meets the licensing requirements under IC 25-34.5.

Respiratory therapy services are reimbursed by the IHCP only when performed by a licensed respiratory therapist or certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency, or clinic. Respiratory therapists are not recognized providers by the IHCP. Services performed by a respiratory therapist must be billed by the supervising physician.

Inpatient Rehabilitation Services

The IHCP provides reimbursement for medically necessary inpatient rehabilitation services provided by licensed, certified, or registered staff members. All rehabilitation center services require PA. A written plan of care is required for all rehabilitation

services. The therapist or psychologist and the attending physician must cooperatively develop the plan of care.

Prior to admission to a physical rehabilitation unit, the member's total rehabilitative potential must be evaluated. Documentation in the medical record must include the member's condition, IHCP criteria, and level of care necessary in the rehabilitation unit. The following conditions must be met for reimbursement for a physical rehabilitation admission.

- The member must be medically stable.
- The member must be responsive to verbal or visual stimuli.
- The member must have sufficient mental alertness to participate in the program.
- The member's premorbid condition(s) indicates a potential for rehabilitation.
- The expectation for improvement is reasonable.

In addition to these conditions, the member must be able to demonstrate the inability to function independently as defined in 405 IAC 5-32-1. The following are evaluated to determine the member's ability or inability to function independently.

- Cognitive function (attention span, memory, or intelligence)
- Communication (aphasia with major receptive or expressive dysfunction)
- Continence (bladder or bowel)
- Mobility (transfer, walk, climb stairs, or wheelchair)
- Pain management (pain behavior limits functional performance)
- Perceptual motor function (spatial orientation or depth or distance perception)
- Self-care activities (drink or feed, dress, maintain personal hygiene, brace or prosthesis)

The following intensity of service criteria must be met for reimbursement for services provided in a rehabilitation center.

- Multidisciplinary team evaluation at least every two weeks.
- Physical therapy must be provided in conjunction with occupational and/or speech therapy.
- Participation in a rehabilitation program must be under the direction of a qualified physician.
- Daily skilled rehabilitative nursing care or supervision.

THERAPY SERVICES ADDENDUM A

Note: This addendum contains provider notifications that have been published since the review of the Therapy Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BR200539 **Publication Date:** 09/27/2005

Subject: Hippotherapy for Physical Therapy

Date Added to Manual: 10/31/2005

Text of Publication

The IHCP has initiated coverage of hippotherapy for physical therapy effective April 1, 2005. To be covered, services must be provided by a licensed physical therapist and should be billed using the appropriate HCPCS code from the following list:

- 97110 – Therapeutic exercises to develop strength and endurance, range of motion, and flexibility
- 97112 – Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
- 97530 – Therapeutic activities to improve functional performance
- 97533 – Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands

Services must be ordered by a physician and included in the patient's treatment plan. Existing PA requirements for physical therapy apply to hippotherapy.

Note: Procedure code S8940 (hippotherapy per person, equestrian, hippotherapy, per session) was a new HCPCS code effective January 1, 2005, and is **not** covered by the IHCP.

THERAPY SERVICES ADDENDUM B

Note: This addendum contains provider notifications that have been published since the review of the Therapy Services Fact Sheet. The information in this addendum will be incorporated into the fact sheet at the next review.

Provider Notification: BT200611 **Publication Date:** 04/20/2006

Subject: Notification of Physical Therapist Assistant's Rule Change

Date Added to Manual: 04/28/2006

Text of Publication

The purpose of this bulletin is to advise providers that the Indiana Administrative Code (IAC) *405 IAC 1-11.5-2* was amended to allow for the reimbursement of services provided by certified physical therapists' assistants (PTA). This rule amends *405 IAC 5-22-8* regarding supervision requirements for services provided by certified physical therapists' assistants. The PTA is precluded from performing and interpreting tests, conducting initial or subsequent assessments, and developing treatment plans. Under direct supervision, a PTA is still required to consult with the supervising physical therapist daily to review treatment. The consultation can be either face-to-face or by telephone.

Covered Procedures for PTAs

Effective April 1, 2006, the Indiana Health Coverage Programs (IHCP) has identified procedures that can be performed by a PTA and are eligible for reimbursement. Providers must bill these services with the modifier *HM-Less than a bachelor's degree*. Pricing for these services will reimburse at 75 percent of the reimbursement level for a physical therapist. Table 1 lists the physical therapy services that PTAs may perform. Evaluation and testing codes are excluded from this list as PTAs may not administer tests or perform evaluations.

**Table 1—Physical Therapy Services that May Be Performed by a PTA Current
Procedural Terminology® Code Description**

Code	Description
29505	Application of long leg splint (thigh to ankle or toes)
29515	Application of short leg splint (calf to foot)
29520	Strapping; hip
29530	Strapping; knee
29540	Strapping; ankle and/or foot
29550	Strapping; toes

Table 1–Physical Therapy Services that May Be Performed by a PTA Current Procedural Terminology® Code Description

Code	Description
29580	Strapping; Unna Boot
29590	Denis-Browne splint strapping
97010	Application of a modality to one or more areas; hot or cold compacts
97012	Application of a modality to one or more areas; traction, mechanical
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97016	Application of a modality to one or more areas; vasopneumatic devices
97018	Application of a modality to one or more areas; paraffin bath
97022	Application of a modality to one or more areas; whirlpool
97024	Application of a modality to one or more areas; diathermy
97026	Application of a modality to one or more areas; infrared
97028	Application of a modality to one or more areas; ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercise
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (two or more individuals)
97760	Orthotic(s) management and training, (including assessment and fitting when not otherwise reported), upper extremity (s) and/or trunk, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity (s), each 15 minutes

**Table 1—Physical Therapy Services that May Be Performed by a PTA Current
Procedural Terminology® Code Description**

Code	Description
97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes.

MEDICAL POLICY FACT SHEET

TITLE: TRANSPORTATION SERVICES

DESCRIPTION

Transportation services enable Indiana Health Coverage Program (IHCP) members to get to and from medically necessary services. General categories within this section include; types of transportation services, definition of a trip, prior authorization requirements and exemptions, covered services, provider requirements, and the transportation code set.

COVERAGE CRITERIA

Transportation services must be for transportation to and/or from an IHCP covered service. In addition, the member being transported for treatment must be present in the vehicle in order for IHCP reimbursement to be available. The transportation provided must be the least expensive type of transportation that meets the medical needs of the member. IHCP reimbursement is available for emergency and non-emergency transportation services, subject to program restrictions. These limitations and restrictions are set out in the Indiana Code (IC), the Indiana Administrative Code (IAC), and IHCP, newsletters, bulletins, and banners.

TYPES OF TRANSPORTATION SERVICES AND DEFINITIONS

Advanced Life Support – ALS

The Indiana Emergency Medical Services Commission (EMSC), *Title 836 of the Indiana Administrative Code (IAC)*, defines advanced life support (ALS) as follows:

- Care given at the scene of an accident, act of terrorism, or illness, care given during transport, or care given at the hospital by a paramedic, emergency medical technician-intermediate, and care that is more advanced than the care usually provided by an emergency medical technician or an emergency medical technician-basic advanced.

The term *advanced life support* may include any of the following acts of care.

- Defibrillation
- Endotracheal intubation
- Parenteral injection of appropriate medications
- Electrocardiogram interpretation
- Emergency management of trauma and illness

The IHCP provides reimbursement for medically necessary emergency and non-emergency ALS ambulance services when the level of service rendered meets the EMSC definition of ALS.

Note: In accordance with *Indiana Code (IC) 16-1-31*, vehicles and staff that provide emergency services must be certified by the EMSC to be eligible for reimbursement for transports involving either ALS or basic life support (BLS) services.

Basic Life Support – BLS

BLS is defined by the EMSC as the following:

- Assessment of emergency patients
- Administration of oxygen
- Use of mechanical breathing devices
- Application of antishock trousers
- Performance of cardiopulmonary resuscitation (CPR)
- Application of dressings and bandage materials
- Application of splinting and immobilization devices
- Use of lifting and moving devices to ensure safe transport
- Use an automatic or semiautomatic defibrillator
- Administration of epinephrine through an auto-injector
- An emergency medical technician-basic advanced may perform the following.
 - Electrocardiogram interpretation
 - Manual external defibrillation
 - Intravenous fluid therapy

The term *basic life support* and BLS services do not include invasive medical care techniques or advanced life support. The IHCP provides reimbursement for medically necessary emergency and non-emergency BLS ambulance services when the level-of-service rendered meets the EMSC definition of BLS.

Commercial or Common Ambulatory Service – CAS

The IHCP provides reimbursement for transportation of ambulatory (walking) members to or from an IHCP-covered service. Commercial or Common Ambulatory Service (CAS) transportation may be provided in any type of vehicle; however, providers must bill all transportation services according to the level of service rendered. For example, if transportation of an ambulatory member is provided by an ambulance, but no ALS or BLS services are medically necessary for the transport of the member, the ambulance

provider must bill the CAS charges. Base rate, waiting time, and mileage are separately billable and reimbursed for CAS transportation.

Non-Ambulatory Service (Wheelchair Van) – NAS

Non-ambulatory services (NAS) or wheelchair services are reimbursable when a member must travel **in a wheelchair** to or from an IHCP-covered service. Claims for ambulatory members transported in a vehicle equipped to transport non-ambulatory members must be billed according to the CAS level of service and rate, and not billed according to the vehicle type. Base rate, waiting time, and mileage are separately billable and reimbursed for NAS transportation.

Taxi

Taxi providers transport ambulatory members and may operate under authority from a local governing body (city taxi or livery license). Taxi providers whose rates are regulated by local ordinance must bill the metered or zoned rate, as established by local ordinance, and are reimbursed up to the maximum allowable fee. Taxi providers whose rates are not regulated by local ordinance are reimbursed the lower of their submitted charge or the maximum allowable fee based on trip length. Taxi providers are not separately reimbursed for mileage above the maximum allowable rate for the trip; however, mileage must be documented on the driver's ticket by odometer readings or mapping software.

Definition of a Trip

For billing purposes, a trip is defined as transporting a member from the initial point of pick-up to the drop off point at the final destination. Transportation must be the least expensive type of transportation available that meets the medical needs of the member. Trips must be billed according to the level of service rendered and not according to the vehicle type. Providers must bill for all transportation services provided to the same member on the same date of service on one claim form.

If the provider makes a round trip for the same member, same date of service, and same level of base code, both runs should be submitted on the same detail with two units of service to indicate a round trip. Additionally, all mileage for the trip must be billed on the one detail with the total number of miles associated for the round trip.

If the provider transports a member on the same date of service, but different trip levels, for example the 'to' trip was a CAS trip, and the 'return' trip was a NAS trip with mileage for each base. These base trips must be billed on two different claim forms with the corresponding mileage for each base.

Note: In the **Units** field on the CMS-1500 or **Service Unit Count** field on the 837P, the provider must use a **1** with the base unit code to indicate a one-way trip and a **2** to indicate a two-way trip. The transportation modifiers must be used to indicate the place of origin and destination for each service.

Multiple Destinations

If the member is transported to multiple points in succession, the provider may not bill for a trip between each point of the destination. The following examples offer explanations of this concept:

- **Example 1:** A vehicle picks up a member at home and transports the member to the physician's office. This is a one-way trip.
- **Example 2:** A vehicle picks up a member from home and transports the member to the physician's office. The provider leaves, and later the same vehicle picks the member up from the physician's office and transports the member back to the member's home. This is considered two one-way trips.
- **Example 3:** A vehicle picks the member up from the physician's office and transports the member to the laboratory for a blood draw, waits outside the laboratory for the member, and then transports the member home. This is a one-way trip, even though there was a stop along the way. A stop along the way is not considered a separate trip.
- **Example 4:** A vehicle picks up Member A at the member's home and begins to transport the Member A to the dialysis center. Along the way, a stop is made to pick up Member B at a nursing home and both Member A and Member B are transported to the dialysis center. The stop at the nursing home is not considered a separate trip and the transportation of Member A from home to the dialysis center is considered a one-way trip.

Prior Authorization

Prior authorization (PA) is required for the following transportation services:

- Trips exceeding 20 one-way trips per member, per rolling 12-month period, with certain exceptions as described in this billing guide
- Trips of 50 miles or more one way, **including** all codes associated with the trip (wait time, parent or attendant, additional attendant, and mileage)
- Interstate transportation or transportation services rendered by a provider located out-of-state in a non-designated area
- Train or bus services
- Airline or air ambulance services

PA requests must include a brief description of the anticipated care and description of the clinical circumstances necessitating the need for the transportation. The PA requests are reviewed and a PA decision letter is sent to the member and the requesting provider. Transportation providers may request authorization for members that exceed 20 one-way trips. Examples of situations that require frequent medical intervention include, but are not limited to, prenatal care, chemotherapy, and other therapy services. PA may be granted up to one year following the date of service.

Twenty One-Way Trip Limitation and Exemptions

Transportation is limited to 20 one-way trips per member, per rolling calendar year. Providers must request PA for members who exceed 20 one-way trips if frequent medical intervention is required. However, some services are exempt from the 20 one-way trip limitation. Information about those services is included in the following sections.

Emergency Transportation Services

Emergency ambulance transportation is exempt from the 20 one-way trip limitation. Providers must indicate that the transportation was an emergency by using the **Y** indicator in **Field 24I** on the *CMS-1500* or in the **Emergency Indicator** on the *837P*. Additional information about ambulance transportation services, including emergency transportation, is included on page 10 of this billing guide.

Hospital Admission or Discharge

Transportation services for transporting a member to a hospital for admission or for transporting the member home following discharge from the hospital are exempt from the 20 one-way trip limitation. This includes inter-hospital transportation when the member is discharged from one hospital for the purpose of admission to another hospital. The transportation modifiers must be used to indicate the place of origin and destination for each service.

Note: Transporting an IHCP member to or from a hospital for any reason unrelated to an admission or discharge is **not** exempt from the 20-trip limitation.

Members on Renal Dialysis or Members Residing in Nursing Homes

Members on renal dialysis and members residing in nursing homes are exempt from the 20 one-way trip limitation. Claims for members undergoing dialysis or members in nursing homes must be filed with one of the diagnosis codes listed in **Table 1.1** on the next page. The diagnosis code should be entered on the *CMS-1500* or *837P*, and a **1** should be placed in **Field 24E** of the *CMS-1500* claim form or the **Diagnosis Code Pointer** on the *837P*, to indicate that the first diagnosis code applies.

Table 1.1 – Diagnosis Codes for Transportation of Renal Dialysis Patients and Patients Residing in Nursing Homes

Diagnosis Code	Usage
V56.0, V56.1, or V56.8	Patient undergoing renal dialysis
V70.5	Patient residing in nursing facility

Accompanying Parent/Attendant

Procedure codes for accompanying parent or attendant are not applied to the member's 20 one-way trip limitation. Prior authorization is required for an accompanying parent or attendant only when the trip exceeds 50 miles one-way.

Additional Attendant

Procedure codes *A0424 – Extra ambulance attendant, ground (ALS or BLS) or air (rotary or fixed wing)* and *A0130 U6 – Non-emergency transportation; wheelchair van, additional attendant*, are not applied to the member's 20 one-way trip limitation. Prior authorization is required for procedure codes A0424 and A0130 U6 when the trip exceeds 50 miles one-way.

Mileage

Transportation providers are expected to transport members along the shortest most efficient route to and from a destination. All transportation providers must document mileage on the driver's ticket using odometer readings or mapping software programs. Reimbursement is available for mileage, in addition to the base rate, under the following circumstances:

- Ambulance providers are reimbursed for loaded mileage for **each mile** of the trip regardless of the type level of service being billed.
- CAS and NAS providers are reimbursed for loaded mileage when the member is transported more than ten miles one way.
- Taxi providers are not reimbursed for mileage and are not required to submit mileage with their claim. However, mileage must be documented on the driver's ticket using odometer readings or mapping software, as outlined in the documentation requirements section of this billing guide.
- Although the first 10 miles of a CAS or NAS trip are automatically deducted from each one-way trip, CAS and NAS providers must bill for **all** mileage, including the first 10 miles to ensure proper reimbursement. For trips less than 10 miles, the provider is not required to bill mileage; however, if mileage is billed, the mileage will process as a denied line item.
- Trips and associated mileage in excess of 50 miles one way require PA. If PA has not been obtained, reimbursement for mileage, the base rate, and any other transportation

services related to the trip are denied. Providers must bill for all transportation services provided to the same member on the same date of service on one claim form.

- Providers must report mileage using procedure code A0425 and the appropriate U modifier for transportation services in conjunction with ALS, BLS, CAS, or NAS base rates. Mileage must not be fragmented. Mileage for round trips must be submitted on one detail line using the appropriate code listed in Table 1.2.
- Effective July 1, 2004, procedure code S0215 *Non-emergency transportation; mileage, per mile* was made non-reimbursable. Providers must bill the appropriate mileage code listed in **Table 1.2**. In addition, procedure code S0215 must not be reported with the codes listed in **Table 1.2**, or providers may be reimbursed incorrectly.

Table 1.2 – Mileage Codes and Descriptions

Code	Description
A0425 U1	ALS ground mileage, per statute mile
A0425 U2	BLS ground mileage, per statute mile
A0425 U3	CAS ground mileage, per statute mile
A0425 U5	NAS ground mileage, per statute mile

Mileage Units and Rounding

Providers must bill the IHCP for whole units only. Partial mileage units must be rounded to the nearest whole unit. For example, if the provider transports a member between 15.5 miles and 16.0 miles, the provider must bill 16 miles. If the provider transports the member between 15.0 and 15.4 miles, the provider must bill 15 miles.

Multiple Passengers

When two or more members are transported simultaneously from the same county to the same vicinity for medical services, the second and subsequent member transported for medical services in a single CAS or NAS vehicle is reimbursed at one-half the base rate. The full base code, mileage, and waiting time are reimbursed for the first member only. For example, no mileage should be billed in conjunction with *T2004 - Non-emergency transport; commercial carrier, multi-pass, individualized service* provided to more than one patient in the same setting.

The IHCP does not provide reimbursement for multiple passengers in ambulances or family member vehicles. Additional reimbursement is not available for multiple passengers when the billing provider does not bill non-IHCP customers for these services. **Table 1.3**, on the next page, shows the correct coding methods for multiple passengers.

Table 1.3 Coding Transportation for Multiple Passengers

Type of Transportation	First Member	Second and Subsequent Members
Commercial Ambulatory Services	T2003 for base rate A0425 U3 for mileage T2007 U3 for waiting time, if applicable	T2004 for base rate No reimbursement for mileage No reimbursement for waiting time
Non-Ambulatory Services	A0130 for base rate A0425 U5 for mileage T2007 U5 for waiting time, if applicable	A0130 TT for base rate No reimbursement for mileage No reimbursement for waiting time
Taxi, non-regulated, 0-5 miles	A0100 UA (no mileage)	A0100 UA TT (no mileage)
Taxi, non-regulated, 6-10 miles	A0100 UB (no mileage)	A0100 UB TT (no mileage)
Taxi, non-regulated, 11 or more miles	A0100 UC (no mileage)	A0100 UC TT (no mileage)

Note: PA for a base code includes both the base code and the multiple passenger code that corresponds to the approved base code. When last minute changes in scheduling modify the service from a single passenger to a multiple passenger, the provider must use the appropriate code.

Accompanying Parent or Attendant

Accompanying parent – When members younger than 18 years of age needs an adult to accompany them to a medical service, the provider should bill the appropriate accompanying parent or attendant code.

Accompanying attendant – When adult members need an attendant to travel or stay with them for a medical service, the provider should bill the appropriate accompanying parent or attendant code.

The following are guidelines for billing the accompanying parent or attendant codes:

- The procedure code for the base rate and the accompanying parent or attendant is billed under the IHCP member's identification number (RID).
- Additional reimbursement is not available for accompanying parent or attendant when the billing provider does not bill non-IHCP customers for like services.

- The provider must maintain documentation on the driver's ticket to support that the accompanying parent or attendant was transported with the IHCP member. This documentation must include the name, signature, and relation of the accompanying parent or attendant.

Table 1.4 lists the base rates and the applicable accompanying parent or attendant code. The provider must bill both the base code and the accompanying parent or attendant code using the member's information.

Table 1.4 – Procedure Codes for Accompanying Parent or Attendant

Type of Transportation	Base Code	Accompanying Parent/Attendant
Commercial Ambulatory Services	T2003	T2001
Non-Ambulatory Services	A0130	A0130 TK
Taxi, non-regulated, 0-5 miles	A0100 UA	A0100 UA TK
Taxi, non-regulated, 6-10 miles	A0100 UB	A0100 UB TK
Taxi, non-regulated, 11 or more miles	A0100 UC	A0100 UC TK

Additional Attendant

Transportation providers sometimes need an additional attendant to help load a member. An additional attendant is needed in situations where the driver cannot load the member without help, such as when wheelchair-bound member lives upstairs and the residence has no wheelchair ramp. This code is not subject the 20-trip limit; however, if the trip exceeds 50 miles one-way prior authorization is required for all procedure codes, including additional attendant codes. The additional attendant who assists must be an employee of the billing provider and is not required to remain for the trip.

Providers must document the need for an additional attendant on the driver's ticket. The documentation is subject to post-payment review. The additional attendant is limited to a maximum of two extra units; although, usually one attendant is sufficient. Reimbursement for an additional attendant is limited to NAS or wheelchair van and ambulance transportation. For ambulance providers, the additional attendant is the third or fourth attendant, as ambulances are required to have two attendants.

Prior to the January 1, 2004, providers were instructed to use procedure code *Z5023 – Additional attendant transportation*. Local code Z5023 was crosswalked to national code *A0424 – Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)*. Procedure code A0424 did not include NAS or wheelchair van transportation. Effective immediately, procedure code *A0130 U6 – Non-ambulatory transportation; wheelchair van, additional attendant* is covered for NAS or wheelchair van additional attendant transportation. Procedure code A0130 U6 is covered retroactively to January 1, 2004, when the local code Z5023 was end-dated. Procedure

code A0424 will continue to be covered for ambulance transportation when an additional attendant is required. **Table 1.5**, on the next page, includes the procedure codes for additional attendant.

Table 1.5 – Procedure Codes for Additional Attendant

Type of Transportation	Procedure Code	Description
Non-ambulatory or wheelchair van transportation	A0130 U6	Non-ambulatory transportation; wheelchair van, U6 = additional attendant
Ambulance transportation (ALS and BLS)	A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)

Waiting Time

Waiting time in excess of 30 minutes is reimbursable only when the vehicle is parked outside the medical service provider, awaiting the return of the member to the vehicle **and** if the member is transported 50 miles or more one-way. PA must be obtained for all codes associated with trips of 50 miles or more one-way, including waiting time. The IHCP does not cover the first 30 minutes of waiting time; however, the total waiting time must be included on the claim, or the claim will not be paid appropriately.

For all procedure codes used to bill waiting time, one unit of service is billed for every 30 minutes of waiting time. When the provider has waited between 15 to 30 minutes, partial 30-minute increments should be rounded up to the next unit. For example, if the provider has waited 45 minutes, the units of service billed would be two or 2.0. Partial 30-minute increments less than 15 minutes, must be rounded down. For example, if the provider has waited one hour and ten minutes, the units of service billed for waiting time would be two or 2.0. Documentation, including start and stop times, must be maintained on the driver's ticket to support the waiting time billed.

Ambulance Transportation Services

The IHCP covers both emergency and non-emergency ALS and BLS ambulance transport services. Emergency ambulance services are exempt from the 20 one-way trip limit and do not require PA. In addition, emergency ambulance services are exempt from the copayment requirement. Providers must bill emergency services by using the **Y** indicator in **Field 24I** on the *CMS-1500* or in the **Emergency Indicator** on the *837P*, to indicate that the service rendered was an emergency. As a reminder, transportation must be the least expensive type of transportation available that meets the medical needs of the member.

Note: Air ambulance and interstate transportation services require PA. In addition, any transportation services provided by a provider located in an out-of-state, non-designated area require PA.

Level of Service Rendered Versus Level of Response

All transportation services must be billed according to the level of service rendered and not the provider's level of response or vehicle type. The IHCP provides reimbursement for the both emergency and non-emergency ambulance services; however ALS services are only covered when the level of service is medically necessary and BLS services are not appropriate due to the medical conditions of the member being transported. Ambulance providers should refer to the Indiana EMSC definitions of ALS and BLS services listed in *Title 836 of the IAC*. Ambulance providers must bill the IHCP according to the level of service rendered. The following examples explain the level of service policy:

- Example 1: ALS personnel and ambulance are dispatched. On arrival, the member is found to need emergency medical transport, but no ALS services. The BLS emergency transport code must be used. Subsequently, if no emergency is present, the non-emergency BLS ambulance transport code should be used to transport the member.
- Example 2: An ambulance is called to transport a member to a scheduled appointment. Upon arrival it is discovered that the member can instead be transported by a CAS service or wheelchair van. The ambulance provider can either call for the appropriate vehicle or transport the patient in the ambulance. If the ambulance provider transports the member, the appropriate CAS or NAS transportation code(s) must be used to bill the IHCP.

A complete listing of ambulance transportation codes is included in **Table 1.11**. The procedure codes listed in **Tables 1.6 and 1.7** are valid for ambulance providers when used to bill for CAS or NAS level of service. Effective May 1, 2005, procedure codes A0426 U3, A0428 U3, A0426 U5, and A0428 U5 will no longer be reimbursable. Ambulance providers must bill the most appropriate CAS or NAS code listed in **Tables 1.6 and 1.7** if the level of service does not meet the EMSC definition of ALS or BLS services. Ambulance providers are still permitted to bill A0425 U1 or A0425 U2 to be reimbursed for mileage.

Table 1.6– Valid CAS Codes for Ambulance Providers

Procedure Code	Reimbursement	Description
T2003	\$10.00	Non-emergency transportation, encounter/trip
T2007 U3	\$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; CAS

Table 1.6– Valid CAS Codes for Ambulance Providers

Procedure Code	Reimbursement	Description
T2003	\$10.00	Non-emergency transportation, encounter/trip
A0426 U3	\$10.00	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); CAS
A0428 U3	\$10.00	Ambulance service, basic life support, non-emergency transport; CAS

Table 1.7– Valid NAS Codes for Ambulance Providers

Procedure Code	Reimbursement	Description
A0130	\$20.00	Non-emergency transportation, wheel chair van base rate
A0130 U6	\$5.00	Non-emergency transportation, wheel chair van base rate; additional attendant
T2007 U5	\$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; NAS
A0426 U5	\$20.00	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); NAS
A0428 U5	\$20.00	Ambulance service, basic life support, non-emergency transport; NAS

Note: Effective May 1, 2005, procedure codes A0426 U3, A0426 U5, A0428 U3, and A0428 U5 are no longer reimbursable. Procedure codes T2003 and T2007 U3 must be billed by ambulance providers when the level of service rendered is that of a CAS provider. Procedure codes A0130, A0130 U6, and T2007 U5 must be billed by ambulance providers when the level of service rendered is that of a NAS or wheelchair van provider. Ambulance providers are still permitted to bill A0425 U1 or A0425 U2 to be reimbursed for mileage.

Ambulance Mileage

Only loaded ambulance mileage is reimbursed for each mile of the trip. The provider's documentation must contain mileage from mapping software or odometer readings indicating starting and ending trip mileage. Ambulance mileage must be billed using *A0425 U1 – Ground mileage, per statute mile; ALS* or *A0425 U2 – Ground mileage, per statute mile; BLS*. The U1 and U2 modifier are used to differentiate between ALS and BLS mileage. Claims billed without the U1 or U2 modifier will deny, and providers will be required to resubmit with the appropriate modifier.

Neonatal Ambulance Transportation

Reimbursement is available for specialized neonatal ambulance services specially equipped for inter-hospital transfers of high-risk or premature infants only when the member has been discharged from one hospital for admission to another hospital. Procedure code *A0225 – Ambulance service, neonatal transport, base rate, emergency transport, one-way* must be used only for neonatal ambulance transport.

Oxygen and Oxygen Supplies

Procedure code *A0422 – Ambulance (ALS or BLS) oxygen, and oxygen supplies, life sustaining situation* **must not be billed** with ALS codes A0426, A0427, and A0433. These base codes for ALS transport include the reimbursement for supplies and oxygen in an ALS situation.

Procedure code A0422 can be billed with BLS codes A0428 or A0429, if medically necessary. Emergency Medical Technicians (EMTs) and paramedics must document the medical necessity for oxygen use in the medical record maintained by the provider.

Member Copayments

Transportation services require a copayment. Providers are advised to review *405 IAC 5-30-2* for complete copayment narratives.

The determination of the member's copayment amount is to be based on the reimbursement for the base rate or loading fee only. No copayment is required for an accompanying parent or attendant. Transportation providers may collect a copayment amount from the IHCP member equal to those listed in **Table 1.8**.

Table 1.8– Transportation Copayments

Transportation Service	Member Copayment
Transportation services that pay \$10.00 or less	\$0.50 each one way trip
Transportation services that pay \$10.01 to \$50.00	\$1 each one way trip
Transportation services that pay \$50.01 or more	\$2 each one way trip

Exemptions to Copayments for Transportation Services

The following services are exempt from the copayment requirement:

- Emergency ambulance services
- Services furnished to members younger than 18 years old

- Services furnished to pregnant women
- Services furnished to members who are in hospitals, nursing facilities (NFs), intermediate care facilities for the mentally retarded (ICFs/MR), or other medical institutions. This includes instances where a member is being transported for the purpose of admission or discharge.
- Transportation services provided under a Managed Care Organization (MCO) to its Hoosier Healthwise enrollees

Federal Guidelines for Copayment Policy

According to *42 CFR 447.15*, providers may not deny services to any member due to the member's inability to pay the copayment amount on the date of service. Pursuant to this federal requirement, this service guarantee does not apply to a member who is able to pay, nor does a member's inability to pay eliminate his or her liability for the copayment. It is the member's responsibility to inform the provider that he or she cannot afford to pay the copayment on the date of service. The provider may bill the member for copayments not paid on the date of service.

Package C Transportation Services

Hoosier Healthwise Package C members are eligible to receive emergency ambulance services, subject to the prudent layperson definition of emergency in *407 IAC 1-1-6*. Non-emergency ambulance transportation between medical facilities is a covered service when ordered by the treating physician.

Risk Based Managed Care Hoosier Healthwise Services

Transportation services for Risk Based Managed Care (RBMC) members are the responsibility of the MCO. Providers must contact the appropriate MCO for more information about transportation guidelines for RBMC members.

Non-covered Transportation Services

Reimbursement is not available for the following transportation services:

- One-way trips exceeding 20 per member, per rolling 12-month period, except when medically necessity for additional trips is documented through the PA process
- Trips of 50 miles or more one way, unless PA is obtained
- First 30 minutes of waiting time for any type of conveyance, including ambulance
- Non-emergency transportation provided by any of the following:
 - A volunteer with no vested or personal interest in the member
 - An interested individual or neighbor of the member
 - A caseworker or social worker

- Ancillary, non-emergency transportation charges including, but not limited to, the following:
 - Parking fees
 - Tolls
 - Member meals or lodging
 - Escort meals or lodging
- Disposable medical supplies, other than oxygen, provided by a transportation provider
- Transfer of durable medical equipment, either from the member's residence to place of storage, or from the place of storage to the member's residence
- Use of red lights and siren for an emergency ambulance call
- All inter-hospital transportation services, except when the member has been discharged from one hospital for admission to another hospital
- Delivery services for prescribed drugs, including transporting a member to or from a pharmacy to pick up a prescribed drug

Documentation Requirements for Transportation Services

Each claim must be supported with the following documentation on the driver's ticket or run sheet:

- Complete date of service, including day, month, and year of service, such as 3/15/04
- Complete member name and address of pick-up, including street address, city, county, state, and ZIP
- Member identification number
- Member signature - If the member is unable to sign, the driver should document that "the patient was unable to sign" and the reason for the inability
- Waiting time including the actual start and stop time of the waiting period, such as wait time from 1 p.m. to 3:20 p.m.
- Complete service provider name and address, including street address, city, county, state, and ZIP

Note: If the service provider's name is abbreviated on the driver's ticket, the provider must document the complete provider name or maintain a facility abbreviation listing. This will help to expedite the post-payment review process.

- Name of the driver who provided transportation service
- Vehicle odometer reading at the beginning and end of the trip or mileage from mapping software, including the date the transportation service was provided and the specific starting and destination address. If mapping software is used, it must indicate the shortest route.

Note: All providers, including taxi providers, must document mileage using either odometer readings or mapping software. Taxi providers must document the distance traveled to support the metered or zoned rate or mileage code billed.

- Indication of a one-way or round trip
- Indication of CAS or NAS transportation
- Name and relationship of any accompanying parent or attendant to support the accompanying parent or attendant code billed, if applicable

Note: When an attendant or parent is billed as part of the transport, the parent or attendant must also sign the driver's ticket.

It is the provider's responsibility to verify that the member is being transported to or from a covered service. It is the provider's responsibility to maintain documentation that supports each transport and/or service provided. Transportation providers put themselves at risk of recoupment of payment if the required documentation is not maintained or covered services cannot be verified.

Registration Requirements

- **Commercial or Common Ambulatory and Non-Ambulatory Providers**
 - All for profit only CAS and NAS providers are required to certify annually through the Indiana Motor Carrier Services (MCS) and obtain a Motor Carrier Certification.
 - Providers must keep a copy of the certification for their records.
- **Taxi Providers**
 - Providers must have documentation showing operating authority from a local governing body (city taxi or livery license), if applicable.
 - Providers must keep a copy of the documentation for their records.
- **Ambulance**
 - Providers must have an Emergency Medical Services (EMS) Commission certification.
 - Providers must keep a copy of the certification for their records.
 - In accordance with *IC 16-1-31*, vehicles and staff that provide ambulance services must be certified by the EMS Commission to be eligible for reimbursement for transports involving either advanced life support or basic life support services. Failure to maintain the EMS Commission certification on all vehicles involved in transporting members results in termination of the *IHCP Provider Agreement*.
- **Bus**
 - Providers must have a MCS certificate from the Indiana Department of Revenue.
 - Providers must keep a copy of the certification for their records.
- **Family Member**
 - Providers must have an authorization letter from the local Office of Family and Children (OFC) (contact caseworker).

- Providers must keep a copy of the authorization letter for their records.
- **Air Ambulance**
 - Providers must have EMS Commission Air Ambulance certification.
 - Providers must keep a copy of the certification for their records.

Chapter 4 of the *IHCP Provider Manual* includes detailed information about enrollment requirements and responsibilities. Providers who fail to maintain the required registration documentation may be referred to the appropriate governing agencies.

Transportation Code Sets

Effective July 1, 2004, transportation providers are limited to specific codes based on the provider specialty listed on the provider enrollment file. **Table 1.9** through **1.15** list the procedures codes allowed for each transportation provider specialty. The transportation HCPCS code (or local code), the national code(s), reimbursement rates, and the procedure code description are listed for each provider specialty. As a reminder, local HCPCS codes were end-dated effective December 31, 2003. The applicable national HCPCS code is listed for each end-dated local code. Due to several coverage changes that were made in 2004, the coverage dates are indicated, where applicable.

Commercial Ambulatory Service Provider

Table 1.9 – CAS Provider Code Set

264 Commercial Ambulatory Service (CAS) Provider				
Transportation HCPCS Code	Rate	National HCPCS Code	Rate	Description
S0215 (Non-reimbursable effective June 30, 2004)	\$1.25	A0425 U3 (January 1, 2004 – present)	\$1.25	Ground mileage, per statute mile; CAS
X3028 (End-dated December 31, 2003)	\$10.00	T2003 U9 (January 1, 2004 – June 30, 2004) T2003 (July 1, 2004 – present)	\$10.00	Non-emergency transportation, encounter/trip (CAS)
X3029 (End-dated December 31, 2003)	\$5.00	T2004 TT (January 1, 2004 – June 30, 2004) T2004 (July 1, 2004 – present)	\$5.00	Non-emergency transportation, commercial carrier, multi-pass (CAS)

Table 1.9 – CAS Provider Code Set

264 Commercial Ambulatory Service (CAS) Provider				
Transportation HCPCS Code	Rate	National HCPCS Code	Rate	Description
X3030 (End-dated December 31, 2003)	\$5.00	T2001 TK (January 1, 2004 – June 30, 2004) T2001 (July 1, 2004 – present)	\$5.00	Non-emergency transportation, patient attendant/escort (CAS)
Y9009 (End-dated December 31, 2003)	\$4.25	T2007 U3 (January 1, 2004 – present)	\$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; CAS

Note: As of July 1, 2004, T2003 U9, T2004 TT, and T2001 TK no longer require a modifier. Additional information is available in IHCP provider newsletter, NL200409, published September 15, 2004.

Non-Ambulatory Service Provider

Note: Ambulatory members transported in a vehicle equipped to transport non-ambulatory members must be billed according to the CAS level of service and rate, and not billed according to the vehicle type. CAS codes are included in the NAS provider code set and listed at the end of **Table 1.10**.

Table 1.10 – NAS Provider Code Set

265 Non-Ambulatory Service (NAS) Provider				
Transportation HCPCS Code	Rate	National HCPCS Code	Rate	Description
S0215 (Non-reimbursable effective June 30, 2004)	\$1.25	A0425 U5 (January 1, 2004 - present)	\$1.25	Ground mileage, per statute mile; NAS
Y9001 (End-dated December 31, 2003)	\$20.00	A0130 (January 1, 2004 - present)	\$20.00	Non-emergency transportation, wheel chair van base rate
X3039 (End-dated December 31, 2003)	\$10.00	A0130 TK (January 1, 2004 - present)	\$10.00	Non-emergency transportation, wheel chair van base rate; extra patient or passenger, non-ambulance
Y9201 (End-dated December 31, 2003)	\$10.00	A0130 TT (January 1, 2004 - present)	\$10.00	Non-emergency transportation, wheel chair van base rate; individualized service provided to more than one patient in same setting
Z5023 (End-dated December 31, 2003)	\$5.00	A0130 U6 (January 1, 2004 - present)	\$5.00	Non-emergency transportation, wheel chair van base rate; additional attendant
Y9009 (End-dated December 31, 2003)	\$4.25	T2007 U5 (January 1, 2004 - present)	\$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; NAS

Table 1.10 – NAS Provider Code Set

265 Non-Ambulatory Service (NAS) Provider				
Transportation HCPCS Code	Rate	National HCPCS Code	Rate	Description
S0215 (Non-reimbursable effective June 30, 2004)	\$1.25	A0425 U3 (January 1, 2004 - present)	\$1.25	Ground mileage, per statute mile; CAS
X3028 (End-dated December 31, 2003)	\$10.00	T2003 U9 (January 1, 2004 – June 30, 2004) T2003 (July 1, 2004 – present)	\$10.00	Non-emergency transportation, encounter/trip (CAS)
X3029 (End-dated December 31, 2003)	\$5.00	T2004 TT (January 1, 2004 – June 30, 2004) T2004 (July 1, 2004 – present)	\$5.00	Non-emergency transportation, commercial carrier, multi-pass (CAS)
X3030 (End-dated December 31, 2003)	\$5.00	T2001 TK (January 1, 2004 – June 30, 2004) T2001 (July 1, 2004 – present)	\$5.00	Non-emergency transportation, patient attendant/escort (CAS)
Y9009 (End-dated December 31, 2003)	\$4.25	T2007 U3 (January 1, 2004 – present)	\$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; CAS

Note: Ambulatory members transported in a vehicle equipped to transport non-ambulatory members must be billed according to the CAS level of service and rate, and not billed according to the vehicle type. CAS codes are included in the NAS provider code set and are listed in Table 1.10.

Ambulance (ALS and BLS) Provider

Note: Transportation must be billed according to the level of service rendered. Therefore, CAS and NAS codes are included in the Ambulance (ALS and BLS) provider code set and are listed in **Table 1.11**. More information about coverage and billing of ambulance services is included on page 10 of this billing guide.

Table 1.11– Ambulance Provider Code Set

260 Ambulance (ALS and BLS) Provider				
Transportation HCPCS Code	Rate	National HCPCS Code	Rate	Description
A0070 (End-dated December 31, 2003)	\$15.00	A0422 (January 1, 2004 – present)	\$15.00	Ambulance (ALS and BLS) oxygen and oxygen supplies, life-sustaining situation

Table 1.11– Ambulance Provider Code Set

260 Ambulance (ALS and BLS) Provider				
Transportation HCPCS Code	Rate	National HCPCS Code	Rate	Description
A0390 (Non-reimbursable effective March 31, 2004)	\$4.00	A0425 U1 (April 1, 2004 – present)	\$4.00	Ground mileage, per statute mile; ALS
A0380 (Non-reimbursable effective March 31, 2004)	\$3.50	A0425 U2 (April 1, 2004 – present)	\$3.00	Ground mileage, per statute mile; BLS
A0420 (Non-reimbursable effective March 31, 2004)	\$20.00	A0420 U1 (April 1, 2004 – present)	\$20.00	Ambulance waiting time ALS, one-half (1/2) hour increments
A0420 (Non-reimbursable effective March 31, 2004)	\$20.00	A0420 U2 (April 1, 2004 – present)	\$20.00	Ambulance waiting time BLS, one-half (1/2) hour increments
A0426 (No changes)	\$85.00	A0426 (No changes)	\$85.00	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0427 (No changes)	\$150.00	A0427 (No changes)	\$150.00	Ambulance service, advanced life support, emergency, level 1 (ALS1-emergency)
A0428 (No changes)	\$85.00	A0428 (No changes)	\$85.00	Ambulance service, basic life support, non-emergency transport; (BLS)
A0429 (No changes)	\$100.00	A0429 (No changes)	\$100.00	Ambulance service, basic life support, emergency transport, (BLS-emergency)
A0433 (No changes)	\$150.00	A0433 (No changes)	\$150.00	Advanced ALS (Level 2)
A0434 (Non-reimbursable effective March 31, 2004)	\$158.30	A0225 (April 1, 2004 – present)	\$150.00	Ambulance service, neonatal transport, base rate, emergency transport, one-way
A0999 (No changes)	Manual	A0999 (No changes)	Manual	Unlisted ambulance service
Z5023 (End-dated December 31, 2003)	\$5.00	A0424 (January 1, 2004 – present)	\$5.00	Extra ambulance attendant, ground (ALS or BLS) or air (rotary and fixed wing)
N/A	N/A	A0426 U3 (January 1, 2004 – May 1, 2005) Use T2003 effective May 1, 2005.	\$10.00	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); CAS
N/A	N/A	A0426 U5 (January 1, 2004 – May 1, 2005) Use A0130 effective May 1, 2005.	\$20.00	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); NAS

Table 1.11– Ambulance Provider Code Set

260 Ambulance (ALS and BLS) Provider				
Transportation HCPCS Code	Rate	National HCPCS Code	Rate	Description
N/A	N/A	A0428 U3 (January 1, 2004 – May 1, 2005) Use T2003 effective May 1, 2005.	\$10.00	Ambulance service, basic life support, non-emergency transport; CAS
N/A	N/A	A0428 U5 (January 1, 2004 – May 1, 2005) Use T2003 effective May 1, 2005.	\$20.00	Ambulance service, basic life support, non-emergency transport; NAS
N/A	N/A	T2003 (Replacement code for A0426 U3 and A0428 U3, effective May 1, 2005.)	\$10.00	Non-emergency transportation, encounter/trip (CAS)
N/A	N/A	A0130 (Replacement code for A0426 U5 and A0428 U5, effective May 1, 2005.)	\$20.00	Non-emergency transportation, wheel chair van base rate (NAS)
N/A	N/A	T2007 U3 (Use this code for waiting time when the transport is a CAS level of service.)	\$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; CAS
Z5023 (End-dated December 31, 2003)	\$5.00	A0130 U6 (January 1, 2004 - present)	\$5.00	Non-emergency transportation, wheel chair van base rate; additional attendant
N/A	N/A	T2007 U5 (Use this code for waiting time when the transport is a NAS level of service.)	\$4.25	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; NAS

Note: Transportation must be billed according to the level of service rendered. Therefore, CAS and NAS codes are included in the Ambulance (ALS and BLS) provider code set and are listed in **Table 1.11**. More information about coverage and billing of ambulance services is included on page 10 of this billing guide.

Air Ambulance

Table 1.12– Air Ambulance Code Set

261 Air Ambulance				
Transportation HCPCS Code	Rate	National HCPCS Code	Rate	Description
A0140 (No changes)	Manual	A0140 (No changes)	Manual	Non-emergency transportation and air travel (private or commercial), intra or interstate
A0430 (No changes)	Manual	A0430 (No changes)	Manual	Ambulance service, conventional air service transport, one way (fixed wing)
A0431 (No changes)	Manual	A0431 (No changes)	Manual	Ambulance service, conventional air service, transport, one way (rotary wing)

Table 1.12– Air Ambulance Code Set

261 Air Ambulance				
Transportation HCPCS Code	Rate	National HCPCS Code	Rate	Description
A0999 (No changes)	Manual	A0999 (No changes)	Manual	Unlisted ambulance service

Taxi Provider**Table 1.13– Taxi Code Set**

263 Taxi Provider				
Transportation HCPCS Code	Rate	National HCPCS Code	Rate	Description
X3031 (End-dated December 31, 2003)	\$6.00	A0100 UA (January 1, 2004 – present)	\$6.00	Taxi, rates non-regulated, 0-5 miles
X3032 (End-dated December 31, 2003)	\$10.00	A0100 UB (January 1, 2004 – present)	\$10.00	Taxi, rates non-regulated, 6-10 miles
X3033 (End-dated December 31, 2003)	\$15.00	A0100 UC (January 1, 2004 – present)	\$15.00	Taxi, rates non-regulated, 11 or more miles
X3034 (End-dated December 31, 2003)	\$3.00	A0100 TK UA (January 1, 2004 – present)	\$3.00	Taxi, rates non-regulated, 0-5 miles for accompanying parent/attendant
X3036 (End-dated December 31, 2003)	\$5.00	A0100 TK UB (January 1, 2004 – present)	\$5.00	Taxi, rates non-regulated, 6-10 miles for accompanying parent/attendant
X3038 (End-dated December 31, 2003)	\$7.50	A0100 TK UC (January 1, 2004 – present)	\$7.50	Taxi, rates non-regulated, 11 or more miles for accompanying parent/attendant
X3035 (End-dated December 31, 2003)	\$3.00	A0100 TT UA (January 1, 2004 – present)	\$3.00	Taxi, rates non-regulated, 0-5 miles for multiple passengers
X3037 (End-dated December 31, 2003)	\$5.00	A0100 TT UB (January 1, 2004 – present)	\$5.00	Taxi, rates non-regulated, 6-10 miles for multiple passengers
Y9210 (End-dated December 31, 2003)	\$7.50	A0100 TT UC (January 1, 2004 – present)	\$7.50	Taxi, rates non-regulated, 11 or more miles for multiple passengers
Y9010 (End-dated December 31, 2003)	\$15.00	A0100 U4 (January 1, 2004 – present)	\$15.00	Non-emergency transportation; taxi, suburban territory

Family Member Transportation Provider**Table 1.14– Family Member Transportation Provider Code Set**

266 Family Member Provider				
Transportation HCPCS Code	Rate	National HCPCS Code	Rate	Description
Y9012 (End-dated December 31, 2003)	\$0.28	A0090 (January 1, 2004 – present)	\$0.28	Non-emergency transportation, per mile-vehicle provided by individual (family member, self, neighbor) with vested interest

Bus Provider**Table 1.15 – Bus Provider Code Set**

262 Bus Provider				
Transportation HCPCS Code	Rate	National HCPCS Code	Rate	Description
N/A	N/A	A0110	Max fee \$25.00 (January 1, 2004 – June 30, 2004) Manual (June 30, 2004 – present)	Non-emergency transportation and bus, intra or interstate carrier

RELATED MEDICAL TOPICS

Case Management – Pregnant Women
 Emergency Medicine – Emergency Room
 Emergency Medicine – Emergency Services
 Intermediate Care Facilities for the Mentally Retarded
 Nursing Facilities
 Obstetric Care
 Out-of-State-Services
 Physical Rehabilitation Services

RULES, CITATIONS, AND SOURCES

405 IAC 5-3-9 (4) PA
 405 IAC 5-4-2 Provider agreement requirements for transportation services
 405 IAC 5-4-3 Enrollment of a family member as a transportation provider
 405 IAC 5-5-2 PA requirements for out-of-state services
 405 IAC 5-5-1 Out-of-state services; general
 405 IAC 5-30 Transportation Services
 405 IAC 5-30-4 PA
 Indiana Health Coverage Programs Banners
 BR199935
 BR200027
 BR200138
 BR200408
 BR200412
 BR200415
 Indiana Medicaid Update Bulletin
 92-05
 92-26
 93-05

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93-19

95-36

95-53

97-05

98-04

BT200353

BT200505

Indiana Health Coverage Programs Newsletter

NL200405

ORIGINATION, REVISIONS, AND REVIEWS

Origination Date: 07/01/91

Revisions and Reviews	Reason	Date
470 IAC 5-8-17; 5-8-17.1; & 5-8-17.2 Transferred	Transportation	07/1/91
405 IAC 1-6-17 Repealed 8/24/97	Transportation	07/1/91
Bulletin 92-21	Transportation	10/22/92
Bulletin 92-15	Transportation	07/13/92
Bulletin 93-05	Transportation	03/24/93
Bulletin 93-12	Transportation	05/01/93
Bulletin 93-19	Transportation	07/01/93

Revisions and Reviews	Reason	Date
Bulletin 93-20	Transportation	10/15/93
Bulletin 97-05	Transportation	01/29/97
405 IAC 5-30	Transportation	08/24/97
405 IAC 5-5-2	PA for out-of-state services	08/24/97
405 IAC 5-4	Provider Enrollment	08/24/97
Bulletin 98-04	Transportation	02/09/98
405 IAC 5-5-2 Amended	PA for out-of-state services	10/27/99
405 IAC 5-30-1 Amended	Transportation	10/27/99
BR200138	Transportation	09/18/01
Newsletter NL200405	Transportation Code Set and Policy Updates	05/15/04
	Scheduled Review	07/30/04
BT200505	Transportation Billing Guide and Policy Updates	03/04/05

APPLICABLE INDIANA A/M EDITS AND AUDITS

- 1012 – Rendering provider specialty not eligible to render procedure
- 3012 – Transportation exceeding fifty miles requires PA
- 4016 – Miles per trip equal to zero
- 4017 – Waiting time not payable with less than 50 miles
- 4068 – Mileage and other services will only paid when billed with base rate
- 4069 – No mileage for multiple passenger base rate
- 4078 – 30 minutes of waiting time not reimbursable
- 4079 – Waiting time reimbursable only when recipient is transported 25 miles or more per 5 one way trip
- 4080 – Ten miles not reimbursable per one way trip
- 6803 – Transportation: one way trip in excess of twenty miles requires PA
- 6804 – Mileage is not payable when billed with a taxi base
- 6805 – Reimbursement for taxi base rate reduced