Medical Policy Manual
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Preface

Overview

The Medical Policy Manual has been developed to ensure the success of the Indiana Health Coverage Programs (IHCP). This manual will be used as a reference handbook for the Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and other state contractors and partners.

The formulation of 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 healthcare delivery system.

This manual addresses the policies of the IHCP. The information regarding prior authorization (PA), 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 that 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.

IHCP Oversight and Delivery

Overview of the Indiana Family and Social Services Administration

The Indiana FSSA is the umbrella agency responsible for administering Indiana’s public assistance programs. FSSA includes the offices and divisions listed below:

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

- **DDRS** 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 individuals with blindness and visual impairments.

- **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.

- **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 (CMHCs) and managed care providers (licensing inpatient psychiatric hospitals and operating state behavioral health hospitals), and administering federal funds earmarked for substance abuse prevention projects.

- **Aging** 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. Aging 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 in 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, Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE), and other appropriate services.

Community-based services provide a variety of services, including Adult Guardianship, Title V Senior Employment, Pre-Admission Screening and Resident Review (PASRR), Indiana Pre-Admission Screening (IPAS), Assistance to Residents in County Homes, Room and Board Assistance, United States Department of Agriculture (USDA) Meals Reimbursement, Title III/VII of the Older Americans Act, Long-Term Care (LTC) 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) addresses and investigates reports of abuse, neglect, and exploitation of adults. The state of Indiana coordinates with Indiana’s prosecuting attorneys, law enforcement, and the FSSA to ensure the safety of adults in need. Multiple services are available through APS, which depends upon the level of need of the individual.

IHCP Eligibility

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 19 years old 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 (QMBs)
  - A 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 (QDWIs) who lost Medicare Part A due to employment status
  - Specified Low Income Medicare Beneficiaries (SLIMBs)
  - Undocumented or unqualified aliens

Medicaid Waiver Programs

1. Overview of Centers for Medicare & Medicaid Services (CMS) Medicaid Waivers

States may apply to the Centers for CMS for waivers of certain federal regulations. There are three major types of waivers; 1115, 1915(b), and 1915(c). Of these, Indiana has one 1115 waiver as well as several waivers under 1915(c). States have the flexibility to design each waiver program and select the mix of waiver services that 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
2. Indiana Waiver Program Overview

The five Home and Community-Based Waiver services currently offered through the Indiana Medicaid program are listed below:

- Aged and Disabled (A&D)
- Traumatic Brain Injury (TBI)
- Community Integration and Habilitation (formerly Developmental Disabilities/Autism)
- Family Supports (formerly Support Services)

The A&D and TBI Waivers are considered Nursing Facility (NF) Level of Care (LOC) Waivers that are administered through the Department of Aging (Aging). The Community Integration and Habilitation and Family Supports Waivers are considered Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) LOC waivers, which are administered through DDRS.

The IHCP Medical Policy Manual will no longer contain policies specific to Medicaid Waiver Programs. A referral for clarification of policies for Medicaid Waiver Programs can be found by contacting the Medicaid Waiver Unit or by visiting the FSSA website.

Medicaid Waiver Unit
402 West Washington Street, W-454
Post Office Box 7083, MS-21
Indianapolis, IN 46207-7083
Traditional Medicaid

1. Overview

The Traditional Medicaid program provides coverage for healthcare services rendered to the following eligibility groups:

- Persons in long-term care facilities and other institutions, such as ICF/IIDs
- Immigrants who do not have documentation or are unable to verify immigration status
- Persons receiving waiver or hospice services
- Persons with both Medicare and Medicaid (duals)
- Persons with waiver liability
- Persons with breast and cervical cancer
- Refugees who do not qualify for any other aid category
- Wards of the State
- Foster Children

Eligible members receive healthcare 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, Hewlett-Packard (HP). Providers are required to sign a Medicaid Provider Agreement.

2. Delivery System

Traditional Medicaid is part of the FFS delivery system:

- Package A (Standard Plan) - Members enrolled in Package A are eligible for full coverage.
- Package E (Emergency Services Only) – Members enrolled in Package E are eligible for treatment of medical emergency situations only.

Medicare Savings Program (QMB, SLMB, QI, QDWI)

1. Overview

Federal law requires that state Medicaid programs pay Medicare premiums, coinsurance, and deductibles for certain elderly and disabled people through a program called the Medicare
Savings Program. These people are designated as QMB, SLMB, QI, or QDWI and 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

2. Aid Categories

- **QMB-Only coverage**: The member’s benefits are limited to payment of the member’s Medicare Part A (if the member is not entitled to free Part A) and Part B premiums, as well as deductibles and coinsurance for Medicare covered services only. Claims for services not covered by Medicare are denied as Medicaid noncovered services.

- **QMB-Also coverage without patient liability**: 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. For these members, Medicaid claims for services not covered by Medicare must be submitted as regular Medicaid claims and not as crossover claims.

- **QMB-Also coverage with patient liability**: 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 after the member’s monthly patient liability is met.

- **SLMB-Only coverage**: The member’s benefits are limited to payment of the member’s Medicare Part B premium only. Providers should tell the member that the service is not a Traditional Medicaid-covered service for an SLMB who has “Only” coverage.

- **SLMB-Also without patient liability**: The member’s benefits include payment of the member’s Medicare Part B premium to Traditional Medicaid benefits throughout the month of eligibility.

- **SLMB-Also with patient liability**: The member’s benefits include payment of the member’s Medicare Part B premium in addition to Traditional Medicaid benefits after his or her monthly patient liability is met.

- **QI coverage**: The member’s benefit is payment of the member’s Medicare Part B premium.
- **QDWI Coverage**: The member’s benefit is payment of the member’s Medicare Part A premium.
Waiver

1. Overview

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 LOC provided in a NF, hospital, or ICF/IID, but choose to remain in the home.

2. Eligibility

Eligibility for all waiver programs requires the following:

- The member must meet IHCP eligibility guidelines.
- The member would require institutionalization in the absence of the waiver or other home-based services.
- Providers must verify member eligibility and if a member is enrolled in managed care, the member must be disenrolled from managed care to participate in the HCBS waiver programs.

1915 (i) Home and Community-Based Services

1. Overview

Section 1915(i) of the Social Security Act gives states the option to offer a wide range of home and community-based services (HCBS) to members through state Medicaid plans. Using this option, states can offer services and supports to a target group of individuals, including individuals with serious mental illness, emotional disturbance, and substance use disorders to help them remain in the community.

2. HCBS Programs

Indiana administers the following 1915(i) HCBS programs through the FSSA, Division of Mental Health and Addiction:

- *Children’s Mental Health Wraparound (CMHW)* – The CMHW program delivers individualized services to children with serious emotional disturbances (SED). The focused nature of the CMHW program is intended to better address the special needs of children and youth with SED.
- *Behavioral and Primary Healthcare Coordination (BPHC)* – The BPHC program consists of the coordination of healthcare services to manage the healthcare needs of eligible
members. This service includes logistical support, advocacy, and education to assist individuals in navigating the healthcare system and activities that help members gain access to physical and behavioral health services needed to manage their health condition.

- *Adult Mental Health and Habilitation (AMHH)* – The AMHH program provides services to adults with serious mental illness (SMI) who may most benefit from keeping or learning skills to maintain a healthy safe lifestyle in community-based settings.

**Hoosier Healthwise**

**1. Overview**

Hoosier Healthwise is Indiana’s Medicaid Managed Care program administered by OMPP and 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 TANF and for low-income pregnant women and children. This program encompasses the three following member eligibility packages:

- Package A – Standard Plan
- Package C – Children’s Health Plan
- Package P – Presumptive Eligibility for Pregnant Women

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 (PMPs) in Indiana must enroll with a Managed Care Entity (MCE) in the RBMC delivery system.

The goals of Hoosier Healthwise are:

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

**2. Delivery System**
The OMPP implemented a statewide Hoosier Healthwise mandatory RBMC enrollment for all Indiana counties in 2005. This transitioned PrimeStep Hoosier Healthwise managed care members from Care Select into local MCEs in the RBMC delivery system.

Under RBMC, OMPP contracts with MCEs and pays each MCE a capitated rate per month, per enrolled Medicaid member. Members in RBMC must obtain most services from the network of the MCE in which they are enrolled.

The RBMC delivery system is a fully capitated prepayment plan in which the MCEs are at risk to arrange for or administer the provision of a comprehensive set of covered services to Hoosier Healthwise members. The MCE 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 a physician who has contracted with the MCE as their PMP.

3. Primary Medical Providers (PMPs)

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 healthcare system and monitors, on an ongoing basis, the member's condition, healthcare 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 select a PMP within 30 days of being 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 PMP or from another qualified provider to whom the member was referred by the PMP. The member's healthcare 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
• 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 a PMP and may serve as a PMP for any members within the physicians’ normal scope of practice. Physicians who enroll in Hoosier Healthwise agree to be listed as 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; some ancillary services such as laboratory and radiology; orthotics/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. Package C – Children’s Health Plan

To be eligible for Package C, a child must meet the following criteria:

• The child must be younger than 19 years old.
• The child’s family income must be better than 158% and 250% of the federal poverty level.
• The child must not have minimum essential coverage at any time during the waiting period lasting no longer than 90 days.
• The child’s family must satisfy all cost sharing requirements.

5. Package P – Presumptive Eligibility for Pregnant Women

To be eligible for Package P, a pregnant woman must meet the following eligibility requirements:

• Be pregnant as self-attested.
• Not be a current IHCP member.
• Be an Indiana resident.
• Be a U.S. citizen or qualified noncitizen.
• Not be currently incarcerated.
• Have a family income level less than 213% of the federal poverty level.
Family Planning Eligibility Program

1. Overview

The Family Planning Eligibility Program provides services and supplies to men and women for the primary purpose of preventing or delaying pregnancy. Services covered under the family planning services aid category include:

- Annual family planning visits, including health education and counseling necessary to understand and make informed choices about contraceptive methods.
- Laboratory tests, if medically indicated as part of the decision-making process regarding contraceptive methods.
- Limited health history and physical examinations.
- Pap smears.
- Initial diagnosis of STDs and STIs, if medically indicated, including the provision of FDA-approved anti-infective agents.
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider.
- FDA-approved oral contraceptives and contraceptive devices and supplies, including emergency contraceptives.
- Screening, testing, counseling, and referral of members as risk for HIV.
- Tubal ligations.
- Hysteroscopic sterilization with an implant device.
- Vasectomies.

2. Eligibility

To qualify for coverage, individuals must meet the following criteria:

- Do not qualify for any other category of Medicaid.
- Are not pregnant.
- Have not had a hysterectomy or sterilization.
- Have income that is at or below 141% of the federal poverty level.
- Are U.S. citizens, certain lawful permanent residents, or certain qualified documented aliens.

**Other State Programs**

The state of Indiana funds various other medical assistance programs for its population. Additional state-funded programs are listed below:

- The 590 Program provides coverage for certain healthcare services provided to members who are residents of state-owned facilities. These facilities operate under the direction of FSSA, DMHA, and the Indiana State Department of Health (ISDH). Incarcerated individuals residing in Department of Corrections (DOC) facilities are not covered by the 590 Program. The 590 Program provides coverage for certain healthcare services delivered off-site to members who are residents of state-owned facilities. These facilities also operate under the direction of FSSA, DMHA, and ISDH.

- The Healthy Indiana Plan (HIP) is an affordable health insurance program for low-income, uninsured adult Hoosiers between the ages of 19 and 64, with an income up to 100 percent of the federal poverty level (FPL), and who are not eligible for Medicaid. HIP provides a comprehensive package of benefits through private insurers. Claims for services provided through the private insurers are processed by Anthem Blue Cross and Blue Shield and MDwise.

- Aid to Residents in County Homes (ARCH) provides case review services to certain residents of county nursing homes.

**Services, Limitation, and Exclusions**

**Services**

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

**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 are available only with PA.
The IAC contains rules and regulations which govern the IHCP, and serves as a comprehensive reference for covered services and PA procedures and parameters. It is the responsibility of each IHCP provider to read the portions of the IAC which apply to their specific areas of service.

The primary objective of PA is to allow payment for those treatments and/or services which are medically necessary, appropriate, and cost effective, and to reduce over-utilization or abuse of certain services. The decisions to authorize, modify, or deny a given request is based upon medical reasonableness and necessity, and other criteria set forth in the IAC.

Detailed PA criteria can be obtained from 405 IAC 5, Chapter 6 of the IHCP Provider Manual, and published newsletters, bulletins, and banner pages.

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

Any non-emergent Medicaid service requiring PA that is provided without receiving PA will not be reimbursed by Medicaid. Services provided out-of-state with exceptions, require PA. 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 PA 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. In addition, requests for PA are reviewed for the criteria set out in 405 IAC 5 for the service requested. The medical reasonableness and necessity of the requested service is based on current professional standards commonly held to be applicable to the case.

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 render treatment to the member when a referral is obtained from the authorized provider. A provider may render service without a referral from the authorized provider when the member has an emergency diagnosis.

All Indiana Medicaid providers are subject to ongoing Surveillance and Utilization Review (SUR) activities. Based on paid claim information, statistical profiles are established on provider peer and class groups to monitor the delivery and receipt of medical services. This information helps 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 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.

Exclusions

The following services are not covered by Medicaid:

- Services not medically reasonable or necessary according to current professional standards commonly held to be applicable to the case
- Services provided outside the scope of a provider’s license, registration, certification, or other authority to practice under state or federal law
- Experimental drugs, treatments, or procedures
- Any new product, service, or technology not specifically covered in IAC. The product, service, or technology will remain a non-covered 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.
- Personal comfort or convenience items, including, but not limited to, television, radio, or telephone rental
- Services for the remediation of learning disabilities
- Treatments or therapies of an educational nature

Experimental radiological or surgical or other modalities and procedures, including, but not limited to, the following items:

- Acupuncture
- Biofeedback therapy
- Carbon dioxide 5 percent inhalator therapy for inner ear disease
- Hyperthermia
- Hypnotherapy
- Hair transplants
- 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.
- Augmentation mammoplasty for cosmetic purposes
- Dermabrasion surgery for acne pitting or marsupialization
• Rhinoplasty or bridge repair of the nose in the absence of a significant obstructive breathing problem

• Otoplasty for protruding ears, unless one of the following applies:
  ➢ Multifaceted craniofacial abnormalities due to congenital malformation or maldevelopment; for example, Pierre Robin Syndrome
  ➢ A member has pending or actual employment in which protruding ears would interfere with wearing required protective devices

• Scar removals or tattoo removals by excision or abrasion

• Earlobe reconstruction

• Removal of keloids complicating pierced ears unless one of the following is present:
  ➢ Keloids are larger than 3 centimeters
  ➢ Obstruction of the ear canal is 50 percent or more

• Rhytidectomy

• Penile implants

• Perineoplasty for sexual dysfunction

• Reconstructive or plastic surgery, unless deformity is related to disease or trauma

• Sliding mandibular osteotomies, unless related to prognathism or micrognathism

• Blepharoplasties when not related to a significant obstructive vision problem

• Radial keratotomy

Miscellaneous procedures or modalities including but not limited to the following:

• Autopsy

• Cryosurgery for chloasma

• Conray dye injection supervision

• Day care or partial day care, or partial hospitalization (PHP), except when provided pursuant to 405 IAC 5

• Formalized and pre-designed rehabilitation programs, including, but not limited to, the following:
  ➢ 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
• Cognitive rehabilitation, except for treatment of TBI
• Ear piercing
• Cybex evaluation or testing or treatment
• High colonic irrigation
• Services which are not prior authorized under the LOC methodology as required by 405 IAC 5-17
• Amphetamines when prescribed for weight control or treatment of obesity
• Under federal law, drug efficacy study implementation drugs not covered by Medicaid
• All anorexics, except amphetamines, both legend and nonaligned
• Physician samples

Prior Authorization

The IAC contains rules and regulations which govern the IHCP, and serves as a comprehensive reference for covered services and PA procedures and parameters. It is the responsibility of each IHCP provider to read the portions of the IAC which apply to their specific areas of service.

The primary objective of PA review is to allow payment for treatments and services which are medically necessary, appropriate, and cost-effective, and to reduce over-utilization and/or abuse of services. The decision to authorize, modify, suspend, or deny a given request is based upon medical reasonableness and medical necessity, as well as other criteria set forth in the IAC.

Prior Authorization Providers

ADVANTAGE Health Solutions FFS PA Department reviews all non-pharmacy PA requests for IHCP members on an individual, case-by-case basis. Advantage Health Solutions does not review FFS PA requests for members enrolled in a MCE.

The PA Departments’ decisions to authorize, modify, or deny a request is based on medical reasonableness, necessity, and other criteria in the IAC.

The PA departments utilize OMPP approved internal criteria, in addition to the IAC, PA guidelines, and IHCP bulletins, banner pages, and newsletters.
Detailed PA criteria can be obtained from 405 IAC 5, Chapter 6 of the IHCP Provider Manual, and published newsletters, bulletins, and banner pages.

HIP insurers are responsible for processing medical service PA requests and notifying members about PA decisions. For more detailed HIP criteria, please refer to the HIP provider in which the Medicaid recipient is enrolled.

The MCEs may develop their own internal criteria for compliance with IAC titles 405 and 407. For more detailed MCE criteria, please refer to the MCE provider in which the Medicaid recipient is enrolled.
Abortion Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding abortion services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

The IHCP uses the word abortion to describe the early termination of pregnancy prior to viability of the fetus. This includes spontaneous abortion, missed abortion, incomplete abortion, or medical interventions required in the case of ectopic pregnancy. Abortion can be performed utilizing medications or surgically.

Reimbursement Requirements

Spontaneous abortion or missed abortion occurs for no apparent reason during early pregnancy and requires treatment to ensure the health of the mother. The IHCP reimburses for therapeutic treatment of spontaneous or missed abortion and services relevant to this treatment.

An elective abortion is an abortion that a doctor performs because the mother has chosen to terminate the pregnancy. The State is prohibited from making payment from any fund under its control for an elective abortion unless:

- The elective abortion is necessary to preserve the life of the pregnant woman (Indiana Code (IC) § 16-34-1-2) or
- Federal law requires the State to cover the procedure, such as in the case of rape or incest (42 CFR § 50.306; 405 IAC 5-28-7).

Under federal law, elective abortions may be provided by Medicaid only in the following situations, subject to limitations and restrictions set out in the Code of Federal Regulations (CFR) at 42 CFR §§ 50.301 – 50.310:

- A physician has found, and certified in writing to the Medicaid agency, on the basis of his professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient.
Abortion Services

Library Reference Number:
Revision Date: December 2014
Version 2.0

OR

- If the pregnancy is the result of an act of rape or incest, and signed documentation has been received from a law enforcement agency or public health service stating:
  - That the person upon whom the medical procedure was performed was reported to have been the victim of an incident of rape or incest
  - The date on which the incident occurred
  - The date on which the report was made, which must have been within 60 days of the date on which the incident occurred; the name and address of the victim; and the name and address of the person making the report (if different from the victim)
  - That the report included the signature of the person who reported the incident

No other abortions, regardless of funding, can be provided as a benefit under the IHCP. Elective abortions performed for any other reason are non-covered services per 405 IAC 5-28-7.

The IHCP does not consider termination of an ectopic pregnancy to be an elective abortion.

The IHCP reimburses for abortions to terminate pregnancies resulting from rape or incest, in addition to abortions necessary to save the life of the pregnant mother.

Non-surgical Abortions

The IHCP only reimburses the Food and Drug Administration (FDA)-approved regimen for medically induced abortions using orally administered mifepristone and misoprostol. The IHCP does not reimburse what is commonly known as the evidence-based regimen for medical abortion with mifepristone and misoprostol, which includes at-home or vaginal administration of misoprostol.

The IHCP reimburses mifepristone and misoprostol for use in medical abortion procedures based on the same coverage criteria referenced above.

The FDA-approved regimen for these medications is as follows:

- Recommended gestational age – 49 days from last menstrual period (LMP)
- Mifepristone dose – 600 mg orally administered on day one office visit
- Misoprostol dose – 400 mcg orally administered on day three office visit
- Misoprostol timing – 48 hours after receiving Mifepristone

Prior Authorization Requirements

PA is not required for abortion services.
Billing Requirements

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs. Providers must bill utilizing the appropriate procedure code. 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. For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.

When billing for spontaneous abortions, the IHCP requires no documentation for providers billing with the appropriate treatment code and for providers following the guidelines below.

When billing for elective abortions, the IHCP requires the physician to specify in writing the following:

- A physician has found, and certified in writing to the Medicaid agency, on the basis of his professional judgment, the life of the mother would be endangered if the fetus were carried to term. The physical condition of the patient leading to the professional judgment the abortion was necessary to preserve the life of the pregnant woman. The certification must contain the name and address of the patient.

OR

- If the pregnancy is the result of an act of rape or incest, and signed documentation has been received from a law enforcement agency or public health service stating:
  - That the person upon whom the medical procedure was performed was reported to have been the victim of an incident of rape or incest
  - The date on which the incident occurred
  - The date on which the report was made, which must have been within 60 days of the date on which the incident occurred; the name and address of the member; and the name and address of the person making the report (if different from the victim) That the report included the signature of the person who reported the incident

- The Date of Service (DOS)

- Physician’s name and signature

Providers must attach the documentation to the paper claim form or send it separately as an attachment to the electronic claim transaction. The IHCP must receive correct documentation with claims before it will pay for the abortion or any directly related service. The primary service provider should forward copies of the physician certification to the related service provider to bill for these services.
The ICD-9 codes listed in Table 1 and Table 2 indicate a possible elective abortion was performed; the IHCP requires documentation for claim payment consideration. The IHCP suspends these claims for review of appropriate documentation supporting medical necessity.

Tables 1 and 2 represent diagnosis and procedure codes that IndianaAIM suspends for appropriate documentation supporting medical necessity.

**Table 1 – Diagnosis Codes that Suspend for Appropriate Documentation Supporting Medical Necessity**

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>635.00–635.92</td>
<td>Legally induced abortion complicated by genital tract and pelvic infection</td>
</tr>
<tr>
<td>637.00–637.92</td>
<td>Unspecified abortion complicated by genital tract and pelvic infection</td>
</tr>
<tr>
<td>638.0–638.9</td>
<td>Failed attempted abortion</td>
</tr>
<tr>
<td>779.6</td>
<td>Termination of pregnancy</td>
</tr>
<tr>
<td>E960.1</td>
<td>Rape</td>
</tr>
</tbody>
</table>

**Table 2 – Procedure Codes that Suspend for Appropriate Documentation Supporting Medical Necessity**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59100</td>
<td>Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)</td>
</tr>
<tr>
<td>59200</td>
<td>Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)</td>
</tr>
<tr>
<td>59840</td>
<td>Induced abortion, by dilation and curettage</td>
</tr>
<tr>
<td>59841</td>
<td>Induced abortion, by dilation and evacuation</td>
</tr>
<tr>
<td>59850</td>
<td>Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;</td>
</tr>
<tr>
<td>59851</td>
<td>Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation</td>
</tr>
<tr>
<td>59852</td>
<td>Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection)</td>
</tr>
<tr>
<td>59855</td>
<td>Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;</td>
</tr>
</tbody>
</table>
| 59856           | Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits,
Non-surgical Abortions

Providers must use HCPCS code S0190–Mifepristone, oral, 200mg, to bill Mifepristone and use code S0191–Misoprostol, oral, 200 mcg to bill Misoprostol. Medical abortion by oral ingestion of Mifepristone and Misoprostol requires three separate office visits to complete the procedure.

Confirmation of pregnancy status must occur prior to the day one office visit. The day one office visit must occur after the 18 hour counseling and waiting period required by IC § 16-34-2-1.1. The IHCP suspends claims for day one and day three office visits, pending submission of required documentation. To be reimbursed for services, the IHCP requires providers to submit all necessary documentation with claims for these office visits.

Table 3 provides the billing guidelines for these office visits and the medications provided during the office visits. Providers must bill all claims for medical abortion by oral ingestion of Mifepristone and Misoprostol on the CMS-1500 claim form or via electronic transaction.

Table 3 – Mifepristone and Misoprostol Billing Guidelines

<table>
<thead>
<tr>
<th>Office Visit</th>
<th>Documentation/Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day One:</td>
<td>Member reviews and signs the Patient Agreement</td>
</tr>
<tr>
<td></td>
<td>Provider orally administers three 200 mg tablets of mifepristone.</td>
</tr>
<tr>
<td></td>
<td>Provider bills HCPCS code S0190–Mifepristone, oral, 200 mg, three units.</td>
</tr>
</tbody>
</table>
Day Three:
- Provider bills the appropriate evaluation and management (E/M) code for the office visit.
- Provider checks pregnancy status with clinical examination or ultrasound (US) exam.
- If an US is performed, provider bills the appropriate code for the service provided.
- Provider orally administers two 200 mcg tablets of misoprostol.
- Provider bills HCPCS code S0191–Misoprostol, oral, 200 mcg, two units.
- Provider bills appropriate E/M code for the office visit.

Day 14:
- Provider verifies pregnancy termination with clinical examination or US exam.
- Provider bills appropriate E/M code for the office visit.
- If an US is performed, the provider bills the appropriate code for the service provided.

The physician must specify in writing the physical condition of the member leading to the professional judgment that the abortion was one of the following:

- Medically necessary because the pregnancy creates a serious risk of substantial and irreversible impairment of a major bodily function
- Necessary to preserve the life of the pregnant woman
- Due to rape or incest

The documentation must contain the name and address of the member, dates of service, physician’s name, and physician’s signature. In addition, medical abortion by oral ingestion of mifepristone and misoprostol requires submission of the signed Prescriber’s Agreement and Patient Agreement.

These agreements are available from Danco Laboratories, which is responsible for manufacturing, marketing, distributing, and monitoring FDA compliance in the use of mifepristone in the United States. Danco also requires use of these forms. Providers must attach documentation to paper claim forms or send them separately as an attachment to the electronic claim transaction. If providers fail to submit this documentation, the IHCP must deny the claims.

**Exclusions:**

The IHCP excludes the following codes in Table 4 from the abortion criteria. However, if providers bill the excluded diagnosis code with any of the codes from Table 1 and/or Table 2 the IHCP suspends these claims for review of appropriate documentation supporting medical necessity.
Table 4 – Excluded Abortion Criteria

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>630</td>
<td>Hydatidiform mole</td>
</tr>
<tr>
<td>631.0 - 631.8</td>
<td>Other abnormal product of conception</td>
</tr>
<tr>
<td>632</td>
<td>Missed abortion</td>
</tr>
<tr>
<td>634.00 - 634.92</td>
<td>Spontaneous abortion, includes miscarriage, spontaneous abortion, and complications</td>
</tr>
<tr>
<td>640.00 - 640.03</td>
<td>Threatened abortion</td>
</tr>
<tr>
<td>640.80 - 640.83</td>
<td>Other specified hemorrhage in early pregnancy</td>
</tr>
<tr>
<td>640.90 - 640.93</td>
<td>Unspecified hemorrhage in early pregnancy</td>
</tr>
<tr>
<td>641.00 - 641.93</td>
<td>Antepartum hemorrhage, abruptio placentae, and placenta previa</td>
</tr>
<tr>
<td>656.40 - 656.43</td>
<td>Intrauterine death</td>
</tr>
</tbody>
</table>

Rules, Citations and Sources

*42 CFR §§ 50.301 – 50.310* – Abortions and Related Medical Services in Federally Assisted Programs

*42 CFR §§ 441.200 – 441.208* – Services – Requirements and Limits Applicable to Specific Services – Abortions

*IC § 16-34-1-2* - Public funds; payment restricted

*Humphrey’s v. Clinic for Women, Inc.,* 796 N.E.2d 247 (Ind. 2003)

*405 IAC 5-28-7* – Medical and Surgical Services – Abortion

IHCP Provider Newsletter

NL200412 – Medical Abortion by Oral Ingestion

IHCP Provider Manual


Related Medical Topics

Gynecology Services
Anesthesia Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding anesthesia services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Anesthesia is defined 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 anesthesia, regional anesthesia, supplementation of local anesthesia, or other supportive services to give a patient the anesthesia care deemed optimal by the anesthesiologist to reduce or mitigate pain during a 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, electrocardiogram (ECG), temperature, blood pressure, oximetry, capnography, and mass spectrometry. Other monitoring services such as intra-arterial, central venous, and Swan-Ganz are not included.

Reimbursement Requirements

IHCP reimbursement is available for covered anesthesia services, subject to the limitations and restrictions set out in the IAC. Providers who are eligible for reimbursement include licensed anesthesiologists, certified registered nurse anesthetists (CRNAs), 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
Medical Direction

IHCP 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. 405 IAC 5-10-2 defines an anesthetist as a CRNA or an anesthesiologist assistant. 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 an anesthesia plan.
- Remain immediately available and not perform other services.

Regional Anesthesia (Epidural, Nerve Block, Spinal)

IHCP reimbursement is available for regional anesthesia or nerve blocks involving 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.

Monitored Anesthesia

IHCP reimbursement is available for monitored anesthesia when the service has been determined to be medically reasonable and necessary. Monitored anesthesia care (MAC) involves the intraoperative monitoring of a patient's vital signs in anticipation of the need to
administer 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.

**Postoperative Pain Management Services**
IHCP reimbursement is available for postoperative epidural catheter management services.

**Anesthesia for Obstetrical Services**
IHCP reimbursement is available for anesthesia during obstetrical services under the following conditions:

- 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.

**Anesthesia for Dental Services**

**General Anesthesia – 21 Years Old and Older**
IHCP reimbursement is available for general anesthesia for dental procedures performed in an inpatient or outpatient hospital or ASC setting for members 21 years old and older. The IHCP does not cover general anesthesia for dental procedures performed in a dentist's office. IHCP reimbursement for nitrous oxide analgesia is not available for adults.

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, including mental retardation and organic brain disease, such that the member’s ability to cooperate with procedures is impaired
- Severe physical disorders affecting the tongue or jaw movements
- Seizure disorders
- Significant psychiatric disorders resulting in an impairment of the recipient’s ability to cooperate with procedures
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication
Documentation for general anesthesia must include why the member 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.

**General Anesthesia – 20 Years Old and Younger**

IHCP reimbursement is available for general anesthesia for dental procedures performed in an inpatient or outpatient hospital or ASC setting. Reimbursement is also available for general anesthesia provided in a dentist’s office for members 20 years old and younger. Documentation for general anesthesia should include why the member 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.

IHCP reimbursement is available for nitrous oxide analgesia for members 20 years of age and younger.

**Monitored Sedation for Children (Dental Procedures)**

IHCP reimbursement is available for monitored sedation of members under the age of 21 when provided in a dentist’s office. Monitored sedation is the administration of subcutaneous, intramuscular, IV, or oral sedation. In addition, the vital signs of the member are monitored.

**IV Sedation**

Pursuant to 405 IAC 5-14-15(b), IHCP reimbursement is available for IV sedation in a dental office when provided for oral surgical services only. Documentation in the patient’s record must include specific reasons why such services are needed, if such services are to be provided on an outpatient basis.

**Prior Authorization Requirements**

PA is required for dental procedures requiring anesthesia services when performed in a hospital or ambulatory surgical center.

For PA information pertaining to specific anesthesia services, please refer to the *IHCP Provider Manual*.

**Billing Requirements**

**Anesthesia for Dental Services**

IHCP reimbursement for general anesthesia billed using code D9220 for the first 30 minutes and code D9221 for each additional 15 minutes is covered only for procedures performed in a dentist’s office for individuals under age 21.
Monitored Sedation for Children (Dental Procedures)

Monitored sedation, provided in a dentist’s office, for members under age 21 should be billed using the following procedure code:

Table 1 – Monitored Sedation for Children

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9248</td>
<td>Non-intravenous conscious sedation</td>
</tr>
</tbody>
</table>

Billing Requirements

Anesthesia services are reimbursed according to a statewide fee schedule calculated on:

- Total base units
- Time units
- Add-on units
- Additional units for specific physical modifiers (as applicable), multiplied by the anesthesia conversion factor established by OMPP

The Administrative Simplification Requirements of the Health Insurance Portability and Accountability Act (HIPAA) mandates that covered entities adopt the standards for anesthesia CPT® codes. Providers billing anesthesia services must use anesthesia CPT® codes 00100 through 01999. Anesthesia charges must be submitted using the anesthesia CPT® code and a physical status modifier 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, should not be billed using an anesthesia services code in addition to the procedure code. The surgical delivery fee includes anesthesia services.

Providers must not report the base units on claims. IndianaAIM automatically determines base units for procedure codes submitted on the CMS-1500 claim form or the 837P electronic transaction.

Telemedicine is not reimbursable for anesthesia services or nurse anesthetist services.

Time

Time starts when the anesthesiologist or anesthetist 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 IHCP reimbursement of the preoperative exam is included in the base units. Time ends when the anesthesiologist or anesthetist releases the patient to the postoperative unit and is no longer in constant attendance.
Providers should indicate the actual time of the service rendered, in minutes, in field 24G of the CMS-1500 claim form. IndianaAIM calculates the time units, and it allows one unit 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.

**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 1 year of age or older than 70 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. Effective for dates of service on or after May 1, 2012, the IHCP only reimburses for one (1) unit of procedure code 99140.

- **Physical status** – Providers must use the appropriate modifier to denote any patient conditions that may warrant payment of additional units. These modifiers are listed in Table 2.

**Table 2 – Physical Status Modifiers for Anesthesia**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Additional Units Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>A normal healthy patient for an elective operation</td>
<td>0 units</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
<td>0 units</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease that limits activity but is not incapacitating</td>
<td>1.0 units</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with a severe system disease that is a constant threat to life</td>
<td>2.0 units</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>3.0 units</td>
</tr>
<tr>
<td>P6</td>
<td>A patient who has been declared brain dead, whose organs are being removed for donor purposes</td>
<td>0 units</td>
</tr>
</tbody>
</table>
Anesthesiologists performing the following procedures (Table 3) must bill with the AA modifier. These procedures must be billed in units instead of minutes.

Table 3 – Procedures Requiring the AA Modifier

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36555</td>
<td>Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age</td>
</tr>
<tr>
<td>36620</td>
<td>Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous</td>
</tr>
<tr>
<td>36625</td>
<td>Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); cutdown</td>
</tr>
<tr>
<td>93503</td>
<td>Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes</td>
</tr>
<tr>
<td>99116</td>
<td>Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)</td>
</tr>
<tr>
<td>99183</td>
<td>Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session</td>
</tr>
</tbody>
</table>

Do not bill procedure code 99140 – Anesthesia complicated by emergency conditions (specify) with the AA modifier.

Medical Direction and CRNA Medical Direction

Anesthesia services that are medically directed by an anesthesiologist are priced at 30 percent of the allowed rate.

Table 4 – Medical Direction Modifier

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QK</td>
<td>Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals</td>
</tr>
</tbody>
</table>

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.

CRNA

Anesthesia services that are rendered by a CRNA are priced at 60 percent of the 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 3, which lists the only modifiers used to identify services provided by CRNAs when patients are not enrolled in the IHCP, and the anesthesiologist is providing medical direction. A CRNA that bills with his or her individual rendering provider number must not use the modifiers listed in Table 5 when billing.

### Table 5 – CRNA Anesthesia Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QS</td>
<td>MAC service</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service, with medical direction by a physician</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA without medical direction by a physician</td>
</tr>
</tbody>
</table>

**General, Regional, or Epidural Anesthesia**

When billing regional anesthesia for a given surgical procedure that is performed by a qualified anesthesia professional, providers bill in the same manner as they do for a general anesthetic, such as base units plus time.

**Regional Anesthesia**

When billing regional anesthesia as the anesthesia type for a given surgical procedure 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. The bilateral procedure code modifier 50 is not used in conjunction with anesthesia modifiers.

Nerve blocks performed as surgical procedures for the treatment of conditions such as chronic pain are billed with the appropriate nerve block code, quantity of one, with no anesthesia modifier.

Regional anesthesia administered by the same provider who performs the surgical or obstetrical delivery procedure is not reimbursable, as reimbursement is included in the surgical delivery fee.

**Monitored Anesthesia**

The IHCP allows payment for medically reasonable and necessary maximum allowable cost (MAC) services on the same basis as other anesthesia services.

**Postoperative Pain Management Services**

Postoperative epidural catheter management service is reimbursable using CPT® procedure code 01996. The IHCP does not pay separately for procedure code 01996 on the same day the epidural is placed. Instead, this code is billed on subsequent days when the epidural is actually being managed. This code is used for daily management for members receiving continuous
epidural, subdural, or subarachnoid analgesia, and is limited to one unit of service for each day of management. Procedure code 01996 is reimbursable only 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 6, and that are billed the same day of surgery must be used in conjunction with modifier 59, – Distinct procedural service and are subject to post-payment review.

### Table 6 – CPT® Codes for Postoperative Pain Management

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>62310</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic</td>
</tr>
<tr>
<td>62311</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)</td>
</tr>
<tr>
<td>62318</td>
<td>Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic</td>
</tr>
<tr>
<td>62319</td>
<td>Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)</td>
</tr>
<tr>
<td>64412</td>
<td>Injection, anesthetic agent; spinal accessory nerve</td>
</tr>
<tr>
<td>64413</td>
<td>Injection, anesthetic agent; cervical plexus</td>
</tr>
<tr>
<td>64415</td>
<td>Injection, anesthetic agent; brachial plexus, single</td>
</tr>
<tr>
<td>64416</td>
<td>Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)</td>
</tr>
<tr>
<td>64417</td>
<td>Injection, anesthetic agent; auxiliary nerve</td>
</tr>
<tr>
<td>64420</td>
<td>Injection, anesthetic agent; intercostal nerve, single</td>
</tr>
<tr>
<td>64421</td>
<td>Injection, anesthetic agent; intercostal nerves, multiple, regional block</td>
</tr>
<tr>
<td>64445</td>
<td>Injection, anesthetic agent; sciatic nerve, single</td>
</tr>
</tbody>
</table>
Table 7 – Anesthesia CPT® Procedure Codes for Vaginal or Cesarean Delivery

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01960</td>
<td>Anesthesia for vaginal delivery only</td>
</tr>
<tr>
<td>01961</td>
<td>Anesthesia for cesarean delivery only</td>
</tr>
<tr>
<td>01962</td>
<td>Anesthesia for urgent hysterectomy following delivery</td>
</tr>
<tr>
<td>01963</td>
<td>Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care</td>
</tr>
<tr>
<td>01965</td>
<td>Anesthesia for incomplete or missed abortion procedures</td>
</tr>
<tr>
<td>01966</td>
<td>Anesthesia for induced abortion procedures</td>
</tr>
<tr>
<td>01967</td>
<td>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)</td>
</tr>
<tr>
<td>*01968</td>
<td>Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)</td>
</tr>
<tr>
<td>*01969</td>
<td>Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)</td>
</tr>
</tbody>
</table>
Anesthesia Services

Anesthesia AIM calculates total units by adding base Relative Value Units (RVUs) to the number of time units, which are calculated by the system, based on the number of minutes billed on the claim. The system converts each 15-minute block of time to one time unit. However, for procedure codes 01960 and 01967, the system calculates one time unit for each 15-minute block of time billed in the first hour of service and, for subsequent hours of service, calculates one unit of service for every 60-minute block of time or portion billed.

When an anesthesiologist starts an epidural anesthesia for labor, and it becomes necessary to switch to a general anesthetic for 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 the provider would be for general anesthesia.

**Rules, Citations, and Sources**

405 IAC 5-10-1 et seq. – Anesthesia Services

405 IAC 5-14-11 – Analgesia (Dental)

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

405 IAC 5-25-1 – Physician Services

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

**IHCP Bulletin**

BT200353 – HIPAA Requirements

**IHCP Banner Pages**

BR201213 - Clarification About Units Allowed for CPT Code 99140 – Anesthesia complicated by emergency conditions

BR201007 - Reimbursement Rates for Current Procedural Terminology Codes 36620, 36625, 93503, and 99183

BR200951 - Reimbursement for Procedure Codes 01952 and 01953

**IHCP Provider Newsletter**

NL201001 - Reimbursement for Procedure Codes 01952 and 01953

**IHCP Provider Manual**
Related Medical Topics
Consultations – Second Opinion
Dental Services
Obstetric Care
Surgery – Surgical Services

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.
Bariatric Surgery and Revisions

Introduction

This section serves as a general summary of the IHCP’s policies regarding bariatric surgery and revisions. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

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,” depending on the procedure used.

Morbid obesity is defined as a body mass index (BMI) of at least 35 kilograms per meter squared, with comorbidity 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 comorbidity.

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 band creating a gastric pouch with a capacity of approximately 15 to 30 cc’s encircles the uppermost portion of the stomach. The band is an inflatable doughnut-shaped balloon, the diameter which can be adjusted in the clinic by adding or removing saline via a port that is positioned beneath the skin. The bands are adjustable, allowing the size of the gastric outlet to be modified

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1 Body mass index is equal to weight in kilograms divided by height in meters squared
as needed, depending on the rate if a patient's weight loss. ABG procedures are laparoscopic only.

- **Vertical banded gastroplasty (VBG)** – VBG involves stapling of the upper part of the stomach, creating a narrow gastric inlet or pouch that remains connected with the remainder of the stomach. Also, a non-adjustable band is placed around this new inlet in an attempt to prevent future enlargement of the stoma (opening). As a result, the patient experiences a sense of fullness after eating small meals.

- **Sleeve gastrectomy** – Sleeve gastrectomy is a 70%-80% greater curvature gastrectomy (sleeve resection of the stomach) with continuity of the gastric lesser curve being maintained while simultaneously reducing stomach volume. Sleeve gastrectomy procedures can be open or laparoscopic.

**Malabsorptive Operations**

Malabsorptive operations are the most common gastrointestinal (GI) 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.

**Reimbursement Requirements**

**Bariatric Surgery**

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

- **Failed weight-loss therapy**: Scope and duration of failed weight-loss therapy must meet the following criteria:
  - Morbid obesity has persisted for at least five years **and**
Physician-supervised nonsurgical medical treatment\(^2\) has been unsuccessful for at least six consecutive months

\[\text{or}\]

Member has successfully achieved weight loss after participating in a physician-supervised nonsurgical medical treatment, but has been unsuccessful at maintaining weight loss for two years (\(> 3\)-kilogram [6.6-pound] 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 \(> 3\) kilograms (6.6 pounds) in two years and the inability to maintain a sustained reduction in waist circumference of at least 4 centimeters.

- Patient must meet age and maturity requirements, including both of the following:
  - Member must be between 18 and 65 years of age \textit{and}
  - Member must be physically mature, as shown by sexual maturity and the closure of growth plates.

Members younger than 21 years of age must have documentation in the medical record by two physicians who have determined 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. In addition, the 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:

- A psychological or psychiatric evaluation by a health service provider in psychology (HSPP) or a psychiatrist is required before surgery. Members with one or more of the following contraindications will \textbf{not} be candidates for bariatric surgery:
  - Active abuse of alcohol, illicit or social drugs and other chemicals, or tobacco use during the six months before the request
  - \textit{Diagnostic and Statistical Manual of Mental Disorders}, Fifth Edition (DSM-5) criteria for bulimia or binge-eating disorder (BED)
  - Other eating patterns that are deemed likely to interfere with postsurgical safety and success

\(^2\) \textit{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.}
Active psychosis
Uncontrolled depression
Borderline personality disorder
Other complex psychiatric problems that might interfere with a successful weight-loss outcome

- Member is able to understand, tolerate, and comply with all phases of care and is committed to long-term follow-up requirements.
- Member is abstinent from alcohol use, illicit drug use, and tobacco use; member has a negative urine drug screen.
- Member’s treatment plan includes preoperative and postoperative dietary evaluations.
- Member has received a thorough explanation of the risks, benefits, and possible complications of the procedure.
- Member’s postoperative expectations have been addressed before the bariatric surgery.
- Member has agreed in writing to participate in all preoperative and postoperative evaluations and sessions considered essential to his or her having a successful outcome to the bariatric surgery.

Non-covered Services
The IHCP does not reimburse for the following:

- Procedures that are considered investigational or not meeting safety or efficacy standards will not be covered. The following procedures are not covered by the IHCP (this list may not be all-inclusive):
  - Fobi-Pouch (limiting proximal gastric pouch)
  - Gastroplasty (stomach stapling)
  - Intestinal bypass (jejunoileal bypass)
  - Intragastric balloon
  - Loop gastric bypass
  - Mini-gastric bypass.
  - Natural orifice transluminal endoscopic surgery (NOTES), e.g., StomphyX is not covered
Panniculectomy following gastric bypass procedures performed for cosmetic reasons, even if performed incidentally to a ventral herniorrhaphy, is a non-covered service.

Surgical Revisions

Members may require subsequent surgery because of a complication during the perioperative period. They may also require a revision to correct a postoperative technical failure. 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:

Gastrointestinal leakage
- Stomal stenosis
- Anastomatic leakage
- Abscess
- Pulmonary Embolism (PE)
- Wound infection
- Wound dehiscence
- Gastrointestinal bleeding
- Small Bowel Obstruction (SBO)
- Incisional hernia
- Symptomatic gallbladder disease

Postoperative technical failures of the primary operation include but are not limited to the following:
- Staple-line disruption – documented by x-ray or endoscopy
- Gastrogastric fistula with weight gain
- Expanded outlet – documented by gastroscopy
- Enlarged anastomosis – documented by gastroscopy
- Intolerance to solid food after a band procedure
- Intractable reflux after a band procedure
- Weight loss as a result of anastomotic stenosis

3 Removal of the gallbladder (cholecystectomy) during bariatric surgery may be completed if medically necessary. Prophylactic removal of the gallbladder during bariatric surgery is not covered.
Prior Authorization Requirements

Prior Authorization is required for all bariatric surgeries as described in Table 1 “Billing Requirements” and per 405 IAC 5-3-13. Surgical procedures performed to correct or revise the initial surgical procedure require PA and are described in the “Surgical Revisions” section.

PA is not required for Healthcare Common Procedure Coding System (HCPCS) procedure code S2083 – Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline. 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; it 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.

However, the IHCP does not provide reimbursement for HCPCS code S2083 during the 90-day global period, because adjustment is already included in the 90-day global period reimbursement.

The request for PA for bariatric surgery must be accompanied by the following documentation requirements:

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

Documentation of an attempt to follow a physician-supervised, nonsurgical medical treatment for a minimum of six consecutive months; documentation of unsuccessful weight loss or unsuccessful weight maintenance after successful weight loss.

The physician requesting PA is responsible for referral of the member to a psychiatrist or a 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.
Prior Authorization Requirements for Surgical 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 perioperative 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 the noncompliant behavior of the member requires six months of documentation in the medical record to include the following:

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

Billing Requirements

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs. Providers must bill utilizing the appropriate procedure code. 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. For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.

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.

The coverage criteria, PA, and billing requirements outlines in this policy apply to services delivered under the FFS delivery system. The individual managed care entities establish and publish coverage criteria, PA, and billing requirements within the risk-based managed care (RBMC) delivery system. For members enrolled in RBMC, providers should contact the managed care entity with which the member is enrolled for specific criteria and requirements.
# Table 1 – Bariatric Surgery Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43644</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)</td>
</tr>
<tr>
<td>43645</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption</td>
</tr>
<tr>
<td>43770</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)</td>
</tr>
<tr>
<td>43771</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only</td>
</tr>
<tr>
<td>43772</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only</td>
</tr>
<tr>
<td>43773</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only</td>
</tr>
<tr>
<td>43774</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components</td>
</tr>
<tr>
<td>43775</td>
<td>Laparoscopy, Surgical, Gastric Restrictive Procedure; Longitudinal Gastrectomy (i.e., Sleeve Gastrectomy)</td>
</tr>
<tr>
<td>43842</td>
<td>Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty</td>
</tr>
<tr>
<td>43843</td>
<td>Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty</td>
</tr>
<tr>
<td>43845</td>
<td>Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)</td>
</tr>
<tr>
<td>43846</td>
<td>Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy</td>
</tr>
<tr>
<td>43847</td>
<td>Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption</td>
</tr>
<tr>
<td>43848</td>
<td>Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric band (separate procedure)</td>
</tr>
<tr>
<td>43886</td>
<td>Gastric restrictive procedure, open; revision of subcutaneous port component only</td>
</tr>
<tr>
<td>43887</td>
<td>Gastric restrictive procedure, open; removal of subcutaneous port component only</td>
</tr>
<tr>
<td>43888</td>
<td>Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only</td>
</tr>
<tr>
<td>43999</td>
<td>Unlisted procedure, stomach</td>
</tr>
</tbody>
</table>
The IHCP does not provide reimbursement for HCPCS Procedure 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. Table 2 lists the CPT® codes in which the adjustment is included in the 90-day global period.

### Table 2 – 90 Day Global Period - Bariatric Surgery Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43770</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)</td>
</tr>
<tr>
<td>43771</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only</td>
</tr>
<tr>
<td>43773</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only</td>
</tr>
<tr>
<td>43886</td>
<td>Gastric restrictive procedure, open; revision of subcutaneous port component only</td>
</tr>
<tr>
<td>43888</td>
<td>Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only</td>
</tr>
</tbody>
</table>

### Rules, Citations and Sources

405 IAC 5-3-13 – Services Requiring PA

405 IAC 5-29 – Non-covered Services

Senate Enrollment Act 360

IHCP Provider Manual

*Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp).*

### Related Medical Topics

Anesthesia Services
Consultations – Second Opinion
Diagnostic Studies
Gastroenterology
Radiology
Cardiac Rehabilitation

Introduction

This section serves as a general summary of the IHCP’s policies regarding cardiac rehabilitation. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Services

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.

The second stage (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.

The third stage (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.

Reimbursement Requirements

The IHCP provides reimbursement for comprehensive cardiac rehabilitation programs. Cardiac rehabilitation requires that specific components be included in the rehabilitation program.

Required components include:

- Medical evaluation
• A program to modify cardiac risk factors (e.g., nutritional counseling)
• Prescribed exercise
• Education
• Counseling
• Under the direct supervision of a physician

Phase I

Phase I reimbursement is included in the inpatient diagnosis related group (DRG); therefore, IHCP does not provide separate reimbursement for Phase I.

Phase II

IHCP reimbursement is available for cardiac rehabilitation services for Phase II when considered medically reasonable and necessary. The member must be referred by the physician and must have at least a moderate level of risk stratification. Services provided in connection with a cardiac rehabilitation program may be considered reasonable and necessary up to a maximum of 36 sessions, usually three sessions a week in a single 12-week period.

Coverage for continued participation in a cardiac rehabilitation program beyond 12 weeks requires documentation (in the member's medical record) that fully supports the medical necessity for cardiac rehabilitation along with exit criteria, as it is covered by IHCP.

Reimbursement is not available for Phase II cardiac rehabilitation services exceeding a maximum of 24 weeks.

The members must have had one of the following preceding the initiation of the Phase II program:

• Stable angina pectoris – International Classification of Diseases, Ninth Revision, Clinical Modification (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 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 during 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, such as 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.

- Documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months
- Coronary artery-bypass surgery
- Heart-valve repair/replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- Heart or heart-lung transplant

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

- Continuous electrocardiogram (ECG) telemetric monitoring during exercise
- ECG rhythm strip with interpretation and physician’s revision of exercise prescription
- Physician’s evaluation to assess the member’s performance, adjust medication, or other treatment changes

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

- 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.
- ECG stress test (treadmill or bicycle ergometer) with physician monitoring and report. One is allowed at the beginning of the program and one after three months (usually at the completion of the program). Pharmacologic stress testing may be indicated in certain circumstances and would be allowed with appropriate documentation of medical necessity in the member’s medical records.

Cardiac rehabilitation programs may be provided by the outpatient department of a hospital or in a freestanding cardiac rehabilitation facility. The IHCP requires facilities rendering cardiac rehabilitation services to be:
- Staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life-support techniques and in exercise therapy for coronary disease; and
- The facility must have available for immediate use the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary—for example, oxygen, cardiopulmonary resuscitation equipment and defibrillator.

**Phase III**

IHCP does not provide reimbursement for Phase III cardiac rehabilitation programs.

A member may progress to the maintenance (Phase III) program when the following criteria are met:

- The member has achieved a stable level of exercise tolerance without ischemia or dysrhythmia, as evidenced by an ECG.
- Symptoms of angina or dyspnea are stable at the member’s maximum exercise level.
- The member’s resting blood pressure and heart rate are within normal limits, or are stable on optimal medical therapy.
- 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 two millimeters, associated with slowly rising, horizontal, or down-sloping ST segment).

**Prior Authorization Requirements**

PA is not required for cardiac rehabilitation services.

**Billing Requirements**

Phase II cardiac rehabilitation services are to be billed with the appropriate Current Procedural Terminology (CPT®) procedure code, as noted in Table 1, and with 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 more 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

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93797</td>
<td>Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)</td>
</tr>
<tr>
<td>93798</td>
<td>Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>410.00</td>
<td>Acute myocardial infarction of anterolateral wall; episode of care unspecified</td>
</tr>
<tr>
<td>410.01</td>
<td>Acute myocardial infarction of anterolateral wall; initial episode of care</td>
</tr>
<tr>
<td>410.02</td>
<td>Acute myocardial infarction of anterolateral wall; subsequent episode of care</td>
</tr>
<tr>
<td>410.10</td>
<td>Acute myocardial infarction of other anterior wall; episode of care unspecified</td>
</tr>
<tr>
<td>410.11</td>
<td>Acute myocardial infarction of other anterior wall; initial episode of care</td>
</tr>
<tr>
<td>410.12</td>
<td>Acute myocardial infarction of other anterior wall; subsequent episode of care</td>
</tr>
<tr>
<td>410.20</td>
<td>Acute myocardial infarction of inferolateral wall; episode of care unspecified</td>
</tr>
<tr>
<td>410.21</td>
<td>Acute myocardial infarction of inferolateral wall; initial episode of care</td>
</tr>
<tr>
<td>410.22</td>
<td>Acute myocardial infarction of inferolateral wall; subsequent episode of care</td>
</tr>
<tr>
<td>410.30</td>
<td>Acute myocardial infarction of inferoposterior wall; episode of care unspecified</td>
</tr>
<tr>
<td>410.31</td>
<td>Acute myocardial infarction of inferoposterior wall; initial episode of care</td>
</tr>
<tr>
<td>410.32</td>
<td>Acute myocardial infarction of inferoposterior wall; subsequent episode of care</td>
</tr>
<tr>
<td>410.40</td>
<td>Acute myocardial infarction of other inferior wall; episode of care unspecified</td>
</tr>
<tr>
<td>410.41</td>
<td>Acute myocardial infarction of other inferior wall; initial episode of care</td>
</tr>
<tr>
<td>410.42</td>
<td>Acute myocardial infarction of other inferior wall; subsequent episode of care</td>
</tr>
<tr>
<td>410.50</td>
<td>Acute myocardial infarction of other lateral wall; episode of care unspecified</td>
</tr>
<tr>
<td>410.51</td>
<td>Acute myocardial infarction of other lateral wall; initial episode of care</td>
</tr>
<tr>
<td>410.52</td>
<td>Acute myocardial infarction of other lateral wall; subsequent episode of care</td>
</tr>
<tr>
<td>410.60</td>
<td>Acute myocardial infarction, true posterior wall infarction; episode of care unspecified</td>
</tr>
<tr>
<td>410.61</td>
<td>Acute myocardial infarction, true posterior wall infarction; initial episode of care</td>
</tr>
<tr>
<td>410.62</td>
<td>Acute myocardial infarction, true posterior wall infarction; subsequent episode of care</td>
</tr>
<tr>
<td>ICD-9-CM Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>410.70</td>
<td>Acute myocardial infarction, subendocardial infarction; episode of care unspecified</td>
</tr>
<tr>
<td>410.71</td>
<td>Acute myocardial infarction, subendocardial infarction; initial episode of care</td>
</tr>
<tr>
<td>410.72</td>
<td>Acute myocardial infarction, subendocardial infarction; subsequent episode of care</td>
</tr>
<tr>
<td>410.80</td>
<td>Acute myocardial infarction of other specified sites; episode of care unspecified</td>
</tr>
<tr>
<td>410.81</td>
<td>Acute myocardial infarction of other specified sites; initial episode of care</td>
</tr>
<tr>
<td>410.82</td>
<td>Acute myocardial infarction of other specified sites; subsequent episode of care</td>
</tr>
<tr>
<td>410.90</td>
<td>Acute myocardial infarction, unspecified site; episode of care unspecified</td>
</tr>
<tr>
<td>410.91</td>
<td>Acute myocardial infarction, unspecified site; initial episode of care</td>
</tr>
<tr>
<td>410.92</td>
<td>Acute myocardial infarction, unspecified site; subsequent episode of care</td>
</tr>
<tr>
<td>412</td>
<td>Old myocardial infarction</td>
</tr>
<tr>
<td>413.0</td>
<td>Angina decubitus*</td>
</tr>
<tr>
<td>413.9</td>
<td>Other and unspecified angina pectoris</td>
</tr>
<tr>
<td>414.8</td>
<td>Other specified forms of chronic ischemic heart disease</td>
</tr>
<tr>
<td>V15.1</td>
<td>Surgery to heart and great vessels</td>
</tr>
<tr>
<td>V42.1</td>
<td>Organ or tissue replaced by transplant; heart</td>
</tr>
<tr>
<td>V42.2</td>
<td>Organ or tissue replaced by transplant; heart valve</td>
</tr>
<tr>
<td>V43.3</td>
<td>Organ or tissue replaced by other means; heart valve</td>
</tr>
<tr>
<td>V45.09</td>
<td>Cardiac device in situ; other specified cardiac device</td>
</tr>
<tr>
<td>V45.81</td>
<td>Other postsurgical status, aortocoronary bypass</td>
</tr>
<tr>
<td>V45.82</td>
<td>Percutaneous transluminal coronary angioplasty status</td>
</tr>
</tbody>
</table>

*Includes nocturnal angina

It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (for example, 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 section, including telemetry and supplies for telemetry, are to be included in this charge.

Separate reimbursements for charges for telemetry, electrodes, and so on, are not provided. One unit equals one cardiac rehabilitation visit. The number of units must be shown on the Uniform Bill- (UB-) 04 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-04 in fields 31-36 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-04 in fields 39-41 with value code 53.

Reasons for Denial

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

- Lack of documentation of a covered diagnosis
- Lack of documentation of the elements of a cardiac rehabilitation visit
- Duration beyond 12 weeks without documentation showing medical necessity, as indicated above
- Services determined to be not reasonable and necessary, as stated previously in this section

Documentation Requirements

The diagnosis of stable angina should be substantiated with a physician history and physical (H&P), 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 and evidence of the elements of a cardiac rehabilitation session (e.g., telemetry-monitoring strips)
- Also, the medical record must indicate the medical necessity for unusual frequency or duration of Phase II cardiac rehabilitation.
- The documentation must be specific in terms of exit criteria and/or setbacks that changed the exercise prescription.

Claims for Phase II cardiac rehabilitation must have documentation indicating the member has not reached an exit level within 12 weeks.

Rules, Citations, and Sources

405 IAC 5-2-17 – Medically reasonable and necessary service

IHCP Provider Manual
Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Hospital Inpatient Services

Hospital Outpatient Services
Chiropractic

Introduction

This section serves as a general summary of the IHCP’s policies regarding chiropractic services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Chiropractic services are defined in IC § 25-10-1-1 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.

Reimbursement Requirements

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 member per rolling 12-month period.

Benefits under the Hoosier Healthwise Package C - Children’s Health Insurance Program - have not been modified. Pursuant to 407 IAC 3-12-2, Package C chiropractic services are restricted to five visits and 14 procedures per rolling 12-month period. Additional procedures that are medically necessary may be reimbursed subject to PA. There is a 50-treatment limit per rolling 12-month period, which includes no more than five office visits.

For IHCP members, reimbursement is limited to a total of 50 visits and spinal manipulations or physical medicine treatments per member per calendar year. (See Billing Requirements section of this fact sheet for details).

Prior Authorization Requirements

Pursuant to 405 IAC 5-12-5, manual or electrical muscle testing services require PA.

Package C chiropractic services are restricted to five visits and 14 procedures per rolling 12-month period. Additional procedures that are medically necessary may be reimbursed subject to
PA 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.

**Billing Requirements**

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

Reimbursement is limited to a total of 50 visits and spinal manipulations or physical medicine treatments per member per calendar year. As part of this limitation, reimbursement will be made for no more than five office visits out of the total 50 visits allowed per member per calendar year. 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.

Pursuant to 405 IAC 5-12-3, the IHCP limits reimbursement to one series of full spine x-rays per recipient per year. Component x-rays of the series are individually reimbursable; however, if components are billed separately, total reimbursement is limited to the allowable amount for the series. Reimbursement for localized spine series x-rays, and for x-rays of the joints or extremities, is allowable only when the x-rays are necessitated by a condition-related diagnosis. Prior authorization is not required for x-rays. 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 CPT® procedure codes and the ICD-9-CM diagnosis codes as listed in the following tables.
Tables 1 through 4 identify the procedure codes that can be billed to the IHCP by chiropractors.

**Table 1 – Covered IHCP Chiropractic Codes for Office Visits**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.</td>
</tr>
<tr>
<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
</tbody>
</table>

Chiropractic
Library Reference Number:
Revision Date: December 2014
Version 2.0
focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

Table 2 – Covered IHCP Chiropractic Codes for Manipulative Treatment

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>98940</td>
<td>Chiropractic manipulative treatment (CMT); spinal, 1-2 regions</td>
</tr>
<tr>
<td>98941</td>
<td>Chiropractic manipulative treatment (CMT); spinal, 3-4 regions</td>
</tr>
<tr>
<td>98942</td>
<td>Chiropractic manipulative treatment (CMT); spinal, 5 regions</td>
</tr>
<tr>
<td>98943</td>
<td>Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions</td>
</tr>
</tbody>
</table>

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

Table 3 – Covered IHCP Chiropractic Codes for Radiology

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>72010</td>
<td>Radiologic examination, spine, entire, survey study, anteroposterior and lateral</td>
</tr>
<tr>
<td>72020</td>
<td>Radiologic examination, spine, single view, specify level</td>
</tr>
<tr>
<td>72040</td>
<td>Radiologic examination, spine, cervical; 3 views or less</td>
</tr>
<tr>
<td>72050</td>
<td>Radiologic examination, spine, cervical; 4 or 5 views</td>
</tr>
<tr>
<td>72052</td>
<td>Radiologic examination, spine, cervical; 6 or more views</td>
</tr>
<tr>
<td>72069</td>
<td>Radiologic examination, spine, thoracolumbar, standing (scoliosis)</td>
</tr>
<tr>
<td>72070</td>
<td>Radiologic examination, spine, thoracic, 2 views</td>
</tr>
<tr>
<td>72072</td>
<td>Radiologic examination, spine, thoracic, 3 views</td>
</tr>
<tr>
<td>72074</td>
<td>Radiologic examination, spine; thoracic, minimum of 4 views</td>
</tr>
<tr>
<td>72080</td>
<td>Radiologic examination, spine; thoracolumbar, 2 views</td>
</tr>
<tr>
<td>72090</td>
<td>Radiologic examination, spine; scoliosis study, including supine and erect studies</td>
</tr>
<tr>
<td>72100</td>
<td>Radiologic examination, spine; lumbosacral, 2 or 3 views</td>
</tr>
<tr>
<td>72110</td>
<td>Radiologic examination, spine; lumbosacral, minimum of 4 views</td>
</tr>
<tr>
<td>CPT® Code</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>72114</td>
<td>Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views</td>
</tr>
<tr>
<td>72120</td>
<td>Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views</td>
</tr>
<tr>
<td>72170</td>
<td>Radiologic examination, pelvis; 1 or 2 views</td>
</tr>
<tr>
<td>72190</td>
<td>Radiologic examination, pelvis; complete, minimum of 3 views</td>
</tr>
<tr>
<td>72200</td>
<td>Radiologic examination, sacroiliac joints; less than 3 views</td>
</tr>
<tr>
<td>72202</td>
<td>Radiologic examination, sacroiliac joints; 3 or more views</td>
</tr>
<tr>
<td>72220</td>
<td>Radiologic examination, sacrum and coccyx, minimum of 2 views</td>
</tr>
<tr>
<td>72300</td>
<td>Radiologic examination; clavicle, complete</td>
</tr>
<tr>
<td>72301</td>
<td>Radiologic examination; scapula, complete</td>
</tr>
<tr>
<td>72302</td>
<td>Radiologic examination, shoulder; 1 view</td>
</tr>
<tr>
<td>72303</td>
<td>Radiologic examination, shoulder; complete, minimum of 2 views</td>
</tr>
<tr>
<td>72305</td>
<td>Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction</td>
</tr>
<tr>
<td>72306</td>
<td>Radiologic examination; humerus, minimum of 2 views</td>
</tr>
<tr>
<td>72307</td>
<td>Radiologic examination, elbow; 2 views</td>
</tr>
<tr>
<td>72308</td>
<td>Radiologic examination, elbow; complete, minimum of 3 views</td>
</tr>
<tr>
<td>72309</td>
<td>Radiologic examination; forearm, 2 views</td>
</tr>
<tr>
<td>72310</td>
<td>Radiologic examination, wrist; 2 views</td>
</tr>
<tr>
<td>72311</td>
<td>Radiologic examination, wrist; complete, minimum of 3 views</td>
</tr>
<tr>
<td>72312</td>
<td>Radiologic examination, hand; 2 views</td>
</tr>
<tr>
<td>72313</td>
<td>Radiologic examination, hand; minimum of 3 views</td>
</tr>
<tr>
<td>72314</td>
<td>Radiologic examination, finger (s), minimum of 2 views</td>
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<tr>
<td>72350</td>
<td>Radiologic examination, hip, unilateral; 1 view</td>
</tr>
<tr>
<td>72351</td>
<td>Radiologic examination, hip, unilateral; complete, minimum of 2 views</td>
</tr>
<tr>
<td>72352</td>
<td>Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis</td>
</tr>
<tr>
<td>72355</td>
<td>Radiologic examination, femur, 2 views</td>
</tr>
<tr>
<td>72356</td>
<td>Radiologic examination, knee; 1 or 2 views</td>
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<tr>
<td>72356</td>
<td>Radiologic examination, knee; 3 views</td>
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### Radiologic Examination Codes

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<th>CPT® Code</th>
<th>Description</th>
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<td>73564</td>
<td>Radiologic examination, knee; complete, 4 or more views</td>
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<tr>
<td>73565</td>
<td>Radiologic examination, knee; both knees, standing, anteroposterior</td>
</tr>
<tr>
<td>73590</td>
<td>Radiologic examination; tibia and fibula, 2 views</td>
</tr>
<tr>
<td>73600</td>
<td>Radiologic examination, ankle; 2 views</td>
</tr>
<tr>
<td>73610</td>
<td>Radiologic examination, ankle; complete, minimum of 3 views</td>
</tr>
<tr>
<td>73620</td>
<td>Radiologic examination, foot; 2 views</td>
</tr>
<tr>
<td>73630</td>
<td>Radiologic examination, foot; complete, minimum of 3 views</td>
</tr>
<tr>
<td>73650</td>
<td>Radiologic examination; calcaneus, minimum of 2 views</td>
</tr>
<tr>
<td>73660</td>
<td>Radiologic examination; toe(s), minimum of 2 views</td>
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### Table 4 – Covered IHCP Chiropractic Codes for Medicine Services

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<tr>
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<th>Description</th>
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<tr>
<td>95831</td>
<td>Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk</td>
</tr>
<tr>
<td>95832</td>
<td>Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side</td>
</tr>
<tr>
<td>97012</td>
<td>Application of a modality to 1 or more areas; traction, mechanical</td>
</tr>
<tr>
<td>97014</td>
<td>Application of a modality to 1 or more areas; electrical stimulation (unattended)</td>
</tr>
<tr>
<td>97016</td>
<td>Application of a modality to 1 or more areas; vasopneumatic devices</td>
</tr>
<tr>
<td>97018</td>
<td>Application of a modality to 1 or more areas; paraffin bath</td>
</tr>
<tr>
<td>97022</td>
<td>Application of a modality to 1 or more areas; whirlpool</td>
</tr>
<tr>
<td>97024</td>
<td>Application of a modality to 1 or more areas; diathermy (eg, microwave)</td>
</tr>
<tr>
<td>97026</td>
<td>Application of a modality to 1 or more areas; infrared</td>
</tr>
<tr>
<td>97028</td>
<td>Application of a modality to 1 or more areas; ultraviolet</td>
</tr>
<tr>
<td>97032</td>
<td>Application of modality to 1 or more areas; electrical stimulation (manual), each 15 minutes</td>
</tr>
<tr>
<td>97033</td>
<td>Application of modality to 1 or more areas; iontophoresis, each 15 minutes</td>
</tr>
<tr>
<td>97034</td>
<td>Application of modality to 1 or more areas; contrast baths, each 15 minutes</td>
</tr>
<tr>
<td>97035</td>
<td>Application of modality to 1 or more areas; ultrasound, each 15 minutes</td>
</tr>
<tr>
<td>97036</td>
<td>Application of modality to 1 or more areas; Hubbard tank, each 15 minutes</td>
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</table>
Table 5 – Diagnosis Codes for Chiropractic Services, Principal ICD-9-CM Codes

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<tr>
<th>Diagnosis Codes</th>
<th>Description</th>
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<tr>
<td>646.93*</td>
<td>Unspecified complication of pregnancy, antepartum</td>
</tr>
<tr>
<td>648.73*</td>
<td>Bone and joint disorders of maternal back, pelvis, and lower limbs, antepartum</td>
</tr>
<tr>
<td>648.93*</td>
<td>Other current maternal conditions classifiable elsewhere, antepartum</td>
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<td>739.0</td>
<td>Nonallopathic lesions, not elsewhere classified – Head region</td>
</tr>
<tr>
<td>739.1</td>
<td>Nonallopathic lesions, not elsewhere classified – Cervical region</td>
</tr>
<tr>
<td>739.2</td>
<td>Nonallopathic lesions, not elsewhere classified – Thoracic region</td>
</tr>
<tr>
<td>739.3</td>
<td>Nonallopathic lesions, not elsewhere classified – Lumbar region</td>
</tr>
<tr>
<td>739.4</td>
<td>Nonallopathic lesions, not elsewhere classified – Sacral region</td>
</tr>
<tr>
<td>739.5</td>
<td>Nonallopathic lesions, not elsewhere classified – Pelvic region</td>
</tr>
<tr>
<td>739.6</td>
<td>Nonallopathic lesions, not elsewhere classified – Lower extremities</td>
</tr>
<tr>
<td>739.7</td>
<td>Nonallopathic lesions, not elsewhere classified – Upper extremities</td>
</tr>
<tr>
<td>739.8</td>
<td>Nonallopathic lesions, not elsewhere classified – Rib cage</td>
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Table 6 – Diagnosis Codes for Chiropractic Services, Secondary ICD-9-CM Codes

<table>
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<tr>
<th>Diagnosis Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>307.81</td>
<td>Tension headache</td>
</tr>
<tr>
<td>333.83</td>
<td>Spasmodic torticollis</td>
</tr>
<tr>
<td>346.00</td>
<td>Classical migraine without mention of intractable migraine</td>
</tr>
<tr>
<td>346.01</td>
<td>Classical migraine with intractable migraine, so stated</td>
</tr>
<tr>
<td>346.10</td>
<td>Common migraine without mention of intractable migraine</td>
</tr>
<tr>
<td>346.11</td>
<td>Common migraine with intractable migraine, so stated</td>
</tr>
<tr>
<td>346.20</td>
<td>Variants of migraine without mention of intractable migraine</td>
</tr>
<tr>
<td>346.21</td>
<td>Variants of migraine with intractable migraine, so stated</td>
</tr>
<tr>
<td>346.80</td>
<td>Other forms of migraine without mention of intractable migraine</td>
</tr>
<tr>
<td>346.81</td>
<td>Other forms of migraine with intractable migraine, so stated</td>
</tr>
<tr>
<td>346.90</td>
<td>Migraine, unspecified, without mention of intractable migraine</td>
</tr>
<tr>
<td>346.91</td>
<td>Migraine, unspecified, with intractable migraine, so stated</td>
</tr>
<tr>
<td>353.0</td>
<td>Brachial plexus lesions</td>
</tr>
<tr>
<td>353.1</td>
<td>Lumbosacral plexus lesions</td>
</tr>
<tr>
<td>353.2</td>
<td>Cervical root lesions, not elsewhere classified</td>
</tr>
<tr>
<td>353.3</td>
<td>Thoracic root lesions, not elsewhere classified</td>
</tr>
<tr>
<td>353.4</td>
<td>Lumbosacral root lesions, not elsewhere classified</td>
</tr>
<tr>
<td>353.8</td>
<td>Other nerve root and plexus disorders</td>
</tr>
<tr>
<td>353.9</td>
<td>Unspecified nerve root and plexus disorder</td>
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<tr>
<td>354.4</td>
<td>Causalgia of upper limb</td>
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<tr>
<td>354.8</td>
<td>Other mononeuritis of upper limb</td>
</tr>
<tr>
<td>354.9</td>
<td>Mononeuritis of upper limb, unspecified</td>
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<td>719.40</td>
<td>Pain in joint, site unspecified</td>
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<tr>
<td>719.48</td>
<td>Pain in joint, other specified sites</td>
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<tr>
<td>719.49</td>
<td>Pain in joint, multiple sites</td>
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<td>720.0</td>
<td>Ankylosing spondylitis</td>
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<td>720.1</td>
<td>Spinal enthesopathy</td>
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<td>Description</td>
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<tr>
<td>721.0</td>
<td>Cervical spondylosis without myelopathy</td>
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<tr>
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<td>Thoracic spondylosis without myelopathy</td>
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<tr>
<td>721.3</td>
<td>Lumbosacral spondylosis without myelopathy</td>
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<tr>
<td>721.6</td>
<td>Anklyosing vertebral hyperostosis</td>
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<tr>
<td>721.7</td>
<td>Traumatic spondylopathy</td>
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<tr>
<td>721.90</td>
<td>Spondylosis of unspecified site without mention of myelopathy</td>
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<td>722.0</td>
<td>Displacement of cervical intervertebral disc without myelopathy</td>
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<td>Lumbar intervertebral disc without myelopathy</td>
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<td>722.2</td>
<td>Displacement of intervertebral disc, site unspecified, without myelopathy</td>
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<td>Schmorl's nodes, unspecified region</td>
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<td>Schmorl's nodes, thoracic region</td>
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<td>Schmorl's nodes, lumbar region</td>
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<td>Degeneration of cervical intervertebral disc</td>
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<td>Degeneration of thoracic or thoracolumbar intervertebral disc</td>
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<td>Degeneration of lumbar or lumbosacral intervertebral disc</td>
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<td>Postlaminectomy syndrome, thoracic region</td>
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<td>Postlaminectomy syndrome, lumbar region</td>
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<td>Other and unspecified disc disorder, unspecified region</td>
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<td>Other and unspecified disc disorder, cervical region</td>
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<td>722.92</td>
<td>Other and unspecified disc disorder, thoracic region</td>
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<td>722.93</td>
<td>Other and unspecified disc disorder, lumbar region</td>
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<td>Spinal stenosis in cervical region</td>
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<td>723.2</td>
<td>Cervicocranial syndrome</td>
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<td>Cervicobrachial syndrome (diffuse)</td>
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<td>Brachial neuritis or radiculitis not otherwise specified (NOS)</td>
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<td>723.8</td>
<td>Other syndromes affecting cervical region</td>
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<td>Unspecified musculoskeletal disorders and symptoms referable to neck</td>
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<td>Disorders of coccyx, other</td>
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<td>Kyphosis (acquired) (postural)</td>
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<td>Resolving infantile idiopathic scoliosis</td>
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<td>Kyphoscoliosis and scoliosis – other</td>
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<td>Certain congenital musculoskeletal deformities of spine</td>
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<td>Cervical vertebra, closed – fourth cervical vertebra</td>
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<td>Cervical vertebra, closed – fifth cervical vertebra</td>
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<td>Cervical vertebra, closed – sixth cervical vertebra</td>
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<td>Cervical vertebra, closed – seventh cervical vertebra</td>
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<td>Cervical vertebra n, closed – multiple cervical vertebra</td>
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<td>839.20</td>
<td>Lumbar vertebra, closed</td>
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<td>839.21</td>
<td>Thoracic vertebra, closed</td>
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<td>Sprains and strains of sacroiliac region, lumbosacral (joint) (ligament)</td>
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<td>846.1</td>
<td>Sprains and strains of sacroiliac region, sacroiliac ligament</td>
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<td>Sprains and strains of sacroiliac region, sacrospinatus (ligament)</td>
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<td>Sprains and strains of sacroiliac region, sacrotuberos (ligament)</td>
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<td>Sprains and strains of sacroiliac region, other specified sites of sacroiliac region</td>
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<tr>
<td>Code</td>
<td>Description</td>
</tr>
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<tr>
<td>846.9</td>
<td>Sprains and strains of sacroiliac region, unspecified site of sacroiliac region</td>
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<td>Sprains and strains of other and unspecified parts of back, thoracic</td>
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<td>Sprains and strains of other and unspecified parts of back, lumbar</td>
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<td>Sprains and strains of other and unspecified parts of back, sacrum</td>
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<td>Sprains and strains of other and unspecified parts of back, coccyx</td>
</tr>
<tr>
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<td>Sprains and strains of other and unspecified parts of back, unspecified site of back</td>
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<td>Late effect of injury to nerve root(s), spinal plexus(es), and other nerves of trunk</td>
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<tr>
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<td>Injury to nerve roots and spinal plexus, dorsal root</td>
</tr>
<tr>
<td>953.2</td>
<td>Injury to nerve roots and spinal plexus, lumbar root</td>
</tr>
<tr>
<td>953.3</td>
<td>Injury to nerve roots and spinal plexus, sacral root</td>
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<tr>
<td>953.4</td>
<td>Injury to nerve roots and spinal plexus, brachial plexus</td>
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<td>953.5</td>
<td>Injury to nerve roots and spinal plexus, lumbrosacral plexus</td>
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</tr>
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<td>Injury to peripheral nerve(s) of pelvic girdle and lower limb, femoral nerve</td>
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<td>Injury to peripheral nerve(s) of pelvic girdle and lower limb, posterior tibial nerve</td>
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<td>Injury to peripheral nerve(s) of pelvic girdle and lower limb, peroneal nerve</td>
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<tr>
<td>956.4</td>
<td>Injury to peripheral nerve(s) of pelvic girdle and lower limb, cutaneous sensory nerve, lower limb</td>
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<tr>
<td>956.5</td>
<td>Injury to peripheral nerve(s) of pelvic girdle and lower limb, other specified nerve(s) of pelvic girdle and lower limb</td>
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<tr>
<td>956.8</td>
<td>Injury to peripheral nerve(s) of pelvic girdle and lower limb, multiple nerves of pelvic girdle and lower limb</td>
</tr>
<tr>
<td>956.9</td>
<td>Injury to peripheral nerve(s) of pelvic girdle and lower limb, unspecified nerve of pelvic girdle and lower limb</td>
</tr>
</tbody>
</table>

**Rules, Citations, and Sources**

*IC art. 25-10 - Chiropractors*

*405 IAC 5-5 - Out-of-State Services*

*405 IAC 5-12 - Chiropractic Services*

*407 IAC 3-12 - Chiropractic Services*
846 IAC - Chiropractic Examiners

IHCP Bulletins

BT200329: Chiropractic Service Limits for All Members
BT200323: Changes in Chiropractic Services

IHCP Banner Page

BR200514: Chiropractic Service Changes

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Consultation – Second Opinions
Diagnostic Studies
Medical Supplies and Durable Medical Equipment – Overview
Out-of-State Services
Obstetric Care
Clinic Services – Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

FQHCs and RHCs can participate with a MCE. The MCE provider contract must specify the contractual arrangements to ensure that the FQHC or RHC is reimbursed for services.

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

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.

Description of Services

FQHCs and RHCs are facilities for physical examination and treatment of ambulatory patients who are not hospitalized where the preliminary diagnosis is made, and treatment is provided. Often, an RHC may provide services to a medically underserved area.

Reimbursement Requirements

Reimbursement is available for IHCP members seeking medical care in FQHCs and RHCs. The provider may be a physician, nurse practitioner, physician assistant, clinical psychologist, or clinical social worker. The IHCP also provides reimbursement to RHCs and FQHCs for services provided by a dentist, dental hygienist, podiatrist and optometrist. 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 as an incident to a physician’s services. Services to a homebound individual are available only in the case of FQHCs located in areas with shortages of home health agencies, as determined by Medicaid. Any 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 CMS. To enroll as an FQHC with the IHCP, the CMS letter granting the FQHC status must be forwarded to HP Provider Enrollment with a completed application. RHCs receive their Medicare designations through CMS and must contact ISDH to receive RHC status as IHCP providers.

IHCP reimbursement is limited to one encounter per IHCP member, per provider, per day unless the diagnosis differs. This means should a member visit an office twice on the same day with a different diagnoses, 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.

Providers can bill only one unit of service on a single detail line of the paper or electronic claim form. When two valid providers see the same patient in the same day, such as a medical provider and a mental health provider, the principal diagnoses should not be the same. Providers should break down consecutive service dates so that they bill each day on a separate line. When a provider has more than one visit per day for the same member for the same provider and the diagnoses are different, the IHCP requires a manual review.

Therefore, providers should submit proper documentation along with the claim to substantiate the need for additional visits. This documentation includes but is not limited to the following:

- Visits performed at separate times of the day – 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 – indicate the type of provider that rendered each visit and denote which practitioner treated which diagnosis
- Documentation in the medical record that 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.

RHC and FQHC rates include payment for the vaccine and administration fee, and cannot be billed separately on claims submitted to HP. RHCs and FQHCs must separately verify the billing policy for each MCE to which they submit claims.

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 HealthWatch services. Refer to the IHCP Provider Manual or the HealthWatch Early and Periodic Screening, Diagnostic & Treatment Program Supplemental Provider Manual for additional information about those services.

The valid FQHC/RHC encounter code list is reviewed annually and is published by Myers and Stauffer, the rate-setting contractor for the OMPP, on Myers and Stauffer’s Web site at http://in.mslc.com.

Prior Authorization Requirements

FQHCs and RHCs are subject to the same PA requirements for IHCP services as traditional Medicaid. The provider may contact the PA department for specific information regarding requirements and guidelines. Additional information can be located in Chapter 6, of the IHCP Provider Manual.

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.

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

For claims submitted with a Place of Service 11-Office; 12-Home; 31-Skilled Nursing Facility (SNF); 32-Nursing Facility (NF); 50-FQHC; or 72-RHC, providers must use both the T1015 encounter code and the appropriate CPT® or HCPCS procedure code. The detail containing the allowable CPT/HCPCS codes will deny appropriately. The claim will reimburse from the T1015 encounter, according to the usual and customary charge, as established in the provider’s file.

Claims submitted with a Place of Service 20-26, described in Table 1, 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Urgent Care Center</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room – Hospital</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
</tr>
</tbody>
</table>

All Third Party Liability (TPL), patient liability, and copayments will continue to apply, as appropriate. Previous TPL payments and spend-down 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.

Effective for claims submitted with a date of service on or after April 1, 2011, FQHCs are required to use Type of Bill (TOB) 77X for all Medicare Crossover claims. As of March 31, 2011, the IHCP no longer accepts TOB 73X for FQHC crossover claims.

**Dental Claims**

Dental claims for FQHC/RHC are to be billed on an American Dental Association (ADA) dental claim form using 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.

**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

IHCP Bulletins

- BT200922 – Healthy Indiana Plan Reimbursement to Federally Qualified Health Centers and Rural Health Clinics
- BT200921 – Notification of Pregnancy
- **BT200318** – Change in Method of Filing Claims
Related Medical Topics

Evaluation and Management Services
Family Planning
Immunizations and Vaccines
Nursing Services

Clinical Trials

Introduction

This section serves as a general summary of the IHCP’s policies regarding clinical trials. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Services

A clinical trial is a research study among 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 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 public’s health.

Medicare has 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. The OMPP has accepted Medicare’s established guidelines to reimburse for routine costs and complications of clinical trials.

Reimbursement Requirements

Medicare defines an experimental item or service as for “research use only” or for “investigational use only.” The terms “experimental” and “investigational” are described under the same definition and have the same coverage guidelines. Thus, in this section, experimental and investigational are used interchangeably.

The IHCP covers the routine costs of approved clinical trials, as well as reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from the participation in all clinical trials. Routine costs of a clinical trial include all items and services that are available to IHCP members (that is, there exists a benefit category, and the item or service is not listed as a noncovered service in the IAC) that are provided in either the experimental or the control arms of the trial.

Items or services already covered by the IHCP will be considered routine costs according to 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.

In order for the IHCP to cover the routine costs involved in clinical trials, the clinical trial must meet all the following requirements:

- The subject or purpose of the trial must be the evaluation of an item or service that would be covered under 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, 405 IAC 5-19-18, 405 IAC 5-24-3, 5-29-1, or 405 IAC 5-30-3.
- 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.
- Trials of therapeutic intervention must enroll only members with diagnosed diseases, rather than healthy members. Trials including diagnostic interventions may enroll healthy members to have a proper control group.
- The clinical trial must be deemed “automatically qualified” under Medicare guidelines. The following clinical trials are deemed automatically qualified:
  - Trials funded by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), CMS, the Department of Defense (DOD), or Veterans Administration (VA)
  - Trials supported by centers or cooperative groups funded by the NIH, CDC, AHRQ, CMS, DOD, or VA, including but not limited to the FDA, the National Heart, Lung, and Blood Institute (NHLBI), the National Human Genome Research Institute (NHGRI), the National Cancer Institute (NCI), the National Institute of Diabetes and Kidney Diseases (NIDDK), the National Institute of Mental Health (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)

**Prior Authorization Requirements**

Please refer to the *Chapter 6 of the IHCP Provider Manual*, for PA requirements for specific procedures and treatments.
Billing Requirements

Items considered routine costs in clinical trials, and thus reimbursable, 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. Examples include nursing/staffing fees, patient monitoring and evaluation, DME, and IV and catheter line placement.

- 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. Examples include the administration fee for an investigational chemotherapeutic agent, equipment and ancillary staffing for the implantation of an investigational device, provision of a nebulizer to administer an investigational drug, and room and board as part of a hospital stay required as part of the clinical trial.

- Items required for the clinically appropriate monitoring of the effects of the investigational item or service. Examples include ECGs, electroencephalograms (EEGs), and blood pressure monitoring.

- Items and services required for the prevention of complications – for example, the cost of an antinausea drug for an investigational chemotherapeutic agent.

- 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. Examples include the treatment of pneumonia caused by an investigational lung procedure.

Items not considered routine costs in a clinical trial, and thus not covered by the IHCP, include the following:

- The investigational items or services, unless otherwise covered outside the clinical trial. 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 be considered investigational and thus, not reimbursable.

- Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient. Examples include monthly CT scans for a condition usually requiring only a single CT scan, weekly blood draws not needed to monitor side effects, and quarterly Papanicolaou (PAP) smears for a condition usually requiring yearly PAP smears.

- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Rules, Citations, and Sources

21 CFR § 312 – Investigational New Drug Application
21 CFR § 812 – Investigational Device Exemption
21 CFR §§ 405.201 and 405.203 – Class I to III devices
IC § 25-22.5-1-2.1 - Experimental or nonconventional treatment; protocols for treatment
405 IAC 5-10-5 – Noncovered services
405 IAC 5-19-18 – Noncovered durable medical equipment
405 IAC 5-24-3 – Coverage of legend drugs
405 IAC 5-29-1 – Noncovered services
405 IAC 5-30-3 – Noncovered transportation services

*National Coverage Determination (NDC) Manual, Section 310*

IHCP Provider Manual


Related Medical Topics

Not Applicable
Collagen Implants for Stress Urinary Incontinence (SUI)

Introduction

This section serves as a general summary of the IHCP’s policies regarding collagen implants for SUI. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Services

A collagen implant is a prosthetic device used in the treatment of SUI resulting from intrinsic sphincter deficiency (ISD). The prosthetic device is injected into the submucosal tissues of the urethra and/or the bladder neck and into tissues adjacent to the urethra. 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 (for example, prostatectomy), urethral, 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. ISD is a cause of SUI in which the urethral sphincter is unable to contract and generate sufficient resistance in the bladder.

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.

Reimbursement Requirements

To use a collagen implant, physicians must have urology training in the use of a cystoscope and must complete a collagen implant training program.

Coverage of a collagen implant, and the procedure to inject it, is limited to the following types of patients with SUI because of ISD:

- Male or female patients with congenital sphincter weakness secondary to conditions such as myelomeningocele or epispadias
- Male or female patients with acquired sphincter weakness secondary to spinal-cord lesions
- Male patients following trauma, including prostatectomy and/or radiation
- Female patients without urethral hypermobility and with abdominal leak point pressures (ALPPs) of 100 cm H$_2$O or less

Patients whose incontinence does not improve with five injection procedures (five separate treatment sessions) are considered treatment failures, and no further treatment of urinary incontinence by collagen implant is covered. Patients who have a reoccurrence of incontinence following successful treatment with collagen implants in the past (for example, six to 12 months previously) may benefit from additional treatment sessions. Coverage of additional sessions may be allowed but must be supported by medical justification.

Prior to collagen implant therapy, a skin test for collagen sensitivity must be administered and evaluated over a four-week period.

In male patients, the evaluation must include a complete history and physical (H&P) examination, and a simple cystometrogram to determine that the bladder fills and stores properly. The patient is asked to stand upright with a full bladder and to cough or otherwise exert abdominal pressure on his bladder. If the patient leaks, the diagnosis of ISD is established.

In female patients, the evaluation must include a complete H&P examination (including a pelvic exam) and a simple cystometrogram to rule out abnormalities of bladder compliance and abnormalities of urethral support. Following that determination, an abdominal leak-point pressure (ALPP) test is performed. Leak-point pressure, stated in cm H$_2$O, is defined as the intra-abdominal pressure at which leakage occurs from the bladder (around a catheter) when the bladder has been filled with a minimum of 150 cc fluid. If the patient has an ALPP of less than 100 cm H$_2$O, the diagnosis of ISD is established.

To use a collagen implant, physicians must have urology training in the use of a cystoscope and must complete a collagen implant training program.

**Prior Authorization Requirements**

PA is not required for collagen implants for SUI.

**Billing Requirements**

Medicaid reimbursement is available for collagen implants used to control urinary incontinence because of ISD and demonstrated by consistent symptoms. Appropriate HCPCS and CPT® codes for billing are listed in Tables 1 and 2.
Table 1 – HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8603</td>
<td>Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies</td>
</tr>
<tr>
<td>Q3031</td>
<td>Collagen skin test</td>
</tr>
</tbody>
</table>

Table 2 – CPT® Codes

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>51715</td>
<td>Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck</td>
</tr>
<tr>
<td>95028</td>
<td>Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests</td>
</tr>
</tbody>
</table>

Rules, Citations, and Sources

IHCP Provider Manual


Related Medical Topics

Anesthesia Services

Consultations – Second Opinion

Diagnostic Studies

Surgery – Surgical Services
Consultations – Second Opinions

Introduction

This section serves as a general summary of the IHCP’s policies regarding consultations – second opinions. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

A consultation is the rendering of a medical opinion by a physician for a specific member, regarding evaluation or management of a specific condition requested by another physician. A consultation implies collaboration between the requesting and consulting 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 regarding the evaluation or management of a condition. Please refer to Section 19, Evaluation and Management Services, for additional information.

Reimbursement Requirements

The IHCP will provide reimbursement for the following four subcategories of consultations when the services are provided in compliance with all applicable IHCP guidelines.

Consultation Categories:

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

Initial Consultation

The IHCP reimbursement for an initial consultation is limited to one per consultant, per member, per inpatient hospital or NF admission. The IHCP will not reimburse consultation codes when a member is referred for management of a condition or when the consulting physician assumes
management of the member’s care. Per 405 IAC 5-8-3(a), a consultation cannot be used for the evaluation of a nonphysician-referred or self-referred recipient.

Pathology and Radiology Consultation

IHCP reimbursement is available for an office or other outpatient consultation. 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 utilizing the appropriate office or other outpatient code for established patients. If a recipient is referred for management of a condition, or if the consulting physician assumes patient management, consultation codes cannot be billed to Medicaid.

Follow-up Inpatient Consultation

IHCP reimbursement is available for follow-up inpatient consultations, when additional visits are needed to complete the initial consultation, or if subsequent consultative visits are requested by the attending physician. These consultative visits include monitoring progress, recommending management modifications, or advising on a new plan of care (POC) 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.

Confirmatory Consultation

A confirmatory consultation must be specifically requested by another physician 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 PA process. The consultation may not be used for the evaluation of a non-physician referred or self-referred member.

Pathology Services

Consultative pathology services are reimbursable if they are requested by the member’s attending physician in writing, and if they 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 ADA has indicated that a consultation is to be used as a second opinion. When billing for a dental consultation, providers are to report one of the oral evaluation codes. Please refer to Section 11 of this manual, Dental Services, for additional information.

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. The second opinion is required regardless of the surgical setting in which the surgery is to be performed, such as an ambulatory surgical treatment center, a hospital, or a clinic.

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.

Consultation services rendered by a podiatrist in a NF 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 Section 79 of this manual, Podiatry, for additional information.

Prior Authorization Requirements

The CPT® codes for E/M services used to report second-opinion and consultative services appear in Table 1. Services with these codes also require PA after 30 visits per member, per provider, per rolling calendar year for IHCP members. See Billing Requirements elsewhere in this section for 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 30 Visits per Member, Per Rolling Calendar Year*

<table>
<thead>
<tr>
<th>CPT® Codes for E/M Services</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>99201</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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</tr>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.</td>
</tr>
</tbody>
</table>
| 99212  | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99214</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99241</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99242</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Typically, 10 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>Code</td>
<td>Consultation Description</td>
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<tr>
<td>99243</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99244</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99245</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
</tbody>
</table>

*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.

**Billing Requirements**

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs. Providers must bill utilizing the appropriate procedure code. 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. For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.

When the provider is billing consultation codes, the medical record must contain written documentation of the request for consultation by the requesting physician. The provider should maintain this documentation in the patient’s medical record at the requesting and receiving.
physician’s office. When a provider performs a consultation, the consulting physician customarily responds in writing to the requesting physician about the opinion or advice of the consulting physician.

**Office Consultation**

The IHCP provides reimbursement for office consultations when billed with the appropriate CPT® codes. Table 2 includes CPT® codes which should be utilized when billing office consultations.

**Table 2 – Office Consultation CPT® Codes**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99242</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99243</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99244</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
</tbody>
</table>
Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.

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.

**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. Inpatient consultation codes are used to report consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting. Inpatient consultation codes should be utilized by the consulting physician for the initial encounter with the patient and subsequent hospital care codes for additional encounters thereafter.

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 99231–99233 for follow-up inpatient consultations.

### Table 3 – Initial Inpatient and Subsequent Consultation CPT® Codes

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99251</td>
<td>Inpatient consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.</td>
</tr>
<tr>
<td>99252</td>
<td>Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling</td>
</tr>
</tbody>
</table>
and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99253</td>
<td>Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.</td>
</tr>
<tr>
<td>99254</td>
<td>Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.</td>
</tr>
<tr>
<td>99255</td>
<td>Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.</td>
</tr>
<tr>
<td>99231</td>
<td>Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.</td>
</tr>
<tr>
<td>99232</td>
<td>Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.</td>
</tr>
</tbody>
</table>

**Consultations – Second Opinions**
Library Reference Number:  
Revision Date: December 2014  
Version 2.0
are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.

99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

Consultations and Second Opinions

The IHCP may provide reimbursement for consultations and second opinions when billed with the appropriate modifier. If a consultation is billed and payment has been made to any provider for a consultation for the same recipient within fifteen (15) days before or after the date on the claim, the claim will suspend for manual review. If the provider specialty on the current claim is 316 (family practitioner) or 318 (general practitioner) the diagnosis related to the consultation is reviewed. It is compared to the specialty of the provider who rendered the consultation in history, the diagnosis related to the consultation in history, and the date of service of each consultation. Note: If the claim was filed under a group number/specialty code, determine the specialty of the rendering provider.

1. If the billing provider specialty is different from the history provider specialty, AND consultation was for an unrelated/different diagnosis, the claim will be paid.
2. If the billing provider specialty is the same as the history provider specialty AND/OR consultation was for the same or related diagnosis, medical documentation will be requested. If the documentation shows the service is medically justified, the claim will be paid. If it is determined the service is not medically justified, the claim will be denied with EOB 6150.
3. If the same provider rendered both current and history consultations and no documentation is submitted to indicate that a request for an additional consultation was received, deny with EOB 6150.

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.

A physician providing a confirmatory consultation is expected to provide an opinion 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.
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

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

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

Introduction

This section serves as a general summary of the IHCP’s policies regarding dental services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

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.

Reimbursement Requirements

Oral Evaluations

The IHCP limits procedure codes D0150 – **Comprehensive oral evaluation – new or established patient** and D0160 – **Detailed and Extensive Oral Evaluation – problem focused** to one per lifetime, per member, per provider. The two-unit limitation applies to any combination of these two codes billed per year, per member with a lifetime limit of one per lifetime, per member, per provider.

The IHCP limits procedure code D0145 – **Oral evaluation, for a patient under 3 years of age and counseling with primary caregiver** to one per year, per member, any provider. The IHCP limits procedure code D0120 – **Periodic Oral Evaluation – established patient** to one every six months, per member, any provider.

The IHCP does not subject procedure code D0140 – **Limited oral evaluation – problem focused** to service limitations; however, providers should use it as defined in CDT. This type of evaluation is for patients who have been referred for specific problems, such as dental emergencies, trauma, acute infections, conditions requiring immediate medical attention, and so forth.
Providers should not use D0140 for periodic oral evaluations or other types of evaluations. The IHCP subjects other periodic oral examinations or other types of evaluations that providers bill using D0140 to recoupment. Documentation in the dental and medical records must support that the provider rendered the oral evaluation in compliance with the procedure definition for the dental code used.

**Preventative**

**Prophylaxis**

Prophylaxis is a covered IHCP service, but is limited to the following restrictions. The program allows for one application of prophylaxis every six months or two units per calendar year for non-institutionalized members 12 months of age, up to their 21st birthdays. One unit of prophylaxis is allowed every 12 months for non-institutionalized members who are 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 unless medical necessity can be established.

**Prophylaxis and Fluoride**

Reimbursement is available for one topical application of fluoride every six months per member (only for members who are 12 months of age or older, but who are younger than 21 years of age). Topical fluoride is not covered for members 21 years of age or older. Brush-in fluoride (topical application of fluoride phosphate) is not a covered service.

Procedure code D1206 – *Topical Fluoride Varnish* is reimbursable by the IHCP. Topical applications of fluoride are billable under procedure codes D1208 – *Topical Application of Fluoride*. Topical applications are not covered for members 21 years old or older. Services rendered to members younger than 21 years old may be reimbursed for the topical application of fluoride using the brush-on method versus using a dental tray. Topical fluoride includes varnish, gel, or foam.

**Radiographs**

Either full-mouth series radiographs or panorex x-rays are limited to one set per member every three years. Bitewing radiographs are limited to one set per member every twelve months. One set of bitewings is defined as either four horizontal films or seven to eight vertical films. Intraoral and extraoral radiographs are limited to one first film and seven additional films per member every 12 months.

The IHCP limits reimbursement of procedure code D0240- occlusal films to two units per member per day. Each occlusal film provides a more extensive view of the maxilla and mandible and reveals the entire arch of teeth in either the upper or lower jaw.

Temporomandibular joint (TMJ) arthrograms, other temporomandibular films, tomographic surveys, and cephalometric films are not covered in a dental office.
Space Maintainers

Medicaid is available for space maintenance in children with deciduous molar teeth subject to the following restrictions:

- Space maintenance for children under three years of age requires PA. Space maintenance for missing permanent teeth requires PA.
- Adjustment to space maintainers, bands, and all other appliances is included in the reimbursement for the service and may not be billed separately.
- All requests for PA will be reviewed on a case-by-case basis.

Dental Extractions

Extraction of teeth must be medically necessary, and the diagnosis must support the extraction. 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 27 on the ADA 2006 Dental Claim form or the 837D electronic claim. 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. Payment for preoperative and postoperative care is included in the allowance for the operative procedure and may not be billed separately to Medicaid. Payment for placement of sutures or tissue trim, or both, in simple extractions is included in the reimbursement fee for the extractions and may not be billed separately.

Restorative

Treatment of dental caries with amalgam, composites, or resin restorations or stainless-steel crowns is covered. The use of pit sealants on permanent molars and premolars only is a covered service for members under 21 years of age. There is a limit of one treatment per tooth, per lifetime. Margination of restorations and occlusal adjustments are not separately reimbursed. Crowns D2930, D2931, D2932, D2933, and D2934 are covered by the IHCP.

Periodontics

The IHCP limits periodontal root planing and scaling for members older than three years and younger than 21 years, and for institutionalized members, to four quadrants every two years. For members 21 years of age and older who are not institutionalized, periodontal root planing and scaling is limited to four quadrants per lifetime. Providers billing D4341 – Periodontal scaling and root planing – four or more teeth per quadrant 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.

Effective January 1, 2015, IHCP will limit coverage of full mouth debridement services to once per three years per member and one unit per date of service.

The IHCP does not require radiographs documenting the periodontal disease to be submitted with the claim, but radiographs must be part of the dental record and maintained in the dentist’s office.

Periodontic surgery is a covered service for cases of drug-induced periodontal hyperplasia; PA 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 PA. 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.

**Dentures**

The IHCP covers acrylic partial dentures, D5211 – *Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)* and D5212 – *Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)* when medically necessary, based on the above criteria. The IHCP covers cast metal partial dentures – D5213 – *Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)* and D5214 – *Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)* – only for members with facial deformity due to congenital, developmental, or acquired defects.

The IHCP covers flexible-base partial dentures, D5225 – *Maxillary partial denture – flexible base (including any clasps, rests and teeth)* and D5226 – *Mandibular partial denture – flexible base (including any clasps, rests and teeth)* – only for members with a documented allergic reaction to other denture materials, or for members with facial deformity due to congenital, developmental, or acquired defects. The provider must meet medical necessity standards for all members, regardless of age and PA.

Procedure codes D5225 – *Maxillary partial denture – flexible base* and D5226 – *Mandibular partial denture – flexible base* are covered. Complete and partial dentures require PA for members 21 years and older. PA for dentures is subject to medical necessity. Eight posterior teeth in occlusion, four maxillary, and four mandibular teeth in functional contact with each other are considered adequate for functional purposes.

Providers must submit PA requests for members 21 years old and older on the IHCP PA Dental Request Form. For members younger than 21 years old, no PA is required; however, the provider must maintain documentation to support the services and type of denture or partial
provided. Providers are responsible for maintaining supporting documentation within the member’s medical record for members of all ages.

The following types of partial dentures are covered by the IHCP:

- Acrylic partial dentures, D5211 and D5212, are covered when medically necessary, based on the PA criteria.
- Cast-metal partial dentures, D5213 and D5214, are covered only for members with facial deformity due to congenital, developmental, or acquired defects. The need for a cast-metal partial must be documented in the member’s medical record for all members, and the PA request for members 21 years and older must include specific reasons for the request.
- Flexible-base partial dentures, D5225 and D5226, are covered only for members with facial deformities due to congenital, developmental, or acquired defects (such as cleft-palate conditions) that require flexible-base partials instead of acrylic or cast-metal partials. The need for flexible-base partials must be documented in the member’s medical record for all members and the PA request for members 21 years of age and older must include specific reasons for the request.

The IHCP covers procedure codes D5110 – Complete denture – Maxillary and D5120 – Complete denture – mandibular for complete dentures for members of all ages, subject to PA. The IHCP covers immediate dentures – D5130 – Immediate denture – maxillary and D5140 – Immediate denture – mandibular only for members 21 years of age and older. The IHCP does not reimburse an additional amount for immediate dentures beyond the current denture allowance.

The IHCP waives the 60-day waiting period between the date of the last extraction and the date of the initial impression. The IHCP does not reimburse for additional charges related to furnishing the dentures prior to the 60-day waiting period. Providers can hold the patient responsible for these additional charges if the provider gives the patient advance notice and documents this in the record, as described above.

Reimbursement rates for dentures are determined by the member’s age. Complete and partial dentures do not require PA for members under 21, while those 21 and older must have PA.

**Services Performed Outside the Dental Office**

Per 405 IAC 5-14-14, covered services provided outside the dental office will be reimbursed at the fee allowed for the same service provided in the office. The IHCP considers reimbursement of dental services provided in the hospital or surgery center to be included in the reimbursement for services actually provided (for example, surgical procedures).
It is not appropriate for providers to bill the IHCP or the IHCP member (or member’s family) an additional charge for covered dental services provided in the hospital or surgery center setting. Code D9420 – Hospital Visit is not covered.

**Orthodontics and Oral Surgery**

Orthodontic procedures for the IHCP are covered only for members younger than 21 years old. The OMPP requires PA for all orthodontic services. PA requests must be submitted on the IHCP Medical PA Form, not the IHCP PA Dental Request Form. It is expected that most patients who meet the criteria for orthodontic services will require comprehensive orthodontic treatment, which is billed using one of the three procedure codes: D8070 – Comprehensive orthodontic treatment of the transitional dentition; D8080 – Comprehensive orthodontic treatment of the adolescent dentition; or D8090 – Comprehensive orthodontic treatment of the adult dentition, listed in the CDT Manual. Appliances, retainers, and repair or replacement of retainers are included in the fee for the comprehensive treatment and may not be separately billed if comprehensive treatment is rendered.

Because the comprehensive treatment codes have a manual-pricing indicator, reimbursement is calculated based on 85 percent of the billed amount. Practitioners are advised to carefully consider the appropriate amount to bill for the service and are to bill their usual and customary charges for services rendered. Patients are expected to continue treatment with the same practitioner for the period of treatment time that is prior authorized.

In the unlikely event that the patient 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.

Procedure code D8680 – Orthodontic retention-removal of appliances, construction and placement of retainer(s) is not 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 not covered. These services are included in the reimbursement for orthodontic treatments and will not be separately reimbursed.

**General Anesthesia**

The IHCP reimburses for general anesthesia provided in the dentist’s office only for members younger than 21 years old. The IHCP covers general anesthesia for members 21 years of age and over only if the procedure is performed in a hospital, as an inpatient or outpatient, or in an ambulatory surgical center. PA is necessary.
Documentation for general anesthesia for adults or children should include why the individual cannot receive necessary dental services unless the provider administers general anesthesia. The provider must retain documentation in the member’s file for at least three years.

The criteria for coverage of general anesthesia services are as follows:

- Mental incapacitation, including mental retardation, organic brain disease, and behavioral problems associated with uncooperative but otherwise healthy children, such that the member’s ability to cooperate with procedures is impaired.
- Severe physical disorders affecting the tongue or jaw movements.
- Seizure disorders.
- Significant psychiatric disorders resulting in impairment of the member’s ability to cooperate with procedures.
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication.

IV Sedation – Nitrous Oxide

The IHCP provides medical reimbursement for IV sedation in a dental office when provided for oral surgery services only. Members 21 years old and older require PA. The IHCP covers nitrous oxide analgesia only for members 20 years old and younger. Preanesthetic medication is a covered service for all.

Monitored Sedation for Children

The IHCP reimburses for monitored sedation for children provided in the dentist's office for members younger than 21 years old. Monitored sedation is the administration of subcutaneous, intramuscular, or oral sedation, in combination with monitoring the patient's vital signs. Providers should bill this service using service code D9248 – Non-IV conscious sedation. The IHCP does not cover non-IV conscious sedation for adults.

Emergency Services

405 IAC 5-14-13 limits palliative treatment of facial pain, such as an abscess incision and drainage, to emergency treatment only. Providers can bill procedure code D0140 – Limited oral evaluation – problem focused for the emergency exam. If the procedure for the palliative care has a corresponding ADA code, providers should bill that code for the procedure.

For example, if a provider performs an emergency incision and drainage of an abscess or intraoral soft-tissue procedure, the provider should bill code D7510 – Incision and drainage of abscess – intraoral soft tissue with code D0140. The IHCP does not cover procedure code D9110 – Palliative (emergency) treatment of dental pain – minor procedure.
Members enrolled in Medicaid under Package E are entitled to emergency services only. The *Omnibus Budget Reconciliation Act (OBRA) of 1990* defines an emergency medical condition as:

> An emergency medical condition is one in which there is sufficient severity (including severe pain) that the absence of medical attention could result in placing the member’s health in serious jeopardy, serious impairment of bodily functions or serious dysfunction of an organ or part.

Table 1 lists all the dental codes that can be billed for Package E members. Radiographs must be billed only when the member presents with symptoms that warrant the diagnostic service.

**Table 1 – Dental Emergency Procedures and Codes for Package E Members**

<table>
<thead>
<tr>
<th>CDT-5 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0140</td>
<td>Limited oral evaluation – problem focused</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral – complete series (including bitewings)</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral – periapical – first film</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral – periapical – each additional film</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral – occlusal film</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing – single film</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings – two films</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings – three films</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings – four films</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic film</td>
</tr>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants – deciduous tooth</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth, or exposed root (elevation and/or forceps removal)</td>
</tr>
<tr>
<td>D7210</td>
<td>Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth – soft tissue</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth – partially bony</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth – completely bony</td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth – completely bony, with unusual surgical complications</td>
</tr>
<tr>
<td>D7250</td>
<td>Surgical removal of residual tooth roots (cutting procedure)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D7260</td>
<td>Oroantral fistula closure</td>
</tr>
<tr>
<td>D7261</td>
<td>Primary closure of sinus perforation</td>
</tr>
<tr>
<td>D7270</td>
<td>Tooth reimplantation and/or stabilization of accidentally evulsed or displaced teeth</td>
</tr>
<tr>
<td>D7280</td>
<td>Surgical access of an unerupted tooth</td>
</tr>
<tr>
<td>D7282</td>
<td>Mobilization of erupted or malpositioned tooth to aid eruption</td>
</tr>
<tr>
<td>D7285</td>
<td>Biopsy of oral tissue – hard (bone, tooth)</td>
</tr>
<tr>
<td>D7286</td>
<td>Biopsy of oral tissue – soft</td>
</tr>
<tr>
<td>D7288</td>
<td>Brush biopsy – transepithelial sample collection</td>
</tr>
<tr>
<td>D7510</td>
<td>Incision and drainage of abscess – intraoral soft tissue</td>
</tr>
<tr>
<td>D7511</td>
<td>Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)</td>
</tr>
<tr>
<td>D7520</td>
<td>Incision and drainage of abscess – extraoral soft tissue</td>
</tr>
<tr>
<td>D7521</td>
<td>Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces )</td>
</tr>
<tr>
<td>D7560</td>
<td>Maxillary sinusotomy for removal of tooth fragment or foreign body</td>
</tr>
<tr>
<td>D7610</td>
<td>Maxilla – open reduction (teeth immobilized, if present)</td>
</tr>
<tr>
<td>D7620</td>
<td>Maxilla – closed reduction (teeth immobilized, if present)</td>
</tr>
<tr>
<td>D7630</td>
<td>Mandible – open reduction (teeth immobilized, if present)</td>
</tr>
<tr>
<td>D7640</td>
<td>Mandible – closed reduction (teeth immobilized, if present)</td>
</tr>
<tr>
<td>D7650</td>
<td>Malar and/or zygomatic arch – open reduction</td>
</tr>
<tr>
<td>D7660</td>
<td>Malar and/or zygomatic arch – closed reduction</td>
</tr>
<tr>
<td>D7670</td>
<td>Alveolus – closed reduction, may include stabilization of teeth</td>
</tr>
<tr>
<td>D7671</td>
<td>Alveolus – open reduction, may include stabilization of teeth</td>
</tr>
<tr>
<td>D7680</td>
<td>Facial bones – complicated reduction with fixation and multiple surgical approaches</td>
</tr>
<tr>
<td>D7710</td>
<td>Maxilla – open reduction</td>
</tr>
<tr>
<td>D7720</td>
<td>Maxilla – closed reduction</td>
</tr>
<tr>
<td>D7730</td>
<td>Mandible – open reduction</td>
</tr>
<tr>
<td>D7740</td>
<td>Mandible – closed reduction</td>
</tr>
<tr>
<td>D7750</td>
<td>Malar and/or zygomatic arch – open reduction</td>
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<tr>
<td>D7760</td>
<td>Malar and/or zygomatic arch – closed reduction</td>
</tr>
<tr>
<td>D7770</td>
<td>Alveolus – open reduction stabilization of teeth</td>
</tr>
<tr>
<td>D7771</td>
<td>Alveolus – closed reduction stabilization of teeth</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>---------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D7780</td>
<td>Facial bones – complicated reduction with fixation and multiple surgical approaches</td>
</tr>
<tr>
<td>D7910</td>
<td>Suture of recent small wounds up to 5 cm</td>
</tr>
<tr>
<td>D7911</td>
<td>Complicated suture – up to 5 cm</td>
</tr>
<tr>
<td>D7912</td>
<td>Complicated suture – greater than 5 cm</td>
</tr>
<tr>
<td>D7999</td>
<td>Unspecified oral surgery procedure, by report</td>
</tr>
<tr>
<td>D9220</td>
<td>Deep sedation/general – first 30 minutes</td>
</tr>
<tr>
<td>D9221</td>
<td>Deep sedation/general anesthesia – each additional 15 minutes</td>
</tr>
<tr>
<td>D9230</td>
<td>Analgesia, anxiolysis, inhalation of nitrous oxide</td>
</tr>
<tr>
<td>D9241</td>
<td>IV conscious sedation/analgesia – first 30 minutes</td>
</tr>
<tr>
<td>D9242</td>
<td>IV conscious sedation/analgesia – each additional 15 minutes</td>
</tr>
<tr>
<td>D9248</td>
<td>Non-IV conscious sedation</td>
</tr>
<tr>
<td>D9920</td>
<td>Behavior management, by report</td>
</tr>
</tbody>
</table>

**Mobile Dental Services**

828 IAC 4-3-1 requires providers of mobile dental services to be licensed as mobile dental facilities. Providers of mobile dental services should contact the Professional Licensing Agency at (317) 234-2054 for an application and forward a copy of the mobile dental license to HP Provider Enrollment.

**Dental Cap**

Effective January 1, 2011 the $600 cap limit was raised to $1000 per calendar year, for members 21 years of age and older, and was expanded to include all dental services including emergency dental services.

On November 4, 2011, the U.S. District Court for the Northern District of Indiana issued a Preliminary Injunction enjoining the agency from enforcing 405 IAC 5-14-1(b). This decision was affirmed by the U.S. Court of Appeals for the Seventh Circuit on September 26, 2012. Consequently, the monetary cap of $1,000 for dental services has been removed, subject to all other requirements, pending further court order.

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

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 filing claims and must be supported by 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.

HealthWatch/Early and Periodic Screening, Diagnosis, and Treatment

HealthWatch is Indiana’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. EPSDT is federally mandated health services for Medicaid-eligible persons from birth through 20 years of age. EPSDT is designed to maintain health by providing early intervention to discover and treat health problems. For more information, see the EPSDT HealthWatch medical policy fact sheet, Section 18 of the Medical policy Manual.

As part of the requirements for providing EPSDT under the federal Medicaid program (Section 1905(r)(3) of the Social Security Act), the IHCP has adopted the American Academy of Pediatric Dentistry’s updated Recommendations for Preventive Pediatric Oral Healthcare. Services expected to be rendered and their frequencies are given in the IHCP EPSDT Dental Periodicity Schedule in Table 2.

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6-12 months</td>
</tr>
<tr>
<td>Clinical Oral examination ¹² to include:</td>
<td>● ● ● ●</td>
</tr>
<tr>
<td>Assess oral growth and development³</td>
<td>● ● ● ●</td>
</tr>
<tr>
<td>Caries-risk assessment⁴</td>
<td>● ● ● ●</td>
</tr>
<tr>
<td>Anticipatory guidance/counseling⁶</td>
<td>● ● ● ●</td>
</tr>
<tr>
<td>Injury prevention counseling⁸</td>
<td>● ● ● ●</td>
</tr>
<tr>
<td>Counseling for nonnutritive habits⁹</td>
<td>● ● ● ●</td>
</tr>
</tbody>
</table>

Table 2 – IHCP EPSDT Dental Periodicity Schedule
Counseling for speech/language development

Substance abuse counseling

Counseling for intraoral/perioral piercing

Assessment for pit and fissure sealants\(^6\)

Transition to adult dental care

Radiographic assessment\(^5\)

Prophylaxis and topical fluoride \(^4,5\)

Assessment and treatment of developing malocclusion

Assessment and/or removal of third molars

---

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by the child’s risk status/susceptibility to disease.
2. Includes assessment of pathology and injuries
3. By clinical examination
4. Must be repeated regularly and frequently to maximize effectiveness
5. Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease
6. Place sealants as soon as possible after eruption

Prior Authorization Requirements

Periodontics

Periodontic surgery is a covered service for cases of drug-induced periodontal hyperplasia; PA 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 PA. 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.
**Space Maintainers**

Space maintenance for children under three years of age requires PA. Space maintenance for missing permanent teeth requires PA.

**Dentures**

IHCP reimburses for dentures and partials, but only with PA and if medically necessary. IHCP also reimburses for reline 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 approved only to extend the tooth’s useful life. Eight posterior teeth in occlusion, four maxillary, and four mandibular teeth in functional contact with each other are considered adequate for functional purposes.

If parenteral/enteral is the member’s primary source of nutrients, dentures and partials will not be approved unless the dentist submits a plan of care (POC) with the PA request that indicates dentures or partials are needed to wean the member from the nutritional supplements. The IHCP considers anterior tooth replacement purely an aesthetic or cosmetic concern and not medically necessary.

A service is “medically necessary” when it meets the definition of a “medically reasonable and necessary service,” as defined in 405 IAC 5-2-17. Indiana Medicaid determines medical necessity by reviewing documentation submitted by the provider to support the functional and medical needs of the patient. When submitting the Indiana Prior Review and Authorization Request form, the dentist should complete all applicable information and include all descriptions necessary to create a complete clinical picture of the patient and the need for the request.

The request should include any information about bone and/or tissue changes due to shrinkage, any recent tooth loss, any weight loss, any bone loss in the upper or lower jaw, any recent sickness or disease, or any changes due to physiological aging. If the member’s primary source of nutrition is parenteral and/or enteral nutritional supplements, a POC to wean the member from the nutritional supplements must be included with the request.

The dentist must also include its office telephone number on the PA request, in case the PA analyst has questions. PA is not required for members younger than 21 years of age; however, the provider must maintain documentation to support medical necessity in the member’s medical record.

**Orthodontics and Oral Surgery**

Orthodontic procedures for the IHCP are covered only for members younger than 21 years old. The OMPP requires PA for all orthodontic services. PA requests must be submitted on the IHCP Medical PA Form, not the IHCP PA 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.

Members must have documentation of one or more of the diagnoses or conditions listed Table 3

Table 3 – Diagnoses and Conditions Appropriate for Orthodontic Services

<table>
<thead>
<tr>
<th>Category I: The following diagnoses or conditions are appropriate for orthodontic services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients in Category I and Category II do not require additional information to be submitted for approval of PA requests.</td>
</tr>
<tr>
<td>Cleft Lip and Palate and Facial Clefts</td>
</tr>
<tr>
<td>Oculoauriculovertebral Dysplasia</td>
</tr>
<tr>
<td>Mandibulofacial Dysostosis (Treacher-Collins Syndrome)</td>
</tr>
<tr>
<td>Pierre Robin</td>
</tr>
<tr>
<td>Cleidocranial Dysplasia</td>
</tr>
<tr>
<td>Frontonasal Malformation</td>
</tr>
<tr>
<td>Crouzon Syndrome</td>
</tr>
<tr>
<td>Apert Syndrome</td>
</tr>
<tr>
<td>Pfeiffer’s Syndrome</td>
</tr>
<tr>
<td>Ectodermal Dysplasia</td>
</tr>
<tr>
<td>Hemifacial Microsomia</td>
</tr>
<tr>
<td>Amniotic Band Syndrome</td>
</tr>
<tr>
<td>Neurofibromatosis of the Facial Region</td>
</tr>
<tr>
<td>Holoprosencephaly</td>
</tr>
<tr>
<td>Gorlin Syndrome</td>
</tr>
<tr>
<td><strong>Category I: The following diagnoses and/or conditions are appropriate for orthodontic services.</strong></td>
</tr>
<tr>
<td>Beckwith-Wiedmann Syndrome</td>
</tr>
<tr>
<td>Klippel-Feil Syndrome</td>
</tr>
<tr>
<td><strong>Category II: The following conditions, when accompanied by moderate to severe malocclusions, are appropriate for orthodontic services.</strong></td>
</tr>
<tr>
<td>Fetal Alcohol Syndrome</td>
</tr>
<tr>
<td>Encephalocele</td>
</tr>
<tr>
<td>Down Syndrome</td>
</tr>
<tr>
<td>Werdnig-Hoffman Disease</td>
</tr>
</tbody>
</table>
Spina Bifida
Developmental Disturbances Related to Oncology Radiation
Cerebral Palsy
Achondroplasia
Osteogenesis Imperfecta
Arthrogryposis of the TMJ (Congenital Contractures)
Ankylosis of the Mandibular Condyles
VATER Association
Hemimandibular Hypertrophy
Condylar Hyperplasia
Condylar Hypoplasia
Arcofacial Dysostosis
Rieger Syndrome

Category III: For patients in Category III – Severe Atypical Craniofacial Skeletal Pattern accompanied by moderate to severe malocclusion – the following listed documentation must be submitted for approval of PA requests.

Patients in this category will likely have a secondary diagnosis of a maxillary or mandibular skeletal problem, such as maxillary vertical hyperplasia, mandibular hypoplasia, maxillary excess, vertical maxillary deficiency, and so forth.

Documentation is by special report and must include frontal and lateral photographs of the face and of the occlusion, a panoramic film, and a lateral cephalometric film (with tracing). For Category III patients with vertical skeletal problems, as noted in guideline number 10 on the next page, the practitioner must enclose a posterior-anterior cephalometric film.

The following is a list of guidelines for defining moderate to severe malocclusion as a medical problem for Categories II and III in Table 1:

- Cleft lip and palate, and other craniofacial anomalies with a severe functional compromise of the occlusion.
- Hypodontia or malalignment (one tooth or more per quadrant), precluding routine restorative dentistry.
- Overjet greater than six millimeters (mm).
- Reverse overjet (underbite) less than one mm.
- Anterior or posterior crossbite with greater than two mm discrepancy.
• Lateral or anterior openbite greater than four mm.
• Severe overbite with gingival or palatal trauma.
• Impaction or impeded eruption of teeth (other than third molars).
• Dysplasia of the vertical dimension of occlusion, lower facial height (LFH) greater than 59 percent or less than 52 percent.
• Facial skeletal vertical asymmetry greater than two standard deviations (SDs) from the norm for menton-zygoma (left or right) or gonion-zygoma (left or right).

A signed statement from a 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. In addition, the member must meet the criteria in this policy to qualify for orthodontia.

Documentation for orthodontic services must be maintained in the patient’s dental or medical record, as required by 405 IAC 1-5-1. This rule states, “Medicaid records must be of sufficient quality to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program. All providers participating in the Indiana Medicaid program shall maintain, for a period of three years from the date Medicaid services are provided, such medical and/or other records, including x-rays, as are necessary to fully disclose and document the extent of the services. A copy of the claim form that has been submitted by the provider for reimbursement is not sufficient documentation, in and of itself, to comply with this requirement. Providers must maintain records which are independent of claims for reimbursement.

The provider must submit a step-wise treatment plan with the treatment phase and length of treatment specified. The PA lasts for the length of treatment specified. The IHCP expects that most patients who meet the criteria require comprehensive orthodontic treatment. The PA contractor reviews limited or interceptive orthodontic treatment (procedure codes D8010 through D8220) PA requests on a case-by-case basis. PA request for removable or fixed-appliance therapy (procedure codes D8210 or D8220) must show that the patient meets the criteria outlined in this policy and has a harmful habit in need of correction.

It is expected that most patients who meet the criteria for orthodontic services will require comprehensive orthodontic treatment, which is billed using one of the three procedure codes: D8070 – Comprehensive orthodontic treatment of the transitional dentition; D8080 – Comprehensive orthodontic treatment of the adolescent dentition; or D8090 – Comprehensive orthodontic treatment of the adult dentition, listed in the CDT Manual. Appliances, retainers, and repair or replacement of retainers are included in the fee for the comprehensive treatment and may not be separately billed if comprehensive treatment is rendered.

Because the comprehensive treatment codes have a manual-pricing indicator, reimbursement is calculated based on 90 percent of the billed amount. Practitioners are advised to carefully
consider the appropriate amount to bill for the service and are to bill their usual and customary charges for services rendered. Patients are expected to continue treatment with the same practitioner for the period of treatment time that is prior authorized.

In the unlikely event that the patient 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.

**General Anesthesia**

The IHCP reimburses for general anesthesia provided in the dentist’s office only for members younger than 21 years old. The IHCP covers general anesthesia for members 21 years of age and over only if the procedure is performed in a hospital, as an inpatient or outpatient, or in an ambulatory surgical center. PA is necessary.

Documentation for general anesthesia for adults or children should include why the individual cannot receive necessary dental services unless the provider administers general anesthesia. The provider must retain documentation in the member’s file for at least three years.

**IV Sedation – Nitrous Oxide**

The IHCP provides medical reimbursement for IV sedation in a dental office when provided for oral surgery services only. Members 21 years old and older require PA. The IHCP covers nitrous oxide analgesia only for members 20 years old and younger. Preanesthetic medication is a covered service for all.

**Billing Requirements**

**Periodontal Scaling and Root Planing**

Providers billing D4341 – *Periodontal scaling and root planing – four or more teeth per quadrant* 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.

The IHCP does not require radiographs documenting the periodontal disease to be submitted with the claim, but radiographs must be part of the dental record and maintained in the dentist’s office.
Extractions

Extraction of teeth must be medically necessary, and the diagnosis must support the extraction. 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 27 on the ADA 2006 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. Payment for preoperative and postoperative care is included in the allowance for the operative procedure and may not be billed separately to Medicaid. Payment for placement of sutures or tissue trim, or both, in simple extractions is included in the reimbursement fee for the extractions and may not be billed separately.

405 IAC 5-14-13 limits palliative treatment of facial pain, such as an abscess incision and drainage, to emergency treatment only. Providers can bill procedure code D0140 – Limited oral evaluation – problem focused for the emergency exam. If the procedure for the palliative care has a corresponding ADA code, providers should bill that code for the procedure.

For extraction of supernumerary teeth, the IHCP has adopted the American dental Association (ADA) tooth designation for supernumerary teeth. Permanent dentition – Supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar.

Permanent dentition – Supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower third molar.

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<th>15</th>
<th>16</th>
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</thead>
<tbody>
<tr>
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<td>52</td>
<td>53</td>
<td>54</td>
<td>55</td>
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<td>61</td>
<td>62</td>
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<td>64</td>
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</table>

<table>
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<th>31</th>
<th>30</th>
<th>29</th>
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<th>19</th>
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<th>17</th>
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<tbody>
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<td>“Super” #</td>
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<td>79</td>
<td>78</td>
<td>77</td>
<td>76</td>
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<td>71</td>
<td>70</td>
<td>69</td>
<td>68</td>
<td>67</td>
</tr>
</tbody>
</table>

Primary dentition – Supernumerary teeth are identified by the placement of the letter “S” following the letter identifying the adjacent primary tooth (supernumerary “AS” is adjacent to “A”).
Periodontic surgery is a covered service for cases of drug-induced periodontal hyperplasia; PA 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 PA. 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.

**Dentures**

Providers must submit PA requests for members 21 years old and older on the IHCP PA Dental Request Form. For members younger than 21 years old, no PA is required; however, the provider must maintain documentation to support the services and type of denture or partial provided. Providers are responsible for maintaining supporting documentation within the member’s medical record for members of all ages.

**Orthodontics and Oral Surgery**

It is expected that most patients who meet the criteria for orthodontic services will require comprehensive orthodontic treatment, which is billed using one of the three procedure codes: D8070 – Comprehensive orthodontic treatment of the transitional dentition; D8080 – Comprehensive orthodontic treatment of the adolescent dentition; or D8090 – Comprehensive orthodontic treatment of the adult dentition, listed in the CDT Manual. Appliances, retainers, and repair or replacement of retainers are included in the fee for the comprehensive treatment and may not be separately billed if comprehensive treatment is rendered.

In the unlikely event that the patient 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.
Procedure code D8680 – *Orthodontic retention-removal of appliances, construction and placement of retainer(s)* is not 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 not covered. These services are included in the reimbursement for orthodontic treatments and will not be separately reimbursed.

**Services Performed Outside the Dental Office**

Per 405 IAC 5-14-14, covered services provided outside the dental office will be reimbursed at the fee allowed for the same service provided in the office. The IHCP considers reimbursement of dental services provided in the hospital or surgery center to be included in the reimbursement for services actually provided (for example, surgical procedures).

It is not appropriate for providers to bill the IHCP or the IHCP member (or member’s family) an additional charge for covered dental services provided in the hospital or surgery center setting. Code D9420 – *Hospital Visit* is not covered.

**Rules, Citations, and Sources**

405 IAC 1-5-1 – Medical Records; Contents and Retention

405 IAC 5-2-17 – “Medical Reasonable and Necessary Service” Defined

405 IAC 5-14-1 – Dental Services

405 IAC 5-14-13 – Emergency Treatment of Dental Pain

405 IAC 5-14-14 – Office Visits

**IHCP Bulletins**

- BT201123 – Extension for Reduction in Reimbursement for Dental Services
- BT201059 – Revision: Dental Cap Increased to $1000
- BT201012 – Revised: Reduction in Dental Reimbursement

**IHCP Banner Page**

- BR201040 – Age Restrictions Change for Child/Adult Prophylaxes

**IHCP Provider Manual**

*Note: For the most updated information regarding the IHCP Provider Manual, bulletins and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp).*
Related Medical Topics

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) HealthWatch Program

Surgery – Plastic and Reconstructive Surgery – Facial and Maxillofacial
Dermatology

Introduction
This section serves as a general summary of the IHCP’s policies regarding dermatology. Additional information specific to this topic may be found in the *IHCP Provider Manual*, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service
Dermatology is the medical specialty concerned with the skin, its structure, functions, and diseases.

Reimbursement Requirements
The IHCP will provide for reimbursement for dermatology services billed with an appropriate procedure code when medically necessary. Generally, PA is not required; however, specific procedure codes may require PA. Please refer to Indiana Medicaid Fee Schedule. Documentation in the medical record must support medical necessity.

The following are non-covered services:

- Dermabrasion surgery for acne pitting or marsupialization – *(405 IAC 5-29-1(12))*
- Scar or tattoo removals by excision or abrasion – *(405 IAC 5-29-1(15))*
- Removal of keloids from pierced ears when they are less than 3 centimeters, or when they obstruct less than 50 percent of the ear canal – *(405 IAC 5-29-1(17))*

Prior Authorization Requirements
Generally PA is not required; however, specific procedure codes may require PA. Please refer to the *Chapter 6* of the *IHCP Provider Manual*, for PA requirements, or visit [http://www.indianamedicaid.com/](http://www.indianamedicaid.com/).

Billing Requirements
Providers must bill for dermatology services using the established billing guidelines. Please refer to the *Chapter 8* of the *IHCP Provider Manual*, or visit [http://www.indianamedicaid.com/](http://www.indianamedicaid.com/).
Rules, Citations and Sources

405 IAC 5-1-5 – Global Billing Fee
405 IAC 5-29-1 – Non-covered services

IHCP Provider Manual


Related Medical Topics

Consultations – Second Opinion
Evaluation and Management Services
Surgery – Plastic and Reconstructive Surgery – Facial and Maxillofacial
Diabetes Self-Management Training

Introduction

This section serves as a general summary of the IHCP’s policies regarding diabetes self-management training (DSMT). Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

IHCP’s 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.

Reimbursement Requirements

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 the following:

- Accessing community health care systems and resources
- Behavior changes, strategies and risk factor reduction
- Blood glucose self-monitoring
- Instruction regarding the diabetic disease state, nutrition, exercise and activity
- Insulin injection
- Foot, skin, eye, and dental care
- Medication counseling
- Preconception care, pregnancy and gestational diabetes

The IHCP defines self-care management training as services provided in accordance with the terms and provisions of IC 27-8-14.5-6. The IHCP intends these services to enable the patient to, or enhance the patient’s ability to properly manage a diabetic condition, thereby optimizing the therapeutic regimen.
Coverage of DSMT is limited to the following clinical circumstances:

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

The IAC limits coverage to 16 units per member, per rolling calendar year. Per the IAC each unit is equal to 15 minutes or a total of four hours. Providers can prior-authorize additional units. The IHCP covers diabetes self-management training services for Package C members.

**Prior Authorization Requirements**

PA 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 PA request process. The IHCP reviews the documentation for additional requested units of service for evidence of medical necessity. 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.

**Billing Requirements**

For dates of service prior to February 1, 2014, providers must bill for diabetes self management training service utilizing HCPCS procedure codes G0108, *Diabetes outpatient self-management training services, individual, per 30 minutes*, or G0109, *Diabetes self-management training services, group session (2 or more), per 30 minutes*. For dates of service on or after February 1, 2014, HCPCS code G0108 will be replaced with HCPCS G0108 U6 – *Diabetes outpatient self-management training services, individual, per 30 minutes; per 15 minutes* and HCPCS G0109 will be replaced with HCPCS G0109 U6 - *Diabetes self-management training services, group session (2 or more), per 30 minutes; per 15 minutes*. Providers must bill the modifier U6 to denote “per 15 minutes.” Providers should not round up to the next unit when billing. Providers may accumulate billable time equivalent to whole units and then bill. Fractional units of service can be billed on the CMS-1500 with allowance for two decimal places when submitting partial units. Limit service to sixteen units per member, or the equivalent of four hours, 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 member's symptoms or condition
- Re-education or refresher training
The IHCP does not provide reimbursement for a diabetes self-management training service which is provided to the general public at no charge. Providers should bill the *usual and customary charge* for the units of service rendered.

The following are examples of IHCP health care professionals who **may** enroll and bill for direct care services or supervision of services:

- Audiologists
- Chiropractors
- Dentists
- Hearing aid dealers
- Nurses
- Occupational therapists
- Optometrists
- Pharmacists
- Physical therapists
- Physicians
- Podiatrists
- Respiratory therapists
- Speech and language pathologists

The following are examples of IHCP practitioners who **may not** enroll in the IHCP. Practitioners in this list must bill under the supervising health care professional's IHCP National Provider Identifier (NPI):

- Athletic trainers
- Dietitians
- Environmental health specialists
- Health facility administrators
- Marriage and family therapists
- Physician assistants
- Psychologists
- Social workers
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 rendering the service (DOS)
- 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

Rules, Citations, and Sources

IC § 27-8-14.5-6 – Coverage for diabetes self-management training

405 IAC 5-36 – Diabetes Self-Management Training

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Nursing Services

Podiatry
Diagnostic Studies

Introduction

This section serves as a general summary of the IHCP’s policies regarding diagnostic studies. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Diagnostic studies are invasive and noninvasive tests completed to determine the probable cause of the patient’s signs and symptoms. These studies can be done on an inpatient or outpatient basis, depending on the severity of the signs and symptoms, and the treatment they require.

Reimbursement Requirements

Medical diagnostic services may not be fragmented and billed separately. Such procedures include, but are not limited to, electromyography, electrocardiography, and muscle testing procedures.

Electro studies that involve needle penetration of the skin are covered only when performed by practitioners not restricted by scope of practice to perform such procedures. Determining medical necessity for all electrodiagnostic studies may be done by post-payment review.

Prior Authorization Requirements

PA is no longer required for electrodiagnostic studies. However, procedures using CPT® code 95999 – Unlisted neurological or neuromuscular diagnostic procedure continue to require PA.

Billing Requirements

For billing requirements, please refer to the Chapter 8 of the IHCP Provider Manual or visit http://www.indianamedicaid.com/.

Rules, Citations, and Sources

405 IAC 5-28-2 – Medical diagnostic procedures
IHCP Banner Page

BR200134 – PA No Longer Required for Electrodiagnosis

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Not applicable
Emergency Medicine – Cardiopulmonary Resuscitation (CPR)

Introduction

This section serves as a general summary of the IHCP’s policies regarding emergency medicine – cardiopulmonary resuscitation (CPR). Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Cardiopulmonary resuscitation (CPR) is the process used to return the patient presenting with sudden cardiac arrhythmia and/or sudden respiratory failure to normal respiratory and cardiac function. CPR is the manual application of chest compressions and breathing in for patients in cardiac arrest, done in an effort to maintain viability until advanced help arrives. In 2010, the American Heart Association updated its guidelines to recommend that everyone — untrained bystanders and medical personnel alike — begin CPR with chest compressions. The preliminary steps are begun immediately: (1) calling for help; (2) establishing unresponsiveness in the victim by tapping or gently shaking and shouting at him or her; (3) positioning the victim in a supine position on a hard surface; and (4) begin CPR with chest compressions. In 2010 the American Heart Association changed its long-held acronym of ABC to CAB — circulation, airway, breathing — to help people remember the order to perform the steps of CPR. This change emphasizes the importance of chest compressions to help keep blood flowing through the heart and to the brain. Since CPR can keep oxygenated blood flowing to the brain and other vital organs until more definitive medical treatment can restore a normal heart rhythm, this procedure is an essential component of basic life support and advanced life support.

Reimbursement Requirements

CPR (92950) is a covered service. It is an all-inclusive procedure and includes central venous pressure catheterization, insertion of arterial lines, endotracheal intubation, and cardioversion. Therefore, separate charges for central venous pressure catheterization (36555, 36556, 36568, 36580, and 36584), insertion of arterial lines (36620), endotracheal intubation (31500), and cardioversion (92960) will be denied, as they are 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, and emergency room visits) will also be denied, as they are also included in the charge for the cardiopulmonary resuscitation.

Payment in full is allowed for a Swan-Ganz catheter (93503), in addition to the CPR charge.

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.

Prior Authorization Requirements

For PA requirements, please refer to Chapter 6 of the IHCP Provider Manual or visit [http://www.indianamedicaid.com/](http://www.indianamedicaid.com/).

Billing Requirements

For billing requirements, please refer to Chapter 8 of the IHCP Provider Manual or visit [http://www.indianamedicaid.com/](http://www.indianamedicaid.com/).

Rules, Citations, and Sources

405 IAC 5-10-3 – Anesthesia Services

IHCP Provider Manual


Related Medical Topics

Not applicable
Emergency Medicine – Emergency Room

Introduction
This section serves as a general summary of the IHCP’s policies regarding emergency medicine – emergency room services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

The Indiana Health Coverage Programs (IHCP) covers services for a member presenting to an emergency room with an emergency medical condition, as determined by the screening physician.

Per 42 U.S.C. § 1395dd(e)(1)(A), an emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency services are services provided in the emergency department of a hospital.

Reimbursement Requirements

Reimbursement is available for emergency department services provided by IHCP enrolled providers if (a) the member’s health is in serious jeopardy; (b) there is serious impairment to a member’s bodily functions; or (c) there is a serious dysfunction of a member’s bodily organ or part, and is limited to reimbursement of one visit per day.
Prior Authorization Requirements

Emergency services, as described above, do not require PA. Emergency services are excluded from copayment requirements. Members on restricted utilization may receive treatment without a referral from the authorized provider if the diagnosis is an emergency diagnosis.

Billing Requirements

The IHCP provides coverage to emergency department physicians who render emergency services to IHCP eligible members. IC §12-15-15-2.5 addresses reimbursement of emergency department physicians.

The IHCP no longer reimburses hospitals and physicians for non-emergency services rendered in the emergency room setting. Hospitals and physicians will each be reimbursed for a screen that is necessary to determine if the member had an emergency condition.

Emergency Department Screenings

The IHCP does not reimburse hospitals for nonemergency services rendered in emergency room settings. Hospitals are reimbursed for screenings that are necessary to determine if the member has an emergency condition.

Revenue code 451 – EMTALA – Emergency Medical Screening Service are reimbursed for the nonemergent screening, and all ancillary charges submitted with revenue code 451 deny with EOB code 4180 – Ancillary services are not payable when a 451 revenue code is billed on an outpatient or outpatient crossover claim.

The IHCP covers services for a member presenting to an emergency room with an emergency medical condition, defined in 42 U.S.C. § 1395dd(e)(1)(A), as determined by the screening physician.

Providers must bill one of the CPT® codes listed in Table 1 – Medical Screening Examination, reflecting the appropriate level of screening exam on a CMS-1500.

<table>
<thead>
<tr>
<th>Code</th>
<th>Screening Examination</th>
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<tbody>
<tr>
<td>99281</td>
<td>Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.</td>
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<tr>
<td>99282</td>
<td>Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded</td>
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problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

99283 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.

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 authorization of the PMP.

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.

**Physician Billing**

If the physician determines the member has a non-emergent medical condition, the physician may bill only one of the CPT® codes listed in Table 1 and will be reimbursed the lesser of the provider’s submitted charge (usual and customary) or the rate on file. If the screen determines the member has an emergency condition, the physician may bill the screening code, as well as medically necessary services.

**Facility Billing**

If the screening identifies the member has a nonemergent medical condition, the facility may only bill Revenue Code 451 – EMTALA-emergency medical screening service and will be reimbursed the lesser of the provider’s submitted charge (usual and customary) or the emergency screening fee. If the screen determines the member has an emergency condition, the hospital would bill for medically necessary emergency services, using the appropriate revenue and Healthcare Common Procedure Coding System (HCPCS) codes. The screening revenue code may not be billed in conjunction with emergency room treatment services.

**Rules, Citations, and Sources**

42 U.S.C. § 1395dd – Examination and Treatment for Emergency Medical Conditions and Women in Labor

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 – PA; exceptions

IHCP Bulletins

BT 201009 – Nonemergency Services Rendered in Emergency Room Settings

BT 200913 – Hoosier Healthwise, Care Select, and Traditional Medicaid Coverage of Emergency Room Services

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Not applicable
Emergency Medicine – Emergency Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding emergency medicine – emergency services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

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

IHCP reimbursement is available for emergency services provided to IHCP members. As defined by 42 U.S.C. § 1395, 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.

Package E members (aliens, noncitizens) receive only emergency services and the services are reimbursed as FFS. 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 indicate in the appropriate field on submitted claim forms that a provided service was an emergency.

Reimbursement Requirements

The IHCP no longer reimburses hospitals for nonemergency services rendered in emergency room settings. Hospitals are reimbursed for screenings that are necessary to determine if the member has an emergency condition.

Revenue code 451 – EMTALA – Emergency Medical Screening Service is no longer reimbursed for the nonemergent screening, and system modifications have been implemented to deny all ancillary charges submitted with revenue code 451 with EOB code 4180 – Ancillary services are not payable when a 451 revenue code is billed on an outpatient or outpatient crossover claim.
The IHCP continues to cover services for a member presenting to an emergency room with an emergency medical condition, as determined by the screening physician. Per 42 U.S.C. § 1395dd(e)(1), an emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

When the screening does not meet the definition of an emergency visit under the layperson review criteria utilizing this definition, the provider should bill only for the screening service (revenue code 451).

IHCP provides reimbursement for emergency services and guidelines for these services are subject to the member’s program enrollment. Hoosier Healthwise Package A 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 DOS. 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 DOS. The provider may bill the member for copayments not made on the DOS. The following information discusses emergency services by program area, as applicable.

**Post-stabilization Care Services**

Post-stabilization services are covered services related to an emergency medical condition that are provided after the member is stabilized to maintain the stabilized condition to improve or resolve the member’s condition.

**CPR**

CPR is the process used to return the patient presenting with sudden cardiac arrhythmia and/or sudden respiratory failure to normal respiratory and cardiac function. The IHCP reimburses cardiopulmonary resuscitation. Refer to Section 15 of this manual, *Emergency Services – Cardiopulmonary Resuscitation*, for specific coverage information.
Emergency Dental Services

The IHCP reimburses medically necessary emergency dental services. 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 2 on the ADA dental claim form must be used to specify if the services performed were for emergency care. Providers must include the word “emergency” in this field 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. CDT 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 billing 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. FFS and Hoosier Healthwise). Refer to the IHCP Hospice Provider Manual and Hospice Services for specific coverage information.

Inpatient Services

Inpatient services for diagnoses reimbursed under the LOC payment methodology and emergency substance abuse require PA. Emergency inpatient admissions for these diagnoses must be reported to PA within 48 hours of admission, not including Saturdays, Sundays, or legal holidays, 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, without otherwise applicable PA (such as on weekends, holidays, and so forth). Pharmacy providers should document the circumstances that support providing the emergency supply and are subject to post-payment review. For specific coverage and billing information on pharmacy services, please visit www.indianapbm.com.

**Emergency Department Physicians**

IHCP reimbursement is available to emergency department physicians who render medically necessary emergency service to IHCP members. *Care Select* 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:

**Table 1 - Current Procedural Terminology Codes – Medical Screening Examinations**

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</tr>
<tr>
<td>99284</td>
<td>Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.</td>
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</table>
needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.

| 99285 | Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function. |

**Psychiatric Services**

The physician or a 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 Mental Health/Behavioral Health – Inpatient Services and Mental Health/Behavioral Health – Outpatient Services within this manual for specific coverage information about inpatient hospitalization and outpatient services.

**Transportation Services**

Emergency transportation services are covered by the IHCP. Refer to Transportation Services within this manual for specific coverage information.

**Prior Authorization Requirements**

PA is not required for emergency services.

Emergency inpatient admissions for diagnoses reimbursed under the LOC payment methodology and emergency substance abuse inpatient admissions must be reported to PA within 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 PA requirements. Refer to *Out-of-State Services* within this manual for additional 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 PMP who is available 24 hours a day to give medical advice.

Members are instructed 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 member without an emergency diagnosis may not be covered. These claims may be suspended for review to determine if the *prudent layperson standard* (see *Emergency Medicine – Emergency Services* within this manual) 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, only revenue code 45X will be paid, as long as the PMP’s National Provider Identifier (NPI) is indicated in field 78 of the UB-04 claim form. As noted previously, 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 RBMC, providers must contact the member’s MCE for more specific guidelines. Refer to Chapter 1 of the *IHCP Provider Manual* for detailed information about the FFS and RBMC delivery systems.

**Billing Requirements**

Facility payments for services rendered in the emergency department are the same for emergency and non-emergency 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 field 67 on the UB-04.

Providers submitting claims for reimbursement of services to 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 Chapter 8 of the IHCP Provider Manual.

Rules, Citations, and Sources

42 CFR 447.15 – Member copayment
405 IAC 5-2-9 – “Emergency service” defined
405 IAC 5-3-12 – PA; 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
IC 12-15-12-17 – Coverage for post-stabilization care services

IHCP Bulletins

BT 201009 – Nonemergency Services Rendered in Emergency Room Settings
BT 200913 – Hoosier Healthwise, Care Select, and Traditional Medicaid Coverage of Emergency Room Services

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Dental Services
Emergency Medicine – Cardiopulmonary Resuscitation (CPR)
Emergency Medicine – Emergency Room
Hospice Services
Hospital Outpatient Services
Mental Health/Behavioral Health – Inpatient Services
Out-of-State Services
Transportation Services
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthWatch Program

Introduction

This section serves as a general summary of the IHCP’s policies regarding the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthWatch program. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

The EPSDT program, referred to as HealthWatch in Indiana, is a federally mandated preventive healthcare program designed to improve the overall health of IHCP eligible members from birth to 21 years old. Special emphasis is given to early detection and treatment, as these efforts can reduce the risk of more costly treatment or hospitalization when detection is delayed. The objectives of the EPSDT Program are:

- To increase the number of members who are up-to-date with their childhood immunizations
- To increase the number of members receiving an initial health examination
- To increase the number of members receiving a preventive care/well visit examination
- To promote interaction between member and provider by developing and coordinating preventive services
- To encourage members to take a more active role in managing their health

Reimbursement Requirements

The IHCP provides reimbursement for EPSDT services subject to applicable coverage limitations.
Initial Screening

An initial screening is performed by the EPSDT screening provider when referred by the OMPP or its designee, or upon the member’s initial request for EPSDT services. The initial screening and subsequent, periodic screenings must be performed according to the HealthWatch Periodicity and Screening Schedule (periodicity schedule) shown on Table 1.

Periodic Screening

Periodic screenings will be provided by the EPSDT screening provider in accordance with the EPSDT periodicity schedule as long as the recipient chooses to participate in the EPSDT program, or until the recipient reaches his or her twenty-first birthday.

A periodic screening shall include the following:

- A comprehensive health and developmental history, including assessment of both physical and mental health development.
- A comprehensive unclothed physical exam.
- A nutritional assessment.
- A developmental assessment.
- Appropriate vision and hearing testing.
- Dental screening.
- Health education, including anticipatory guidance.

In addition to the required procedures listed in this subsection, the periodic screening shall include administration of or referral for any other test, procedure, or immunization that is medically necessary or clinically indicated.

HealthWatch Periodicity and Screening Schedule

The initial screening and subsequent, periodic screenings must be performed according to the HealthWatch Periodicity and Screening Schedule (periodicity schedule) shown on Table 1.

Table 1 – HealthWatch/EPSDT Periodicity and Screening Schedule (next page)
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  
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.

<table>
<thead>
<tr>
<th>AGE</th>
<th>INFANCY</th>
<th>EARLY CHILDHOOD</th>
<th>MIDDLE CHILDHOOD</th>
<th>ADOLESCENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NEWBORN</td>
<td>2-4m</td>
<td>By 1mo</td>
<td>2mo</td>
</tr>
<tr>
<td>HISTORY INITIAL/INTERVAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEASUREMENTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height and Weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Circumference</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SENSORY SCREENING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Hearing</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>DEVELOPMENTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BEHAVIOR ASSESSMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHYSICAL EXAMINATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROCEDURES GENERAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Lead Screening</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Hematocrit or Hemoglobin</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>PROCEDURES PATIENTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AT RISK</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculin Test</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>&quot;Sickle Cell Test&quot;</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Drug/HIV Testing</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>STD Screening</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pelvic Exam</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>ANTICIPATORY GUIDANCE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury Prevention</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Dental Referral</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Dental Observation</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Newborn Infant Screen</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>
With regard to dental care, once the member has been referred for dental screening, the dental provider must follow IHCP EPSDT Dental Periodicity Schedule shown in Table 2.

### Table 2 – IHCP EPSDT Dental Periodicity Schedule

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6-12 months</td>
</tr>
<tr>
<td>Clinical oral examination ¹,² to include:</td>
<td>●</td>
</tr>
<tr>
<td>Assess oral growth and development³</td>
<td>●</td>
</tr>
<tr>
<td>Caries-risk assessment⁴</td>
<td>●</td>
</tr>
<tr>
<td>Anticipatory guidance/ counseling⁶</td>
<td>●</td>
</tr>
<tr>
<td>Injury prevention counseling⁷</td>
<td>●</td>
</tr>
<tr>
<td>Counseling for nonnutritive habits⁸</td>
<td>●</td>
</tr>
<tr>
<td>Counseling for speech/language development</td>
<td>●</td>
</tr>
<tr>
<td>Substance abuse counseling</td>
<td>●</td>
</tr>
<tr>
<td>Counseling for intraoral/perioral piercing</td>
<td>●</td>
</tr>
<tr>
<td>Assessment for pit and fissure sealants⁹</td>
<td>●</td>
</tr>
<tr>
<td>Transition to adult dental care</td>
<td>●</td>
</tr>
<tr>
<td>Radiographic assessment⁵</td>
<td>●</td>
</tr>
<tr>
<td>Prophylaxis and topical fluoride ⁴,⁵</td>
<td>●</td>
</tr>
<tr>
<td>Assessment and treatment of developing malocclusion</td>
<td>●</td>
</tr>
<tr>
<td>Assessment and/or removal of third molars</td>
<td>●</td>
</tr>
</tbody>
</table>

¹ First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child’s risk status/susceptibility to disease.
² Includes assessment of pathology and injuries
³ By clinical examination
⁴ Must be repeated regularly and frequently to maximize effectiveness
⁵ Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.
⁶ Appropriate discussion and counseling should be an integral part of each visit for care.
⁷ Initially play objects, pacifiers, car seats; then, when learning to walk, sports and routine playing, including the importance of mouth guards
⁸ At first, discuss the need for additional sucking: digits vs. pacifiers; then, the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
⁹ For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.
Treatment

Any treatment found necessary as a result of a diagnosis pursuant to an initial or periodic screening may be provided subject to any prior authorization requirements for the services set out in this article. However, if a service is not covered under the state plan, it is still available to EPSDT eligible recipients subject to prior authorization requirements of 405 IAC 5-4 if it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Recipient and Provider Participation

Any Medicaid recipient under twenty-one (21) years of age may participate in the EPSDT program. Each recipient will be informed about the program by the office or its designee in accordance with federal regulations. Participation in EPSDT by Medicaid recipients is voluntary.

Individual physicians, physician group practices, hospitals, or physician-directed clinics that are enrolled as Medicaid providers may provide a complete EPSDT screen.

Any enrolled Medicaid provider may provide EPSDT diagnostic and/or treatment services within the scope of his or her practice upon referral from the screening provider.

Screening Referrals

HealthWatch/EPSDT 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 to an optometrist or ophthalmologist starting when objective screening methods indicate a problem is present. Newborns with hearing deficits identified under the Universal Newborn Screening Program are followed up by the Early Hearing Detection and Intervention Program (EHDI) at the Indiana State Department of Health (ISDH) and encouraged to follow up with an audiologist. Older members needing additional hearing testing should be referred for additional testing and treatment when screening results indicate a possible hearing deficit. Tables 3, 4, and 5 show the schedules for dental, vision, and hearing observation and screenings.

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

### Table 4 – Periodicity Schedule – Vision Observation and Screening

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>Recommended (S) or Required (R)</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 3 years</td>
<td>S</td>
<td>Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality is suspected.</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>R</td>
<td>Annual objective screening test by standard testing method. If warranted, refer child to an appropriate specialist.</td>
</tr>
<tr>
<td>6, 8, 14, 16, 20 years</td>
<td>S</td>
<td>Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality is suspected.</td>
</tr>
<tr>
<td>10, 12, 18</td>
<td>R</td>
<td>Objective screening test by a standard testing method. If warranted, refer child to an appropriate specialist.</td>
</tr>
</tbody>
</table>

### Table 5 – Periodicity Schedule – Hearing Observation and Screening

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

Objective hearing screening by a standard testing method (hearing tests are given by the Indiana Department of Education in grades one, four, seven, and 10; several schools also test kindergarten students). Do not duplicate school screenings unless a child is considered at risk and rescreening is warranted.

Providers of services who perform screening or treatment services as a result of an EPSDT screening referral shall be subject to the same limitations for such services.

Blood Lead Screenings

Blood lead screenings must be performed at nine-month, 12-month, and 24-month visits. If the member is at high risk for lead exposure, the initial screening should be performed at the six-month visit. Providers are required to report the results of the screening to the ISDH no later than one week after completing the examination.

Vaccines for Children (VFC)

The VFC program is a federally funded program that works to raise childhood immunization levels in the United States by supplying healthcare 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:

- Enrolled in the 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 A (HepA)
- Hepatitis B (HepB)
- Human papillomavirus (HPV)
- Influenza
- Measles, mumps, and rubella (MMR)
- Meningococcal
- Pertussis (whooping cough)
- Pneumoccocal
- Poliomyelitis
- Rotavirus
- Tetanus
- Varicella (chickenpox)

IHCP providers are not required to participate in this program. If a provider chooses not to participate in this program, he or she 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.

**Prior Authorization Requirements**

Prior authorization is not required for screening services. Treatment services are subject to the same prior authorization requirements as the services.

**Billing Requirements**

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs. Providers must bill utilizing the appropriate procedure code(s). 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. For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.

HealthWatch/EPSDT claims billed to the IHCP must utilize the appropriate examination codes which vary by the age of the member. The appropriate examination procedure codes are listed in Table 6 by age.

When billing for the examinations:

- The appropriate patient examination code 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/EPSDT visit.

- The appropriate EPSDT reimbursement rate for the initial or established patient exam billed.

### Table 6 – EPSDT Screening Examination Codes

<table>
<thead>
<tr>
<th>Age</th>
<th>CPT® Codes</th>
<th>Description</th>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>99381</td>
<td>Initial Comprehensive Preventive Medicine</td>
<td>99391</td>
<td>Periodic Comprehensive Preventive Medicine</td>
</tr>
<tr>
<td>1 to 4 years</td>
<td>99382</td>
<td>Initial Comprehensive Preventive Medicine</td>
<td>99392</td>
<td>Periodic Comprehensive Preventive Medicine</td>
</tr>
<tr>
<td>5 to 11 years</td>
<td>99383</td>
<td>Initial Comprehensive Preventive Medicine</td>
<td>99393</td>
<td>Periodic Comprehensive Preventive Medicine</td>
</tr>
<tr>
<td>12 to 17 years</td>
<td>99384</td>
<td>Initial Comprehensive Preventive Medicine</td>
<td>99394</td>
<td>Periodic Comprehensive Preventive Medicine</td>
</tr>
<tr>
<td>18 to 20 years</td>
<td>99385</td>
<td>Initial Comprehensive Preventive Medicine</td>
<td>99395</td>
<td>Periodic Comprehensive Preventive Medicine</td>
</tr>
</tbody>
</table>

When a member presents to a provider for a sick visit, and his or her records indicate the need for an updated EPSDT visit, physicians can include services for both visits and bill two visit codes for reimbursement of both services on the same day. Providers must maintain a complete problem-focused visit exam for the presenting problem and a complete preventive visit documenting the EPSDT components of the screening exam within the member’s health records.

Providers may bill and be reimbursed for services provided in addition to the EPSDT visit. In this instance, the problem-oriented exam can be billed separately with the -25 modifier (separate 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/EPSDT appointments or follow-up appointments must be identified and their names forwarded to the Hoosier Healthwise MCE or Care Select MCE. Claim submission for missed appointments is not required, and missed appointments will not be reimbursed. Providers may not bill IHCP members for missed appointments.

HealthWatch/EPSDT screening services are not subject to TPL. Providers do not have to submit EPSDT claims for TPL payment prior to submitting the claim to IHCP.
Blood Samples:

Providers that send blood samples to private labs should use the codes in Table 7, as appropriate.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36415</td>
<td>Collection of venous blood by venipuncture</td>
</tr>
<tr>
<td>99000</td>
<td>Handling and/or conveyance of specimen for transfer from the office to a laboratory</td>
</tr>
<tr>
<td>99001</td>
<td>Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)</td>
</tr>
</tbody>
</table>

Lead Testing

For lead testing in the office setting, the coverage and reimbursement rate for code 83655 was expanded to include tests administered using filter paper and hand held testing devices. Providers should bill utilizing the appropriate procedure codes and modifier combinations in Table 8 when billing for lead testing.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>83655 U1</td>
<td>Assay of lead, using filter paper</td>
</tr>
<tr>
<td>83655 U2</td>
<td>Assay of lead, using hand-held testing device</td>
</tr>
<tr>
<td>83655</td>
<td>Assay of lead (venous blood)</td>
</tr>
</tbody>
</table>

Vaccines for Children (VFC)

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

To bill the IHCP for VFC vaccine administration, ICD-9-CM 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 allows only 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 be billed only if a
separate, identifiable service is performed during the same visit. Table 9 shows the procedure codes for vaccines covered in the VFC program.

**Table 9 – Procedure Codes for VFC Vaccines**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>90645</td>
<td>Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use</td>
</tr>
<tr>
<td>90647</td>
<td>Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use</td>
</tr>
<tr>
<td>90648</td>
<td>Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use</td>
</tr>
<tr>
<td>90649</td>
<td>Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use</td>
</tr>
<tr>
<td>90655</td>
<td>Influenza virus vaccine, trivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use</td>
</tr>
<tr>
<td>90656</td>
<td>Influenza virus vaccine, trivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use</td>
</tr>
<tr>
<td>90657</td>
<td>Influenza virus vaccine, trivalent, split virus, when administered to children 6-35 months of age, for intramuscular use</td>
</tr>
<tr>
<td>90658</td>
<td>Influenza virus vaccine, trivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use</td>
</tr>
<tr>
<td>90660</td>
<td>Influenza virus vaccine, trivalent, live, for intranasal use</td>
</tr>
<tr>
<td>90669</td>
<td>Pneumococcal conjugate vaccine, 7 valent, for intramuscular use</td>
</tr>
<tr>
<td>90700</td>
<td>Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use</td>
</tr>
<tr>
<td>90702</td>
<td>Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for intramuscular use</td>
</tr>
<tr>
<td>90707</td>
<td>Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use</td>
</tr>
<tr>
<td>90713</td>
<td>Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use</td>
</tr>
<tr>
<td>90715</td>
<td>Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use</td>
</tr>
<tr>
<td>90716</td>
<td>Varicella virus vaccine, live, for subcutaneous use</td>
</tr>
<tr>
<td>90721</td>
<td>Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use</td>
</tr>
<tr>
<td>90723</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use</td>
</tr>
</tbody>
</table>
### Procedure Code

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>90733</td>
<td>Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use</td>
</tr>
<tr>
<td>90734</td>
<td>Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use</td>
</tr>
<tr>
<td>90744</td>
<td>Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use</td>
</tr>
<tr>
<td>90748</td>
<td>Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use</td>
</tr>
</tbody>
</table>

### Documentation

HealthWatch/EPSDT screens include more components than a simple well-child office visit. Therefore, Medicaid-enrolled providers must furnish and document all components of the EPSDT visit in order to bill for the higher rate of reimbursement for EPSDT screens.

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.
- Hearing observation at each screening and objective testing with audiometer at four (4) years, administered or referred
- Dental observation at each screening.
- Laboratory tests, including blood lead level assessment appropriate for age and risk factors
- Immunizations administered or referred, if needed at the time of screening
- Health education, including anticipatory guidance

Rules, Citations, and Sources

405 IAC 5-14-2 – Covered services

405 IAC 5-14-19 – PA for covered Early and Periodic Screening, Diagnosis, and Treatment services

405 IAC 5-15 – Early and Periodic Screening, Diagnosis, and Treatment services

405 IAC 5-23-3 – Covered vision care services

410 IAC 29-2-2 – Case closure

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Hearing Services

Immunizations and Vaccines

Laboratory Services

Screening Services – Newborn Screening
Evaluation and Management Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding evaluation and management (E/M) services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

E/M services are those that are provided for the assessment of a member’s health or condition, and for the direction of a member’s healthcare. 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.

Reimbursement Requirements

E/M services must be appropriate to the diagnosis and treatment. Providers are advised to select the CPT® code that most closely describes the services rendered which includes the three components listed above. IHCP reimbursement for office visits is limited to a maximum of 30 visits per year, per IHCP member, per provider without PA. If a physician uses an emergency room as a substitute for the physician’s office for non-emergency 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.

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 below. Refer to Ophthalmological Services within this manual for additional information.
### Table 1 – Evaluation and Management Services to Report Eye Examinations

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92002</td>
<td>Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient</td>
</tr>
<tr>
<td>92004</td>
<td>Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits</td>
</tr>
<tr>
<td>92012</td>
<td>Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient</td>
</tr>
<tr>
<td>92014</td>
<td>Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits</td>
</tr>
<tr>
<td>99201</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate severity.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.</td>
</tr>
<tr>
<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99214</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99241</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99242</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99243</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99244</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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</tr>
<tr>
<td>99245</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99251</td>
<td>Inpatient consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.</td>
</tr>
<tr>
<td>99252</td>
<td>Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.</td>
</tr>
<tr>
<td>99253</td>
<td>Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.</td>
</tr>
<tr>
<td>99254</td>
<td>Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.</td>
</tr>
<tr>
<td>99255</td>
<td>Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination;</td>
</tr>
</tbody>
</table>
and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.

Prior Authorization Requirements

E/M services described below, which exceed 30 visits per rolling calendar year, per member, require PA. Additionally, PA is required for any physician service that is rendered during an inpatient hospital stay and reimbursed using a LOC methodology, such as psychiatric, rehabilitation, and burn treatment.

Table 2 – Evaluation and Management Services Requiring PA After 30 Visits – Per Member, Per Rolling Calendar Year

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
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<tr>
<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.</td>
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<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.</td>
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</tr>
<tr>
<td>99214</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other</td>
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<td>Description</td>
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<tr>
<td>99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99241</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99242</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
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<td>99243</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to low severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.</td>
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<td>99244</td>
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<td>Code</td>
<td>Description</td>
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<td>----------</td>
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</tr>
<tr>
<td>99245</td>
<td>Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99381</td>
<td>Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)</td>
</tr>
<tr>
<td>99382</td>
<td>Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)</td>
</tr>
<tr>
<td>99383</td>
<td>Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)</td>
</tr>
<tr>
<td>99384</td>
<td>Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)</td>
</tr>
<tr>
<td>99385</td>
<td>Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years</td>
</tr>
<tr>
<td>99386</td>
<td>Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years</td>
</tr>
</tbody>
</table>
| 99387    | Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99391</td>
<td>Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older</td>
</tr>
<tr>
<td>99392</td>
<td>Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)</td>
</tr>
<tr>
<td>99393</td>
<td>Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)</td>
</tr>
<tr>
<td>99394</td>
<td>Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)</td>
</tr>
<tr>
<td>99395</td>
<td>Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)</td>
</tr>
<tr>
<td>99396</td>
<td>Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years</td>
</tr>
<tr>
<td>99397</td>
<td>Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years</td>
</tr>
</tbody>
</table>

**Billing Requirements**

Professional services rendered during the course of a hospitalization must be submitted on a **CMS-1500** or via an 837P electronic transaction. If a physician uses an emergency department...
as a substitute for the physician’s office for non-emergency services, these visits should be billed with the appropriate CPT® code for office visits, with the site of services 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.

New patient office visits are limited to one visit per member, per provider, within a three-year period. 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.

**Pre-surgical and Post-surgical Visits**

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 DOS.

**Prenatal Visits**

The initial 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. Additionally, outpatient office visits rendered to pregnant members, if related to a concurrent medical condition requiring medical care or consultative referral, are to be billed 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 Section 69 of this manual, Obstetric Care, for additional information.

**Rules, Citations, and Sources**

405 IAC 5-9 – Evaluation and Management Services

IHCP Banner Page
BR201113 - Reminder of Billing Guidelines for Evaluation and Management Codes

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Chiropractic

Clinic Services – Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services

Consultations – Second Opinions

Emergency Medicine – Emergency Services

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthWatch Program

Family Planning

Hospital Inpatient Services

Hospital Outpatient Services

Obstetric Care

Ophthalmologic Services

Podiatry
Family Planning

Introduction

This section serves as a general summary of the IHCP’s policies regarding family planning. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

The IHCP does not place restrictions on access to family planning services for members who are not pregnant and who desire such services and supplies. For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, the providers may contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Family planning services are services provided to individuals who are not pregnant to temporarily or permanently prevent or delay pregnancy. Services include the following:

- Initial 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 H&P examinations
- Pregnancy testing and counseling
- Provision of contraceptive pills, devices, and supplies
- Cytology and cervical cancer screening, including high-risk HPV DNA testing
- Emergency contraceptive
- Screening, testing, and counseling of members at risk for HIV, as well as referral and treatment
- Tubal ligations
- Essure sterilization procedure
• Vasectomies
• Abortions, in accordance with 405 IAC 5-28-7 (see Section 2 of this manual, Abortion).

Reimbursement Requirements

The 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 outpatient hospitals. Family planning services may be self-referred. The IHCP does not place any restrictions on access to family planning services for members of childbearing age who desire such services and supplies.

Contraception

Effective October 1, 2005, the IHCP covers HCPCS codes J7303 – Contraceptive supply, hormone containing vaginal ring, each and J7304 – Contraceptive supply, hormone containing patch, each. Providers must bill J7303 and J7304 instead of a miscellaneous supply code, because these codes are more specific to the service being supplied.

For HCPCS code J1055 – Injection, medroxyprogesterone acetate for contraceptive use, 150 mg the gender indicator will be “Female,” and the allowable units per DOS will be limited to one.

According to the FDA, Depo-Provera Contraceptive Injection (CI) is a long-term contraceptive for women and is indicated only for the prevention of pregnancy. The recommended dose for women is 150 mg every three months. An appropriate HCPCS code for billing medroxyprogesterone for non-contraceptive use is J1051 – Injection, medroxyprogesterone acetate, 50 mg, which may be billed for multiple units, per member, on a single DOS.

The IHCP no longer covers the Norplant System; however, reimbursement is available for removal of the Norplant System. Providers removing Norplant Systems must bill using CPT code 11976.

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

Sterilization

The IHCP reimburses for sterilizations when the consent form accompanies all claims connected with the service for men and women, according to 405 IAC 5-28-8.

Medicaid reimbursement is available for sterilization with the following restrictions:

• Sterilization procedures must comply with the mandates of federal rules.
• The patient must be 21 years of age or older at the time the informed consent form is signed.
• The patient must be neither mentally incompetent nor institutionalized.
• The patient must have voluntarily given informed consent on forms prescribed for such purposes by the federal Department of Health and Human Services.
• All appropriate documentation must be attached to the claim and to claims for directly related services before reimbursement shall be made.

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 ASC.

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 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 PMP should be made for ongoing treatment and follow up of chronic STDs to maintain continuity of patient care.

Cervical Cancer Screenings

The IHCP follows the cervical cancer screening recommendations from the United States Preventative Services Task Force (USPSTF). The IHCP currently covers services including cytology (Pap test) and an HPV test, as well as medically necessary services such as the collection of the samples, screening by a cytotechnologist, and the physician’s interpretation of the test results. The USPSTF has concluded most cases of cervical cancer occur in women who are not adequately screened. The USPSTF recommends cervical cancer screenings for women aged 21 to 65 with cytology every three years. For women aged 30 to 65 who want to lengthen the screening interval, screening with a combination of cytology and HPV testing is recommended every five years.

For repeat testing, cytologic thresholds for further diagnostic testing (colposcopy) and treatments, and extended surveillance, the IHCP follows the recommendations established in the joint guidelines released by the American Cancer Society (ACS), the American Society for Colposcopy and Cervical Pathology (ASCCP), and the American Society for Clinical Pathology (ASCP).

Abortions

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 refer to Section 2 of this manual.
When billing for emergency services, providers must appropriately code claims as emergency. The primary diagnosis code must be pregnancy-related, or IHCP denies the claim. Providers must indicate the pregnancy-related diagnosis code in primary diagnosis field 67 on the UB-04 claim form. If the pregnancy diagnosis does not adequately address the specific reason for the visit or care, providers must also include the visit or care diagnosis as a secondary or tertiary diagnosis on the claim form.

In addition to drug coverage, transportation, family planning, routine prenatal care, delivery, and postpartum care, the IHCP reimburses providers for conditions that may complicate the pregnancy. In other words, the IHCP covers services provided to pregnant women for the treatment of chronic or abnormal disorders, as identified by ICD-9-CM diagnosis codes 630 through 648.94 and 652.00 through 676.94, as well as urgent care.

The IHCP defines a condition that may complicate the pregnancy as any 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 LOC.

The IHCP does not dictate to physicians conditions that may or may not complicate a pregnancy. Therefore, if the physician determines that the illness or injury could complicate the pregnancy or have an adverse effect on the outcome of the pregnancy, the IHCP covers the care provided for that illness or injury. Providers should list a pregnancy diagnosis code as the primary diagnosis code and identify the illness or injury being treated as the secondary diagnosis code, if the condition is considered a risk of complication of the pregnancy.

Prior Authorization Requirements
Prior authorization is not required for family planning services.

Billing Requirements
For billing requirements, please refer to Chapter 8 of the IHCP Provider Manual or visit http://www.indianamedicaid.com.

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 healthcare; minors
405 IAC 5-24-7 – Pharmacy services – copayment for legend and non-legend drugs
405 IAC 5-22-3 – Nursing and therapy services – certified nurse midwife services
Related Medical Topics

Abortion Services

Clinic Services – Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) HealthWatch Program

Gynecology Services
Family Planning Eligibility Program

Introduction

This section serves as a general summary of the IHCP’s policies regarding the Family Planning Eligibility Program. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

Effective January 1, 2013, the IHCP implemented the Family Planning Eligibility Program, which provides only family planning services to recipients who:

- Do not qualify for any other category of Medicaid
- Are male or female of any age
- Are not pregnant
- Have not had a hysterectomy or sterilization
- Have income that is at or below 141% of the federal poverty level
- Are U.S. citizens, certain lawful permanent residents, or certain qualified documented aliens

Description of Service

The Family Planning Eligibility Program provides services and supplies to men and women for the primary purpose of preventing or delaying pregnancy.

Family Planning Eligibility Program services include:

- Annual family planning visits, including health education and counseling necessary to make informed choices and understand contraceptive methods
- Limited history and physical (H&P) examinations
- Laboratory tests, if medically indicated as part of the decision making process for choice of contraceptive methods
- Pap smears
- Follow up care for complications associated with contraceptive methods issued by the family planning provider
- Provision of FDA-approved oral contraceptives, devices, and supplies including emergency contraceptives
- Initial diagnosis and treatment of sexually transmitted infections (STIs) and sexually transmitted diseases (STDs), if medically indicated
• Screening, testing, counseling, and referral of members at risk for HIV
• Tubal ligations
• Hysteroscopic sterilization with an implant device
• Vasectomies

The following services are **not** covered under the Family Planning Eligibility Program:

• Abortions
• Any drug or device intended to terminate fertilization
• Artificial insemination
• IVF (*in vitro* fertilization)
• Fertility counseling
• Fertility treatment
• Fertility drugs
• Inpatient hospital stays
• Reversal of tubal ligation and vasectomies
• Treatment for any chronic condition, including STDs and/or STIs that have advanced to a chronic condition
• Services unrelated to family planning

**Reimbursement Requirements**

IHCP reimbursement is available for Family Planning Eligibility Program services rendered by IHCP enrolled providers, including but not limited to physicians, certified nurse midwives, family planning clinics, and outpatient hospitals. Family Planning Eligibility Program services may be self referred.

**Annual Examinations and Office Visits**

IHCP reimbursement is available for annual examinations and office visits for the purpose of family planning.

An annual Family Planning Eligibility Program examination consists of a limited H&P, including Pap smears, testing for STDs and STIs when indicated, and medical laboratory evaluations as necessary for determination of contraceptive use.

Members enrolled in the Family Planning Eligibility Program are eligible for one annual examination in a 12-month period.
The IHCP considers counseling services to be part of evaluation and management (E/M) services. As such, separate reimbursement is not available for counseling-only services.

**Contraception**

IHCP reimbursement is available for most FDA-approved oral contraceptives, supplies, and devices. Covered drugs, supplies, and devices are as follows:

- Birth control pills
- Contraceptive vaginal ring
- Contraceptive patch
- Male condoms
- Female condoms
- Spermicide
- Injectable drugs
- Emergency contraception
- Intrauterine devices (IUDs)
- Contraceptive capsules
- Diaphragms

Members must be given information and education for all methods of contraception available, including reversible methods (for example, oral, emergency, injectable, implant, IUD, diaphragm, contraceptive patch, vaginal ring, foam, condom, and rhythm) and irreversible methods (for example, tubal ligation, vasectomy). Education regarding all contraceptive methods must include relative effectiveness, common side effects, risks, appropriate use, and difficulty in usage. Basic information concerning STDs and STIs must also be discussed.

Prescriptions for a contraceptive method must reflect the member’s choice, except where such choice is in conflict with sound medical practice.

Generic medications must be dispensed when available; however, if generic drugs are not available, brand name drugs may be dispensed. Generic and preferred drugs must be used when available, unless the physician indicates a medical reason for using a different drug.

In exception, brand name drugs may be dispensed, even if generic drugs are available, if Indiana Medicaid determines that the brand name drugs are less costly to the Indiana Medicaid program.

Contraceptive drugs and supplies may be administered, dispensed, prescribed or ordered. Prescriptions for family planning drugs and supplies may be refilled as prescribed by the practitioner for up to one year. Emergency contraception may be dispensed or prescribed.
Members are encouraged to follow up with their family planning provider when a specific problem related to the contraceptive method occurs, or additional services and supplies are needed. All members, regardless of the contraceptive method chosen, must be encouraged to return for a physical examination, laboratory services, and health history at least once per year.

**Sterilization**

The IHCP reimburses for sterilizations when the consent form accompanies all claims connected with the service for men and women, according to 405 IAC 5-28-8.

Medicaid reimbursement is available for sterilization with the following restrictions:

- Sterilization procedures must comply with the mandates of federal rules.
- The patient must be 21 years of age or older at the time the informed consent form is signed.
- The patient must be competent and not be institutionalized.
- The patient must have voluntarily given informed consent on forms prescribed for such purposes by the federal Department of Health and Human Services.
- All appropriate documentation must be attached to the claim and to claims for directly related services before reimbursement shall be made.

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).

**STIs and STDs**

The IHCP considers the initial diagnosis and treatment of STIs, STDs, HIV testing, and counseling provided during a family planning encounter to be part of family planning services.

When an STI or STD is diagnosed during a family planning visit, the member has 180 days, from the date of the initial diagnosis, to receive treatment for the STI or STD. The treatment for the STI or STD must be prescribed in conjunction with a family planning visit and be related to family planning.

The Family Planning Eligibility Program does not cover ongoing treatment of STIs and STDs. This program covers antiviral medications for the initial treatment of a STI or STD, which is limited to general antiviral and topical antiviral medications. This does not include pharmaceuticals for the treatment of hepatitis B, hepatitis C, or HIV.

Referral to a physician, clinic, or other medical professional should be made for ongoing treatment and follow up of chronic STDs to maintain continuity of patient care.
Cervical Cancer Screenings

The IHCP follows the cervical cancer screening recommendations from the United States Preventative Services Task Force (USPSTF). The IHCP currently covers services including cytology (Pap test) and an HPV test, as well as medically necessary services such as the collection of the samples, screening by a cytotechnologist, and the physician’s interpretation of the test results. The USPSTF has concluded most cases of cervical cancer occur in women who are not adequately screened. The USPSTF recommends cervical cancer screenings for women aged 21 to 65 with cytology every three years. For women aged 30 to 65 who want to lengthen the screening interval, screening with a combination of cytology and HPV testing is recommended every five years.

For repeat testing, cytologic thresholds for further diagnostic testing (colposcopy) and treatments, and extended surveillance, the IHCP follows the recommendations established in the joint guidelines released by the American Cancer Society (ACS), the American Society for Colposcopy and Cervical Pathology (ASCCP), and the American Society for Clinical Pathology (ASCP).

Prior Authorizations Requirements

The IHCP requires prior authorization (PA) for selected procedures, services, and items. Providers are expected to meet all PA and other IHCP requirements applicable to any covered services provided under the Family Planning Eligibility Program. Providers are responsible for obtaining PA.

Billing Requirements

Reimbursement requires compliance with all IHCP guidelines. Providers must bill utilizing the appropriate procedure code(s). 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. Clinics and ASCs bill using the most appropriate procedure and revenue codes on the UB-04 claim form.

When billing Family Planning Eligibility Program services, providers must utilize the appropriate diagnosis code identified in Table 1 – *Family Planning Eligibility Program Diagnosis Codes* as the primary diagnosis.

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
<td>Prescription of oral contraceptives</td>
</tr>
<tr>
<td>V2502</td>
<td>Initiation of other contraceptive measures</td>
</tr>
<tr>
<td>V2503</td>
<td>Encounter for emergency contraceptive counseling and prescription</td>
</tr>
</tbody>
</table>
Family Planning Eligibility Program
Library Reference Number:
Revision Date: December 2014
Version 2.0

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2504</td>
<td></td>
<td>Counseling and instruction in natural family planning to avoid pregnancy</td>
</tr>
<tr>
<td>V2509</td>
<td></td>
<td>Other – Family Planning Advice</td>
</tr>
<tr>
<td>V251</td>
<td></td>
<td>Insertion of intrauterine contraceptive device</td>
</tr>
<tr>
<td>V2511</td>
<td></td>
<td>Encounter for insertion of intrauterine contraceptive device</td>
</tr>
<tr>
<td>V2512</td>
<td></td>
<td>Encounter for removal of intrauterine contraceptive device</td>
</tr>
<tr>
<td>V2513</td>
<td></td>
<td>Encounter for removal and reinsertion of intrauterine contraceptive device</td>
</tr>
<tr>
<td>V252</td>
<td></td>
<td>Sterilization</td>
</tr>
<tr>
<td>V253</td>
<td></td>
<td>Menstrual extraction</td>
</tr>
<tr>
<td>V2540</td>
<td></td>
<td>Contraceptive surveillance, unspecified</td>
</tr>
<tr>
<td>V2541</td>
<td></td>
<td>Contraceptive pill</td>
</tr>
<tr>
<td>V2542</td>
<td></td>
<td>Intrauterine contraceptive device (IUD)</td>
</tr>
<tr>
<td>V2543</td>
<td></td>
<td>Implantable subdermal contraceptive</td>
</tr>
<tr>
<td>V2549</td>
<td></td>
<td>Other contraceptive method</td>
</tr>
<tr>
<td>V255</td>
<td></td>
<td>Insertion of implantable subdermal contraceptive</td>
</tr>
<tr>
<td>V258</td>
<td></td>
<td>Other specified contraceptive management</td>
</tr>
<tr>
<td>V259</td>
<td></td>
<td>Contraceptive management, unspecified</td>
</tr>
</tbody>
</table>

Family Planning Annual and Follow-up Examinations

Family Planning Eligibility Program providers must bill the most appropriate E/M procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, one of the following procedure codes must be billed with modifier FP and a family planning diagnosis code. Table 2 lists the E/M procedure codes that family planning providers are allowed to bill.

Table 2 – Family Planning E/M Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>FP</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99202</td>
<td>FP</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
<td></td>
</tr>
<tr>
<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.</td>
<td></td>
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<tr>
<td>99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.</td>
<td></td>
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<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.</td>
<td></td>
</tr>
</tbody>
</table>
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or
<table>
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<tr>
<th>Code</th>
<th>Description</th>
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</table>
| 99213  | FP  
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family. |
Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

<table>
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<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99243</td>
<td>FP Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99244</td>
<td>FP Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99245</td>
<td>FP Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99383</td>
<td>FP Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)</td>
</tr>
<tr>
<td>99384</td>
<td>FP Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)</td>
</tr>
<tr>
<td>99385</td>
<td>FP Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years</td>
</tr>
</tbody>
</table>
| 99386 | FP Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination,
counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years

99393 FP Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)

99394 FP Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)

99395 FP Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years

99396 FP Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years

---

### Surgical Procedures

Please refer to Table 3 for surgical procedures that may be reimbursed when performed during a family planning visit.

**Table 3 – Surgical Procedures**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10060</td>
<td>Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single</td>
</tr>
<tr>
<td>10140</td>
<td>Incision and drainage of hematoma, seroma or fluid collection</td>
</tr>
<tr>
<td>11004</td>
<td>Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum</td>
</tr>
<tr>
<td>11420</td>
<td>Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less</td>
</tr>
<tr>
<td>17000</td>
<td>Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17003</td>
<td>Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)</td>
</tr>
<tr>
<td>17004</td>
<td>Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions</td>
</tr>
<tr>
<td>17110</td>
<td>Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions</td>
</tr>
<tr>
<td>17111</td>
<td>Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions</td>
</tr>
<tr>
<td>17250</td>
<td>Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)</td>
</tr>
<tr>
<td>36415</td>
<td>Collection of venous blood by venipuncture</td>
</tr>
<tr>
<td>36416</td>
<td>Collection of capillary blood specimen (eg, finger, heel, ear stick)</td>
</tr>
<tr>
<td>46900</td>
<td>Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical</td>
</tr>
<tr>
<td>46924</td>
<td>Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)</td>
</tr>
<tr>
<td>49321</td>
<td>Laparoscopy, surgical; with biopsy (single or multiple)</td>
</tr>
<tr>
<td>53040</td>
<td>Drainage of deep periurethral abscess</td>
</tr>
<tr>
<td>53230</td>
<td>Excision of urethral diverticulum (separate procedure); female</td>
</tr>
<tr>
<td>53260</td>
<td>Excision or fulguration; urethral polyp(s), distal urethra</td>
</tr>
<tr>
<td>54050</td>
<td>Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical</td>
</tr>
<tr>
<td>54056</td>
<td>Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery</td>
</tr>
<tr>
<td>54065</td>
<td>Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)</td>
</tr>
<tr>
<td>55450</td>
<td>Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)</td>
</tr>
<tr>
<td>55600</td>
<td>Vesculotomy;</td>
</tr>
<tr>
<td>55605</td>
<td>Vesculotomy; complicated</td>
</tr>
<tr>
<td>56405</td>
<td>Incision and drainage of vulva or perineal abscess</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>56420</td>
<td>Incision and drainage of Bartholin's gland abscess</td>
</tr>
<tr>
<td>56440</td>
<td>Marsupialization of Bartholin's gland cyst</td>
</tr>
<tr>
<td>56501</td>
<td>Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)</td>
</tr>
<tr>
<td>56515</td>
<td>Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)</td>
</tr>
<tr>
<td>56605</td>
<td>Biopsy of vulva or perineum (separate procedure); 1 lesion</td>
</tr>
<tr>
<td>56606</td>
<td>Biopsy of vulva or perineum (separate procedure); each separate additional lesion (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>56740</td>
<td>Excision of Bartholin's gland or cyst</td>
</tr>
<tr>
<td>56820</td>
<td>Colposcopy of the vulva;</td>
</tr>
<tr>
<td>56821</td>
<td>Colposcopy of the vulva; with biopsy(s)</td>
</tr>
<tr>
<td>57061</td>
<td>Destruction of vaginal lesion(s); simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)</td>
</tr>
<tr>
<td>57065</td>
<td>Destruction of vaginal lesion(s); extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)</td>
</tr>
<tr>
<td>57100</td>
<td>Biopsy of vaginal mucosa; simple (separate procedure)</td>
</tr>
<tr>
<td>57105</td>
<td>Biopsy of vaginal mucosa; extensive, requiring suture (including cysts)</td>
</tr>
<tr>
<td>57130</td>
<td>Excision of vaginal septum</td>
</tr>
<tr>
<td>57135</td>
<td>Excision of vaginal cyst or tumor</td>
</tr>
<tr>
<td>57150</td>
<td>Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease</td>
</tr>
<tr>
<td>57160</td>
<td>Fitting and insertion of pessary or other intravaginal support device</td>
</tr>
<tr>
<td>57170</td>
<td>Diaphragm or cervical cap fitting with instructions</td>
</tr>
<tr>
<td>57410</td>
<td>Pelvic examination under anesthesia (other than local)</td>
</tr>
<tr>
<td>57420</td>
<td>Colposcopy of the entire vagina, with cervix if present;</td>
</tr>
<tr>
<td>57421</td>
<td>Colposcopy of the entire vagina, with cervix if present;</td>
</tr>
<tr>
<td>57452</td>
<td>Colposcopy of the cervix including upper/adjacent vagina;</td>
</tr>
<tr>
<td>57454</td>
<td>Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage</td>
</tr>
<tr>
<td>54755</td>
<td>Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix</td>
</tr>
<tr>
<td>57456</td>
<td>Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>57460</td>
<td>Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix</td>
</tr>
<tr>
<td>57461</td>
<td>Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix</td>
</tr>
<tr>
<td>57500</td>
<td>Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)</td>
</tr>
<tr>
<td>57505</td>
<td>Endocervical curettage (not done as part of a dilation and curettage)</td>
</tr>
<tr>
<td>57510</td>
<td>Cautery of cervix; electro or thermal</td>
</tr>
<tr>
<td>57511</td>
<td>Cautery of cervix; cryocautery, initial or repeat</td>
</tr>
<tr>
<td>57513</td>
<td>Cautery of cervix; laser ablation</td>
</tr>
<tr>
<td>57520</td>
<td>Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser</td>
</tr>
<tr>
<td>57522</td>
<td>Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision</td>
</tr>
<tr>
<td>57558</td>
<td>Dilation and curettage of cervical stump</td>
</tr>
<tr>
<td>57800</td>
<td>Dilation of cervical canal, instrumental (separate procedure)</td>
</tr>
<tr>
<td>58100</td>
<td>Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)</td>
</tr>
<tr>
<td>58110</td>
<td>Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>58120</td>
<td>Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)</td>
</tr>
<tr>
<td>58340</td>
<td>Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography</td>
</tr>
<tr>
<td>58345</td>
<td>Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography</td>
</tr>
<tr>
<td>58558</td>
<td>Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D &amp; C</td>
</tr>
<tr>
<td>58565</td>
<td>Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants</td>
</tr>
<tr>
<td>58600</td>
<td>Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral</td>
</tr>
<tr>
<td>58615</td>
<td>Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach</td>
</tr>
<tr>
<td>58661</td>
<td>Add on code for 58660 - removal of Adnexal structures</td>
</tr>
<tr>
<td>58670</td>
<td>Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)</td>
</tr>
</tbody>
</table>
### Contraceptive Drugs and Supplies

Providers must bill services and supplies not classified as drugs or biologicals using the CMS-1500 or 837P with the appropriate CPT or HCPCS codes and appropriate ICD-9-CM diagnosis codes for services rendered or condition treated. For example, use ICD-9-CM diagnosis codes V25.01 through V25.9 for contraceptive management, and use ICD-9-CM diagnosis code 099.53 for acute chlamydial vaginitis.

Providers must ensure that the member’s chart contains the date of the office visit, the national drug code (NDC), and name of the product dispensed or administered, the name of the product, and the number of units dispensed or administered (for example, four boxes of 30 items).

### Oral and Injectable Contraceptives

Reimbursement is available for oral and injectable contraceptives under the Family Planning Eligibility Program. Providers must bill the appropriate NDC for the drug dispensed or administered, with the appropriate code in Table 4.

**Table 4 – Family Planning Eligibility Program Procedure Codes for Oral and Injectable Contraceptives Requiring NDC**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1055</td>
<td>Injection, medroxyprogesterone acetate for contraceptive use, 150 mg</td>
</tr>
<tr>
<td>J1056</td>
<td>Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg</td>
</tr>
<tr>
<td>S4993</td>
<td>Contraceptive pills for birth control</td>
</tr>
</tbody>
</table>
Contraceptive Devices

Contraceptive devices listed in Table 5 must be billed with a primary Family Planning Eligibility Program diagnosis code listed in Table 1 above.

Condoms are considered medically necessary for men and women for the prevention of pregnancy, and to reduce the risk of STDs. Therefore, reimbursement is available for both male and female Family Planning members. For a pharmacy provider to be reimbursed for over-the-counter (OTC) external contraceptive supplies, a licensed IHCP-enrolled practitioner with prescriptive authority must prescribe them. The member may receive up to a three-month supply at one time.

Procedure codes A4261 - Cervical cap for contraceptive use and A4266 - Diaphragm for contraceptive use may be reimbursed separately from procedure code 57170 - Diaphragm or cervical cap fitting with instructions.

Table 5 – Family Planning Eligibility Program Procedure Codes for Contraceptive Devices and Supplies not Requiring NDC

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4261</td>
<td>Cervical cap for contraceptive use</td>
</tr>
<tr>
<td>A4266</td>
<td>Diaphragm for contraceptive use</td>
</tr>
<tr>
<td>A4267</td>
<td>Contraceptive supply, condom, male, each</td>
</tr>
<tr>
<td>A4268</td>
<td>Contraceptive supply, condom, female, each</td>
</tr>
<tr>
<td>A4269</td>
<td>Contraceptive supply, spermicide (e.g., foam, gel), each</td>
</tr>
</tbody>
</table>

Intrauterine Devices

The IHCP reimburses for the intrauterine device (IUD) and the insertion of the IUD. Additionally, the IHCP reimburses for the IUD insertion on the same date of service (DOS) as a dilation and curettage.

The IHCP also reimburses for the removal of an IUD. A provider will not be reimbursed for both an office visit and an IUD removal when billed on the same DOS.

Refer to Table 6 for procedure codes that may be reimbursed for IUDs. Procedure codes J7300 Intrauterine copper contraceptive - and J7302 - Levonorgestrel-releasing intrauterine contraceptive system, 52 mg must be billed with the NDC of the product administered.

Table 6 – Procedure Codes for IUDs

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7300</td>
<td>Intrauterine copper contraceptive</td>
</tr>
<tr>
<td>J7302</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52 mg</td>
</tr>
</tbody>
</table>
Vaginal Ring and Hormone Patch

The IHCP reimburses for vaginal ring and hormone patch contraceptive devices under the Family Planning program. Providers must bill the specific codes listed in Table 7 instead of miscellaneous supply code to identify the service being supplied. The NDC of the product dispensed or administered must be included with the procedure code.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7303</td>
<td>Contraceptive supply, hormone containing vaginal ring, each</td>
</tr>
<tr>
<td>J7304</td>
<td>Contraceptive supply, hormone containing patch, each</td>
</tr>
</tbody>
</table>

Contraceptive Implants

The IHCP reimburses for contraceptive implants. Refer to Table 8 for procedure codes that may be reimbursed for implants. Procedure codes J7306 - *Levonorgestrel (contraceptive) implant system, including implants and supplies* and J7307 - *Etonogestrel (contraceptive) implant system, including implant and supplies* must be billed with the NDC of the product administered.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7306</td>
<td><em>Levonorgestrel (contraceptive) implant system, including implants and supplies</em></td>
</tr>
<tr>
<td>J7307</td>
<td><em>Etonogestrel (contraceptive) implant system, including implant and supplies</em></td>
</tr>
<tr>
<td>11981</td>
<td>Insertion, non-biodegradable drug delivery implant</td>
</tr>
<tr>
<td>11982</td>
<td>Removal, non-biodegradable drug delivery implant</td>
</tr>
<tr>
<td>11983</td>
<td>Removal with insertion, non-biodegradable drug delivery implant</td>
</tr>
</tbody>
</table>

Norplant Systems

Norplant is no longer available in the United States; however, the IHCP reimburses the removal of the implanted contraceptive capsule when billed with diagnosis code V2543.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11976</td>
<td>Removal, implantable contraceptive capsules</td>
</tr>
</tbody>
</table>
Sterilization and Sterilization Related Procedures

Sterilization renders a person unable to reproduce. The IHCP reimburses for sterilizations when the consent form accompanies all claims connected with the service for men and women according to 405 IAC 5-28-8.

Limitations

The IHCP may reimburse for the sterilization of an individual only if that individual meets the following requirements:

- Is 21 years old or over at the time the informed consent is given, per 42 CFR 441.253
- Is neither mentally incompetent nor institutionalized, per 42 CFR 441.251.
- Has voluntarily given informed consent, per 42 CFR 441.257 through 441.258

Hysteroscopic Sterilizations

Hysteroscopic sterilizations with an implant device provide a permanent sterilization option that does not require an incision. The IHCP covers this procedure for eligible female members 21 years and older. This procedure can be performed in the office, in an outpatient hospital, or in an ASC.

Providers should bill the procedure using CPT® code 58565 – Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants. However, CPT code 58579 – Unlisted hysterectomy procedure, uterus is not appropriate billing for the hysteroscopic sterilization procedure with an implant device, and claims will suspend for manual review.

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 an MD or a DO trained in the procedure, and can be performed in the office, at an outpatient hospital facility, or in an ASC. The implant device must be billed separately on the CMS-1500 claim form using HCPCS code A9900 – Miscellaneous DME supply, accessory, and/or service component of another HCPCS code. This is the only code billable for the implant device.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>58565</td>
<td>Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants</td>
</tr>
<tr>
<td>A9900</td>
<td>Miscellaneous DME supply, accessory, and/or service component of another HCPCS code</td>
</tr>
</tbody>
</table>
An outpatient hospital or ASC must adhere to the following billing instructions to receive reimbursement for the implant device in addition to the outpatient ASC rate.

**Table 11 – Billing Instructions for the Hysteroscopic Sterilization Procedure with Implant Device**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Claim Type</th>
<th>Bill for the Procedure and the Supply</th>
<th>Additional Billing Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital or ASC</td>
<td>UB-04</td>
<td>58565 with appropriate revenue code</td>
<td>• Print “Essure Sterilization” in the body of the claim form or on the accompanying invoice</td>
</tr>
<tr>
<td></td>
<td>CMS-1500</td>
<td>Bill the device using A9900 – Include a cost invoice with the claim to support the actual cost of the device</td>
<td>• Submit a manufacturer’s cost invoice with the claim to support the cost of the Essure device.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Submit a valid, signed Sterilization Consent Form with the claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Enter ICD-9-CM V25.2-Sterilization as the primary diagnosis on the claim</td>
</tr>
<tr>
<td>Physician</td>
<td>CMS-1500</td>
<td>58565</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bill the device on a separate line using A9900 – Include a cost invoice</td>
<td></td>
</tr>
</tbody>
</table>

**Tubal Ligation**

Tubal ligations may be reimbursed by the IHCP under the Family Planning program. Refer to Table 12 for procedure codes. Tubal ligations are considered permanent, one-per-lifetime procedures. If a tubal ligation has previously been reimbursed for the client, providers may appeal with documentation that supports the medical necessity for the repeat sterilization.

**Table 12 – Procedure Codes for Tubal Ligation**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>58600</td>
<td>Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral</td>
</tr>
<tr>
<td>58615</td>
<td>Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach</td>
</tr>
<tr>
<td>58670</td>
<td>Laparoscopy, surgical; with fulguration of oviducts (with or without transection)</td>
</tr>
<tr>
<td>58671</td>
<td>Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)</td>
</tr>
</tbody>
</table>
Vasectomy
The IHCP may reimburse for a vasectomy for sterilization that is performed on a male by an IHCP-enrolled provider. Vasectomies are considered permanent, once-per-lifetime procedures. If a vasectomy has previously been reimbursed for the client, providers may appeal with documentation that supports the medical necessity for the repeat sterilization. Refer to Table 13 for procedure codes.

Table 13 – Procedure Codes for Vasectomy

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00921</td>
<td>Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral</td>
</tr>
<tr>
<td>55200</td>
<td>Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)</td>
</tr>
<tr>
<td>55250</td>
<td>Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)</td>
</tr>
<tr>
<td>55300</td>
<td>Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral</td>
</tr>
</tbody>
</table>

Anesthesia for Sterilization
Refer to Table 14 for anesthesia procedure codes that may be billed with the sterilization procedure.

Table 14 – Procedure Codes for Anesthesia Services

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00840</td>
<td>Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified</td>
</tr>
<tr>
<td>00851</td>
<td>Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transaction</td>
</tr>
<tr>
<td>00920</td>
<td>Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified</td>
</tr>
<tr>
<td>00921</td>
<td>Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral</td>
</tr>
<tr>
<td>00940</td>
<td>Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified</td>
</tr>
<tr>
<td>00950</td>
<td>Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); culdoscopy</td>
</tr>
<tr>
<td>00952</td>
<td>Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography</td>
</tr>
</tbody>
</table>
Sexually Transmitted Diseases and Infections (STDs and STIs)

Reimbursement is available for the initial diagnosis and treatment of a STD and/or STI when diagnosed during a family planning visit. The member has 180 days from the date of initial diagnosis to seek treatment. The treatment for the STD or STI must be prescribed in conjunction with a family planning visit and be related to family planning. Ongoing treatment after 180 days from initial diagnosis date will not be reimbursed. Refer to Tables 15 and 16 for procedure codes that are billable for the treatment of STDs and STIs.

Table 15 – CPT Codes to Diagnosis STDs and STIs

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>86255</td>
<td>Fluorescent noninfectious agent antibody; screen, each antibody</td>
</tr>
<tr>
<td>86256</td>
<td>Fluorescent noninfectious agent antibody; titer, each antibody</td>
</tr>
<tr>
<td>86317</td>
<td>Immunoassay for infectious agent antibody, quantitative, not otherwise specified</td>
</tr>
<tr>
<td>86318</td>
<td>Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip)</td>
</tr>
<tr>
<td>86592</td>
<td>Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)</td>
</tr>
<tr>
<td>86593</td>
<td>Syphilis test, non-treponemal antibody; quantitative</td>
</tr>
<tr>
<td>86628</td>
<td>Antibody; Candida</td>
</tr>
<tr>
<td>86631</td>
<td>Antibody; Chlamydia</td>
</tr>
<tr>
<td>86632</td>
<td>Antibody; Chlamydia, IgM</td>
</tr>
<tr>
<td>86687</td>
<td>Antibody; HTLV-I</td>
</tr>
<tr>
<td>86688</td>
<td>Antibody; HTLV-II</td>
</tr>
<tr>
<td>86689</td>
<td>Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot)</td>
</tr>
<tr>
<td>86692</td>
<td>Antibody; hepatitis, delta agent</td>
</tr>
<tr>
<td>86694</td>
<td>Antibody; herpes simplex, non-specific type test</td>
</tr>
<tr>
<td>86695</td>
<td>Antibody; herpes simplex, type 1</td>
</tr>
<tr>
<td>86696</td>
<td>Antibody; herpes simplex, type 2</td>
</tr>
<tr>
<td>86701</td>
<td>Antibody; HIV-1</td>
</tr>
<tr>
<td>86702</td>
<td>Antibody; HIV-2</td>
</tr>
<tr>
<td>86703</td>
<td>Antibody; HIV-1 and HIV-2, single result</td>
</tr>
<tr>
<td>86704</td>
<td>Hepatitis B core antibody (HBcAb); total</td>
</tr>
<tr>
<td>86705</td>
<td>Hepatitis B core antibody (HBcAb); IgM antibody</td>
</tr>
<tr>
<td>86706</td>
<td>Hepatitis B surface antibody (HBsAb)</td>
</tr>
<tr>
<td>86707</td>
<td>Hepatitis Be antibody (HBeAb)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>86780</td>
<td>Antibody; Treponema pallidum</td>
</tr>
<tr>
<td>86787</td>
<td>Antibody; varicella-zoster</td>
</tr>
<tr>
<td>86803</td>
<td>Hepatitis C antibody;</td>
</tr>
<tr>
<td>86804</td>
<td>Hepatitis C antibody; confirmatory test (eg, immunoblot)</td>
</tr>
<tr>
<td>87040</td>
<td>Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)</td>
</tr>
<tr>
<td>87070</td>
<td>Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates</td>
</tr>
<tr>
<td>87073</td>
<td>Culture, bacterial; quantitative, anaerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool</td>
</tr>
<tr>
<td>87075</td>
<td>Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates</td>
</tr>
<tr>
<td>87076</td>
<td>Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate</td>
</tr>
<tr>
<td>87077</td>
<td>Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate</td>
</tr>
<tr>
<td>87081</td>
<td>Culture, presumptive, pathogenic organisms, screening only;</td>
</tr>
<tr>
<td>87084</td>
<td>Culture, presumptive, pathogenic organisms, screening only; with colony estimation from density chart</td>
</tr>
<tr>
<td>87086</td>
<td>Culture, bacterial; quantitative colony count, urine</td>
</tr>
<tr>
<td>87088</td>
<td>Culture, bacterial; with isolation and presumptive identification of each isolate, urine</td>
</tr>
<tr>
<td>87101</td>
<td>Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail</td>
</tr>
<tr>
<td>87102</td>
<td>Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; other source (except blood)</td>
</tr>
<tr>
<td>87109</td>
<td>Culture, mycoplasma, any source</td>
</tr>
<tr>
<td>87110</td>
<td>Culture, chlamydia, any source</td>
</tr>
<tr>
<td>87140</td>
<td>Culture, typing; immunofluorescent method, each antiserum</td>
</tr>
<tr>
<td>87147</td>
<td>Culture, typing; immunologic method, other than immunofluorescence (eg, agglutination grouping), per antiserum</td>
</tr>
<tr>
<td>87149</td>
<td>Culture, typing; identification by nucleic acid (DNA or RNA) probe, direct probe technique, per culture or isolate, each organism probed</td>
</tr>
<tr>
<td>87164</td>
<td>Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>87166</td>
<td>Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection</td>
</tr>
<tr>
<td>87181</td>
<td>Susceptibility studies, antimicrobial agent; agar dilution method, per agent (eg, antibiotic gradient strip)</td>
</tr>
<tr>
<td>87184</td>
<td>Susceptibility studies, antimicrobial agent; disk method, per plate (12 or fewer agents)</td>
</tr>
<tr>
<td>87185</td>
<td>Susceptibility studies, antimicrobial agent; enzyme detection (eg, beta lactamase), per enzyme</td>
</tr>
<tr>
<td>87186</td>
<td>Susceptibility studies, antimicrobial agent; microdilution or agar dilution [minimum inhibitory concentration (MIC) or breakpoint], each multi-antimicrobial, per plate</td>
</tr>
<tr>
<td>87187</td>
<td>Susceptibility studies, antimicrobial agent; microdilution or agar dilution, minimum lethal concentration (MLC), each plate (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>87188</td>
<td>Susceptibility studies, antimicrobial agent; macrobroth dilution method, each agent</td>
</tr>
<tr>
<td>87205</td>
<td>Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types</td>
</tr>
<tr>
<td>87206</td>
<td>Smear, primary source with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types</td>
</tr>
<tr>
<td>87207</td>
<td>Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses)</td>
</tr>
<tr>
<td>87210</td>
<td>Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)</td>
</tr>
<tr>
<td>87220</td>
<td>Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies)</td>
</tr>
<tr>
<td>87252</td>
<td>Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect</td>
</tr>
<tr>
<td>87254</td>
<td>Virus isolation; centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus</td>
</tr>
<tr>
<td>87255</td>
<td>Virus isolation; including identification by non-immunologic method, other than by cytopathic effect (eg, virus specific enzymatic activity)</td>
</tr>
<tr>
<td>87270</td>
<td>Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis</td>
</tr>
<tr>
<td>87273</td>
<td>Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 2</td>
</tr>
<tr>
<td>87274</td>
<td>Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 1</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>87285</td>
<td>Infectious agent antigen detection by immunofluorescent technique; Treponema pallidum</td>
</tr>
<tr>
<td>87320</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis</td>
</tr>
<tr>
<td>87340</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)</td>
</tr>
<tr>
<td>87341</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg) neutralization</td>
</tr>
<tr>
<td>87350</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis Be antigen (HBeAg)</td>
</tr>
<tr>
<td>87390</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1</td>
</tr>
<tr>
<td>87391</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-2</td>
</tr>
<tr>
<td>87449</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism</td>
</tr>
<tr>
<td>87480</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique</td>
</tr>
<tr>
<td>87481</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique</td>
</tr>
<tr>
<td>87482</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Candida species, quantification</td>
</tr>
<tr>
<td>87485</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, direct probe technique</td>
</tr>
<tr>
<td>87486</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, amplified probe technique</td>
</tr>
<tr>
<td>87487</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, quantification</td>
</tr>
<tr>
<td>87490</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique</td>
</tr>
<tr>
<td>87491</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique</td>
</tr>
<tr>
<td>87492</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>87495</td>
<td>Infectious agent antigen detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>cytomegalovirus, direct probe technique</td>
</tr>
<tr>
<td>87496</td>
<td>Infectious agent antigen detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>cytomegalovirus, amplified probe technique</td>
</tr>
<tr>
<td>87497</td>
<td>Infectious agent antigen detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>cytomegalovirus, quantification</td>
</tr>
<tr>
<td>87510</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>Gardnerella vaginalis, direct probe technique</td>
</tr>
<tr>
<td>87511</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>Gardnerella vaginalis, amplified probe technique</td>
</tr>
<tr>
<td>87512</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>Gardnerella vaginalis, quantification</td>
</tr>
<tr>
<td>87516</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>hepatitis B virus, amplified probe technique</td>
</tr>
<tr>
<td>87517</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>hepatitis B virus, quantification</td>
</tr>
<tr>
<td>87521</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>hepatitis C, amplified probe technique</td>
</tr>
<tr>
<td>87522</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>hepatitis C, quantification</td>
</tr>
<tr>
<td>87528</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>Herpes simplex virus, direct probe technique</td>
</tr>
<tr>
<td>87529</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>Herpes simplex virus, amplified probe technique</td>
</tr>
<tr>
<td>87530</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>Herpes simplex virus, quantification</td>
</tr>
<tr>
<td>87531</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>Herpes virus-6, direct probe technique</td>
</tr>
<tr>
<td>87532</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>Herpes virus-6, amplified probe technique</td>
</tr>
<tr>
<td>87533</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>Herpes virus-6, quantification</td>
</tr>
<tr>
<td>87534</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>HIV-1, direct probe technique</td>
</tr>
<tr>
<td>87535</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>HIV-1, amplified probe technique</td>
</tr>
<tr>
<td>87536</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA);</td>
</tr>
<tr>
<td></td>
<td>HIV-1, quantification</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>87537</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique</td>
</tr>
<tr>
<td>87538</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique</td>
</tr>
<tr>
<td>87539</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification</td>
</tr>
<tr>
<td>87590</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique</td>
</tr>
<tr>
<td>87591</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique</td>
</tr>
<tr>
<td>87592</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification</td>
</tr>
<tr>
<td>87620</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, direct probe technique</td>
</tr>
<tr>
<td>87621</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique</td>
</tr>
<tr>
<td>87622</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, quantification</td>
</tr>
<tr>
<td>87660</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique</td>
</tr>
<tr>
<td>87797</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism</td>
</tr>
<tr>
<td>87798</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism</td>
</tr>
<tr>
<td>87799</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism</td>
</tr>
<tr>
<td>87800</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique</td>
</tr>
<tr>
<td>87801</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique</td>
</tr>
<tr>
<td>87808</td>
<td>Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis</td>
</tr>
<tr>
<td>87810</td>
<td>Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis</td>
</tr>
<tr>
<td>87850</td>
<td>Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhoeae</td>
</tr>
<tr>
<td>87901</td>
<td>Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, reverse transcriptase and protease regions</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>87902</td>
<td>Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis C virus</td>
</tr>
<tr>
<td>88141</td>
<td>Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician</td>
</tr>
<tr>
<td>88142</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision</td>
</tr>
<tr>
<td>88143</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision</td>
</tr>
<tr>
<td>88147</td>
<td>Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision</td>
</tr>
<tr>
<td>88148</td>
<td>Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision</td>
</tr>
<tr>
<td>88150</td>
<td>Cytopathology, slides, cervical or vaginal; manual screening under physician supervision</td>
</tr>
<tr>
<td>88152</td>
<td>Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision</td>
</tr>
<tr>
<td>88153</td>
<td>Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision</td>
</tr>
<tr>
<td>88154</td>
<td>Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision</td>
</tr>
<tr>
<td>88155</td>
<td>Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code[s] for other technical and interpretation services)</td>
</tr>
<tr>
<td>88160</td>
<td>Cytopathology, smears, any other source; screening and interpretation</td>
</tr>
<tr>
<td>88164</td>
<td>Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision</td>
</tr>
<tr>
<td>88165</td>
<td>Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision</td>
</tr>
<tr>
<td>88166</td>
<td>Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision</td>
</tr>
<tr>
<td>88167</td>
<td>Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision</td>
</tr>
<tr>
<td>88174</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>88175</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision</td>
</tr>
<tr>
<td>88300</td>
<td>Level I - Surgical pathology, gross examination only</td>
</tr>
<tr>
<td>88302</td>
<td>Level II - Surgical pathology, gross and microscopic examination Appendix, incidental, Fallopian tube, sterilization, Fingers/toes, amputation, traumatic, Foreskin, newborn, Hernia sac, any location, Hydrocele sac, Nerve, Skin, plastic repair, Sympathetic ganglion, Testis, castration, Vaginal mucosa, incidental, Vas deferens, sterilization</td>
</tr>
<tr>
<td>88304</td>
<td>Level III - Surgical pathology, gross and microscopic examination Abortion, induced, Abscess, Aneurysm - arterial/ventricular, Anus, tag, Appendix, other than incidental, Artery, atheromatous plaque, Bartholin's gland cyst, Bone fragment(s), other than pathologic fracture, Bursa/synovial cyst, Carpal tunnel tissue, Cartilage, Cholesteatoma, Colon, colostomy stoma, Conjunctiva biopsy/pterygium, Cornea, Diverticulum - esophagus/small intestine, Dupuytren's contracture tissue, Femoral head, other than fracture, Fissure/fistula, Foreskin, other than newborn, Gallbladder, Ganglion cyst, Hematoma, Hemorrhoids, Hydatid of Morgagni, Intervertebral disc, Joint, loose body, Meniscus, Mucocoele, salivary, Neuroma - Morton's/traumatic, Pilonidal cyst/sinus, Polyps, inflammatory - nasal/sinusoidal, Skin - cyst/tag/debridement, Soft tissue, debriement, Soft tissue, lipoma, Spermatocele, Tendon/tendon sheath, Testicular appendage, Thrombus or embolus, Tonsil and/or adenoids, Varicocele, Vas deferens, other than sterilization, Vein, varicosity</td>
</tr>
<tr>
<td>88305</td>
<td>Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed, Artery, biopsy, Bone marrow, biopsy, Bone exostosis, Brain/meninges, other than for tumor resection, Breast, biopsy, not requiring microscopic evaluation of surgical margins, Breast, reduction mammoplasty, Bronchus, biopsy, Cell block, any source, Cervix, biopsy, Colon, biopsy, Duodenum, biopsy, Endocervix, curetttings/biopsy, Endometrium, curetttings/biopsy, Esophagus, biopsy, Extremitry, amputation, traumatic, Fallopian tube, biopsy, Fallopian tube, ectopic pregnancy, Femoral head, femur, Fingers/toes, amputation, non-traumatic, Gingiva/oral mucosa, biopsy, Heart valve, Joint, resection, Kidney, biopsy, Larynx, biopsy, Leiomyoma(s), uterine myometomy - without uterus, Lip, biopsy/wedge resection, Lung, transbronchial biopsy, Lymph node, biopsy, Muscle, biopsy, Nasal mucosa, biopsy, Nasopharynx/oropharynx, biopsy, Nerve, biopsy, Odontogenic/dental cyst, Omentum, biopsy, Ovary with or without tube, non-neoplastic, Ovary, biopsy/wedge resection, Parathyroid gland, Peritoneum, biopsy, Pituitary tumor, Placenta, other than third trimester, Pleura/pericardium - biopsy/tissue, Poly, cervical/endometrial, Polyp, colorectal, Polyp, stomach/small intestine, Prostate, needle biopsy, Prostate, TUR, Salivary gland, biopsy, Sinus, paranasal biopsy, Skin, other than cyst/tag/debridement/plastic repair, Small intestine, biopsy, Soft tissue, other than tumor/mass/lipoma/debridement, Spleen, Stomach, biopsy,</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>88307</td>
<td>Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapsed</td>
</tr>
<tr>
<td>88309</td>
<td>Level VI - Surgical pathology, gross and microscopic examination Bone resection, Breast, mastectomy - with regional lymph nodes, Colon, segmental resection for tumor, Colon, total resection, Esophagus, partial/total resection, Extremity, disarticulation, Fetus, with dissection, Larynx, partial/total resection - with regional lymph nodes, Lung - total/lobe/segment resection, Pancreas, total/subtotal resection, Prostate, radical resection, Small intestine, resection for tumor, Soft tissue tumor, extensive resection, Stomach - subtotal/total resection for tumor, Testis, tumor, Tongue/tonsil - resection for tumor, Urinary bladder, partial/total resection, Uterus, with or without tubes and ovaries, neoplastic, Vulva, total/subtotal resection</td>
</tr>
<tr>
<td>88312</td>
<td>Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)</td>
</tr>
<tr>
<td>88313</td>
<td>Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry</td>
</tr>
<tr>
<td>88314</td>
<td>Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>88319</td>
<td>Special stain including interpretation and report; Group III, for enzyme constituents</td>
</tr>
<tr>
<td>88323</td>
<td>Consultation and report on referred material requiring preparation of slides</td>
</tr>
<tr>
<td>89321</td>
<td>Semen analysis; sperm presence and motility of sperm, if performed</td>
</tr>
<tr>
<td>90371</td>
<td>Hepatitis B immune globulin (HBlg), human, for intramuscular use</td>
</tr>
</tbody>
</table>
### STD and STI Treatment

The codes in Table 16 must be billed along with the appropriate NDC.

**Table 16 – Procedure Codes to Treat STDs and STIs**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0133</td>
<td>Injection, acyclovir, 5 mg</td>
</tr>
<tr>
<td>J0290</td>
<td>Injection, ampicillin sodium, 500 mg</td>
</tr>
<tr>
<td>J0456</td>
<td>Injection, azithromycin, 500 mg</td>
</tr>
<tr>
<td>J0561</td>
<td>Injection, penicillin G benzathine, 100,000 units</td>
</tr>
<tr>
<td>J0696</td>
<td>Injection, ceftriaxone sodium, per 250 mg</td>
</tr>
<tr>
<td>J0697</td>
<td>Injection, sterile cefuroxime sodium, per 750 mg</td>
</tr>
<tr>
<td>J0698</td>
<td>Injection, cefotaxime sodium, per g</td>
</tr>
<tr>
<td>J0744</td>
<td>Injection, ciprofloxacin for intravenous infusion, 200 mg</td>
</tr>
</tbody>
</table>
STD and STI Diagnosis Codes

Table 17 lists the ICD-9 diagnosis codes that may be billed during a family planning visit.

### Table 17 – STD and STI ICD-9 Diagnosis Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>042</td>
<td>Human immunodeficiency virus (hiv) disease</td>
</tr>
<tr>
<td>78.88</td>
<td>Other specified diseases due to Chlamydiae</td>
</tr>
<tr>
<td>79.4</td>
<td>Human papillomavirus</td>
</tr>
<tr>
<td>79.98</td>
<td>Unspecified chlamydial infection</td>
</tr>
<tr>
<td>079.53</td>
<td>Human immunodeficiency virus type 2 [hiv-2]</td>
</tr>
<tr>
<td>090.1</td>
<td>Early congenital syphilis latent</td>
</tr>
<tr>
<td>090.2</td>
<td>Early congenital syphilis unspecified</td>
</tr>
<tr>
<td>090.3</td>
<td>Syphilitic interstitial keratitis</td>
</tr>
<tr>
<td>090.4</td>
<td>Juvenile neurosyphilis</td>
</tr>
<tr>
<td>090.40</td>
<td>Juvenile neurosyphilis unspecified</td>
</tr>
<tr>
<td>090.41</td>
<td>Congenital syphilitic encephalitis</td>
</tr>
<tr>
<td>090.42</td>
<td>Congenital syphilitic meningitis</td>
</tr>
<tr>
<td>090.49</td>
<td>Other juvenile neurosyphilis</td>
</tr>
<tr>
<td>090.5</td>
<td>Other late congenital syphilis symptomatic</td>
</tr>
<tr>
<td>090.6</td>
<td>Late congenital syphilis latent</td>
</tr>
<tr>
<td>090.7</td>
<td>Late congenital syphilis unspecified</td>
</tr>
<tr>
<td>090.9</td>
<td>Congenital syphilis unspecified</td>
</tr>
<tr>
<td>091</td>
<td>Early syphilis symptomatic</td>
</tr>
<tr>
<td>091.0</td>
<td>Genital syphilis (primary)</td>
</tr>
<tr>
<td>091.1</td>
<td>Primary anal syphilis</td>
</tr>
<tr>
<td>091.2</td>
<td>Other primary syphilis</td>
</tr>
<tr>
<td>091.3</td>
<td>Secondary syphilis of skin or mucous membranes</td>
</tr>
<tr>
<td>091.4</td>
<td>Adenopathy due to secondary syphilis</td>
</tr>
<tr>
<td>091.5</td>
<td>Uveitis due to secondary syphilis</td>
</tr>
<tr>
<td>091.50</td>
<td>Syphilitic uveitis unspecified</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>091.51</td>
<td>Syphilitic chorioretinitis (secondary)</td>
</tr>
<tr>
<td>091.52</td>
<td>Syphilitic iridocyclitis (secondary)</td>
</tr>
<tr>
<td>091.6</td>
<td>Secondary syphilis of viscera and bone</td>
</tr>
<tr>
<td>091.61</td>
<td>Secondary syphilitic periostitis</td>
</tr>
<tr>
<td>091.62</td>
<td>Secondary syphilitic hepatitis</td>
</tr>
<tr>
<td>091.69</td>
<td>Secondary syphilis of other viscera</td>
</tr>
<tr>
<td>091.7</td>
<td>Secondary syphilis relapse</td>
</tr>
<tr>
<td>091.8</td>
<td>Other forms of secondary syphilis</td>
</tr>
<tr>
<td>091.81</td>
<td>Acute syphilitic meningitis (secondary)</td>
</tr>
<tr>
<td>091.82</td>
<td>Syphilitic alopecia</td>
</tr>
<tr>
<td>091.89</td>
<td>Other forms of secondary syphilis</td>
</tr>
<tr>
<td>091.9</td>
<td>Unspecified secondary syphilis</td>
</tr>
<tr>
<td>092</td>
<td>Early syphilis latent</td>
</tr>
<tr>
<td>092.0</td>
<td>Early syphilis latent serological relapse after treatment</td>
</tr>
<tr>
<td>092.9</td>
<td>Early syphilis latent unspecified</td>
</tr>
<tr>
<td>093</td>
<td>Cardiovascular syphilis</td>
</tr>
<tr>
<td>093.0</td>
<td>Aneurysm of aorta specified as syphilitic</td>
</tr>
<tr>
<td>093.1</td>
<td>Syphilitic aortitis</td>
</tr>
<tr>
<td>093.2</td>
<td>Syphilitic endocarditis</td>
</tr>
<tr>
<td>093.20</td>
<td>Syphilitic endocarditis of valve unspecified</td>
</tr>
<tr>
<td>093.21</td>
<td>Syphilitic endocarditis of mitral valve</td>
</tr>
<tr>
<td>093.22</td>
<td>Syphilitic endocarditis of aortic valve</td>
</tr>
<tr>
<td>093.23</td>
<td>Syphilitic endocarditis of tricuspid valve</td>
</tr>
<tr>
<td>093.24</td>
<td>Syphilitic endocarditis of pulmonary valve</td>
</tr>
<tr>
<td>093.8</td>
<td>Other specified cardiovascular syphilis</td>
</tr>
<tr>
<td>093.81</td>
<td>Syphilitic pericarditis</td>
</tr>
<tr>
<td>093.82</td>
<td>Syphilitic myocarditis</td>
</tr>
<tr>
<td>093.89</td>
<td>Other specified cardiovascular syphilis</td>
</tr>
<tr>
<td>093.9</td>
<td>Cardiovascular syphilis unspecified</td>
</tr>
<tr>
<td>094</td>
<td>Neurosyphilis</td>
</tr>
<tr>
<td>094.0</td>
<td>Tabes dorsalis</td>
</tr>
<tr>
<td>094.1</td>
<td>General paresis</td>
</tr>
<tr>
<td>094.2</td>
<td>Syphilitic meningitis</td>
</tr>
<tr>
<td>Code</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------</td>
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<tr>
<td>094.3</td>
<td>Asymptomatic neurosyphilis</td>
</tr>
<tr>
<td>094.8</td>
<td>Other specified neurosyphilis</td>
</tr>
<tr>
<td>094.81</td>
<td>Syphilitic encephalitis</td>
</tr>
<tr>
<td>094.82</td>
<td>Syphilitic parkinsonism</td>
</tr>
<tr>
<td>094.83</td>
<td>Syphilitic disseminated retinochoroiditis</td>
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<tr>
<td>094.84</td>
<td>Syphilitic optic atrophy</td>
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<tr>
<td>094.85</td>
<td>Syphilitic retrobulbar neuritis</td>
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<tr>
<td>094.86</td>
<td>Syphilitic acoustic neuritis</td>
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<tr>
<td>094.87</td>
<td>Syphilitic ruptured cerebral aneurysm</td>
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<tr>
<td>094.89</td>
<td>Other specified neurosyphilis</td>
</tr>
<tr>
<td>094.9</td>
<td>Neurosyphilis unspecified</td>
</tr>
<tr>
<td>095</td>
<td>Other forms of late syphilis with symptoms</td>
</tr>
<tr>
<td>095.0</td>
<td>Syphilitic episcleritis</td>
</tr>
<tr>
<td>095.1</td>
<td>Syphilis of lung</td>
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<tr>
<td>095.2</td>
<td>Syphilitic peritonitis</td>
</tr>
<tr>
<td>095.3</td>
<td>Syphilis of liver</td>
</tr>
<tr>
<td>095.4</td>
<td>Syphilis of kidney</td>
</tr>
<tr>
<td>095.5</td>
<td>Syphilis of bone</td>
</tr>
<tr>
<td>095.6</td>
<td>Syphilis of muscle</td>
</tr>
<tr>
<td>095.7</td>
<td>Syphilis of synovium tendon and bursa</td>
</tr>
<tr>
<td>095.8</td>
<td>Other specified forms of late symptomatic syphilis</td>
</tr>
<tr>
<td>095.9</td>
<td>Late symptomatic syphilis unspecified</td>
</tr>
<tr>
<td>096</td>
<td>Late syphilis latent</td>
</tr>
<tr>
<td>097</td>
<td>Other and unspecified syphilis</td>
</tr>
<tr>
<td>097.0</td>
<td>Late syphilis unspecified</td>
</tr>
<tr>
<td>097.1</td>
<td>Latent syphilis unspecified</td>
</tr>
<tr>
<td>097.9</td>
<td>Syphilis unspecified subacute to chronic infectious venereal disease caused by the spirochete treponema pallidum.</td>
</tr>
<tr>
<td>098</td>
<td>Gonococcal infections acute infectious disease</td>
</tr>
<tr>
<td>098.0</td>
<td>characterized by primary invasion of the urogenital tract; the etiologic agent is Neisseria gonorrhoeae.</td>
</tr>
<tr>
<td>098.1</td>
<td>Gonococcal infection (acute) of upper genitourinary tract</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>098.10</td>
<td>Gonococcal infection (acute) of upper genitourinary tract site unspecified</td>
</tr>
<tr>
<td>098.11</td>
<td>Gonococcal cystitis (acute)</td>
</tr>
<tr>
<td>098.12</td>
<td>Gonococcal prostatitis (acute)</td>
</tr>
<tr>
<td>098.13</td>
<td>Gonococcal epididymo-orchitis (acute)</td>
</tr>
<tr>
<td>098.14</td>
<td>Gonococcal seminal vesiculitis (acute)</td>
</tr>
<tr>
<td>098.15</td>
<td>Gonococcal cervicitis (acute)</td>
</tr>
<tr>
<td>098.16</td>
<td>Gonococcal endometritis (acute)</td>
</tr>
<tr>
<td>098.17</td>
<td>Gonococcal salpingitis specified as acute</td>
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<tr>
<td>098.19</td>
<td>Other gonococcal infection (acute) of upper genitourinary tract</td>
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<tr>
<td>098.2</td>
<td>Gonococcal infection chronic of lower genitourinary tract</td>
</tr>
<tr>
<td>098.3</td>
<td>Gonococcal infection chronic of upper genitourinary tract</td>
</tr>
<tr>
<td>098.30</td>
<td>Chronic gonococcal infection of upper genitourinary tract site unspecified</td>
</tr>
<tr>
<td>098.31</td>
<td>Gonococcal cystitis chronic</td>
</tr>
<tr>
<td>098.32</td>
<td>Gonococcal prostatitis chronic</td>
</tr>
<tr>
<td>098.33</td>
<td>Gonococcal epididymo-orchitis chronic</td>
</tr>
<tr>
<td>098.34</td>
<td>Gonococcal seminal vesiculitis chronic</td>
</tr>
<tr>
<td>098.35</td>
<td>Gonococcal cervicitis chronic</td>
</tr>
<tr>
<td>098.36</td>
<td>Gonococcal endometritis chronic</td>
</tr>
<tr>
<td>098.37</td>
<td>Gonococcal salpingitis (chronic)</td>
</tr>
<tr>
<td>098.39</td>
<td>Other chronic gonococcal infection of upper genitourinary tract</td>
</tr>
<tr>
<td>098.4</td>
<td>Gonococcal infection of eye</td>
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<tr>
<td>098.40</td>
<td>Gonococcal conjunctivitis (neonatorum)</td>
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<tr>
<td>098.41</td>
<td>Gonococcal iridocyclitis</td>
</tr>
<tr>
<td>098.42</td>
<td>Gonococcal endophthalming</td>
</tr>
<tr>
<td>098.43</td>
<td>Gonococcal keratitis</td>
</tr>
<tr>
<td>098.49</td>
<td>Other gonococcal infection of eye</td>
</tr>
<tr>
<td>098.5</td>
<td>Gonococcal infection of joint</td>
</tr>
<tr>
<td>098.50</td>
<td>Gonococcal arthritis</td>
</tr>
<tr>
<td>098.51</td>
<td>Gonococcal synovitis and tenosynovitis</td>
</tr>
<tr>
<td>098.52</td>
<td>Gonococcal bursitis</td>
</tr>
<tr>
<td>098.53</td>
<td>Gonococcal spondylitis</td>
</tr>
<tr>
<td>098.59</td>
<td>Other gonococcal infection of joint</td>
</tr>
<tr>
<td>098.6</td>
<td>Gonococcal infection of pharynx</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>098.7</td>
<td>Gonococcal infection of anus and rectum</td>
</tr>
<tr>
<td>098.8</td>
<td>Gonococcal infection of other specified sites</td>
</tr>
<tr>
<td>098.81</td>
<td>Gonococcal keratosis (blennorrhagica)</td>
</tr>
<tr>
<td>098.82</td>
<td>Gonococcal meningitis</td>
</tr>
<tr>
<td>098.83</td>
<td>Gonococcal pericarditis</td>
</tr>
<tr>
<td>098.84</td>
<td>Gonococcal endocarditis</td>
</tr>
<tr>
<td>098.85</td>
<td>Other gonococcal heart disease</td>
</tr>
<tr>
<td>098.86</td>
<td>Gonococcal peritonitis</td>
</tr>
<tr>
<td>098.89</td>
<td>Gonococcal infection of other specified sites</td>
</tr>
<tr>
<td>099</td>
<td>Other venereal diseases</td>
</tr>
<tr>
<td>099.0</td>
<td>Chancroid</td>
</tr>
<tr>
<td>099.1</td>
<td>Lymphogranuloma venereum subacute inflammation of the inguinal lymph glands caused by certain immunotypes of Chlamydia trachomatis; a sexually transmitted disease in the United States but is more widespread in developing countries; do not confuse with granuloma venereum, which is caused by Calymmatobacterium granulomatis, for this use ENTEROBACTERIACEAE DISEASE.</td>
</tr>
<tr>
<td>099.2</td>
<td>Granuloma inguinale</td>
</tr>
<tr>
<td>099.3</td>
<td>Reiter's disease triad of nongonococcal urethritis followed by conjunctivitis and arthritis.</td>
</tr>
<tr>
<td>099.4</td>
<td>Other nongonococcal urethritis</td>
</tr>
<tr>
<td>099.40</td>
<td>Other nongonococcal urethritis unspecified</td>
</tr>
<tr>
<td>099.41</td>
<td>Other nongonococcal urethritis chlamydia trachomatis</td>
</tr>
<tr>
<td>099.49</td>
<td>Other nongonococcal urethritis other specified organism</td>
</tr>
<tr>
<td>099.50</td>
<td>Other venereal diseases due to chlamydia trachomatis unspecified site</td>
</tr>
<tr>
<td>099.51</td>
<td>Other venereal diseases due to chlamydia trachomatis pharynx</td>
</tr>
<tr>
<td>099.52</td>
<td>Other venereal diseases due to chlamydia trachomatis anus and rectum</td>
</tr>
<tr>
<td>099.53</td>
<td>Other venereal diseases due to chlamydia trachomatis lower genitourinary sites</td>
</tr>
<tr>
<td>099.54</td>
<td>Other venereal diseases due to chlamydia trachomatis other genitourinary sites</td>
</tr>
<tr>
<td>099.55</td>
<td>Other venereal diseases due to chlamydia trachomatis unspecified genitourinary site</td>
</tr>
<tr>
<td>099.56</td>
<td>Other venereal diseases due to chlamydia trachomatis peritoneum</td>
</tr>
<tr>
<td>099.59</td>
<td>Other venereal diseases due to chlamydia trachomatis other specified site</td>
</tr>
<tr>
<td>099.8</td>
<td>Other specified venereal diseases</td>
</tr>
</tbody>
</table>
| 099.9 | Venereal disease unspecified diseases due to or propagated by sexual contact. Any contagious disease acquired during sexual contact; e.g. syphilis, gonorrhea,
chancroid.

V73.88 Other specified chlamydial diseases
V73.98 Unspecified chlamydial disease
V76.2 Special screening for malignant neoplasms; Cervix

Radiology Services

Radiology services may be reimbursed separately when performed in conjunction with the initial or annual examinations. Refer to Table 18 for a list of billable radiology procedure codes under the Family Planning program.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>71010</td>
<td>Radiologic examination, chest; single view, frontal</td>
</tr>
<tr>
<td>71020</td>
<td>Radiologic examination, chest, 2 views, frontal and lateral;</td>
</tr>
<tr>
<td>72190</td>
<td>Radiologic examination, pelvis; complete, minimum of 3 views</td>
</tr>
<tr>
<td>74000</td>
<td>Radiologic examination, abdomen; single anteroposterior view</td>
</tr>
<tr>
<td>74740</td>
<td>Hysterosalpingography, radiological supervision and interpretation</td>
</tr>
<tr>
<td>74742</td>
<td>Transcervical catheterization of fallopian tube, radiological supervision and interpretation</td>
</tr>
<tr>
<td>76830</td>
<td>Ultrasound, transvaginal</td>
</tr>
<tr>
<td>76856</td>
<td>Ultrasound, pelvic (nonobstetric), real time with image documentation; complete</td>
</tr>
<tr>
<td>76857</td>
<td>Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)</td>
</tr>
<tr>
<td>76870</td>
<td>Ultrasound, scrotum and contents</td>
</tr>
<tr>
<td>76872</td>
<td>Ultrasound, transrectal</td>
</tr>
<tr>
<td>76998</td>
<td>Ultrasonic guidance, intraoperative</td>
</tr>
</tbody>
</table>

Laboratory Procedures

Laboratory services may be reimbursed separately when performed in conjunction with the initial or annual examinations. A list of family planning covered laboratory procedure codes is listed in Table 19.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>G0123</td>
<td>Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision</td>
</tr>
<tr>
<td>80048</td>
<td>Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310), Carbon dioxide (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)</td>
</tr>
<tr>
<td>80050</td>
<td>General health panel This panel must include the following: Comprehensive metabolic panel (80053), Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004), OR, Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009), Thyroid stimulating hormone (TSH) (84443)</td>
</tr>
<tr>
<td>80051</td>
<td>Electrolyte panel This panel must include the following: Carbon dioxide (82374), Chloride (82435), Potassium (84132), Sodium (84295)</td>
</tr>
<tr>
<td>80053</td>
<td>Comprehensive metabolic panel This panel must include the following: Albumin (82040), Bilirubin, total (82247), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphatase, alkaline (84075), Potassium (84132), Protein, total (84155), Sodium (84295), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450), Urea nitrogen (BUN) (84520)</td>
</tr>
<tr>
<td>80061</td>
<td>Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)</td>
</tr>
<tr>
<td>80074</td>
<td>Acute hepatitis panel This panel must include the following: Hepatitis A antibody (HAAb), IgM antibody (86709), Hepatitis B core antibody (HBCAb), IgM antibody (86705), Hepatitis B surface antigen (HBsAg) (87340), Hepatitis C antibody (86803)</td>
</tr>
<tr>
<td>80076</td>
<td>Hepatic function panel This panel must include the following: Albumin (82040), Bilirubin, total (82247), Bilirubin, direct (82248), Phosphatase, alkaline (84075), Protein, total (84155), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450)</td>
</tr>
<tr>
<td>81000</td>
<td>Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy</td>
</tr>
<tr>
<td>81001</td>
<td>Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy</td>
</tr>
<tr>
<td>81002</td>
<td>Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>81003</td>
<td>Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy</td>
</tr>
<tr>
<td>81005</td>
<td>Urinalysis; qualitative or semiquantitative, except immunoassays</td>
</tr>
<tr>
<td>81007</td>
<td>Urinalysis; bacteriuria screen, except by culture or dipstick</td>
</tr>
<tr>
<td>81015</td>
<td>Urinalysis; microscopic only</td>
</tr>
<tr>
<td>81025</td>
<td>Urine pregnancy test, by visual color comparison methods</td>
</tr>
<tr>
<td>82120</td>
<td>Amines, vaginal fluid, qualitative</td>
</tr>
<tr>
<td>82270</td>
<td>Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)</td>
</tr>
<tr>
<td>82465</td>
<td>Cholesterol, serum or whole blood, total</td>
</tr>
<tr>
<td>82565</td>
<td>Creatinine; blood</td>
</tr>
<tr>
<td>82670</td>
<td>Estradiol</td>
</tr>
<tr>
<td>82728</td>
<td>Ferritin</td>
</tr>
<tr>
<td>82746</td>
<td>Folic acid; serum</td>
</tr>
<tr>
<td>82947</td>
<td>Glucose; quantitative, blood (except reagent strip)</td>
</tr>
<tr>
<td>82948</td>
<td>Glucose; blood, reagent strip</td>
</tr>
<tr>
<td>82950</td>
<td>Glucose; post glucose dose (includes glucose)</td>
</tr>
<tr>
<td>82951</td>
<td>Glucose; tolerance test (GTT), 3 specimens (includes glucose)</td>
</tr>
<tr>
<td>83001</td>
<td>Gonadotropin; follicle stimulating hormone (FSH)</td>
</tr>
<tr>
<td>83002</td>
<td>Gonadotropin; luteinizing hormone (LH)</td>
</tr>
<tr>
<td>83020</td>
<td>Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F)</td>
</tr>
<tr>
<td>83026</td>
<td>Hemoglobin; by copper sulfate method, non-automated</td>
</tr>
<tr>
<td>83036</td>
<td>Hemoglobin; glycosylated (A1C)</td>
</tr>
<tr>
<td>83518</td>
<td>Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, single step method (eg, reagent strip)</td>
</tr>
<tr>
<td>83901</td>
<td>Molecular diagnostics; amplification, target, multiplex, each additional nucleic acid sequence beyond 2 (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>83986</td>
<td>pH; body fluid, not otherwise specified</td>
</tr>
<tr>
<td>84144</td>
<td>Progesterone</td>
</tr>
<tr>
<td>84146</td>
<td>Prolactin</td>
</tr>
<tr>
<td>84181</td>
<td>Protein; Western Blot, with interpretation and report, blood or other body fluid</td>
</tr>
<tr>
<td>Code</td>
<td>Test Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>84443</td>
<td>Thyroid stimulating hormone (TSH)</td>
</tr>
<tr>
<td>84450</td>
<td>Transferase; aspartate amino (AST) (SGOT)</td>
</tr>
<tr>
<td>84478</td>
<td>Triglycerides</td>
</tr>
<tr>
<td>84702</td>
<td>Gonadotropin, chorionic (hCG); quantitative</td>
</tr>
<tr>
<td>84703</td>
<td>Gonadotropin, chorionic (hCG); qualitative</td>
</tr>
<tr>
<td>85002</td>
<td>Bleeding time</td>
</tr>
<tr>
<td>85004</td>
<td>Blood count; automated differential WBC count</td>
</tr>
<tr>
<td>85007</td>
<td>Blood count; blood smear, microscopic examination with manual differential WBC count</td>
</tr>
<tr>
<td>85008</td>
<td>Blood count; blood smear, microscopic examination without manual differential WBC count</td>
</tr>
<tr>
<td>85009</td>
<td>Blood count; manual differential WBC count, buffy coat</td>
</tr>
<tr>
<td>85013</td>
<td>Blood count; spun microhematocrit</td>
</tr>
<tr>
<td>85014</td>
<td>Blood count; hematocrit (Hct)</td>
</tr>
<tr>
<td>85018</td>
<td>Blood count; hemoglobin (Hgb)</td>
</tr>
<tr>
<td>85025</td>
<td>Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count</td>
</tr>
<tr>
<td>85027</td>
<td>Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)</td>
</tr>
<tr>
<td>85032</td>
<td>Blood count; manual cell count (erythrocyte, leukocyte, or platelet) each</td>
</tr>
<tr>
<td>85041</td>
<td>Blood count; red blood cell (RBC), automated</td>
</tr>
<tr>
<td>85048</td>
<td>Blood count; leukocyte (WBC), automated</td>
</tr>
<tr>
<td>85049</td>
<td>Blood count; platelet, automated</td>
</tr>
<tr>
<td>85610</td>
<td>Prothrombin time;</td>
</tr>
<tr>
<td>85651</td>
<td>Sedimentation rate, erythrocyte; non-automated</td>
</tr>
<tr>
<td>85652</td>
<td>Sedimentation rate, erythrocyte; automated</td>
</tr>
<tr>
<td>85660</td>
<td>Sickling of RBC, reduction</td>
</tr>
<tr>
<td>85730</td>
<td>Thromboplastin time, partial (PTT); plasma or whole blood</td>
</tr>
<tr>
<td>86580</td>
<td>Skin test; tuberculosis, intradermal</td>
</tr>
</tbody>
</table>

**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 12-15-46 – Medicaid Waivers and State Plan Amendments

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

405 IAC 5-24-7 – Pharmacy services – copayment for legend and non-legend drugs

405 IAC 5-22-3 – Nursing and therapy services – certified nurse midwife services

IHCP Provider Bulletins

BT201429

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Clinic Services – Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Healthwatch Program

Evaluation and Management

Family Planning

Gynecology Services
Freestanding Birthing Centers

Introduction

This section serves as a general summary of the IHCP’s policies regarding freestanding birthing center services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

A freestanding birthing center as defined by IC 16-18-2-36.5 and 410 IAC 27-1-3, is a licensed, freestanding entity that has the sole purpose of delivering a normal or uncomplicated pregnancy. This term does not include a hospital under IC 16-21-2, an ambulatory surgical center, or the residence of the woman giving birth.

Freestanding birth centers are licensed to provide care during pregnancy, birth, and the immediate postpartum period to the low-risk expectant mother and her newborn. Each center shall admit and retain only low-risk expectant mothers anticipating a normal full-term, spontaneous vaginal birth.

Reimbursement Requirements

The IHCP provides reimbursement for services and supplies furnished by an IHCP enrolled freestanding birthing center for the delivery and care of the mother and newborn child when the service is provided by a licensed free standing birthing center in compliance with all IHCP guidelines.

The IHCP reimburses the free standing birthing center at a flat rate for the facility, nursing care, the cost of most medical and nonmedical supplies and equipment.

Providers eligible to render services in a freestanding birthing center include physicians and licensed certified nurse midwives (CNMs). Other staff services such as registered nurses (RNs), licensed nurse practitioners (LPNs), and other birth attendants are included in the delivery rate. Professional changes are reimbursed directly to the professional practitioner at the applicable reimbursement rate effective as of the date of service.

Services provided in a birthing center shall be limited in the following manner:

- Recipients must be considered low-risk, normal or having an uncomplicated pregnancy as defined in 410 IAC 27-1-15.5
• Delivery shall be performed by a:
  ➢ certified nurse midwife; or
  ➢ physician.
• Surgical services are limited to episiotomy and episiotomy repair; and shall not include operative obstetrics or cesarean sections.
• Labor shall not be inhibited, stimulated or augmented with chemical agents during the first or second stage of labor.
• Systemic analgesia may be administered and local anesthesia for pudendal block and episiotomy repair may be performed.
• General and conductive anesthesia shall not be administered at birthing centers.
• Recipients shall not routinely remain in the facility in excess of twenty-four (24) hours.

Prior Authorization Requirements
PA is not required for freestanding birthing centers.

Billing Requirements
Physicians and certified nurse midwives may render services to low-risk women that could ordinarily be performed in a physician’s office setting such as prenatal care, family planning and newborn screening visits. Medicaid reimbursement is not available for facility charges if the services provided are such that they ordinarily could have been provided in a physician's office. Such services provided outside a physician's office will be reimbursed at the fee allowed for the same service provided in the office.

Birthing centers report all services inclusive, using revenue code 724 – Birthing Center on the UB-04 form. This applies to vaginal deliveries only. When labor occurs but does not result in delivery, providers should bill revenue code 724, along with Healthcare Common Procedure Coding System (HCPCS) code S4005 interim labor facility global (labor occurring but not resulting in delivery).

Professional services rendered at birthing centers are billed on a CMS-1500 Professional claim form or the HIPAA 837P transaction. Services rendered by the following rendering provider types and specialty are payable when performed at birthing centers:
  • Rendering Provider Type 09 – Advanced practice nurse with rendering provider specialty 095 – Certified nurse mid-wife
  • Rendering Provider Type 31 – Physician

Birthing center services are to be billed with place-of-service code 25 – Birthing center.
Rules, Citations and Sources

IC 16-18-2-36.5 – Birthing center

405 IAC 5-16.5 – Freestanding Birthing Centers

410 IAC 27 – Birthing Centers

IHCP Bulletins

BT201158 - The IHCP to allow birthing centers, CORFs, and IDTFs to enroll as Medicaid providers

BT201206 - The IHCP to allow birthing centers to enroll as Medicaid providers

IHCP Provider Manual


Related Medical Topics

Gynecology Services

Obstetric Care

Nursing Services
Gastroenterology

Introduction
This section serves as a general summary of the IHCP’s policies regarding gastroenterology. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service
Gastrointestinal disorders are disorders that affect the digestive system, including but not limited to the esophagus, stomach, and small 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, CT/ 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.

- **CT/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.

Reimbursement Requirements
IHCP reimbursement is available for medically necessary GI services for the evaluation, diagnosis, and treatment of such disorders.
Prior Authorization Requirements

Services must be medically reasonable and necessary, and required for the care and well-being of the member. Services must be provided according to generally accepted standards of medical or professional practice. Gastroplasty and GI surgeries require PA. Services rendered without appropriate PA are not covered. Refer to “Related Medical Topics” later in this section and to the IHCP Provider Manual for specific procedure requirements and limitations.

The following information describes the coverage for two diagnostic examinations – CT and upper GI studies. Services rendered outside of these guidelines are not covered.

CT

Diagnostic examinations performed by CT scanners are covered services and do not require PA in Indiana. 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 FDA.
- CT scans for the treatment of cancer, whole abdomen, or whole pelvis areas (greater than 20 cuts) are reimbursable.

MRI

Diagnostic examinations performed by MRI are covered services and do not require PA in Indiana. These examinations are subject to the following guidelines:

- The scan should be reasonable and necessary for the individual member.
- The use of a MRI must be found to be medically appropriate considering the member’s symptoms and preliminary diagnosis.

Upper Gastrointestinal Studies

Medicaid reimbursement is available for upper GI studies when performed for the detection and evaluation of diseases of the esophagus, stomach, and duodenum. These specific studies are covered and do not require PA in Indiana.

- An upper GI study is not a covered service for a patient with a history of duodenal or gastric ulcer disease, unless the patient is 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

The IHCP will allow CPT® code 91110 – Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with physician interpretation and report, to be reported with revenue code 329 – Diagnostic radiology, other, for outpatient hospital procedures.

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

Rules, Citations, and Sources

405 IAC 5-3-13 – Services requiring PA
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; non-covered services

IHCP Bulletin

   BT200306 – All Pharmacy Providers and Prescribing Practitioners

IHCP Banner Page

   BR200513 – Gastrointestinal Tract Imaging

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Not applicable
Genetic Testing - Overview

Introduction

This section serves as a general overview of the IHCP’s policies regarding genetic testing. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Services

Per The National Human Genome Research Institute, “The term "genetic testing" covers an array of techniques including analysis of human DNA, RNA or protein. Genetic tests are used as a health care tool to detect gene variants associated with a specific disease or condition, as well as for non-clinical uses such as paternity testing and forensics. In the clinical setting, genetic tests can be performed to confirm a suspected diagnosis, to predict the possibility of future illness, to detect the presence of a carrier state in unaffected individuals (whose children may be at risk), and to predict response to therapy. They are also performed to screen fetuses, newborns or embryos used in in-vitro fertilization for genetic defects.”

Reimbursement Requirements

The IHCP provides reimbursement for a variety of genetic tests when the service is provided with in compliance with all IHCP guidelines, including obtaining Prior Authorization when required. Guidelines pertaining to ALL genetic testing are as follows:

- The genetic disorder is associated with a potentially significant disability; and
- The risk of the significant disability from the genetic disorder cannot be identified through biochemical or other testing (e.g. ultrasound screening for aortic disease in Marfan’s); and
- A specific mutation, or set of mutations, has been established in the scientific literature to be reliably associated with the disease; and
- The results of the genetic test could impact the medical management of the individual with improved net health outcomes; and
No determinable diagnosis can be gathered from the history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies.

Genetic testing is not covered in the following circumstances:

- For the sole convenience of information for the patient without impacting treatment
- All screening tests, except those listed under the Newborn Screening.
- The test is performed for the medical management of other family members unless otherwise specified.
- History, physical examination, pedigree analysis, genetic counseling, or completion of conventional diagnostic studies has given a definitive diagnosis.
- If a genetic test has previously been performed in order to provide a conclusive diagnosis of the same genetic disorder
- The establishment of paternity

Other guidelines vary based on the category of the genetic test. These categories are Molecular Genetics, Cytogenetics, and Multiple-Analyte Assays with Algorithmic Analyses (MAAA).

**Molecular Pathology**

Molecular pathology procedures are medical laboratory procedures involving the analyses of nucleic acid to detect variants in genes that may be indicative of germline (e.g., constitutional disorders) or somatic (e.g., neoplasia) conditions, or to test for histocompatibility antigens (e.g., HLA). This is the largest group of genetic tests.

Many molecular genetic tests are covered by Indiana Medicaid. In order to be reimbursed for these services, all tests must meet the general criteria; and

- Meet all test specific American College of Medical Genetics guidelines; and
- Receive appropriate Prior Authorization if required

**Cytogenetics**

The National Human Genome Research Institute defines cytogenetics as “the branch of genetics that studies the structure of DNA within the cell nucleus. This DNA is condensed during cell division and form chromosomes. The cytogenetic studies the number and morphology of chromosomes. Using chromosome banding techniques (classical cytogenetics) or hybridization fluorescently labeled probes (molecular cytogenetics).”

Most cytogenetic tests are covered by Indiana Medicaid. In order to be reimbursed for these services, all tests must meet the general criteria; and
Meet all test specific American College of Medical Genetics guidelines; and

Receive appropriate Prior Authorization if required

**Multi-analyte Assays with Algorithmic Analyses (MAAA)**

Multianalyte Assays with Algorithmic Analyses (MAAAs) are procedures that utilize multiple results derived from assays of various types, including molecular pathology assays, fluorescent in situ hybridization assays, and non-nucleic acid-based assays (eg, proteins, polypeptides, lipids, carbohydrates). Algorithmic analysis using the results of these assays as well as other patient information is then performed and reported typically as a numeric score(s) or a probability.

Multi-analyte Assays with Algorithmic Analyses (MAAA) are non-covered by Indiana Medicaid, unless specifically stated, as they do not provide a definitive diagnosis or change the course of treatment.

**Genetic Tests for Cancer Susceptibility**

Several genetic tests exist for a determination or risk score associated with inheritable cancer susceptibility, such as BRCA or HNPCC testing. Providers should check the online Fee Schedule for coverage of specific tests. Cancer susceptibility genetic testing is covered when the general criteria AND the following conditions are met:

- A specific mutation, or set of mutations, has been established in the scientific literature to be reliably associated with the risk of developing malignancy; AND
- The results of the genetic test must potentially affect at least one of the management options considered by the referring physician in accordance with accepted standards of medical care. This includes any one of the following list:
  - Surgery, or the extent of surgery; OR
  - A change in surveillance; OR
  - Hormonal manipulation; OR
  - A change from standard therapeutic or adjuvant chemotherapy.

In addition, any specific policy requirements set forth in individual policies are also required.

**Genetic Testing Panels**

Genetic testing panels are non-covered for Traditional Medicaid.

**Prior Authorization Requirements**

Prior Authorization is always required unless otherwise noted within the Indiana Medicaid fee schedule or by test specific policy.
Prior Authorization is test specific and providers must follow all American College of Medical Genetics guidelines if available. If no guidelines are available, then providers should follow commonly accepted medical guidelines (eg, Amsterdam II or revised Bethesda guidelines for hereditary non-polyposis colorectal cancer [HNPCC]) and all other requirements must still be met. The following documentation must be submitted for Prior Authorization review:

- Documentation outlining medical necessity, specifically stating the impact on the patient’s treatment
- Documentation that genetic counseling has been performed prior to testing
- Results from any commonly used conventional diagnostic testing showing inconclusive diagnosis
- All other required documentation for general Prior Authorization

**Billing Requirements**

Providers are reminded that each genetic test specific to a gene or diagnosis is limited to once per member, per lifetime unless otherwise specified. For procedure codes not related to a specific gene or condition must have medical documentation kept on file showing the testing is for a separate and distinct diagnosis.

Providers should refer to the online Indiana Medicaid fee schedule, IHCP Provider Manual, or individual policies for billing guidelines.

**Rules, Citations, and Sources**

405 IAC 5-18 Laboratory Services

INHCP Provider Manual

*Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp).*

**Related Medical Topics**

Section XX: Genetic Testing - Oncotype Dx® Testing for Breast Cancer
Section XX: Genetic Testing – Breast Cancer Susceptibility Gene 1 (BRCA1) and Breast Cancer Susceptibility Gene 2 (BRCA2) for Breast and Ovarian Cancer
Section XX: Genetic Testing – Chromosomal Microarray Analysis
Genetic Testing – Breast Cancer Susceptibility Gene 1 (BRCA1) and Breast Cancer Susceptibility Gene 2 (BRCA2) for Breast and Ovarian Cancer

Introduction
This section serves as a general summary of the IHCP’s policies regarding BRCA1 and BRCA2 genetic testing. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service
Two genes (BRCA1 and BRCA2) 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.

Reimbursement Requirements
The IHCP provides reimbursement for BRCA1 and BRCA2 genetic testing when it is determined to be medically necessary for members with a personal history of breast cancer, contralateral disease (disease in the opposite breast), or families with a 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:

- Relatives with breast, ovarian, and other relevant cancers, such as prostate and colon cancer
- Age at diagnosis in affected family members

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

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4 The acronym BRCA has been given to the genes that are specific to breast and ovarian cancer.
• Other significant factors, such as ethnic background

Definitions

Please note for the purpose of this policy:

• Close blood relatives are first, second, and third degree relatives as defined below:
  ➢ First degree relatives include parents, siblings and offspring
  ➢ Second degree relatives include half-brothers/sisters, aunts/uncles, grandparents, grandchildren, and nieces/nephews affected on the same side of the family
  ➢ Third degree relatives include first cousins, great-aunt/uncles, great-grandchildren and great grandparents affected on the same side of the family

• A breast cancer diagnosis includes either invasive or non-invasive (ductal carcinoma in situ) types.

• Ovarian cancer also includes fallopian tube cancers and primary peritoneal carcinoma.

• Persons are NOT considered to have a limited family history unless they have fewer than two first-degree or second-degree female relatives or female relatives surviving beyond 45 years of age on either side of the family.

• Two breast primary cancers include cancers appearing at the same time (synchronous) and one is not a metastasis of the other, or primary cancers developing at intervals (metachronous). The tumors may be in one or two breasts.

• Hereditary Breast Ovarian Cancer Syndrome (HBOC)-associated malignancies include prostate cancer, pancreatic cancer, or melanoma. The presence of these malignancies does not necessarily justify BRCA testing. For example, a female with breast cancer over age 50 whose sister had melanoma at 40 and whose father has prostate cancer would meet criteria. In another example a female with breast cancer over age 50 whose maternal aunt had pancreatic cancer and whose paternal uncle had prostate cancer would not meet criteria because the aunt and uncle are on different sides of the family.

• Triple-negative breast cancer refers to any breast cancer that does not express the genes for estrogen receptor (ER), progesterone receptor (PR) or HER2/neu. This subtype of breast cancer is clinically characterized as more aggressive and less responsive to standard treatment and is associated with poorer overall patient prognosis. It is diagnosed more frequently in younger women, women with BRCA1 mutations and those belonging to African-American and Hispanic ethnic groups.
Prior Authorization Requirements

The IHCP requires PA for genetic testing related to breast and ovarian cancer using the CPT® codes listed in Table 24.1, when medically necessary as described below.

Individuals with a personal history of at least one of the following (no family history required):

- Breast cancer diagnosis at age 45 or younger with or without family history; OR
- Breast cancer diagnosis at age 50 or younger with:
  - Two breast primary cancers, with the first breast cancer diagnosis occurring prior to age 50; OR
  - At least one close blood relative(s) with breast cancer at or before age 50; OR
  - At least one blood relative(s) with epithelial ovarian/fallopian tube/primary peritoneal cancer; OR
  - Diagnosed before age 50 with a limited family history, as defined as few than 2 first- or second- degree female relatives or female relatives surviving beyond 45 years of age in either lineage..

- Breast cancer diagnosed at any age with:
  - Two breast primary cancers in a single individual with at least one close blood relative with breast cancer diagnosed at age 50 or younger; OR
  - Two breast primary cancers in a single individual with at least one close blood relative with epithelial ovarian/fallopian tube/primary peritoneal cancer; OR
  - Diagnosed at any age, with at least 2 blood relatives with breast and/or epithelial ovarian/fallopian tube/primary peritoneal cancer; OR
  - Close male blood relative with breast cancer; OR
  - A close relative with a known BRCA1 or BRCA 2 gene mutation; OR
  - At least two close blood relatives on the same side of the family with other HBOC syndrome associated malignancies (prostate, pancreatic, melanoma); OR
  - Ashkenazi Jewish or ethnic groups associated with higher mutation frequency.

- Diagnosed before age 60 with a triple negative breast cancer (ER-, PR-, HER2-)
• Personal history of epithelial ovarian/fallopian tube/primary peritoneal cancer

• Men rarely develop breast cancer. 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.\(^5\). BRCA 1 and BRCA 2 testing is not medically necessary to assess the risk of breast or prostate cancer in men without breast cancer.

  ➢ Personal history of male breast cancer; OR
  ➢ To assess the man’s risk of recurrent breast cancer; OR
  ➢ To assess the breast cancer risk of a female member when the affected male is a first- or second-degree blood relative of that member.

• Individuals with Ashkenazi (Eastern European) Jewish ancestry with invasive breast cancer at any age, or meeting any of the above criteria.

Providers must submit documentation with the PA request and must maintain the documentation in the member’s medical record:

**Billing Requirements**

The IHCP provides reimbursement for BRCA1 and BRCA2 genetic testing billed with the appropriate HCPCS codes, noted in Table 1.

**Table 1 – HCPCS Codes for Reporting Genetic Testing For Breast and Ovarian Cancer – Diagnosis Only**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81211</td>
<td>BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)</td>
</tr>
<tr>
<td>81212</td>
<td>BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants</td>
</tr>
<tr>
<td>81213</td>
<td>BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; uncommon duplication/deletion variants</td>
</tr>
<tr>
<td>81214</td>
<td>BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)</td>
</tr>
</tbody>
</table>

\(^5\) 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.
CPT codes 81211-81217 are limited to once per lifetime. If the IHCP has provided reimbursement for CPT code 81211, 81214, or 81216, the IHCP will not reimburse 81212, 81213, 81215, or 81217, because 81211, 81214, and 81216 represents complete BRCA1 and BRCA2 gene sequence analysis.

Rules, Citations, and Sources

IAC – 405 IAC 5-3-13 – Services requiring prior authorization

405 IAC 5-25 – Physician services

IHCP Bulletin

   BT200605 – Billing Requirements and PA Criteria

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Laboratory Services

Oncology – Breast and Cervical Cancer Program
Genetic Testing – Chromosomal Microarray Analysis

Introduction

This section serves as a general summary of the IHCP’s policies regarding Chromosomal Microarray Analysis genetic testing services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCO or plan administrator for more specific guidelines regarding their policies and PA procedures.

Description of Service

CMA testing is considered a first-line test in postnatal evaluation of individuals with unexplained developmental delay/intellectual delay (DD/ID) or Autism Spectrum Disorder (ASD) and multiple cognitive abnormalities not specific to a well defined genetic syndrome.

Reimbursement Requirements

The IHCP provides reimbursement for CMA testing when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization (PA). The IHCP covers CMA testing when it is determined to be medically necessary for diagnosing a genetic abnormality in children with apparent nonsyndromic cognitive DD/ID or ASD, according to the latest accepted Diagnostic and Statistical Manual Disorders guidelines.

CMA testing is not considered medically necessary and will not be covered under the following circumstances:

- To confirm the diagnosis of a disorder or syndrome that is routinely diagnosed based on clinical evaluation alone
- For prenatal genetic testing
- For the screening, diagnosis, and management of hematologic or oncologic malignancies
- As a means to predict or evaluate pregnancy loss
- In cases of family history of chromosome rearrangement in a phenotypically normal individual
- All other cases of suspected genetic abnormality in children with DD/ID or ASD
Prior Authorization Requirements

The IHCP requires prior authorization (PA) for CMA testing. To obtain PA for the CPT codes listed in Table 1, all the following conditions must be met:

- Any indicated biochemical tests for metabolic disease have been performed, and results are nondiagnostic.
- FMR1 gene analysis (for Fragile X), when clinically indicated, is negative.
- In addition to a diagnosis of nonsyndromic DD/ID or ASD, the child has one or more of the following (see definitions following the requirements)
  - Two or more major malformations
  - A single major malformation or multiple minor malformations in an infant or child who is also small-for-dates
  - A single major malformation and multiple minor malformations
  - The results for the genetic testing have the potential to impact the clinical management of the patient.
  - Testing is requested after the parent(s) have been engaged in face-to-face genetic counseling with a healthcare professional who is licensed under Indiana Code Article 25-17.3.

Definitions

Definitions from the American College of Medical Genetics Guidelines, Evaluation of the Newborn with Single or Multiple Congenital Abnormalities:

- A malformation refers to abnormal structural development.
- A major malformation is a structural defect that has a significant effect on function or social acceptability, e.g. ventricular septal defect or cleft lip.
- A minor malformation is a structural abnormality that has a minimal effect on function or social acceptance, e.g. preauricular ear pit or partial syndactyly (fusion) of the second or third toes.
- A syndrome is a recognizable pattern of multiple malformations. Syndrome diagnoses are often relatively straightforward and common enough to be clinically recognized without specialized testing. Examples include Down Syndrome, neural tube defects, and achondroplasia. However, in the very young, or in the case of symptoms with variable presentation, confident identification may be difficult without additional testing.
Billing Requirements

Reimbursement requires compliance with all IHCP billing guidelines, including obtaining appropriate referrals for recipients enrolled in managed care programs. Providers must bill using the appropriate procedure code. 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.

The IHCP reimburses for CMA testing when billed with the appropriate procedure codes, as listed in Table 1. Covered codes will be linked to revenue code 310 to allow for hospital-based laboratory billing. CMA testing will be limited to one unit per recipient, per lifetime. Codes 81228 and 81229 cannot be billed together. Testing cannot be reported using a combination of molecular diagnostic codes (83890-83913) and array-based evaluation of molecular probes codes (88384-88386).

Table 1 – Codes covered for CMA genetic testing

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81228</td>
<td>Cytogenetic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (e.g., Bacterial Artificial Chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)</td>
</tr>
<tr>
<td>81229</td>
<td>Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities</td>
</tr>
</tbody>
</table>

For additional information on billing requirements, please refer to Chapter 8 of the IHCP Provider Manual or visit www.indianamedicaid.com.

Rules, Citations and Sources

IHCP BulletinPage

**BT201408** – Chromosomal Microarray Analysis genetic testing to be an IHCP covered service

*Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp).*
Genetic Testing – Oncotype DX® Testing for Breast Cancer

Introduction

This section serves as a general summary of the IHCP’s policies regarding Oncotype DX genetic testing of breast cancer tumors. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCO or plan administrator for more specific guidelines regarding their policies and PA procedures.

Description of Service

The Oncotype DX breast cancer test is a test that examines a breast cancer patient’s tumor tissue at a molecular level and gives information about a patient’s individual disease. This information can help individualize breast cancer treatment planning and identify options. The Oncotype DX gene expression assay is intended to be used by women with early-stage (stage I or II), node-negative, estrogen receptor-positive (ER+) invasive breast cancer who will be treated with therapy.

Reimbursement Requirements

The IHCP provides reimbursement for Oncotype DX services when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization (PA). The IHCP covers Oncotype DX when it is considered medically necessary for managing the treatment of breast cancer. The 21-gene RT-PCR assay should only be ordered after surgery and subsequent pathological examination of the tumor have been completed. The test should be ordered in the context of a provider-patient discussion regarding risk preferences when the test result will aid in making decisions regarding chemotherapy.

Gene expression profiling as a technique of managing the treatment of breast cancer is considered investigational and not medically necessary when a gene profiling test other than the Oncotype DX Breast Cancer Assay is being used, including but not limited to:

- Breast Cancer Gene Expression Ratio (also known as Theros H/ISM)
- Breast Cancer IndexSM
- Insight® DX Breast Cancer Profile
- MammaPrint® (also referred to as the "Amsterdam signature" or "70-gene signature")
• Mammostrat
• Oncotype DX DCIS
• PAM50 Breast Cancer Intrinsic Classifier™
• The 41-gene signature assay
• The 76-gene “Rotterdam signature” assay
• THEROS Breast Cancer IndexSM

Gene expression profiling as a technique of managing the treatment of ductal carcinoma in situ (DCIS) is considered investigational and not medically necessary under all circumstances.

Repeat gene expression profiling with the Oncotype DX Breast Cancer Assay for the same tumor, such as a metastatic focus, or from more than one site when the primary tumor is multifocal is considered investigational and not medically necessary.

**Prior Authorization Requirements**

The IHCP requires prior authorization (PA) for Oncotype DX. To obtain PA for code S3854, all the following criteria must be met:

• Individual has had surgery and full pathological evaluation of the specimen has been completed.
• Histology is ductal, lobular, mixed, or metaplastic.
• Histology is not tubular or colloid.
• Estrogen receptor is positive (ER+), or progesterone receptor is positive (PR+), or both.
• HER2 receptor is negative.
• pN0 (node negative) or pN1mi with axillary lymph node micrometastasis is less than or equal to 2mm.
• Individual has one of the following:
  • Tumor size 0.6-1.0 cm moderate/poorly differentiated
  • Tumor size 0.6-1.0 cm well-differentiated with any of the following unfavorable features: angiolymphatic invasion, or high nuclear grade, or high histologic grade
  • Tumor size greater than 1.0 cm and less than or equal to 4.0 cm
  • Individual does not have a pT4 lesion.
• Chemotherapy is a therapeutic option being considered and will be supervised by the practitioner ordering the gene expression profile.
Gene expression profiling with the Oncotype DX Breast Cancer Assay as a technique of managing the treatment of breast cancer is considered not medically necessary when the criteria listed have not been met.

**Billing Requirements**

Reimbursement requires compliance with all IHCP billing guidelines, including obtaining appropriate referrals for recipients enrolled in managed care programs. Providers must bill using the appropriate procedure code. 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.

Oncotype DX genetic testing of breast cancer tumors services may be billed with procedure code S3854 – Gene expression profiling panel for use in the management of breast cancer treatment. is linked to revenue codes 300, 301, 309, 310, and 319.

For additional information on billing requirements, please refer to Chapter 8 of the IHCP Provider Manual or visit www.indianamedicaid.com.

**Rules, Citations and Sources**

*IHCP Bulletin*

**BT2014086** – Oncotype DX® genetic testing for breast cancer to be an IHCP covered service

*Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp).*

**Related Medical Topics**
Gynecology Services

Introduction
This section serves as a general summary of the IHCP’s policies regarding gynecology services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service
Gynecology services are provided to women, particularly for the diagnosis and treatment of disorders affecting the female reproductive organs. Treatment begins with thorough diagnosis to evaluate the condition and its causes. Gynecologists provide care for women of all ages and have the knowledge to address a full span of health conditions related to the female reproductive system, including but not limited to:

- Cancers (cervical, ovarian, uterine)
- Cervical dysplasia
- Endometriosis
- Excessively heavy menstrual bleeding
- Fibroids
- Infertility
- Menopause and post-menopausal symptoms
- Pelvic floor disorders
- Pelvic pain
- Urinary incontinence
- Urogynecology
Reimbursement Requirements

Cervical Cancer Screenings

The IHCP follows the cervical cancer screening recommendations from the United States Preventative Services Task Force (USPSTF). The IHCP currently covers services including cytology (Pap test) and an HPV test, as well as medically necessary services such as the collection of the samples, screening by a cytotechnologist, and the physician’s interpretation of the test results. The USPSTF has concluded most cases of cervical cancer occur in women who are not adequately screened. The USPSTF recommends cervical cancer screenings for women aged 21 to 65 with cytology every three years. For women aged 30 to 65 who want to lengthen the screening interval, screening with a combination of cytology and HPV testing is recommended every five years.

For repeat testing, cytologic thresholds for further diagnostic testing (colposcopy) and treatments, and extended surveillance, the IHCP follows the recommendations established in the joint guidelines released by the American Cancer Society (ACS), the American Society for Colposcopy and Cervical Pathology (ASCCP), and the American Society for Clinical Pathology (ASCP).

Pelvic Examination

IHCP provides coverage for pelvic examinations (including breast examination) for female recipients, subject to certain frequency and other limitations. A pelvic examination screening should include at least seven of the following eleven elements:

- External genitalia (for example, general appearance, hair distribution, or lesions)
- Urethral meatus (for example, size, location, lesions, or prolapse)
- Urethra (for example, masses, tenderness, or scarring)
- Bladder (for example, fullness, masses, or tenderness)
- Vagina (for example, general appearance, estrogen effect, discharge lesions, pelvic support, cystocele, or rectocele)
- Cervix (for example, general appearance, lesions, or discharge)
- Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support)
- Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity)
- Anus and perineum

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
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.

**Hysterectomy**

The IHCP covers hysterectomy only when medically necessary, and only when the member has given informed consent. The provider must have informed the member orally and in writing that the procedure will render the member permanently incapable of reproducing, and the member must have signed a written acknowledgement of receipt of that information.

The member or member’s representative must sign an informed consent or acknowledgement except when the patient is already sterile or a life-threatening emergency exists for which the physician determines prior acknowledgement is not possible. However, the physician who performs the hysterectomy under these circumstances must complete the following requirements:

- Certify in writing that the individual was already sterile at the time the hysterectomy was performed.
- State the cause of the sterility at the time of the hysterectomy.
- Certify in writing that the hysterectomy was performed under a life-threatening emergency in which the physician determined that prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

The IHCP denies improperly completed acknowledgment statements. **Providers cannot use the sterilization consent form for hysterectomy procedures under any circumstances.**

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:

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

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.
**Prior Authorization Requirements**

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 noted.

**Table 1 – CPT® Codes for Reporting Total or Partial Hysterectomy**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>PA Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>45126</td>
<td>Pelvic exenteration for colorectal malignancy, with proctectomy [with or without colostomy], with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube[s], with or without removal of ovary[s], or any combination thereof</td>
<td>Yes</td>
</tr>
<tr>
<td>51597</td>
<td>Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof</td>
<td>Yes</td>
</tr>
<tr>
<td>51925</td>
<td>Closure of vesicouterine fistula; with hysterectomy</td>
<td>Yes</td>
</tr>
<tr>
<td>58150</td>
<td>Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)</td>
<td>Yes</td>
</tr>
<tr>
<td>58152</td>
<td>Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colposcopic urethrocystostomy (eg, Marshall-Marchetti-Krantz, Burch)</td>
<td>Yes</td>
</tr>
<tr>
<td>58180</td>
<td>Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)</td>
<td>Yes</td>
</tr>
<tr>
<td>58200</td>
<td>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)</td>
<td>Yes</td>
</tr>
<tr>
<td>58210</td>
<td>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)</td>
<td>Yes</td>
</tr>
<tr>
<td>58240</td>
<td>Pelvic exenertation for gynecologic malignancy, with total hysterectomy or cervicectomy, w/ removal of bladder</td>
<td>Yes</td>
</tr>
<tr>
<td>58260</td>
<td>Vaginal hysterectomy, for uterus 250 g or less;</td>
<td>Yes</td>
</tr>
<tr>
<td>58262</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)</td>
<td>Yes</td>
</tr>
<tr>
<td>58263</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele</td>
<td>Yes</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Allowed</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>58267</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with colpos-urethrocytostomy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control</td>
<td>Yes</td>
</tr>
<tr>
<td>58270</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocoele</td>
<td>Yes</td>
</tr>
<tr>
<td>58275</td>
<td>Vaginal hysterectomy, with total or partial vaginectomy</td>
<td>Yes</td>
</tr>
<tr>
<td>58280</td>
<td>Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocoele</td>
<td>Yes</td>
</tr>
<tr>
<td>58285</td>
<td>Vaginal hysterectomy, radical (Schauta type operation)</td>
<td>Yes</td>
</tr>
<tr>
<td>58290</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g;</td>
<td>Yes</td>
</tr>
<tr>
<td>58291</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
<td>Yes</td>
</tr>
<tr>
<td>58292</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocoele</td>
<td>Yes</td>
</tr>
<tr>
<td>58293</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with colpos-urethrocytostomy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control</td>
<td>Yes</td>
</tr>
<tr>
<td>58294</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocoele</td>
<td>Yes</td>
</tr>
<tr>
<td>58541</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less</td>
<td>Yes</td>
</tr>
<tr>
<td>58542</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)</td>
<td>Yes</td>
</tr>
<tr>
<td>58543</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g</td>
<td>Yes</td>
</tr>
<tr>
<td>58544</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)</td>
<td>Yes</td>
</tr>
<tr>
<td>58548</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)</td>
<td>Yes</td>
</tr>
<tr>
<td>58550</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;</td>
<td>Yes</td>
</tr>
<tr>
<td>58552</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
<td>Yes</td>
</tr>
<tr>
<td>58553</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;</td>
<td>Yes</td>
</tr>
<tr>
<td>58554</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
<td>Yes</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>PA</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>58570</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less</td>
<td>Yes</td>
</tr>
<tr>
<td>58571</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)</td>
<td>Yes</td>
</tr>
<tr>
<td>58572</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g</td>
<td>Yes</td>
</tr>
<tr>
<td>58573</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)</td>
<td>Yes</td>
</tr>
<tr>
<td>58951</td>
<td>Resection (initial) of ovarian, tubal, or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy; pelvic and limited para-aortic lymphadenectomy</td>
<td>Yes</td>
</tr>
<tr>
<td>58953</td>
<td>Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking</td>
<td>Yes</td>
</tr>
<tr>
<td>58954</td>
<td>Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy</td>
<td>Yes</td>
</tr>
<tr>
<td>58956</td>
<td>Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy</td>
<td>Yes</td>
</tr>
<tr>
<td>59135</td>
<td>Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy</td>
<td>Yes</td>
</tr>
<tr>
<td>59525</td>
<td>Subtotal or total hysterectomy after cesarean delivery (list separately in addition to code for primary procedure)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

PA will be granted for members with documentation supporting one of the following:

- Non-malignant uterine tumor causing abnormal pressure or bleeding (lasting longer than eight days for more than two cycles, requiring additional bleeding protection, defined as large clots and gushes, limiting activity).

- Non-malignant uterine tumor causing one of the following:
  - Uterus of 12-week gestational size or larger, with ill defined adnexa (less than 12-week gestational size, or less than 8 cm could have vaginal procedure)
  - Postmenopausal enlargement (more than 12-week gestational size necessitates abdominal procedure)
  - Rapid uterine growth over the last six months
  - Pressure on adjacent organs

  - 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

- Fibroids in premenopausal woman with both of the following:
  - Uterus greater than 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 US or intravenous pyelogram (IVP)
    - Other symptoms, such as pelvic or abdominal pain or discomfort without other explanation, urinary frequency or urgency, or dyspareunia

- Fibroids in postmenopausal woman with all of the following:
  - Uterus greater than 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

- 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 US
  - Pap smear within six months

- 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 US
  - Pap smear within six months

- Pelvic inflammatory disease (PID) with one of the following:
  - Suspected rupture or leakage of pelvic abscess
Unsuccessful management with antibiotics for 10 to 14 days
Surgery for residual, inactive but symptomatic disease, if conservative therapy is not possible.

- Chronic PID with both of the following:
  - Chronic pelvic pain
  - Adhesions, scarring, or hydrosalpinx

- Recurrent abnormal uterine bleeding (lasting longer than eight days for more than 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 those with intrauterine devices (IUDs).

- Chronic incapacitating pelvic pain, unresponsive to conservative therapy, such as analgesics, and evidence of normal GI/genitourinary (GU) evaluations.
  - A four- to six-month failed trial of oral contraceptives, diuretics, anti-inflammatories, or induced amenorrhea
  - Negative examinations of UT, GI tract, and musculoskeletal
  - Psychological and psychosexual counseling reveals no etiology of pain

- Postmenopausal bleeding more than one year after 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).

- Premalignant adenomatous hyperplasia or adenocarcinoma of the endometrium, confirmed by pathology report

- Postmenopausal (more than one year) with benign or malignant ovarian tumor and/or cyst

- Abdominal procedure when associated with abdominal procedure for correction of urinary stress incontinence or vaginal repair of cystocele, rectocele, enterocoele, or uterine prolapse

- Uncontrolled postpartum bleeding within six hours of delivery, uncontrolled by drug therapy (e.g., Pitocin, Methergine, or Prostaglandin therapy) or D&C

- Endometriosis uncontrolled by hormonal therapy (for example, depot medroxyprogesterone, oral contraceptives, Gonadotropin-releasing hormone [GnRH] agonist, or danazol), surgical ablation, or excision

- Tubo-ovarian abscess

- Urinary incontinence due to fistula into vagina, uterus, or perineum, and fistula demonstrated by cystoscopy, radiological examination, visual inspection, or probing
• 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., hospital, anesthesiologists, etc.) must attach photocopies of the appropriate sterilization acknowledgements or physician certification statements to the claims.

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.

For additional information on billing requirements, please refer to Chapter 8 of the IHCP Provider Manual or visit www.indianamedicaid.com.

Rules, Citations, and Sources

42 CFR 441.255
405 IAC 5-17 – Hospital Services
405 IAC 5-28 – Medical and Surgical Services
405 IAC 5-28-7 – Abortion
405 IAC 5-28-9 - Hysterectomy

IHCP Provider Bulletins

BT201429

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.
Related Medical Topics

Abortion Services
Anesthesia services
Clinic Services – Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services
Collagen Implants for Stress Urinary Incontinence (SUI)
Family Planning
Freestanding Birthing Centers
Hospital Inpatient Services
Hospital Outpatient Services
Obstetric Care
Surgery – Surgical Services
Hearing Services

Introduction
This section serves as a general summary of the IHCP’s policies regarding hearing services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service
Hearing services are provided for 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.

Reimbursement Requirements
The IHCP provides reimbursement for medically necessary audiology services within the limitations set forth in the 405 IAC 5-22. Refer to Therapy Services within this manual for additional information pertaining to speech therapy (ST) services.

Audiology/Hearing Tests
Audiology services are allowed, with these 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 that 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 1-1
- 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 (MCAT) 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 MCAT Form no earlier than six months prior to the provision of the hearing aid. Children 14 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 percent in either ear.
  ➢ Pure tone testing indicates an air bone gap of fifteen (15) 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 results must be documented on the prior authorization request and indicate that significant benefit can be derived from amplification before prior authorization is granted.
• 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.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) HealthWatch

Ensuring that all children in the IHCP receive age-appropriate, comprehensive, preventive services is the primary goal of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) HealthWatch 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.

Hearing Aids 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 bond conduction hearing aids (BAHA), and programmable hearing aids, under the following conditions.

- PA is required for the purchase of 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 MCAT 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 IHCP. All hearing aids purchased by the IHCP, which are no longer needed by a member, must be returned to the county Department of Family Resources (DFC).
- Hearing aids are not covered for members with a unilateral pure tone average loss (500, 1,000, 2,000, or 3,000 hertz) equal to or less than thirty decibels.
- Binaural aids and Contralateral Routing of Signals- (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 ear mold, 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

Contralateral Routing of Signals (CROS)/Bilateral-Contralateral Routing of Signals (BiCROS) Hearing Aids

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 frequency modulation (FM) to a receiver in (or at) the normal hearing ear. BiCROS 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 BiCROS 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 are pre-programmed based on 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 different types of noise when a member enters different sound environments. The device can also be re-programmed to make adjustments to the sound quality. In addition, because they are custom programmed specifically to a member’s hearing loss, programmable hearing aids offer advantages over conventional devices, such as better sound quality, flexibility, and better clarity of speech.

Programmable hearing aids are usually considered a comfort/convenience and not medically reasonable or necessary. Programmable hearing aids require PA and will be authorized only if they are medically necessary and objective evidence of significant benefit to the member is documented.
Programmable hearing aids may be authorized for monaural amplification (one ear) or for binaural amplification (two ears). 405 IAC 5-19-13(5) mandates that 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 on not only the hearing aid model and style, but also on the degree of hearing loss, and the special options chosen to personalize the instrument.

IHCP classifies programmable hearing aids as a customized item, which is defined as equipment uniquely constructed or substantially modified to meet the specific needs of an individual member.

**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.
- 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 will not be replaced prior to five years from the purchase date.
- Replacements may be prior authorized more frequently for members under 21 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 ID 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 if there is a demonstrated ability to improve on age-appropriate, closed-set word ID 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 (HI) 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
- The device must be used in accordance with 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 CMS Clinical Trial Policy as defined at section 310.1 of the National Coverage Determinations Manual (NCDM), 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 Trials 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 21 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.
Prior Authorization Requirements

Audiology/Hearing Tests

All PA audiology/hearing tests requests are reviewed on a case-by-case basis.

Audiological assessments are limited to one assessment every three years per member. PA is required if more frequent audiological assessments are necessary.

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 NF or large ICF/IID, which are included in the facility’s established per diem rate

Out-of-state services require PA. (See 405 IAC 5-5-2). Refer to Out-Of-State Services within this manual for further information.

Hearing Aids

- PA is required for hearing aids.
- A medical clearance form and audiometric test form must be completed and submitted with the PA request form.
- Batteries do not require PA.

Programmable Hearing Aids

Programmable hearing aids will receive PA only when they are medically necessary. Documentation must include significant, objective benefit to the member. Coverage may be considered for the specific instances below:

- 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, 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
• Hearing loss with unusual audiometric configurations

The PA request must be accompanied by the following documentation:

• A completed IHCP Medical Clearance and Audiometric Test (MCAT) form. The MCAT form reflects current policy for all types of hearing aids and can be located on the IHCP Web site at http://www.indianamedicaid.com/. Medical necessity for programmable hearing aids must be clearly documented in the sections entitled, “Recommendation Information” or “Special Conditions” on page 2 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, which includes the medical etiology and diagnosis for the hearing loss.
• A diagnosis supporting the medical necessity must be included on the PA request and on the claim form.
• A documented case history should include at least the following information regarding the member’s needs and lifestyle:
  ➢ The past history of hearing aid use.
  ➢ The reason programmable hearing aids, rather than conventional hearing aids, would be medically necessary.
  ➢ A description of the hearing environments 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.
  ➢ Documentation of any other factors, such as lack of normal dexterity, should be included.
  ➢ Documentation must be provided that supports the medical necessity of the programmable hearing aids outside vocational needs.

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.

Billing Requirements

The IHCP provides reimbursement to IHCP enrolled providers for services billed with the appropriate HCPCS procedure code.
Hearing services code sets were 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. 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.

Effective September 24, 2010, the IHCP began requiring a cost invoice to be submitted with the claim in conjunction with the retail invoice for claim adjudication for Healthcare Common Procedure Coding System (HCPCS) codes for durable medical equipment (DME), supplies, and hearing aids that are manually priced. A cost invoice is an itemized bill issued directly from the seller of the supply to the provider listing the goods supplied and stating the sum of money due to the supplier. Providers that historically submit claims with a cost invoice are not required to make any modifications to their current claim submission procedures.

Retail invoices (for example, MSRP or invoices custom generated by the provider) that include the price of the goods plus the provider’s margin must be accompanied by a manufacturer's cost invoice for HCPCS codes identified in Table 28.1 for dates of service prior to May 18, 2012. (Custom-molded items are an exception, please see note below.)* In the event the cost invoice contains more than one item, providers must identify on each attachment which item corresponds to the procedure code and amount identified on the claim form. Claims will continue to be reimbursed using the retail invoice, unless no retail invoice is submitted by the provider. Effective May 18, 2012, a cost invoice is no longer required to be submitted for the codes listed in Table 28.1.

**Programmable Hearing Aids**

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 as identified in Table 1 and Table 2.

Unlike HCPCS codes V5130 (binaural, in the ear) and V5140 (binaural, behind the ear), 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.

Programmable hearing aids are manually priced and require an MSRP attachment

*Note: Providers that are creating or manufacturing custom-molded items specific to an individual member’s needs, such as a custom-molded seating system produced in house, may continue to submit only a retail invoice for processing the claim. The item should be identified as “custom” in the description field on the attached invoice. A cost invoice is not required in this circumstance.
### Table 1 – Hearing Aid Codes That Must Be Submitted With An MSRP for Manual Pricing

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5080</td>
<td>Glasses, bone conduction</td>
</tr>
<tr>
<td>V5095</td>
<td>Semi-implantable middle-ear hearing prosthesis</td>
</tr>
<tr>
<td>V5100</td>
<td>Hearing aid, bilateral, body worn</td>
</tr>
<tr>
<td>V5120</td>
<td>Binaural, body</td>
</tr>
<tr>
<td>V5170</td>
<td>Hearing aid, CROS, in the ear</td>
</tr>
<tr>
<td>V5180</td>
<td>Hearing aid, CROS, behind the ear</td>
</tr>
<tr>
<td>V5210</td>
<td>Hearing aid, BICROS, in the ear</td>
</tr>
<tr>
<td>V5220</td>
<td>Hearing aid, BICROS, behind the ear</td>
</tr>
<tr>
<td>V5246</td>
<td>Hearing aid, digitally programmable analog, monaural, ITE (in the ear)</td>
</tr>
<tr>
<td>V5247</td>
<td>Hearing aid, digitally programmable analog, monaural, BTE (behind the ear)</td>
</tr>
<tr>
<td>V5252</td>
<td>Hearing aid, digitally programmable, binaural, ITE</td>
</tr>
<tr>
<td>V5253</td>
<td>Hearing aid, digitally programmable, binaural, BTE</td>
</tr>
<tr>
<td>V5299</td>
<td>Hearing service, miscellaneous</td>
</tr>
</tbody>
</table>

### Table 2 – Hearing Aid Codes That Have Established Rates

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5050</td>
<td>Hearing aid, monaural, in the ear</td>
</tr>
<tr>
<td>V5060</td>
<td>Hearing aid, monaural, behind the ear</td>
</tr>
<tr>
<td>V5130</td>
<td>Binaural, in the ear</td>
</tr>
<tr>
<td>V5140</td>
<td>Binaural, behind the ear</td>
</tr>
<tr>
<td>V5256</td>
<td>Hearing aid, digital, monaural, ITE</td>
</tr>
<tr>
<td>V5257</td>
<td>Hearing aid, digital, monaural, BTE</td>
</tr>
<tr>
<td>V5260</td>
<td>Hearing aid, digital, binaural, ITE</td>
</tr>
<tr>
<td>V5261</td>
<td>Hearing aid, digital, binaural, BTE</td>
</tr>
</tbody>
</table>

Effective July 1, 2011, the IHCP has also established reimbursement rates for hearing aid dispensing fees. This is a one-time dispensing fee. The procedure codes for billing hearing aid dispensing fees are listed in Table 3 – Dispensing Fee. The dispensing fee codes below may be billed only in conjunction with hearing aid codes that have an established Medicaid rate. The dispensing fee codes below may not be billed with hearing aid codes that are manually priced.
The dispensing fee includes all services related to the initial fitting and adjustment of the hearing aid, orientation of the patient, and instructions on hearing aid use.

Table 3 – Hearing Aid Dispensing Fee Codes That Have Established Rates

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5241</td>
<td>Dispensing fee, monaural hearing aid, any type</td>
</tr>
<tr>
<td>V5160</td>
<td>Dispensing fee, binaural</td>
</tr>
</tbody>
</table>

The IHCP designates one unit of code V5266- Battery for use in hearing device, to represent four batteries, therefore, when submitting claims to the IHCP for reimbursement, providers are to report one unit of V5266 for each package of four batteries supplied.

Rules, Citations, and Sources

405 IAC 5-3 – Prior Authorization

405 IAC 5-4 – Provider Enrollment

405 IAC 5-15 – Early and Periodic Screening, Diagnostic, and Treatment Services

405 IAC 5-19 – Medical Supplies and Equipment

405 IAC 5-22 – Nursing and Therapy Services

405 IAC 5-25 – Physician Services

880 IAC Speech – Language Pathology and Audiology Board

IHCP Bulletins

BT201037

BT201117

BT201213

IHCP Provider Manual

Related Medical Topics

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) HealthWatch Program

Evaluation and Management Services

Home Health Services

Intermediate Care Facilities for the Intellectually Disabled

Medical Supplies and Durable Medical Equipment – Overview

Nursing Facilities

Out-of-State Services

Therapy Services

Transportation Services
Home Health Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding home health services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Home health services are available to IHCP members who are medically confined to home when services are ordered by the member’s physician and performed in accordance with a written POC. IHCP members who, because of illness or injury, are unable to leave home without the assistance of another person or of 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.

Reimbursement Requirements

IHCP reimbursement is available to home health agencies for skilled nursing care services provided by an RN or licensed practical nurse (LPN), home health aide (HHA) services; physical, occupational, or ST services; respiratory therapy (RT) services; renal dialysis; and home infusion therapies, subject to limitations in 405 IAC 5-3, 405 IAC 5-16, and 405 IAC 5-22.

All home health services require PA. The exception is services provided by RNs, LPNs, or HHAs, which are ordered in writing by a physician prior to a member’s discharge from a hospital and which 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 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.

Diabetes self-management training services can be provided in a home setting but are not included under home health care services. See Diabetes Self-Management Training within manual 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 departs.

Multiple member care situation – A home care situation in which more than one member of a single household is receiving home health services. 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 – RN, LPN, physical therapist (PT), occupational therapist (OT), ST, speech language pathologist (SLP), RT, or HHA.

Prior Authorization Requirements

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 an RN or LPN
- Home health aide services
- Physical, occupational, and ST services
- RT services
- Renal dialysis
- Home tocolytic infusion therapy

Home health services require PA, except in the following circumstances:
• Services provided by an RN, LPN, or home health aide that have been 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 do not require PA. These services may not continue beyond 30 calendar days, unless PA is obtained.

• Any combination of therapy services ordered in writing by a physician prior to the member’s hospital discharge that does not exceed 30 units in 30 calendar days does not require PA. These services may not continue beyond 30 days following discharge, unless PA is obtained.

• 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 PAs, 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 periods requested, as reflected on the plan of treatment.

• PA requests for home health services should provide documentation of all services – for example, Medicare, CHOICE, IHCP waiver programs, private insurance, and any other paid caregivers – received by the IHCP member. 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 situation of multiple members, and more than one member is receiving home health services in a single household, care must be coordinated to provide 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, therapists, 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 problems 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.

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 addresses the impact this change will have on the Medicaid PA 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 PA.

Providers should note that Chapter 6 of the IHCP Provider Manual and state regulations 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 405 IAC 5-5-5, it is permissible for the agency to use a signature stamp for the Indiana Prior Review and Authorization Request form.

In conclusion, physician signature stamps may be used on the Indiana Prior Review and Authorization Request form when requesting Medicaid PA 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.

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 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 the ability of the caregiver(s) to provide care to the member
  - Number of hours requested, compared to availability of caregiver(s) available time
  - Whether the caregiver has additional child care responsibilities
  - Whether 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 to 16 Hours a Day of Home Health Care Services

Members requiring 24-hour monitoring may be authorized for up to 12 hours a day of 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; and neuromuscular disorders, such as muscular dystrophy and 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 part-time hours) 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 child care responsibilities. Significant is defined as:
  ➢ Three or more children under the age of six, or four or more children under the age of 10
  ➢ 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 caregivers must be caring for these children, as well as for 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. These situations are evaluated individually, on a case-by-case basis. Examples of these situations are as follows:

• Significant deterioration in the member’s condition, 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:
  ➢ Illness or injury that requires an inpatient acute-care stay
  ➢ Chemotherapy or radiation treatments
  ➢ 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 caregiver’s call to military duty
  ➢ 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 a Day Home Health Care Services

Members who require extensive care and daily monitoring of their medical/physical conditions, but who 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 eight hours of care daily. An additional hour or two may be allowed for transportation to and from work in situations where the caregivers work full time outside the home. Examples of these situations/conditions 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 RT required (in the form of updrafts, chest PT, or CPT®
• Nutrition 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:
  ➢ Illness or injury that requires an inpatient acute care stay
  ➢ Chemotherapy or radiation treatments
  ➢ 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 caregiver’s call to military duty
  ➢ 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 short periods of time to assist members with transitions.

**Three to Seven Hours a Day of 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 three to seven 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 and 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 to maintain meaningful employment and a relationship with the community. Such adults may be considered for assistance from a HHA for up to three to four 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 Requirements**

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 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 use the UB-04 occurrence code, occurrence date, and occurrence span for fields 31-34, a–b, on the UB-04 to indicate the appropriate overhead fees. Use the following occurrence code to identify the overhead rate.

- **Code 61** indicates that one encounter with the member occurred on the date shown.

All home health visits must be documented on any PA request submitted on behalf of members.

If the dates of service billed are not consecutive, the provider should enter the correct occurrence code corresponding to each DOS billed on the UB-04 in the Occurrence Code and Occurrence Date fields, Locators 32–35 a–b, on the UB-04. 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. Providers that submit more than one UB-04 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 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

Table 1 – CPT®/HCPCS Codes Home Health Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99600 TD</td>
<td>Unlisted home visit service or procedure; RN</td>
</tr>
<tr>
<td>99600</td>
<td>Unlisted home visit service or procedure; some health aide</td>
</tr>
<tr>
<td>99600 TE</td>
<td>Unlisted home visit service or procedure; skilled nurse, LPN/licensed vocational nurse (LVN)</td>
</tr>
<tr>
<td>99601</td>
<td>Home infusion/specialty drug administration, per visit (up to 2 hours);</td>
</tr>
<tr>
<td>99602</td>
<td>Home infusion/specialty drug administration, per visit; each additional hour (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>G0151</td>
<td>Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G0152</td>
<td>Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G0153</td>
<td>Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes</td>
</tr>
</tbody>
</table>

Table 2 – Tocolytic Therapy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99601</td>
<td>Home infusion/specialty drug administration, per visit (up to 2 hours);</td>
</tr>
<tr>
<td>99602</td>
<td>Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>S9349</td>
<td>Home infusion therapy, tocolytic infusion therapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>
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 – monitoring 24 hours per day.
- The member desires to stay in the home, rather than in a LTC 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 is employed and absent from the home, or is unable to provide the necessary care.
- Primary caregiver has additional child care responsibilities, disallowing the time needed to care for the member (three or more children under six years of age, or four or more children under the age of 10).
- Primary caregiver also has additional children with special needs to care for (one or more children with special healthcare needs requiring extensive medical and physical care).
- Major illness or injury of caregivers, with expectation of recovery (physician’s statement required)
- Temporary but significant change in the availability of caregiver – for example, military service (commanding officer, other military representative, or employer’s statement required).
- Significant permanent change in caregiver’s status – for example, death or divorce with loss of one caregiver (physician’s statement required).

**Home Health Care for Central Nervous System Disorders**
Table 3 – CPT®/HCPCS Codes Home Health Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99600</td>
<td>Unlisted home visit service or procedure; RN</td>
</tr>
<tr>
<td>99600</td>
<td>Unlisted home visit service or procedure; home health aide</td>
</tr>
<tr>
<td>99600</td>
<td>Unlisted home visit service or procedure; skilled nurse, LPN/LVN</td>
</tr>
<tr>
<td>G0151</td>
<td>Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G0152</td>
<td>Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G0153</td>
<td>Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes</td>
</tr>
</tbody>
</table>

Indicators for Central Nervous System (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.

<table>
<thead>
<tr>
<th>Services Requiring Skilled Care</th>
<th>Services Requiring Nonskilled Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Vital signs</td>
<td>1. Bathing/linen change/dressing</td>
</tr>
<tr>
<td>2. Ventilator operation/maintenance</td>
<td>2. Catheter care</td>
</tr>
<tr>
<td>3. Central line maintenance/dressings</td>
<td>3. Skin care</td>
</tr>
<tr>
<td>4. Complex treatment modalities (sterile dressings, soaks, packing, etc.)</td>
<td>4. Minor treatment modalities</td>
</tr>
<tr>
<td>5. Parenteral/enteral nutrition</td>
<td>5. Oral care</td>
</tr>
<tr>
<td>7. Respiratory treatments</td>
<td>7. Continue plan of OT/PT</td>
</tr>
<tr>
<td>8. Tracheostomy maintenance/change</td>
<td>8. Assist with transfers/ambulation</td>
</tr>
<tr>
<td>9. Suctioning (frequency/secretion type)</td>
<td>9. Positioning</td>
</tr>
<tr>
<td>10. Stimulation (verbal/tactile)</td>
<td>10. I&amp;O records</td>
</tr>
<tr>
<td>11. Tube feedings/maintenance of tube</td>
<td>11. Assist with oral feedings</td>
</tr>
<tr>
<td>12. IV medication administration</td>
<td>12. Splint or brace application</td>
</tr>
<tr>
<td>13. Urinary catheter maintenance/change</td>
<td>13. Exercise (active/passive)</td>
</tr>
<tr>
<td>14. Exercise (active/passive)</td>
<td>14. Ensure safety measures (seizure precautions)</td>
</tr>
<tr>
<td>15. Vital signs</td>
<td>15. Vital signs</td>
</tr>
</tbody>
</table>

*Note: On the above table and subsequent Skilled vs. Nonskilled Care tables, those services appearing on both sections may be either, as justified by the required Plan of Treatment during PA review.

**Home Health Care for Gastrointestinal Disorders**

**Table 4 – CPT®/HCPCS Codes Home Health Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99600 TD</td>
<td>Unlisted home visit service or procedure; RN</td>
</tr>
<tr>
<td>99600</td>
<td>Unlisted home visit service or procedure; home health aide</td>
</tr>
<tr>
<td>99600 TE</td>
<td>Unlisted home visit service or procedure; skilled nurse, LPN/LVN</td>
</tr>
<tr>
<td>G0151</td>
<td>Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G0152</td>
<td>Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G1053</td>
<td>Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes</td>
</tr>
</tbody>
</table>
Indicators for Gastrointestinal Disorders

One of the following indicators must be present for a member to receive home health care for GI disorders:

- Nutritional impairment
  - Malabsorption
  - Mechanical cause
- Stomatitis, pharyngitis, esophagitis
- Swallowing disorders
- Gastric reflux
- Vomiting
- Anorexia
- Pain
- Orthostatic blood pressure (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 GI disorders:

<table>
<thead>
<tr>
<th>Services Requiring Skilled Care</th>
<th>Services Requiring Nonskilled Care</th>
</tr>
</thead>
</table>
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

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

Table 5 – CPT®/HCPCS Codes Home Health Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99600 TD</td>
<td>Unlisted home visit service or procedure; RN</td>
</tr>
<tr>
<td>99600</td>
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</tr>
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<td>Unlisted home visit service or procedure; skilled nurse, LPN/LVN</td>
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<tr>
<td>G0151</td>
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</tr>
<tr>
<td>G0152</td>
<td>Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G0153</td>
<td>Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes</td>
</tr>
</tbody>
</table>

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
• Postamputation
• 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:

<table>
<thead>
<tr>
<th>Services Requiring Skilled Care</th>
<th>Services Requiring Non-Skilled Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assistance with prostheses, braces, splints</td>
<td>1. Bathing/linen/dressing</td>
</tr>
<tr>
<td>2. Treatments requiring sterile procedures</td>
<td>2. Assistance with activities of daily living (ADLs)</td>
</tr>
<tr>
<td>3. Assistance with transfers/ambulation</td>
<td></td>
</tr>
<tr>
<td>4. Assistance with prostheses, braces, splints</td>
<td></td>
</tr>
<tr>
<td>5. Exercise – active or passive</td>
<td></td>
</tr>
<tr>
<td>6. Position changes</td>
<td></td>
</tr>
<tr>
<td>7. Non-invasive treatments, comfort measures</td>
<td></td>
</tr>
</tbody>
</table>

### Home Health Care for Respiratory Disorders

**Table 6 – CPT®/HCPCS Codes Home Health Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99600 TD</td>
<td>Unlisted home visit service or procedure; RN</td>
</tr>
<tr>
<td>99600</td>
<td>Unlisted home visit service or procedure; home health aide</td>
</tr>
<tr>
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<td>Unlisted home visit service or procedure; skilled nurse, LPN/LVN</td>
</tr>
<tr>
<td>G0151</td>
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</tr>
<tr>
<td>G0152</td>
<td>Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G0153</td>
<td>Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes</td>
</tr>
</tbody>
</table>
### 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
  - 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 arterial blood gases (ABGs)
- 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.

<table>
<thead>
<tr>
<th>Services Requiring Skilled Care</th>
<th>Services Requiring Non-Skilled Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Oral medication administration</td>
<td>1. Assist with bathing, dressing, ADLs (total care may be required)</td>
</tr>
<tr>
<td>2. IV medication administration</td>
<td>2. Skin care</td>
</tr>
<tr>
<td>3. Parenteral/enteral nutrition</td>
<td>3. Oral care</td>
</tr>
<tr>
<td>4. Vital signs</td>
<td>4. Force fluids as instructed</td>
</tr>
<tr>
<td>5. Ventilator operation/maintenance</td>
<td>5. Assist with ambulation</td>
</tr>
<tr>
<td>6. Tracheostomy maintenance/change</td>
<td>6. Exercise active/passive</td>
</tr>
<tr>
<td>7. Suctioning</td>
<td>7. Assist with meals (oral feeding)</td>
</tr>
<tr>
<td>8. Complex treatment modalities (sterile)</td>
<td></td>
</tr>
</tbody>
</table>
dressing, wound care) 8. Vital signs

9. Respiratory treatments

### Home Tocolytic Infusion Therapy

#### Table 7 – Tocolytic Therapy Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9349</td>
<td>Home infusion therapy, tocolytic infusion therapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>99601</td>
<td>Home infusion/specialty drug administration, per visit (up to 2 hours);</td>
</tr>
<tr>
<td>99602</td>
<td>Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

#### 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 percent
- The member must have experienced secondary failure to wean from infused tocolytics, or have failed oral therapy and requires continued infusion therapy
- 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 24 hours a day, seven days a week
- Provide the member with a tocolytic infusion pump and a uterine monitoring device (including setup and delivery); provide member education regarding equipment use and be available for trouble shooting for the equipment 24 hours a day, seven days a week
- Provide pharmacological consultation regarding the use of tocolytics and individualized member dosing 24 hours a day, seven days a week
- Provide member education regarding uterine contractions and other subtle symptoms of preterm labor
- Contact the member’s physician at least weekly for updates on the member’s condition/compliance
Code S9349 denotes the total global package of services with home health agencies providing all the components under home tocolytic infusion therapy.

S9349 covers the following items:

- Home uterine monitor
- Skilled nursing services that include the following:
  - Initial nursing assessment
  - Instructions given to the patient about the proper use of the monitoring equipment
  - Home visits as needed to monitor signs and symptoms of preterm labor
  - Twenty-four-hour telephone support for troubleshooting on the monitoring equipment, for pharmacological support, and for patient symptoms
- Ambulatory infusion pump
- Tocolytic drugs
- All other supplies necessary to maintain a patient at home on this therapy including the following:
  - Conductive paste or gel
  - Dressings
  - Extra batteries for infusion pump
  - Sharps container
  - Site kits
  - Syringes
  - Tubing
  - Other supplies
This global package also includes any costs involved in transmitting reports to the physician electronically, such as a fax or telephone modem.

Codes 99601 and 99602 are used if a member meets the criteria for home tocolytic infusion therapy and the agency is providing the home uterine monitoring and skilled nursing components of the therapy only (rather than the entire package noted in S9349). When the home health agency bills 99601 and 99602, the tocolytic drugs and other supplies must be supplied and billed separately through another provider. The home health agency should provide only the home uterine monitor and the skilled nursing components of the home tocolytic infusion therapy. The home health agency may bill 99601 for the first two hours of therapy and bill 99602 for each additional hour of therapy, up to 22 additional hours for each 24-hour period.

Codes 99601 and 99602 cover the following items:

- Home uterine monitor
- Skilled nursing services that include the following:
  - Initial nursing assessment
  - Instructions given to the patient about the proper use of the monitor
  - Home visits to monitor signs and symptoms of preterm labor
  - Twenty-four hour telephone support for troubleshooting the monitoring equipment and for reporting patient symptoms
- This package also includes any costs involved in transmitting reports to the physician electronically, such as fax or telephone modem.

**Home Health Care For Urinary/Renal Disorders**

**Table 8 – CPT®/HCPCS Codes Home Health Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99600 TD</td>
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</tr>
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<td>99600</td>
<td>Unlisted home visit service or procedure; home health aide</td>
</tr>
<tr>
<td>99600 TE</td>
<td>Unlisted home visit service or procedure; skilled nurse, LPN/LVN</td>
</tr>
<tr>
<td>G0151</td>
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</tr>
<tr>
<td>G0152</td>
<td>Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G0153</td>
<td>Services performed by a qualified speech-language pathologist in the home health</td>
</tr>
</tbody>
</table>
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 blood urea nitrogen (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 UT 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.
<table>
<thead>
<tr>
<th>Services Requiring Skilled Care</th>
<th>Services Requiring Non-Skilled Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complex treatment modalities</td>
<td>1. Assist bathing/linens/dressing</td>
</tr>
<tr>
<td>• Sterile dressings</td>
<td>2. Skin care</td>
</tr>
<tr>
<td>• Special catheter care (ureteral catheters, irrigation, etc.)</td>
<td>3. Oral care</td>
</tr>
<tr>
<td>2. Urinary, suprapubic catheter care</td>
<td>4. Assist with exercise and ambulation</td>
</tr>
<tr>
<td>3. Input and Output (I&amp;O)</td>
<td>5. Reinforce nutritional teaching</td>
</tr>
<tr>
<td>4. Weight</td>
<td>6. Weight</td>
</tr>
<tr>
<td>5. Vital Signs</td>
<td>7. I&amp;O</td>
</tr>
<tr>
<td></td>
<td>8. Vital signs</td>
</tr>
<tr>
<td></td>
<td>9. Safety measures</td>
</tr>
</tbody>
</table>

**Home Infusion Therapy**

**Table 9 – Home Infusion Therapy Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99601</td>
<td>Home infusion/specialty drug administration, per visit (up to 2 hours);</td>
</tr>
<tr>
<td>99602</td>
<td>Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

When providers bill for home infusion therapy, they should bill the following three components separately:

- DME and HME providers bill all supplies, equipment, and formulas required to administer home infusion and enteral therapy using the appropriate HCPCS code.

- Home Health Agencies bill only for services provided in the home by an RN or LPN on the UB-04 claim form or 837I transaction using the appropriate HCPCS codes.

- Pharmacies bill for compound drugs or any drugs used in parenteral therapy on an Indiana Family and Social Services Administration (FSSA) Drug Claim Form using the appropriate NDC.

**Rules, Citations and Sources**

*42 CFR 441.15*, Subpart A – General Provisions

*42 CFR 440.70*, Subpart A – Definitions

*IC 16-41-6* – Communicable disease
405 IAC 5-16 – Home health agency and clinic services
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 5-34 – Hospice services

IHCP Bulletins

BT201227 - Home Health Rates for State Fiscal Year 2013 Are Effective July 1, 2012
BT200353 – HIPAA-Mandated Elimination of Local Codes and Local Code Modifiers
BT200237 – Required Documentation for Prior Authorization Requests for Home Health Services

IHCP Provider Manual


Related Medical Topics

Not applicable.
Hospice Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding hospice services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

Members enrolled in an IHCP MCE must disenroll prior to receiving hospice services. Disenrollment is necessary for hospice authorization to be completed. Members become eligible for hospice services the business day following disenrollment from the MCE.

To facilitate the hospice authorization process, the hospice provider may fax the Medicaid Hospice Election form to the PA Department of ADVANTAGE Health SolutionsSM to initiate MCE disenrollment. The corresponding Medicaid Hospice Physician Certification form and Medicaid Hospice POC form must be sent to the PA Department of ADVANTAGE Health SolutionsSM within 10 business days. If the hospice provider fails to verify IHCP eligibility or fails to fax the Medicaid Hospice Election form to the ADVANTAGE Health SolutionsSM PA Department, the hospice provider will not receive payment for the dates of service the member is an MCE member.

ADVANTAGE Health SolutionsSM preferred method for providers to submit PA requests is by faxing to (317) 810-4488. The fax is the most efficient manner for providers and the contractor to process hospice authorizations.

Because ADVANTAGE receives fax PA requests from all provider types, it is recommended that hospice providers follow up the fax with a telephone call to ADVANTAGE notifying the ADVANTAGE staff that a fax has been sent for disenrollment of a hospice member from managed care.

Benefit Periods

Hospice eligibility is available to qualifying IHCP-eligible members in three consecutive benefit periods. Table 1 lists the benefit periods.

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period I</td>
<td>90 days</td>
</tr>
<tr>
<td>Period II</td>
<td>90 days (expected maximum length of illness to run its course)</td>
</tr>
<tr>
<td>Period III</td>
<td>60 days</td>
</tr>
</tbody>
</table>
IHCP Hospice Provider Manual

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, TPL, medical policy, PA, utilization review, or inspection of care.

Description of Service

Hospice Care is a specialized form of interdisciplinary health care designed to alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phase of a terminal illness or disease. Hospice care also provides for the psychological, social, spiritual, and other needs of the hospice program patient's family before and after the patient's death.

Reimbursement Requirements

IHCP members in need of hospice care must be eligible for program services, must have a prognosis of six months or less to live, and must elect hospice services. In order for an individual to receive Medicaid-covered hospice services, a physician must certify in writing the individual is terminally ill and expected to die from that illness within six (6) months.

Covered Services

Hospice core services are covered services in the Medicare and IHCP hospice per diem that must be provided directly to members by hospice employees. Hospice core services include nursing services, medical social work services, and counseling services (including bereavement, dietary, spiritual, and other services). Hospice non-covered services are services in the Medicare or IHCP hospice per diem not identified as hospice core services. The following is a list of hospice services included in the Medicare and Medicaid hospice per diem:

- Nursing care provided by or under the supervision of an RN
- 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 who is part of the IDT participating in services as follows:
  - General supervising services, participating in the establishment, supervision, and periodic review of the POC, 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 in a hospice inpatient unit, participating hospital, or nursing home setting
• Medical equipment and supplies, including palliative drugs, related to the palliation or management of the member’s terminal illness
• Home health aide services furnished by certified home health aides
• Homemaker services that assist in providing a safe and healthy environment
• PT, OT, and speech-language pathology services provided for the purpose of symptom control
• Inpatient hospice care, such as inpatient hospice respite or general inpatient care
• Room and board (dually eligible hospice members) residing in LTC facilities
• Room and board for IHCP-only hospice members who reside in LTC facilities
• Any other item or service specified in the member’s POC, if the item or service is a covered service under the Medicare program and required to treat the terminal illness or related conditions

Concurrent Hospice and Curative Care Services for Children

Section 2302 of the Affordable Care Act (ACA), titled “Concurrent Care for Children,” requires hospice services to be provided to children without forgoing any other service to which the child is entitled under Medicaid for treatment of a terminal condition. This provision was effective with the March 23, 2010, enactment of the Affordable Care Act. Before the ACA’s enactment, curative treatment for terminal illnesses ceased when Medicaid members elected hospice benefits. In compliance with the ACA, the IHCP covers hospice care for children, 20 years of age and under, concurrently with all medically necessary curative treatment for the terminal illness, for dates of service on or after March 23, 2010.

Hospice Plan of Care

The IHCP hospice benefit program mirrors the covered services and reimbursement methodology of the Medicare hospice program. IHCP hospice providers are required to comply with federal hospice regulations located at CFR, 42 CFR, Part 418 et seq. The Medicare Conditions of Participation (CoPs) were updated January 23, 2006 to affect change in the Balanced Budget Act of 1997.

These regulations require hospice providers to list all hospice covered services in frequency and scope on the hospice POC necessary to treat the terminal illness and related conditions. Additionally, IHCP hospice providers must be Medicare-certified and licensed as hospice providers by ISDH as a condition of provider enrollment.

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 NF 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 providers’ 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 non-terminal condition.
- To ensure that the hospice member is not billed for these services, the hospice provider must ensure the non-hospice provider is enrolled as an IHCP provider.
- The hospice provider must communicate and coordinate with the non-hospice provider’s personnel to ensure the source 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 a Change in Status of Medicaid Hospice Patient form to the PA Department of ADVANTAGE Health SolutionsSM. 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’s safety is compromised
- Member is admitted to a NF that does not have a contract with a hospice

When a member moves out of the service area, the hospice provider notifies the fiscal intermediary of the discharge, so 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 increased 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 of the circumstances surrounding the impending discharge. Hospice providers must submit specific forms to facilitate the discharge.

- Hospice providers may fax the Medicaid Hospice Discharge form to the PA Department of ADVANTAGE Health Solutions, if 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 NF to ensure that the form is included in the clinical record the NF maintains for the hospice member. This coordination ensures that staff is aware of the exact date the hospice provider discharged the member. Additionally, hospice providers must develop a coordination procedure with the NF billing department to notify of discharge.
- Hospice providers must bill the IHCP for the hospice per diem for NF room and board for the hospice discharge date.
- Nursing facilities may resume billing the IHCP directly for NF care for the DOS following the hospice discharge date.
- Hospice providers are reminded that it is a violation of medical record standards to predate the hospice discharge. The documented discharge date cannot precede the actual discharge.
- For reimbursement, hospice program guidelines must be followed.

**Dually Eligible and Medicaid-Only Hospice Members in Nursing Facilities**

The IHCP hospice benefits must comply with the *OBRA of 1989*. *OBRA of 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 NF providers. To ensure that the IHCP member’s enrollment in the IHCP hospice benefit is clear to both hospice and NF staffs, the hospice provider must furnish the NF staff with the member's Medicaid hospice forms. The hospice must develop coordination procedures with the NF billing department to inform the NF of hospice care status.

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 the direct care of an IHCP hospice provider for services that both programs have in common. Members may receive waiver services unrelated and non-duplicative of the hospice services. Hospice providers must coordinate with non-hospice providers to ensure that overall care is met and that the hospice POC is not compromised. Authorization of services 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.

Prior Authorization Requirements

IHCP reimbursement is available for hospice services when PA is received in accordance with the PA guidelines. The Indiana Health Coverage Programs (IHCP) Hospice Provider Manual provides complete information about the hospice program and prior authorization process. Specific criteria pertaining to PA for hospice services can be found in 405 IAC 5-34-4.

IHCP reimbursement is not available for hospice services furnished without prior authorization.

Hospice providers are required to use hospice revenue code 651 when requesting PA hospice services. Providers are also required to use the Indiana Prior Review and Authorization Request Form. If any other revenue code is used, the hospice PA review from ADVANTAGE Health Solutions℠ will suspend the request pending correction by the provider. For billing purposes, providers should use the most appropriate revenue code.

The IHCP requires hospice providers to request PA for Medicaid-only members at the beginning of each hospice benefit period. Dually eligible Medicare/Medicaid member requests must be submitted for the election benefit only on the Hospice Authorization Notice for Dually Eligible Medicare/Medicaid NF Residents. PA requests for hospice services may be modified by the PA Department of ADVANTAGE Health Solutions℠

Hospice care is dependent upon a physician’s certification endorsing a member’s life expectancy to be six months or less, if the terminal condition runs its normal course. Hospice services must be reasonable and must 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 POC. Additionally, documentation must include any comorbidities.
Documentation is used in the 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 in the hospice program. This practice is consistent with the IHCP provider agreement.

**Documentation Requirements**

Any IHCP member who is terminally ill and meets medical necessity criteria may receive services from an IHCP hospice provider. In compliance with 42 CFR, Part 418 et. seq, providers are required to document in the member’s hospice medical record support for a terminal diagnosis versus a chronic condition.

When entering the third hospice benefit period of 60 continuous days, hospice providers must submit specific medical documentation that supports the need for continued hospice care. If it is determined the information is insufficient to process the PA request, the PA hospice reviewer will suspend the request for 30 calendar days 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 and 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 IDT 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 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 Website at www.indianamedicaid.com for detailed information regarding these forms.

**Billing Requirements**

Hospice providers follow the general directions for completing the *UB-04* claim form and use the following hospice-specific information to fill in the claim form. Refer to the Hospice Provider Manual on indianamedicaid.com for complete coverage information and billing instructions. Hospice providers are paid a *per diem* at the hospice level of care they are providing. Hospice providers should bill only one hospice revenue code per day. Revenue codes 183, 185, and 657 are the only revenue codes that can be billed on the same day as another hospice revenue code.

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 seq. The following information describes the four levels of service and two levels of care available to members. Table 2 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 NF
- Continuous home care delivered in a NF
- Inpatient respite care (available to private home hospice members only)*
- General inpatient hospice care
### Table 2 – Hospice Reimbursement Methodology

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Revenue Code Descriptions and Explanations</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td><strong>Routine home care in a private home</strong></td>
</tr>
<tr>
<td></td>
<td>- The IHCP pays the hospice 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.</td>
</tr>
<tr>
<td></td>
<td>- The IHCP pays this rate without regard to the volume or intensity of routine home care services on any given day.</td>
</tr>
<tr>
<td></td>
<td>- One day equals one unit of service.</td>
</tr>
<tr>
<td>652</td>
<td><strong>Continuous home care in a private home</strong></td>
</tr>
<tr>
<td></td>
<td>- The provider gives continuous home care only during a period of crisis.</td>
</tr>
<tr>
<td></td>
<td>- A period of crisis occurs when a patient requires continuous care, primarily nursing care, to achieve palliation and management of acute medical symptoms.</td>
</tr>
<tr>
<td></td>
<td>- The provider must provide a minimum of eight hours of care during a 24-hour day that begin and ends at midnight.</td>
</tr>
<tr>
<td></td>
<td>- An RN or LPN must provide care for more than half the total time. This care need not be continuous and uninterrupted.</td>
</tr>
<tr>
<td></td>
<td>- Less skilled care needed continuously to enable the member to remain at home is covered as routine home care.</td>
</tr>
<tr>
<td></td>
<td>- Divide the continuous home care per diem rate by 24 hours to calculate an hourly rate. For every hour or part of an hour of continuous care furnished, the IHCP reimburses the hourly rate to the hospice provider, up to 24 hours a day.</td>
</tr>
<tr>
<td></td>
<td>- One hour equals one unit of service.</td>
</tr>
<tr>
<td>Revenue Code</td>
<td>Revenue Code Descriptions and Explanations</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>653</td>
<td><strong>Routine home care in a NF</strong></td>
</tr>
<tr>
<td></td>
<td>• The IHCP pays the hospice provider at the routine home care rate for each day the member is in a NF under the care of the hospice provider and not receiving continuous home care.</td>
</tr>
<tr>
<td></td>
<td>• The IHCP pays this rate without regard to the volume or intensity of routine home care service on any given day.</td>
</tr>
<tr>
<td></td>
<td>• In addition, the IHCP pays the hospice provider 95% of the lowest NF per diem to cover room--and-board costs incurred by the contracted NF. The provider should bill only normal and customary routine home care amounts as the billed amount; IndianaAIM calculates 95% of the lowest NF per diem and pays accordingly.</td>
</tr>
<tr>
<td></td>
<td>• Nursing facility room and board are not billable for the date of death.</td>
</tr>
<tr>
<td></td>
<td>• Providers also cannot bill for NF room and board for the date the member is physically discharged from the NF.</td>
</tr>
<tr>
<td></td>
<td>• One day equals one unit of service.</td>
</tr>
<tr>
<td>654</td>
<td><strong>Continuous home care in a NF</strong></td>
</tr>
<tr>
<td></td>
<td>• As in the private home setting, divide the continuous home care rate by 24 hours to calculate an hourly rate. For every hour or part of an hour of continuous care furnished, the IHCP reimburses the hourly rate to the hospice provider, up to 24 hours a day.</td>
</tr>
<tr>
<td></td>
<td>• All limitations listed for the private home setting also apply in the NF setting.</td>
</tr>
<tr>
<td></td>
<td>• In addition, the IHCP pays the hospice an additional 95% of the NF case mix rate to cover room--and-board costs incurred by the contracted NF.</td>
</tr>
<tr>
<td></td>
<td>• Providers cannot bill for NF room and board for the date of death.</td>
</tr>
<tr>
<td></td>
<td>• Providers also cannot bill for NF room and board for the date the member is physically discharged from the NF.</td>
</tr>
<tr>
<td></td>
<td>• One hour equals one unit of service.</td>
</tr>
<tr>
<td>Revenue Code</td>
<td>Revenue Code Descriptions and Explanations</td>
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<tr>
<td>-------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>655</td>
<td><strong>Inpatient respite care</strong></td>
</tr>
<tr>
<td></td>
<td>• The IHCP pays the hospice provider at the inpatient respite care rate for each day the member is in an approved inpatient facility and is receiving respite care.</td>
</tr>
<tr>
<td></td>
<td>• Respite care is short-term inpatient care provided to the member only when necessary to relieve the family members or other people caring for the member. Respite care may be provided only on an occasional basis.</td>
</tr>
<tr>
<td></td>
<td>• The IHCP pays for respite care for a maximum of five consecutive days at a time, including the date of admission but not counting the day of discharge.</td>
</tr>
<tr>
<td></td>
<td>• The IHCP pays for the sixth and any subsequent days at the routine home care rate.</td>
</tr>
<tr>
<td></td>
<td>• This service applies only to members who normally reside in private homes.</td>
</tr>
<tr>
<td></td>
<td>• The additional amount for room and board is not available for members receiving respite care.</td>
</tr>
<tr>
<td></td>
<td>• One day equals one unit of service.</td>
</tr>
</tbody>
</table>
|             | • According to 405 IAC 1-16-2(i), when a member is receiving general inpatient or inpatient respite care, the applicable inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the member is discharged deceased, the applicable inpatient rate (general or respite) is paid for the date of discharge.
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Revenue Code Descriptions and Explanations</th>
</tr>
</thead>
<tbody>
<tr>
<td>656</td>
<td><strong>General inpatient hospice care</strong></td>
</tr>
<tr>
<td></td>
<td>• The IHCP pays the hospice provider at the general inpatient hospice rate for each day the member is in an approved inpatient hospice facility and is receiving general inpatient hospice care for pain control, or acute or chronic symptom management, that cannot be managed in other settings.</td>
</tr>
<tr>
<td></td>
<td>• This service applies only to members who normally reside in <em>private</em> homes.</td>
</tr>
<tr>
<td></td>
<td>• The additional amount for room and board is not available for members receiving respite care.</td>
</tr>
<tr>
<td></td>
<td>• One day equals one unit of service.</td>
</tr>
<tr>
<td></td>
<td>• According to 405 IAC 1-16-2(i), when a member is receiving general inpatient or inpatient respite care, the applicable inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the member is discharged deceased, the applicable inpatient rate (general or respite) is paid for the date of discharge.</td>
</tr>
<tr>
<td>657</td>
<td><strong>Hospice direct-care physician services</strong></td>
</tr>
<tr>
<td></td>
<td>• The IHCP reimburses on a fee-for-service (FFS) basis for physician services provided by a physician who is an employee of the hospice provider or subcontracted by the hospice. The hospice provider bills for these services under the hospice NPI.</td>
</tr>
<tr>
<td></td>
<td>• Providers can bill this revenue code on the same day as other hospice revenue codes.</td>
</tr>
<tr>
<td></td>
<td>• One day equals one unit of service.</td>
</tr>
<tr>
<td>Revenue Code</td>
<td>Revenue Code Descriptions and Explanations</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>659</td>
<td>Room and Board for Dually-eligible Medicare/Medicaid NF members only (room and board portion of the hospice <em>per diem</em> rate)</td>
</tr>
<tr>
<td></td>
<td>• Use this revenue code for dually eligible members residing in a NF.</td>
</tr>
<tr>
<td></td>
<td>• This code represents the room-and-board portion of the hospice <em>per diem</em>.</td>
</tr>
<tr>
<td></td>
<td>• The IHCP pays the hospice provider an additional 95% of the NF case mix rate to cover room-and-board costs incurred by the contracted NF.</td>
</tr>
<tr>
<td></td>
<td>• Revenue code 659 must not be billed with the following hospice-related revenue codes: 651, 652, 653, 654, 655, and 656.</td>
</tr>
<tr>
<td></td>
<td>• Providers cannot bill for NF room and board for the date of death.</td>
</tr>
<tr>
<td></td>
<td>• Providers also cannot bill for NF room and board for the date the member is physically discharged from the nursing facility.</td>
</tr>
<tr>
<td></td>
<td>• One day equals one unit of service.</td>
</tr>
<tr>
<td>180</td>
<td><strong>NF Bed Hold Nonpaid Revenue Code</strong></td>
</tr>
<tr>
<td></td>
<td>The hospice provider should bill the IHCP using this revenue code for leave days when the NF occupancy is less than 90 percent. This code generates an IHCP denial; however, providers may charge members for the nonreimbursed bed hold days.</td>
</tr>
<tr>
<td>183</td>
<td><strong>NF bed hold for hospice therapeutic leave days</strong></td>
</tr>
<tr>
<td></td>
<td>• The hospice provider receives 50% of the 95% nursing facility (NF) case mix rate for the room-and-board rate associated with therapeutic leave of absence days.</td>
</tr>
<tr>
<td></td>
<td>• A total of 18 therapeutic leave of absence days are allowed per patient, per calendar year.</td>
</tr>
<tr>
<td></td>
<td>• One day equals one unit of service.</td>
</tr>
<tr>
<td></td>
<td>• Revenue code 183 may be billed on the same day as other hospice revenue codes.</td>
</tr>
<tr>
<td>185</td>
<td><strong>NF bed hold for hospitalization for services unrelated to the terminal illness</strong></td>
</tr>
<tr>
<td></td>
<td>• The hospice provider receives 50% of the 95% NF case mix rate associated with each hospitalization up to 15 days per occurrence.</td>
</tr>
<tr>
<td></td>
<td>• One day equals one unit of service.</td>
</tr>
<tr>
<td></td>
<td>• Revenue Code 185 may be billed on the same day as other hospice revenue codes.</td>
</tr>
</tbody>
</table>
**Inpatient facility is defined as a hospital, LTC facility, or the facility of a hospice provider that provides RN care 24 hours a day.**

**Reimbursement for Room and Board on Date of Death or Date of Physical Discharge**

The OMPP does not pay the NF per diem or room-and-board services for the day a member is discharged from the NF. When a hospice member dies in a NF, the date of death follows the same reimbursement procedures as the date of physical discharge from the NF. If a hospice member is admitted and dies in the NF on the same day, the NF 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 NF**

An IHCP member (dually eligible Medicare/IHCP or IHCP-only) residing in a NF is responsible for the member’s portion of the payment before the IHCP pays the remaining balance of NF 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 DOS the member resides and is eligible for the IHCP NF LOC.

Hospice providers can obtain a member’s patient liability for a particular month by contacting HP Customer Assistance or using one of the eligibility verification system (EVS). When a provider obtains the patient liability amount, the Residential Allowance (RA) is used to determine how HP calculates the paid amount. The following formula is used if the RA does not match the rates the provider submitted on the claim:

- NF case mix rate on file x 95% (.95) = allowed amount on the RA for room and board
- Number of dates of service x allowed amount on the RA minus member liability = room and board amount

**Prior Authorized Physician Services**

The IHCP reimburses a physician’s direct patient services not rendered by a hospice physician volunteer as an additional payment, in accordance with the usual IHCP reimbursement methodology for physician services. The hospice must not bill these services under the hospice NPI.

An attending physician may bill only the physician’s personal professional services. Do not include the costs for services, such as laboratory or X-ray, on the attending physician’s billed charges when those services relate to the terminal condition. Include these costs in the daily hospice care rates because they are expressly the responsibility of the hospice provider. Providers may bill independent physician services on the CMS-1500 claim form or 837P transaction.
NF Quality Assessment

OBRA 1989 and 405 IAC 1-16:4 require the IHCP to reimburse hospice providers for NF room and board payments; hospice providers reimburse nursing facilities according to their contracts. The IHCP pays the hospice 95 percent of the nursing home rate on file.

Rules, Citations and Sources

42 CFR § 418 – Conditions of Participation for Hospice Care
IC ch. 16-25-3 – Licensure of Hospices
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

IHCP Bulletins

BT201205
BT200933
BT200607
BT200372
BT200367
BT200365
BT200331
BT200259
BT200234
BT200146
BT200116
BT200107
BT200041
BT200011
BT200002
IHCP Banner Pages
BR200914

IHCP Provider Newsletters
NL200905

IHCP Provider Manual

IHCP Hospice Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Emergency Medicine – Emergency Services
Home Health Services
Hospital Inpatient Services
Hospital Outpatient Services
Mental Health/Behavioral Health – Outpatient Services
Nursing Facilities
Nursing Services
Out-of-State Services
Hospital Inpatient Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding hospital inpatient hospital services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

“Inpatient” is defined as a patient required to be admitted to the hospital to treat a condition requiring close monitoring or skilled professional management. Inpatient hospital services may be covered when determined to be medically reasonable and necessary for the services to be performed only in an inpatient hospital setting.

Reimbursement Requirements

Inpatient Acute Care Hospital Admissions

Per 405 IAC 5-17-1 et seq., inpatient hospital services are covered when such services are provided or prescribed and documented by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition, subject to the following limitations:

- Reimbursement for inpatient hospital services is available only when it is determined to be medically reasonable and necessary for the services to be performed only in an inpatient hospital setting.
- Reimbursement will be denied for any days of the hospital stay during which the inpatient hospitalization is found not to have been medically necessary.
- If an inpatient procedure requires prior authorization and prior authorization is either not obtained or denied, reimbursement for the inpatient procedure and any associated services, including inpatient days, shall be denied.
- The recipient's medical condition, as described and documented in the medical record by the primary or attending physician must justify the intensity of service provided.
- Reimbursement shall not be made for any hospital services not covered under the Medicaid program.
Reimbursement is not available for reserving a bed during a therapeutic leave of absence from an acute care hospital.

Inpatient Psychiatric Admissions

The IHCP reimburses for inpatient psychiatric services provided to eligible individuals between 22 and 65 years old only in certified psychiatric hospitals with 16 beds or less. 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. Additional information regarding the certification of need for admission may be found at 405 IAC 5-20-5.

Reimbursement for inpatient psychiatric services is not available in institutions for mental diseases for a recipient under sixty-five (65) years of age unless the recipient is under twenty-one (21) years of age, or under twenty-two years of age and had begun receiving inpatient psychiatric services immediately before his or her twenty-first birthday.

Emergency Inpatient Psychiatric Admission

Emergency inpatient psychiatric admission is available only in cases of 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 (1) of the following:

- Danger to the individual
- Danger to others
- Death of the individual

Inpatient Rehabilitation Admission

Per CMS, inpatient rehabilitation is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

The IHCP provides reimbursement for inpatient rehabilitation services when such services are prior authorized and determined to be medically necessary.

Acute Care Hospital Admission

Mosby’s Dictionary defines acute care as “a pattern of health care in which a patient is treated for a brief but severe episode of illness, for the sequelae of an accident or other trauma, or during recovery from surgery...This pattern of care is often necessary for only a short time, unlike chronic care.”

The IHCP provides reimbursement for acute care hospitalization admissions when the care is determined to medically necessary and prior authorization has been obtained.
Prior Authorization Requirements

In addition to prior authorization information set forth at 405 IAC 5-3, general prior authorization requirements for hospital services can be found in 405 IAC 5-17-2. These requirements include:

- Prior authorization is required for all nonemergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. This applies to medical and surgical inpatient admissions. Emergency admissions, routine vaginal deliveries, C-section deliveries, newborns stays, and inpatient hospital admissions covered by Medicare do not require PA.

- Prior authorization is required for all Medicaid covered rehabilitation, burn, and psychiatric inpatient stays that are reimbursed under the level of care methodology described in 405 IAC 1-10.5 as well as substance abuse stays that are reimbursed under the DRG methodology also described at 405 IAC 1-10.5.

- Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient procedure, must be prior authorized. The length of stay for the inpatient admission is determined by the appropriate DRG, but will be subject to retrospective review for medical necessity.

Criteria for determining the medical necessity for inpatient admission shall include the following:

- Technical or medical difficulties during the outpatient procedure as documented in the medical record.

- Presence of physical or mental conditions that make prolonged preoperative or postoperative observations by a nurse or skilled medical personnel a necessity.

- Performance of another procedure simultaneously, which itself requires hospitalization.

- Likelihood of another procedure following the initial procedure, which would require hospitalization.

Days that are not prior authorized under the level of care methodology as required by 405 IAC 5-17 will not be covered by Medicaid.

PA must be obtained for all admissions within 48 hours, excluding Saturdays, Sundays, and legal holidays. Concurrent review is necessary beyond the approved days.

Acute Care Hospital Admission

Prior Authorization is required for all nonemergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. 405 IAC 5-33 provides criteria for acute care hospital admissions for both adult and pediatric recipients. The specific criteria are listed below in Table 1 – Acute Care Hospital Admission Criteria for Adults and Table 2 - Acute Care Hospital Admission Criteria for Pediatrics.
Table 1 - Acute Care Hospital Admission Criteria for Adults

<table>
<thead>
<tr>
<th>Severity of Illness Criteria</th>
<th>Day of Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden onset of unconsciousness or disorientation (coma or unresponsiveness);</td>
<td></td>
</tr>
<tr>
<td>Pulse rate:</td>
<td></td>
</tr>
<tr>
<td>less than fifty (50) per minute; or</td>
<td></td>
</tr>
<tr>
<td>greater than one hundred forty (140) per minute;</td>
<td></td>
</tr>
<tr>
<td>Blood pressure:</td>
<td></td>
</tr>
<tr>
<td>systolic less than ninety (90) or greater than two hundred (200) millimeters mercury; or</td>
<td></td>
</tr>
<tr>
<td>diastolic less than sixty (60) or greater than one hundred twenty (120) millimeters mercury;</td>
<td></td>
</tr>
<tr>
<td>Acute loss of sight or hearing;</td>
<td></td>
</tr>
<tr>
<td>Acute loss of ability to move body part;</td>
<td></td>
</tr>
<tr>
<td>Persistent fever equal to or greater than one hundred (100) (p.o.) or greater than one hundred one (101) (R) for more than five (5) days;</td>
<td></td>
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<tr>
<td>Active bleeding;</td>
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<tr>
<td>Severe electrolyte/blood gas abnormality, including any of the following:</td>
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<tr>
<td>Na &lt; 123 mEq/L</td>
<td></td>
</tr>
<tr>
<td>Na &gt; 156 mEq/L</td>
<td></td>
</tr>
<tr>
<td>K &lt; 2.5 mEq/L</td>
<td></td>
</tr>
<tr>
<td>K &gt; 6.0 mEq/L</td>
<td></td>
</tr>
<tr>
<td>CO2 combining power (unless chronically abnormal) &lt; 20 mEq/L</td>
<td></td>
</tr>
<tr>
<td>CO2 combining power (unless chronically abnormal) &gt; 36 mEq/L</td>
<td></td>
</tr>
<tr>
<td>Blood pH &lt; 7.30</td>
<td></td>
</tr>
<tr>
<td>Blood pH &gt; 7.45;</td>
<td></td>
</tr>
<tr>
<td>Acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, or breathe); must also meet intensity of service criterion simultaneously in order to certify; do not use for back pain;</td>
<td></td>
</tr>
<tr>
<td>EKG evidence of acute ischemia; must be suspicion of a new MI; or</td>
<td></td>
</tr>
</tbody>
</table>
### Intensity of Service

- Wound dehiscence of evisceration.
- Intravenous medications and/or fluid replacement (does not include tube feedings);
- Surgery or procedure scheduled within twenty-four (24) hours requiring:
  - general or regional anesthesia; or
  - use of equipment, facilities, or procedure available only in a hospital;
- Vital sign monitoring every two (2) hours or more often (may include telemetry or bedside cardiac monitor);
- Chemotherapeutic agents that require continuous observation for life-threatening toxic reaction;
- Treatment in an intensive care unit;
- Intramuscular antibiotics at least every eight (8) hours; and
- Intermittent or continuous respirator use at least every eight (8) hours

### Criteria of Appropriateness of Day of Care

- Medical services:
  - procedure in operating room that day;
  - scheduled for procedure in operating room the next day, requiring preoperative consultation or evaluation;
  - cardiac catheterization that day;
  - angiography that day;
  - biopsy of internal organ that day;
  - thoracentesis or paracentesis that day;
  - invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day;
  - any test requiring strict dietary control for the duration of the diet;
  - new or experimental treatment requiring frequent dose adjustments under direct medical supervision;
  - close medical monitoring by a doctor at least three (3) times daily (observations must be documented in record); or
- postoperative day for any procedure covered listed below:
  - procedure in operating room that day;
  - cardiac catheterization that day;
  - angiography that day;
biopsy of internal organ that day;
- thoracentesis or paracentesis that day;
- invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day

\textbf{Nursing/life support services:}
- respiratory care—intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB) at least three (3) times daily;
- parenteral therapy—intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein, or medications);
- continuous vital sign monitoring, at least every thirty (30) minutes, for at least four (4) hours;
- IM and/or SC injections at least twice daily;
- intake and output measurement;
- major surgical wound and drainage care (chest tubes, T-tubes, hemovacs, Penrose drains); or
- close medical monitoring by nurse at least three (3) times daily, under doctor’s orders.

\textbf{Patient condition:}
- within twenty-four (24) hours before day of review inability to void or move bowels (past twenty-four (24) hours) not attributable to neurologic disorder;
- within forty-eight (48) hours before day of review:
  - transfusion due to blood loss;
  - ventricular fibrillation or ECG evidence of acute ischemia, as stated in progress note or in ECG report;
  - fever at least one hundred one (101) degrees rectally (at least one hundred (100) degrees orally), if patient was admitted for reasons other than fever;
  - coma—unresponsiveness for at least one (1) hour;
  - acute confusional state, not due to alcohol withdrawal;
  - acute hematologic disorders, significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis yielding signs or symptoms; or
<table>
<thead>
<tr>
<th>Severity of Illness</th>
<th>Day of Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sudden onset of unconsciousness (coma or unresponsiveness) or disorientation;</td>
<td></td>
</tr>
<tr>
<td>• Acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, breathe, or urinate);</td>
<td></td>
</tr>
<tr>
<td>• Acute loss of sight or hearing;</td>
<td></td>
</tr>
<tr>
<td>• Acute loss of ability to move body part;</td>
<td></td>
</tr>
<tr>
<td>• Persistent fever (&gt; one hundred (100) degrees orally or &gt; one hundred one (101) degrees rectally) for more than ten (10) days;</td>
<td></td>
</tr>
<tr>
<td>• Active bleeding;</td>
<td></td>
</tr>
<tr>
<td>• Wound dehiscence or evisceration;</td>
<td></td>
</tr>
<tr>
<td>• Severe electrolyte/acid-base abnormality, including any of the following:</td>
<td></td>
</tr>
<tr>
<td>- Na &lt; 123 mEq/L</td>
<td></td>
</tr>
<tr>
<td>- Na &gt; 156 mEq/L</td>
<td></td>
</tr>
<tr>
<td>- K &lt; 2.5 mEq/L</td>
<td></td>
</tr>
<tr>
<td>- K &gt; 6.0 mEq/L</td>
<td></td>
</tr>
<tr>
<td>- CO2 combining power (unless chronically abnormal) &lt;20 mEq/L</td>
<td></td>
</tr>
<tr>
<td>- CO2 combining power (unless chronically abnormal) &gt; 36 mEq/L</td>
<td></td>
</tr>
<tr>
<td>- Arterial pH &lt; 7.30</td>
<td></td>
</tr>
<tr>
<td>- Arterial pH &gt; 7.45;</td>
<td></td>
</tr>
<tr>
<td>- Hematocrit &lt; thirty percent (30%);</td>
<td></td>
</tr>
<tr>
<td>• Pulse rate outside following ranges (optimally a sleeping pulse for &lt; twelve (12) years old):</td>
<td></td>
</tr>
<tr>
<td>- 2–6 years old 70–200/minute</td>
<td></td>
</tr>
<tr>
<td>- 7–11 years old 60–180/minute</td>
<td></td>
</tr>
<tr>
<td>- 12 years old 50–140/minute</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 - Acute Care Hospital Admission Criteria for Pediatrics
### Blood pressure outside following ranges:
- **Systolic/Diastolic**
  - 2–6 years old: 75–125 mm Hg/ 40–90 mm Hg
  - 7–11 years old: 80–130 mm Hg/ 45–90 mm Hg
  - < 12 years old: 90–200 mm Hg/ 60–120 mm Hg

### Need for lumbar puncture, where this procedure is not done routinely on an outpatient basis;
### Any conditions not responding to outpatient, including emergency room:
- seizures;
- cardiac arrhythmia;
- bronchial asthma or croup;
- dehydration;
- encopresis (for clean-out); or
- other physiologic problem (specify);
### Special pediatric problems:
- child abuse;
- noncompliance with necessary therapeutic regimen; or
- need for special observation or close monitoring of behavior, including calorie intake in cases of failure to thrive.

### Intensity of Service
- Surgery or procedure scheduled within twenty-four (24) hours requiring:
  - general or regional anesthesia; or
  - use of equipment, facilities, or procedure available only in a hospital;
- Treatment in an intensive care unit;
- Vital sign monitoring every two (2) hours or more often (may include telemetry or bedside cardiac monitor);
- Intravenous medications and/or fluid replacement (does not include tube feedings);
- Chemotherapeutic agents that require continuous observation for life-threatening toxic reaction;
- Intramuscular antibiotics at least every eight (8) hours; and
- Intermittent or continuous respirator use at least eight (8) hours.
### Criteria of appropriateness of day of care

- For medical services, the following documented criteria will be used for continued stay reviews; at least one (1) of the criteria must be met for the continued stay to be recertified:
  - Procedure in operating room that day.
  - Procedure scheduled in operating room the next day, requiring preoperative consultation or evaluation.
  - If day being reviewed is the day of admission, any procedure listed below (cardiac catheterization through gastrointestinal endoscopy) scheduled for the day after admission unless that procedure is usually done at that facility on a same-day basis.
  - Cardiac catheterization that day.
  - Angiography that day.
  - Biopsy of internal organ that day.
  - Thoracentesis or paracentesis that day.
  - Invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day.
  - Gastrointestinal endoscopy that day.
  - Any test requiring strict dietary control for the duration of the diet.
  - New or experimental treatment requiring frequent dose adjustments under direct medical supervision.
  - Close medical monitoring by a doctor at least three (3) times daily (observations must be documented in record).
  - Postoperative day for any procedure covered below:
    - Procedure in operating room that day
    - Cardiac catheterization that day
    - Angiography that day
    - Biopsy of internal organ that day
    - Thoracentesis or paracentesis that day
    - Invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day
    - Gastrointestinal endoscopy that day
- Nursing/life support services shall be as follows:
  - Respiratory care—intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB), at least three (3) times daily, Bronkosol with oxygen,
oxyhoids, or oxygen tents.

- Parenteral therapy—intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein, or medications).
- Continuous vital sign monitoring, at least every thirty (30) minutes for at least four (4) hours.
- IM and/or SC injections at least twice daily.
- Intake and/or output measurement.
- Major surgical wound and drainage care, for example, chest tubes, T-tubes, hemovacs, or Penrose drains.
- Traction for fractures, dislocations, or congenital deformities.
- Close medical monitoring by nurse at least three (3) times daily, under doctor's orders.

- Patient condition:
  - within twenty-four (24) hours on or before day of review, inability to void or move bowels, not attributable to neurologic disorder—usually a post-op;
  - within forty-eight (48) hours on or before day of review:
    - transfusion due to blood loss;
    - ventricular fibrillation or ECG evidence of acute ischemia as stated in progress note or in ECG report;
    - fever at least one hundred one (101) degrees rectally (at least one hundred (100) degrees orally) if patient was admitted for reason other than fever;
    - coma—unresponsiveness for at least one (1) hour;
    - acute confusional state, including withdrawal from drugs and alcohol;
    - acute hematologic disorders—significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis—yielding signs of symptoms; or
    - progressive acute neurologic difficulties; and
  - within fourteen (14) days before day of review, occurrence of a documented, new acute myocardial
Infarction or cerebrovascular accident (stroke).

Inpatient Psychiatric Admissions

Prior Authorization is required for all inpatient psychiatric admissions, including admissions for substance abuse. The facility is responsible for initiating the PA review process. Providers should contact the appropriate PA entity for the initial pre-certification and concurrent review.

Medicaid reimbursement will be denied for any days during which the inpatient psychiatric hospitalization is found not to have been medically necessary. Telephone precertification of medical necessity will provide a basis for Medicaid reimbursement only if adequately supported by the written certification of need submitted. If the required written documentation is not submitted within the specified time frame, Medicaid reimbursement will be denied.

Table 3 – Inpatient Psychiatric Admissions

<table>
<thead>
<tr>
<th>Inpatient Psychiatric Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telephone Precertification Reviews and 1261A Forms</strong></td>
</tr>
<tr>
<td>Emergency and non-emergency admissions to psychiatric units of acute care hospitals require telephone precertification and concurrent review. The facility is responsible for initiating both with the appropriate PA department based on the program assignment of the member for each admission. The precertification review must be followed by a written certification of need (1261A form) within 10 days of a non-emergency admission and within 14 working days of an emergency admission.</td>
</tr>
</tbody>
</table>

| **Certificate of Need Requirements** |
| All mental health service admissions, including admissions for substance abuse and chemical dependency regardless of the setting, require a Certification of Need, Form 1261A. For nonemergency admissions, the IHCP must receive the 1261A form within 10 working days of the admission. For emergency admissions, the IHCP must receive the 1261A form within 14 working days of the admission. The 1261A form must include detailed information to document the admission. If the 1261A form does not meet the requirements, any claim associated with the admission is denied. The certification of need must be completed in writing at least every 60 days after admission, or as requested, to recertify that the member continues to require inpatient psychiatric hospital services. |
The certification of need must be completed as follows:

- By the attending physician or staff physician for a Medicaid recipient between twenty-two (22) and sixty-five (65) years of age in a psychiatric hospital of sixteen (16) beds or less and for a Medicaid recipient sixty-five (65) years of age and over.
- In accordance with 42 CFR 441.152(a), effective October 1, 1995, (not including secondary Code of Federal Regulations citations therein) and 42 CFR 441.153, effective October 1, 1995, (not including tertiary Code of Federal Regulations citations resulting there from) for an individual twenty-one (21) years of age and under.
- By telephone precertification review prior to admission for an individual who is a recipient of Medicaid when admitted to the facility as a nonemergency admission, to be followed by a written certification of need within ten (10) working days of admission.
- By telephone precertification review within forty-eight (48) hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, to be followed by a written certification of need within fourteen (14) working days of admission.
- If the provider fails to call within forty-eight (48) hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, Medicaid reimbursement shall be denied for the period from admission to the actual date of notification.
- In writing within ten (10) working days after receiving notification of an eligibility determination for an individual applying for Medicaid while in the facility and covering the entire period for which Medicaid reimbursement is being sought.
- In writing at least every sixty (60) days after admission, or as requested by the office or its designee, to recertify that the patient continues to require inpatient psychiatric hospital services.

| Basis for Reimbursement | Reimbursement is denied for any days during the inpatient psychiatric hospitalization that are not found to be medically necessary. Telephone precertifications of medical necessity provide a basis for reimbursement only if adequately supported by the written certification of need submitted in accordance with the above requirements. If the required written documentation is not submitted within the specified time frame, reimbursement is denied. |
Inpatient Detoxification, Rehabilitation, and Aftercare

Medicaid reimbursement is available for inpatient detoxification, rehabilitation, and aftercare for chemical dependency when such services are prior authorized and:

- Admission to a general hospital floor is not indicated unless the medical services are required for life support and cannot be rendered in a substance abuse treatment unit or facility.
- Prior authorization for inpatient detoxification, rehabilitation, and aftercare for chemical dependency shall include consideration of the following:
  - All requests for prior authorization will be reviewed on a case-by-case basis by the contractor.
  - The treatment, evaluation, and detoxification are based on the stated medical condition.
  - The need for safe withdrawal from alcohol or other drugs.
  - A history of recent convulsions or poorly controlled convulsive disorder.
  - Reasonable evidence that detoxification and aftercare cannot be accomplished in an outpatient setting.

The PA entity reviews each request and determines whether the 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. Refer to Mental Health/Behavioral Health – Inpatient Services within this manual for specific coverage information.

Inpatient Rehabilitation Admissions

Prior authorization is required for all inpatient rehabilitation admissions. Prior to admission to a physical rehabilitation unit, an assessment of the patient's total rehabilitative potential must be completed and documented in the medical record. Also, a written plan of care, cooperatively developed by the therapist or psychologist and the attending physician, is required for all rehabilitation services.

Prior to admission to a physical rehabilitation unit, the member's total rehabilitation 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 physical rehabilitation admission:

- The patient is medically stable.
- The patient is responsive to verbal or visual stimuli.
- The patient has sufficient mental alertness to participate in the program.
The patient's premorbid condition indicates a potential for rehabilitation.
The expectation for improvement is reasonable.
The criteria listed in 405 IAC 5-32 are met.

Per 405 IAC 5-32 the following criteria shall demonstrate the inability to function independently with demonstrated impairment. Table 4 – Inpatient Rehabilitation Admissions contains the evaluation criteria necessary to determine the member’s ability or inability to function independently.

Table 4 – Inpatient Rehabilitation Admissions

<table>
<thead>
<tr>
<th>Severity of Illness Criteria</th>
<th>Inpatient Rehabilitation Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cognitive function (attention span, memory, or intelligence).</td>
</tr>
<tr>
<td></td>
<td>Communication (aphasia with major receptive or expressive dysfunction).</td>
</tr>
<tr>
<td></td>
<td>Continence (bladder or bowel).</td>
</tr>
<tr>
<td></td>
<td>Mobility (transfer, walk, climb stairs, or wheelchair).</td>
</tr>
<tr>
<td></td>
<td>Pain management (pain behavior limits functional performance).</td>
</tr>
<tr>
<td></td>
<td>Perceptual motor function (spatial orientation or depth or distance perception).</td>
</tr>
<tr>
<td></td>
<td>Self-care activities (drink or feed, dress, maintain personal hygiene, brace or prosthesis).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensity of Service Criteria</th>
<th>Inpatient Rehabilitation Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multidisciplinary team evaluation at least every two (2) weeks.</td>
</tr>
<tr>
<td></td>
<td>Physical therapy and at least one (1) of the following therapies (totaling a minimum of three (3) hours daily):</td>
</tr>
<tr>
<td></td>
<td>Occupational therapy.</td>
</tr>
<tr>
<td></td>
<td>Speech therapy.</td>
</tr>
<tr>
<td></td>
<td>Participation in a rehabilitation program under the direction of a qualified physician.</td>
</tr>
<tr>
<td></td>
<td>Skilled rehabilitative nursing care or supervision required at least daily.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge Criteria</th>
<th>Inpatient Rehabilitation Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Evidence in record that patient has achieved stated goals.</td>
</tr>
<tr>
<td></td>
<td>Medical complications preclude intensive rehabilitative effort.</td>
</tr>
<tr>
<td></td>
<td>Multidisciplinary therapy no longer needed.</td>
</tr>
<tr>
<td></td>
<td>No additional functional improvement is anticipated.</td>
</tr>
<tr>
<td></td>
<td>Patient's functional status has remained unchanged for fourteen (14) days.</td>
</tr>
</tbody>
</table>
Inpatient Surgical Admissions

Prior authorization is required for all surgical procedures typically performed on an outpatient basis, when performed on an inpatient basis, require PA (405 IAC 5-17-2). Table 5 – Inpatient Surgical Admission provides additional criteria for determining medical necessity.

Table 5 - Inpatient Surgical Admission

<table>
<thead>
<tr>
<th>Admission Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgical Procedures</strong></td>
</tr>
<tr>
<td>Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient, must be prior authorized. The length of stay for the inpatient admission is determined by the appropriate DRG but is subject to retrospective review for medical necessity.</td>
</tr>
<tr>
<td>Criteria for determining the medical necessity for inpatient admission includes the following information:</td>
</tr>
<tr>
<td>➢ Technical or medical difficulty during the outpatient procedure as documented in the medical record</td>
</tr>
<tr>
<td>➢ Presence of physical or mental conditions, which make prolonged preoperative or postoperative observations by a nurse or other skilled medical personnel a necessity</td>
</tr>
<tr>
<td>➢ Performance of another procedure simultaneously, which itself requires hospitalization</td>
</tr>
<tr>
<td>➢ Likelihood of another procedure, which would require hospitalization following the initial procedure</td>
</tr>
</tbody>
</table>

Dental Admissions

Prior authorization is required for all dental admissions. Table 6 – Inpatient Dental Admission lists the admission indicators for inpatient dental admissions.

Table 6 - Inpatient Dental Admission

<table>
<thead>
<tr>
<th>Admission Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>One of the following:</td>
</tr>
<tr>
<td>➢ 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</td>
</tr>
<tr>
<td>➢ Severe physical disorders affecting the tongue or jaw movements</td>
</tr>
<tr>
<td>➢ Seizure disorders</td>
</tr>
<tr>
<td>➢ Significant psychiatric disorders resulting in impairment of the recipient’s ability to cooperate with procedures</td>
</tr>
<tr>
<td>➢ Previously demonstrated idiosyncratic or severe reactions to IV sedation medication</td>
</tr>
</tbody>
</table>
• The need for oral surgery, listed in 405 IAC 5-19-17; or in extreme cases of facial trauma, pathology, or deformity
• Periodontal surgery only in cases of drug-induced periodontal hyperplasia
• Elective oral surgery when recipient is unable to cooperate with or tolerate the procedure

Inpatient Burn Admissions

Prior authorization is required for inpatient hospitalizations for the immediate treatment of burns, except those with an admit of type 1 (emergency) or type 5 (trauma)

The following criteria listed in Tables 7 and 8 – Hospitalization for Adults and Children with Burns are to be used for reference in determining IHCP appropriate inpatient burn admissions.

Table 7 - Hospitalization for Adults with Burns (Age 10 and Over)

<table>
<thead>
<tr>
<th>Degree of Burn</th>
<th>Description/Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Degree</td>
<td>• Superficial</td>
</tr>
<tr>
<td></td>
<td>• Damage is limited to the epidermis</td>
</tr>
<tr>
<td></td>
<td>• Erythema appears</td>
</tr>
<tr>
<td></td>
<td>• Between 10 and 20 percent of total body surface (TBS) area – Minor Burn</td>
</tr>
<tr>
<td>Second Degree</td>
<td>• Deep partial thickness burns of eyes, ears, face, hands, feet, or perineum; or</td>
</tr>
<tr>
<td></td>
<td>• Burns complicated by fractures or respiratory damage;</td>
</tr>
<tr>
<td></td>
<td>• Electrical burns; and</td>
</tr>
<tr>
<td></td>
<td>• All burns in poor-risk patients</td>
</tr>
<tr>
<td></td>
<td>• Involvement of less than 15 percent TBS area – Minor Burn</td>
</tr>
<tr>
<td></td>
<td>• Involvement of 15 to 25 percent TBS area – Moderate Burn</td>
</tr>
<tr>
<td></td>
<td>• Involvement of more than 25 percent TBS area – Major Burn</td>
</tr>
<tr>
<td>Third Degree</td>
<td>• Full thickness burns covering less than 3 percent of the body – Minor Burn</td>
</tr>
<tr>
<td></td>
<td>➢ Excluding the eyes, ears, face, hands, feet or perineum – OR</td>
</tr>
<tr>
<td></td>
<td>• Full thickness burns covering greater than 3 percent and less than 10 percent TBS area – Moderate Burn</td>
</tr>
<tr>
<td></td>
<td>➢ Including the eyes, ears, face, hands, feet, or perineum – OR</td>
</tr>
<tr>
<td></td>
<td>• Full thickness burns of more than 10 percent of the TBS – Major Burn</td>
</tr>
</tbody>
</table>

Admission Indicators
The admission may be approved without referral for physician review if one of the following is present (recent onset):

- Loss or damage of skin ≥ 15 percent of TBS area
- High-voltage burn with devitalized skin, fat, or muscle
- Second- or third-degree burns of one of the following: face, hands, perineal region, encircling neck or extremities, anterior or posterior neck or limbs
- T ≥ 104.0°F
- T ≥ 102.0°F and one of the following:
  - White blood cells (WBC) ≥ 18,000/cu.mm
  - WBC ≥ 15,000/cu.mm with ≥ 7 percent bands
- T ≥ 100.5°F and one of the following:
  - Absolute neutrophil count ≤ 500/cu.mm
  - WBC ≤ 1,500/cu.mm
- 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):

- Post surgery or procedure care ≤ three days and at least two of the following:
  - IV fluids ≥ 100 mL/h
  - IV or IM analgesics
  - IV or IM anti-emetics
  - Graft or wound care
- Burn therapy with at least three of the following:
  - IV electrolyte (K, Ca, Mg, P)
  - IV fluids ≥ 100 mL/h
  - IV plasma expanders
  - O2 ≥ 28 percent (4L) or hyperbaric
  - Total parenteral nutrition (TPN)

Or at least three of the following treatments are being provided:

- Blood or blood products
- Complex burn, graft, or wound care
- IV fluids ≥ 100 mL/h
- Restorative PT or OT at least 2x/24h
- TPN
- IV or IM corticosteroids at least 3x/24h
- IV or IM diuretics at least 2x/24h
- IV or IM analgesics at least 4x/24h
- IV or IM anti-emetics at least 4x/24h
- IV or IM anti-infectives at least 3x/24h
## Table 8 - Hospitalization for Children with Burns (Age 10 and Under)

<table>
<thead>
<tr>
<th>Degree of Burn</th>
<th>Definition/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Degree</strong></td>
<td>• Superficial</td>
</tr>
<tr>
<td></td>
<td>• Damage is limited to the epidermis</td>
</tr>
<tr>
<td></td>
<td>• Erythema appears</td>
</tr>
<tr>
<td></td>
<td>• Between 10 and 20 percent area – Minor Burn</td>
</tr>
<tr>
<td><strong>Second Degree</strong></td>
<td>• Deep partial thickness burns of eyes, ears, face, hands, feet, or perineum; or</td>
</tr>
<tr>
<td></td>
<td>• Burns complicated by fractures or respiratory damage;</td>
</tr>
<tr>
<td></td>
<td>• Electrical burns; and</td>
</tr>
<tr>
<td></td>
<td>• All burns in poor-risk patients</td>
</tr>
<tr>
<td></td>
<td>• Involvement of less than 10 percent TBS area – Minor Burn</td>
</tr>
<tr>
<td></td>
<td>• Involvement of 10 to 20 percent TBS area – Moderate Burn</td>
</tr>
<tr>
<td></td>
<td>• Involvement of more than 20 percent TBS area – Major Burn</td>
</tr>
<tr>
<td><strong>Third Degree</strong></td>
<td>• Full thickness burns covering 2 percent of the body – Major Burn</td>
</tr>
<tr>
<td></td>
<td>– Excluding the eyes, ears, face, hands, feet or perineum – OR</td>
</tr>
<tr>
<td></td>
<td>• Full thickness burns covering greater than 1 percent and less than 10 percent TBS area – Major Burn</td>
</tr>
<tr>
<td></td>
<td>– Including the eyes, ears, face, hands, feet, or perineum</td>
</tr>
</tbody>
</table>

### Admission Indicators

The admission may be approved without referral for physician review if **one** of the following is present (recent onset):

- Electrical burns with devitalized skin, fat, or muscle
- First-degree burns covering 40 percent of TBS
- Second-degree burns covering 15 percent of TBS
- Second-degree burns covering face, genitalia, hands, or feet
- Third-degree burns covering 5 percent or more of TBS

**And** at least **one** of the following treatments is being provided at least daily:

- Post surgery or procedure care ≤ two days
- IV electrolytes
- Burn therapy with at least **two** of the following:
  - IV fluids ≥ 30 mL/kg/24h
  - IV plasma expanders
  - 02> 28 percent (4L)

**Or** at least **three** of the following treatments are being provided:
### Hospital Inpatient Services

<table>
<thead>
<tr>
<th>Service Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood or blood products</td>
</tr>
<tr>
<td>Complex burn, graft, or wound care</td>
</tr>
<tr>
<td>PT</td>
</tr>
<tr>
<td>IV fluids ≥ 30 mL/kg/24h</td>
</tr>
<tr>
<td>IV plasma expanders</td>
</tr>
<tr>
<td>TPN or enteral feeding</td>
</tr>
<tr>
<td>IV or IM corticosteroids at least 3x/24h</td>
</tr>
<tr>
<td>IV diuretics at least 2x/24h</td>
</tr>
<tr>
<td>IV or IM analgesics at least 4x/24h</td>
</tr>
<tr>
<td>IV or IM anti-emetics at least 4x/24h</td>
</tr>
<tr>
<td>IV or IM anti-infectives at least 3x/24h</td>
</tr>
<tr>
<td>Inpatient Dental Admission</td>
</tr>
</tbody>
</table>

### Out-Of-State Services

All out-of-state services require Prior Authorization (see 405 IAC 5-5-1). The following services are exceptions:

- Emergency services
- Recipients of the adoption assistance program placed outside of Indiana
- Services that are provided by designated cities listed in 405 IAC 5-5-2(a) (3)-(4)

### Emergency Inpatient Admissions

Per 405 IAC 5-17-3, emergency inpatient admissions for diagnoses reimbursed under the level of care payment methodology and emergency substance abuse inpatient admissions 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.

### Billing Requirements

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs. Providers must bill utilizing the appropriate procedure code. 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. For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.

Although the IHCP reimburses inpatient hospital services using a diagnosis-related group (DRG)/Level of Care (LOC) methodology, the IHCP requires a complete itemization of services.
performed using appropriate revenue codes in field 42 of the claim form. The revenue code reveals crucial information about the type of service provided during the inpatient stay. Therefore, providers need to ensure that each claim properly identifies the appropriate revenue code. The revenue code that is used must reflect the setting in which the care was delivered.

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 DRG payment. The hospital stay must be billed on the UB-04 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.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>120</td>
<td>Inpatient days (appropriate procedure code for dental procedure must also be authorized)</td>
</tr>
</tbody>
</table>

**Inpatient Psychiatric**

The IHCP reimburses for inpatient psychiatric services provided by facilities that are freestanding, or distinct parts at an all-inclusive, statewide per diem rate that includes routine, ancillary, and capital costs. The IHCP bases reimbursement for substance abuse and chemical dependency admissions on DRG payment methodology. Direct care services of physicians, including psychiatric evaluations, are excluded from the per diem rate and are billable separately by the rendering provider on the CMS-1500 claim form. The per diem rate includes all other supplies and services provided to patients in inpatient psychiatric facilities, including services of health service providers in psychology (HSPP), clinical psychologists, and clinical social workers, regardless of whether salaried, contracted, or independent providers and providers cannot bill these supplies and services separately.

Providers must submit inpatient psychiatric claims using the revenue code that has been authorized for this admission.

The IHCP reimburses providers for reserving beds in a psychiatric hospital but not in a general acute care hospital for hospitalization of Traditional Medicaid members, as well as for reserving beds for a therapeutic leave of absence. In both instances, the IHCP reimburses the facility at one-half the regular per diem rate. 405 IAC 5-20-2 provides specific criteria about the reservation of beds in an inpatient psychiatric facility.

**Inpatient Burn**

To ensure proper reimbursement of burn treatment, the provider must contact the prior authorization department and provide all the necessary information for the admission. Once the
member has been discharged, the provider must call the prior authorization department with the date of discharge.

Table 10 – Revenue Code – Admission for Burns

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Narrative Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>207</td>
<td>Admissions for burns</td>
</tr>
</tbody>
</table>

**Inpatient Stay Less than 24 Hours**

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 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.

**Observation Billing**

Providers can retain members for more than one 23-hour observation period when the member has not met criteria for admission but the treating physician believes that allowing the member to leave the facility would likely put the member at serious risk. This observation period can last not more than three days or 72 hours and is billed as an outpatient claim.

Please refer to Chapter 8 of the IHCP Provider Manual, at www.indianamedicaid.com for complete billing requirements.

**Rules, Citations and Sources**

- 405 IAC 5-3-13 – Services requiring prior authorization
- 405 IAC 1-10.5 – Reimbursement for Inpatient Hospital Services
- 405 IAC 5-17 – Hospital Services
- 405 IAC 5-32 – Rehabilitation Unit
- 405 IAC 5-33 – Acute Care Hospital Admission
- IHCP Provider Manual

**Note:** For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

**Related Medical Topics**

Hospital Inpatient – Readmissions
Mental Health/Behavioral Health – Inpatient Services

Nursing Facilities
Hospital Inpatient Readmissions

Introduction

This section serves as a general summary of the IHCP’s policies regarding hospital inpatient readmissions. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Readmission is the term used when patients are admitted into the hospital, acute care or other, following a previous admission and discharge for the same or a related diagnosis.

Reimbursement Requirements

Readmissions are subject to medical review to determine if the 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. For payment purposes, readmissions within three days after discharge will be treated as the same admissions, while readmissions after three days will be treated as separate stays but are subject to medical review.

Prior Authorization Requirements

PA is not required for hospital inpatient readmissions.

Billing Requirements

Providers should bill one inpatient claim (UB-04) when a patient is readmitted to their facility within three days of the previous inpatient discharge. If the previous inpatient claim is paid before the readmission, the provider should adjust the paid claim and resubmit one inpatient claim for both the previous inpatient stay and the readmission stay.

Rules, Citations and Sources

405 IAC 1-10.5-2 – Definitions

405 IAC 1-10.5-3 – Reimbursement for Inpatient Hospital Services
IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Hospital Inpatient Services

Mental Health/Behavioral Health – Inpatient Services

Mental Health/Behavioral Health – Outpatient Services

Nursing Facilities
Hospital Outpatient Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding hospital outpatient services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

The IHCP defines hospital outpatient as a member whom the hospital has not admitted as an inpatient but who is registered in hospital records as an outpatient and receives services directly from the hospital. If personnel not employed by the hospital take a tissue sample, blood sample, or specimen and send it to the hospital for tests, the IHCP classifies the tests as non-patient (rather than outpatient) hospital services, because the patient did not directly receive services from the hospital.

Reimbursement Requirements

Outpatient services are covered for members who are not registered as inpatients in acute care or psychiatric hospitals. Outpatient services may include surgery, therapy, laboratory, radiology, chemotherapy, renal dialysis, clinic, treatment room, and emergency department care. The IHCP covers outpatient services when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member’s condition. The member’s medical condition, as described and documented in the medical record by the primary or attending physician, must justify the intensity of service provided.

The four categories of service within the defined outpatient hospital prospective payment system are as follows:

- Outpatient surgeries
- Treatment room visits
- Stand alone 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 a related diagnosis will be considered part of the corresponding inpatient admission.

Outpatient services within three days preceding an inpatient stay of less than 24 hours 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.

Prior Authorization Requirements

Surgical procedures that are usually provided on an outpatient basis but are performed as inpatient services (that is, medical difficulties during the outpatient procedure, prolonged pre- or post-operative observation, and simultaneous procedures requiring hospitalization) require PA.

The following services require PA:

- All out-of-state services
- Separately reimbursable, implantable durable medical equipment (DME) items

Billing Requirements

Outpatient Surgeries

Outpatient surgeries are reimbursed at a flat fee that includes reimbursement for related procedures in an all-inclusive rate. The outpatient surgery reimbursement methodology was designed using the Medicare-established ambulatory surgical center (ASC) methodology. Surgical procedure codes are classified into one of several reimbursement categories, with specific reimbursement rates established for each category. All services are included in the all-inclusive reimbursement rate.

Rate Information from HP Customer Assistance

The IHCP Web site includes ASC assignment codes and pricing. The ASC assignment codes classify CPT® and HCPCS codes to a payment group based on an estimate of the facility costs associated with performing the procedures.

Providers may access this information on the IHCP Web site at www.indianamedicaid.com under Fee Schedule. The ASC listing contains assignment codes, effective dates, and pricing. Additionally, assignment codes relating to specific CPT® and HCPCS codes are available on the IHCP Web site under Fee Schedule, using the procedure code or description search feature.
Treatment Room Services

For the purposes of the IHCP’s outpatient prospective-payment system, treatment rooms include emergency departments, clinics, cast rooms, labor and delivery rooms, recovery rooms, and observation rooms.

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. The IHCP does allow for multiple treatment room visits in the same day. Services must be billed on the UB-04 claim form using the appropriate revenue code. Over utilization will be subject to post payment review.

Stand alone services may be billed in conjunction with treatment room services. Stand alone services include therapies, dialysis, radiology, and laboratory services. Certain add-on services are allowed if they are billed in conjunction with a treatment room. All other add-on services are denied if they are billed in conjunction with a treatment room service.

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.

Stand-alone Services

Stand-alone services, such as dialysis and physical, occupational, and speech therapies, are reimbursable at an established flat statewide rate. A maximum of one unit of service per revenue code for each date of service (DOS) is allowed.

Laboratory and radiology services are reimbursed at the lower of the submitted charge on the claim or the fee schedule amount. Multiple units of laboratory and radiology services are available for reimbursement.

Add-on Services

Add-on services are separately reimbursable in conjunction with a stand-alone 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.

Add-on services are complementary outpatient services provided either in a treatment room or with a stand-alone service. Add-on services are reimbursed at a flat rate.

**Non-Covered Services**

Reimbursement shall not be made for any hospital services not covered under the IHCP. In addition, if a service requires 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.

**Rules, Citations and Sources**

*42 CFR § 440.20 – Outpatient hospital services*

*405 IAC 5-17-2 – Hospital Services*

IHCP Provider Bulletin

**BT200943: Reduction in Reimbursement for Inpatient and Outpatient Hospital Services**

IHCP Provider Manual

**Note:** For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp).

**Related Medical Topics**

Anesthesia Services

Clinic Services – Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services

Consultations – Second Opinions

Diagnostic Studies

Emergency Medicine – Emergency Room

Emergency Medicine – Emergency Services

Evaluation and Management Services

Home Health Services

Hospital Inpatient Services
Laboratory Services
Mental Health/Behavioral Health – Outpatient Services
Nursing Services
Radiology
Surgery – Surgical Services
Hyperbaric Oxygen Therapy

Introduction

This section serves as a general summary of the IHCP’s policies regarding hyperbaric oxygen (HBO) therapy. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

HBO is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure, increasing vascular flow and improving 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 noted in Coverage Criteria of this section.

Reimbursement Requirements

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

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM Codes</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflammatory conditions of jaw</td>
<td>526.2</td>
<td></td>
</tr>
<tr>
<td>Irradiation cystitis</td>
<td>595.82</td>
<td></td>
</tr>
<tr>
<td>Diabetic wounds of the lower extremities</td>
<td>250.70 – 250.73 and 250.80 – 250.83, 707.10 – 707.19</td>
<td>CMS criteria described in Transmittal AB-02-183</td>
</tr>
<tr>
<td>Acute carbon monoxide intoxication</td>
<td>986</td>
<td></td>
</tr>
<tr>
<td>Decompression illness</td>
<td>993.2, 993.3</td>
<td></td>
</tr>
<tr>
<td>Gas embolism</td>
<td>958.0, 999.1</td>
<td></td>
</tr>
<tr>
<td>Gas gangrene</td>
<td>040.0</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>ICD Codes</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Acute traumatic peripheral ischemia</td>
<td>902.53, 903.1, 903.01, 903.4, 904.0, 904.41, 996.9</td>
<td>Adjunctive treatment to be used in combination with accepted standards and therapeutic measures</td>
</tr>
<tr>
<td>Complications of reattached extremity or body part</td>
<td>996.90, 996.91, 996.92, 996.93, 996.94, 996.95, 996.96, 996.99</td>
<td>Adjunctive treatment when loss of function, limb or life is threatened.</td>
</tr>
<tr>
<td>Crush injuries and suturing of severed limbs</td>
<td>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</td>
<td>Other types of cutaneous ulcers are not covered.</td>
</tr>
<tr>
<td>(Meleney Ulcers) Progressive necrotizing infections</td>
<td>686.0, 686.09, 728.86</td>
<td></td>
</tr>
<tr>
<td>Acute peripheral arterial insufficiency</td>
<td>444.21, 444.22, 444.81</td>
<td>Na</td>
</tr>
<tr>
<td>Preparation and preservation of compromised skin grafts</td>
<td>996.52</td>
<td>Preparation and preservation</td>
</tr>
<tr>
<td>Chronic Refractory Osteomyelitis</td>
<td>730.10-730.19</td>
<td>Use when unresponsive to conventional medical and surgical management.</td>
</tr>
<tr>
<td>Osteoradionecrosis</td>
<td>526.89</td>
<td>Adjunct to conventional treatment</td>
</tr>
<tr>
<td>Soft tissue radionecrosis</td>
<td>990</td>
<td>Adjunct to conventional treatment</td>
</tr>
<tr>
<td>Cyanide poisoning</td>
<td>987.7, 989.0</td>
<td>N/A</td>
</tr>
<tr>
<td>Actinomycosis</td>
<td>039.0-039.4, 039.8, 039.9</td>
<td>Only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment</td>
</tr>
<tr>
<td>Acute cerebral edema</td>
<td>348.5</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Pursuant to 405 IAC 5-28-11, (b)(1) through (b)(22), Medicaid reimbursement is not available for hyperbaric oxygen (HBO) therapy 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
- Skin burns (thermal)
- 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
- Hepatic necrosis
- Aerobic septicemia
- Nonvascular causes of chronic brain syndrome, including Pick's, Alzheimer's, 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, which 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 for submission of documentation to support medical necessity of continued therapy.
405 IAC 5-28-11(c) provides, “Hyperbaric therapy shall be clinically practical and shall not be a replacement for other standard successful therapeutic measures.”

Prior Authorization Requirements

PA is not required for HBO therapy.

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 32.1) must be included on claims. When billing outpatient services, the appropriate diagnosis code for HBO therapy must be the first diagnosis indicated on the claim.

Note: The evaluation and management services and/or procedures (such as wound debridement) provided in a hyperbaric oxygen treatment must be reported separately from CPT® code 99183.

Rules, Citations and Sources

405 IAC 5-28-11

IHCP Banner Page

BR200952 - New Audit 6290 for Hyperbaric Oxygen Therapy

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Not applicable
Immunizations and Vaccines

Introduction
This section serves as a general summary of the IHCP's policies regarding immunizations and vaccines. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service
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 to prevent disease.

The IHCP provides coverage for many immunizations and vaccines. In addition, a variety of free vaccines are available for members 18 years of age and younger through the Vaccine for Children (VFC) program administered through the Indiana State Department of Health (ISDH).

VFC Program
The VFC program is a federally funded program intended to help raise childhood immunization levels in the United States by supplying healthcare providers with free vaccines to administer to children 18 years old and younger. Recipients must meet one or more of the following criteria:

- Be enrolled in the IHCP
- Have no health insurance
- Be identified by a parent or guardian as an American Indian or Alaskan native
- Be underinsured – for example, children with health insurance that does not cover immunizations (administered in FQHCs or RHCs only)

The VFC program makes vaccines available at no cost to providers for members 18 years old and younger (including those 18 years old and younger enrolled in Hoosier Healthwise Package C).

- All vaccine ordering, distribution, and accountability processes are administered through the ISDH's Indiana Immunization Program. The federal VFC program includes private and public practitioners across Indiana. 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. Providers should contact ISDH to enroll in the VFC program.

The VFC program offers the following free vaccines to children 18 years old and younger who meet criteria:

- Hepatitis A vaccine
- Hepatitis B vaccine
- Hemophilus influenza b vaccine
- Human Papilloma Virus (HPV) vaccine
- Influenza vaccine
- Pneumococcal conjugate vaccine
- Rotavirus vaccine
- DTaP vaccine
- DT vaccine
- Measles, mumps, and rubella virus vaccine
- Poliovirus vaccine
- Meningococcal conjugate vaccine
- Varicella virus vaccine

* The IHCP provides coverage for CPT® 90649 for both female and male members ages 9-26 years old and for CPT® 90650 for female members ages 10-26 years old. This coverage limitation includes members receiving VFC vaccines. Thus coverage and reimbursement is not available for 90649 and 90650 for members who do not meet the age and gender limitations regardless of the source of the vaccine (private stock or VFC). For members receiving 90649 or 90650 VFC vaccines, reimbursement of the $8 administration fee is subject to the member meeting the above age and gender criteria.

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 PMPs 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 Helpline.
Reimbursement Requirements

Vaccines not supplied through the VFC program or vaccines administered to members 19 years old and older are reimbursed the lesser of the provider’s usual and customary charge and the IHCP allowed amount. This includes vaccines typically supplied by the VFC program but have been supplied out of the provider’s private stock due to a shortage of VFC supplies. The IHCP calculates the maximum allowable reimbursement amount for physician office-administered injectable drugs, including vaccines and immunizations, on the basis of the most cost-effective, current, appropriate NDC, identified as the benchmark NDC. The maximum allowable reimbursement is equal to Wholesale Acquisition Cost (WAC) plus 5 percent (WAC+5%) of the benchmark NDC or, if no WAC data is available, CMS' reimbursement, currently Average Sales Price (ASP) plus 6 percent (ASP+6%). The IHCP maximum allowable reimbursement amount for physician administered drugs and vaccines are updated once each quarter and may be found on the fee schedule located on the Indiana Medicaid website (www.indianamedicaid.com).

VFC Program

For vaccines supplied through the VFC program, reimbursement for the vaccine itself is not available since the vaccine is supplied at no cost to the provider. However, providers may be reimbursed either the lower of their submitted charge or $8 for the administration of each vaccine.

Prior Authorization Requirements

For dates of service prior to November 1, 2011, Synagis, 90378 – Respiratory syncytial virus, antibody, recombinant, for intramuscular use, 50 mg, each, requires prior authorization (PA). The PA criteria may be found in the medical policy fact sheet "Pharmacy – Synagis."

For dates of service on or after November 1, 2011, Synagis remains a covered IHCP service, but only as a pharmacy benefit. Therefore, for dates of service on or after November 1, 2011, claims for 90378 will deny for non-coverage. Prior authorization for Synagis is still required and may be obtained by contacting Affiliated Computer Service (ACS) via fax at 1-866-780-2198. PA criteria may be found in provider banners and bulletins located on the Indiana Medicaid website (www.indianamedicaid.com).

Billing Requirements

Vaccines Not Part of the VFC Program

Providers may bill for both the vaccine and its administration (using CPT® code 96372 – Therapeutic, prophylactic, or diagnostic injections (specify substance or drug); subcutaneous or intramuscular). However, if an E/M service code is billed with the same date of service as an office-administered immunization, providers should not bill the vaccine administration code separately. Reimbursement for the administration is included in the E/M code-allowed amount.
Separate reimbursement is allowed when the administration of the drug is the only service billed by the practitioner. In addition, if more than one vaccine is administered on the same date of service and no E/M code is billed, providers may bill an administration fee for each injection.

**Vaccines Typically Part of VFC Program but Supplied From Private Stock**

Billing guidelines are the same as those for vaccines not part of the VFC program. Providers may bill for both the vaccine and its administration (using CPT® code 96372 – Therapeutic, prophylactic, or diagnostic injections (specify substance or drug); subcutaneous or intramuscular). However, if an evaluation and management (E/M) service code is billed with the same date of service as an office-administered immunization, providers should not bill the vaccine administration code separately. Reimbursement for the administration is included in the E/M code-allowed amount. Separate reimbursement is allowed only when the administration of the drug is the only service billed by the practitioner.

**Vaccines Part of the VFC Program and Received at No Cost to Providers**

The provider may bill the appropriate Current Procedural Terminology (CPT®) vaccine procedure code with a primary diagnosis of V20.2 – Routine infant or child health check and the lesser of the usual and customary administration fee or $8. Providers should not bill a separate CPT® administration code for a VFC-administered vaccine.

**Rules, Citations and Sources**

405 IAC 5-28-11

IHCP Provider Bulletin

**BT200007** - Vaccine for Children Update

IHCP Provider Manual


**Related Medical Topics**

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) HealthWatch Program
Intermediate Care Facilities for Individuals with Intellectual Disabilities

Introduction

This section serves as a general summary of the IHCP’s policies regarding intermediate care facilities for individuals with intellectual disabilities (ICF/IID). Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

Managed care members must be disenrolled from their managed care plans prior to becoming eligible for LOC services. Once disenrolled, IHCP coverage continues under the FFS traditional Medicaid program.

In unusual circumstances, a RBMC member may be placed in an ICF/IID 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/IID 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/IID determines, on checking eligibility on the date of admission (the first or 15th of each month) that the member is enrolled in RBMC, the facility must notify the RBMC organization within 72 hours after admission.**

- **If the ICF/IID notifies the RBMC organization within 72 hours, the RBMC organization is responsible for charges up to 60 calendar days from the date of admission.**

- **If the ICF/IID fails to verify a member’s coverage in the RBMC organization within 72 hours of admission, the facility may be responsible for charges incurred until the facility has notified the RBMC organization of the member’s status.**

- **In the case of notification past the 72-hour deadline, the RBMC organization is liable for charges incurred in the ICF/IID 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/IID, LOC determination has not been implemented, and the member is still enrolled in RBMC, the ICF/IID 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 for preadmission screening, LOC determination, disenrollment from managed care, and to ensure appropriate reimbursement to the facility for services rendered.

**Description of Service**

ICF/IID provide healthcare and rehabilitative services to individuals who do not require acute treatment interventions; however, as a result of intellectual disability, these individuals require consistent, daily interventions to improve daily functioning.

An ICF/IID IDT must develop a POC 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 quarterly and annually to prevent regression or loss of functional abilities.

**Reimbursement Requirements**

ICF/IID services provide a specific LOC to members who are intellectually disabled or who have certain other conditions meeting medical necessity requirements for placement in institutions meeting the certification standards for participating Medicaid providers. ICF/IID services and treatment programs are delivered on an inpatient basis, and under the direction and supervision of the required professional staff.

Admissions to an ICF/IID must be based upon a determination of the need for such care by a professional IDT. Approval by the Indiana Family and Social Services Administration – DDRS/Bureau of Developmental Disabilities Services (BDDS) must be received by the ICF/IID prior to admission, or in cases of those individuals who apply while in the institution, prior to payment for that service. The interdisciplinary professional team completes a comprehensive evaluation covering physical, emotional, social, and cognitive factors.

ICF/IID reimbursement will be provided by the Medicaid program for eligible members who meet all the following criteria:

- Diagnosis of intellectual disability or related conditions of epilepsy, cerebral palsy, or other developmental disability found to be closely related to intellectual disability; or conditions that require treatment similar to services required for individuals with intellectual disability. Eligible members may:
  - Have severe and profound intellectual disabilities, moderate intellectual disabilities, severely physically handicapped, aggressive, assaultive, or
represent security risks; or they may manifest severe hyperactive or psychotic-like behavior

- Have moderate intellectual disabilities and may require habit training, training, and guidance in the activities of daily living, and development of self-help skills for maximum independence, as needed by the member
- Participate in vocational training programs or adults who work in sheltered workshops

**Categories of ICF/IID**

There are three different categories of ICF/IID available to IHCP members. The three categories are listed below:

- Large private ICF/IID – greater than eight beds
- Small ICF/IID (commonly referred to as 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
- State operated facilities – greater than eight beds

**Admission and Readmission Criteria for Large Private and Small ICF/IID**

IHCP covers services provided by certified ICF/IID when such services are rendered to Medicaid members. Admissions to large private and small ICF/IID are based on a determination of the need for such care by DDRA/BDDS. The interdisciplinary professional team from the proposed placement facility reviews a comprehensive evaluation including physical, emotional, social, and cognitive factors to ensure that the facility can meet the member’s needs.

The interdisciplinary professional team includes a physician, certified social worker, Qualified Developmental Disability Professional (QDDP) (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/IID. 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 members to large private or small ICF/IID:
Diagnostic evaluation, including social and psychological components

A Form 450B – "Physician Certification for LTC Services," completed by the physician, must be submitted to DDRS/BDDS or its designee. The payment period will not be approved for any period of time preceding the date the physician signs the Form 450B certifying the need for ICF/IID 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/IID 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 IDT.

The certification must specify the LOC 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 re-certifications must be signed by a physician, a physician assistant, or a nurse practitioner, and dated at the time of signature. Electronic signatures may be utilized if the provider has an established written policy governing use of such electronic signatures. Such policy must be made available for audit purposes. Use of electronic signature is not mandated. (A stamped signature will not be accepted.)

- The admission certification and the three latest re-certifications 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 service plan (ISP) must be reviewed by the physician and the QDDP (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 IDT for relevancy and must be updated, as needed.

Admission to Large State ICF/IID

Admissions to large state-operated ICF/IID are based on a determination of the need for such care by DDRS/BDDS. The interdisciplinary professional team from the proposed placement facility reviews the comprehensive evaluation covering physical, emotional, social, and cognitive factors to ensure that the member’s needs are met. A physician must complete a Form 450B – "Physician Certification for LTC Services" prior to receiving the first IHCP payment.

Transfer to Another ICF/IID

A current Form 450B must be submitted for any transfer to another ICF/IID. Diagnosis and evaluation documentation completed within the last year must be submitted, as well. For large
state ICF/IID, if the member is transferred to a noncertified unit, the admission procedure must be followed for any readmission to the large state ICF/IID for determination of appropriate reimbursement.

Covered Services

Multiple services are provided to IHCP members once enrolled in an ICF/IID. Facilities provide all-inclusive per diem programs to ICF/IID-enrolled members. The following services are included in the programs as part of the per diem rate for large private and small ICF/ID:

- Room and board (including routine and special dietary services, laundry services, and room accommodations)
- Nursing services and supervision of health services
- Habilitation services provided in a family and social services administration approved setting that are required by the resident’s program plan of active treatment developed in accordance with 42 CFR 483.440, including, but not limited to the following:
  - Training in activities of daily living
  - Training in development of self help and social skills
  - Development and execution of activity schedules
  - Vocational/habilitation services
- All medical and nonmedical supplies and equipment furnished by the facility for the usual care and treatment of residents are covered in the per diem rate and may not be billed separately to Medicaid by the facility or by a pharmacy or other provider.
- Physical and occupational therapy, speech pathology, and audiology services provided by a licensed, registered, or certified therapist, as applicable, employed by the facility or under contract with the facility are included in the all-inclusive rate. Therapy services provided away from the facility must meet the criteria outlined in 405 IAC 5-22. All therapies must be specific and effective treatment for the improvement of function. Reimbursement is not available for services for remediation of learning disabilities.
- The reasonable cost of necessary transportation for the recipient is included in the per diem rate, including transportation to vocational/habilitation services, except for transportation that is provided to accommodate the delivery of emergency services. Emergency transportation services must be billed to Medicaid directly by the transportation provider.
- Durable medical equipment (DME) and associated repair costs, including, but not limited to:
  - Ice bags;
Bed rails;
Canes;
Walkers;
Crutches;
Standard wheelchairs; or
Traction equipment;

Are covered in the per diem rate and may not be billed to Medicaid by the facility, a pharmacy or any other provider. Any other type of nonstandard DME requires prior approval by the office and must be billed to the Medicaid recipients to purchase or rent DME with their personal funds. DME purchased with Medicaid funds becomes the property of the office. The facility must notify the county office of family and children when the recipient no longer needs the equipment.

- Mental health services provided by the ICF/ID are included in the all-inclusive residential per diem rate. These services include the following:
  - Behavior management services and consulting
  - Psychiatric services
  - Psychological services

The following services are included in the programs as part of the per diem rate for a large state ICF/IID:
- Room and board (room accommodations, dietary services, and laundry services).
- Medical services
- Mental health services
- Dental services
- Therapy and habilitation services
- Durable medical equipment (DME)
- Medical and nonmedical supplies
- Pharmaceutical products
- Transportation
- Optometric services

The following services are provided to a Medicaid resident residing in a large state ICF/IID and are reimbursed through the per diem rate except as follows:
Hospital services rendered due to an acute illness or injury may be billed to Medicaid directly by the hospital. Individual exceptions to other medical care that must be rendered by practitioners outside the facility require prior authorization from the office.

Dental services provided in the facility shall be included in the per diem rate. Necessary dental services that cannot be provided on-site by the dental staff require prior authorization by the office. Dental services prior authorized by the office must be billed to the Medicaid program directly by the outside dental provider. Admission of a recipient to a hospital for the purpose of performing dental services requires prior authorization by the office.

DME and associated repair costs, including, but not limited to:
- Ice bags;
- Bed rails;
- Canes;
- Walkers;
- Crutches;
- Standard wheelchairs; or
- Traction equipment;

are covered in the per diem rate and may not be billed separately to Medicaid. Any other type of nonstandard DME requires prior authorization by the office and must be billed to Medicaid directly by the DME provider. Facilities cannot require recipients to purchase or rent such equipment with their personal funds. DME purchased by Medicaid becomes the property of the office. Such DME must be returned to the local county office of family and children when the recipient no longer requires the DME.

Transportation services, except for emergency medical transportation services, are covered in the per diem rate.

Transportation for emergency medical services must be billed to Medicaid directly by the transportation provider.

Prior Authorization Requirements

PA requirements are not applicable except when services are rendered outside the large state ICF/IID.

Medical care rendered by practitioners outside the large state ICF/IID requires prior authorization. PA will not be given for medical services included in the per diem rate. Written evidence of physician involvement and personal patient evaluation in the progress notes and attached to the prior authorization form is required to document the medical necessity of the service. PA will include consideration of the following:
• Review of the properly completed Medicaid prior review and authorization request form substantiating both of the following:
  ➢ Medical necessity of the service.
  ➢ Explanation of why the service cannot be rendered at the facility.

Billing Requirements

All ICF/IID 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/IID. The following information explains these exceptions:

• Medical services, rendered by healthcare providers outside large state ICF/IID, require PA. PA 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, attached to the PA form, is required to document the medical necessity of the service. Documentation for PA 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 PA. 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 PA. Refer to Chapter 8 of the *IHCP Provider Manual*, for additional dental information.

• Emergency transportation is billable outside the *per diem* rate. The transportation provider must bill the IHCP directly.

• Nonstandard DME services require PA. 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.

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/IID are exempt from copayment requirements.

Respite Care
Respite care is not available for members residing in ICF/IID.

Reservation of Beds
Reimbursement is available for reserving beds for members in a private or State-operated ICF/IID, provided that the criteria set out in 405 IAC 5-13-6 is met.

Providers must use the appropriate room-and-board revenue code for the days the member was a patient in the ICF/IID and use the applicable leave of absence revenue code for the days the member was out of the ICF/IID.

The two types of reimbursed leave days are as follows:

• Hospitalization – Must be ordered by the physician for treatment of an acute condition that cannot be treated in the facility. The total time allowed for payment of a reserved bed for a single hospital stay is 15 consecutive days. If the member requires hospitalization longer than 15 consecutive days, the member must be discharged from the ICF/IID. If the member is discharged from the ICF/IID following a hospitalization in excess of 15 consecutive days, the ICF/IID is still responsible for appropriate discharge planning. Discharge planning is required if the ICF/IID does not intend to provide ongoing services following the hospitalization for those members who continue to require ICF/IID Level of Care services. The facility must maintain a physician’s order for hospitalization in the member’s file at the facility. Providers must use revenue code 185 to denote a leave of absence for hospitalization.

• Therapeutic Leave of Absence – Must be for therapeutic reasons, as prescribed by the attending physician and as indicated in the member’s habilitation plan. The maximum total length of time allotted for therapeutic leaves in any calendar year is 60 days per member residing in an ICF/IID. The leave days need not be consecutive. If the member is absent for more than 60 days per year, no further reimbursement is available to reserve a bed for that member in that year. The facility must maintain a physician’s order for the therapeutic leave in the member’s file at the facility. Providers must use revenue code 183 to denote a therapeutic leave of absence.
Use revenue code 180 when the hold days are not eligible for payment.

**Rules, Citations and Sources**

*42 CFR §483.400-483.480* – Intermediate Care Facilities for Individuals with Intellectual Disabilities

*IC 12-15-39.6* – Long-Term Care Program

*IC 12-15-32* – Community Residential Facilities for the Developmentally Disabled

*405 IAC 1-1-10* – Intermediate care for the intellectually disabled; governing provisions

*405 IAC 1-1-11* – Intermediate care for the intellectually disabled; eligibility

*405 IAC 1-12-24* – Rate Setting Criteria for State-Owned Intermediate Care Facilities for Individuals with Intellectual Disabilities and Community Residential Facilities for the Developmentally Disabled

*405 IAC 1-17* – Rate Setting Criteria for State-Owned Intermediate Care Facilities for the Intellectually Disabled

*405 IAC 5-13* – Intermediate Care Facilities for Individuals with Intellectual Disabilities

IHCP Provider Bulletins

- BT201129
- BT201124
- BT201061
- BT200412
- BT200371
- BT200347
- BT200343
- BT200305
- BT200252
- BT200123
- BT200113

IHCP Provider Manual

*Home and Community Based Services Waiver Provider Manual*
Related Medical Topics

Not applicable.
Laboratory Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding laboratory services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

A clinical laboratory is a place where materials derived from the human body are tested, measured, or examined to provide information on diagnosis, monitoring, prevention, or treatment of disease or for information about impairment or assessment of health.

Reimbursement Requirements

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 rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA).

In order to be eligible for reimbursement, a laboratory service must be ordered in writing by a physician or other practitioner authorized to do so under state law.

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 tests, these tests are classified as non-patient hospital services (rather than outpatient) because to the member did not directly receive services from the hospital.

IHCP reimbursement is also available for the drawing or collection of specimens provided by physicians, independent laboratories, or hospital laboratories. These services are covered only in circumstances in which blood samples are drawn through venipuncture or urine samples are collected by catheterization.
Laboratory services are reimbursable for well-child screenings or when services are necessitated by a condition-related diagnosis.

**Well-Child Screenings**

For specific coverage and reimbursement for well-child screenings, refer to the Section 18, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) HealthWatch Program and Section 84, Screening Services – Newborn Screening.

**Clinical Diagnostic Laboratory Procedure**

The pathology and laboratory guidelines noted in the CPT® and the 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 – 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 80048 through 89356 of the CPT® book, except for the following categories: blood, blood products, blood testing, and tests involving physician interpretation. Providers must have a valid CLIA number on file with the IHCP to be reimbursed for clinical laboratory services under CLIA regulations.

For procedures on the Medicare Fee Schedule that do not have Relative Value Units (RVUs), the IHCP reimburses based on the Medicare Clinical Laboratory Fee Schedule or manual pricing methodology, if a rate has not yet been established by Medicare. On the Medicare Fee Schedule, some procedures do not have RVUs because the procedure meets one of the following criteria:

- Associated with special restrictions
- Carrier-priced
- Excluded from the definition of physician services
- Excluded from the Medicare Fee Schedule
- Noncovered by Medicare
- Not valid for Medicare

For laboratory procedures not covered by the Medicare Fee Schedule as not meeting the definition of physician-provided services, the IHCP reimburses from the Medicare Clinical Laboratory Fee Schedule. The IHCP reimburses through manual pricing until Medicare assigns
a rate for codes for which Medicare has not yet established a specific rate, either in the Medicare Fee Schedule or in the Medicare Clinical Laboratory Fee Schedule.

Clinical diagnostic laboratory services include all laboratory tests listed in codes 80047 through 89398, as well as some G, P, and Q codes listed in the HCPCS Level II Code book.

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.

**Table 1 – Codes Classified as Clinical Diagnostic Lab Tests if Submitted on Claims with No Charge for Blood or Blood Products**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>86021</td>
<td>Antibody identification; leukocyte antibodies</td>
</tr>
<tr>
<td>86022</td>
<td>Antibody identification; platelet antibodies</td>
</tr>
<tr>
<td>86880</td>
<td>Antihuman globulin test (Coombs test); direct, each antiserum</td>
</tr>
<tr>
<td>86885</td>
<td>Antihuman globulin test (Coombs test); indirect, qualitative, each reagent red cell</td>
</tr>
<tr>
<td>86886</td>
<td>Antihuman globulin test (Coombs test); indirect, each antibody titer</td>
</tr>
<tr>
<td>86900</td>
<td>Blood typing; ABO</td>
</tr>
<tr>
<td>86901</td>
<td>Blood typing; Rh (D)</td>
</tr>
<tr>
<td>86902</td>
<td>Blood typing; antigen testing of donor blood using reagent serum, each antigen test</td>
</tr>
<tr>
<td>86904</td>
<td>Blood typing; antigen screening for compatible unit using patient serum, per unit screened</td>
</tr>
<tr>
<td>86905</td>
<td>Blood typing; RBC antigens, other than ABO or Rh (D), each</td>
</tr>
<tr>
<td>86910</td>
<td>Blood typing, for paternity testing, per individual’ ABO, Rh and MN</td>
</tr>
<tr>
<td>86911</td>
<td>Blood typing, for paternity testing, per individual; each additional antigen system</td>
</tr>
<tr>
<td>86970</td>
<td>Pretreatment of RBSs for use in RBC antibody detection, identification, and/or compatibility testing; incubation with chemical agents or drugs, each</td>
</tr>
<tr>
<td>86971</td>
<td>Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; incubation with enzymes, each</td>
</tr>
<tr>
<td>86972</td>
<td>Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; by density gradient separation</td>
</tr>
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</table>
| 86975    | Pretreatment of serum for use in RBC antibody identification; incubation with drugs,
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>86976</td>
<td>Pretreatment of serum for use in RBC antibody identification; by dilution</td>
</tr>
<tr>
<td>86977</td>
<td>Pretreatment of serum for use in RBC antibody identification; incubation with inhibitors, each</td>
</tr>
<tr>
<td>86978</td>
<td>Pretreatment of serum for use in RBC antibody identification; by differential red cell absorption using patient RBCs or RBCs of known phenotype each absorption</td>
</tr>
</tbody>
</table>

**Professional and Technical Components**

Some clinical diagnostic laboratory procedures encompass professional and technical components of service. A physician typically performs the professional component of the lab procedure. The IHCP reimburses the physician for the professional component because the physician bills the appropriate CPT® lab code along with modifier 26, professional component. When billing only the technical component, providers should append modifier TC, technical component, with the appropriate CPT® lab code. When billing for professional and technical components of service, providers should use no modifiers. Providers should bill the appropriate lab code only. Refer to the Federal Register under Relative Value Units and Related Information section to see a list of lab codes billed using these modifiers.

**Specimen Collection**

A minimal fee will be allowed for separate charges made by physicians, independent laboratories, or hospital laboratories for drawing or collecting 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 – that is, 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. Providers will be reimbursed for no more than two conveyance fees (CPT® procedure codes 99000 and 99001) per patient per provider on the same DOS. Providers can charge this only if the physician has an expense involved in the conveyance.

**Consultative Laboratory Services**

Consultative laboratory services are covered for clinical laboratory tests if the following conditions are met:

- Service was 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
• Service requires the exercise of medical judgment by the consulting physician

Hospice providers should note that they must not include costs for services, such as laboratory and X-rays, with the attending physician’s billed charges. The daily hospice care rates that the IHCP pays include these costs, and they are expressly the responsibility of the hospice provider

**CLIA**

Providers rendering laboratory services must obtain a CLIA number. Information regarding CLIA can be obtained at [www.cms.hhs.gov](http://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 highly complex 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.

To receive reimbursement from the IHCP for laboratory services falling under CLIA regulations, the provider must have a valid copy of the CLIA certificate on file with the provider enrollment contractor and must bill only lab codes allowed by the certificate. For additional information about CLIA, the provider can contact the ISDH at (317) 233-7502. Provider types subject to CLIA rules include those in Table 2.
Table 2 – CLIA Provider Types

<table>
<thead>
<tr>
<th>CLIA Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Hospitals, type/specialty010-012</td>
</tr>
<tr>
<td>04</td>
<td>Rehabilitation facilities</td>
</tr>
<tr>
<td>05</td>
<td>Home health agencies</td>
</tr>
<tr>
<td>06</td>
<td>Hospices</td>
</tr>
<tr>
<td>08</td>
<td>Clinics, type/specialty 080-085</td>
</tr>
<tr>
<td>11</td>
<td>Mental health, type and specialty110-111</td>
</tr>
<tr>
<td>13</td>
<td>Public health agencies</td>
</tr>
<tr>
<td>14</td>
<td>Podiatrists</td>
</tr>
<tr>
<td>15</td>
<td>Chiropractors</td>
</tr>
<tr>
<td>28</td>
<td>Laboratories, type/specialty 280-281</td>
</tr>
<tr>
<td>30</td>
<td>End-stage renal disease clinics</td>
</tr>
<tr>
<td>31</td>
<td>Physicians, all types/specialties</td>
</tr>
</tbody>
</table>

Information regarding the procedure codes allowed to be billed by specific certificate type can be obtained at [www.cms.hhs.gov](http://www.cms.hhs.gov).

**Physician Interpretation of Laboratory Procedures**

Both the technical and professional components are reported separately to ensure proper reimbursement. Providers bill the IHCP for the technical component (TC) 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 TC and interpretation of CPT® code 84165 report CPT® code 84165 for the TC and the CPT® code modifier combination 84165-26 for the interpretation.

**Prior Authorization Requirements**

For Prior Authorization requirements, please see specific test policies. If a test requires PA and no independent section is available, then the Prior Authorization will be reviewed by clinical staff for standard medical necessity.

Billing Requirements

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 that day. Laboratories performing services must bill the IHCP directly. Hospitals must bill laboratory services using the most appropriate HCPCS code. Revenue codes billed without the
appropriate HCPCS procedure code are denied. Providers must bill the professional component of a laboratory service performed in an outpatient hospital setting on the CMS-1500 claims form or an 837P transaction with the appropriate HCPCS code and 26 modifier.

Rules, Citations and Sources

42 CFR § 441.17 – Laboratory Services
42 CFR § 440.30 – Other Laboratory and X-ray Services
405 IAC 5-18 – Laboratory Services
405 IAC 5-12-4 – Chiropractic Services – Laboratory Services
405 IAC 5-26-4 – Podiatric Services – Laboratory or X-ray Services
405 IAC 5-18-2(c) – Reimbursement Restrictions

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Chiropractic Services
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) HealthWatch Program
Laboratory Services – Group A Beta Hemolytic Streptococcal Pharyngitis Tests
Laboratory Services – Human Immunodeficiency Virus (HIV) Testing
Laboratory Services – Sweat Chloride Test
Podiatry
Screening Services – Newborn Screening
Laboratory Services – Group A Beta Hemolytic Streptococcal Pharyngitis Tests

Introduction

This section serves as a general summary of the IHCP’s policies regarding laboratory services – Group A Hemolytic Streptococcal Pharyngitis Tests. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Group A Beta Hemolytic Streptococcus is a bacteria that causes sore throat, pharyngitis, and 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.

Reimbursement Requirements

Providers must order all laboratory services in writing and include a condition-related diagnosis that necessitates the laboratory services.

Prior Authorization Requirements

PA is not required for Group A Beta Hemolytic Streptococcal Pharyngitis testing.

Billing Requirements

Medicaid reimbursement is available for approved laboratory tests used for the detection of Group A Beta Streptococcus.

Please refer to Chapter 8 of the IHCP Provider Manual at www.indianamedicaid.com for billing requirements.

Rules, Citations and Sources

405 IAC 5-12-4 – Laboratory Services

405 IAC 5-18 – Laboratory Services
Related Medical Topics

Not applicable.
Laboratory Services – Human Epidermal growth factor Receptor 2 (HER-2/neu) Gene Detection Test and HER-2 Protein Expression Test

Introduction
This section serves as a general summary of the IHCP’s policies regarding laboratory services – HER-2/neu gene detection tests and HER-2 protein expression tests. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service
The human HER-2/neu gene (also known as c-erbB-2, ERBB2 or neu) encodes a protein called HER-2 protein or p185HER-2P. 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® phosphorlated HER-2/neu (pHER-2/neu) Gene Detection Test). This test is a deoxyribonucleic acid (DNA) probe assay known as fluorescent in situ hybridization (FISH).

Reimbursement Requirements
Laboratory testing for HER-2 protein and gene detection tests is covered by the IHCP when medically necessary for recipients who have been diagnosed with a malignant neoplasm of the breast. 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 tests ordered. Laboratories performing the test must have documentation indicating laboratory personnel education has been completed in the proper performance of the test and reporting of the test results. Reimbursement will be provided to CLIA-certified laboratories only.

Prior Authorization Requirements

Prior Authorization is not required for HER-2 testing. However, as described above, documentation of medical necessity is required.

Billing Requirements

Reimbursement for HER-2 testing, when medically necessary for recipients who have been diagnosed with a malignant neoplasm of the breast, is available using the following codes.

Providers should use the codes listed below to bill HER2 Protein Overexpression Tests, the Hercep Test®, as an aid in assessment of patients who use trastuzumab, HERCEPTIN®.

Table 1 – HCPCS Codes for HER-2 Test

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>88342</td>
<td>Immunohistochemistry (including tissue immunoperoxidase), each antibody</td>
</tr>
<tr>
<td>88365</td>
<td>In situ hybridization (eg, FISH), each probe</td>
</tr>
</tbody>
</table>

HER-2/neu Gene Detection Test, such as Oncor’s INFORM®, is an adjunct to existing clinical and pathological information as an aid to stratify breast cancer patients with a primary, invasive, or localized breast cancer who are lymph node negative for risk of recurrence or disease-related death. Providers should use the codes listed below to bill this test.
Table 2 – HCPCS Codes for HER-2/neu Gene Detection Test

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>83950</td>
<td>Oncoprotein; HER-2/neu</td>
</tr>
<tr>
<td>88271</td>
<td>Molecular cytogenetics; DNA probe, each (eg, FISH)</td>
</tr>
<tr>
<td>88274</td>
<td>Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells</td>
</tr>
<tr>
<td>88275</td>
<td>Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells</td>
</tr>
<tr>
<td>88291</td>
<td>Cytogenetics and molecular cytogenetics, interpretation and report</td>
</tr>
<tr>
<td>88360</td>
<td>Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual</td>
</tr>
<tr>
<td>88361</td>
<td>Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology</td>
</tr>
<tr>
<td>88367</td>
<td>Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology</td>
</tr>
<tr>
<td>88368</td>
<td>Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; manual</td>
</tr>
</tbody>
</table>

Rules, Citations and Sources

405 IAC 5-18 – Laboratory Services

IHCP Bulletins

BT200005

IHCP Provider Manual


Related Medical Topics

Laboratory Services

Oncology
Laboratory Services – Human Immunodeficiency Virus (HIV) Testing

Introduction

This section serves as a general summary of the IHCP’s policies regarding testing for HIV. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

HIV is the human immunodeficiency virus which is the virus that can lead to acquired immunodeficiency syndrome, or AIDS. HIV progressively damages and kills CD4+ blood cells of the body’s immune system, destroying the body’s ability to 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) through unprotected sexual activity with an infected partner; (2) through contact with infected blood; or (3) 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 immunosorbent assay (ELISA) or enzyme immunoassay (EIA) 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 whether 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.

Reimbursement Requirements

Laboratory testing for HIV is covered by the IHCP when it is medically necessary for establishing a HIV diagnosis. HIV testing is covered only 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.

**HIV Testing of Pregnant Women and Newborns**

The IC § 16-41-6-8 requires, as a routine component of prenatal care, physicians, advanced practice nurses, or the physicians or advance practice nurses designee explain the purpose, risks, and benefits of HIV testing and order HIV tests for pregnant women. The results of this test are confidential. Pregnant women have the right to refuse this test. A signed statement acknowledging 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 consents 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 referral options available to her for HIV prevention, healthcare, 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.
- The physician believes that testing the newborn is medically necessary for reasons other than those listed above.

If the parent objects, in writing, to testing the newborn for religious reasons, the newborn is exempt from the testing requirement.

The results of the HIV test must be released to the newborn’s mother. If the test results are positive, the individual who provides the test results must provide the mother with treatment or referral options available to the newborn.

Testing for HIV is also covered in conjunction with family planning services and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

**EPSDT**

Reimbursement for HIV testing is available for at-risk children and youth ages 0-20.

**Prior Authorization Requirements**

PA is not required for HIV testing.
Billing Requirements

Reimbursement for HIV testing, when medically necessary for establishing an HIV diagnosis, is available using the following codes.

**Table 1 – HCPCS Codes for HIV Testing**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>86689</td>
<td>Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot)</td>
</tr>
<tr>
<td>86701</td>
<td>Antibody; HIV-1</td>
</tr>
<tr>
<td>86702</td>
<td>Antibody; HIV-2</td>
</tr>
<tr>
<td>86703</td>
<td>Antibody; HIV-1 and HIV-2, single result</td>
</tr>
<tr>
<td>87390</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1</td>
</tr>
<tr>
<td>87391</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-2</td>
</tr>
<tr>
<td>87534</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique</td>
</tr>
<tr>
<td>87535</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, reverse transcription and amplified probe technique</td>
</tr>
<tr>
<td>87537</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique</td>
</tr>
<tr>
<td>87538</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, reverse transcription and amplified probe technique</td>
</tr>
</tbody>
</table>

Rules, Citations and Sources

*IC ch. 16-41-6 - Communicable Disease: Mandatory Testing of Individuals With Communicable or Dangerous Diseases*

405 IAC 5-18 – Laboratory Services

IHCP Provider Manual


Related Medical Topics

Laboratory Services
Screening Services – Newborn Screening
Laboratory Services – Placental Alpha Microglobulin-1 (PAMG-1) Test for Detection of Rupture of Membranes (ROM)

Introduction

This section serves as a general summary of the IHCP’s policies regarding placental alpha microglobulin-1 (PAMG-1) testing to detect rupture of membranes (ROM). Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Premature rupture of the membranes (PROM) is defined by the American College of Obstetricians and Gynecologists (ACOG) as rupture of the amniotic sac and leakage of amniotic fluid prior to the onset of labor at any gestational age. Preterm premature rupture of membranes (PPROM) is defined as rupture of fetal membranes that occurs prior to thirty-seven (37) weeks of gestation.

PROM is a complication in approximately one third of preterm birth and is typically associated with brief latency between membrane rupture and delivery, increased potential for perinatal infection, and in utero umbilical cord compression. Because of this, both PROM at and before term can lead to significant perinatal morbidity and mortality.

The PAMG-1 test detects the presence of the PAMG-1 protein marker found in the amniotic fluid in vaginal secretions, and is intended to aid in detecting PROM in pregnant women with signs, symptoms or complaints suggestive of PROM.

Reimbursement Requirements

The IHCP reimburses the PAMG-1 test when considered medically necessary to confirm the diagnosis of PROM. This test can be performed in a hospital setting (either inpatient or outpatient); or in a non-hospital setting (e.g. a physician’s office or clinic), when the member is experiencing signs and symptoms of PROM.

Prior Authorization Requirements

PA is not required for PAMG-1. However, use of the PAMG-1 test is closely monitored for appropriateness of use.
Billing Requirements

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs. Providers must bill utilizing the appropriate procedure code. 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. For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.

Reimbursement for PAMG-1, when medically necessary for establishing a PROM diagnosis, is available when billed using CPT® code 84112 - Placental alpha microglobulin-1 [PAMG-1], cervicovaginal secretion, qualitative and the appropriate trimester modifier listed in Table 1.

<table>
<thead>
<tr>
<th>Modifiers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>Trimester one – 0 through 14 weeks, 0 days</td>
</tr>
<tr>
<td>U2</td>
<td>Trimester two – 14 weeks, one day through 28 weeks, 0 days</td>
</tr>
<tr>
<td>U3</td>
<td>Trimester three – 28 weeks, one day, through delivery</td>
</tr>
</tbody>
</table>

Rules, Citations and Sources

405 IAC 5-18 – Laboratory Services

Note: For the most updated information regarding the IHCP Provider Manual, bulletins and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Laboratory Services
Obstetric Care
Laboratory Services – Sweat Chloride Test

Introduction
This section serves as a general summary of the IHCP’s policies regarding sweat chloride tests. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service
The sweat chloride test (sweat test), is used to diagnose cystic fibrosis (CF). According to the Merck 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.

Reimbursement Requirements
The IHCP reimburses sweat chloride testing when used to confirm a diagnosis of CF. Usage of the sweat test as a predictor of efficacy of sympathectomy in peripheral vascular disease is unproven and, therefore, is not covered.

Prior Authorization Requirements
PA is not required for sweat chloride testing.
Billing Requirements

Reimbursement for sweat chloride testing, when medically necessary for establishing the diagnosis of CF, is available using the following CPT® code:

- 89230 – Sweat collection by iontophoresis

Rules, Citations and Sources

405 IAC 5-18 – Laboratory Services

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Laboratory Services

Medical Supplies and Equipment – High Frequency Chest Wall Oscillation System (Formery ThAlRpy Vest, aka The Vest)
Locum Tenens and Substitute Physician

Introduction

This section serves as a general summary of the IHCP’s policies regarding *locum tenens* and substitute physicians. Additional information specific to this topic may be found in the *IHCP Provider Manual*, program notices, and any applicable banners, bulletins or newsletters.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

*Locum tenens* and substitute physician are terms used to describe the relationship of a physician who is filling in for a member’s regular physician. The regular physician may be the member’s primary care physician or PMP. The regular physician could also be a specialist the member sees regularly for a specific problem or chronic condition.

According to 42 U.S.C.§ 1395x(r), the term physician includes: a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. 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.

Reimbursement Requirements

A *locum tenens* or substitute physician must be from the same discipline as the regular physician. The *locum tenens* arrangement is made when the regular physician must leave his or her practice due to illness, vacation, or medical education opportunity and does not want to leave his or her patients without service during the period. The *locum tenens* physician cannot be a member of the group in which the regular physician is a member. The *locum tenens* physician must meet all requirements to practice in Indiana; however, the *locum tenens* physician is not required to be an enrolled IHCP provider. A *substitute physician* is a physician who is asked to see a member in a reciprocal arrangement when the regular physician is unavailable to see the member. Substitute physicians are required to be enrolled in the IHCP.

Prior Authorization Requirements

PA of services performed by a *locum tenens* or substitute physician is the same as for the member’s regular physician and is defined by the service rendered.
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. *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’s absence. This means that various physicians would be required to fill in for different 90-day periods. *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, he or she must enroll as an IHCP provider.

Substitute Physician

For provision of substitute physician services as defined in this section, 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.

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 on 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

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Substitute Physician</th>
<th>Locum Tenens Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must be enrolled as an IHCP Provider</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>May be employed by the same group as the regular physician</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Claims are submitted by the regular physician’s office and that office receives payment</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Modifier required to identify the arrangement</td>
<td>Yes, Q5</td>
<td>Yes, Q6</td>
</tr>
<tr>
<td>May use the regular physician’s certification code for Care Select PMP authorizations</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Maximum time frame allowed</td>
<td>14 days</td>
<td>90 days</td>
</tr>
</tbody>
</table>

Rules, Citations and Sources

Social Security Act Amendments of 1994, Section 125

OBRA of 1990, Section 4110

IHCP Bulletins

  BT200201
  BT200115
  BT200125

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Chiropractic
Dental Services
Evaluation and Management Services
Ophthalmologic Services
Long Term Acute Care Hospitals

Introduction

This section serves as a general summary of the IHCP’s policies regarding long term acute care (LTAC) hospitals. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

LTAC hospitals are designed to provide specialized acute care for patients that require especially long recovery periods. These patients are usually in acute-care facilities. Their medical conditions have stabilized, but they continue to require an acute level-of-care (LOC). A lesser LOC, such as a SNF or sub acute care facility, is not appropriate.

Federal regulations for LTAC hospitals require average inpatient stays greater than 25 days. Medicare program criteria are used 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, sub acute 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).

Reimbursement Requirements

LTAC hospital admissions that have been determined to meet criteria for admission are covered by the IHCP and reimbursed under the LOC methodology described in IAC 405 IAC 1-10.5. 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 LOC per diem. The LTAC LOC per diem payments are in lieu of 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.
Prior Authorization Requirements

Admission Criteria

PA is required for LTAC hospital admissions. Before admission to a LTAC hospital, assessment of the patient’s current medical status and discharge goals must be provided to the appropriate PA vendor 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.

The proposed admission needs to be to a facility that meets the definition of a LTAC hospital in 405 IAC 1-10.5-2(s), which states, “LTC hospital means a freestanding general acute care hospital licensed under Indiana Code IC 16-21 that:

- Is designated by the Medicare program as a long-term hospital; or
- 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.”

The Indiana Code goes on to state: “Freestanding does not mean a wing or specialized unit within a general acute care hospital.” However, LTC hospitals 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 readmitted from a NF or rehabilitation facility. No PA will be approved for requests for initial admission directly from a NF, from a physician’s 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 the PA Department or 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 conditions. 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, depending 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 Prior Authorization Request Form, located at www.indianamedicaid.com. Click on forms. Scroll down to PA.

**Note:** The provider is responsible for compiling and submitting the necessary documentation for PA requests in a timely manner.

All 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 workup 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 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. Examples include but are not limited to full service and STAT laboratory, radiology, and respiratory care services.
- There is a patient-centered, outcome-focused, interdisciplinary approach requiring a physician directed professional team that includes 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 healthcare needs.

During the PA process, the medical director may help determine whether the admission is medically necessary. 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:
• Requires ventilator assistance and has failed attempts to be extubated or maintain adequate ventilation, oxygenation, or functional level after extubation

• Requires one or more of the following IV medications daily:
  - Bronchodilators
  - Corticosteroids
  - Diuretics
  - Antiviral agents
  - Anti-tuberculosis agents
  - Antiprotozoal agents
  - Chemotherapy
  - Antibiotics
  - Antifungal agents
  - Anticoagulation medications

• Requires frequent monitoring of tissue oxygenation (for example, pulse oximetry), frequent RT treatments, or suctioning or inhalation medications

**Impaired Skin Integrity**

Impaired skin integrity means the patient has stage three or stage 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:

• The patient has non-healing wounds that have failed to improve while receiving home care, SNF, or acute hospital care.

• The patient requires complex dressing changes using daily whirlpool, debridement, frequent intramuscular or IV analgesics or antifungals, frequent positioning, or hyperbaric treatments.

• The patient requires more than one of the following IV medications at least daily:
  - Antiviral agent
  - Antibiotics
  - Antifungal agent
  - IV plasma expanders
  - IV electrolytes
  - Total parenteral nutrition (TPN)
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:

- The patient requires frequent monitoring of tissue oxygenation (for example, pulse oximetry) and continuous telemetry.
- 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.
- The patient requires two or more of the following medications intravenously to maintain cardiovascular integrity:
  - Anticoagulants
  - Anti-anginal agents
  - Anti-arrhythmics
  - Antibiotics
  - Alpha/beta-adrenoreceptor blocking agents
  - Antihypertensives
  - Beta blockers
  - Calcium channel blockers
  - Cardiac glycosides
  - Corticosteroids
  - Diuretics
  - Inotropic agents
  - Mucarinic receptor antagonists
  - Sodium channel blockers
  - Thrombolytic enzymes
  - Tissue plasminogen activators
  - 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 LOC, 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 Prior Authorization Request Form, which may be found at www.indianamedicaid.com. Click on forms. Scroll down to PA. In the upper right corner of the form, include the existing PA number. Indicate on a separate line item the additional dates and units/days requested.
- 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 medical director’s review when any of the following conditions occur:

- There is evidence in the patient record that the patient has achieved stated goals.
- Medical complications require readmission to an 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 Requirements

Long-term acute care facilities must submit charges on a UB-04 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-04 claim form by the billing provider.

The discharging hospital must enter the patient status code 63 in Field Locator (FL) 22 on the UB-04 claim form. This indicates that the status of the patient as of the ending service date was “discharged” or “transferred to a LTC hospital.”

Rules, Citations and Sources

405 IAC 1-10.5-2(s) – Definitions – Long term care hospital

405 IAC 1-10.5-3 – Prospective reimbursement methodology

IHCP Bulletin

   BT200360

IHCP Provider Manual


Related Medical Topics

Hospital Inpatient Services
Medical Supplies and Durable Medical Equipment – Overview

Introduction

This section serves as a general summary of the IHCP’s policies regarding medical supplies – durable medical equipment (DME). Additional information specific to this topic may be found in the *IHCP Provider Manual*, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Medical and surgical supplies are:

- Disposable items that are not reusable and must be replaced on a frequent basis
- Used primarily and customarily to serve a medical purpose
- Generally not useful to a person in the absence of an illness or injury
- Covered only for the treatment of a medical condition

DME is 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. Items include but are not limited to the following:

- Hospital beds
- Wheelchairs
- Iron lungs
- Respirators
- Oxygen tents
- Commodes
- Traction equipment

Coverage of specific medical supplies and DME may be addressed in individual sections.
Reimbursement Requirements

Medical Supplies

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 pads
- Catheters
- Incontinence supplies
- Irrigation supplies
- Diabetic supplies
- Ostomy supplies
- Respiratory supplies
- Tracheotomy supplies

The IHCP does not cover the following supplies:

- Sanitary napkins
- Cosmetics
- Dentifrice items
- Tissue
- Nonostomy deodorizing products, soap, disposable wipes, and shampoo, or other items generally used for personal hygiene

Providers shall bill in accordance with the instructions set forth in the IHCP Provider Manual or update bulletins. Incontinence supplies, including underpads, incontinent briefs and liners, diapers, and disposable diapers, are covered only:

- In cases of documented necessity, at a rate determined by the office
- For recipients 3 years old or older

The IHCP will pay claims only for incontinence supplies from one of these two providers:

- Binson’s Home Health Care Centers
- J & B Medical
Claims for incontinence supplies from any other provider will be denied. Refer to BT200813 for additional information.

Medical supplies that are included in facility reimbursement or that are otherwise included as part of reimbursement for a medical or surgical procedure are not separately reimbursable to any party. All covered medical supplies, whether for routine or non-routine use, are included in the per diem for nursing facilities, even if the facility does not include the cost of medical supplies in facility cost reports.

Reimbursement is not available for medical supplies dispensed in quantities greater than a one-month supply for each calendar month, except when:

- They are packaged by the manufacturer only in larger quantities.
- The recipient is a Medicare beneficiary and Medicare allows reimbursement for a larger quantity.

**DME**

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 is reimbursable by the IHCP within one of the classifications listed in Table 1.

**Table 1 – DME Classification Codes**

<table>
<thead>
<tr>
<th>DME Classification Number</th>
<th>DME Classification Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Capped rental items</td>
</tr>
<tr>
<td>2</td>
<td>Inexpensive or other routinely purchased items</td>
</tr>
<tr>
<td>3</td>
<td>Items requiring frequent or substantial servicing</td>
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<tr>
<td>4</td>
<td>Customized items</td>
</tr>
<tr>
<td>5</td>
<td>Prosthetic and orthotic devices</td>
</tr>
<tr>
<td>6</td>
<td>Oxygen and oxygen equipment</td>
</tr>
</tbody>
</table>

**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.

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 of more than 60 days in the rental period may include the following:

- Change in medical necessity
- Hospitalization
- NF 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 PA. Providers should refer to Chapter 8 of the IHCP 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 percent 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 lump sums, 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.

**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 of the IHCP 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 material 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 PA.

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 manufactures 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 lump sum amounts and may not be rented. Prosthetic and orthotic devices billed with HCPCS L codes require PA. All PA reviews are based upon medical necessity.
Orthopedic or Therapeutic Footwear

With a physician’s written order, the IHCP provides reimbursement for members of all ages for the following:

- Corrective features built into shoes such as heels, lifts, wedges, arch supports, and inserts
- Orthopedic footwear, such as, shoes, boots, and sandals
- Orthopedic shoe additions

If a member currently has a brace, the IHCP covers the shoes and supportive devices if providers document continued medical necessity.

The IHCP also provides coverage for therapeutic shoes for members with severe diabetic foot disease.

Oxygen and Oxygen Equipment

The IHCP reimburses liquid and gaseous oxygen systems as rental only items, subject to PA. 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.

Manually Priced Items

Reimbursement for DME services and supplies that are billed with a non-specific 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. Effective July 1, 2011, manually priced HCPCS codes are reimbursed at 75 percent of the manufacturer’s suggested retail price (MSRP). A provider is required to submit documentation of the MSRP for medical supplies codes that do not have established rates when submitting the claim for adjudication. For dates of service on or after May 18, 2012, providers are no longer required to submit a manufacturer’s cost invoice with their claims for manually priced medical supplies.

A provider must not bill more than his or her usual and customary charge for any item. When requesting PA 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.
Used Items

The IHCP does not reimburse for used DME except for the following: A4638 - replacement battery for patient-owned ear pulse generator, each and A7046-water chamber for humidifier, used with positive airway pressure device, replacement, each. A new item placed with a member initially as a rental item shall be considered a new item by OMPP at the time of purchase. A used DME item placed with a member initially as a rental item shall be replaced by the supplier with a new item prior to purchase by OMPP.

Reimbursement for the purchase of DME, medical/surgical supplies, orthotics, non-preparatory prosthetics and orthopedic footwear is for new, unused items.

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 K0739 – Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes or K0740 – Repair or nonroutine service for oxygen equipment 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.
- Maintenance charges of properly functioning equipment are not covered.
- Repair costs for DME included in a LTC facility’s per diem rate is also included in the per diem rate.

In addition, the IHCP will reimburse E1340 only 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 from 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 his or her 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 his or her records to support the reason for replacement. This documentation is 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 natural disaster, fire, or theft. The provider should maintain documentation in his or her 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 PA 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 to wheelchairs after their assembly are attachments to convert a wheelchair to a one-arm drive, or the addition of brake extensions, wheelchair hand rims, or anti-tipping devices.

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 equipment that does not require a technician’s skill.
DME in 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 Individuals with Intellectual Disabilities (ICFs/ID), and CRFS/DD.

Non-standard or custom/special equipment and its associated repair costs may be billed separately to the IHCP for LTC facility members, subject to PA. PA requests for separate reimbursement of this DME for LTC facility members will be considered on a case-by-case basis.

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. 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 based on annual and quarterly HCPCS updates and policy changes. Providers should monitor the Web site for changes to the DME provider code set.

Prior Authorization Requirements

PA is not required for the reimbursement of medical supplies unless they are requested by an out-of-state supplier.

PA is required for capped rental items, selected inexpensive or other routinely purchased items, and oxygen equipment. Providers should refer to Chapter 8 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:

- The item must be medically reasonable and necessary, as defined in 405 IAC 5-2-17, for the treatment of an illness or injury or to improve the member’s functional level.
- The item must be adequate for the medical need; however, items with unnecessary convenience or luxury features will not be authorized.
- 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 will 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 PA:

- Hospital beds
- Wheelchairs
- Ventilators
- Heated and non-heated humidifiers
- Oxygen and oxygen equipment
- Patient lifts
- Standers
- 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 PA 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 non-motorized wheelchairs
- Negative pressure wound therapy (NPWT) devices
- Standers
- Transcutaneous electrical nerve stimulation (TENS) units

**Out-of-State DME Providers**

*405 IAC 5-5-3* states that to be treated as an in-state provider for purposes of the PA rule, any out-of-state supplier of medical equipment must comply with the following criteria:

- Maintain an Indiana business office, staffed during regular business hours, with telephone service.
• Provide service, maintenance, and replacements for Indiana Medicaid recipients whose equipment has malfunctioned.

• 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 PA by use of an emergency indicator. If DME or medical supplies are needed in an emergency situation, PA may be obtained by telephone.

**Telephone Prior Authorization**

PA may be obtained by telephone for DME services under the following circumstances:

- For medically reasonable and necessary supplies to facilitate discharge from or prevent admission to a general hospital or LTC facility
- For repair of DME when the equipment is necessary for life support or safe mobility of the patient

The DME provider must subsequently submit a properly completed PA request form signed by the ordering physician for the service to be approved for reimbursement. Refer to 405 IAC 5-3-2(b) for further instructions.

**Billing Requirements**

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 when 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 incontinence 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. Refer to banner BR200449 for the list of procedure codes that may be billed with a span date of 90 days, as well as for 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 LTC facilities. LTC facilities include skilled nursing facilities, Intermediate Care Facilities for the Intellectually Disabled (ICFs/ID), and CRF/DD.

Medical supplies 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 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.

**Rules, Citations and Sources**

*405 IAC 5-19 – Medical Supplies and Equipment*

**IHCP Bulletins**

- BT201118
- BT201037

*Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp).*

**Related Medical Topics**

- Medical Supplies and Equipment – Automatic External Defibrillators
- Medical Supplies and Equipment – Hospital Beds and Specialty Beds
- Medical Supplies and Equipment – Gloves
- Medical Supplies and Equipment – Implantable Infusion Pumps
- Medical Supplies and Equipment – Incontinence Supplies
- Medical Supplies and Equipment – Ventricular Assist Device (VAD)
- 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 – Wheelchairs and Accessories
Medical Supplies and Equipment – Standers

Medical Supplies and Equipment – Standing Wheelchair

Medical Supplies and Equipment – High Frequency Chest Wall Oscillation System ThAIRapy Vest
Medical Supplies and Equipment – Automatic External Defibrillators

Introduction

This section serves as a general summary of the IHCP’s policies regarding medical supplies and equipment – automatic external defibrillators (AEDs). Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

The IHCP covers two types of automatic external defibrillators for individual use. The first is a stand-alone model referred to as an AED, E0617 – External defibrillator with integrated electrocardiogram analysis. The FDA approved the AED for individual use in the home November 2003. An AED is similar to a manual defibrillator, except that an AED detects and analyzes heart rhythms automatically. A microprocessor inside the AED analyzes the member’s heart rhythm through adhesive electrodes and determines the need for defibrillation to restore normal cardiac rhythm.

The AED is programmed to recognize different shockable heart rhythms, such as ventricular fibrillation (VF) or ventricular tachycardia (VT), 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 emergencies 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 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), K0606 – Automatic external defibrillator, with integrated electrocardiogram analysis, garment type. 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 VF, 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, wearable cardioverter defibrillator NET (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 in the member database.

Reimbursement Requirements

AEDs and WCDs are indicated for members who normally are candidates for an implanted cardioverter defibrillator (ICD), but for whom ICDs are contraindicated or need to be removed. These defibrillators are most often used for members who are awaiting heart transplants, who have recently had heart attacks, or who have had their ICDs removed due to ICD pocket infections. The average time of use is approximately two to three months, although some members awaiting transplant have used the device for more than one year.

Members who are not able to use WCD vests 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 placed only 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 who do not have spouses/live-in companions able and 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. Members must download the ECG data from the WCD to computers, so their physicians can access the information. Physicians 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 is unavailable, the AED is an alternative to the WCD.

If a defibrillator is indicated, the decision to prescribe the AED versus the WCD should be the physician’s, in consultation with the member. The option of an AED or a WCD is a clinical decision, influenced by the practical matters discussed above.

The IHCP covers AEDs and WCDs and their accessories, with PA, under the following codes.

Table 1 – Wearable Cardioverter Defibrillator

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0606</td>
<td>Automatic external defibrillator with integrated electrocardiogram analysis,</td>
</tr>
<tr>
<td></td>
<td>garment type</td>
</tr>
<tr>
<td>K0607</td>
<td>Replacement battery for automatic external defibrillator, garment type only,</td>
</tr>
<tr>
<td></td>
<td>each</td>
</tr>
<tr>
<td>K0608</td>
<td>Replacement garment for use with automatic external defibrillator, each</td>
</tr>
<tr>
<td>K0609</td>
<td>Replacement electrodes for use with automatic external defibrillator, garment type</td>
</tr>
</tbody>
</table>
Medical Supplies and Equipment – Automatic External Defibrillators

Table 2 – Automatic External Defibrillator

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0617</td>
<td>External defibrillator with integrated electrocardiogram analysis</td>
</tr>
<tr>
<td>K0607</td>
<td>Replacement battery for automatic external defibrillator, garment type only, each</td>
</tr>
<tr>
<td>K0609</td>
<td>Replacement electrodes for use with automatic external defibrillator, garment type only, each</td>
</tr>
</tbody>
</table>

Prior Authorization Requirements

For Automatic External Defibrillators (E0617) and WCDs (K0606)

The IHCP covers AEDs (E0617) and WCDs (K0606) under the same PA criteria. An AED or a WCD is covered for members in two circumstances below.

Members must meet either both criteria A and B or Criterion C.

A. The member has one of the following conditions:

1. A documented episode of cardiac arrest due to VF, not due to a transient or reversible cause\(^6\)
2. A sustained (lasting 30 seconds or longer), ventricular tachyarrhythmia, either spontaneous or induced during an electrophysiologic (EP) study, not associated with acute MI\(^7\), and not due to a transient or reversible cause
3. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmias, such as long QT syndrome or hypertrophic cardiomyopathy
4. Coronary artery disease with a documented prior MI, with a measured left ventricular ejection fraction (LVEF)\(^8\) less than or equal to 0.35, and inducible, sustained VT or VF during an EP study. To meet this criterion both (a) and (b) below must occur:
   a. The MI must have occurred more than four weeks prior to the external defibrillator prescription; and

---

\(^6\) Transient or reversible causes include conditions such as drug toxicity, severe hypoxia, acidosis, hypocalcemia, hyperkalemia, systemic infections, and myocarditis (not all-inclusive).

\(^7\) MIs must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram. Ejection fractions must be measured by angiography, radionuclide scanning, or electrocardiography.

\(^8\) MIs must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram. Ejection fractions must be measured by angiography, radionuclide scanning, or electrocardiography.
b. The EP test must have been performed more than four weeks after the qualifying MI.

5. Documented prior MI; and a measured LVEF **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 (NYHA) 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 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 candidates for coronary revascularization; or
   f. Irreversible brain damage from preexisting cerebral disease; or
   g. Any disease, other than cardiac disease (for example, cancer, uremia, liver failure) associated with a likelihood of survival of less than one year.

B. Implantation surgery is contraindicated.

C. A previously implanted defibrillator now requires removal.

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.

**For Accessories K0607-K0609**

PA criteria for accessories are based on the estimated average life expectancies of the accessories. The accessories replacement batteries K0607 and replacement electrodes K0609 are used for both AEDs (E0617) and WCDs (K0606).

**K0607 – Replacement Battery**

- The member must currently be renting or have purchased an AED (E0617) or WCD (K0606 with integrated ECG analysis, garment type).
- The battery being replaced must be at least 11 months old or completely discharged.

**K0608 – Replacement Garment (only for WCD)**

- The member must currently rent or have purchased a WCD with integrated ECG analysis, garment type, K0606.
• The garment must be damaged or worn beyond repair and have been in use at least five months.

K0609 – Replacement Electrodes
• The member must currently rent or have purchased an AED (E0617) or the WCD with integrated ECG analysis, garment type (K0606).
• 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.

Billing Requirements
See the IHCP Provider Manual for additional billing instructions.

Rules, Citations and Sources
405 IAC 5-19-2 – “Durable medical equipment” or “DME” defined
405 IAC 5-19-3 – Reimbursement parameters for durable medical equipment
IHCP Provider Newsletter
NL200411

Note: For the most updated information regarding the IHCP Provider Manual, bulletins and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics
Emergency Medicine – Cardiopulmonary Resuscitation (CPR)
Hospital Outpatient Services
Medical Supplies and Durable Medical Equipment – Overview
Medical Supplies and Equipment – Cardiac Pacemakers

Introduction

This section serves as a general summary of the IHCP’s policies regarding cardiac pacemakers. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Cardiac pacemakers are self-contained, battery-operated units that send electrical stimulation to the heart. They are generally implanted to alleviate symptoms of decreased cardiac output related to abnormal heart rate and/or rhythm. Pacemakers are generally used for persistent, symptomatic second- or third-degree atrioventricular (AV) block and symptomatic sinus bradycardia.

Reimbursement Requirements

IHCP reimbursement is available for implantation of cardiac pacemakers and monitoring when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization and appropriate referrals for recipients enrolled in MCE programs.

Single Chamber Cardiac Pacemaker Implantation

IHCP reimbursement is available for implantation of the single chamber cardiac pacemakers provided the conditions are:

- Chronic or recurrent condition
- Not due to transient causes, such as acute myocardial infarction (MI), drug toxicity, or electrolyte imbalance.

And meet any of the following conditions:

- Acquired complete (also referred to as third degree) AV heart block.
- Congenital complete heart block with severe bradycardia in relation to age or significant physiological deficits or significant symptoms due to the bradycardia.
- Second degree AV heart block of Type II.
- Second degree AV heart block of Type I.
- Sinus bradycardia associated with major symptoms or substantial sinus bradycardia with heart rate less than fifty (50) associated with dizziness or confusion. The correlation between symptoms and bradycardia must be documented, or the symptoms must be clearly attributable to the bradycardia rather than to some other cause.
- Sinus bradycardia of lesser severity (heart rate fifty (50) to fifty-nine (59)) with dizziness or confusion. The correlation between symptoms and bradycardia must be documented, or the symptoms must be clearly attributable to the bradycardia rather than to some other cause.
- Sinus bradycardia, which is the consequence of long term necessary drug treatment for which there is no acceptable alternative, when accompanied by significant symptoms. The correlation between symptoms and bradycardia must be documented, or the symptoms must be clearly attributable to the bradycardia rather than to some other cause.
- Sinus node dysfunction, with or without tachyarrhythmias or AV conduction block, when accompanied by significant symptoms.
- Sinus node dysfunction, with or without symptoms, when there are potentially life-threatening ventricular arrhythmias or tachycardia secondary to the bradycardia.
- Bradycardia associated with supraventricular tachycardia with high degree AV block, which is unresponsive to appropriate pharmacological management and when the bradycardia is associated with significant symptoms.
- Hypersensitive carotid sinus syndrome with syncope due to bradycardia and unresponsive to prophylactic medical measures.
- Bifascicular or trifascicular block accompanied by syncope, which is attributed to transient complete heart block after other plausible causes of syncope have been reasonably excluded.
- Prophylactic pacemaker use following recovery from acute myocardial infarction during which there was temporary complete (third degree) or Mobitz Type II second degree AV block in association with bundle branch block.
- Recurrent and refractory ventricular tachycardia, overdrive pacing (pacing above the basal rate) to prevent ventricular tachycardia.
- Second degree AV heart block of Type I with the QRS complexes prolonged.

Reimbursement is not available for implantation of the single-chamber pacemaker for the following:
- Syncope of undetermined cause.
- Sinus bradycardia without significant symptoms.
- Sinoatrial block or sinus arrest without significant symptoms.
- Prolonged PR intervals (slow ventricular response) with atrial fibrillation without third degree atrial ventricular (AV) block.
- Bradycardia during sleep.
- Right bundle branch block with left axis deviation and other forms of fascicular or bundle branch blocks without significant signs or symptoms.
- Asymptomatic second degree AV block of Mobitz Type I (Wenckebach).

**Dual Chamber Cardiac Pacemaker Implantation**

IHCP reimbursement is available for implantation of the dual chamber cardiac pacemaker provided the conditions are:

- Chronic or recurrent condition
- Not due to transient causes, such as acute myocardial infarction (MI), drug toxicity, or electrolyte imbalance.

And meet any of the following conditions:

- A definite drop in blood pressure, retrograde conduction, or discomfort during insertion of a single-chamber (ventricular) pacemaker.
- Pacemaker syndrome (atrial ventricular asynchrony) with significant symptoms with a pacemaker that is being replaced.
- A condition in which even a relatively small increase in cardiac efficiency will importantly improve the quality of life.
- A condition in which the pacemaker syndrome can be anticipated.
- Dual-chamber pacemakers will be covered for the conditions listed under the single chamber pacemaker implantation if determined to be medically necessary.

Reimbursement is not available for implantation of the dual-chamber pacemaker for the following:

- Ineffective atrial contractions.
- Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of the tachycardia.
- A clinical condition in which pacing takes place only intermittently and briefly and is not associated with a reasonable likelihood that pacing needs will become prolonged.
• Prophylactic pacemaker use following recovery from acute myocardial infarction during which there was temporary complete (third degree) or Type II second degree AV block in association with bundle branch block.

Monitoring of Pacemakers

The IHCP provides reimbursement for clinic and telephone monitoring of cardiac pacemakers when the frequency of monitoring does not exceed the following unless medically necessary:

• For clinic monitoring of lithium battery pacemakers with single-chamber pacemakers, twice in the first six (6) months following implant, then once every twelve (12) months.
• For clinic monitoring of lithium battery pacemakers with dual-chamber pacemakers, twice in the first six (6) months following implant, then once every six (6) months.
• For telephone monitoring with single-chamber pacemaker following the first month of the implant, once every two (2) weeks.
• For telephone monitoring with single-chamber pacemaker following the second month of the implant through the thirty-sixth month, once every eight (8) weeks.
• For telephone monitoring with single-chamber pacemaker following the thirty-seventh month of the implant through failure, once every four (4) weeks.
• For telephone monitoring with dual-chamber pacemaker following the first month of the implant, once every two (2) weeks.
• For telephone monitoring with dual-chamber pacemaker following the second through the sixth month of the implant, once every four (4) weeks.
• For telephone monitoring with dual-chamber pacemaker following the seventh through the thirty-sixth month of the implant, once every eight (8) weeks.
• For telephone monitoring with dual-chamber pacemaker following the seventh through the thirty-seventh month through failure of the implant, once every four (4) weeks.

Prior Authorization Requirements

Prior authorization is not required for the implantation of a pacemaker when performed in an outpatient setting.

Billing Requirements

Reimbursement requires compliance with all IHCP guidelines. Providers must bill utilizing the appropriate procedure code in addition to the highest ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity. For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.
The IHCP will reimburse the cost of single and dual chamber pacemakers identified in Table 1 in addition to the ASC rate when the implantation is performed in an outpatient surgical setting. The facility purchasing the pacemaker must submit a manufacturer’s cost invoice showing the purchase price for the pacemaker as an attachment to the CMS-1500 claim form or 837P electronic transaction.

Table 1 – Separate Pacemaker Reimbursement

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1785</td>
<td>Pacemaker, dual chamber, rate-responsive (implantable)</td>
</tr>
<tr>
<td>C1786</td>
<td>Pacemaker, single chamber, rate-responsive (implantable)</td>
</tr>
<tr>
<td>C2619</td>
<td>Pacemaker, dual chamber, nonrate-responsive (implantable)</td>
</tr>
<tr>
<td>C2620</td>
<td>Pacemaker, single chamber, nonrate-responsive (implantable)</td>
</tr>
<tr>
<td>C2621</td>
<td>Pacemaker, other than single or dual chamber (implantable)</td>
</tr>
</tbody>
</table>

Pacemaker Analysis – Two within Six Months

The provider should use the claim note to document the medical reason for the second analysis in the six-month time frame, such as a dysfunctional pacemaker.

Please note: Removal of a patient-activated event recorder – ILR on the same day as the insertion of a cardiac pacemaker is considered part of the pacemaker insertion procedure and is not reimbursed separately.

Rules, Citations and Sources

405 IAC 5-28-3 – Cardiac pacemaker
405 IAC 5-28-4 – Single-chamber cardiac pacemaker implantation
405 IAC 5-28-5 – Dual-chamber cardiac pacemaker implantation
405 IAC 5-28-6 – Monitoring of pacemakers

IHCP Bulletins

BT200511
BT200622

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.
Related Medical Topics

Medical Supplies and Durable Medical Equipment – Overview
Medical Supplies and Equipment – Continuous Glucose Monitors

Introduction

This section serves as a general summary of the IHCP’s policies regarding continuous glucose monitors. Additional information specific to this topic may be found in the *IHCP Provider Manual*, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Diabetes is characterized by high blood sugar levels related to problems with the body’s ability to react to or produce insulin, a substance created in the pancreas. According to the American Diabetes Association, approximately 17 million people in the United States have diabetes. There are three types of diabetes:

- Type 1 diabetes: Previously called Juvenile Diabetes
- Type 2 diabetes: The most common form of diabetes
- Gestational diabetes: A type of diabetes that elevates blood sugar levels in pregnant women who do not have blood sugar problems.

Continuous Glucose Monitors (CGM) are FDA-approved devices used to record ongoing glucose levels in interstitial fluid. CGM monitoring provides information about glucose fluctuations which might not otherwise be obtained with traditional testing methods. The purpose of continuous glucose monitoring is to provide additional information to the provider and the member in order to aid improved glycemic control.

CGM system typically consists of:

- A disposable glucose sensor placed just under the skin, which is worn for a few days (per manufacturer recommendations) until replacement.
- A link from the sensor to a non-implanted transmitter which communicates to a radio receiver
- An electronic receiver worn like a pager (or insulin pump) that displays blood glucose levels on a practically continuous manner, as well as monitors rising and falling trends in glycemic excursions
Information collected from the continuous glucose monitor system is intended to supplement blood glucose levels obtained by standard finger stick testing. Diabetics must continue to perform finger stick tests while using the system and before adjusting medication dosing.

Reimbursement Requirements

Continuous Glucose Monitors are reimbursable by the IHCP for adults and children (age 7 and above) for both short-term and long-term use when considered medically necessary.

- The member must not have achieved control of glucose levels despite consistent monitoring via the use of the finger stick method.
- The member must have shown compliance in their own care;
- The member must have one of the three types of diabetes
- The member must show continued inappropriate glucose levels while utilizing multiple techniques (including an insulin pump) to manage glucose levels.

Short-Term Continuous Glucose Monitoring – Up to 72 hours

IHCP reimbursement is available for a continuous glucose monitor for up to 72 hours (three days) as an evaluation tool for providers to treat members who have not obtained acceptable glycemic control. The CGM is deemed medically necessary when the following criterion is met. Members must be compliant with their own care and have:

- Been instructed by a health care professional regarding diabetic management; and
- Type 1 diabetes; or
- Type II insulin dependent diabetes; or
- Type I or II diabetic woman who is newly pregnant or who has developed gestational diabetes that requires insulin

And:

- Inadequate glycemic control despite compliance and documented frequency of standard glucose self testing (a minimum of four times per day) and insulin administration (a minimum of three times a day).
  - Hemoglobin A1C value of <6.0 and >8.5; or
  - Wide fluctuation of blood glucose levels; or
  - Unexplained frequent hypoglycemic episodes; or
  - Episodes of Ketoacidosis or hospitalizations for glucose out of control; or
  - Starting insulin or an insulin pump for the first time
The 72 hour continuous glucose monitoring device should be used on appropriate periodic basis (as determined by medical necessity) in order to direct changes in diabetic management.

*** Continuous Glucose Monitoring for Children – the device utilized must be approved by the FDA for use in children. Additionally, the IHCP will not reimburse for CGM in children under the age of 7.

**Long Term Continuous Glucose Monitoring:**

IHCP reimbursement is available for long term continuous glucose monitoring when considered medically necessary and the following criteria has been met: The member must be compliant and have:

- Type I diabetes; or
- Type I diabetes who are pregnant; or
- Type II insulin dependent diabetes

And one of the following criteria:

- Inadequate glycemic control despite compliance and documented frequency of standard glucose self testing and insulin administration.
  - Insulin injections of three or more times per day
  - Four or more finger sticks per day.
- Inadequate glycemic control with:
  - Fasting hyperglycemia >150 mg/dl; or
  - Recurring episodes of severe hypoglycemia <50 mg/dl; or
  - Hemoglobin A1C values <6.0 and >8.5; or
  - History of hypoglycemic unawareness or wide variations in blood glucose levels; or
  - Inadequate control in spite of compliance with multiple alterations in self-monitoring and insulin administration regimens to optimize care; and
- An insulin pump used for maintenance of blood sugar control.

*** Continuous Glucose Monitoring for Children – the device utilized must be approved by the FDA for use in children. Additionally, the IHCP will not reimburse for CGM in children under the age of 7.

**Prior Authorization Requirements**

Prior authorization must be obtained for use of temporary and long term continuous glucose monitor. PA requests for DME are reviewed on a case-by-case basis, using the criteria found in 405 IAC 5-3-1:
• The item must be medically necessary for the treatment of an illness or injury or to improve the function of a body part.

• The item must be adequate for the medical need; however, items with unnecessary convenience or luxury features are not authorized.

• The anticipated period of need, plus the cost of the item is considered in determining whether the item is rented or purchased.

• The monitoring must be performed for a minimum of 24 hours. If the service is performed less than 24 hours, the service is not considered medically necessary.

Table 1 - Continuous Glucose Monitor Prior Authorization

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>*95250</td>
<td>Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording</td>
<td>Yes</td>
</tr>
<tr>
<td>*95251</td>
<td>Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; physician interpretation and report</td>
<td>No</td>
</tr>
<tr>
<td>A9276</td>
<td>Sensor; invasive (e.g. subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply</td>
<td>Yes</td>
</tr>
<tr>
<td>A9277</td>
<td>Transmitter; external, for use with interstitial continuous glucose monitoring system</td>
<td>Yes</td>
</tr>
<tr>
<td>A9278</td>
<td>Receiver (monitor); external, for use with interstitial continuous glucose monitoring system</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Billing Requirements

The IHCP reimburses for use of short term and long term Continuous Glucose Monitoring when the service is considered medically necessary. Tables 2 and 3 identify the appropriate codes to bill for the particular need of the Continuous Glucose Monitor. The codes for Long Term Continuous Glucose Monitoring requires an itemized cost invoice and retail invoice be submitted with the claim when it is submitted.
Table 2 - Short Term Continuous Glucose Monitoring

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95250</td>
<td>Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording</td>
</tr>
<tr>
<td>95251</td>
<td>Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; physician interpretation and report</td>
</tr>
</tbody>
</table>

Table 3 - Long Term Continuous Glucose Monitoring

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9276</td>
<td>Sensor; invasive (e.g. subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply</td>
</tr>
<tr>
<td>A9277</td>
<td>Transmitter; external, for use with interstitial continuous glucose monitoring system</td>
</tr>
<tr>
<td>A9278</td>
<td>Receiver (monitor); external, for use with interstitial continuous glucose monitoring system</td>
</tr>
</tbody>
</table>

Rules, Citations and Sources

405 IAC 5-19 – Medical Supplies

405 IAC 5-3 – Prior Authorization

IHCP Provider Manual


Related Medical Topics

Laboratory Services

Medical Supplies and Durable Medical Equipment – Overview
Medical Supplies and Equipment – Gloves

Introduction

This section serves as a general summary of the IHCP’s policies regarding gloves. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

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 the member and/or the 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, gloves 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 that they are not worn or torn, and are free of holes that could lead to exposure.

Reimbursement Requirements

The IHCP provides coverage for sterile and non-sterile gloves for use in the home by the member, family, or other non-paid caregiver.
All gloves must be ordered in writing by a physician. Sterile gloves must be used only when medical necessity is provided. 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 twelve months to ensure that the need for gloves is ongoing. The order should reflect any changes in the POC in the home treatment setting. Providers must maintain records of quantities supplied. If these supplies are delivered or mailed, a record showing proof of delivery must be maintained.

**Non-Sterile**

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**

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:

- Gloves are used in the home by a paid caregiver.
- Gloves are not used for a medically necessary treatment.
- For members who reside in nursing facilities, 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 Requirements
PA is not required for sterile or non-sterile gloves.

Billing Requirements
The following HCPCS codes are used to report the use of sterile and non-sterile gloves:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4927</td>
<td>Gloves, non-sterile, per 100 (Limited to five (5) units per month)</td>
</tr>
<tr>
<td>A4930</td>
<td>Gloves, sterile, per pair</td>
</tr>
</tbody>
</table>

As a reminder, sterile and non-sterile gloves are covered only when used for medical purposes by nonpaid caregivers

In accordance with the provider agreement and the regulations governing this program, providers may not bill the IHCP for any amount that exceeds providers’ usual and customary charges to the general public.

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 – Non-Covered Services
405 IAC 5-31-4 – Per Diem Services
IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.
Related Medical Topics

Home Health Services
Hospital Outpatient Services
Medical Supplies and Durable Medical Equipment – Overview
Nursing Facilities
Medical Supplies and Equipment – High Frequency Chest Wall Oscillation System (Formerly ThAIRapy®, aka the Vest)

Introduction

This section serves as a general summary of the IHCP’s policies regarding the high frequency chest wall oscillation system. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

A high frequency chest wall oscillation system is a mechanical device that utilizes a vest and a generator to loosen bronchial secretions and clears the airway. All requests for this durable medical equipment device require PA with an appropriate clinical summary and physician prescription.

High-frequency chest wall compression devices include but are not limited to the following: The Vest™ Airway Clearance System formally known as ThAIRapy® Vest or ABI vest (Hill-Rom Services, Inc.), The Medpulse™ Respiratory Vest System and The Smartvest® Airway Clearance System (Electromed Inc., Minnetonka, MN), The Incourage ™ System (RespirTech, Inc.)

Reimbursement Requirements

The following criteria must be met for a high frequency chest wall oscillation system to be approved and covered by the IHCP:

- A physician order
- The physician’s determination that the patient requires airway clearance therapy at least once a day
- A pulmonary function study, done within 90 days of the date of the request, that demonstrates:
  - A Forced Expiratory Volume (FEV1) 80 percent of predicted
  - A forced vital capacity (FVC) 50 percent of predicted
  - A 25 percent decrease on small airway score (Forced Expiratory Flow [FEF] 25-75) over one year
- Documentation supporting that chest physiotherapy or flutter devices used twice a day have been ineffective in managing bronchial secretions
- Documentation supporting that family members and caregivers have been unable to provide effective chest therapy, or that the member is living independently or is away at school
- Risk of continued hospitalization for the member
- The member does not have a cardiac condition

Rental of a high frequency chest wall oscillation system for three months is required before purchase of the equipment is covered or reimbursable. At the end of three months, documentation that the system has been used on a regular basis is required. Medical records must indicate patient’s compliance and tolerance before purchase will be approved.

**Prior Authorization Requirements**

PA is required for a high frequency chest wall oscillation system.

**Billing Requirements**

E0483 – High frequency chest wall oscillation air-pulse generator system (includes hoses and vest), each

A7025 – High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each

A7026 – High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each

The three-month rental prior to purchasing only pertains to the generator system, E0483. Reimbursement for the system vest (A7025) and hose (A7026) replacements are purchase only.

**Rules, Citations and Sources**

405 IAC 5-2-17 – “Medically reasonable and necessary service” defined

405 IAC 5-19-1 – Medical supplies

405 IAC 5-25 – Physician Services

405 IAC 5-29-1 – Non-covered services

IHCP Bulletins

[BT200205 – Policy Revision for Coverage of the ThAIRapy Vest]
IHCP Banner Pages

BR200224
BR10-20-1998

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Home Health Services

Medical Supplies and Durable Medical Equipment – Overview
Medical Supplies and Equipment – Hospital and Specialty Beds

Introduction

This section serves as a general summary of the IHCP’s policies regarding hospital and specialty beds. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

The IHCP will provide coverage for hospital and specialty beds when they are medically necessary in a non-institutional setting, when there is a written physician’s order, and when the beds have received PA. The purpose for this policy is to standardize use by providing a guide for determining the medical necessity of hospital and specialty beds.

Note: For purposes of the IHCP, “hospital beds” refers to adjustable height, semi-electric, and total electric beds. “Specialty beds” refers to enclosed beds or pediatric hospital beds.

The following is a definition of terms used in this section.

Hospital Beds

- A fixed-height hospital bed is one with manual adjustment elevation for head and leg.
- A variable-height hospital bed is one with manual adjustment elevation for the head, height, and legs.
- A semi-electric hospital bed is one with manual adjustment elevation for height and with electric elevation adjustments for the leg and head.
- A total-electric hospital bed is one with electric elevation adjustments for height, head, and leg.

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 TBI.
• A pediatric hospital bed has higher side rails that are close together to prevent injury from falling through the rails. Pediatric hospital beds usually also have a protective covering over the rails.

Reimbursement Requirements
A hospital bed is considered medically necessary if one or more of the following conditions are met:

• Physician ordered positioning of the body 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.
• Physician ordered positioning of the body in ways to alleviate pain that are not possible in an ordinary bed.
• Physician ordered positioning of the body that requires head elevation greater than 30 degrees most of the time. The need for head elevation must be related to a medical condition, such as congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed.
• Physician ordered traction that requires traction equipment, which can be attached only to a hospital bed.
• A variable height hospital bed is covered if, in addition to meeting one or more of the above criteria for a hospital bed, the physician orders a bed height different from 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 or more of the above criteria for a hospital bed, the physician orders frequent changes in body positioning 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 that could include but is not limited to the following:
  • Severe intellectual disabilities
  • Profound intellectual disabilities
  • Leukodystrophy
  • Picks disease
  • Obstructive hydrocephalus
  • Infantile cerebral palsy
  • Generalized convulsive epilepsy
• Grand mal status epileptic
• Anoxic brain damage
• Convulsions
• Intracranial injury of other and unspecified nature

B) Documentation of medical necessity must include at least one of the following:
• Daily seizure activity
• Uncontrolled perpetual movement related to diagnosis
• Self-injurious behavior, such as uncontrolled head banging

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 or other complications related to aspiration
• Respiratory complications related to positioning, requiring 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. IHCP 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:
- Tracheostomy
- Gastrostomy
- Heart failure
- Pleural effusion, except tuberculous
- Acute respiratory failure
- Pulmonary insufficiency
- Diseases of the lung
- Diseases of trachea and bronchus
- Respiratory distress syndrome in newborn
- Other respiratory problems after birth
- Other symptoms involving respiratory system and chest

B) Mandatory criteria for PA include all the following requirements:
- A physician’s order for a multi-positional bed because of the need for frequent position changes
- Elevation of upper body and head greater than 30 degrees
- Written documentation of why a standard crib is not appropriate and what alternative methods have been tried and failed
- A medical clearance form completed and signed by the physician

C) Recommended criteria (patient must meet at least one of the following criteria):
- Documentation that indicates there is a risk for aspiration pneumonitis or gastric reflux related to disease
- Documentation of a history of aspiration pneumonitis

Capped Rental

Most hospital beds are classified as capped rental items under the IHCP. The beds are available for rental using the RR modifier or purchase using the NU modifier. The rental beds are limited to 15 months of continuous rental. The IHCP defines continuous rental 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.

Please refer to Chapter 8 of the IHCP Provider Manual for further information regarding capped rental.
Prior Authorization Requirements

Prior authorization is required for all types of hospital beds and specialty beds.

The IHCP has developed a medical clearance form to assist providers in supplying the necessary documentation required for evaluation of the medical information by PA staff. The medical clearance form must be signed by the physician who orders the bed, and must be included with the PA request. The medical clearance form can be found at indianamedicaid.com under forms.

Recommended criteria

- A medical clearance form completed and signed by the physician
- Documentation of medical necessity in a non-institutional setting
- A written physician’s order
- Appropriate diagnosis demonstrating the medical necessity for a bed; and conditions are met under the coverage criteria section of the policy

Billing Requirements

Providers are to bill their usual and customary charge for the equipment and will be reimbursed the lesser of the submitted charges for the equipment or the maximum fee amount. The equipment is to be billed on a CMS-1500 claim form.

Please refer to Chapter 8 of the IHCP Provider Manual for billing requirements – see www.indianamedicaid.com.

Table 1 – HCPCS Codes – Fixed-height Beds

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0250</td>
<td>Hospital bed, fixed height, with any type side rails, with mattress</td>
</tr>
<tr>
<td>E0251</td>
<td>Hospital bed, fixed height, with any type side rails, without mattress</td>
</tr>
<tr>
<td>E0290</td>
<td>Hospital bed, fixed height, without side rails, with mattress</td>
</tr>
<tr>
<td>E0291</td>
<td>Hospital bed, fixed height, without side rails, without mattress</td>
</tr>
</tbody>
</table>

Table 2 – HCPCS Codes – Variable-height Beds

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0255</td>
<td>Hospital bed variable height hi-lo, with any type side rails, with mattress</td>
</tr>
<tr>
<td>E0256</td>
<td>Hospital bed variable height hi-lo, with any type side rails, without mattress</td>
</tr>
</tbody>
</table>
### Table 3 – HCPCS Codes – Semi-electric Beds

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0260</td>
<td>Hospital bed, semi-electric (head and foot adjustments), with any type side rails, with mattress</td>
</tr>
<tr>
<td>E0261</td>
<td>Hospital bed, semi-electric (head and foot adjustments), with any type side rails, without mattress</td>
</tr>
<tr>
<td>E0294</td>
<td>Hospital bed, semi-electric (head and foot adjustments), without side rails, with mattress</td>
</tr>
<tr>
<td>E0295</td>
<td>Hospital bed, semi-electric (head and foot adjustments), without side rails, without mattress</td>
</tr>
</tbody>
</table>

### Table 4 – HCPCS Codes – Total Electric Beds

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0265</td>
<td>Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress</td>
</tr>
<tr>
<td>E0266</td>
<td>Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress</td>
</tr>
<tr>
<td>E0296</td>
<td>Hospital bed, total electric (head, foot, and height adjustments). Without side rails, with mattress</td>
</tr>
<tr>
<td>E0297</td>
<td>Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress</td>
</tr>
</tbody>
</table>

### Table 5 – HCPCS Codes – Pediatric Beds

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0300</td>
<td>Pediatric crib, hospital grade, fully enclosed</td>
</tr>
<tr>
<td>E0328</td>
<td>Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress</td>
</tr>
<tr>
<td>E0329</td>
<td>Hospital bed, pediatric, electric or semi-electric, 360 degrees side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress</td>
</tr>
</tbody>
</table>
### Table 6 – HCPCS Codes – Specialty Beds

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0270</td>
<td>Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress</td>
</tr>
<tr>
<td>E0301</td>
<td>Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress</td>
</tr>
<tr>
<td>E0302</td>
<td>Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress</td>
</tr>
<tr>
<td>E0303</td>
<td>Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress</td>
</tr>
<tr>
<td>E0304</td>
<td>Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress</td>
</tr>
</tbody>
</table>

### Table 7 – HCPCS Codes – Bed Accessories and Trapeze Bars

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0271</td>
<td>Mattress, inner spring</td>
</tr>
<tr>
<td>E0272</td>
<td>Mattress, foam rubber</td>
</tr>
<tr>
<td>E0273</td>
<td>Bed board</td>
</tr>
<tr>
<td>E0274</td>
<td>Over-bed table</td>
</tr>
<tr>
<td>E0275</td>
<td>Bed pan, standard, metal or plastic</td>
</tr>
<tr>
<td>E0276</td>
<td>Bed pan, fracture, metal or plastic</td>
</tr>
<tr>
<td>E0277</td>
<td>Powered pressure-reducing air mattress</td>
</tr>
<tr>
<td>E0280</td>
<td>Bed cradle, any type</td>
</tr>
<tr>
<td>E0305</td>
<td>Bedside rails, half length</td>
</tr>
<tr>
<td>E0310</td>
<td>Bedside rails, full length</td>
</tr>
<tr>
<td>E0315</td>
<td>Bed accessories – boards or tables, any type</td>
</tr>
<tr>
<td>E0316</td>
<td>Safety enclosure frame/canopy for use with hospital bed, any type</td>
</tr>
<tr>
<td>E0325</td>
<td>Urinal; male, jug-type, any material</td>
</tr>
<tr>
<td>E0326</td>
<td>Urinal; female, jug-type, any material</td>
</tr>
<tr>
<td>E0350</td>
<td>Control unit for electronic bowel irrigation/evacuation system</td>
</tr>
<tr>
<td>E0352</td>
<td>Disposable pack (water reservoir bag, speculum, valving mechanism and collection bag/box) for use with electronic bowel irrigation/evacuation system</td>
</tr>
<tr>
<td>E0370</td>
<td>Air pressure elevator for heel</td>
</tr>
</tbody>
</table>
E0371 Non powered advanced pressure reducing overlay for mattress, standard mattress length and width
E0372 Powered air overlay for mattress, standard mattress length and width
E0373 Non powered advanced pressure reducing mattress
E0910 Trapeze bars, patient helper, attached to bed, with grab bar
E0911 Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar
E0912 Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar
E0920 Fracture frame, attached to bed, includes weights
E0930 Fracture frame, free standing, includes weights
E0940 Trapeze bar, free standing, complete with grab bar
E0946 Fracture frame, dual with cross bars, attached to bed, (e.g. Balken, 4 poster)
E0947 Fracture frame, attachments for complex pelvic traction
E0948 Fracture frame, attachments for complex cervical traction

Rules, Citations and Sources

405 IAC 5-19-2 – “Durable medical equipment” or “DME” defined

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Home Health Services
Medical Supplies and Durable Medical Equipment – Overview
Medical Supplies and Equipment – Implantable Cardioverter Defibrillator

Introduction

This section serves as a general summary of the IHCP’s policies regarding implantable cardioverter defibrillators. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

The implantable cardioverter defibrillator is an electronic device surgically implanted into members identified at high risk for sudden cardiac death (SCD) due to ventricular tachyarrhythmia (i.e. ventricular tachycardia (VT) and ventricular fibrillation). The implantable cardioverter defibrillator continuously monitors the heart rhythm, automatically senses a tachyarrhythmia, and restores the normal rhythm via electrical impulses or a transcardial electrical shock. The implantable cardioverter defibrillator consists of an impulse generator, batteries, and electrodes.

Reimbursement Requirements

The IHCP provides reimbursement for implantable cardioverter defibrillator when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization. Implantable cardioverter defibrillator therapy is considered medically necessary for the treatment of ventricular tachyarrhythmias and for the prevention of sudden cardiac death (SCD) in individuals who are receiving optimal medical therapy.

Prior Authorization Requirements

Prior Authorization is required for all implantable cardioverter defibrillators. An implantable cardioverter defibrillator is indicated for members who are receiving ongoing optimal medical therapy, have a reasonable expectation of survival with good functional status for more than one (1) year, and have one of the following conditions:

- Survivors of cardiac arrest due to ventricular fibrillation or hemodynamically unstable sustained VT after evaluation to define the cause of the event and to exclude any completely reversible causes.
  - The following must also be meet:
- Members must be able to give informed consent.
- Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography.
- Myocardial Infarctions (MIs) must be documented and defined according the Joint European Society of Cardiology/American College of Cardiology Committee for the Redefinition of Myocardial Infarction as identified in Table 50.1.

- Left ventricular (LV) dysfunction with prior myocardial infarction (Ischemic Cardiomyopathy) and one of the following:
  - With left ventricular ejection fraction (LVEF) less than or equal to 35 percent due to prior myocardial infarction who are at least 40 days post-myocardial infarction and who are in New York Heart Association (NYHA) functional Class II or III. The NYHA functional class levels are identified in Table 50.2.
  - With LV dysfunction due to prior myocardial infarction who are at least 40 days post-myocardial infarction, have an LVEF less than or equal to 30 percent, and are in NYHA functional Class I.
  - With nonsustained VT due to prior myocardial infarction, LVEF less than or equal to 40 percent, and inducible ventricular fibrillation or sustained VT at electrophysiological study.
  - The following must also be meet:
    - Members must be able to give informed consent.
    - Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography.
    - MIs must be documented and defined according the Joint European Society of Cardiology/American College of Cardiology Committee for the Redefinition of Myocardial Infarction as identified in Table 50.1.

- Nonischemic dilated cardiomyopathy with a LVEF less than or equal to 35 percent and are in NYHA functional Class II or III.
- Sustained VT, either spontaneous or induced by an electrophysiology (EP) study, not associated with an acute MI and not due to a transient or reversible cause.
- Syncope of undetermined origin with one of the following:
  - Clinically relevant, hemodynamically significant sustained VT.
  - Ventricular fibrillation induced at electrophysiological study.
  - Unexplained syncope, significant LV dysfunction, and nonischemic dilated cardiomyopathy.
Familial or inherited conditions with a high risk of life-threatening VT (one of the following):

- Hypertrophic Cardiomyopathy with one or more of the following major risk factors for SCD:
  - Prior cardiac arrest.
  - Spontaneous sustained VT.
  - Spontaneous nonsustained VT.
  - Family History of SCD.
  - Syncope.
  - LV thickness greater than or equal to 30 mm.
  - Abnormal blood pressure response to exercise.

- For the prevention of SCD in members with arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVD/C) who have one (1) or more risk factor for SCD.
  - Induction of VT during electrophysiological testing.
  - Detection of nonsustained VT on noninvasive testing.
  - Male gender.
  - Severe right ventricular dilation.
  - Extensive right ventricular involvement.
  - Young age at presentation (less than five (5) years).
  - LV involvement.
  - Prior cardiac arrest.
  - Unexplained syncope.
  - Deleterious genetic mutations associated with ARVD/C.

- To reduce SCD in members with long QT syndrome who are experiencing syncope and/or VT while receiving beta blockers.

- Brugada syndrome and one of the following:
  - Previous syncope.
  - Documented VT that has not resulted in cardiac arrest.
  - Catecholaminergic polymorphic VT who have syncope and/or documented sustained VT while receiving beta blockers.
Non-hospitalized members awaiting transplantation.
Cardiac sarcoidosis.
Giant cell myocarditis.
Chagas disease.

**Pediatric Members and Members with Congenital Heart Disease**

An implantable cardioverter defibrillator is indicated for pediatric members and members with congenital heart disease who have one of the following conditions:

- Survivor of cardiac arrest after evaluation to define the cause of the event and to exclude any reversible causes.
  - Members with symptomatic sustained VT in association with congenital heart disease who have undergone hemodynamic and electrophysiological evaluation. Catheter ablation or surgical repair may offer possible alternatives in carefully selected patients.
  - Members with congenital heart disease with recurrent syncope of undetermined origin in presence of either ventricular dysfunction or inducible ventricular arrhythmias at electrophysiological study.
  - Members with recurrent syncope associated with complex congenital heart disease and advanced systemic ventricular dysfunction when thorough invasive and noninvasive investigations have failed to define a cause.

**Non-Covered Indications**

Implantable cardioverter defibrillators are not covered when members have any of the following conditions:

- Irreversible brain damage, disease or dysfunction that precludes the ability to give informed consent.
- Significant psychiatric illnesses that may be aggravated by device implantation or that may preclude systematic follow-up.
- Any disease, other than cardiac disease (e.g. cancer, uremia, liver failure, advanced cerebrovascular disease) associated with survival less than one year.
- Ventricular tachyarrhythmias due to a completely reversible disorder in the absence of structural heart disease (e.g., electrolyte imbalance, drugs, or trauma).
- Member has asymptomatic VT or symptomatic VT/VF:
  - Associated with acute MI within two (2) days.
  - Due to a remediable cause.
- Controlled by appropriate drug therapy.
- Manageable through the use of other therapies (e.g. ablation procedures, surgery).

- Incessant VT or ventricular fibrillation.
- Syncope of undetermined cause without inducible ventricular tachyarrhythmias and without structural heart disease.
- Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm.
- Had a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angiography within the past three (3) months.
- Had an acute MI within the past 40 days.
- Clinical symptoms or findings that would make the member a candidate for coronary revascularization.
- With NYHA Class IV symptoms and drug-refractory congestive heart failure who are not candidates for cardiac transplantation or implantation of a CRT device that incorporates both pacing and defibrillation capabilities.
- When ventricular fibrillation or VT is amenable to surgical or catheter ablation (e.g., atrial arrhythmias associated with Wolff-Parkinson-White syndrome, right ventricular or LV outflow tract VT, idiopathic VT, or fascicular VT in the absence of structural heart disease).
- The planned implantable cardioverter defibrillator has not received full market approval from the FDA.

### Table 1 - Criteria for Acute, Evolving or Recent MI

<table>
<thead>
<tr>
<th>Criteria for diagnosis for an acute, evolving or recent MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Either one of the following criteria satisfies the diagnosis for an acute, evolving or recent MI:</td>
</tr>
<tr>
<td>- Typical rise and gradual fall (Troponin) or more rapid rise and fall (CK-MB) of biochemical markers of myocardial necrosis with at least one (1) of the following:</td>
</tr>
<tr>
<td>- Ischemic symptoms</td>
</tr>
<tr>
<td>- Development of pathologic Q waves on the ECG</td>
</tr>
<tr>
<td>- ECG changes indicative of ischemia (ST segment elevation or depression)</td>
</tr>
<tr>
<td>- Coronary artery intervention (e.g., coronary angioplasty)</td>
</tr>
<tr>
<td>- Pathologic findings of an acute MI</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criteria for Established MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Development of new pathologic Q waves on serial ECGs</td>
</tr>
</tbody>
</table>
Member may or may not remember previous symptoms
- Biochemical markers of myocardial necrosis may have normalized, depending on the length of time that has passed since the infarct developed.

- Pathologic findings of a healed or healing MI

**Table 2 - New York Heart Association (NYHA) Functional Classification**

<table>
<thead>
<tr>
<th>NYHA Class</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>No symptoms and no limitation in ordinary physical activity, e.g. shortness of breath when walking, climbing stairs etc.</td>
</tr>
<tr>
<td>II</td>
<td>Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity.</td>
</tr>
<tr>
<td>III</td>
<td>Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (20–100 m). Comfortable only at rest</td>
</tr>
<tr>
<td>IV</td>
<td>Severe limitations. Experiences symptoms even while at rest. Mostly bedbound patients.</td>
</tr>
</tbody>
</table>

**Billing Requirements**

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs. Providers must bill utilizing the appropriate procedure codes. 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. For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.

The IHCP will provide reimbursement for the surgical implantation of the implantable cardioverter defibrillator device when billed utilizing the procedure codes listed in Table 3.

**Table 3 – implantable cardioverter defibrillator Surgical CPT® Codes**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33212</td>
<td>Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular</td>
</tr>
<tr>
<td>33216</td>
<td>Insertion of a single transvenous electrode, permanent pacemaker or cardioverter-defibrillator</td>
</tr>
<tr>
<td>33217</td>
<td>Insertion of 2 transvenous electrodes, permanent pacemaker or cardioverter-defibrillator</td>
</tr>
</tbody>
</table>
Insertion or replacement of implantable cardioverter-defibrillator pulse generator only

Insertion or replacement of implantable cardioverter-defibrillator lead(s) by other than thoracotomy, with insertion of cardio-defibrillator pulse generator

The IHCP will provide reimbursement for the implantable cardioverter defibrillator device when billed on a CMS-1500 claim form or 837P transaction. The IHCP permits only certain implantable items to have separate reimbursement. Providers must bill utilizing the procedure codes listed in Table 4.

Table 4 – Implantable Cardioverter Defibrillator Device HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1721</td>
<td>Cardioverter-defibrillator, dual chamber (implantable)</td>
</tr>
<tr>
<td>C1722</td>
<td>Cardioverter-defibrillator, single chamber (implantable)</td>
</tr>
<tr>
<td>C1777</td>
<td>Lead, cardioverter-defibrillator, endocardial single coil (implantable)</td>
</tr>
<tr>
<td>C1779</td>
<td>Lead, pacemaker, transvenous VDD single pass</td>
</tr>
<tr>
<td>C1882</td>
<td>Cardioverter-defibrillator, other than single or dual chamber (implantable)</td>
</tr>
<tr>
<td>C1895</td>
<td>Lead, cardioverter-defibrillator, endocardial dual coil (implantable)</td>
</tr>
<tr>
<td>C1896</td>
<td>Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)</td>
</tr>
<tr>
<td>C1898</td>
<td>Lead, pacemaker, other than transvenous VDD single pass</td>
</tr>
<tr>
<td>C1899</td>
<td>Lead, pacemaker/cardioverter-defibrillator combination (implantable)</td>
</tr>
<tr>
<td>C1900</td>
<td>Lead, left ventricular coronary venous system</td>
</tr>
</tbody>
</table>

Rules, Citations and Sources

405 IAC 5-3-13 – Services Requiring Prior Authorization

IHCP Provider Manual


Related Medical Topics

Emergency Medicine – Cardiopulmonary Resuscitation (CPR)

Hospital Outpatient Services
Medical Supplies and Durable Medical Equipment – Overview
Medical Supplies and Equipment - Implantable Infusion Pumps

Introduction

This section serves as a general summary of the IHCP’s policies regarding implantable infusion pumps. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Implantable infusion pumps 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. Implantable infusion pumps 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 infusion 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 by using specially designed needles that are inserted transcutaneously into a self-sealing rubber septum that covers the reservoir.

Reimbursement Requirements

The IHCP provides coverage for services considered medically necessary and reasonable. These services are provided by a doctor of medicine or doctor of osteopathy and are related to implantable infusion pumps provided within the scope of practice of medicine as set forth in 405 IAC 5-25-1.

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 pump implantation is required for up to three days to monitor for a cerebrospinal 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 administer approximately 30-90 days of medication and are refilled at intervals – usually every 25 to 50 days – that depend on the pump’s delivery rate. Members may utilize their physician, hospital, or home health agency (if they are homebound) 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. The IHCP may reimburse 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 Requirements**

PA 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.

**Chemotherapy for liver cancer**

- The implantable infusion pump is covered for intra-arterial infusion of 5-Floxuridine (FUDR) 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 where (1) the disease is unresectable, or (2) the member refuses surgical excision of the tumor.

**Anti-spasmodic drugs**

- To intrathecally administer anti-spasmodic drugs (Baclofen, for example) 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 member must have responded favorably to a trial epidural or intrathecal dose of an anti-spasmodic drug.

**Opioid drugs**
To intrathecally administer opioid drugs (for example, morphine) to treat severe, chronic, intractable pain of non-malignant or malignant origin in 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 the person responsible for the member must be fully aware of the risks and benefits of the surgery, including the providers’ mortality and morbidity experience
- A documented medical history of less invasive medical therapy that was tried and failed

Other uses

- Coverage for other uses of implanted infusion pumps may be approved if the practitioner has documented in the member’s medical record all of the following:
  - The drug is reasonable and necessary for the treatment of the individual member.
  - It is medically necessary that the drug be administered by an implanted infusion pump.
  - FDA-approved labeling for the pump specifies:
    - The drug being administered
    - The purpose for which it is administered is an indicated use for the implantable infusion pump.

*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 Using Implantable Infusion Pumps

The implantation of an infusion pump is contraindicated in the following situations:

- Known allergy or hypersensitivity to the drug (for example, oral Baclofen, morphine, and so on) being used
- An infection affecting the area of implantation
- Insufficient body size to support the weight and bulk of the device
- Other implanted programmable devices, due to crosstalk between devices may inadvertently change the prescribed settings
Billing Requirements

Providers must submit claims for procedure codes E0782 and E0783 on the CMS-1500 claim form or 837P transaction. Table 1 details the codes providers must use to bill implantable fusion pumps.

**Table 1 – Implantable Infusion Pump – Durable Medical Equipment Codes**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>PA</th>
<th>IHCP Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0782</td>
<td>Infusion pump, implantable, nonprogrammable (includes all components, such as; pump, catheter, connectors, etc)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>E0783</td>
<td>Infusion pump system, implantable, programmable (includes all components, such as; pump, catheter, connectors, etc.)</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 2 details the procedure codes, and corresponding ASC groups for each code.

**Table 2 – Implantable Infusion Pumps Procedure Codes and Corresponding ASC Groups**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>ASC Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>36260</td>
<td>Insertion of implantable intra-arterial infusion pump</td>
<td>4</td>
</tr>
<tr>
<td>36261</td>
<td>Revision of implantable intra-arterial infusion pump</td>
<td>2</td>
</tr>
<tr>
<td>36262</td>
<td>Removal of implantable intra-arterial infusion pump</td>
<td>1</td>
</tr>
<tr>
<td>62350</td>
<td>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</td>
<td>2</td>
</tr>
<tr>
<td>62351</td>
<td>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</td>
<td>2</td>
</tr>
<tr>
<td>62355</td>
<td>Removal of previously implanted intrathecal or epidural catheter</td>
<td>3</td>
</tr>
<tr>
<td>62360</td>
<td>Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir</td>
<td>2</td>
</tr>
<tr>
<td>62361</td>
<td>Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump</td>
<td>2</td>
</tr>
<tr>
<td>62362</td>
<td>Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming</td>
<td>2</td>
</tr>
<tr>
<td>62365</td>
<td>Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion</td>
<td>2</td>
</tr>
<tr>
<td>62367</td>
<td>Electronic analysis of programmable, implanted pump for intrathecal or epidural infusion</td>
<td>2</td>
</tr>
</tbody>
</table>
### Related Medical Topics

- Hospital Inpatient Services
- Hospital Outpatient Services
- Medical Supplies and Durable Medical Equipment – Overview
- Surgery – Surgical Services
Medical Supplies and Equipment – Incontinence Supplies

Introduction

This section serves as a general summary of the IHCP’s policies regarding incontinence supplies. Additional information specific to this topic may be found in the *IHCP Provider Manual*, program notices, or the IAC.

The 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.

IHCP

Members enrolled in the Hoosier Healthwise RBMC program, the HIP, 590 Program, Medical Review Team (MRT), First Steps, Pre-Admission Screening and Resident Review (PASRR), and LTC are excluded from the incontinence supply vendor restrictions that are placed on Traditional Medicaid FFS members. Members with Medicare or third-party insurance must follow the guidelines of Medicare and/or their primary plan to receive reimbursement of these products. Crossover claims and claims with a third-party payment amount indicated for these supplies are not affected by this policy change.

Description of Service

The IHCP covers incontinence supplies for members three years old 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 of more than $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 Web interChange.

Incontinence supplies must be ordered in writing by a physician. The written order should include, at a minimum, the following information, when applicable:

- Patient’s name
- Date ordered
- Physician’s signature
- Area of body for use (for items that may be appropriate for multiple sites)
- Type and size of the product
- Quantity intended for use
- Frequency of use (for example, change dressing three times per day)
• Anticipated duration of need

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 be provided to members only in one month increments. The supplier must maintain documentation in the member’s 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.

Reimbursement Requirements

Effective June 1, 2008, all FFS members are required to obtain incontinence, ostomy, and colostomy supplies, including but not limited to diapers, underpads, ostomy bags, gloves, and other like supplies, through mail order from one of the following contracted providers:

- Binson’s Home Health Care Centers
  1-888-217-9610
  8 a.m. to 6 p.m. Eastern Standard Time (EST), Monday through Friday
  [www.binsons.com](http://www.binsons.com)

- J & B Medical Supply Company
  1-866-674-5850
  8 a.m. to 6 p.m. EST, Monday through Friday
  [www.jandbmedical.com](http://www.jandbmedical.com)

There are instances when the use of tapes, adhesives, gloves, and other supplies is not related to incontinence, ostomy, or urological conditions. IHCP members will not be restricted to purchasing these only through mail order from one of the three contracted vendors. Therefore, the procedure codes listed in Table 3 are billable by appropriate providers.

Incontinence supplies are included in the *per diem* rate for 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 Individuals with Intellectual Disabilities (ICFs/ID), and CRFs/DD.

Members enrolled in the 590 Program, Medical Review Team (MRT), First Steps, PASRR, LTC, and RBMC programs are excluded from this policy change.
Members with Medicare or third-party insurance must follow the guidelines of Medicare or their primary insurance plan to receive reimbursement for these products. Crossover claims and claims with a third-party payment amount indicated for these supplies are not affected by this policy change.

Members are required to participate in a nursing assessment to assist with determining the appropriate products, brands, and quantities. All nursing assessments are performed by a licensed nurse employed by the vendor.

**Non-Covered Items**

According to 405 IAC 5-29-1(5), personal comfort or convenience items are not covered by the IHCP. Therefore, products such as periwash spray, wet wipes or baby wipes, and soap or cleansers used for incontinence care are not covered by the IHCP.

**Prior Authorization Requirements**

PA is not required for the reimbursement of incontinence supplies unless they are supplied by an out-of-state provider, or the member is utilizing high-end incontinence products.

Prior authorization, for high-end incontinence products, will be granted based upon medical necessity. At minimum, the following information must be submitted in order to determine medical necessity:

- Member has sampled all applicable products from the three vendors and submitted documentation indicating why the products sampled were not appropriate. (i.e. leakage, skin breakdown, etc.)
- Documentation submitted supporting medical necessity for the high end ostomy supplies. The documentation must include the following:
  - Recurrent infections or skin breakdown
  - Issues the member are having with the current product (allergic reaction, redness, irritation, etc.).
  - Enzymes dissolving the adhesive or causing skin breakdown

The documentation must include the actual quantity needed per month for the member and factors which affect the frequency of the change.

**Billing Requirements**

**Coding**

The IHCP utilizes the following HCPCS T codes (T4521-T4542) for the reimbursement of incontinence supplies. Table 1 lists the covered codes for incontinence supplies; Table 2 lists the covered codes for ostomy supplies.
**Table 1 – Incontinence Supply Codes**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T4521</td>
<td>Adult-sized disposable incontinence product, brief/diaper, small each</td>
</tr>
<tr>
<td>T4522</td>
<td>Adult-sized disposable incontinence product, brief/diaper, medium each</td>
</tr>
<tr>
<td>T4523</td>
<td>Adult-sized disposable incontinence product, brief/diaper, large, each</td>
</tr>
<tr>
<td>T4524</td>
<td>Adult-sized disposable incontinence product, brief/diaper, extra large, each</td>
</tr>
<tr>
<td>T4525</td>
<td>Adult-sized disposable incontinence product, protective underwear/pull-on, small size, each</td>
</tr>
<tr>
<td>T4526</td>
<td>Adult-sized disposable incontinence product, protective underwear/pull-on, medium size, each</td>
</tr>
<tr>
<td>T4527</td>
<td>Adult-sized disposable incontinence product, protective underwear/pull-on, large size, each</td>
</tr>
<tr>
<td>T4528</td>
<td>Adult-sized disposable incontinence product, protective underwear/pull-on, extra large size, each</td>
</tr>
<tr>
<td>T4529</td>
<td>Pediatric-sized disposable incontinence product, brief/diaper, small/medium size, each</td>
</tr>
<tr>
<td>T4530</td>
<td>Pediatric-sized disposable incontinence product, brief/diaper, large size, each</td>
</tr>
<tr>
<td>T4531</td>
<td>Pediatric-sized disposable incontinence product protective underwear/pull-ons, small/medium size, each</td>
</tr>
<tr>
<td>T4532</td>
<td>Pediatric-sized disposable incontinence product protective underwear/pull-ons, large size, each</td>
</tr>
<tr>
<td>T4533</td>
<td>Youth-sized disposable incontinence product, brief/diaper, each</td>
</tr>
<tr>
<td>T4534</td>
<td>Youth-sized disposable incontinence product, protective underwear/pull-ons, each</td>
</tr>
<tr>
<td>T4535</td>
<td>Disposable liner/shield/guard/pad/ undergarment for incontinence, each</td>
</tr>
<tr>
<td>T4536</td>
<td>Incontinence product, protective underwear/pull-on reusable, any size, each</td>
</tr>
<tr>
<td>T4537</td>
<td>Incontinence product, protective underpad, reusable, bed size, each</td>
</tr>
<tr>
<td>T4539</td>
<td>Incontinence product, diaper/brief, reusable, any size, each</td>
</tr>
<tr>
<td>T4540</td>
<td>Incontinence product, protective underpad, reusable, chair size</td>
</tr>
<tr>
<td>T4541</td>
<td>Incontinence product, disposable underpad, large, each</td>
</tr>
<tr>
<td>T4542</td>
<td>Incontinence product, disposable underpad, small, each</td>
</tr>
<tr>
<td>T4543</td>
<td>Disposable incontinence product, brief/diaper, bariatric, each</td>
</tr>
</tbody>
</table>
### Table 2 – Ostomy Supply Codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4310</td>
<td>Insertion tray without drainage bag and without catheter (accessories only)</td>
</tr>
<tr>
<td>A4311</td>
<td>Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)</td>
</tr>
<tr>
<td>A4312</td>
<td>Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone</td>
</tr>
<tr>
<td>A4313</td>
<td>Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation</td>
</tr>
<tr>
<td>A4314</td>
<td>Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)</td>
</tr>
<tr>
<td>A4315</td>
<td>Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone</td>
</tr>
<tr>
<td>A4316</td>
<td>Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation</td>
</tr>
<tr>
<td>A4320</td>
<td>Irrigation tray with bulb or piston syringe, any purpose</td>
</tr>
<tr>
<td>A4321</td>
<td>Therapeutic agent for urinary catheter irrigation</td>
</tr>
<tr>
<td>A4322</td>
<td>Irrigation syringe, bulb or piston, each</td>
</tr>
<tr>
<td>A4326</td>
<td>Male external catheter with integral collection chamber, any type each</td>
</tr>
<tr>
<td>A4327</td>
<td>Female external urinary collection device, metal cup, each</td>
</tr>
<tr>
<td>A4328</td>
<td>Female external urinary collection device, pouch, each</td>
</tr>
<tr>
<td>A4331</td>
<td>Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each</td>
</tr>
<tr>
<td>A4332</td>
<td>Lubricant, individual sterile packet, each</td>
</tr>
<tr>
<td>A4333</td>
<td>Urinary catheter anchoring device, adhesive skin attachment, each</td>
</tr>
<tr>
<td>A4334</td>
<td>Urinary catheter anchoring device, leg strap, each</td>
</tr>
<tr>
<td>A4338</td>
<td>Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each</td>
</tr>
<tr>
<td>A4340</td>
<td>Indwelling catheter; specialty type, (e.g., Coude, mushroom, wing, etc.), each</td>
</tr>
<tr>
<td>A4344</td>
<td>Indwelling catheter, Foley type, two-way, all silicone, each</td>
</tr>
<tr>
<td>A4346</td>
<td>Indwelling catheter; Foley type, three-way for continuous irrigation, each</td>
</tr>
<tr>
<td>A4349</td>
<td>Male external catheter, with or without adhesive, disposable, each</td>
</tr>
<tr>
<td>A4351</td>
<td>Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A4352</td>
<td>Intermittent urinary catheter; Coude (curved) tip, with or without coating</td>
</tr>
<tr>
<td></td>
<td>(Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each</td>
</tr>
<tr>
<td>A4353</td>
<td>Intermittent urinary catheter, with insertion supplies</td>
</tr>
<tr>
<td>A4354</td>
<td>Insertion tray with drainage bag but without catheter</td>
</tr>
<tr>
<td>A4355</td>
<td>Irrigation tubing set for continuous bladder irrigation through a three-way</td>
</tr>
<tr>
<td></td>
<td>Foley catheter, each</td>
</tr>
<tr>
<td>A4356</td>
<td>External urethral clamp or compression device (not to be used for catheter</td>
</tr>
<tr>
<td></td>
<td>clamp), each</td>
</tr>
<tr>
<td>A4357</td>
<td>Bedside drainage bag, day or night, with or without anti-reflux device,</td>
</tr>
<tr>
<td></td>
<td>with or without tube, each</td>
</tr>
<tr>
<td>A4358</td>
<td>Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with</td>
</tr>
<tr>
<td></td>
<td>straps, each</td>
</tr>
<tr>
<td>A4361</td>
<td>Ostomy faceplate, each</td>
</tr>
<tr>
<td>A4362</td>
<td>Skin barrier; solid, 4 x 4 or equivalent; each</td>
</tr>
<tr>
<td>A4363</td>
<td>Ostomy clamp, any type, replacement only, each</td>
</tr>
<tr>
<td>A4364</td>
<td>Adhesive, liquid or equal, any type, per oz.</td>
</tr>
<tr>
<td>A4366</td>
<td>Ostomy vent, any type, each</td>
</tr>
<tr>
<td>A4367</td>
<td>Ostomy belt, each</td>
</tr>
<tr>
<td>A4368</td>
<td>Ostomy filter, any type, each</td>
</tr>
<tr>
<td>A4369</td>
<td>Ostomy skin barrier, liquid (spray, brush, etc.), per oz.</td>
</tr>
<tr>
<td>A4371</td>
<td>Ostomy skin barrier, powder, per oz.</td>
</tr>
<tr>
<td>A4372</td>
<td>Ostomy skin barrier, solid 4 x 4 or equivalent, standard wear with built-in</td>
</tr>
<tr>
<td></td>
<td>convexity, each</td>
</tr>
<tr>
<td>A4373</td>
<td>Ostomy skin barrier, with flange (solid, flexible or accordion), with</td>
</tr>
<tr>
<td></td>
<td>built-in convexity, any size, each</td>
</tr>
<tr>
<td>A4375</td>
<td>Ostomy pouch, drainable, with faceplate attached, plastic, each</td>
</tr>
<tr>
<td>A4376</td>
<td>Ostomy pouch, drainable, with faceplate attached, rubber, each</td>
</tr>
<tr>
<td>A4377</td>
<td>Ostomy pouch, drainable, for use on faceplate, plastic, each</td>
</tr>
<tr>
<td>A4378</td>
<td>Ostomy pouch, drainable, for use on faceplate, rubber, each</td>
</tr>
<tr>
<td>A4379</td>
<td>Ostomy pouch, urinary, with faceplate attached, plastic, each</td>
</tr>
<tr>
<td>A4380</td>
<td>Ostomy pouch, urinary, with faceplate attached, rubber, each</td>
</tr>
<tr>
<td>A4381</td>
<td>Ostomy pouch, urinary, for use on faceplate, plastic, each</td>
</tr>
<tr>
<td>A4382</td>
<td>Ostomy pouch, urinary, for use on faceplate, heavy plastic, each</td>
</tr>
<tr>
<td>A4383</td>
<td>Ostomy pouch, urinary, for use on faceplate, rubber, each</td>
</tr>
<tr>
<td>A4384</td>
<td>Ostomy faceplate equivalent, silicone ring, each</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A4385</td>
<td>Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, without built-in convexity, each</td>
</tr>
<tr>
<td>A4387</td>
<td>Ostomy pouch, closed, with barrier attached, with built-in convexity (one piece), each</td>
</tr>
<tr>
<td>A4388</td>
<td>Ostomy pouch, drainable, with extended wear barrier attached, (one piece), each</td>
</tr>
<tr>
<td>A4389</td>
<td>Ostomy pouch, drainable, with barrier attached, with built-in convexity (one piece), each</td>
</tr>
<tr>
<td>A4390</td>
<td>Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (one piece), each</td>
</tr>
<tr>
<td>A4391</td>
<td>Ostomy pouch, urinary, with extended wear barrier attached (one piece), each</td>
</tr>
<tr>
<td>A4392</td>
<td>Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (one piece), each</td>
</tr>
<tr>
<td>A4393</td>
<td>Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (one piece), each</td>
</tr>
<tr>
<td>A4394</td>
<td>Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce</td>
</tr>
<tr>
<td>A4395</td>
<td>Ostomy deodorant for use in ostomy pouch, solid, per tablet</td>
</tr>
<tr>
<td>A4396</td>
<td>Ostomy belt with peristomal hernia support</td>
</tr>
<tr>
<td>A4397</td>
<td>Irrigation supply, sleeve, each</td>
</tr>
<tr>
<td>A4398</td>
<td>Ostomy irrigation supply, bag, each</td>
</tr>
<tr>
<td>A4399</td>
<td>Ostomy irrigation supply, cone/catheter, including brush</td>
</tr>
<tr>
<td>A4400</td>
<td>Ostomy irrigation set</td>
</tr>
<tr>
<td>A4402</td>
<td>Lubricant, per oz.</td>
</tr>
<tr>
<td>A4404</td>
<td>Ostomy ring, each</td>
</tr>
<tr>
<td>A4405</td>
<td>Ostomy skin barrier, nonpectin-based, paste, per oz.</td>
</tr>
<tr>
<td>A4406</td>
<td>Ostomy skin barrier, pectin-based, paste, per oz.</td>
</tr>
<tr>
<td>A4407</td>
<td>Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 in. or smaller, each</td>
</tr>
<tr>
<td>A4408</td>
<td>Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 x 4 in., each</td>
</tr>
<tr>
<td>A4409</td>
<td>Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 in. or smaller, each</td>
</tr>
<tr>
<td>A4410</td>
<td>Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 in., each</td>
</tr>
<tr>
<td>A4411</td>
<td>Ostomy skin barrier, solid 4 x 4 in., or equivalent, extended wear, with built-in convexity, each</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A4412</td>
<td>Ostomy pouch, drainable, high output, for use on a barrier with flange (two piece system), with filter, each</td>
</tr>
<tr>
<td>A4413</td>
<td>Ostomy pouch, drainable, high output, for use on a barrier with flange (two piece system), with filter, each</td>
</tr>
<tr>
<td>A4414</td>
<td>Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, 4 x 4 in. or smaller, each</td>
</tr>
<tr>
<td>A4415</td>
<td>Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, larger than 4 x 4 in., each</td>
</tr>
<tr>
<td>A4416</td>
<td>Ostomy pouch, closed, with barrier attached, with filter (one piece), each</td>
</tr>
<tr>
<td>A4417</td>
<td>Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (one piece), each</td>
</tr>
<tr>
<td>A4418</td>
<td>Ostomy pouch, closed; without barrier attached, with filter (one piece), each</td>
</tr>
<tr>
<td>A4419</td>
<td>Ostomy pouch, closed; for use on barrier with nonlocking flange, with filter (two piece), each</td>
</tr>
<tr>
<td>A4420</td>
<td>Ostomy pouch, closed; for use on barrier with locking flange (two piece), each</td>
</tr>
<tr>
<td>A4421</td>
<td>Ostomy supplies; miscellaneous</td>
</tr>
<tr>
<td>A4422</td>
<td>Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each</td>
</tr>
<tr>
<td>A4423</td>
<td>Ostomy pouch, closed; for use on barrier with locking flange, with filter (two piece), each</td>
</tr>
<tr>
<td>A4424</td>
<td>Ostomy pouch, drainable, with barrier attached, with filter (one piece), each</td>
</tr>
<tr>
<td>A4425</td>
<td>Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (two piece system), each</td>
</tr>
<tr>
<td>A4426</td>
<td>Ostomy pouch, drainable, for use on barrier with locking flange (two piece system), each</td>
</tr>
<tr>
<td>A4427</td>
<td>Ostomy pouch, drainable; for use on barrier with locking flange, with filter (two piece system), each</td>
</tr>
<tr>
<td>A4428</td>
<td>Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (one piece), each</td>
</tr>
<tr>
<td>A4429</td>
<td>Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each</td>
</tr>
<tr>
<td>A4430</td>
<td>Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each</td>
</tr>
<tr>
<td>A4431</td>
<td>Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (one piece), each</td>
</tr>
<tr>
<td>A4432</td>
<td>Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet type tap with valve (two piece), each</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A4433</td>
<td>Ostomy pouch, urinary; for use on barrier with locking flange (two piece), each</td>
</tr>
<tr>
<td>A4434</td>
<td>Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (two-piece), each</td>
</tr>
<tr>
<td>A4435</td>
<td>Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each</td>
</tr>
<tr>
<td>A4450</td>
<td>Tape, nonwaterproof, per 18 sq. in.</td>
</tr>
<tr>
<td>A4452</td>
<td>Tape, waterproof, per 18 sq. in.</td>
</tr>
<tr>
<td>A4455</td>
<td>Adhesive remover or solvent (for tape, cement or other adhesive), per oz.</td>
</tr>
<tr>
<td>A4456</td>
<td>Adhesive remover, wipes, any type, each</td>
</tr>
<tr>
<td>A4458</td>
<td>Enema bag with tubing, reusable</td>
</tr>
<tr>
<td>A4927</td>
<td>Gloves, nonsterile, per 100</td>
</tr>
<tr>
<td>A5051</td>
<td>Ostomy pouch, closed; with barrier attached (one piece), each</td>
</tr>
<tr>
<td>A5052</td>
<td>Ostomy pouch, closed; without barrier attached (one piece), each</td>
</tr>
<tr>
<td>A5053</td>
<td>Ostomy pouch, closed; for use on faceplate, each</td>
</tr>
<tr>
<td>A5054</td>
<td>Ostomy pouch, closed; for use on barrier with flange (two piece), each</td>
</tr>
<tr>
<td>A5055</td>
<td>Stoma cap</td>
</tr>
<tr>
<td>A5061</td>
<td>Ostomy pouch, drainable; with barrier attached, (one piece), each</td>
</tr>
<tr>
<td>A5062</td>
<td>Ostomy pouch, drainable; without barrier attached (one piece), each</td>
</tr>
<tr>
<td>A5063</td>
<td>Ostomy pouch, drainable; for use on barrier with flange (two piece system), each</td>
</tr>
<tr>
<td>A5071</td>
<td>Ostomy pouch, urinary; with barrier attached (one piece), each</td>
</tr>
<tr>
<td>A5072</td>
<td>Ostomy pouch, urinary without barrier attached (one piece), each</td>
</tr>
<tr>
<td>A5073</td>
<td>Ostomy pouch, urinary; for use on barrier with flange (two piece), each</td>
</tr>
<tr>
<td>A5081</td>
<td>Continent device; plug for continent stoma</td>
</tr>
<tr>
<td>A5082</td>
<td>Continent device; catheter for continent stoma</td>
</tr>
<tr>
<td>A5083</td>
<td>Continent device, stoma absorptive cover for continent stoma</td>
</tr>
<tr>
<td>A5093</td>
<td>Ostomy accessory; convex insert</td>
</tr>
<tr>
<td>A5102</td>
<td>Bedside drainage bottle, with or without tubing, rigid or expandable, each</td>
</tr>
<tr>
<td>A5105</td>
<td>Urinary suspensory with leg bag, with or without tube, each</td>
</tr>
<tr>
<td>A5112</td>
<td>Urinary leg bag; latex</td>
</tr>
<tr>
<td>A5113</td>
<td>Leg strap; latex, replacement only, per set</td>
</tr>
<tr>
<td>A5114</td>
<td>Leg strap; foam or fabric, replacement only, per set</td>
</tr>
<tr>
<td>A5120</td>
<td>Skin barrier, wipes or swabs, each</td>
</tr>
<tr>
<td>A5121</td>
<td>Skin barrier; solid, 6 x 6 or equivalent, each</td>
</tr>
</tbody>
</table>
A5122 Skin barrier; solid, 8 x 8 or equivalent, each
A5126 Adhesive or nonadhesive; disk or foam pad
A5131 Appliance cleaner, incontinence and ostomy appliances, per 16 oz.

**Table 3 – Billable by Appropriate Providers**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4364</td>
<td>Adhesive, liquid, or equal, any type, per oz.</td>
</tr>
<tr>
<td>A4402</td>
<td>Lubricant, per oz.</td>
</tr>
<tr>
<td>A4450</td>
<td>Tape, nonwaterproof, per 18 sq. in.</td>
</tr>
<tr>
<td>A4452</td>
<td>Tape, waterproof, per 18 sq. in.</td>
</tr>
<tr>
<td>A4455</td>
<td>Adhesive remover or solvent (for tape, cement or other adhesive), per oz.</td>
</tr>
<tr>
<td>A4456</td>
<td>Adhesive remover, wipes, any type, each</td>
</tr>
<tr>
<td>A4927</td>
<td>Gloves, nonsterile, per 100</td>
</tr>
<tr>
<td>A5120</td>
<td>Skin barrier, wipes or swabs, each</td>
</tr>
<tr>
<td>A5121</td>
<td>Skin barrier; solid, 6 x 6 or equivalent, each</td>
</tr>
<tr>
<td>A5122</td>
<td>Skin barrier; solid, 8 x 8 or equivalent, each</td>
</tr>
</tbody>
</table>

High-end incontinence products require PA and are currently limited to only HCPCS T codes listed in Table 4. For high-end products, provider must submit claim with U9 modifier in order for the claim to process correctly. Provider must also submit a cost invoice with each claim to be paid at 30% above wholesale.

**Table 4 – Billable with U9 Modifier**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T4521</td>
<td>Adult-sized disposable incontinence product, brief/diaper, small each</td>
</tr>
<tr>
<td>T4522</td>
<td>Adult-sized disposable incontinence product, brief/diaper, medium each</td>
</tr>
<tr>
<td>T4523</td>
<td>Adult-sized disposable incontinence product, brief/diaper, large, each</td>
</tr>
<tr>
<td>T4524</td>
<td>Adult-sized disposable incontinence product, brief/diaper, extra large, each</td>
</tr>
<tr>
<td>T4525</td>
<td>Adult-sized disposable incontinence product, protective underwear/pull-on, small size, each</td>
</tr>
<tr>
<td>T4526</td>
<td>Adult-sized disposable incontinence product, protective underwear/pull-on, medium size, each</td>
</tr>
<tr>
<td>T4527</td>
<td>Adult-sized disposable incontinence product, protective underwear/pull-on, large size, each</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>T4528</td>
<td>Adult-sized disposable incontinence product, protective underwear/pull-on, extra large size, each</td>
</tr>
<tr>
<td>T4529</td>
<td>Pediatric-sized disposable incontinence product, brief/diaper, small/medium size, each</td>
</tr>
<tr>
<td>T4530</td>
<td>Pediatric-sized disposable incontinence product, brief/diaper, large size, each</td>
</tr>
<tr>
<td>T4531</td>
<td>Pediatric-sized disposable incontinence product protective underwear/pull-ons, small/medium size, each</td>
</tr>
<tr>
<td>T4532</td>
<td>Pediatric-sized disposable incontinence product protective underwear/pull-ons, large size, each</td>
</tr>
<tr>
<td>T4533</td>
<td>Youth-sized disposable incontinence product, brief/diaper, each</td>
</tr>
<tr>
<td>T4534</td>
<td>Youth-sized disposable incontinence product, protective underwear/pull-ons, each</td>
</tr>
<tr>
<td>T4536</td>
<td>Incontinence product, protective underwear/pull-on reusable, any size, each</td>
</tr>
<tr>
<td>T4539</td>
<td>Incontinence product, diaper/brief, reusable, any size, each</td>
</tr>
<tr>
<td>T4543</td>
<td>Disposable incontinence product, brief/diaper, bariatric, each</td>
</tr>
</tbody>
</table>

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.

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.

Crossover claims for members with primary insurance which 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.

**Rules, Citations and Sources**

*405 IAC 5-5 – Out of State Services*

*405 IAC 5-19-1 – Medical Supplies*

*405 IAC 5-29-1 – Non-covered Services*

**Note:** For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp).
Related Medical Topics

Medical Supplies and Durable Medical Equipment – Overview
Introduction

This section serves as a general summary of the IHCP’s policies regarding apnea monitors, non-invasive pulse oximetry, pneumograms, and trend event monitoring. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Cardiorespiratory monitoring is the observation of cardiac and respiratory activities by a device that displays or records data. Trend-event and apnea monitors are used to monitor for apnea episodes, bradycardia, or absences of respiration. Non-invasive 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.

Reimbursement Requirements

Trend-Event Monitoring and Apnea Monitors

Trend-event monitoring is performed with an apnea monitor that has recording features. The appropriate 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, HCPCS code E0618 – Apnea monitor, without recording feature must be used.
Table 1 – Coding Options for Trend-event Monitoring and Apnea Monitors

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0618 RR (Rental)</td>
<td>Apnea monitor, without recording feature</td>
</tr>
<tr>
<td>E0618 NU (Purchase)</td>
<td>Apnea monitor, without recording feature</td>
</tr>
<tr>
<td>E0619 RR (Rental)</td>
<td>Apnea monitor, with recording feature</td>
</tr>
<tr>
<td>E0619 NU (Purchase)</td>
<td>Apnea monitor, with recording feature</td>
</tr>
<tr>
<td>93268</td>
<td>Patient demand single- or multiple-event recording with pre-symptom memory loop, 24-hour attended monitoring, per 30-day time period; includes transmission, physician review, and interpretation</td>
</tr>
<tr>
<td>93270</td>
<td>Patient demand single- or multiple-event recording with pre-symptom memory loop, per 30-day time period; recording (includes hookup, recording, and disconnection)</td>
</tr>
<tr>
<td>93271</td>
<td>Patient demand single- or multiple-event recording with pre-symptom memory loop, per 30-day time period; monitoring, receipt of transmissions, and analysis</td>
</tr>
<tr>
<td>93272</td>
<td>Patient demand single- or multiple-event recording with pre-symptom memory loop, per 30-day time period; physician review and interpretation only</td>
</tr>
</tbody>
</table>

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. 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.

Non-Invasive 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 non-invasively. Oximetry determination should be billed using the appropriate CPT® code. Current coding options are illustrated in Table 2. Reimbursement for non-invasive pulse oximetry is available using the CPT® codes 94760 – Non-invasive ear or pulse oximetry for oxygen saturation; single determination, 94761 – Non-invasive ear or pulse oximetry for oxygen saturation; multiple determinations, and 94762 – Non-invasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring.
PA is not required for non-invasive pulse oximetry reimbursement. Reimbursement of codes 94760, 94761, and 94762 includes the physician interpretation of the oximetry results and any related equipment. Non-invasive pulse oximetry is not separately reimbursable during a pneumogram.

When billing for procedure code 94762, providers should be aware that one unit of service equals one day for billing an oximetry service on a daily basis, up to and including a maximum of eight units of service per month.

Non-invasive 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 non-invasive pulse oximeters with HCPCS code E0445 includes all cords, batteries, alarms, sensors, probes, printers, and all supplies.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0445 RR (Rental)</td>
<td>Oximeter device for measuring blood oxygen levels non-invasively</td>
</tr>
<tr>
<td>E0445 NU (Purchase)</td>
<td>Oximeter device for measuring blood oxygen levels non-invasively</td>
</tr>
<tr>
<td>94760</td>
<td>Non-invasive ear or pulse oximetry for oxygen saturation, single determination</td>
</tr>
<tr>
<td>94761</td>
<td>Non-invasive ear or pulse oximetry for oxygen saturation, multiple determination (e.g., during exercise)</td>
</tr>
<tr>
<td>94762</td>
<td>Non-invasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)</td>
</tr>
</tbody>
</table>

Prior Authorization Requirements

PA is not required for apnea or trend-event monitors, non-invasive pulse oximetry, or pneumograms.

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 Web site under Provider Code Sets.
Rules, Citations and Sources

405 IAC 5-19 – Medical Supplies and Equipment

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp

Related Medical Topics

Home Health Services

Medical Supplies and Durable Medical Equipment – Overview
Medical Supplies and Equipment – Negative Pressure Wound Therapy (NPWT)

Introduction

This section serves as a general summary of the IHCP’s policies regarding negative pressure wound therapy (NPWT). Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

NPWT is a controlled application of subatmospheric pressure to a wound. NPWT uses an electrical pump to apply, 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.

IHCP will provide coverage for NPWT in a home-care setting or in a LTC setting, based on the criteria described in this policy. PA is required, and the service will be reimbursed as a capped rental item.

Reimbursement Requirements

- 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, chronic (being present for at least 30 days) ulcer of mixed etiology, or a traumatic or surgically created wound.
- A complete wound program described below, depending on the type of wound, must have been tried and failed before applying the NPWT.

For all ulcers or wounds, all the following minimum general measures of a wound-therapy program must be addressed, applied, or considered and ruled out before applying the 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

In addition to criteria 1, 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 two or three support surface
• The patient’s moisture and incontinence has been appropriately managed

In addition to criteria 1, 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

In addition to criterion 1, venous stasis ulcers must also be evaluated for all the following components:

• Compression bandages or garments have been consistently applied
• Leg elevation and ambulation have been encouraged

Prior Authorization Requirements

PA is required for reimbursement of NPWT. The provider must submit a completed PA form and a completed medical clearance form signed by the physician to the PA contractor for review of medical necessity. The NPWT is authorized for only 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 PA period. If a PA is modified and authorized for less time than the physician’s order had requested initially, a new PA 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.
Continued Coverage

To obtain PA for continued service after the initial PA 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 10 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 sub-atmospheric pressure at the wound. No more than 15 units for dressing sets, any size, will be authorized per wound, per month. No more than 10 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.

Billing Requirements

Claims must be submitted on a CMS-1500 form or using the 837P using the appropriate HCPCS codes. Codes E2402, A6550, and A7000 are described in Table 1, with maximum fees and monthly allowable amounts listed. Code A7000 must include modifier NU in order to get reimbursement

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description of Code</th>
<th>Maximum Monthly Allowable Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2402</td>
<td>Negative pressure wound therapy electrical pump, stationary or portable</td>
<td>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.</td>
</tr>
<tr>
<td>A6550</td>
<td>Wound care set for negative-pressure wound therapy electrical pump; includes all supplies and accessories</td>
<td>15 per month, all sizes; per wound</td>
</tr>
<tr>
<td>A7000 NU</td>
<td>Canister, disposable, used with suction pump, each</td>
<td>10 per month, any size; per wound</td>
</tr>
</tbody>
</table>
Hospital Reimbursement

When the NPWT is used during an inpatient admission, reimbursement for the NPWT is included in the hospital DRG rate.

Rules, Citations and Sources

IC § 12-8-6-5

IC 12-15

405 IAC 5-3 – Prior Authorization

405 IAC 5-12 – Chiropractic Services

405 IAC 5-13 – Intermediate Care Facilities for the Intellectually Disabled

405 IAC 5-19 – Medical Supplies and Equipment

405 IAC 5-31 – Nursing Facility Services

IHCP Provider Manual

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Related Medical Topics

Not Applicable
Medical Supplies and Equipment - Non-invasive Respiratory-Assist Devices (Continuous Positive Airway Pressure [CPAP] and Bi-level Positive Airway Pressure [BiPAP])

Introduction

This section serves as a general summary of the IHCP’s policies regarding non-invasive respiratory-assist devices. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Non-invasive positive pressure respiratory assist (NPPRA) 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. Non-invasive respiratory assist is 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 member’s demise. In this section, these devices are referred to as respiratory assist devices (RADs). The three types of RADs are as follows:

- CPAP devices
- BiPAP with a backup rate feature
- BiPAP without a backup rate feature

Reimbursement Requirements

CPAP systems provide air pressure by means of a nose mask and flow generator system to prevent collapse of the oropharyngeal walls and obstruction of airflow during sleep, which occurs in obstructive sleep apnea (OSA).
The IHCP reimburses for CPAP for members meeting the following criteria:

- A diagnosis of OSA with an apnea-hypopnea index (AHI) equal to or greater than fifteen (15) events per hour, documented in a recorded polysomnography, or
- A diagnosis of OSA with an AHI from five (5) to fourteen (14) events per hour documented in a recorded polysomnography with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia or hypertension, ischemic heart disease, or history of stroke, or
- A diagnosis of moderate or severe OSA in a member for whom surgery is a likely alternative to CPAP

**Note:** “Apnea” is the cessation of airflow for at least ten (10) seconds documented on a polysomnogram “Hypopnea” is an abnormal respiratory rate lasting at least ten (10) seconds associated with at least a thirty percent (30%) reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least four percent (4%) decrease in oxygen saturation. The AHI is the average number of apneas and hypopneas per hour and, for purposes of this policy, must be based on a minimum of six (6) hours of recorded sleep (for example, a polysomnogram), and may not be extrapolated or projected.

Copies of the member’s sleep lab evaluation, including a polysomnogram, must be retained in the physician’s record.

**Note:** 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 EEG, electro-oculogram (EOG), and submental EMG. It must also include at least the following parameters of sleep: air flow, respiratory effort, and oxygen saturation by oximetry. For the purpose of this policy, polysomnographic studies must be performed in a sleep-study laboratory, not in the home or in a mobile facility. Testing must comply with all applicable state regulatory requirements.

**BiPAP with Backup and Without Backup**

BiPAP without backup 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).

BiPAP with backup rate delivers adjustable, variable levels (within a single respiratory cycle) of positive airway 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, BiPAP with backup rate has a timed backup feature to deliver this air pressure whenever spontaneous inspiratory efforts fail to occur.
Initial Coverage Criteria for BiPAP (First Three Months of Rental)

The IHCP provides reimbursement for BiPAP without backup rate (E0470) or BiPAP with backup rate (E0471) for members meeting the specified criteria:

- Coverage will be considered when the physician’s documentation includes a statement stating the member is experiencing symptoms of sleep associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc., and
- Medical necessity must be documented.
- BiPAP devices will be covered for members with clinical disorder groups characterized as:
  - Restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities)
  - Severe chronic obstructive pulmonary disease (COPD)
  - Central sleep apnea (CSA), or
  - OSA (E0470 only)

These members must also meet the following criteria:

Restrictive Thoracic Disorders

- 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
- An arterial blood gas PaCO2, done while the member is awake and breathing the member’s usual FIO2, is greater than or equal to 45 mm Hg, or
  - Sleep oximetry, done while breathing the member’s usual FIO2, demonstrates oxygen saturation of less than or equal to 88 percent for at least five continuous minutes, or
  - Member has a progressive neuromuscular disease only, maximal inspiratory pressure is less than 60 cm H2O, or forced vital capacity is less than 50 percent predicted, and
- Chronic pulmonary disease does not contribute significantly to the member’s pulmonary limitation

If all of the above criteria are met, either an E0470 or E0471 device (based upon the judgment of the treating physician) will be covered for members within this group for the first three months of NPPRA therapy. (See below for continued coverage after the initial three months.) If all the above criteria are not met, E0470 and E0471 will be denied as not medically necessary.
Note: 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, his or her 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.

Severe COPD

- An arterial blood gas PaCO2, done while the member is 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 percent for at least five continuous minutes done while the member is breathing oxygen at 2 LPM or the member’s usual FIO2 (whichever is higher), and
- Prior to initiating therapy, OSA and treatment with CPAP has been considered and ruled out.

If all the above criteria for members with COPD are met, an E0470 device will be covered for the first three months of NPPRA therapy. (See below for continued coverage after the initial three months.)

An E0471 device will usually not be covered for a member with COPD during the first two months, because therapy with an E0470 device with properly adjusted settings and the member’s accommodation to its use will usually result in sufficient improvement without the need of a backup rate. (See below for coverage of an E0471 device for COPD after two months’ use of an E0470 device.)

If all the above criteria are not met, E0470 and related accessories will be denied as not medically necessary.

Criteria for Coverage for Severe COPD after Two Months – E0470 and E0471

- Arterial blood gas PaCO2 repeated no sooner than 61 days after initiation of compliant use of E0470 and done while the member is awake and breathing the member's usual FIO2, remains greater than or equal to 52 mm Hg, and
- Sleep oximetry, repeated no sooner than 61 days after initiation of compliant use of E0470 device and while the member is breathing with the E0470 device, demonstrates oxygen saturation less than or equal to 88 percent for at least five continuous minutes 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 E0470 device, declaring that the member has been compliantly using the E0470 device an average of four hours per 24-hour
period, but that the member is not benefiting from its use. The statement should also say that the physician feels the member meets the listed criteria for an E0471 device.

- If the above criteria for the E0471 device are not met, the E0471 will be denied as not medically necessary.

**CSA (Apnea Not Due to Airway Obstruction)**

Prior to initiating therapy, a complete facility-based, attended polysomnogram must be performed documenting the following:

- The diagnosis of CSA, and
- The ruling out of a single level device (CPAP) as effective therapy if either CSA or OSA is a component of sleep-associated hypoventilation, and
- Significant improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the member's usual FIO2.

If all the above criteria are met, an E0470 or E0471 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 the above criteria are not met, E0470 and E0471 and related accessories will be denied as not medically necessary.

**OSA**

- A complete facility-based, attended polysomnogram has established the diagnosis of OSA, and
- A single level device (CPAP) has been tried and proven medically ineffective.

If the above criteria are met, an E0470 device will be covered for the first three months of NPPRA therapy. (See below for continued coverage after the initial three months.) If all the above criteria are not met, the E0470 and related accessories will be denied as not medically necessary.

An E0471 device is not medically necessary if the primary diagnosis is OSA.

**Hypoventilation Syndrome**

An E0470 device is covered if the following criteria are met:

- An initial arterial blood gas PaCO₂, done while awake and breathing the beneficiary’s prescribed FIO₂, is greater than or equal to 45 mm Hg, and
• Spirometry shows an FEV1/FVC of greater than or equal to 70% and an FEV1 of greater than or equal to 50% of predicted, and

• An initial arterial blood gas PaCO$_2$, done during sleep or immediately upon awakening, and breathing the beneficiary’s prescribed FIO$_2$, shows the beneficiary’s PaCO$_2$ worsened greater than or equal to 7 mm Hg compared to the original result of the first requirement, or

  o A facility-based PSG demonstrates oxygen saturation of less than or equal to 88% for greater than or equal to 5 minutes of nocturnal recording time that is not caused by obstructive upper airway events.

If the above criteria are not met, E0470 and related accessories will be denied as not reasonable and necessary.

An E0471 device is covered for a member with hypoventilation syndrome if the following criteria are met:

• A covered E0470 device is being used, and

• Spirometry shows an FEV1/FVC of greater than or equal to 70% and an FEV1 of greater than or equal to 50% of predicted, and

• An arterial blood gas PaCO$_2$, done while awake, and breathing the beneficiary’s prescribed FIO$_2$, worsens greater than or equal to 7 mm Hg compared to the result performed to qualify the beneficiary for the E0470 device, or

  o A facility-based PSG demonstrates oxygen saturation of less than or equal to 88% for greater than or equal to 5 minutes of nocturnal recording time that is not caused by obstructive upper airway events while using an E0470 device.

**Note:** For members under the age of 19, appropriate noninvasive testing (such as capillary blood gas and end tidal CO$_2$ tests) may be substituted in place of an arterial blood gas PaCO$_2$ test to meet medical criteria for all conditions. All other required criteria listed under each condition must be followed.

**Continued Coverage Beyond the First Three Months of Therapy**

Members covered for the first three months of using an E0470 or E0471 device must be reevaluated to establish the medical necessity of continued coverage by the IHCP. While the member may need to be evaluated at earlier intervals after the initiation of therapy, the reevaluation 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 the member’s usage of the device up to that time. Failure of the member to consistently use the E0470 or E0471 device for an average of four hours per 24-hour period by the time of the 61- to 90-day re-evaluation represents non-compliant utilization for the intended purposes and expected benefits of this therapy. This constitutes reason for the IHCP to deny continued service as not medically necessary.

To continue coverage beyond the first three months of therapy, the above documentation must be in the member’s medical record. In addition, the device supplier must obtain documentation signed and dated by the treating physician no sooner than 61 days after initiating use of the device. This documentation must declare 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 PA for continued service.

**Criteria for Coverage for Humidifiers (E0561 and E0562)**

IHCP reimbursement is available for a non-heated (E0561) and a heated (E0562) humidifier for use with a non-invasive respiratory assistive device (RAD) (E0470 and E0471) or CPAP (E0601), when ordered by a physician, based on medical necessity, and subject to prior authorization (PA).

Providers must meet the following criteria for reimbursement:

- A non-heated (E0561) or heated humidifier (E0562) for use with a non-invasive RAD or a CPAP will be considered for coverage only when physician documentation supports the medical necessity of the humidifier.
- Documentation must indicate that the member suffers from nosebleeds, extreme dryness of the upper airways, or other conditions that interfere with compliance or use of the RAD or a CPAP, and that the humidifier could improve this condition.

E0561 and E0562 are considered single patient use devices, categorized as inexpensive and routinely purchased items available for purchase only for Traditional Medicaid members. A rental trial period is no longer required before purchase for these items.

**Prior Authorization Requirements**

BiPAP respiratory assist devices require PA, as referenced under Coverage Criteria. CPAP devices do not require PA.

**Reasons for Non-coverage**

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 PA has not been obtained before providing a service for which PA is required.
Billing Requirements

HCPCS Codes

RAD (CPAP or BiPAP) accessories will be reimbursed according to specific limitations when the RAD is owned by the member. Otherwise, the cost of the accessories is included in the rental reimbursement rate. E0470 and E0471 will be rented on a frequent and substantial servicing basis – i.e., ongoing rental. E0561 and E0562 are inexpensive and are available for purchase only.

Table 1 – HCPCS Procedure Codes for CPAP and BiPAP

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7030</td>
<td>Full face mask used with positive airway pressure device, each</td>
</tr>
<tr>
<td>A7031</td>
<td>Face mask interface, replacement for full face mask, each</td>
</tr>
<tr>
<td>A7032</td>
<td>Cushion for use on nasal mask interface, replacement only, each</td>
</tr>
<tr>
<td>A7033</td>
<td>Pillow for use on nasal cannula type interface, replacement only, pair</td>
</tr>
<tr>
<td>A7034</td>
<td>Nasal interface (mask or cannula type) used with positive air pressure device, with or without head strap</td>
</tr>
<tr>
<td>A7036</td>
<td>Chin strap used with positive airway pressure device</td>
</tr>
<tr>
<td>A7037</td>
<td>Tubing used with positive airway pressure device</td>
</tr>
<tr>
<td>A7038</td>
<td>Filter, disposable, used with positive airway pressure device</td>
</tr>
<tr>
<td>A7039</td>
<td>Filter, non-disposable, used with positive airway pressure device</td>
</tr>
<tr>
<td>A7046</td>
<td>Water chamber for humidifier, used with positive airway pressure device, replacement, each</td>
</tr>
<tr>
<td>E0561</td>
<td>Humidifier, non-heated, used with positive pressure airway device</td>
</tr>
<tr>
<td>E0562</td>
<td>Humidifier, heated, used with a positive pressure airway device</td>
</tr>
<tr>
<td>E0470</td>
<td>BiPAP – Respiratory assist device, bi-level pressure capability, without backup rate feature, used with non-invasive interface; e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) – BiPAP without backup rate</td>
</tr>
<tr>
<td>E0471</td>
<td>BiPAP – Respiratory assist device, bi-level pressure capability, with backup rate feature, used with non-invasive interface; e.g., nasal or facial mask (intermittent assist device with continuous positive-airway pressure device) – BiPAP with backup</td>
</tr>
<tr>
<td>E0601</td>
<td>CPAP – Continuous positive airway pressure device</td>
</tr>
</tbody>
</table>

Rules, Citations and Sources
405 IAC 5-2-17 – Medically Reasonable and Necessary Service Defined
405 IAC 5-19 – Medical Supplies and Equipment

IHCP Provider Bulletins

- BT200042
- BT200401
- BR201447

IHCP Provider Newsletters

- NL 200405

IHCP Provider Manual

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Related Medical Topics

Medical Supplies and Durable Medical Equipment – Overview
Medical Supplies and Equipment – Patient-activated Event Recorder – ILR

Introduction

This section serves as a general summary of the IHCP’s policies regarding patient-activated event recorders – ILRs. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

The implantable 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 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.

Reimbursement Requirements

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 the following conditions:
  - Complete history and physical examination
  - Electrocardiogram (EKG)
  - 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 using external monitoring systems inappropriate

Removal of an ILR on the same day as the insertion of a cardiac pacemaker is considered part of the pacemaker insertion procedure and is not reimbursed separately.

Only one ILR is covered for a given patient in any two-year time period (24 months).

ECG analyses obtained during device insertion for signal quality and amplification are considered part of the implant procedure and are not reimbursed separately.

Device Monitoring

The CPT® code for analysis of information collected by the recorder is 93285 – Programming device evaluation (in person) with iterative adjustment of the implantable device 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 93285 may not be billed on the date of insertion. The programmer used to program the ILR, and to retrieve, display, and print stored data is furnished to the physician but remains the property of the manufacturer.

Prior Authorization Requirements

Neither the implantation of the device nor the patient-activated event recorder – ILR requires PA, but both will be subject to retrospective review, according to IHCP criteria. If a replacement recorder activator is needed, PA is required.

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 during an inpatient stay for a related problem, submit a UB-04 using the International Classification of Diseases, Ninth Revision, Clinical Modification (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-04 using revenue code 360 – Operating Room Services and 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 codes. 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 CMS-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 CMS-1500. Table 1 illustrates coding for places of service:

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Physician’s Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Diagnosis Code</td>
<td>UB-04</td>
<td>UB-04 (and CMS-1500 if billing for device)</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>CPT® Codes</td>
<td>not necessary</td>
<td>33282 for insertion</td>
<td>33282 for insertion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>33284 for removal</td>
<td>33284 for removal</td>
</tr>
<tr>
<td>Revenue Code</td>
<td>360</td>
<td>360</td>
<td>Not necessary</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Not needed</td>
<td>On CMS-1500 – E0616</td>
<td>E0616</td>
</tr>
</tbody>
</table>

Table 2 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>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33282</td>
<td>Implantation of patient-activated cardiac event recorder</td>
</tr>
<tr>
<td>33284</td>
<td>Removal of an implantable, patient-activated cardiac event recorder</td>
</tr>
<tr>
<td>93285</td>
<td>Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system</td>
</tr>
<tr>
<td>E0616</td>
<td>Implantable cardiac event recorder with memory, activator, and programmer. (The programmer is furnished by the manufacturer to the physician to use in the office for reading saved information in the recorder.)</td>
</tr>
<tr>
<td>E1399</td>
<td>Recorder activator (replacement)</td>
</tr>
</tbody>
</table>
Rules, Citations and Sources

405 IAC 5-17-1 – Reimbursement; limitations
405 IAC 5-28-1 – Reimbursement; limitations

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp

Related Medical Topics

Evaluation and Management Services
Hospital Inpatient Services
Hospital Outpatient Services
Medical Supplies and Durable Medical Equipment – Overview
Surgery – Surgical Services
Medical Supplies and Equipment – Phrenic Nerve Stimulator

Introduction

This section serves as a general summary of the IHCP’s policies regarding phrenic nerve stimulators. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

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.

Reimbursement Requirements

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 (SNF) and be more independent. 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, and larynx)
- Family support that includes an unpaid physical caregiver of adequate quality and the availability of nursing and medical care

Medical Review Documentation

Prior authorization (PA) for medical necessity is required for this device and its implantation. The equipment is costly and requires preoperative testing of the components, as well as thorough education of the member and his or her caregiver(s) 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 school attendance. Increased mobility will allow the patient to function without the 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, 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 (CSA) 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 PA request.
   - The breathing pacemaker should never be recommended for treatment of obstructive sleep apnea (OSA).

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 (FDA) require that the manufacturer of the device be notified when the following occurs:

- Diaphragm pacing system is implanted.
Medical Supplies and Equipment – Phrenic Nerve Stimulator

Prior Authorization Requirements

PA is required for this device and its implantation, whether it is implanted on an inpatient or outpatient basis. 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 – non-obstructive sleep apnea
- 786.09 – congenital respiratory abnormalities, other

Billing Requirements

For inpatient billing of the device’s implantation, 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 an CMS-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-04 claim form, and the device billed as a DME item on an CMS-1500 claim form. The decision for either outpatient or inpatient status is made by the physician and is 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 be enrolled as a DME provider with a DME Legacy Provider Identifier (LPI).

Table 1 provides the CPT® codes and description information to use when submitting inpatient or outpatient claims.
### Table 1 – CPT® Codes for Inpatient and Outpatient Claims

<table>
<thead>
<tr>
<th>CPT®/HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64585</td>
<td>Revision or removal of peripheral neurostimulator electrode array</td>
</tr>
<tr>
<td>95970*</td>
<td>Electronic analysis of implanted neurostimulator pulse generator system (e.g., 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, without reprogramming.</td>
</tr>
<tr>
<td>95974**</td>
<td>Complex cranial nerve neurostimulator pulse generator/ transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour.</td>
</tr>
<tr>
<td>L8680</td>
<td>Implantable neurostimulator electrode, each</td>
</tr>
<tr>
<td>L8681</td>
<td>Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only</td>
</tr>
<tr>
<td>L8682</td>
<td>Implantable neurostimulator radiofrequency receiver</td>
</tr>
<tr>
<td>L8683</td>
<td>Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver</td>
</tr>
<tr>
<td>L8685</td>
<td>Implantable neurostimulator pulse generator, single array, rechargeable, includes extension</td>
</tr>
<tr>
<td>L8686</td>
<td>Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension</td>
</tr>
<tr>
<td>L8687</td>
<td>Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension</td>
</tr>
<tr>
<td>L8688</td>
<td>Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension</td>
</tr>
<tr>
<td>L8689</td>
<td>External recharging system for battery (internal) for use with implantable neurostimulator, replacement</td>
</tr>
</tbody>
</table>

*Included in initial fee

**Included in initial fee, provided by manufacturer at the time of implant, then by telephone for the life of the power source at no cost to the member.

### Rules, Citations and Sources

405 IAC 5-17-1 – Reimbursement; limitations

405 IAC 5-17-2 – Prior authorization; generally

405 IAC 5-19-2 – “Durable medical equipment” or “DME” defined
IHCP Provider Bulletins:

BT200108 – Phrenic Nerve Stimulator

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

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp

Related Medical Topics

Home Health Services
Hospital Inpatient Services
Hospital Outpatient Services
Medical Supplies and Durable Medical Equipment – Overview
Medical Supplies and Equipment – Spinal Cord Stimulators

Introduction

This section serves as a general summary of the IHCP’s policies regarding spinal cord stimulators. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

An implanted spinal cord stimulator (SCS) is an electronic device consisting of surgically implanted electrodes connected by leads to a receiver or pulse generator. The power source can be either external or internally implanted. Implantation is often preceded by a trial with a percutaneous electrode system. Electrodes are surgically placed on or near the spinal cord to stimulate large-fiber neurons. In turn, this stimulation blocks small-fiber neuronal signals that are interpreted as pain, thus relieving pain that has otherwise been intractable to standard treatment.

SCS is used to treat chronic pain syndromes intractable to other treatment modalities. SCS is frequently used to treat failed back surgery, complex regional pain syndromes, peripheral neuropathies, angina, peripheral vascular disease, post-herpetic neuralgia, occipital neuralgia, and chronic pelvic pain. This treatment is considered a last resort for individuals who have failed other treatment options for the management of intractable, chronic pain.

Reimbursement Requirements

Three- to Seven-Day Trial Stimulation Period

The first phase of SCS must be evaluated prior to a permanent SCS implantation. Members must meet the following criteria for the three- to seven-day trial stimulation period:

- The implantation of the stimulator is used only as a treatment of last resort for members with chronic intractable, non-malignant pain.
- There is documented pathology, such as an objective basis for the pain complaint.
- There must be documentation of failure of at least six (6) months of conservative treatment, including at least three (3) of the following:
  - Pharmacological therapy
- Surgical management
- Physical therapy
- Psychological therapy
- The member must not be a candidate for further surgical interventions.
- An evaluation must be performed by a physician experienced in treating chronic pain, which includes documentation of a psychological evaluation, as well as a consultation from another pain specialist, that indicates the member would benefit from SCS.
  - The psychological evaluation should reveal no evidence of an inadequately controlled mental health problem (e.g., alcohol or drug dependence, depression, psychosis) that would negatively impact the success of a SCS or contraindicate its placement
- The member must not have any existing, untreated drug addictions.

**Permanent SCS Implantation**

Following the trial stimulation period, PA will be approved for permanent implantation after the following criteria have been met. These criteria meet medical necessity for permanent implantation:
- All six criteria for a three- to seven-day trial implantation period must be met.
- The trial implantation must show a 50 percent reduction in pain for at least two days in order to receive approval for permanent implantation. Providers must submit documentation of successful treatment.
- IHCP providers are directed to use the Multidimensional Affect and Pain Scale, the Brief Pain Inventory, and/or the Faces Pain Scale to measure pain levels. Providers are responsible for deciding which pain measurement scale is appropriate for each member.

**Intractable Angina**

The IHCP covers SCS for the treatment of intractable angina for members who are not surgical candidates and whose pain is unresponsive to standard therapy. Following the trial stimulation period, PA will be approved for permanent implantation after the following criteria have been met for the treatment of intractable angina:
- Angiography documents significant coronary artery disease, and the patient is not a candidate for percutaneous transluminal coronary angiography (PTCA) or coronary artery bypass grafting (CABG).
- The angina pectoris is New York Heart Association Functional Class III or IV.
- Reversible ischemia is documented by symptom-limited treadmill exercise tests.
- The member has had optimal pharmacotherapy for at least one month. Optimal pharmacotherapy includes the maximum tolerated doses of at least two of the following medications: long-acting nitrates, beta-adrenergic blockers, or calcium channel blockers have failed to adequately improve angina symptoms.

- There is documentation of successful trial spinal cord stimulator implantation showing a 50 percent reduction in pain for at least two days.

### Table 1 - New York Heart Association Functional Class

<table>
<thead>
<tr>
<th>Class</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I (Mild)</td>
<td>No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath).</td>
</tr>
<tr>
<td>Class II (Mild)</td>
<td>Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnea.</td>
</tr>
<tr>
<td>Class III (Moderate)</td>
<td>Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea</td>
</tr>
<tr>
<td>Class IV (Severe)</td>
<td>Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.</td>
</tr>
</tbody>
</table>

### Prior Authorization Requirements

SCS treatment must be evaluated in a three- to seven-day trial stimulation period prior to permanent implantation. Providers must request PA for both the trial and permanent phases of this service. The IHCP will only cover SCS services with the appropriate ICD-9-CM diagnosis codes listed in Table 2, the Current Procedural Terminology (CPT) codes listed in Table 3, and the Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 4. All other diagnoses of chronic, non-malignant, neuropathic pain will be considered for approval on a case-by-case basis by a pain management consultant if all other PA criteria are met.

### Billing Requirements

Following PA approval, providers must bill using the appropriate ICD-9-CM, CPT, and HCPCS codes for SCS services. Effective January 1, 2006, separate outpatient reimbursement for the SCS implantable device is covered.

Please refer to Table 4 for the spinal cord stimulation equipment. Providers are reminded that separate outpatient reimbursement is also subject to medical necessity and PA guidelines.

### Table 2 –ICD-9 CM Diagnosis Codes for SCS

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>036.0</td>
<td>Meningococcal meningitis</td>
</tr>
<tr>
<td>250.60</td>
<td>Diabetes with neurological manifestations; type II or unspecified type, not stated as uncontrolled</td>
</tr>
<tr>
<td>250.61</td>
<td>Diabetes with neurological manifestations; type I [juvenile type], not stated as uncontrolled</td>
</tr>
<tr>
<td>250.62</td>
<td>Diabetes with neurological manifestations; type II or unspecified type, uncontrolled</td>
</tr>
<tr>
<td>250.63</td>
<td>Diabetes with neurological manifestations; type I [juvenile type], uncontrolled</td>
</tr>
<tr>
<td>322.0</td>
<td>Nonpyogenic meningitis</td>
</tr>
<tr>
<td>322.1</td>
<td>Eosinophilic meningitis</td>
</tr>
<tr>
<td>322.2</td>
<td>Chronic meningitis</td>
</tr>
<tr>
<td>322.9</td>
<td>Meningitis, unspecified</td>
</tr>
<tr>
<td>337.20</td>
<td>Reflex sympathetic dystrophy, unspecified</td>
</tr>
<tr>
<td>337.21</td>
<td>reflex sympathetic dystrophy of the upper limb</td>
</tr>
<tr>
<td>337.22</td>
<td>Reflex sympathetic dystrophy of the lower limb</td>
</tr>
<tr>
<td>337.29</td>
<td>Reflex sympathetic dystrophy of other specified site</td>
</tr>
<tr>
<td>353.0</td>
<td>Brachial plexus lesions</td>
</tr>
<tr>
<td>353.1</td>
<td>Lumbosacral plexus lesions</td>
</tr>
<tr>
<td>353.6</td>
<td>Phantom limb (syndrome)</td>
</tr>
<tr>
<td>353.8</td>
<td>Other nerve root and plexus disorders</td>
</tr>
<tr>
<td>353.9</td>
<td>Unspecified nerve root and plexus disorder</td>
</tr>
<tr>
<td>354.4</td>
<td>Causalgia of upper limb</td>
</tr>
<tr>
<td>354.8</td>
<td>Other mononeuritis of upper limb</td>
</tr>
<tr>
<td>354.9</td>
<td>Mononeuritis of upper limb, unspecified</td>
</tr>
<tr>
<td>355.71</td>
<td>Causalgia of lower limb</td>
</tr>
<tr>
<td>355.79</td>
<td>Other mononeuritis of lower limb</td>
</tr>
<tr>
<td>355.8</td>
<td>Mononeuritis of lower limb, unspecified</td>
</tr>
<tr>
<td>413.9</td>
<td>Other and unspecified angina pectoris</td>
</tr>
<tr>
<td>440.22</td>
<td>Atherosclerosis of the extremities with rest pain</td>
</tr>
<tr>
<td>443.9</td>
<td>Peripheral vascular disease, unspecified</td>
</tr>
<tr>
<td>722.81</td>
<td>Postlaminectomy syndrome, cervical region</td>
</tr>
<tr>
<td>722.82</td>
<td>Postlaminectomy syndrome, thoracic region</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>63650</td>
<td>Percutaneous implantation of neurostimulator electrode array, epidural</td>
</tr>
<tr>
<td>63655</td>
<td>Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural</td>
</tr>
<tr>
<td>63661</td>
<td>Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63662</td>
<td>Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63663</td>
<td>Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63664</td>
<td>Revision incluing replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed</td>
</tr>
<tr>
<td>63685</td>
<td>Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling</td>
</tr>
<tr>
<td>63688</td>
<td>Revision or removal of spinal neurostimulator receiver</td>
</tr>
<tr>
<td>95970</td>
<td>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</td>
</tr>
</tbody>
</table>
95971  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 spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming  No

95972  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 spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour  No

95973  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 spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour  No

Table 4 – HCPCS Codes for Spinal Cord Stimulators

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8680</td>
<td>Implantable neurostimulator electrode, each</td>
<td>Yes</td>
</tr>
<tr>
<td>L8681</td>
<td>Patient programmer (external for use with implantable programmable neurostimulator pulse generator, replacement only)</td>
<td>Yes</td>
</tr>
<tr>
<td>L8682</td>
<td>Implantable neurostimulator radiofrequency receiver</td>
<td>Yes</td>
</tr>
<tr>
<td>L8683</td>
<td>Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver</td>
<td>Yes</td>
</tr>
<tr>
<td>L8685</td>
<td>Implantable neurostimulator pulse generator, single array, rechargeable, includes extension</td>
<td>Yes</td>
</tr>
<tr>
<td>L8686</td>
<td>Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension</td>
<td>Yes</td>
</tr>
<tr>
<td>L8687</td>
<td>Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension</td>
<td>Yes</td>
</tr>
<tr>
<td>L8688</td>
<td>Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension</td>
<td>Yes</td>
</tr>
<tr>
<td>L8689</td>
<td>External recharging system for battery (internal) for use with implantable neurostimulator, replacement only</td>
<td>Yes</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>L8695</td>
<td>External recharging system for battery (external) for use with implantable neurostimulator; replacement only.</td>
<td>No</td>
</tr>
</tbody>
</table>

### Rules, Citations and Sources

405 IAC 5-19-2 – “Durable Medical Equipment or DME” defined

**IHCP Provider Manual**

*Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp)*

### Related Medical Topics

Medical Supplies and Durable Medical Equipment – Overview
Medical Supplies and Equipment – Standers

Introduction

This section serves as a general summary of the IHCP’s policies regarding standers. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

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).

Reimbursement Requirements

The IHCP will reimburse for standers considered medically necessary in non-institutional settings. A written physician’s order is required and 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 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 members 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, 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 a standing position using manual power, a hydraulic lift, or an electric lift. If members lift themselves manually, slings are commonly hooked behind the member and foot positioners and knee blocks are used to assist members to extend their knees and hips to a standing position. The hydraulic lift uses a gas-spring system with a push handle to assist lifting the member’s weight.

Non-covered Items

Some standers are categorized as mobile or dynamic standers (code E0642 – Standing frame system, mobile (dynamic stander), any size including pediatric). 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.

Prior Authorization Requirements

The IHCP has developed a medical clearance form to help providers supply the necessary documentation required for PA staff to evaluate medical information. The medical clearance form must be signed by the physician who orders the stander and must be included with the PA request.

All initial requests for standers require PA and a completed medical clearance form signed by the physician. A copy of a PT and/or 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 PA. The request for initial PA must also include documentation of medical necessity and a plan of care (POC) signed by the ordering physician. Subsequent requests for PA will require ongoing documentation indicating progress towards goals up through the 15th month or the final month, and a completed medical clearance form signed by a physician.
Plan of Care (POC)

The POC must include the following documentation:

- 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.

- 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.

- 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 following benefits:
  - Aids in the prevention of atrophy in the trunk and leg muscles
  - Improves circulation to the trunk and lower extremities
  - Prevents formation of decubitus ulcers (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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>318.1</td>
<td>Severe mental retardation</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>318.2</td>
<td>Profound mental retardation</td>
</tr>
<tr>
<td>335.20</td>
<td>Amyotrophic lateral sclerosis</td>
</tr>
<tr>
<td>336.9</td>
<td>Unspecified disease of the spinal cord</td>
</tr>
<tr>
<td>340</td>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>341.9</td>
<td>Demyelinating disease of the central nervous system, unspecified</td>
</tr>
<tr>
<td>342.xx</td>
<td>Hemiplegia and hemiparesis</td>
</tr>
<tr>
<td>343.0</td>
<td>Diplegic</td>
</tr>
<tr>
<td>343.2</td>
<td>Quadriplegic</td>
</tr>
<tr>
<td>343.9</td>
<td>Infantile cerebral palsy, unspecified</td>
</tr>
<tr>
<td>344.0x</td>
<td>Quadriplegia and quadriaparesis</td>
</tr>
<tr>
<td>344.1</td>
<td>Paraplegia</td>
</tr>
<tr>
<td>348.3x</td>
<td>Encephalopathy, not elsewhere classified</td>
</tr>
<tr>
<td>359.x</td>
<td>Muscular dystrophies and other myopathies</td>
</tr>
<tr>
<td>741.9x</td>
<td>Spina bifida, without mention of hydrocephalus</td>
</tr>
<tr>
<td>742.4</td>
<td>Other specified anomalies of brain</td>
</tr>
<tr>
<td>783.4x</td>
<td>Lack of expected normal physiological development in childhood</td>
</tr>
<tr>
<td>952.xx</td>
<td>Spinal cord injury without evidence of spinal bone injury</td>
</tr>
<tr>
<td>995.55</td>
<td>Shaken infant syndrome</td>
</tr>
</tbody>
</table>

**Multi-Positional Stander Prior Authorization 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 following examples:

- The member requires postural drainage.
- The member requires suctioning related to excessive secretions while in the stander.
- 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 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 Prior Authorization 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 a sitting to a 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 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 frame/table system, any size including pediatric, with seat lift feature, with or without wheels on a case-by-case basis. The mobility option will be approved only for members with independent capabilities, and the bilateral upper-body strength and coordination to maneuver themselves.

Children are not required to be independent to meet the criteria for sit-to-stand standers. Decisions regarding approval for children will be made on a case by case basis.

The PA will specify the brand name, model number, type of stander, and base price of the stander. Trays are included in the stander’s base price. Upgraded trays will not be reimbursed. Certain supports and straps are included in the stander’s base price, as noted previously. Upgraded supports and straps are considered on a case-by-case basis. An itemized list of any additional attachments and accessories with individual prices must be included with the PA request.
Billing Requirements

Standers 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. Interruption must be the member’s inability to utilize the service and should not be interpreted as an interruption in billing. Claims submitted for capped rental items are paid until the number of rental payments made reaches 15 months, or the purchase price of the equipment is reached.

Providers are to bill their usual and customary charges for the equipment and will be reimbursed the lesser of the submitted charge for the equipment or the maximum fee amount for equipment rental. The equipment is to be billed on an HCFA-1500 claim form using a DME provider number. The provider is obligated to provide repairs and maintenance for the first 15 months or until the item is purchased. After 15 months, repairs and maintenance are billed using E1399 for replacement parts and K0739 for labor charges.

The IHCP will provide reimbursement for multipositional standers if they are prior authorized. Providers should use code E0641 – Standing frame/table system, multi-position (e.g., three-way stander), any size including pediatric, with or without wheels. Multi-positional standers are priced using max fee pricing.

The sit-to-stand stander should be billed with HCPCS code E0637. (Wheels in this definition are considered casters by the IHCP.) HCPCS code E0637 requires PA and is reimbursed at a max fee.

IHCP reimbursement is available with PA for HCPCS code E0638 – Standing frame/table 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 charge or max fee price.

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 requires PA. Providers should use K0739 – Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes for labor charges, as appropriate. Labor charges do not require PA.
Rules, Citations and Sources

405 IAC 5-19-2 – “Durable Medical Equipment or DME” defined

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp

Related Medical Topics

Not Applicable
Medical Supplies and Equipment – Standing Wheelchairs

Introduction

This section serves as a general summary of the IHCP’s policies regarding standing wheelchairs. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Half-power/Half-manual Standing Wheelchair

A half-power/half-manual standing wheelchair has a manual standing mechanism. The manual standing mechanism moves the person in the chair from a sitting to a 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 functions as an 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 high levels 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 whether a patient can lift a 10-pound bar. Individuals diagnosed with a high level of paraplegia or low quadriplegia, advanced cerebral palsy, advanced muscular dystrophy, or multiple sclerosis usually qualify for this type of 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, which moves upward with the chair to the standing position.
Depending on how the chair is manufactured, once the standing position is achieved, an individual may drive the machine while in the standing position or remain stationary.

These types of wheelchairs are used primarily for individuals who have high levels of quadriplegia, advanced cerebral palsy, muscular dystrophy, or multiple sclerosis, and who have little to no upper body strength but do have some arm and hand control to operate the joystick.

**Used Items**

The IHCP does not reimburse for used DME except for the following: A4638 - replacement battery for patient-owned ear pulse generator, each and A7046-water chamber for humidifier, used with positive airway pressure device, replacement, each. A new item placed with a member initially as a rental item shall be considered a new item by OMPP at the time of purchase. A used DME item placed with a member initially as a rental item shall be replaced by the supplier with a new item prior to purchase by OMPP.

Reimbursement for the purchase of DME, medical/surgical supplies, orthotics, non-preparatory prosthetics and orthopedic footwear is for new, unused items.

**Reimbursement Requirements**

The 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 OTs, and physician providers.

**Prior Authorization Requirements**

PA is not required for standing wheelchairs.

**Billing Requirements**

Billing requirements are not applicable.

**Rules, Citations and Sources**

405 IAC 5-19-9 – Wheelchairs and similar motorized vehicles

IHCP Provider Manual

Related Medical Topics

Medical Supplies and Durable Medical Equipment – Overview
Medical Supplies and Equipment – Standers
Medical Supplies and Equipment – Wheelchairs and Accessories
Medical Supplies and Equipment – Vagus Nerve Stimulator for Epilepsy

Introduction

This section serves as a general summary of the IHCP’s policies regarding vagus nerve stimulators for epilepsy. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

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. The IHCP does not cover vagus nerve stimulators for resistant depression or treatment of chronic pain.

Reimbursement Requirements

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 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 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 must 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

Medical Supplies and Equipment – Vagus Nerve Stimulator for Epilepsy
Library Reference Number: Revision Date: December 2014 Version 2.0
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 ICD-9-CM diagnosis and procedure codes listed in Tables 1 and 2 and the CPT® codes noted in Table 3 are appropriate for reporting implantation, revision, programming and reprogramming, and removal of vagus nerve stimulators. 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**

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>345.41</td>
<td>Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy</td>
</tr>
<tr>
<td>345.51</td>
<td>Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy</td>
</tr>
</tbody>
</table>

**Table 2 – ICD-9-CM Procedure Codes for Reporting Vagus Nerve Stimulator Services**

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>04.92</td>
<td>Implantation or replacement of peripheral neurostimulator lead(s)</td>
</tr>
<tr>
<td>04.93</td>
<td>Removal of peripheral neurostimulator lead(s)</td>
</tr>
<tr>
<td>86.94</td>
<td>Insertion or replacement of single array neurostimulator pulse generator, not specified as rechargeable</td>
</tr>
<tr>
<td>86.95</td>
<td>Insertion or replacement of dual array neurostimulator pulse generator, not specified as rechargeable</td>
</tr>
<tr>
<td>86.96</td>
<td>Insertion or replacement of other neurostimulator pulse generator</td>
</tr>
<tr>
<td>86.97</td>
<td>Insertion or replacement of single array rechargeable neurostimulator pulse generator</td>
</tr>
<tr>
<td>86.98</td>
<td>Insertion or replacement of dual array rechargeable neurostimulator pulse generator</td>
</tr>
</tbody>
</table>
### Table 3– CPT® Procedure Codes for Reporting Vagus Nerve Stimulator Services

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>61885</td>
<td>Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to a single electrode array</td>
</tr>
<tr>
<td>61888</td>
<td>Revision or removal of cranial neurostimulator pulse generator or receiver</td>
</tr>
<tr>
<td>64553</td>
<td>Percutaneous implantation of neurostimulator electrodes; cranial nerve</td>
</tr>
<tr>
<td>64568</td>
<td>Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator</td>
</tr>
<tr>
<td>64569</td>
<td>Revision or replacement of cranial nerve (eg., vagus nerve) neurostimulator electrode array, including connection to existing pulse generator</td>
</tr>
<tr>
<td>64570</td>
<td>Removal of cranial nerve (eg., vagus nerve) neurostimulator electrode array and pulse generator</td>
</tr>
<tr>
<td>64585</td>
<td>Revision or removal of peripheral neurostimulator electrodes</td>
</tr>
<tr>
<td>64590</td>
<td>Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling</td>
</tr>
<tr>
<td>64595</td>
<td>Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver</td>
</tr>
<tr>
<td>95970</td>
<td>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</td>
</tr>
<tr>
<td>95974</td>
<td>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, with or without nerve interface testing, first hour</td>
</tr>
<tr>
<td>95975</td>
<td>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 (bill with 95974)</td>
</tr>
</tbody>
</table>
Prior Authorization Requirements

PA must be obtained by the physician for implantation procedures regardless of setting. The following documentation must be maintained in the medical record and submitted with the request for PA:

- Documentation indicating an evaluation has been made by a neurologist
- Documentation of the member’s type of epilepsy
- Documentation indicating 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 indicating that the member is not an intracranial surgical candidate or that surgery has been unsuccessful (for example, the member is not a surgical candidate due to multiple epileptic foci)

Billing Requirements

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-04 claim form. Also included in the table are the corresponding 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-04 claim form.

Table 4 – Procedure Codes and Corresponding ASC Groups and Rates

<table>
<thead>
<tr>
<th>Category</th>
<th>CPT® Code</th>
<th>Description</th>
<th>ASC Group</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implantation</td>
<td>64568</td>
<td>Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator</td>
<td>G</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>64553</td>
<td>Percutaneous implantation of neurostimulator electrodes; cranial nerve</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>61885</td>
<td>Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to a single-electrode array</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>64590</td>
<td>Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>Revision/</td>
<td>64569</td>
<td>Revision or replacement of cranial nerve</td>
<td>8</td>
<td>No</td>
</tr>
</tbody>
</table>
The surgical procedure involves two separate incisions. Therefore, both CPT® codes 64568 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 PA 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8680</td>
<td>Implantable neurostimulator electrode, each</td>
<td>Yes</td>
</tr>
<tr>
<td>L8681</td>
<td>Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only</td>
<td>Yes</td>
</tr>
<tr>
<td>L8685</td>
<td>Implantable neurostimulator pulse generator, single array, rechargeable, includes extension</td>
<td>Yes</td>
</tr>
<tr>
<td>L8686</td>
<td>Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension</td>
<td>Yes</td>
</tr>
<tr>
<td>L8687</td>
<td>Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension</td>
<td>Yes</td>
</tr>
<tr>
<td>L8688</td>
<td>Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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 DRG payment. PA is required for the admission but is not required for the device, which is included in the DRG reimbursement.

The physician must obtain PA for the surgical procedure. The hospital stay must be billed on the UB-04 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 IHCP Provider Manual), using the appropriate procedure codes in the following tables.

<table>
<thead>
<tr>
<th>Category</th>
<th>CPT® Code</th>
<th>Description</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implanting</td>
<td>64568</td>
<td>Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>64553</td>
<td>Percutaneous implantation of neurostimulator electrodes; cranial nerve</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>61885</td>
<td>Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or indirect coupling, with connection to a single electrode array</td>
<td>Yes</td>
</tr>
<tr>
<td>Revision/Removal</td>
<td>64585</td>
<td>Revision or removal of peripheral neurostimulator electrodes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>61888</td>
<td>Revision or removal of cranial neurostimulator pulse generator or receiver</td>
<td>No</td>
</tr>
</tbody>
</table>
The physician should use the codes in Table 7 to report interrogation and programming services provided for members with implants.

Table 7 – Neurologist CPT® Procedure Codes for Implanted Devices

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>95970</td>
<td>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</td>
<td>No</td>
</tr>
<tr>
<td>95974</td>
<td>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, with or without nerve interface testing, first hour</td>
<td>No</td>
</tr>
<tr>
<td>95975</td>
<td>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 (bill with 95974)</td>
<td>No</td>
</tr>
</tbody>
</table>

Rules, Citations and Sources

405 IAC 5-19 – Medical Supplies and Equipment
405 IAC 5-28 – Medical and Surgical Services

Indiana Provider Bulletin
BT200032

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.
Related Medical Topics

Hospital Inpatient Services
Hospital Outpatient Services
Medical Supplies and Durable Medical Equipment – Overview
Surgery – Surgical Services
Medical Supplies and Equipment – Ventricular Assist Device (VAD)

Introduction

This section serves as a general summary of the IHCP’s policies regarding ventricular assist devices (VADs). Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

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 (biventricular [BiVAD]). 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.

Use 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 MI. Post-operatively, 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 (NYHA Class III or IV) whose hemodynamic status
deteriorates despite maximal pharmacologic therapy or 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 left ventricle (LV) diameter, improved hemodynamic status, normalized of fluid load, improved renal and hepatic function, and reversed passive pulmonary hypertension. Many patients will decrease from NYHA 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 NYHA 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.

**Reimbursement Requirements**

The IHCP only covers VADs that have been approved by the FDA. VADs, including LVADs, RVADs, and BIVADs, are considered medically necessary by the IHCP under the following conditions.

**Postcardiotomy Cardiogenic Shock**

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 intra-aortic balloon pump (IABP).

**Bridge-To-Transplant**

Covered by the IHCP for members who meet the following criteria:

- The member must be at risk of imminent death from nonreversible left ventricular failure (New York Heart Association [NYHA] Class III or IV).
- The member has been prior authorized for a heart transplant (excluding dual eligible members).
- The member is listed as a candidate for heart transplantation by a Medicare and Medicaid approved heart transplant center.
- If the VAD is implanted at a different site than the Medicare and Medicaid-approved transplant center, the implanting site must receive written permission from the Medicare and Medicaid-approved center under which the patient is listed for transport prior to implantation of the VAD.

**Destination Therapy**

Covered by the IHCP for members who meet the following criteria:

- The member must not be a candidate for heart transplant.
- 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 two years.
- 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
  - Angiotensin receptor blockers (ARBs) or angiotensin-converting enzyme (ACE) inhibitors (if tolerated)
- Left Ventricular Ejection Fraction (LVEF) must be less than 25%.
- 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.
The member has the appropriate body size (greater than or equal to 1.5m^2) to support the LVAD implantation.

VAD implantation must occur at a Medicare and 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.

Non-covered Services

- VADs are non-covered for all other conditions not listed above.
- Use of a non-FDA approved VAD is considered investigational and is a non-covered service.
- The artificial heart (i.e. AbioCor, CardioWest) as a replacement heart for a diseased heart is non-covered by the IHCP.

Prior Authorization Requirements

VADs, including LVADs, RVADs, and BiVADs, and their surgical implantation do not require PA. 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 HCPCS codes listed in Table 62.1 require PA for patient supply and replacement equipment.

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 PA 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 PA**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q0480</td>
<td>Drive for use with pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0481</td>
<td>Microprocessor control unit for use with electric VAD, replacement only</td>
</tr>
<tr>
<td>Q0482</td>
<td>Microprocessor control unit for use with electric/pneumatic combination VAD, replacement only</td>
</tr>
<tr>
<td>Q0483</td>
<td>Monitor/display module for use with electric VAD, replacement only</td>
</tr>
<tr>
<td>Q0484</td>
<td>Monitor/display module for use with electric or electric/pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0485</td>
<td>Monitor control cable for use with electric VAD, replacement only</td>
</tr>
<tr>
<td>Q0486</td>
<td>Monitor control cable for use with electric/pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0487</td>
<td>Leads (pneumatic/electrical) for use with any type electric/pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0488</td>
<td>Power pack base for use with electric VAD, replacement only</td>
</tr>
<tr>
<td>Q0489</td>
<td>Power pack base for use with electric/pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0490</td>
<td>Emergency power source for use with electric VAD, replacement only</td>
</tr>
<tr>
<td>Q0491</td>
<td>Emergency power source for use with electric/pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0492</td>
<td>Emergency power supply cable for use with electric VAD, replacement only</td>
</tr>
<tr>
<td>Q0493</td>
<td>Emergency power supply cable for use with electric/pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0494</td>
<td>Emergency hand pump for use with electric or electric/pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0495</td>
<td>Battery/power pack charger for use with electric or electric/pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0496</td>
<td>Battery, other than lithium-ion, for use with electric or electric/pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0497</td>
<td>Battery clips for use with electric or electric/pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0498</td>
<td>Holster for use with electric or electric/pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0499</td>
<td>Belt/vest/bag for use to carry external peripheral components of any type VAD, replacement only</td>
</tr>
<tr>
<td>Q0500</td>
<td>Filters for use with electric or electric/pneumatic VAD, replacement only</td>
</tr>
<tr>
<td>Q0501</td>
<td>Shower cover for use with electric or electric/pneumatic VAD, replacement only</td>
</tr>
</tbody>
</table>
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.

Billing Requirements

Table 2 lists the ICD-9-CM procedure codes that are to be billed on the UB-04 claim form or the 837I electronic transaction.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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 |
Implant of implantable heart assist system device directly connected to the heart and implanted in the upper left quadrant of peritoneal cavity.

Includes:
- Axial flow heart assist system
- Diagonal pump heart assist system
- LVAD
- Pulsatile heart assist system
- Right ventricular assist device (RVAD)
- Rotary pump heart assist system
- Transportable, implantable heart assist system
- VAD, not otherwise specified

Table 3 list the appropriate CPT® codes for billing implantation and removal of the VADs. The CPT® code should be billed on a CMS-1500 claim form or 837P electronic transaction.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33975</td>
<td>Insertion of VAD; extracorporeal, single ventricle</td>
</tr>
<tr>
<td>33976</td>
<td>Insertion of VAD; extracorporeal, biventricular</td>
</tr>
<tr>
<td>33977</td>
<td>Removal of VAD; extracorporeal, single ventricle</td>
</tr>
<tr>
<td>33978</td>
<td>Removal of VAD; extracorporeal, biventricular</td>
</tr>
<tr>
<td>33979</td>
<td>Insertion of VAD, implantable, intracorporeal, single ventricle</td>
</tr>
<tr>
<td>33980</td>
<td>Removal of VAD, implantable intracorporeal, single ventricle</td>
</tr>
<tr>
<td>33990</td>
<td>Insertion of VAD percutaneous including radiological supervision and interpretation; arterial access only</td>
</tr>
<tr>
<td>33991</td>
<td>Insertion of VAD percutaneous including radiological supervision and interpretation; both arterial and venous access, with transeptal puncture</td>
</tr>
<tr>
<td>33992</td>
<td>Removal of percutaneous VAD at separate and distinct session from insertion</td>
</tr>
<tr>
<td>33993</td>
<td>Reposition of percutaneous VAD with imaging guidance at separate and distinct session from insertion</td>
</tr>
</tbody>
</table>

Items Included in the DRG for Hospital Inpatients Utilizing the VAD System

- ICD-9-CM Diagnoses (Primary, Secondary, Tertiary, as needed)
- ICD-9-CM Procedures
- VAD (included in the ICD-9-CM Procedure code)
• Stationary Power Base and Display Module (capital purchase by the hospital)
• Rechargeable batteries and harness (for untethered systems)
• Miscellaneous Supplies

**Billing Instructions for Outpatient Equipment Utilizing the CMS-1500 Claim Form**

• PA must be obtained for LVAD equipment.
• 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.
• 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.
• An invoice for each detail must accompany the CMS-1500 claim form when submitted.

**Rules, Citations and Sources**

*405 IAC 5-19 – Medical Supplies and Equipment*

*405 IAC 5-28 – Medical and Surgical Services*

*IHCP Provider Manual*

*Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp)*

**Related Medical Topics**

Evaluation and Management Services
Hospital Inpatient Services
Hospital Outpatient Services
Medical Supplies and Durable Medical Equipment – Overview
Surgery – Surgical Services
Surgery – Transplants
Medical Supplies and Equipment – Wheelchairs and Accessories

Introduction

This section serves as a general summary of the IHCP’s policies regarding wheelchairs and accessories. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

The IHCP will reimburse for a manual wheelchair, motorized/power wheelchair, power operated vehicle (POV), and wheelchair accessories when medically necessary for IHCP members with PA. Certain medical criteria must be met for the approval of each piece of equipment. The different wheelchair accessories included in this section are listed below:

- Programmable electronic parts
- Wheelchair cushions
- Wheelchair positioning accessories
- Mounting hardware
- Universal headrest plates
- Power seating systems
- Leg rests

Reimbursement Requirements

IHCP will reimburse for one manual wheelchair, motorized/power wheelchair, or power operated vehicle (POV) per five (5) year period, unless there is a change in the recipient’s medical needs documented in writing by the requesting provider. The change in medical needs must be significant enough to warrant a different type of equipment. Any wheelchair designated for use as a backup 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 wheelchairs, power/motorized wheelchairs, and POVs also includes emergency services, delivery, setup, and
items covered under warranty. See Section 43 of this manual, Medical Supplies and Durable Medical Equipment – Overview, for further information regarding reimbursement of labor, repairs, and replacement of durable medical equipment for wheelchairs.

All medical equipment, including wheelchairs and accessories, require written orders by physicians. Pursuant to 405 IAC 5-19-1, “medical supplies shall be for a specific medical purpose, not incidental or general purpose usage.”

**Physician Orders for Durable Medical Equipment (DME)**

Physicians must be aware that their signature on an order for DME authorizes those items to be dispensed to the member. The prescriber is also responsible for maintaining documentation in the member’s medical record that supports the medical necessity of specific DME prescribed. To ensure that the appropriate quantity and type of item are dispensed, it is especially important that the written order be detailed. Providing a detailed written order does not eliminate the need for other IHCP requirements in effect at the time services are rendered.

The written order for DME should include, at a minimum, the following information, when applicable:

- Member’s name
- Date ordered
- Physician’s signature
- Area of body for use (for items that may be appropriate for multiple sites)
- Type and size of the product
- Quantity intended for use
- Frequency of use (for example, change dressing three times a day)
- Anticipated duration of need
- Indication of refill authorization and the number of refills

Suppliers of DME, including those supplying wheelchairs, must maintain the prescriber’s written order in the member’s medical record. Suppliers are responsible for ensuring that the written order contains the necessary information to complete the order. If the physician’s order lacks information necessary to accurately dispense the appropriate specific DME, including type or quantity, the supplier must contact the physician’s office for written clarification.

Suppliers must maintain the written physician’s order to support medical necessity during post-payment review. The IHCP requires that Medicaid providers maintain medical records for a period of seven years, per 405 IAC 1-5-1. Services may be subject to recoupment if the physician’s orders are modified after the service is rendered, or if orders are obtained after the provision of service.
Long Term Care (LTC) Facilities

The IHCP includes standard non-motorized wheelchairs in the *per diem* rate for LTC facilities, per 405 IAC 5-13-3-4 and 405 IAC 5-13-3-7. Providers can submit requests for custom wheelchairs for LTC members to the appropriate PA entity for approval only if there is a medical necessity for the custom wheelchair.

The care of members in LTC facilities includes safety, propulsion, evaluation of the member for breakdown, and an active POC to prevent and treat decubitus ulcers, providers should not request custom wheelchairs for the sole purpose of providing safety, preventing decubitus ulcers, allowing self propulsion, or providing restraint. However, if a member's diagnosis supports the medical necessity for a custom wheelchair, providers must follow normal PA process using IHCP PA and medical clearance forms.

Manual Wheelchairs

The IHCP will reimburse for both standard and nonstandard manual adult wheelchairs, and for manual pediatric wheelchairs. A standard adult wheelchair is defined as a wheelchair with a base that weighs more than 36 pounds, with seat dimensions of 16 to 18 inches wide, 16 inches deep, and between 19 and 21 inches high. A standard wheelchair includes a non-adjustable back height of 16 to 17 inches, fixed or detachable arm rests, fixed or detachable foot rests, and footplate extensions of 16 to 21 inches.

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.

The IHCP will reimburse for a manual wheelchair, when medically necessary, subject to PA. Requests for manual wheelchairs require completed medical clearance forms submitted with the PA request.

Power Mobility Devices (PMDs)

PMDs includes POVs and power wheelchairs. According to 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.”

The following defined criteria must be met for a member to qualify for any PMD:

- The member must have significant mobility limitations that restrict his or her ability to complete one or more mobility related activities of daily living (MRADLs), such as toileting, feeding, dressing, or bathing.
• The member’s mobility issues are not resolved safely with the use of a cane or walker.

• The member is unable to utilize a properly fitted and functioning manual wheelchair in the home, at work, at school, or in the workshop to complete the MRADL for the following reasons:
  - Lack of upper body strength
  - Lack of coordination
  - Limited range of motion in upper body
  - Presence of pain that limits upper body mobility
  - Upper body physical deformity or amputations

A medical clearance form must be completed for the IHCP to consider requests for power wheelchairs or similar motorized equipment.

Motorized/Power Wheelchairs

A member who requires a motorized/power wheelchair is usually non-ambulatory 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 (6) months).

All IHCP members requesting a motorized/power wheelchair must meet the following criteria:

• The CMS defined basic coverage criteria are met.
• The member does not qualify for a POV.
• The member is physically and mentally able to safely operate a power wheelchair or has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available and willing to operate the power wheelchair for the IHCP member.
• The home environment allows appropriate access with a power wheelchair, including maneuvering space and appropriate surfaces.
• The member does not exceed the weight limitations for the power wheelchair provided.
• A power wheelchair will significantly improve the member’s ability to independently perform MRADLs.
• The IHCP member is willing to use a power wheelchair.

Providers cannot bill separately for programmable electronic systems that come standard on the specific motorized or power wheelchair model provided. The IHCP allows separate
reimbursement only if an electronic system is an upgrade to a system that comes standard on a specific wheelchair model.

Certain patients may need adaptive switch controls such as a sip-and-puff, or patients with degenerative diseases whose prognosis could worsen in the future may need additional drive controls and programming not available on the basic one-drive electronic system. The medical necessity supporting the need for a programmable electronic system upgrade must be included on the IHCP medical clearance form for motorized/power wheelchairs.

The following accessories and options are considered to be included in the basic equipment package for power wheelchairs. Any exceptions must be submitted for PA consideration at the time of the wheelchair is purchased or rented.

- Lap belt or safety belt
- Battery charger
- A complete set of tires and casters, any type
- Leg rests
- Leg rest/leg rest platform
- Arm rest
- Weight specific components, such as braces, bars, upholstery, brackets, motors, or gears, mandated by additional patient weight
- Any seat width and depth
- Any back width
- Controller and input devices for non-expandable and standard proportional joystick

**Motorized/Power Wheelchairs – Single Power Option**

For groups 2 and 5, single-power, option-power wheelchairs, the following additional criteria apply:

- The IHCP member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as head control, sip and puff, switch control, and so forth), or
- The IHCP member meets the requirements for a power tilt or power recline seating system, and the system is being used on the wheelchair.

For groups 3 and 4, single-power, option-power wheelchairs, the following additional criteria apply:

- The IHCP member has mobility limitations due to a neurological condition, myopathy, or congenital skeletal deformity.
• And one of the following additional criteria:
  ➢ The IHCP member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as, head control, sip and puff, switch control, and so forth).
  ➢ The IHCP member meets the requirements for a power tilt or power recline seating system, and the system is being used on the wheelchair.

**Motorized/Power Wheelchairs – Multiple Power Option**

Groups 2 and 5, multiple-power, option-power wheelchairs, require any **two** of the three criteria listed below:

- The IHCP member uses a ventilator that is mounted to the wheelchair.
- The IHCP member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as, head control, sip and puff, switch control, and so forth)
- The IHCP member meets the requirements for a power tilt or power recline seating system and the system is being used on the wheelchair.

For groups 3 and 4, multiple-power, option-power wheelchairs, the following criteria apply:

- The IHCP member has mobility limitations due to a neurological condition, myopathy, or congenital skeletal deformity.
- And any **two** of the three criteria listed below:
  ➢ The IHCP member uses a ventilator that is mounted to the wheelchair.
  ➢ The IHCP member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as, head control, sip and puff, switch control, and so forth)
  ➢ The IHCP member meets the requirements for a power tilt or power recline seating system and the system is being used on the wheelchair.

**Motorized/Power Wheelchairs – No Power Option**

For no-power option groups 3 and 4 power wheelchairs, the IHCP member must have mobility limitations due to a neurological condition, myopathy or congenital skeletal deformity.

**Power Operated Vehicles (POVs)**

The IHCP will reimburse for a POV, such as scooters, subject to PA, for members who are unable to operate manual wheelchairs 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 power wheelchairs. POVs are not covered by the IHCP when they
are 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.

The criteria for all POVs are listed below:

- The CMS defined basic coverage criteria are met.
- The member has the ability to safely transfer to and from the POV.
- The member has the ability to operate the tiller-steering system.
- The member has the ability to maintain proper body position and stability while operating the POV.
- The member has the physical and mental capability to safely operate a POV.
- The home environment allows appropriate access with a POV, including maneuvering space and appropriate surfaces.
- The patient does not exceed the weight limitations for the POV provided.
- A POV will significantly improve the IHCP member’s ability to independently perform MRADL.
- All accessories and options for a POV are included in the initial reimbursement rate of the POV, including but not limited to the following:
  - Lap or safety belt
  - Battery or batteries required for operation
  - Battery charger, single mode
  - Complete set of tires
  - Weight appropriate upholstery and seating system
  - Tiller steering
  - Non-expandable controller with proportional response to input
  - All accessories needed for the safe operation of the POV

Wheelchair Accessory – Power Seating

The IHCP has determined that HCPCS codes E1002, E1003, E1004, E1005, E1006, E1007, and E1008 for power seating systems, E1009 and E1010 for power-elevating leg rests, and E2310 and E2311 for electric connectors are medically necessary items. The IHCP covers these HCPCS codes as inexpensive and routinely purchased items for rental or purchase with PA.
Wheelchair Accessory – Seat Cushions

The following codes are reimbursable for adjustable seat cushions:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2622</td>
<td>Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>E2623</td>
<td>Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth</td>
</tr>
<tr>
<td>E2624</td>
<td>Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>E2625</td>
<td>Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth</td>
</tr>
</tbody>
</table>

Wheelchair Accessories – Universal Headrest Plate

Reimbursement of the universal plates are subject to the following PA criteria:

- The IHCP covers universal headrest plates with PA. They are covered when the initial headrest ordered for a new wheelchair does not meet the member’s needs upon the first or subsequent fittings.
- The IHCP covers universal headrest plates for a used wheelchair if the member’s condition changes, and if the wheelchair back is not pre-drilled for the headrest. The provider must provide documentation of the medical necessity for the headrest.
- The IHCP covers replacement universal headrest plates with documentation of an explanation for the replacement (for example, the plate is damaged due to high tone or spasticity of the patient).

The IHCP does not cover universal headrest plates for the initial headrest ordered for use on a new wheelchair. The wheelchair back should be predrilled to accommodate the headrest initially ordered with the wheelchair.

Wheelchair Accessories – Elevating Leg Rests

IHCP covers elevated leg rests if the member meets the following criteria:

- Documentation of musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee
- Documentation of significant edema of the lower extremities
• Evidence that the IHCP member meets the criteria for and has a reclining back on the wheelchair

The provider must provide documentation that the member meets the above criteria.

Wheelchair Accessories – Power Tilt and/or Recline Seating System

The following criteria must be met to be reimbursed for a power tilt or recline seating system, or the combination of a power tilt and recline seating system:

• The IHCP member must qualify for a power wheelchair that accommodates a power tilt and/or recline seating system.

• The IHCP member had an evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or a physician who has specific training and experience in rehabilitation wheelchair evaluations. These professionals must document the medical necessity for the device and its special features in the patient’s home, work, school, or workshop. The PT, OT, or physician may have no financial relationship with the supplier. And,

• The provider must substantiate and document that the IHCP member meets one of the following in addition to criteria 1 and 2 above:
  – IHCP member is unable to perform a functional weight shift and therefore at high risk of developing pressure ulcers.
  – Patient utilizes intermittent catheterization for bladder management and is unable to transfer independently from the wheelchair to the bed.
  – The seating system will be used to manage increased tone and spasticity.

Used Items

The IHCP does not reimburse for used DME except for the following: A4638 - replacement battery for patient-owned ear pulse generator, each and A7046-water chamber for humidifier, used with positive airway pressure device, replacement, each. A new item placed with a member initially as a rental item shall be considered a new item by OMPP at the time of purchase. A used DME item placed with a member initially as a rental item shall be replaced by the supplier with a new item prior to purchase by OMPP.

Reimbursement for the purchase of DME, medical/surgical supplies, orthotics, non-preparatory prosthetics and orthopedic footwear is for new, unused items.

Prior Authorization Requirements

PAs are reviewed on a case-by-case basis per 405 IAC 5-19-7. Certain medical criteria must be met for the approval of each piece of equipment:
The item must be medically reasonable and necessary, as defined by 405 IAC 5-2-17.

The item must be adequate for the medical need of the IHCP member; however, items with unnecessary convenience or luxury features will not be authorized.

The anticipated period of need and 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.

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

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. 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. The member’s physician may prescribe a motorized/power wheelchair or POV.

The services listed below are allowed outside the basic equipment package for all power wheelchairs in groups 1 through 5 with PA and only if medical necessity criteria are met. Any services billed outside the basic equipment package must be submitted on the same day claim for the same date of service:

- Adjustable height arm rests
- Shoulder harness/straps or chest/straps/vest
- Elevating leg rests
- An expandable controller
- Nonstandard joystick, that is, non-proportional or mini, compact, or short throw proportional

Similarly, the services listed below are allowed outside the basic equipment package for all power wheelchairs in groups 3, 4, and 5 with PA, and only if medical necessity criteria are met. Any services billed outside the basic equipment package must be submitted on the same day claim for the same date of service:

- Angle adjustable foot plates
- Power wheelchairs with a sling/solid seat/back:
- Standard duty, seat width and/or depth greater than 20 inches
- Heavy duty, seat width and/or depth greater than 22 inches
- Very heavy duty, seat width and/or depth greater than 24 inches

- Power wheelchairs with a sling/solid seat/back:
  - Standard duty, back width greater than 20 inches
  - Heavy duty, back width greater than 22 inches
  - Very heavy duty, back width greater than 24 inches

Non-standard seat and back will only be provided if the IHCP member’s physical dimensions are provided and require the additional seat width and depth. PA and medical necessity criteria are required.

**Power Operated Vehicles (POVs)**

A completed IHCP Motorized Wheelchair Purchase Medical Clearance Form 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.

**Wheelchair Accessories – Universal Headrest Plate:**

The IHCP covers universal headrest plates with PA. On the PA request, the provider must document 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.

**Billing Requirements**

Providers should determine which HCPCS code 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.

**Programmable Electronic Systems**

Providers cannot bill separately for programmable electronic systems that come standard on the specific motorized or power wheelchair model provided because the total reimbursement for the
motorized or power wheelchair with programmable electronics (K0011) is all-inclusive under that code.

The IHCP allows separate reimbursement only for programmable electronic system upgrades, determined to be medically necessary for the patient, made on motorized/power wheelchair bases. Any such upgrades must have PA, and providers must bill them under HCPCS code K0108 with a KA modifier. Providers must bill the wheelchair base with HCPCS code K0014. For claims submission, providers must attach a cost invoice or retail price invoice to document the cost or price of the wheelchair base and upgraded electronic system.

**Wheelchair Accessory – Seat Cushions**

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 SADMERC classification list to be reimbursed by the IHCP.

Providers must use HCPCS code E1028 – *Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory* for PA and billing. The IHCP denies requests for approval of the universal headrest plate using HCPCS code E1399 – *Durable medical equipment, miscellaneous* for appropriate coding. Providers should submit their usual and customary charge using HCPCS code E1028.

**Manual Wheelchairs**

The HCPCS codes for manual wheelchairs (adult and pediatric), and rollabout and transport chairs are summarized in Table 2 – Billing Codes for Manual Wheelchairs and Transport Chairs.

### Table 2 – Billing Codes for Manual Wheelchairs and Transport Chairs

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1031</td>
<td>Rollabout chair, any and all types with casters 5” or greater</td>
</tr>
<tr>
<td>E1035</td>
<td>Multi-positional patient transfer system, with integrated seat, operated by caregiver, patient weight capacity up to and including 300 lbs</td>
</tr>
<tr>
<td>E1036</td>
<td>Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 lbs</td>
</tr>
<tr>
<td>E1037</td>
<td>Transport chair, pediatric size</td>
</tr>
<tr>
<td>E1038</td>
<td>Transport chair, adult size, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>E1039</td>
<td>Transport chair, adult size, heavy duty, patient weight capacity greater than 300 pounds</td>
</tr>
<tr>
<td>E1050</td>
<td>Fully-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E1060</td>
<td>Fully-reclining wheelchair, detachable arms, desk or full length, swing away, detachable, elevating, leg rests</td>
</tr>
<tr>
<td>E1070</td>
<td>Fully-reclining wheelchair, detachable arms (desk or full length), swing away, detachable footrest</td>
</tr>
<tr>
<td>E1083</td>
<td>Hemi-wheelchair, fixed full length arms, swing away detachable, elevating leg rests</td>
</tr>
<tr>
<td>E1084</td>
<td>Hemi-wheelchair, detachable arms, desk or full length arms, swing-away detachable elevating leg rests</td>
</tr>
<tr>
<td>E1085</td>
<td>Hemi-wheelchair, fixed full length arms, swing away detachable foot rests</td>
</tr>
<tr>
<td>E1086</td>
<td>Hemi-wheelchair, detachable arms desk or full length, swing away detachable foot rests</td>
</tr>
<tr>
<td>E1087</td>
<td>High-strength lightweight wheelchair, fixed full length arms, swing away detachable elevating leg rests</td>
</tr>
<tr>
<td>E1088</td>
<td>High-strength lightweight wheelchair, detachable arms desk or full length, swing away detachable elevating leg rests</td>
</tr>
<tr>
<td>E1089</td>
<td>High-strength lightweight wheelchair, fixed length arms, swing away, detachable footrests</td>
</tr>
<tr>
<td>E1090</td>
<td>High-strength lightweight wheelchair, detachable arms desk or full length, swing away detachable footrests</td>
</tr>
<tr>
<td>E1092</td>
<td>Wide heavy duty wheelchair, detachable arms (desk or full length), swing away detachable elevating leg rests</td>
</tr>
<tr>
<td>E1093</td>
<td>Wide heavy duty wheelchair, detachable arms (desk or full length) swing away, detachable footrests</td>
</tr>
<tr>
<td>E1100</td>
<td>Semi-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests</td>
</tr>
<tr>
<td>E1110</td>
<td>Semi-reclining wheelchair, detachable arms (desk or full length), elevating leg rest</td>
</tr>
<tr>
<td>E1130</td>
<td>Standard wheelchair, fixed full length arms, fixed or swing away detachable footrests</td>
</tr>
<tr>
<td>E1140</td>
<td>Wheelchair, detachable arms, desk or full length, swing away detachable footrests</td>
</tr>
<tr>
<td>E1150</td>
<td>Wheelchair, detachable arms, desk or full length, swing away detachable elevating legrests</td>
</tr>
<tr>
<td>E1160</td>
<td>Wheelchair, fixed full length arms, swing away detachable elevating legrests</td>
</tr>
<tr>
<td>E1161</td>
<td>Manual adult size wheelchair, includes tilt in space</td>
</tr>
<tr>
<td>E1170</td>
<td>Amputee wheelchair, fixed full length arms, swing away detachable elevating legrests</td>
</tr>
<tr>
<td>E1171</td>
<td>Amputee wheelchair, fixed full-length arms, without footrests or legrests</td>
</tr>
<tr>
<td>E1172</td>
<td>Amputee wheelchair, detachable arms (desk or full length) without footrests or legrest</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E1180</td>
<td>Amputee wheelchair, detachable arms (desk or full length) swing away detachable footrests</td>
</tr>
<tr>
<td>E1190</td>
<td>Amputee wheelchair, detachable arms (desk or full length), swing away detachable elevating legrests</td>
</tr>
<tr>
<td>E1195</td>
<td>Heavy duty wheelchair, fixed full length arms, swing away detachable elevating legrests</td>
</tr>
<tr>
<td>E1200</td>
<td>Amputee wheelchair, fixed full length arms, swing away detachable footrest</td>
</tr>
<tr>
<td>E1220</td>
<td>Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification</td>
</tr>
<tr>
<td>E1221</td>
<td>Wheelchair with fixed arm, footrests</td>
</tr>
<tr>
<td>E1222</td>
<td>Wheelchair with fixed arm, elevating legrests</td>
</tr>
<tr>
<td>E1223</td>
<td>Wheelchair with detachable arms, footrests</td>
</tr>
<tr>
<td>E1224</td>
<td>Wheelchair with detachable arms, elevating legrests</td>
</tr>
<tr>
<td>E1229</td>
<td>Wheelchair, pediatric size, not otherwise specified</td>
</tr>
<tr>
<td>E1231</td>
<td>Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system</td>
</tr>
<tr>
<td>E1232</td>
<td>Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system</td>
</tr>
<tr>
<td>E1233</td>
<td>Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system</td>
</tr>
<tr>
<td>E1234</td>
<td>Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system</td>
</tr>
<tr>
<td>E1235</td>
<td>Wheelchair, pediatric size, rigid, adjustable, with seating system</td>
</tr>
<tr>
<td>E1236</td>
<td>Wheelchair, pediatric size, folding, adjustable, with seating system</td>
</tr>
<tr>
<td>E1237</td>
<td>Wheelchair, pediatric size, rigid, adjustable, without seating system</td>
</tr>
<tr>
<td>E1238</td>
<td>Wheelchair, pediatric size, folding, adjustable, without seating system</td>
</tr>
<tr>
<td>E1240</td>
<td>Lightweight wheelchair, detachable arms, (desk or full length) swing away detachable, elevating leg rests</td>
</tr>
<tr>
<td>E1250</td>
<td>Lightweight wheelchair, fixed full length arms, swing away detachable footrest</td>
</tr>
<tr>
<td>E1260</td>
<td>Lightweight wheelchair, detachable arms (desk or full length), swing away detachable footrest</td>
</tr>
<tr>
<td>E1270</td>
<td>Lightweight wheelchair, fixed full length arms, swing away detachable elevating legrests</td>
</tr>
<tr>
<td>E1280</td>
<td>Heavy duty wheelchair, detachable arms (desk or full length), elevating legrests</td>
</tr>
<tr>
<td>E1285</td>
<td>Heavy duty wheelchair, fixed full length arms, swing away detachable footrest</td>
</tr>
<tr>
<td>E1290</td>
<td>Heavy duty wheelchair, detachable arms (desk or full length), swing away detachable footrest</td>
</tr>
<tr>
<td>E1295</td>
<td>Heavy duty wheelchair, fixed full-length arms, elevating legrest</td>
</tr>
<tr>
<td>E1296</td>
<td>Special wheelchair seat height from floor</td>
</tr>
</tbody>
</table>
POV

Providers should submit their usual and customary charge on the CMS-1500 or 837P electronic claim. The IHCP has determined procedure codes K0806, K0807, and K0808 not medically necessary and thus, these codes are not reimbursable. The IHCP provides other alternatives to these products that serve the same function. Covered codes are summarized in Table 3.

Table 3 – Billing Codes for POVs

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0800</td>
<td>Power-operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0801</td>
<td>Power-operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0802</td>
<td>Power-operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td>K0812</td>
<td>Power-operated vehicle, not otherwise classified</td>
</tr>
</tbody>
</table>

Power Wheelchairs – No Power Option

Billing codes for no-power option power wheelchairs are listed in Table 4.

Table 4 – Billing Codes for No-Power Option Power Wheelchairs

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0813</td>
<td>Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0814</td>
<td>Power wheelchair, group 1 standard, portable, captain’s chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0815</td>
<td>Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0816</td>
<td>Power wheelchair, group 1 standard, captain’s chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0820</td>
<td>Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0821</td>
<td>Power wheelchair, group 2 standard, portable, captain’s chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>K0822</td>
<td>Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0823</td>
<td>Power wheelchair, group 2 standard, captain’s chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0824</td>
<td>Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0825</td>
<td>Power wheelchair, group 2 heavy duty, captain’s chair, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0826</td>
<td>Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td>K0827</td>
<td>Power wheelchair, group 2 very heavy duty, captain’s chair, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td>K0828</td>
<td>Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more</td>
</tr>
<tr>
<td>K0829</td>
<td>Power wheelchair, group 2 extra heavy duty, captain’s chair, patient weight capacity 601 pounds or more</td>
</tr>
<tr>
<td>K0848</td>
<td>Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0849</td>
<td>Power wheelchair, group 3 standard, captain’s chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0850</td>
<td>Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0851</td>
<td>Power wheelchair, group 3 heavy duty, captain’s chair, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0852</td>
<td>Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td>K0853</td>
<td>Power wheelchair, group 3 very heavy duty, captain’s chair, patient weight capacity, 451 to 600 pounds</td>
</tr>
<tr>
<td>K0854</td>
<td>Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more</td>
</tr>
<tr>
<td>K0855</td>
<td>Power wheelchair, group 3 extra heavy duty, captain’s chair, patient weight capacity 601 pounds or more</td>
</tr>
<tr>
<td>K0868</td>
<td>Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0869</td>
<td>Power wheelchair, group 4 standard, captain’s chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0870</td>
<td>Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
</tbody>
</table>
K0871 | Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0898 | Power wheelchair, not otherwise classified

**Power Wheelchairs – Single Power Option**

Billing codes for single power option power wheelchairs are listed in Table 5.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0835</td>
<td>Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0836</td>
<td>Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0837</td>
<td>Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0838</td>
<td>Power wheelchair, group 2 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0839</td>
<td>Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td>K0840</td>
<td>Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more</td>
</tr>
<tr>
<td>K0856</td>
<td>Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0857</td>
<td>Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0858</td>
<td>Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0859</td>
<td>Power wheelchair, group 3 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0860</td>
<td>Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td>K0877</td>
<td>Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0878</td>
<td>Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>K0879</td>
<td>Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0880</td>
<td>Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td>K0890</td>
<td>Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds</td>
</tr>
<tr>
<td>K0898</td>
<td>Power wheelchair, not otherwise classified</td>
</tr>
</tbody>
</table>

**Power Wheelchairs – Multiple Power Option**

Billing codes for multiple power option power wheelchairs are listed in Table 6.

**Table 6 – Billing Codes for Multiple Power Option Power Wheelchairs**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0841</td>
<td>Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0842</td>
<td>Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0843</td>
<td>Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0861</td>
<td>Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0862</td>
<td>Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0863</td>
<td>Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td>K0864</td>
<td>Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pound or more</td>
</tr>
<tr>
<td>K0884</td>
<td>Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0885</td>
<td>Power wheelchair, group 4 standard, multiple power option, captain's chair, weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0886</td>
<td>Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0891</td>
<td>Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds</td>
</tr>
<tr>
<td>K0898</td>
<td>Power wheelchair, not otherwise classified</td>
</tr>
</tbody>
</table>
Basic Equipment Package

The codes listed in Table 7 are part of routine equipment for all power wheelchairs and therefore are included in the initial reimbursement rates. These codes will be reimbursed as replacement codes only with documentation that the requested part is not covered under the standard manufacturer’s warranty. PA must be obtained.

Table 7 – Billing Codes for Basic Equipment Package

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0971</td>
<td>Manual wheelchair accessory, anti-tipping device, each</td>
</tr>
<tr>
<td>E0978</td>
<td>Wheelchair accessory, positioning belt/safety belt/pelvic strap, each</td>
</tr>
<tr>
<td>E0981</td>
<td>Wheelchair accessory, seat upholstery, replacement only, each</td>
</tr>
<tr>
<td>E0982</td>
<td>Wheelchair accessory, back upholstery, replacement only, each</td>
</tr>
<tr>
<td>E0985</td>
<td>Wheelchair accessory, seat-lift mechanism</td>
</tr>
<tr>
<td>E1225</td>
<td>Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each</td>
</tr>
<tr>
<td>E2366</td>
<td>Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each</td>
</tr>
<tr>
<td>E2368</td>
<td>Power wheelchair component, motor, replacement only</td>
</tr>
<tr>
<td>E2369</td>
<td>Power wheelchair component, gearbox, replacement only</td>
</tr>
<tr>
<td>E2370</td>
<td>Power wheelchair component, motor and gear box combination, replacement only</td>
</tr>
<tr>
<td>E2374</td>
<td>Power wheelchair accessory, hand- or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only</td>
</tr>
<tr>
<td>E2375</td>
<td>Power wheelchair accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only</td>
</tr>
<tr>
<td>E2376</td>
<td>Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only</td>
</tr>
<tr>
<td>E2381</td>
<td>Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2382</td>
<td>Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2383</td>
<td>Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each</td>
</tr>
<tr>
<td>E2384</td>
<td>Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each</td>
</tr>
</tbody>
</table>
E2385 | Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each
E2386 | Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each
E2387 | Power wheelchair accessory, foam filled caster tire, any size, replacement only, each
E2388 | Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each
E2389 | Power wheelchair accessory, foam caster tire, any size, replacement only, each
E2390 | Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each
E2391 | Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each
E2392 | Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each
E2394 | Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each
E2395 | Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each
E2396 | Power wheelchair accessory, caster fork, any size, replacement only, each
K0043 | Footrest, lower extension tube, each
K0044 | Footrest, upper hanger bracket, each
K0045 | Footrest, complete assembly

**Replacement Parts and Accessories**

Table 8 lists codes that may be billed separately as replacement equipment.

**Table 8 – Billing Codes for Replacement Parts and Accessories**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0955</td>
<td>Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each</td>
</tr>
<tr>
<td>E0956</td>
<td>Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each</td>
</tr>
<tr>
<td>E0957</td>
<td>Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each</td>
</tr>
<tr>
<td>E0958</td>
<td>Manual wheelchair accessory, one-arm drive attachment, each</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E0959</td>
<td>Manual wheelchair accessory, adapter for amputee, each</td>
</tr>
<tr>
<td>E0960</td>
<td>Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware</td>
</tr>
<tr>
<td>E0961</td>
<td>Manual wheelchair accessory, wheel lock brake extension (handle), each</td>
</tr>
<tr>
<td>E0966</td>
<td>Manual wheelchair accessory, headrest extension, each</td>
</tr>
<tr>
<td>E0967</td>
<td>Manual wheelchair accessory, hand rim with projections, any type, each</td>
</tr>
<tr>
<td>E0968</td>
<td>Commode seat, wheelchair</td>
</tr>
<tr>
<td>E0969</td>
<td>Narrowing device, wheelchair</td>
</tr>
<tr>
<td>E0970</td>
<td>No. 2 footplates, except for elevating leg rest</td>
</tr>
<tr>
<td>E0971</td>
<td>Manual wheelchair accessory, anti-tipping device, each</td>
</tr>
<tr>
<td>E0973</td>
<td>Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each</td>
</tr>
<tr>
<td>E0974</td>
<td>Manual wheelchair accessory, anti-rollback device, each</td>
</tr>
<tr>
<td>E0978</td>
<td>Wheelchair accessory, positioning belt/safety belt/pelvic strap, each</td>
</tr>
<tr>
<td>E0980</td>
<td>Safety vest, wheelchair</td>
</tr>
<tr>
<td>E0981</td>
<td>Wheelchair accessory, seat upholstery, replacement only, each</td>
</tr>
<tr>
<td>E0982</td>
<td>Wheelchair accessory, back upholstery, replacement only, each</td>
</tr>
<tr>
<td>E0983</td>
<td>Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control</td>
</tr>
<tr>
<td>E0984</td>
<td>Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control</td>
</tr>
<tr>
<td>E0985</td>
<td>Wheelchair accessory, seat-lift mechanism</td>
</tr>
<tr>
<td>E0990</td>
<td>Elevating leg rest, each</td>
</tr>
<tr>
<td>E0992</td>
<td>Solid seat insert</td>
</tr>
<tr>
<td>E0994</td>
<td>Arm rest, each</td>
</tr>
<tr>
<td>E0995</td>
<td>Wheelchair accessory, calf rest/pad, each</td>
</tr>
<tr>
<td>E1002</td>
<td>Wheelchair accessory, power seating system, tilt only</td>
</tr>
<tr>
<td>E1003</td>
<td>Wheelchair accessory, power seating system, recline only, without shear reduction</td>
</tr>
<tr>
<td>E1004</td>
<td>Wheelchair accessory, power seating system, recline only, with mechanical shear reduction</td>
</tr>
<tr>
<td>E1005</td>
<td>Wheelchair accessory, power seating system, recline only, with power-shear reduction</td>
</tr>
<tr>
<td>E1006</td>
<td>Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E1007</td>
<td>Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction</td>
</tr>
<tr>
<td>E1008</td>
<td>Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction</td>
</tr>
<tr>
<td>E1009</td>
<td>Wheelchair accessory, addition to power seating system, mechanically linked leg-elevation system, including pushrod and leg rest, each</td>
</tr>
<tr>
<td>E1010</td>
<td>Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair</td>
</tr>
<tr>
<td>E1011</td>
<td>Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)</td>
</tr>
<tr>
<td>E1014</td>
<td>Reclining back, addition to pediatric size wheelchair</td>
</tr>
<tr>
<td>E1015</td>
<td>Shock absorber for manual wheelchair, each</td>
</tr>
<tr>
<td>E1016</td>
<td>Shock absorber for power wheelchair, each</td>
</tr>
<tr>
<td>E1017</td>
<td>Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each</td>
</tr>
<tr>
<td>E1018</td>
<td>Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each</td>
</tr>
<tr>
<td>E1020</td>
<td>Residual limb support system for wheelchair</td>
</tr>
<tr>
<td>E1028</td>
<td>Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory</td>
</tr>
<tr>
<td>E1029</td>
<td>Wheelchair accessory, ventilator tray, fixed</td>
</tr>
<tr>
<td>E1030</td>
<td>Wheelchair accessory, ventilator tray, gimbaled</td>
</tr>
<tr>
<td>E1225</td>
<td>Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each</td>
</tr>
<tr>
<td>E1226</td>
<td>Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each</td>
</tr>
<tr>
<td>E1227</td>
<td>Special height arms for wheelchair</td>
</tr>
<tr>
<td>E1228</td>
<td>Special back height for wheelchair</td>
</tr>
<tr>
<td>E2201</td>
<td>Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches</td>
</tr>
<tr>
<td>E2202</td>
<td>Manual wheelchair accessory, nonstandard seat frame width, 24 to 27 inches</td>
</tr>
<tr>
<td>E2203</td>
<td>Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches</td>
</tr>
<tr>
<td>E2204</td>
<td>Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches</td>
</tr>
<tr>
<td>E2205</td>
<td>Manual wheelchair accessory, handrim without projections (includes ergonomic or contoured), any type, replacement only, each</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E2206</td>
<td>Manual wheelchair accessory, wheel lock assembly, complete, each</td>
</tr>
<tr>
<td>E2209</td>
<td>Accessory arm trough, with or without hand support, each</td>
</tr>
<tr>
<td>E2210</td>
<td>Wheelchair accessory, bearings, any type, replacement only, each</td>
</tr>
<tr>
<td>E2211</td>
<td>Manual wheelchair accessory, pneumatic propulsion tire, any size, each</td>
</tr>
<tr>
<td>E2212</td>
<td>Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each</td>
</tr>
<tr>
<td>E2213</td>
<td>Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each</td>
</tr>
<tr>
<td>E2214</td>
<td>Manual wheelchair accessory, pneumatic caster tire, any size, each</td>
</tr>
<tr>
<td>E2215</td>
<td>Manual wheelchair accessory, tube for pneumatic caster tire, any size, each</td>
</tr>
<tr>
<td>E2216</td>
<td>Manual wheelchair accessory, foam filled propulsion tire, any size, each</td>
</tr>
<tr>
<td>E2217</td>
<td>Manual wheelchair accessory, foam filled caster tire, any size, each</td>
</tr>
<tr>
<td>E2218</td>
<td>Manual wheelchair accessory, foam propulsion tire, any size, each</td>
</tr>
<tr>
<td>E2219</td>
<td>Manual wheelchair accessory, foam caster tire, any size, each</td>
</tr>
<tr>
<td>E2220</td>
<td>Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each</td>
</tr>
<tr>
<td>E2221</td>
<td>Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each</td>
</tr>
<tr>
<td>E2222</td>
<td>Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each</td>
</tr>
<tr>
<td>E2224</td>
<td>Manual wheelchair accessory, propulsion wheel excludes tire, any size, each</td>
</tr>
<tr>
<td>E2225</td>
<td>Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2226</td>
<td>Manual wheelchair accessory, caster fork, any size, replacement only, each</td>
</tr>
<tr>
<td>E2227</td>
<td>Manual wheelchair accessory, gear-reduction drive wheel, each</td>
</tr>
<tr>
<td>E2228</td>
<td>Manual wheelchair accessory, wheel-braking system and lock, complete, each</td>
</tr>
<tr>
<td>E2231</td>
<td>Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware</td>
</tr>
<tr>
<td>E2291</td>
<td>Back, planar, for pediatric size wheelchair, including fixed attaching hardware</td>
</tr>
<tr>
<td>E2292</td>
<td>Seat, planar, for pediatric size wheelchair, including fixed attaching hardware</td>
</tr>
<tr>
<td>E2293</td>
<td>Back, contoured, for pediatric size wheelchair, including fixed attaching hardware</td>
</tr>
<tr>
<td>E2294</td>
<td>Seat, contoured, for pediatric size wheelchair, including fixed attaching hardware</td>
</tr>
<tr>
<td>E2295</td>
<td>Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features</td>
</tr>
<tr>
<td>E2310</td>
<td>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</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E2311</td>
<td>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</td>
</tr>
<tr>
<td>E2321</td>
<td>Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware</td>
</tr>
<tr>
<td>E2322</td>
<td>Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware</td>
</tr>
<tr>
<td>E2323</td>
<td>Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated</td>
</tr>
<tr>
<td>E2324</td>
<td>Power wheelchair accessory, chin cup for chin control interface</td>
</tr>
<tr>
<td>E2325</td>
<td>Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware</td>
</tr>
<tr>
<td>E2326</td>
<td>Power wheelchair accessory, breath tube kit for sip and puff interface</td>
</tr>
<tr>
<td>E2327</td>
<td>Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware</td>
</tr>
<tr>
<td>E2328</td>
<td>Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware</td>
</tr>
<tr>
<td>E2329</td>
<td>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</td>
</tr>
<tr>
<td>E2330</td>
<td>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</td>
</tr>
<tr>
<td>E2331</td>
<td>Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware</td>
</tr>
<tr>
<td>E2340</td>
<td>Power wheelchair accessory, nonstandard seat frame width, 20 to 23 inches</td>
</tr>
<tr>
<td>E2341</td>
<td>Power wheelchair accessory, nonstandard seat frame width, 24 to 27 inches</td>
</tr>
<tr>
<td>E2342</td>
<td>Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches</td>
</tr>
<tr>
<td>E2343</td>
<td>Power wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches</td>
</tr>
<tr>
<td>E2358</td>
<td>Power wheelchair accessory, group 34 non-sealed lead acid battery, each</td>
</tr>
<tr>
<td>E2359</td>
<td>Power wheelchair accessory, group 34 sealed lead acid battery, each (e.g. gel cell, absorbed grassmat)</td>
</tr>
<tr>
<td>E2360</td>
<td>Power wheelchair accessory, 22 NF nonsealed lead acid battery, each</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E2361</td>
<td>Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)</td>
</tr>
<tr>
<td>E2362</td>
<td>Power wheelchair accessory, group 24 nonsealed lead acid battery, each</td>
</tr>
<tr>
<td>E2363</td>
<td>Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)</td>
</tr>
<tr>
<td>E2364</td>
<td>Power wheelchair accessory, U-1 nonsealed lead acid battery, each</td>
</tr>
<tr>
<td>E2365</td>
<td>Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)</td>
</tr>
<tr>
<td>E2366</td>
<td>Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each</td>
</tr>
<tr>
<td>E2368</td>
<td>Power wheelchair component, motor, replacement only</td>
</tr>
<tr>
<td>E2369</td>
<td>Power wheelchair component, gearbox, replacement only</td>
</tr>
<tr>
<td>E2370</td>
<td>Power wheelchair component, motor and gearbox combination, replacement only</td>
</tr>
<tr>
<td>E2371</td>
<td>Power wheelchair accessory, group 27 sealed lead acid battery, (e.g. gel cell, absorbed glassmat), each</td>
</tr>
<tr>
<td>E2372</td>
<td>Power wheelchair accessory, group 27 non-sealed lead acid battery, each</td>
</tr>
<tr>
<td>E2373</td>
<td>Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware</td>
</tr>
<tr>
<td>E2374</td>
<td>Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only</td>
</tr>
<tr>
<td>E2375</td>
<td>Power wheelchair accessory, nonexpandable controller, including all related electronics and mounting hardware, replacement only</td>
</tr>
<tr>
<td>E2376</td>
<td>Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only</td>
</tr>
<tr>
<td>E2377</td>
<td>Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue</td>
</tr>
<tr>
<td>E2381</td>
<td>Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2382</td>
<td>Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2383</td>
<td>Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each</td>
</tr>
<tr>
<td>E2384</td>
<td>Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2385</td>
<td>Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>E2386</td>
<td>Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2387</td>
<td>Power wheelchair accessory, foam filled caster tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2388</td>
<td>Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2389</td>
<td>Power wheelchair accessory, foam caster tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2390</td>
<td>Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2391</td>
<td>Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each</td>
</tr>
<tr>
<td>E2392</td>
<td>Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each</td>
</tr>
<tr>
<td>E2394</td>
<td>Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2395</td>
<td>Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each</td>
</tr>
<tr>
<td>E2396</td>
<td>Power wheelchair accessory, caster fork, any size, replacement only, each</td>
</tr>
<tr>
<td>E2397</td>
<td>Power wheelchair accessory, lithium-based battery, each</td>
</tr>
<tr>
<td>E2601</td>
<td>General use wheelchair seat cushion, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>E2602</td>
<td>General use wheelchair seat cushion, width 22 inches or greater, any depth</td>
</tr>
<tr>
<td>E2603</td>
<td>Skin protection wheelchair seat cushion, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>E2604</td>
<td>Skin protection wheelchair seat cushion, width 22 inches or greater, any depth</td>
</tr>
<tr>
<td>E2605</td>
<td>Positioning wheelchair seat cushion, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>E2606</td>
<td>Positioning wheelchair seat cushion, width 22 inches or greater, any depth</td>
</tr>
<tr>
<td>E2607</td>
<td>Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>E2608</td>
<td>Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth</td>
</tr>
<tr>
<td>E2609</td>
<td>Custom fabricated wheelchair seat cushion, any size</td>
</tr>
<tr>
<td>E2611</td>
<td>General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2612</td>
<td>General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2613</td>
<td>Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E2614</td>
<td>Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2615</td>
<td>Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2616</td>
<td>Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2617</td>
<td>Custom fabricated wheelchair back cushion, any size, including any type mounting hardware</td>
</tr>
<tr>
<td>E2619</td>
<td>Replacement cover for wheelchair seat cushion or back cushion, each</td>
</tr>
<tr>
<td>E2620</td>
<td>Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2621</td>
<td>Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2622</td>
<td>Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>E2623</td>
<td>Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth</td>
</tr>
<tr>
<td>E2624</td>
<td>Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>E2625</td>
<td>Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth</td>
</tr>
<tr>
<td>E2626</td>
<td>Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable</td>
</tr>
<tr>
<td>E2627</td>
<td>Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable, rancho style</td>
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<tr>
<td>E2628</td>
<td>Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining</td>
</tr>
<tr>
<td>E2629</td>
<td>Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)</td>
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<td>Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension, arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support.</td>
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<td>E2631</td>
<td>Wheelchair accessory, addition to mobile arm support, elevating proximal arm</td>
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<td>Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control</td>
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<td>E2633</td>
<td>Wheelchair accessory, addition to mobile arm support, supinator</td>
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Rule, Citations and Sources

405 IAC 5-19-9

IHCP Provider Newsletter

NL200402

IHCP Bulletins

BT200832 – Medicaid Coverage of K Codes for Power Mobility Devices
BT200335 – Motorized/Power Wheelchairs and Programmable Electronics
BT200136 – Nonmotorized Wheelchair or Motorized Wheelchair Purchase

IHCP Banner Pages

BR200650
BR200307

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Medical Supplies and Durable Medical Equipment – Overview
Mental Health/Behavioral Health – Inpatient Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding inpatient services for mental health/behavioral health. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Acute psychiatric and substance abuse inpatient services are mental health interventions used to stabilize and manage people with severe symptoms and behaviors that have harmed or may result in harm to themselves or others. The following information describes presenting factors that may meet medical necessity for inpatient services:

- Current or recent serious suicide ideation, with plan and potential means with lethal intent
- Current or recent serious, violent, impulsive, and unpredictably dangerous homicidal ideation, with plan and potential means with lethal intent
- Current 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 psychomotor agitation or retardation that cannot be safely treated in a less restrictive level of care (LOC)

Depending on the patients’ needs, 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.

Admission Criteria

Members must meet medical necessity to be eligible for acute inpatient 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
  ➢ There is a history of recent convulsions or poorly controlled convulsive disorder

• Medicaid reimbursement is available for inpatient detoxification, rehabilitation, and aftercare for chemical dependency when such services are prior authorized

Plan of Care (POC)

Each Medicaid eligible patient admitted to an acute psychiatric facility or unit must have an individually developed POC. For members between 22 and 65 years old in a psychiatric hospital of 16 beds or fewer, or a person 65 years old or older, a POC must be developed by the attending or staff physician. For members under 21 years old, POCs must be developed by a physician and Interdisciplinary team.

All POCs must be developed within 14 days of the admission date, regardless of the member’s age. For a patient who becomes eligible for Medicaid after admission to a facility, the POC must be prepared to cover all periods for which Medicaid coverage is claimed. The following components must be documented in each member’s POC:

• Treatment objectives and goals, including an integrated program of appropriate therapies, activities, and experiences designed to meet the objectives

• At the appropriate time, a post-discharge plan and a plan for coordination of inpatient services with partial discharge plans, including appropriate services in the...
The POC 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 POC must be reviewed and updated at least every 90 days for members between 22 and 65 years old in psychiatric hospitals with 16 beds or fewer and for members 65 years old or older.

The POC will be reviewed by the attending or staff physician to ensure that appropriate services are being provided and that they continue to be medically necessary. The attending or staff physician will also recommend necessary adjustments in the plan, as indicated by the member’s overall adjustment as an inpatient. The quarterly POC must be in writing and must be part of the member’s record.

The requirements for the development of a POC for all members 21 years old or younger are the same as for members who are older than age 22, as stated above, with the following exceptions:

- An Interdisciplinary Team (IDT), which will include the child and parents, legal guardians, or others to whose care or custody the individual will be released following discharge, is required to develop and direct the POC.
- This team is responsible for developing and updating POCs at least every 30 days.
- The team will be responsible for determining that the services provided were and are required on an inpatient basis and for determining adjustments that may be needed in the POC.

Recertification is required at least every 60 days. Initial evaluative examinations are exempt from prior review and authorization.

One of the following professionals or combination of professionals must be active in the development of the POC 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 a HSPP or licensed psychologist

A professional who is qualified to make determinations regarding mental health conditions and treatments must be part of the IDT, as well. At least one of the following professionals must be active in planning and implementing the POC:
• A licensed clinical social worker (LCSW), licensed marital and family therapist (LMFT), licensed mental health counselor (LMHC), or a person holding a master’s degree in social work, marital and family therapy, or mental health counseling

• An advanced practice nurse or RN who has specialized training or one year’s experience in treating people with mental illnesses

• An occupational therapist (OT), registered with the National Association of OTs who has specialized training or one year of experience treating people with mental illnesses

• A psychologist endorsed as a HSPP or a licensed psychologist

Reimbursement Requirements

Inpatient Services

Medicaid reimbursement is available for mental health services provided by licensed physicians, psychiatric hospitals, general hospitals, psychiatric residential treatment facilities for children under 21 years of age, outpatient mental health facilities, and psychologists endorsed as health service providers in psychology subject to the limitations set out in 405 IAC 5-20-1.

Reimbursement for inpatient psychiatric services is not available in institutions for mental diseases for a recipient under sixty-five (65) years of age unless the recipient is under 21 years of age, or under 22 years of age and had begun receiving inpatient psychiatric services immediately before his or her 21st birthday.

Medicaid reimbursement is available for inpatient psychiatric services provided to an individual between 22 and 65 years of age in a certified psychiatric hospital of 16 beds or less.

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 only if adequately 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 LOC or a diagnosis related group (DRG) methodology based on the type of admission. The reimbursement includes all other supplies and services provided to members in inpatient psychiatric facilities, including services of HSPPs, clinical psychologists, and clinical social workers, regardless of whether salaried, contracted, or independent providers. Providers cannot bill these supplies and services separately.

The following information describes reimbursement for psychiatric and substance abuse inpatient services:
• Acute psychiatric inpatient services are reimbursed on an LOC reimbursement methodology; therefore, these services are paid on a *per diem* basis. The *per diem* rate includes routine, ancillary, and capital costs.

• Substance abuse inpatient services are reimbursed on a DRG reimbursement methodology; therefore, this service is paid on a per case basis.

Direct care services of physicians, including psychiatric evaluations, are excluded from inpatient facility’s reimbursement and are billable separately by the rendering provider on the *CMS-1500* claim form or the 837P electronic transaction.

**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 a 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.

• If the initial admission was paid on a per diem basis, the readmission should be considered a new admission and billed accordingly. The readmission is treated as a separate stay for payment purposes, but is subject to medical review.

• If the initial admission was paid using the DRG methodology, providers should bill one inpatient claim when a member 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 a 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 that 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* 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 inpatient services 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 a 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 the same facility.

If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim will be denied with an explanation of benefits (EOB) 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 consecutive days, the member must be discharged from the psychiatric facility. Facilities are reimbursed for the reserved bed at one-half the regular per diem rate.

Therapeutic Leave of Absence (LOA)

Reimbursement is available for a therapeutic LOA from psychiatric hospitals; it is not available from general acute hospitals. A LOA must be for therapeutic reasons and ordered by a physician, as indicated in the member’s POC. 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.

Prior Authorization Requirements

PA is required for all inpatient psychiatric admissions, including admissions for substance abuse. The IHCP reimburses providers for inpatient psychiatric services provided to eligible individuals between 22 and 65 years old only in certified psychiatric hospitals with 16 beds or fewer. If the member is 22 years old and began receiving inpatient psychiatric services
immediately before the member’s 22nd birthday, inpatient psychiatric services are available. The facility is responsible for initiating the PA review process. Providers should contact the appropriate PA entity for the initial PA and concurrent review.

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 44697, OMPP 1261A – Certification Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility fulfills the written certification of need requirements. The certification of need must be completed in writing at least every 60 days after admission, or as requested, to recertify that the member continues to require inpatient psychiatric hospital services.

All requests for PA will be reviewed on a case-by-case basis. The PA entity 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 from the admission to the actual date of notification.

Emergency Admissions

- A telephone precertification 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 must be received via U.S. mail within 10 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 the PA entity in writing within 10 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 sought.

Continuation of Services after Discharge from an Inpatient Hospital

When a member’s physician determines that an inpatient hospital setting is no longer necessary, but that Medicaid covered services should continue after the recipient is discharged from inpatient hospital care, services may continue for a period not to exceed 120 hours within 30 calendar days of discharge without prior review and authorization, if the physician has specifically ordered such services in writing upon the member’s discharge from the hospital. Services provided are subject to all appropriate limitations. This exemption does not apply to
durable medical equipment, neuropsychological and psychological testing, or out-of-state medical services.

Prior review and authorization by the office must be obtained for reimbursement beyond the 120 hours within 30 calendar days of the discharge period. Physical, speech, respiratory, and occupational therapies may continue for a period not to exceed 30 hours, sessions, or visits in 30 calendar days without prior approval, if the physician has specifically ordered such services in writing upon the member’s discharge or transfer from the hospital. Prior review and authorization must be obtained for reimbursement beyond the 30 hours, sessions, or visits in the 30 calendar day period for physical, speech, respiratory, and occupational therapies.

**Billing Requirements**

Not Applicable

**Rules, Citations and Sources**

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 5-20-1 – Reimbursement limitations

405 IAC 5-20-4 – Individually developed plan of care

405 IAC 5-20-6 – Emergency admissions

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

*IHCP Bulletin*

BT 200719
IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Emergency Medicine – Emergency Room
Emergency Medicine – Emergency Services
Evaluation and Management Services
Intermediate Care Facility for Individuals with Intellectual Disabilities
Hospital Inpatient Services
Hospital Outpatient Services
Mental Health/Behavioral Health – Outpatient Services
Mental Health/Behavioral Health – Outpatient Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding mental health/behavioral health outpatient services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Outpatient mental health services are interventions intended to reduce or alleviate symptoms, improve level of functioning, and prevent further 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 when 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 the client’s new goals.

Reimbursement Requirements

The IHCP covers outpatient mental health services provided by a licensed medical doctor, doctor of osteopathy, psychologist endorsed as an HSPP, psychiatric hospitals, psychiatric wings of acute care hospitals, and outpatient 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 outpatient mental health services must have obtained one of the following credentials:

- Advanced practice nurse who is a licensed RN with a master’s degree in nursing, with a major in psychiatric or mental health nursing from an accredited school of nursing
- Independent practice school psychologist
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)
- Licensed psychologist
- Master’s degree in social work, marital and family therapy, or mental health counseling

These mid-level practitioners cannot be separately enrolled as individual providers to receive direct reimbursement. Mid-level practitioners can be employed by an outpatient mental health facility, clinic, physician, or a HSPP enrolled in the IHCP.

The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and supervising the treatment plan. 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.

The IHCP requires written evidence of physician or HSPP involvement and personal evaluation to document the member’s acute medical needs. If practicing independently, a physician or a HSPP must order therapy in writing.

**Prior Authorization Requirements**

Medicaid reimbursement is available for one psychiatric diagnostic interview examination without PA per member, per provider, per rolling 12-month period (refer to *Chapter 2 of the IHCP Provider Manual* for an explanation of rolling 12-month period). A maximum of two diagnostic interview examinations per member, per 12-month period 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.

PA is required for mental health services provided in an outpatient facility or office setting that exceeds 20 units per member, per provider, per rolling 12-month period. 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 in combination are subject to the 20 units per member, per provider, per rolling 12-month period:

- 90791-90792
- 90832-90834
- 90836-90840
- 90845–90853
- 96151-96153

The IHCP requires PA for all units of neuropsychology and psychological testing. This applies to CPT® codes 96101 – psychological testing with interpretation and report by psychologist or physician per hour, 96110 – developmental screening, with interpretation and report, 96111 – developmental testing with interpretation and report, and 96118 – neuropsychological testing interpretation, and report by psychologist or physician per hour. According to 405 IAC 5-20-8(5), a physician or HSPP must provide these services.

**Billing Requirements**

All rendered outpatient services must be identified and itemized on the CMS-1500 or in the 837P. 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.

The IHCP reimburses for services provided by mid-level practitioners in an outpatient mental health facility when a HSPP supervises services. Mid-level practitioners who render services must bill using the rendering provider number of the supervising practitioner and the billing provider number of the outpatient mental health clinic or facility. Providers must use modifiers with the appropriate procedure codes when billing mid-level practitioner services.

Table 1 lists mid-level practitioners and the appropriate corresponding modifiers for billing purposes.

<table>
<thead>
<tr>
<th>Mid-level Practitioner</th>
<th>Modifier</th>
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</thead>
<tbody>
<tr>
<td>Services provided by a clinical psychologist</td>
<td>AH</td>
</tr>
<tr>
<td>Services provided by a clinical social worker</td>
<td>AJ</td>
</tr>
<tr>
<td>Services provided by a nurse practitioner or clinical nurse specialist</td>
<td>HE in conjunction with SA</td>
</tr>
<tr>
<td>Services provided by a nurse practitioner or clinical nurse specialist in a non-mental health arena</td>
<td>SA</td>
</tr>
</tbody>
</table>
Services funded by State mental health agency (Medicaid Rehabilitation Option services) | HW
---|---
Any other mid-level practitioner | HE

Claims billed for services provided by mid-level practitioners and billed with the appropriate modifier will reimburse at the lesser of 75 percent of the IHCP allowed amount or the billed amount. HSPPs should not bill using modifiers. IHCP reimburses HSPPs at the lesser of 100 percent of the allowed amount or billed amount.

CPT® codes 90833, 90836, and 90838 for psychotherapy with medical evaluation and management are medical services. Therefore, the IHCP does not reimburse clinical social workers, clinical psychologists, or any midlevel practitioners (excluding nurse practitioners) for these codes.

The following services are not covered by the IHCP:

- Day care or partial day care
- Hypnosis
- Biofeedback
- Missed appointments
- Experimental drugs, treatments, and procedures, and all related services
- Services for the remediation of learning disabilities
- Treatments or therapies of an educational nature
- Acupuncture
- Hyperthermia
- Hypnotherapy
- PHP, except when provided pursuant to 405 IAC 5-21
- Cognitive rehabilitation, except for treatment of TBI

Partial Hospitalization

Effective September 1, 2013, the IHCP began covering acute partial hospitalization for mental health using CPT® Code H0035 – Mental health, partial hospitalization, treatment, less than 24 hours. Providers inquired about the need to bill third-party insurance prior to submitting claims to Medicaid. Acute partial hospitalization is not a Medicaid Rehabilitation Option Service, and the IHCP requires that third-party insurance, including commercial carriers and Medicare, be billed prior to submission of the claim to Medicaid. For more information about the process for billing claims when a member has coverage through another insurer or policy, see Chapter 6 of the IHCP Provider Manual.
According to 405 IAC 5-20-8 (4), Medicaid will reimburse partial hospitalization services under the following conditions and subject to prior authorization:

(A) Partial hospitalization programs must be highly intensive, time-limited medical services that either provide a transition from inpatient psychiatric hospitalization to community-based care, or serve as a substitute for an inpatient admission. Partial hospitalization programs are highly individualized with treatment goals that are measureable and medically necessary. Treatment goals must include specific time frames for achievement of goals, and treatment goals must be directly related to the reason for admission.

(B) Partial hospitalization programs must have the ability to reliably contract for safety. Consumers with clear intent to seriously harm the self or others are not candidates for partial hospitalization services.

(C) Services may be provided for consumers of all ages who are not at imminent risk to harm to self or others. Consumers who currently reside in a group home or other residential care setting are not eligible for partial hospitalization services. Consumers must have a diagnosed or suspected behavioral health condition and one (1) of the following:

(i) A short-term deficit in daily functioning.

(ii) An assessment of the consumer indicating a high probability of serious deterioration of the consumer's general medical or behavioral health.

(D) Program standards shall be as follows:

(i) Services must be ordered and authorized by a psychiatrist.

(ii) Services require prior authorization pursuant to 405 IAC 5-3-13(a).

(iii) A face-to-face evaluation and an assignment of a behavioral health diagnosis must take place within twentyfour (24) hours following admission to the program.

(iv) A psychiatrist must actively participate in the case review and monitoring of care.

(v) Documentation of active oversight and monitoring of progress by a physician, a psychiatrist, or a HSPP must appear in the consumer's clinical record.

(vi) At least one (1) individual psychotherapy service or group psychotherapy service must be delivered daily.

(vii) For consumers under eighteen (18) years of age, documentation of active psychotherapy must appear in the consumer's clinical record.

(viii) For consumers under eighteen (18) years of age, a minimum of one (1) family encounter per five (5) business days of episode of care is required.

(ix) Programs must include four (4) to six (6) hours of active treatment per day and be provided at least four (4) days per week.
(x) Programs must not mix consumers receiving partial hospitalization services with consumers receiving outpatient behavioral health services.

(E) Exclusions shall be as follows:

(i) Consumers at imminent risk of harm to self or others are not eligible for services.

(ii) Consumers who concurrently reside in a group home or other residential care setting are not eligible for services.

(iii) Consumers who cannot actively engage in psychotherapy are not eligible for services.

(iv) Consumers with withdrawal risk or symptoms of a substance-related disorder whose needs cannot be managed at this level of care or who need detoxification services.

(v) Consumers who by virtue of age or medical condition cannot actively participate in group therapies are not eligible for services.

**Mental Health Rehabilitation Option (MRO) Services**

**Description of Service**

Effective July 1, 2010, the Medicaid Rehabilitation Option (MRO) Program went through a transformation from its current process. The Office of Medicaid Policy and Planning (OMPP), in conjunction with the Division of Mental Health and Addiction (DMHA), has developed a benefit plan structure for Medicaid members receiving MRO services. Currently, there are no prior authorization (PA) requirements and no benefit limitations imposed for members receiving MRO services during the benefit period. While members can continue to access MRO providers based on a self-referral, members who have a qualifying MRO diagnosis will be assigned a service package based on their individual level of need (LON).

The MRO service package will ensure the delivery of the right services, to the right person, at the right time.

**Overview**

MRO services are designed to assist in the rehabilitation of the consumer’s optimum functional ability in daily living activities. This is accomplished by assessing the consumer’s needs and strengths, developing an IICP that outlines objectives of care, including how MRO services assist in reaching the consumer’s rehabilitative and recovery goals, and delivering appropriate MRO services to the consumer.

**Provider Qualifications**

Three categories of providers may provide MRO services: Licensed Professional, QBHP, and OBHP. Each MRO service includes specific provider qualifications noted in the corresponding service definition.
Licensed Professional

A licensed professional is defined by any of the following provider types:

- A psychiatrist.
- A physician.
- A licensed psychologist or a psychologist endorsed as an HSPP.
- A Licensed Clinical Social Worker (LCSW).
- A Licensed Mental Health Clinician. (LMHC)
- A Licensed Marriage and Family Therapist. (LMFT)
- A Licensed Clinical Addiction Counselor, as defined under IC § 25-23.6-10.5.

Qualified Behavioral Health Professional (QBHP)

A QBHP is defined by any of the following provider types:

- An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
  - In psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana;
  - In pastoral counseling from an accredited university; or
  - In rehabilitation counseling from an accredited university.
- An individual who is under the supervision of a licensed professional, as defined above, is eligible for and working toward licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
  - In social work from a university accredited by the Council on Social Work Education;
  - In psychology from an accredited university;
  - In mental health counseling from an accredited university; or
  - In marital and family therapy from an accredited university.
- A licensed independent practice school psychologist under the supervision of a licensed professional, as defined above.
- An AHCP:
A physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5; or

A nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person’s license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC § 25-23-1-19.4(b).

Other Behavioral Health Professional (OBHP)

An OBHP is defined by any of the following provider types:

- An individual with an associate or bachelor degree, and/or equivalent behavioral health experience, meeting minimum competency standards set forth by the CMHC and supervised by a licensed professional, as defined above, or QBHP, as defined above.
- A LAC, as defined under IC§ 25-23.6-10.5 supervised by a licensed professional, as defined above, or QBHP, as defined above.

Service Requirements

MRO services are clinical behavioral health services provided to consumers and families of consumers living in the community who need aid intermittently for emotional disturbances, mental illness and addiction. Services may be provided in individual or group settings, and in the community. The IHCP provides reimbursement for the following MRO outpatient mental health services:

- AIRS (Adult intensive rehabilitative services)
- Addiction counseling
- Behavioral health counseling and therapy
- Behavioral health level of need redetermination
- Case management
- CAIRS (Child and adolescent intensive rehabilitative services)
- Crisis intervention
- IOT (Intensive outpatient treatment)
- Medication training and support
- Peer recovery services
• Psychiatric assessment and intervention
• Skills training and development

As stated in 405 IAC 5-21.5, IHCP reimbursement is available for consumers who meet specific diagnosis and LON criteria under the approved DMHA assessment tool or who submit PA for MRO services. Services must be provided through a behavioral health service provider that is an enrolled IHCP provider and offers a full continuum of care as defined under IC § 12-7-2-40.6 and 440 IAC 9. These providers may subcontract for services as appropriate. Provider staff delivering service must meet appropriate federal, state, and local regulations for their respective disciplines.

IICP/Treatment Plan Requirements

The IICP is a treatment plan that integrates all components and aspects of care deemed medically necessary, are clinically indicated and provided in the most appropriate setting to achieve recovery. An IICP must be developed for each consumer (405 IAC 5-21.5-16). The IICP must include all indicated medical and remedial services needed by the consumer to promote and facilitate independence and recovery. In addition, the IICP focuses on treating the disability and improving the consumer’s level of functioning. The IICP is developed through a collaborative effort that includes the consumer, identified community supports (family/nonprofessional caregivers), and all individuals involved in assessing and/or providing care for the consumer. The IICP is developed after completing a holistic clinical and biopsychosocial assessment. The holistic assessment includes documentation in the consumer’s medical record of the following:

• Review, discussion, and documentation of the consumer’s recovery desires, needs, and goals
  ➢ Goals are recovery oriented.
• Review of psychiatric symptoms and how they affect the consumer’s functioning and ability to attain recovery desires, needs, and goals
• Review of the consumer’s skills and the support needed for the consumer to participate in a recovery process, including the ability to function in living, working, and learning environments
• Review of the consumer’s strengths and needs, including medical, behavioral, social, housing, and employment

An IICP is developed with the consumer and must reflect the consumer’s desires and choices. The consumer’s signature demonstrating his or her participation in the development and ongoing IICP reviews is required. If a consumer refuses to sign, the provider must document that the IICP was discussed and the consumer chose not to sign. It also must include the following documentation:
• Outline of goals directed at recovery that promotes independence and integration into the community, treatment of mental illness symptoms, and rehabilitating areas of functional deficits related to the mental illness

• Individuals or teams responsible for treatment, coordination of care, linkage, and referrals to internal or external resources, and care providers to meet identified needs

• A comprehensive listing of all specific treatments and services that will be provided to the consumer

• Frequency, duration, and time frame of each service

• Review or a face-to-face visit by the supervising physician or HSPP at intervals not to exceed 90 days

A licensed professional, QBHP, or OBHP may document the consumer’s diagnosis(es) and complete the IICP. The diagnosis or diagnoses and IICP must be certified by a supervising physician or HSPP. Certification should be consistent with the Clinical Plan for Professional Services or similar document defining services under policies and procedures for the facility. Certification standards include date signed, statement of agreement with diagnoses and IICP, printed name, signature, and credentials of the licensed professional, QBHP, or OBHP completing the IICP, and the signature (written or electronic) and credentials of the certifying physician or HSPP.

Qualifying Diagnosis

The behavioral health diagnoses available through the ICD-9 and the DSM-IV-TR indicates a qualifying MRO diagnosis. A consumer must have at least one qualifying diagnosis from the list to be eligible for a MRO service package. Please note that adults and children/adolescents have unique qualifying diagnosis lists. The qualifying diagnosis for each consumer must be entered by the provider into the DMHA DARMHA system in order for a service package to be assigned. The approved diagnosis list for MRO services can be found in the MRO Provider Manual located at www.indiana.com.

Level of Need

In addition to a qualifying diagnosis, a Medicaid consumer must also have a qualifying LON, as demonstrated by the DMHA approved assessment tool. Currently, DMHA has approved the use of the CANS or ANSA. The CANS and ANSA are comprehensive, uniform assessment tools developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

The CANS or ANSA data for each consumer must be entered by the provider into the DMHA DARMHA system in order for an LON to be established and eligibility for an MRO service package to be determined.
Children with an LON of 2 and higher are eligible for an MRO service package. Adults with an LON of 3 and higher are also eligible for an MRO service package. Details regarding service packages may be found in Section 4 (Service Packages) and Appendix A of the MRO Provider Manual.

Consumers may present with the same diagnosis but have very different levels of needs. Service packages are designed to meet the consumer’s behavioral health needs based on his/her functional assessment and resulting LON.

**Exceptions**

A consumer who does not have either a qualifying diagnosis or LON necessary to access an MRO service package may submit PA for medically necessary MRO services. To do so, a provider must demonstrate that the consumer has a significant behavioral health need that would benefit from the provision of MRO services.

**Prior Authorization Requirements**

**Overview**

This section outlines the PA guidelines for MRO services provided beyond the assigned MRO service package. For more information about general PA, please refer to 405 IAC 5 and Chapter 6 of the IHCP Provider Manual. IHCP providers are responsible for reading and understanding portions of the IAC and manuals that apply to their areas of service.

**PA Vendor**

On behalf of the OMPP, ADVANTAGE Health Solutions-FFS Prior Authorization Department will review all MRO PA requests for IHCP consumers on a case-by-case basis. The decision to authorize, modify, or deny a PA request is based on medical necessity all applicable IACs provisions, PA guidelines, and IHCP bulletins, banner pages and newsletters.

**Allowable PA**

For the majority of consumers receiving MRO services, the assigned MRO service packages will provide a sufficient number of services and units of services to meet their needs. However, for consumers who require additional medically necessary services not included in the service package, or additional units of services assigned in the service package, a PA request is required. Under the four scenarios below (405 IAC 5-21.5-17), an MRO service provider will be required to submit a PA request to the PA vendor to be reimbursed for additional medically necessary services or units of service:

1. A consumer uses all of one (1) or more of the services authorized in the service package term, and additional units of that service are needed.
2. A consumer needs a service that is not authorized within a service package.
3. A service package provided through a certified DMHA ACT team

4. A consumer is who is denied an MRo service package may submit prior authorization for a specific MRO service.

Retroactive PA Policy

Requests for retroactive PA will not be authorized except where a consumer is newly eligible for Medicaid or had a lapse in his or her Medicaid eligibility and was determined Medicaid eligible for a retroactive period. Retroactive PA requests must be made within 12 months of a consumer’s eligibility determination date or 60 days of the provider receiving notice of a member’s eligibility. For all of the above scenarios, please note that MRO service providers are required to submit documentation that supports medical necessity.

Billing Requirements for MRO Services

Overview

This section outlines MRO billing guidelines. For more information about general billing, please refer to 405 IAC 1 or Chapter 8 of the IHCP Provider Manual. IHCP providers are responsible for reading and understanding portions of the IAC and manuals that apply to their areas of services.

Billing Standards

- IHCP rendering provider numbers are assigned to physicians or HSPPs. The rendering provider numbers are linked to the group provider number of the participating billing group.
- Reimbursement will be at 100% of the rate for all staff meeting provider qualifications for each service.
- Providers are responsible for internally tracking MRO service utilization to ensure that service units are available. Provider can confirm service unit availability via Web interChange, the State’s recognized final reference for this information.
- Units of MRO services, as displayed in Web interChange, are decremented based on adjudicated claims. Failure to submit claims in a timely fashion may place the provider at risk for nonpayment.
- In order for an MRO provider to receive reimbursement for the delivery of MRO services, a consumer must have an assigned MRO service package or prior authorized service units.
- Service packages will be assigned by IndianaAIM, the State’s Medicaid Management Information System (MMIS) or claims payment system.
A stepwise process has been created in AIM to assign service packages, pay claims, and track available service units.

All assignments for service packages and PA approvals/denials will be viewable on Web interChange. [https://interChange.indianamedicaid.com](https://interChange.indianamedicaid.com)

The AIM system and the service package assignment process is dependent upon reliable, accurate data submitted by the provider via DARMHA. Providers have the responsibility of ensuring that data and claims are submitted accurately and timely.

In order for an MRO provider to receive reimbursement for the delivery of MRO services, a consumer must have an assigned MRO service package or prior authorized service units.

Modifiers for MRO Services

The modifiers in Table 2 are needed for the submission of MRO claims.

**Table 2 – MRO Modifiers**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HW</td>
<td>Funded by State mental health program</td>
</tr>
<tr>
<td>U1</td>
<td>Group setting</td>
</tr>
<tr>
<td>HR</td>
<td>Family/couple with client present</td>
</tr>
<tr>
<td>HS</td>
<td>Family/couple without client present</td>
</tr>
<tr>
<td>UA</td>
<td>Non face-to-face encounter</td>
</tr>
<tr>
<td>HA</td>
<td>Child/adolescent program</td>
</tr>
<tr>
<td>HB</td>
<td>Adult program</td>
</tr>
</tbody>
</table>

CMHCs must use the HW modifier to denote MRO services, in addition to any modifiers that identify services rendered.

Midlevel Provider Modifiers

Midlevel provider modifiers should not be used when submitting MRO claims. The use of midlevel provider modifiers will result in the denial of the MRO claim.

HCPCS Codes

**Table 3 – MRO HCPCS Codes**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| H0004 HW   | Behavioral health counseling and therapy, per 15 minutes (Individual/Group
Managed Care Considerations

MRO services by provider type and specialty are carved out of the HHW managed care program. MRO providers are reimbursed for a carved-out service only if the rendering or supervising provider is enrolled with mental health provider specialty 011, 110-117, or 339 and is linked to a MRO provider billing number with the same specialty. Those claims for RBMC consumers are submitted to HP for processing. Chapter 8 of the IHCP Provider Manual provides additional information about mental health services for managed care enrollees.

MRO services are not available to consumers enrolled in the HIP.

For additional information on MRO services, please review the Medicaid Rehabilitation Option Provider Manual located at www.indianamedicaid.com.

Home and Community Based Waiver Services

A consumer may receive waiver services and other IHCP services, such as MRO services, at the same time. However, a federally approved waiver requires that waiver services not duplicate services already available. Service duplication would most likely occur in the following two areas:

- Skills Training and Development
- Case Management

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0005 HW</td>
<td>Alcohol and/or other drug services; group counseling by a clinician (Addiction counseling-group setting)</td>
</tr>
<tr>
<td>H0015 HW</td>
<td>Alcohol and/or other drug services; intensive outpatient, including assessment, counseling; crisis intervention, and activity therapy or education</td>
</tr>
<tr>
<td>H0031 HW</td>
<td>Mental health assessment, by non physician (Behavioral health level of need redetermination)</td>
</tr>
<tr>
<td>H0034 HW</td>
<td>Medication training and support, per 15 minutes</td>
</tr>
<tr>
<td>H0038 HW</td>
<td>Self help/peer recovery service, per 15 minutes</td>
</tr>
<tr>
<td>H2011 HW</td>
<td>Crisis intervention service, per 15 minutes</td>
</tr>
<tr>
<td>H2012 HW</td>
<td>Behavioral health day treatment, per hour</td>
</tr>
<tr>
<td>H2014 HW</td>
<td>Skills training and development, per 15 minutes</td>
</tr>
<tr>
<td>H2019 HW</td>
<td>Therapeutic behavioral services, per 15 minutes (Psychiatric Assessment and Intervention)</td>
</tr>
<tr>
<td>H2035 HW</td>
<td>Alcohol and/or other drug treatment program, per hour (Addiction counseling (individual setting))</td>
</tr>
<tr>
<td>T1016 HW</td>
<td>Case management, each 15 minutes</td>
</tr>
</tbody>
</table>
Waiver case managers are responsible for monitoring services to prevent duplication. The behavioral health service provider must coordinate the provision of services with the waiver case manager.

Other Outpatient Mental Health Services

Testing Services

PA is required for all units of testing which include codes CPT® 96101 – Psychological testing with interpretation and report by psychologist or physician per hour; 96110 – Developmental testing, with interpretation and report, per standardized instrument form; 96111 – Developmental testing (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report; 96116 – Neurobehavioral status exam, interpretation and report by psychologist or physician per hour, and 96118 – Neuropsychological testing.interpretation and report, by psychologist or physician per hour. A physician or a HSPP must provide all testing services, as well as interpretation and reporting.

Screening and Brief Intervention Services

Beginning October 1, 2008, the IHCP began reimbursing providers for screening and brief intervention (SBI) services. SBI identifies and intervenes with individuals who are at risk for substance abuse related problems or injuries. SBI services use established systems, such as trauma centers, emergency rooms, community clinics, and school clinics, to screen patients who are at risk for substance abuse and, if necessary, provide the patients with brief interventions or referrals to appropriate treatment. The IHCP reimburses providers when they bill procedure codes 99408 or 99409. The descriptions for the procedure codes are listed in Table 4.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99408</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services, 15-30 minutes</td>
</tr>
<tr>
<td>99409</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services, greater than 30 minutes</td>
</tr>
</tbody>
</table>

The new CPT® codes were developed by the American Medical Association (AMA) to make it possible for the healthcare system to “efficiently report screening services for drug and alcohol abuse.” Providers can bill procedure code 99408 or 99409 only after an individual has been screened for alcohol or drug abuse by a healthcare professional. SBI services currently do not require prior authorization. Procedure codes 99408 and 99409 are limited to one time per year, per member per provider. This does not count toward the number of annual office visits allowed per year for an individual.
Effective November 15, 2014, the IHCP will allow SBI services to be performed by the following midlevel licensed individuals under the supervision of a physician:

- Nurse practitioner (NP)
- Health service provider in psychology (HSPP)
- Licensed clinical social worker (LCSW)
- Licensed mental health counselor (LMHC)
- Licensed marriage and family therapist (LMFT)

Reimbursement for SBI services is restricted to the following places of service (POS) and corresponding codes:

- 04 – Homeless shelter
- 11 – Office
- 20 – Urgent care facility
- 23 – Emergency room
- 50 – Federally Qualified Health Center (FQHC)
- 72 – Rural Health Clinic (RHC)

Bridge Appointments

Effective December 1, 2011, the IHCP covers bridge appointments for Traditional Medicaid Fee-For-Service (FFS) members, for dates of service on or after December 1, 2011.

Bridge appointments are follow-up appointments after inpatient hospitalization for behavioral health issues, when no outpatient appointment is available within seven days of discharge. The goal of the bridge appointment is to provide proper discharge planning while establishing a connection between the member and the outpatient treatment provider.

During the bridge appointment, the provider should ensure at minimum that:

- The member understands the medication treatment regimen as prescribed.
- The member has ongoing outpatient care.
- The family understands the discharge instructions for the member.
- Barriers to continuing care are addressed.
- Any additional questions from the member or family are answered.

The following conditions must be met for bridge appointments to be reimbursed:

- Appointments must be conducted face-to-face in an outpatient setting on the day of discharge from an inpatient setting.
- Appointments must be a minimum of 15 minutes long.
- The member must have one or more identified barriers to continuing care, such as:
  - Special needs
  - Divorce or custody issues
- Work conflicts
- Childcare problems
- Inability to schedule within seven days
- History of noncompliance
- Complex discharge plans
- The member must have one of the diagnosis codes listed in Table 65.5. Bridge appointments may be appropriate for members with psychiatric diagnoses not listed; however, documentation must be maintained in the member’s chart, indicating the reason the bridge appointment service was necessary.

### Table 5 – Bridge Appointment Diagnosis Codes

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>295.XX - 295.9X</td>
<td>Schizophrenic Disorders</td>
</tr>
<tr>
<td>296.0X – 296.9X</td>
<td>Episodic Mood Disorders</td>
</tr>
<tr>
<td>297.0 – 297.9</td>
<td>Delusional Disorders</td>
</tr>
<tr>
<td>298.0 – 298.9</td>
<td>Depressive Type Psychosis</td>
</tr>
<tr>
<td>299.0X – 299.9X</td>
<td>Pervasive Development Disorders</td>
</tr>
<tr>
<td>300.3</td>
<td>Obsessive Compulsive Disorder</td>
</tr>
<tr>
<td>300.4</td>
<td>Dysthymic Disorder</td>
</tr>
<tr>
<td>309.0 – 309.9</td>
<td>Adjustment Reaction with Adjustment Disorder with Depressed Mood</td>
</tr>
<tr>
<td>311</td>
<td>Depressive Disorder Not Elsewhere Classified</td>
</tr>
<tr>
<td>312.0X – 312.9</td>
<td>Disturbance of Conduct Not Elsewhere Classified</td>
</tr>
<tr>
<td>313.0 – 313.9</td>
<td>Disturbance of Emotions Specific to Childhood and Adolescence</td>
</tr>
<tr>
<td>314.0X – 314.9</td>
<td>Hyperkinetic Syndrome of Childhood</td>
</tr>
</tbody>
</table>

The appointment must be conducted by a qualified mental health provider, defined as:

- A licensed psychologist
- A licensed independent practice school psychologist
- A licensed clinical social worker (LCSW)
- A licensed marital and family therapist (LMFT)
- A licensed mental health counselor (LMHC)
- A person holding a master’s degree in social work, marital and family therapy, or mental health counseling
- An advanced practice nurse (APN) who is a licensed, registered nurse holding a master’s degree in nursing, with a major in psychiatric or mental health nursing from an accredited school of nursing

The IHCP limits reimbursement of bridge appointments to one unit per member, per hospitalization. As previously noted, bridge appointments must be conducted face-to-face for a minimum of 15 minutes.

Providers must bill bridge appointments on a CMS-1500 form using CPT code 99401 – Preventive Medicine Counseling and/or Risk Factor Reduction Intervention(s) provided to an Individual, along with the HK modifier, to indicate bridge appointment service.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99401</td>
<td>Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual</td>
</tr>
</tbody>
</table>

**Rules, Citations and Sources**

405 IAC 5-2-19 – Outpatient Services Defined

405 IAC 5-3 – Prior Authorization

405 IAC 5-20-8 – Outpatient Mental Health Services

405 IAC 5-21.5 – Medicaid Rehabilitation Option Services

**IHCP Bulletins**

- BT201253
- BT 201149
- BT 201023
- BT 201015
- BT 201013
- BR 200923
IHCP Banner Page
BR200923

Medicaid Rehabilitation Option Provider Manual
IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics
Mental Health/Behavioral Health – Inpatient Services
Non-Cancer Hospice

Introduction

This section serves as a general summary of the IHCP’s policies regarding non-cancer hospice services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

Members enrolled in an IHCP MCE must disenroll. Disenrollment is necessary for hospice authorization to be completed. Members become eligible for hospice services the business day following disenrollment from the MCE.

To facilitate the hospice authorization process, the hospice provider may fax the Medicaid Hospice Election form to the PA Department of ADVANTAGE Health SolutionsSM to initiate MCE disenrollment. The corresponding Medicaid Hospice Physician Certification form and Medicaid Hospice POC form must be sent to the PA Department of ADVANTAGE Health SolutionsSM within 10 business days. If the hospice provider fails to verify IHCP eligibility or fails to fax the Medicaid Hospice Election form to the ADVANTAGE Health SolutionsSM PA Department, the hospice provider will not receive payment for the dates of service the member is an MCE member.

ADVANTAGE Health SolutionsSM preferred method for providers to submit PA requests is by faxing to (317) 810-4488. The fax is the most efficient manner for providers and the contractor to process hospice authorizations.

Because ADVANTAGE receives fax PA requests from all provider types, it is recommended that hospice providers follow up the fax with a telephone call to ADVANTAGE notifying the ADVANTAGE staff that a fax has been sent for disenrollment of a hospice member from managed care.

Description of Service

Hospice Care is a specialized form of interdisciplinary health care designed to alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phase of a terminal illness or disease. Hospice care also provides for the psychological, social, spiritual, and other needs of the hospice program patient’s family before and after the patient’s death.

The diagnostic information in this section was researched from the following organizations: American Academy of Neurology, American College of Cardiology, American Heart Association, American Lung Association, American Psychiatric Association, National Institute of Neurological Disorders and Stroke, Renal Physicians Association and American Society of Nephrology, and the U.S. National Library of Medicine and NIH.
Reimbursement Requirements

IHCP members in need of hospice care must be eligible for program services, must have a prognosis of six (6) months or less to live, and must elect hospice services.

In order for an individual to receive Medicaid-covered hospice services, a physician must certify in writing the individual is terminally ill and expected to die from that illness within six (6) months, if the terminal illness runs its normal course. Services provided in hospice care must be reasonable and medically necessary for the palliation or management of the terminal illness.

Benefit Periods

Hospice eligibility is available to qualifying IHCP-eligible members in three consecutive benefit periods. Table 1 lists the benefit periods.

Table 1 – Hospice Benefit Periods

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period I</td>
<td>90 days</td>
</tr>
<tr>
<td>Period II</td>
<td>90 days (expected maximum length of illness to run its course)</td>
</tr>
<tr>
<td>Period III</td>
<td>Unlimited 60 day period</td>
</tr>
</tbody>
</table>

IHCP Hospice Provider Manual

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, TPL, medical policy, PA, utilization review, or inspection of care.

Covered Services

Hospice core services are covered services in the Medicare and IHCP hospice per diem that must be provided directly to members by hospice employees. Hospice core services include nursing services, medical social work services, and counseling services (including bereavement, dietary, spiritual, and other services). Hospice non-covered services are services in the Medicare or IHCP hospice per diem not identified as hospice core services. The following is a list of 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 who is part of the IDT participating in services as follows:
General supervising services, participating in the establishment and supervision of 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 and occupation therapy, and speech-language pathology services provided for the purpose of symptom control
- Inpatient hospice care, such as inpatient hospice respite or general inpatient 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 POC, if the item or service is a covered service under the Medicare program and required to treat the terminal illness or related conditions

Hospice Plan of Care

The IHCP hospice benefit program mirrors the covered services and reimbursement methodology of the Medicare hospice program. IHCP hospice providers are required to comply with federal hospice regulations located at 42 CFR, Part 418 et seq. The Medicare Conditions of Participation (CoPs) were updated January 23, 2006 to affect change in the Balanced Budget Act of 1997.

These regulations require hospice providers to list all hospice covered services in frequency and scope on the hospice POC necessary to treat the terminal illness and related conditions. Additionally, IHCP hospice providers must be Medicare-certified and licensed as hospice providers by ISDH as a condition of provider enrollment.

Treatment of Non-terminal 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 non-terminal conditions may be met by one of the following methods:
• Outpatient physician services
• Inpatient and outpatient hospital admissions
• Emergency admissions to a NF 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 providers’ responsibility for the treatment of non-terminal 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 non-terminal condition, the hospice provider is required to locate appropriate IHCP services for the treatment of a non-terminal condition.
• To ensure that the hospice member is not billed for these services, the hospice provider must ensure the non-hospice provider is enrolled as an IHCP provider.
• The hospice provider must communicate and coordinate with the non-hospice provider’s personnel to ensure the source 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 a Change in Status of Medicaid Hospice Patient form to the PA Department of ADVANTAGE Health SolutionsSM. 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 non-terminal illness must obtain PA for these services. The following services do not require PA for the treatment of non-terminal conditions:

• Pharmacy services not related to the member’s terminal condition
• Dental services
• Vision care services

Any Medicaid member who is terminally ill and meets medical necessity criteria may receive services from an IHCP hospice provider. Hospice providers are required to comply with federal hospice regulations at 42 CFR, Part 418, and the Balanced Budget Act of 1997, which requires hospice providers to list all hospice covered services in frequency and scope on the hospice plan of care (POC) necessary to treat the terminal illness and related conditions.

Furthermore, 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 care.
Amyotrophic Lateral Sclerosis (ALS)

The following information is for general diagnosis and consideration of medical necessity for ALS.

- ALS tends to progress in a linear fashion over time; therefore, the overall rate of decline in each patient is fairly constant and predictable, unlike many other non-cancer diseases.
- No single variable deteriorates at a uniform rate in all patients; therefore, multiple clinical parameters are required to judge the progression of ALS.
- Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time patients become end-stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist.
- Progression of disease differs markedly from patient to patient. Some patients decline rapidly and die quickly; others progress more slowly. For this reason, the history of the rate of progression in individual patients is important to predict prognosis.
- In end-stage ALS, two factors are critical in determining prognosis. These factors are the ability to breathe and the ability to swallow. The ability to breathe can be managed by artificial ventilation, and the ability to swallow by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. While not necessarily a contraindication to hospice care, the decision to institute either artificial ventilation or artificial feeding will significantly alter a six-month prognosis.
- Examination by a neurologist within three months of assessment for hospice is advised, both to confirm the diagnosis and to assist with prognosis.

All members must demonstrate a rapid progression of ALS within the 12 months preceding initial hospice certification. All the following clinical findings document this progression:

- Progression from independent ambulation to wheelchair, or to bed-bound status
- Progression from normal to barely intelligible or unintelligible speech
- Progression from normal to pureed diet
- Progression from independence in most or all ADLs to needing maximum assistance by caretaker in all ADLs

All members must demonstrate critically impaired breathing capacity by the following characteristics occurring within 12 months preceding initial hospice certification. Presence of any of the following will support a terminal illness status:

- Vital capacity is less than 30 percent of normal
- Significant dyspnea at rest
• Requiring supplemental oxygen at rest
• Patient declines artificial ventilation

All members must demonstrate critical nutritional impairment by all the following characteristics occurring within 12 months preceding initial hospice certification:

• Oral intake of nutrients and fluids insufficient to sustain life
• Continuing weight loss
• Dehydration or hypovolemia
• Absence of artificial feeding methods

All members must demonstrate life-threatening complications by one of the following characteristics occurring within 12 months preceding initial hospice certification:

• Recurrent aspiration pneumonia (with or without tube feedings)
• Upper UT infection, e.g., pyelonephritis
• Sepsis
• Fever recurrent after antibiotic therapy

Table 2 includes the only ICD-9-CM code for ALS. This is the only code appropriate for ALS hospice services.

Table 2 – ALS Diagnosis

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>335.20</td>
<td>Amyotrophic Lateral Sclerosis</td>
</tr>
</tbody>
</table>

Alzheimer’s disease and related disorders

Alzheimer’s disease and related disorders must support a prognosis of six months or fewer to meet the medical necessity for hospice services. The identification of specific structural impairments, functional impairments, and relevant activity limitations serves as the basis for palliative interventions and care planning.

The structural and functional impairments associated with a primary diagnosis of Alzheimer’s disease may be complicated by co-morbid or secondary conditions. Documentation of structural impairments, functional impairments, and activity limitations facilitates the selection of intervention strategies and provides objective criteria for determining the effects of such interventions.
Co-morbid conditions

- The significance of a given co-morbid condition is defined by the structural and functional impairments, together with any limitation in activity related to the co-morbid condition.
- Ultimately, the combined effect of Alzheimer’s disease (stage 7) and any co-morbid condition should be such that most members with Alzheimer’s disease and similar impairments would have a prognosis of six months or fewer.

Secondary conditions

- Secondary conditions, such as delirium and pressure ulcers, are directly related to a primary condition.
- Secondary conditions may be described by defining the structural or functional impairments, together with any limitation in activity or related to the secondary condition.
- The occurrence of secondary conditions in members with Alzheimer’s disease may be facilitated by the presence of impairments in body functions, such as mental functioning and movement functions.
- Such functional impairments may contribute to the increased incidence of secondary conditions, such as delirium and pressure ulcers.
- Secondary conditions themselves may be associated with a new set of structural or functional impairments that may respond to treatment.
- The combined effects of the Alzheimer’s disease and any secondary condition may indicate a prognosis of six months or fewer.

The Reisberg Functional Assessment Staging (FAST) Scale may be used to assess the functional level of members with Alzheimer’s disease and establish a prognosis of six months or fewer. Members who have a FAST score of 7 and specific co-morbid or secondary conditions may meet medical necessity.

Table 3 includes appropriate ICD-9-CM codes for Alzheimer’s disease and related diagnoses that may meet medical necessity for non-cancer hospice services.

**Table 3 – Alzheimer’s Disease and Related Disorder Diagnoses**

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>291.2</td>
<td>Alcohol-induced persisting dementia</td>
</tr>
<tr>
<td>331.0</td>
<td>Alzheimer’s disease</td>
</tr>
<tr>
<td>331.11</td>
<td>Pick’s disease</td>
</tr>
<tr>
<td>331.2</td>
<td>Senile degeneration of brain</td>
</tr>
</tbody>
</table>
**Cardiopulmonary Disease**

Cardiopulmonary conditions are associated with impairments, activity limitations, and disability. Their impact on any given individual depends on the individual’s overall health status. Cardiopulmonary conditions may support a prognosis of six months or less under many clinical scenarios.

The health status changes associated with cardiopulmonary conditions can be characterized using categories contained in the ICF. The ICF contains domains (for example, structures of cardiovascular and respiratory systems, functions of the cardiovascular and respiratory system, communication, mobility, and self-care) that allow for a comprehensive description of an individual’s health status and service needs. Information addressing relevant ICF categories, defined within each of these domains, should form the core of the clinical record and be incorporated into the care plan, as appropriate.

Additionally, the care plan may be impacted by relevant secondary and/or comorbid conditions. Secondary conditions are directly related to a primary condition. In the case of cardiopulmonary conditions, examples of secondary conditions could include delirium, pneumonia, stasis ulcers, and pressure ulcers. Comorbid conditions affecting beneficiaries with cardiopulmonary conditions are, by definition, distinct from the primary condition itself. An example of a comorbid condition would be end-stage renal disease (ESRD).

The important roles of secondary and comorbid conditions are described in the following sections to facilitate their recognition and assist providers in documenting their impact. The identification and documentation of relevant secondary and comorbid conditions, together with the identification and description of associated structural/functional impairments, activity limitations, and environmental factors would help establish hospice eligibility and maintain a beneficiary-centered plan of care.

**Secondary Conditions**

Cardiopulmonary conditions may be complicated by secondary conditions. The significance of a given secondary condition is best described by defining the structural/functional impairments – together with any limitation in activity and restriction in participation – related to the secondary condition. The occurrence of secondary conditions in beneficiaries with cardiopulmonary conditions results from the presence of impairments in such body functions as heart/respiratory rate and rhythm, contraction force of ventricular muscles, blood supply to the heart, sleep functions, and depth of respiration. These impairments contribute to the increased incidence of secondary conditions such as delirium, pneumonia, stasis ulcers, and pressure ulcers observed in Medicaid beneficiaries with cardiopulmonary conditions. Secondary conditions themselves may be associated with a new set of structural/functional impairments that may or may not respond/be amenable to treatment.
Ultimately, to support a hospice plan of care, the combined effects of the primary cardiopulmonary condition and any identified secondary conditions should be such that most beneficiaries with the identified impairments would have a prognosis of six months or less.

Comorbid Conditions

The significance of a given comorbid condition is best described by defining the structural/functional impairments – together with any limitation in activity and restriction in participation – related to the comorbid condition. For example, a beneficiary with a primary cardiopulmonary condition and ESRD could have specific ESRD-related impairments of water, mineral, and electrolyte balance functions coexisting with the cardiopulmonary impairments associated with the primary cardiopulmonary condition, such as aortic stenosis, chronic obstructive pulmonary disease, or heart failure)

Ultimately, to support a hospice plan of care, the combined effects of the primary cardiopulmonary condition and any identified comorbid conditions should be such that most beneficiaries with the identified impairments would have a prognosis of six months or less.

The documentation of structural/functional impairments and activity limitations facilitate the selection of the most appropriate intervention strategies (palliative/hospice vs. long-term disease management) and provide objective criteria for determining the effects of such interventions. The documentation of these variables is thus essential in the determination of reasonable and necessary IHCP Hospice Services

Heart Disease

Member must have current findings from numbers 1 and 2 below. Findings from number 3 are primarily supportive documentation for medical necessity.

1. Member has been treated with diuretics and vasodilators, which may include ACE inhibitors or the combination of hydralazine and nitrates. If side effects, such as hypotension or hyperkalemia, prohibit the use of ACE inhibitors or the combination of hydralazine and nitrates, the documentation submitted must reflect this reasoning. If a member has angina pectoris at rest that is resistant to standard nitrate therapy; and if the member is not a candidate for or declines invasive procedures, these factors must be documented in the medical records.

2. Member has significant findings of recurrent congestive heart failure at rest and is classified as NYHA Class III or IV. Class III or IV patients with heart disease cannot carry on any physical activity without discomfort. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort increases. Class III heart failure (moderate) is defined as the marked limitation of physical activity. These patients are comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea. Class IV heart failure (severe) is defined as the inability to carry out any physical activity without
discomfort, along with symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort increases.

3. Congestive heart failure may be documented by an ejection fraction of < 40 percent. Documentation of an ejection fraction is not required if it is not already available.

4. Documentation of the following findings will support eligibility for hospice care:
   a. Treatment resistant symptomatic supraventricular or ventricular arrhythmias
   b. History of cardiac arrest or resuscitation
   c. History of unexplained syncope
   d. Brain embolism of cardiac origin
   e. Concomitant HIV disease
   f. Documentation of ejection fraction – 40 percent or less

Table 4 includes appropriate ICD-9-CM codes for heart disease diagnoses that may meet medical necessity for non-cancer heart disease hospice services.

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>411.1</td>
<td>Intermediate coronary syndrome</td>
</tr>
<tr>
<td>412</td>
<td>Old myocardial infarction</td>
</tr>
<tr>
<td>428.0</td>
<td>Congestive heart failure, unspecified</td>
</tr>
<tr>
<td>428.1</td>
<td>Left heart failure</td>
</tr>
<tr>
<td>428.30</td>
<td>Diastolic heart failure, unspecified</td>
</tr>
<tr>
<td>428.9</td>
<td>Heart failure, unspecified</td>
</tr>
</tbody>
</table>

**Pulmonary Disease**

Member must have current findings from numbers 1 through 5. Findings from numbers 6 through 9 primarily support documentation for medical necessity.

1. Severe chronic lung disease, as documented by both sections a and b:
   a. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, which results in decreased functional capacity; e.g., bed to chair existence, fatigue, and cough.
   b. Prior visits to the emergency department or hospitalizations, which have increased over time, for pulmonary infections or respiratory failure indicating end-stage pulmonary disease.

2. Progression of end-stage pulmonary disease, as evidenced by the following:
a. Prior increasing visits to the emergency department  
b. Prior hospitalizations for pulmonary infections  
c. Respiratory failure (documentation of FEV1 – forced expiratory volume after one second) < 30 percent is objective evidence for disease progression that may not be necessary to obtain  

3. Swelling in the lower extremities which may indicate cor pulmonale or right-sided heart failure, secondary to pulmonary disease, e.g., not secondary to left heart disease or valvulopathy  

4. Hypoxemia  

5. Long-term oxygen therapy  

6. Unintentional progressive weight loss of greater than 10 percent of body weight over the preceding six months  

7. Resting tachycardia >100/min  

8. Previous use of ventilator during hospital admissions  

9. Pulmonary hypertension  

There is no ICD-9-CM diagnosis code for end-stage pulmonary disease. Diagnoses for pulmonary diseases which lead to end-stage pulmonary disease will be covered with appropriate documentation supporting medical necessity.  

Table 5 includes appropriate ICD-9-CM codes for pulmonary disease diagnoses that may meet medical necessity for non-cancerous pulmonary disease hospice services.  

### Table 5 – Pulmonary Disease Diagnoses  

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>416.0</td>
<td>Primary pulmonary hypertension</td>
</tr>
<tr>
<td>416.9</td>
<td>Chronic pulmonary heart disease, unspecified</td>
</tr>
<tr>
<td>496</td>
<td>Chronic airway obstruction, not elsewhere classified</td>
</tr>
<tr>
<td>799.02</td>
<td>Hypoxemia</td>
</tr>
<tr>
<td>799.1</td>
<td>Respiratory arrest</td>
</tr>
</tbody>
</table>

### HIV/AIDS  

Member must have current findings from numbers 1 and 2 below. Findings from number 3 primarily support documentation for medical necessity.  

1. CD4+ count less than or equal to 200 cells/mm3 or persistent viral load >100,000 copies/ml, plus one of the following findings:  
   a. CNS lymphoma
b. Wasting (loss of 33 percent of lean body mass), untreated or not responsive to treatment

c. Mycobacterium avium complex bacteremia, untreated, unresponsive to treatment, or treatment refused

d. Progressive multifocal leukoencephalopathy

e. Systemic lymphoma with advanced HIV disease and partial response to chemotherapy

f. Visceral Kaposi’s sarcoma, unresponsive to therapy

g. Renal failure in the absence of dialysis

h. Cryptosporidium infection

i. Toxoplasmosis, unresponsive to therapy

2. Decreased performance status, as measured by the Karnofsky Performance Status Scale, of < 50 percent

3. Documentation of the following findings will support eligibility for hospice care:

   a. Chronic persistent diarrhea for one year

b. Persistent serum albumin <2.5 gm/dl

c. Age > 50 years old.

d. Absence of antiretroviral, chemotherapeutic, and prophylactic drug therapy related specifically to HIV disease

e. Toxoplasmosis

f. Congestive heart failure, symptomatic at rest

g. Advanced AIDS dementia complex

h. Concomitant, active substance abuse

Table 6 includes the appropriate ICD-9-CM code for HIV diagnosis that meets medical necessity for non-cancerous HIV hospice services. No other HIV-related diagnosis will be covered. Table 7 illustrates examples of ICD-9-CM codes that are non-covered.

**Table 6 – HIV Diagnosis**

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>042</td>
<td>Human immunodeficiency virus (HIV) disease</td>
</tr>
</tbody>
</table>
Table 7 – Examples of Non-Covered HIV ICD-9-CM Codes

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>795.71</td>
<td>Nonspecific serologic evidence of human immunodeficiency virus (HIV)</td>
</tr>
<tr>
<td>V08</td>
<td>Asymptomatic human immunodeficiency virus (HIV) infection status</td>
</tr>
</tbody>
</table>

Liver Disease

Members must have current findings from numbers 1 and 2 below. Findings from number 3 primarily support documentation for medical necessity.

1. The member must present with findings from both a and b:
   a. Prothrombin time prolonged more than five seconds over control, or International Normalized Ratio (INR) >1.5
   b. Serum albumin <2.5 gm/dl

2. End-stage liver disease is present, and the patient shows at least one of the following:
   a. Ascites, refractory to treatment or patient non-compliant
   b. Spontaneous bacterial peritonitis
   c. Hepatorenal syndrome (elevated creatinine and BUN with oliguria (<400 ml/day) and urine sodium concentration <10 meq/l)
   d. Hepatic encephalopathy, refractory to treatment, or patient non-compliant
   e. Recurrent variceal bleeding, despite intensive therapy

3. Documentation of the following findings will support eligibility for hospice care:
   a. Progressive malnutrition
   b. Muscle wasting with reduced strength and endurance
   c. Continued active alcoholism (>80 gm ethanol/day)
   d. Hepatocellular carcinoma
   e. Hepatitis B surface antigen (HBsAg) positive
   f. Hepatitis C refractory to interferon treatment

Members awaiting a liver transplant who otherwise fit the non-cancerous hospice criteria may receive hospice benefits. However, if a donor organ is procured, the member must be discharged from hospice services.

Table 8 includes appropriate ICD-9-CM liver disease diagnoses that meet medical necessity for non-cancerous liver disease hospice services.
Table 8 – Liver Disease Diagnoses

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>155.0</td>
<td>Malignant neoplasm of liver, primary</td>
</tr>
<tr>
<td>571.2</td>
<td>Alcoholic cirrhosis of liver</td>
</tr>
<tr>
<td>571.40</td>
<td>Chronic hepatitis, unspecified</td>
</tr>
<tr>
<td>571.41</td>
<td>Chronic persistent hepatitis</td>
</tr>
<tr>
<td>571.49</td>
<td>Chronic hepatitis, other</td>
</tr>
<tr>
<td>571.5</td>
<td>Cirrhosis of liver without mention of alcohol</td>
</tr>
<tr>
<td>571.6</td>
<td>Biliary cirrhosis</td>
</tr>
<tr>
<td>572.2</td>
<td>Hepatic encephalopathy</td>
</tr>
<tr>
<td>572.4</td>
<td>Hepatorenal syndrome</td>
</tr>
<tr>
<td>573.3</td>
<td>Hepatitis, unspecified</td>
</tr>
</tbody>
</table>

Renal Disease

Members with acute renal failure must have current findings from numbers 1 and 2 below. Findings from number 3 primarily support documentation for medical necessity.

1. Creatinine clearance < 10 cc/min (<15 cc/min for diabetics)
2. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)
3. Co-morbid conditions
   a. Mechanical ventilation
   b. Malignancy (other organ system)
   c. Intractable hyperkalemia (>7.0), not responsive to treatment
   d. Uremic pericarditis
   e. Hepatorenal syndrome
   f. Intractable fluid overload, not responsive to treatment
   g. Immunosuppression/AIDS
   h. Albumin <3.5 gm/dl
   i. Cachexia
   j. Platelet count <25,000
   k. Disseminated intravascular coagulation
   l. Gastrointestinal bleeding
m. Chronic lung disease
n. Advanced cardiac disease
o. Advanced liver disease
p. Sepsis

Member with chronic renal failure must have current findings from numbers 1 and 2 below. Findings from number 3 primarily support documentation for medical necessity.

1. Creatinine clearance <10cc/min (<15 cc/min for diabetics)
2. Serum creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics)
3. Signs and symptoms of renal failure
   a. Uremia
   b. Oliguria (<400 cc/day)
   c. Intractable hyperkalemia (>7.0) not responsive to treatment
   d. Uremic pericarditis
   e. Hepatorenal syndrome
   f. Intractable fluid overload, not responsive to treatment

Table 9 includes appropriate ICD-9-CM codes for kidney disease diagnoses that meet medical necessity for non-cancerous kidney disease hospice services.

**Table 9 – Renal Diagnoses**

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>403.11</td>
<td>Hypertensive chronic kidney disease, benign, with chronic kidney disease,</td>
</tr>
<tr>
<td></td>
<td>Stage V or end stage renal disease</td>
</tr>
<tr>
<td>584.5</td>
<td>Acute kidney failure with lesion of tubular necrosis</td>
</tr>
<tr>
<td>584.6</td>
<td>Acute kidney failure with lesion of renal cortical necrosis</td>
</tr>
<tr>
<td>584.7</td>
<td>Acute kidney failure with lesion of renal medullary (papillary) necrosis</td>
</tr>
<tr>
<td>584.8</td>
<td>Acute kidney failure with other specified pathological lesion in kidney</td>
</tr>
<tr>
<td>584.9</td>
<td>Acute kidney failure, unspecified</td>
</tr>
<tr>
<td>585.6</td>
<td>End stage renal disease</td>
</tr>
<tr>
<td>586</td>
<td>Renal failure, unspecified</td>
</tr>
</tbody>
</table>

**Stroke and Coma**

**Stroke**
The medical criteria listed below support a terminal prognosis for members with a diagnosis of stroke. Medical criteria are indicators of functional and nutritional status that support medical necessity for hospice services.

- **Palliative Performance Scale (PPS) of 40.**
  - Degree of ambulation (i.e., bedridden)
  - Activity and extent of disease (i.e., unable to work and extensive disease)
  - Inability for self-care (i.e., assistance needed) or the incapability of regaining the ability for self-care
  - Food and fluid intake (i.e., greatly reduced or reduced to the point of inability to maintain homeostasis)
  - State of consciousness (i.e., fully conscious, drowsy, or confused)
- **Inability to maintain hydration and caloric intake with one of the following:**
  - Weight loss > 10 percent during previous six months
  - Weight loss > 7.5 percent in previous three months
  - Serum albumin > 2.5 gm/dl
  - Current history of pulmonary aspiration without effective response to intervention by a speech/language therapist
  - Calorie counts documenting inadequate caloric and fluid intake
- **Determination of the inability to improve by a neurologist, neurosurgeon, internal medicine specialist, or family practitioner, along with a review by a PT or OT.**

If a member does not meet the medical criteria, documentation must describe a relevant co-morbidity and rapid decline of functional abilities. For example, a stroke patient with a co-morbidity (i.e., Alzheimer’s, Parkinson’s disease, adult failure to thrive syndrome, or ALS) may not be able to regain functionality.

**Coma**

Medical criteria listed below may support a terminal prognosis for members with a diagnosis of coma when any three of the following conditions are met on day three of a coma:

- Abnormal brain stem response
- Absent verbal response
- Absent withdrawal response to pain
- Serum creatinine > 1.5 mg/dl
Medical criteria is based on a neurological evaluation, which may include an electroencephalography (EEG), magnetic resonance imaging (MRI), or computed axial tomography (CT scan).

Table 10 includes appropriate ICD-9-CM codes for stroke and coma diagnoses that meet medical necessity for non-cancerous stroke or coma hospice services.

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>430</td>
<td>Subarachnoid hemorrhage</td>
</tr>
<tr>
<td>431</td>
<td>Intracerebral hemorrhage</td>
</tr>
<tr>
<td>432.0</td>
<td>Nontraumatic extradural hemorrhage</td>
</tr>
<tr>
<td>432.1</td>
<td>Subdural hemorrhage</td>
</tr>
<tr>
<td>432.9</td>
<td>Unspecified intracranial hemorrhage</td>
</tr>
<tr>
<td>433.01</td>
<td>Occlusion and stenosis of basilar artery, with cerebral infarction</td>
</tr>
<tr>
<td>433.11</td>
<td>Occlusion and stenosis of carotid artery, with cerebral infarction</td>
</tr>
<tr>
<td>433.21</td>
<td>Occlusion and stenosis of vertebral artery, with cerebral infarction</td>
</tr>
<tr>
<td>433.31</td>
<td>Occlusion and stenosis of arteries multiple and bilateral, with cerebral infarction</td>
</tr>
<tr>
<td>433.81</td>
<td>Occlusion and stenosis of other specified precerebral artery, with cerebral infarction</td>
</tr>
<tr>
<td>433.91</td>
<td>Occlusion and stenosis of unspecified precerebral artery, with cerebral infarction</td>
</tr>
<tr>
<td>434.01</td>
<td>Cerebral thrombosis, with cerebral infarction</td>
</tr>
<tr>
<td>434.11</td>
<td>Cerebral embolism, with cerebral infarction</td>
</tr>
<tr>
<td>434.91</td>
<td>Cerebral artery occlusion, unspecified, with cerebral infarction</td>
</tr>
<tr>
<td>436</td>
<td>Acute but ill-defined cerebrovascular disease</td>
</tr>
<tr>
<td>780.01</td>
<td>Coma</td>
</tr>
<tr>
<td>850.4</td>
<td>Concussion with prolonged loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.05</td>
<td>Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.15</td>
<td>Cortex (cerebral) contusion with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>851.25</td>
<td>Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.35</td>
<td>Cortex (cerebral) laceration with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.45</td>
<td>Cerebellar or brainstem contusion without mention of open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.55</td>
<td>Cerebellar or brainstem contusion with open intracranial wound with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.65</td>
<td>Cerebellar or brainstem laceration without mention of open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.75</td>
<td>Cerebellar or brain stem laceration with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.85</td>
<td>Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.95</td>
<td>Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>852.05</td>
<td>Subarachnoid hemorrhage following injury without mention of open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>852.15</td>
<td>Subarachnoid hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness without return to pre-existing conscious level</td>
</tr>
<tr>
<td>852.25</td>
<td>Subdural hemorrhage following injury without mention of open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>852.35</td>
<td>Subdural hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>852.45</td>
<td>Extradural hemorrhage following injury without mention of open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level</td>
</tr>
</tbody>
</table>
### 852.55
Extradural hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level

### 853.05
Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level

### 853.15
Other and unspecified intracranial hemorrhage following injury with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level

### 854.05
Intracranial injury of other and unspecified nature without mention of open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level

### 854.15
Intracranial injury of other and unspecified nature with open intracranial wound, with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level

### 997.02
Iatrogenic cerebrovascular infarction or hemorrhage

## Adult Failure to Thrive Syndrome

The following information is for general diagnosis and consideration of medical necessity for adult failure to thrive syndrome:

- The adult failure to thrive syndrome is characterized by unexplained weight loss, malnutrition, and disability.
- This syndrome has been associated with multiple primary conditions (e.g., infections and malignancies), but always includes two defining conditions, those being malnutrition and disability.
- The syndrome may be an irreversible progression in the member’s malnutrition or worsening of disability despite therapy (i.e., failure of treatment intended to affect the primary condition responsible for the patient’s clinical presentation).
- Co-morbid conditions may increase the progression of this syndrome and should be identified and addressed.

The following medical criteria would support a terminal prognosis of adult failure to thrive syndrome.

- Nutritional impairment should be significant enough to have an impact on the member’s weight.
  - Member’s BMI is below 22kg/m².
  - Member is either refusing enteral/parenteral nutritional support or has not responded to such nutritional support, despite an adequate caloric intake.
• Disability associated with adult failure to thrive should be such that the member is significantly disabled, which would be demonstrated by a Karnofsky or Palliative Performance scale value less than or equal to 40 percent.

Both the BMI and the level of disability of the member should be determined using measurements and observations made within six months (180 days) of the most recent certification/recertification date. If enteral nutritional support has been instituted before considering hospice and will be continued, the BMI and levels of disability should be determined using measurements and observations at the time of the initial certification and at each subsequent recertification for hospice.

At the time of recertification, recumbent measurements, such as mid-arm muscle area in cm², may be used instead of BMI measurement, so long as there is documentation proving the necessity of such replacement in the member’s file.

Also, in the event a member with nutritional impairment does not meet the criteria of refusing enteral/parenteral nutritional support or has not responded to nutritional support (as listed above) but is still considered eligible for non-cancerous hospice care, he or she may have an alternative diagnosis that adequately describes the clinical circumstances of the member (e.g., 783.2 – abnormal loss of weight and 799.4 – Cachexia).

Following are the documentation requirements needed for non-cancer hospice admission of members with adult failure to thrive syndrome:

• Documentation supporting the medical necessity should be legible, maintained in the member’s medical records, and be available for review on request.

• Documentation certifying terminal status must contain sufficient information to confirm that the status is based on the criteria of medical necessity.

• Both measurement of BMI and functional status of the member using the Karnofsky scale must be documented every 180 days for recertification of hospice benefits.

Table 11 includes appropriate ICD-9-CM codes for diagnoses that meet medical necessity for non-cancerous adult failure to thrive syndrome.

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>783.41</td>
<td>Failure to thrive</td>
</tr>
<tr>
<td>783.7</td>
<td>Adult failure to thrive</td>
</tr>
<tr>
<td>799.3</td>
<td>Debility, unspecified</td>
</tr>
<tr>
<td>799.89</td>
<td>Other ill-defined conditions</td>
</tr>
<tr>
<td>799.9</td>
<td>Other unknown and unspecified cause of morbidity or mortality</td>
</tr>
</tbody>
</table>
Medicaid Waiver Members

Members who receive home and community-based services through one of the IHCP waiver programs are eligible for IHCP hospice services. IHCP waiver members who choose the IHCP hospice benefit do not have to disenroll from the waiver program.

However, they must be under direct care of the IHCP hospice provider for those services that both programs have in common. The member may continue to receive waiver services that are not related to the terminal condition and are not duplicative of hospice services.

The IHCP expects the hospice provider to coordinate with other non-hospice providers to ensure the member’s overall care is met and non-hospice providers do not compromise the hospice POC. The hospice provider and the waiver case manager must collaborate and communicate regularly to ensure that the best possible care is provided.

The number of hours related to the member’s non-terminal condition is determined on a case specific basis. The member should not be provided with additional waiver services other than those the IHCP waiver program would have provided if the waiver member had not elected hospice care.

Prior Authorization Requirements

IHCP reimbursement is available for hospice services when PA is received in accordance with the PA guidelines. The Indiana Health Coverage Programs (IHCP) Hospice Provider Manual provides complete information about the hospice program and prior authorization process. Specific criteria pertaining to PA for hospice services can be found in 405 IAC 5-34-4.

IHCP reimbursement is not available for hospice services furnished without prior authorization.

Hospice providers are required to use hospice revenue code 651 when requesting PA for non-cancerous hospice services. Providers are also required to use the Indiana Prior Review and Authorization Request Form. If any other revenue code is used, the hospice PA review from ADVANTAGE Health Solutions SM will suspend the request pending correction by the provider. For billing purposes, providers should use the most appropriate revenue code.

Documentation Requirements

The individual must have a terminal prognosis as well as the physician certification that meets the Medicare guidelines of participation (providers can refer to Chapter 6 of the IHCP Provider Manual for a description of the certification requirements).

- The clinical evidence must support the terminal diagnosis at the time of the initial certification and at the time of each subsequent certification and must describe the patient’s condition.
• Documentation must illustrate why the patient is considered to be terminal and not chronic. History is helpful when it provides clarification as to why the current documentation only reflects a chronic condition.

• Each patient’s documentation must be specific to the individual and include any additional documentation, which distinguishes this patient from other patients with the same disease who may be chronic but who are not terminal.

• For each hospice benefit period, the interdisciplinary team must assess the patient’s condition and hospice appropriateness and the documentation must distinguish between exacerbation and stabilization as well as exacerbation and deterioration.

• The documentation must include the most specific and most terminal ICD-9 code appropriate to the patient.

• The documentation must specify why any medication, treatments, or services could be considered aggressive are considered necessary for the patient’s palliative treatment.

• The patient’s decline must be documented in detail.

• Providers must show how the systems of the body are in a terminal condition.

For PA, 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 LMRP, to determine when hospice services meet medical necessity.

Hospice providers are reminded that the IHCP recognizes that the local medical review policies (LMRP) are only guidelines to determine when members may qualify for hospice or 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.

Documentation is used in the PA and review process to determine the presence of medical necessity. Each case will be evaluated on its own merit. The existence of documented co-morbidities, as well as the documentation of decline in the member’s health status, will be used in the evaluation. Existence of a patient advance directive should also be taken into consideration.

The IHCP will use existing medical documentation submitted by the hospice provider to determine medical necessity for hospice. Existing labs and other forms of medical tests may be helpful to determine appropriateness for hospice care and may be requested of the provider if such documentation exists; however, the IHCP would not expect the patient to undergo invasive tests at the end of life unless they were absolutely necessary to validate a prognosis.
The IHCP and its contractors are not prevented from requesting medical documentation about any hospice member at any point during that member’s enrollment in the IHCP. This practice is consistent with the IHCP provider agreement.

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.seq. Table 12 reflects Medicare LMRP hospice guidelines and IHCP services.
<table>
<thead>
<tr>
<th>Admission Criteria</th>
<th>Continued Services</th>
<th>Discharge Criteria</th>
<th>Covered IHCP Services</th>
<th>Non-Covered IHCP Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA required</td>
<td>IHCP physician certification</td>
<td>Member dies</td>
<td>All services stipulated within POC must be reasonable and meet medical necessity for palliation or management of terminal illness and related conditions</td>
<td>Treatment to cure terminal illnesses</td>
</tr>
<tr>
<td>Terminally ill with a life expectancy of six months or less</td>
<td>Clinical documentation supporting the member’s terminal condition for the first benefit period and indicating a decline since the last request period</td>
<td>Member is determined to have a prognosis greater than six months</td>
<td>IDT approach</td>
<td></td>
</tr>
<tr>
<td>Recipient election statement</td>
<td>If a decline has not occurred, the physician certification must provide information that distinguishes the member from other patients with the same disease who may be chronic but who are not terminal</td>
<td>Member moves out of the service area</td>
<td>Physician and nursing services</td>
<td></td>
</tr>
<tr>
<td>IHCP physician certification</td>
<td>Safety of the member, other patients, or hospice staff is compromised</td>
<td></td>
<td>Medical equipment and supplies</td>
<td></td>
</tr>
<tr>
<td>Hospice POC must include services that are reasonable and meet medical necessity</td>
<td>Member is admitted to a noncontracted nursing facility or noncontracted hospital where hospice cannot retain professional management</td>
<td></td>
<td>Medicine for symptom control and pain relief</td>
<td></td>
</tr>
<tr>
<td>Hospice POC must be signed by the medical director and two of the other disciplines listed</td>
<td></td>
<td></td>
<td>Short-term inpatient respite care</td>
<td></td>
</tr>
</tbody>
</table>

Non-Cancer Hospice
Library Reference Number:
Revision Date: December 2014
Version 2.0
Billing Requirements

Hospice providers follow the general directions for completing the UB-04 claim form and use the following hospice-specific information to fill in the claim form. Refer to the Hospice Provider Manual on indianamedicaid.com for complete coverage information and billing instructions. Hospice providers are paid a *per diem* at the hospice level of care they are providing. Hospice providers should bill only one hospice revenue code per day. Revenue code 183, 185, and 657 are the only revenue codes that can be billed on the same day as another hospice revenue code.

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 seq. The following information describes the four levels of service and two levels of care available to members. Table 13 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 NF
- Continuous home care delivered in a NF
- Inpatient respite care (available to private home hospice members only)*
- General inpatient hospice care

**Table 13 – Hospice Reimbursement Methodology**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Revenue Code Descriptions and Explanations</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td><strong>Routine home care in a private home</strong></td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>652</td>
<td><strong>Continuous home care in a private home</strong> *</td>
</tr>
<tr>
<td></td>
<td>Continuous home care <em>per diem</em> 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 the level of staffing and services provided.</td>
</tr>
</tbody>
</table>
### 653 Routine home care in a NF
The hospice provider is paid at the routine home care rate for each day the member is in a NF, 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 percent of the lowest NF rate for contracted NF cost.

### 654 Continuous home care in a NF
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 the level of staffing and services provided. The hospice provider is paid an additional room and board *per diem* at 95 percent of the lowest NF rate for contracted NF cost.

### 655 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.

### 656 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 or chronic symptom management not manageable in other settings.

### 657 Hospice direct-care physician services
Physician services, hospice provider employee or authorized hospice provider, are separately reimbursable on a FFS 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.

### 659 Room and Board for Dually-eligible Medicare/Medicaid NF members only (room and board portion of the hospice *per diem* rate)
The hospice provider must bill Medicare for hospice services and Medicaid for room and board. The hospice provider is paid 95 percent of the lowest NF *per diem* to cover the room and board cost incurred by the contracted NF. Revenue code 659 may not billed with the hospice related revenue codes 651, 652, 653, 654, 655, or 656. These codes are designated for IHCP-only hospice services.
**NF Bed Hold Nonpaid Revenue Code**
The hospice provider should bill the IHCP using this revenue code for leave days when the NF occupancy is less than 90 percent. This code generates an IHCP denial; however, providers may charge members for the nonreimbursed bed hold days.

**NF bed hold for hospice therapeutic leave days**
Therapeutic leave days are reimbursed at 50 percent of the 95 percent of the NF 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 NF occupancy rate is below 90 percent.

**NF 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 percent of the 95 percent of the NF 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 NF occupancy rate is below 90 percent.

*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, must provide more than half the total care. This care need not be continuous and uninterrupted.*

**Inpatient facility is defined as a hospital, LTC facility, or the facility of a hospice provider that provides RN care 24 hours a day.**

### Reimbursement for Room and Board on Date of Death or Date of Physical Discharge

The OMPP does not pay the NF *per diem* or room-and-board services for the day a member is discharged from the NF. When a hospice member dies in a NF, the date of death follows the same reimbursement procedures as the date of physical discharge from the NF. If a hospice member is admitted and dies in the NF on the same day, the NF is not paid the room and board *per diem*; 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 NF

An IHCP member (dually eligible Medicare/IHCP or IHCP-only) residing in a NF is responsible for the member’s portion of the payment before the IHCP pays the remaining balance of NF 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 DOS the member resides and is eligible for the IHCP NF LOC.

Hospice providers can obtain a member’s patient liability for a particular month by contacting HP Customer Assistance or using one of the eligibility verification system (EVS). When a provider obtains the patient liability amount, the Residential Allowance (RA) is used to determine how HP calculates the paid amount. The following formula is used if the RA does not match the rates the provider submitted on the claim:
• NF case mix rate on file x 95% (.95) = allowed amount on the RA for room and board
• Number of dates of service x allowed amount on the RA minus member liability = room and board amount

Prior Authorized Physician Services

The IHCP reimburses a physician’s direct patient services not rendered by a hospice physician volunteer as an additional payment, in accordance with the usual IHCP reimbursement methodology for physician services. The hospice must not bill these services under the hospice NPI.

An attending physician may bill only the physician’s personal professional services. Do not include the costs for services, such as laboratory or X-ray, on the attending physician’s billed charges when those services relate to the terminal condition. Include these costs in the daily hospice care rates because they are expressly the responsibility of the hospice provider. Providers may bill independent physician services on the CMS-1500 claim form or 837P transaction.

NF Quality Assessment

OBRA 1989 and 405 IAC 1-16-4 require the IHCP to reimburse hospice providers for NF room and board payments; hospice providers reimburse nursing facilities according to their contracts. The IHCP pays the hospice 95 percent of the nursing home rate on file.

Rules, Citations, and Sources

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

IHCP Banner Pages
BR200914
BR200513
BR200503
BR200502
BR200501
BR200452
BR200446
BR200442
BR200413
BR200412
BR200411
BR200410
BR200409
BR200331
BR200329
BR200315
BR200216
BR200043
BR200025
BR12-29-1998
BR12-22-1998
BR12-15-1998
BR11-10-1998

IHCP Bulletins

BT200933
BT200607
BT200372
BT200331
BT200259
BT200234
BT200146
BT200107
IHCP Provider Newsletters
NL200905
NL200411

IHCP Hospice Provider Manual

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp

Related Medical Topics
Emergency Medicine – Emergency Services
Home Health Services
Hospital Inpatient Services
Hospital Outpatient Services
Mental Health/Behavioral Health – Outpatient Services

Nursing Facilities

Nursing Services

Out-of-State Services
Nursing Facilities

Introduction

This section serves as a general summary of the IHCP’s policies regarding nursing facilities. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

A nursing facility (NF) or Long Term Care (LTC) is an extended-care facility for persons who require medical attention of the type and complexity not requiring hospitalization. Nursing facilities provide 24-hour nursing supervision, rehabilitation services, activity and social services, a restraint-appropriate environment, measures to prevent complications of decreased mobility and careful attention to nutritional needs.

Reimbursement Requirements

Inpatient long-term care (LTC) services are available to IHCP members who meet the threshold of nursing care needs required for admission to, or continued stay in, an IHCP-certified nursing facility.

Services and products furnished by a NF for the usual care and treatment of IHCP members are reimbursed at the per diem rate. The per diem rate for nursing facilities includes room and board, nursing care, the cost of most 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 an RN, an LPN, 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 Section 28 of this manual, Hospice Services, and the IHCP Hospice Provider Manual for information regarding hospice services provided to IHCP members residing in nursing facilities.
Transportation Services

Providers are advised to consult Section 94 of this manual, Transportation Services, for additional information.

Pharmacy Services

The IHCP does not reimburse for pharmacy services provided to dually eligible IHCP members in nursing facilities during a Medicare covered post-hospitalization period. Drug products dispensed for these members should be billed to nursing facilities only. Providers are advised to consult Chapter 8 of the IHCP Provider Manual for additional information.

Case-mix Reimbursement

Under the case mix reimbursement system, each NF has one NF Level of Care (LOC) designation in Indiana AIM and one per diem rate calculated on resource usage for residents within the facility. The per diem rate is updated quarterly and is calculated by the IHCP’s rate setting contractor.

Indiana Pre-Admission Screening

Pre-Admission Screening and Resident Review

Congress created the Pre-Admission Screening and Resident Review (PASRR) program under the Omnibus Budget Reconciliation Act (OBRA) of 1987 to address concerns that many people with serious mental illness or mental retardation were inappropriately placed in nursing facilities (NFs).

Indiana Pre-Admission Screening (PAS) refers to the assessment and determination of a member’s eligibility before he or she is admitted to a NF. Resident Review (RR) refers to the annual evaluation to determine whether services need to continue if there has been a change in the member’s condition. Initial medical information is submitted for all NF admissions utilizing the Form 450B (see below).

The PASRR is a two level screening process and is a requirement in all Indiana Health Coverage Programs (IHCP)-certified NFs. All residents of an IHCP-certified NF are subject to the PASRR process regardless of known diagnoses or methods of payment (IHCP or non-IHCP). Screening occurs prior to admission or when there is a significant change in the physical or mental condition of a resident.

PASRR Level I identifies individuals who may be Mentally Ill or Intellectually Disabled/Developmentally Disabled (ID/DD). A PASRR Level II assessment is conducted by community mental health centers for NF residents who may be Mentally Ill. NF residents who may be MR/DD receive the PASRR Level II assessment by the Diagnostic and Evaluation Team. NF residents may also require assessment under the RR Level II process if they are identified as possibly being Mentally Ill 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 his or her Mental Illness or MR/DD condition, which may require a change in services or placement.

Diagnostic and Evaluation Teams (D&E Teams)

To conduct the PASRR Level II MR/DD assessments, D&E teams must be contracted with and approved by Division of Disability and Rehabilitative Service (DDARS) and Bureau of Developmental Disabilities (BDDS). To be eligible to submit Level II MR/DD claims, D&E teams must be enrolled with the IHCP. Providers may obtain a list of contracted and authorized D&E teams from DDARS.

Community Mental Health Centers (CMHCs)

CMHCs are contracted and approved by Division of Mental Health and Addiction (DMHA) to conduct the PASRR Level II MR/DD assessments and are enrolled with the IHCP, meaning they are eligible to submit Level II MR/DD claims. Providers may obtain a list of contracted and authorized CMHCs from the DMHA.

Form 450B/NF LOC

The Form 450B, Physician Certification for LTC Services, must be submitted by the NF 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 NF to the 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 1 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 NF level of services, State authorization, and data entry.
• OMPP 450B SA/DE (computer-generated) (State Form 49210) is used for NF level of service, State authorization, and data entry. This computer-generated OMPP 450B SA/DE includes a signature from the Indiana FSSA and is considered the official Form 450B. It must be maintained in the resident’s medical records.

Table 1 – Use of Forms 450B, 450B SA/DE (Paper- or Computer-generated) for IHCP Members

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Qualifier</th>
<th>Form Required</th>
<th>Accompanying Information</th>
<th>Official Form To Be Retained on Chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial admission to NF (IPAS and PASRR)</td>
<td>All IPAS/PASRR cases</td>
<td>Entire Form 450B (Sections I and II) completed</td>
<td>Complete IPAS/PASRR packet (no change)</td>
<td>Computer-generated OMPP 450B SA/DE – AAAs now generate these forms on all cases. The provider should receive the computer-generated OMPP 450B SA/DE in all cases. When this form comes from the AAAs, it does not have an effective Medicaid reimbursement date. Because of the missing information, the NF is responsible for forwarding this form along with the Form 4B to the Division of Aging for an effective date. If the AAAs have a Medicaid number, admission date, and an NF listed on the Form 450B, the computer-generated form will not be in the packet from the AAA. It is sent to the provider from the LOC Unit at the Division of Aging (State Level) and has an effective Medicaid reimbursement date on this form when it is received in the mail.</td>
</tr>
<tr>
<td>From the HCBS waiver to an NF</td>
<td>All HCBS waiver cases coming into an NF</td>
<td>Long Form 450B (sections I and II) completed and/or 450B SA/DE with a fully completed MDS**</td>
<td>Freedom of Choice Letter, Level I (Triggered Level II outside the short term exclusions PASRR certification) needed</td>
<td>Returned Form 450B or 450B SA/DE with an effective Medicaid reimbursement date</td>
</tr>
<tr>
<td>Short-term PASRR exclusions</td>
<td>Respite APS (seven days only) exempted hospital discharge</td>
<td>Long Form 450B (Sections I and II) completed and/or 450B SA/DE with a fully completed MDS***</td>
<td>Level I – Section 5, Part B1 Section 5, Part B2 Section 4, Part A</td>
<td>Returned Form 450B with an effective Medicaid reimbursement date</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Short-term PASRR exclusions</td>
<td>Respite APS (seven days only) exempted hospital discharge</td>
<td>Long Form 450B (Sections I and II) completed and/or 450B SA/DE with a fully completed MDS***</td>
<td>Level I – Section 5, Part B1 Section 5, Part B2 Section 4, Part A</td>
<td>Returned Form 450B with an effective Medicaid reimbursement date</td>
</tr>
<tr>
<td>PAS not completed</td>
<td>Client discharged and so forth</td>
<td>Long Form 450B (Sections I and II) completed</td>
<td>Form 4B PAS application Level I</td>
<td>Returned Form 450B with an effective Medicaid reimbursement date</td>
</tr>
<tr>
<td>NF to hospital and return to same NF (with an existing effective Medicaid reimbursement date)</td>
<td>Exceeding 15-day bed-hold policy</td>
<td>Form 450B (Section I only) or 450B SA/DE</td>
<td>None</td>
<td>Returned Form 450B with an effective Medicaid reimbursement date</td>
</tr>
<tr>
<td>Scenario</td>
<td>Action</td>
<td>Documentation</td>
<td>Result</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>NF to hospital and return to another NF (with an effective Medicaid reimbursement date)</td>
<td>Following any length of hospitalization</td>
<td>Form 450B (Section I only) or 450B SA/DE</td>
<td>None</td>
<td>Returned Form 450B with an effective Medicaid reimbursement date</td>
</tr>
<tr>
<td>Transfer from NF to NF (no intervening hospitalization)</td>
<td>Transfer to another NF</td>
<td>Entire Form 450B (Sections I and II) completed or Form 450B SA/DE with fully completed MDS**</td>
<td>Copy of PAS 4B from previous NF (copy of MDS from admitting NF)</td>
<td>Returned Form 450B with effective Medicaid reimbursement date</td>
</tr>
<tr>
<td>Resident change from private pay (non-Medicaid) to Medicaid members</td>
<td>Including changes in eligibility status from Medicaid MCE to regular Medicaid</td>
<td>Entire Form 450B (Section I and II) completed or Form 450B SA/DE with fully completed MDS** or computer-generated OMPP 450B SA/DE***</td>
<td>Copy of PAS 4B</td>
<td>Returned Form 450B with an effective Medicaid reimbursement date or computer-generated OMPP 450B SA/DE</td>
</tr>
</tbody>
</table>
The nursing facility is not required to submit a new form 450B or to process a new Indiana Pre-Admission Screening (PAS) application for re-admission following a hospitalization or therapeutic leave if the resident has not been discharged. As long as the resident intends to return to a nursing facility, there is no requirement to discharge the resident.

If the nursing facility does not anticipate the return of the resident, the resident must be discharged from the nursing facility, and all applicable new admission criteria (for example, PAS, 450B) must be followed if the resident is re-admitted to the nursing facility.

To clarify, if the resident intends to return to the sending nursing facility or to transfer to another nursing facility, a new Indiana Pre-Admission Screening application is not required. If a resident does not return to the sending facility, however, but chooses to transfer to another facility following hospitalization, the new facility must complete a new form 450B and notify the local Area Agency on Aging of the resident's admission to the new facility. The pre-admission screening application and paperwork from the prior facility can be requested by and forwarded to the new facility.

The key factor in determining if a resident must go through the pre-admission screening process is whether the resident goes home. As long as the resident does not discharge from the hospital to home, it will not be necessary to complete the entire pre-admission screening process - only a new form 450B is required if the patient transfers to a new nursing facility. If the resident does discharge from the hospital to home, the resident will have to undergo the full pre-admission screening process.

**Note:** Nursing facilities must contact the MCE immediately for IHCP members enrolled in RBMC for determination of the initial admission.
screening process - including the pre-admission screening application and the form 450B - to be re-admitted to any long term care facility.

To reinstate NF reimbursement, nursing facilities are required to submit the OMPP 450B SA/DE (computer-generated) to the OMPP in place of the paper Form 450B to enter data about the resident’s readmission date and to add the appropriate facility provider number in IndianaAIM. If the facility intends to reflect other changes, such as new Medicaid eligibility, readmission, or a transfer from another NF, this information should not be entered in the “LOC Transfer Date” box.

Resident LOC Information on the IndianaAIM System

Federal law requires all residents admitted to nursing facilities be assessed using the Minimum Data Set (MDS) Functional Assessment Tool. Under case mix, the reimbursement rate is based on the information submitted on the most current MDS form for each resident. This information is then to be used to compute a facility-average case-mix index and rate. Therefore, residents certified for NF placement by OMPP will be denoted with the “N” LOC indicator.

Additional information regarding LOC, 450B, and pre-admission screening can be found in Chapter 14 – Long Term Care of the IHCP Provider Manual.

Prior Authorization Requirements

PA is not required for nursing facility service.

Billing Requirements

The IHCP does not provide separate reimbursement for medical supplies, non-medical supplies, and routine DME items for members residing in LTC facilities. LTC facilities include nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), and community residential facilities for developmentally disabled (CRFs/DD). The costs for these services are included in the facility per diem rate, and the medical or DME supplier should bill the LTC facility directly for such services.

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 if applicant is not Developmentally Disabled (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 approved only to conduct PASRR Level II assessments through contractual arrangements with DDARS and DMHA. PASRR providers must be enrolled as IHCP providers.
PASRR applicants or members may be dually eligible in the IHCP.

Providers are advised to submit claims for the member using the PASRR member ID 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 HP Customer Assistance Unit.

Providers may not bill members for a PASRR Level II assessment.

Services cannot be combined with other non-PASRR service types, even if the services are rendered on the same day or during the 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 is suspended or denied.

Provider reimbursement for rendered services is determined by the procedure codes, modifiers as defined in Table 67.2, and the associated maximum (max) fee rate. Procedure codes, modifiers, and max fee rates must accompany all PASRR claim submissions.

Providers may void or replace PASRR claims.

PASRR financial information is available on the 835 Remittance Advice transactions.

PASRR claims must be submitted via a paper CMS-1500 claim form. Web interChange, or the 837P transaction within one year of the date of service. Providers must properly identify and itemize all services rendered.

### Table 2 – CPT® codes for Reporting PASRR Services

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T2011 U1 UA</td>
<td>T2011 – PASRR level II evaluation, per evaluation U1 – PAS (preadmission screening) UA – Mental retardation/developmental disability</td>
</tr>
<tr>
<td>T2011 U1 UA HI</td>
<td>T2011 – PASRR level II evaluation, per evaluation U1 – PAS UA – Mental retardation/developmental disability HI – Integrated mental health and mental retardation/developmental disabilities program</td>
</tr>
<tr>
<td>T2011 U2 UA</td>
<td>T2011 – PASRR level II evaluation, per evaluation U2 – RR UA – Mental retardation/developmental disability</td>
</tr>
<tr>
<td>T2011 U2 UA HI</td>
<td>T2011 – PASRR level II evaluation, per evaluation</td>
</tr>
</tbody>
</table>
**Therapeutic Leave Days/Hospital Leave Days**

Nursing facilities are not required to submit claims for bed-hold days under any circumstances, even for Revenue Code 180 (bed-hold days not eligible for payment) as the State no longer tracks bed-hold days.

**Ancillary Charges**

The IHCP does not provide separate reimbursement for medical, nonmedical supplies, and routine medical equipment. These items are included in the NF 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.

**NF 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 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 NF is reviewed, including residents whose care is not directly funded by the Indiana Medicaid program.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U2 – RR</td>
<td>U2 – Mental retardation/developmental disability</td>
</tr>
<tr>
<td>UA – M. retardation/developmental disability</td>
<td></td>
</tr>
<tr>
<td>HI – Integrated mental health and mental retardation/developmental disabilities program</td>
<td></td>
</tr>
<tr>
<td>T2011 U1 UB</td>
<td>T2011 – PASRR level II evaluation, per evaluation</td>
</tr>
<tr>
<td>U1 – PAS</td>
<td>U1 – Mental illness</td>
</tr>
<tr>
<td>UB – Mental illness</td>
<td></td>
</tr>
<tr>
<td>T2011 U1 UB TS</td>
<td>T2011 – PASRR level II evaluation, per evaluation</td>
</tr>
<tr>
<td>U1 – PAS</td>
<td>U1 – Mental illness</td>
</tr>
<tr>
<td>UB – Mental illness</td>
<td></td>
</tr>
<tr>
<td>TS – Follow-up service</td>
<td></td>
</tr>
<tr>
<td>T2011 U2 UB</td>
<td>T2011 – PASRR level II evaluation, per evaluation</td>
</tr>
<tr>
<td>U2 – RR</td>
<td>U2 – Mental retardation/developmental disability</td>
</tr>
<tr>
<td>UB – Mental illness</td>
<td></td>
</tr>
</tbody>
</table>
Managed Care

Nursing facilities and the Area Agency on Aging must notify the specific MCE immediately when a MCE member is admitted to a facility or undergoes IPAS/PASRR. The MCE is financially responsible for all care provided to its members until enrollment termination is effective. IHCP FFS is financially responsible for NF reimbursement when the member is approved for intermediate LOC, skilled LOC, or general case mix, and the member is disenrolled from the MCE.

Nursing facilities must coordinate with the MCE to allow members to use appropriate in-network service during the period when the member is assigned to the MCE. Providers are advised to contact the individual MCE for additional information.

NF and Hospice

The IHCP pays for room and board under the IHCP hospice benefit for dually eligible Medicare/Medicaid NF residents and Medicaid-only NF residents who elect the hospice benefit. Each provider group must complete its respective responsibilities to disenroll the member from managed care and ensure 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.

Additional information regarding billing requirements, HP Audits, and Managed Care Considerations can be found in Chapter 14 of the IHCP Provider Manual.

Rules, Citations and Sources

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 intellectually disabled
405 IAC 5-13-3 – Services included in the per diem for large private and small ICFs/ID
405 IAC 5-31 – Nursing facility services
405 IAC 5-5-2 – Out-of-State Services
405 IAC 5-30-1 – Transportation services

IHCP Bulletins

BT200002
IHCP Banner Pages
BR200302
BR200506
BR200524
BR201040

IHCP Provider Newsletters
NL200503
NL201011

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp

Related Medical Topics
Evaluation and Management Services
Hospice Services
Hospital Inpatient Services
Hospital Outpatient Services
Intermediate Care Facilities for the Intellectually Disabled
Nursing Services
Therapy Services
Transportation Services
Nursing Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding nursing services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

General nursing services for this policy include services rendered by RNs and LPNs in office settings, in-patient or out-patient hospital settings, clinics, or home health settings. Other nursing services included in this policy are services rendered by advance practice nurses.

Reimbursement Requirements

Summary of Current Policy

IHCP reimbursement is available for nursing services rendered by Registered Nurses (RNs) and Licensed Practical Nurses (LPNs), subject to the following limitations:

- The nurse must possess a current and active license from the Indiana State Board of Nursing.
- 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 rendering providers of appropriate services in settings including but not limited to physicians’ offices, in-patient or out-patient hospital settings, clinics, and home health settings.
- The IHCP will reimburse nursing services to the billing provider supervising the nursing services (e.g. physician or home health agency).
- Pursuant to 405 IAC 5-22-2, nursing services provided by a home health agency require PA. For additional information, see Section 27, Home Health Services, of this manual.
Advanced Practice Nurse

An advanced practice nurse is a nurse practitioner, a certified nurse midwife, or a clinical nurse specialist who is an RN holding a current Indiana license and is qualified to practice nursing in a specialty role based upon the additional knowledge and skill gained through a formal organized program of study and clinical experience, or the equivalent as determined by the Indiana State Board of Nursing (Board), which does not limit but extends or expands the function of the nurse which may be initiated by the client or provider in settings that shall include hospital outpatient clinics and health maintenance organizations. Pursuant to IC § 25-23-1-19.4, an advanced practice nurse must operate in collaboration with a licensed practitioner as evidenced by a practice agreement, or by privileges granted by the governing board of a hospital licensed under IC art. 16-21 with the advice of the medical staff of the hospital that sets forth the manner in which an advanced practice nurse and a licensed practitioner will cooperate, coordinate, and consult with each other in the provision of health care to their patients.

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 IHCP enrolls the following advanced nurse practitioners:

- Pediatric Nurse Practitioner
- Obstetric Nurse Practitioner
- Family Nurse Practitioner
- Nurse Practitioner (other)
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Nurse Midwife

The IHCP will provide coverage of services performed by an advanced practice nurse, in accordance with the criteria set forth in IC § 25-23-1-1 and 848 IAC 4-1-3. An advanced practice nurse can enroll as a billing provider. Additional information regarding provider enrollment can be found in Chapter 4 of the IHCP Provider Manual. An advanced practice nurse has prescriptive authorities, as described in IC § 25-23-1.19.6 and 848 IAC 5-1. Advanced practice nurses must include their signatures, credentials, and ID numbers on each prescription for the prescription to be valid.

An Advanced practice nurse is a RN holding a current Indiana license who:

- Makes independent decisions about the nursing needs of clients
- Operates in collaboration with a licensed practitioner as evidenced by:
  - a practice agreement, or
  - by privileges granted by the governing board of a hospital licensed under IC 16-21 with the advice of the medical staff of the hospital establishes the manner in which an advanced practice nurse and a licensed practitioner
cooperates, coordinates, and consults with each other in providing care to
their patients.

Registered Nurse

The IHCP will provide coverage of services performed by a RN, according to the criteria set in
IC § 25-23-1-1.1. A RN is not enrolled as a billing provider in the IHCP and may not directly bill
the IHCP for any services provided. A RN does not have medical diagnostic or prescriptive
privileges and may not sign prescriptions or member records on behalf of the physician.

A RN is a person who holds a valid license issued under IC §25-23-1; or by 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. “Registered nursing” includes
performance of services which comprise but are not limited to:

- Assessing health conditions
- Deriving a nursing diagnosis
- Executing a nursing regimen through the selection, performance, and management
  of nursing actions based on nursing diagnoses
- Advocating the provision of health care services through collaboration with or
  referral to other health professionals
- 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
- Teaching, administering, supervising, delegating, and evaluating nursing practice
- Delegating tasks which assist in implementing the nursing, medical, or dental
  regimen
- Performing acts which are approved by the board or by the board in collaboration
  with the medical licensing board of Indiana

For additional information on the responsibilities of a RN, refer to 848 IAC 2-2.

Licensed Practical Nurse

The IHCP will provide coverage of services performed by a LPN, in accordance with the criteria
set forth in IC § 25-23-1-1.2 and IC § 25-23-1-1.3. A LPN is not enrolled as a billing provider in
the IHCP and may not directly bill the IHCP for any services provided. A LPN does not have
medical diagnostic or prescriptive privileges and may not sign prescriptions or member records
on behalf of the physician.
A LPN is a person who holds a valid Indiana license issued under IC §25-23-1; or by a party state (as defined in IC § 25-23.2-1-11), performs activities commonly performed by practical nurses and requiring special knowledge or skill. This person would function at the direction of a:

- RN.
- Physician with an unlimited license to practice medicine or osteopathic medicine.
- Licensed dentist.
- Licensed chiropractor.
- Licensed optometrist.
- Licensed podiatrist.

Practical nursing means the performance of services commonly performed by practical nurses, including:
- Contributing to the assessment of the health status of individuals or groups
- Participating in the development and modification of the strategy of care
- Implementing the appropriate aspects of the strategy of care
- Maintaining safe and effective nursing care
- Participating in the evaluation of responses to the strategy of care

For additional information on the responsibilities of an LPN, refer to 848 IAC 2-3.

**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.

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 of competent practice of nurse practitioners:

- Assess clients by using advanced knowledge and skills to:
  - Identify abnormal conditions
  - Diagnose health problems
  - Develop and implement nursing treatment plans
  - Evaluate patient outcomes
  - Collaborate with or refer to a practitioner, as defined in IC § 25-23-1-19.4, in managing the POC
• Use advanced knowledge and skills in teaching and guiding clients and other health team members
• Use appropriate critical thinking skills to make independent decisions, commensurate with the autonomy, authority, and responsibility of a nurse practitioner
• 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:
  ➢ State and federal drug laws and regulations
  ➢ State and federal confidentiality laws and regulations
  ➢ State and federal medical records access laws
• Consult and collaborate with other members of the health team as appropriate to provide reasonable client care, both acute and ongoing
• Recognize the limits of individual knowledge and experience, and consult with or refer clients to other health care providers as appropriate
• Retain professional accountability for any delegated intervention, and delegate interventions only as authorized by IC §25-23-1 and 848 IAC 4-2-1
• Maintain current knowledge and skills in the nurse practitioner area
• Conduct an assessment of clients and families which may include health history, family history, physical examination, and evaluation of health risk factors
• Assess normal and abnormal findings obtained from the history, physical examination, and laboratory results
• Evaluate clients and families regarding development, coping ability, and emotional and social well-being
• Plan, implement, and evaluate care
• Develop individualized teaching plans with each client based on health needs
• Counsel individuals, families, and groups about health and illness and promote attention to wellness
• Participate in periodic or joint evaluations of service rendered, including, but not limited to, the following:
  ➢ Chart reviews.
  ➢ Client evaluations.
  ➢ Outcome statistics.
• Conduct and apply research findings appropriate to the area of practice
• 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.

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 of competent practice of clinical nurse specialists:

• Assess clients by using advanced knowledge and skills to:
  ➢ Identify abnormal conditions
  ➢ Diagnose health problems
  ➢ Develop and implement nursing treatment plans
  ➢ Devaluate patient outcomes

• Use advanced knowledge and skills in teaching and guiding clients and other health team members

• Use appropriate critical thinking skills to make independent decisions, commensurate with the autonomy, authority, and responsibility of the clinical nurse specialist

• 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:
  ➢ State and federal drug laws and regulations
  ➢ State and federal confidentiality laws and regulations
  ➢ State and federal medical records access laws

• Consult and collaborate with other members of the health team as appropriate to provide reasonable client care

• Recognize the limits of individual knowledge and experience, and consult with or refer clients to other health care providers as appropriate

• Retain professional accountability for any delegated intervention, and delegate interventions only as authorized by IC §25-23-1 and 848 IAC 3-1

• Maintain current knowledge and skills in the nurse practitioner area
• 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

• 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 848 IAC 3-1

• 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

• 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

• 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

• Participate in periodic or joint evaluations of service rendered, including, but not limited to, the following:
  - Chart reviews.
  - Case reviews.
  - Patient evaluations.
  - Outcome of case statistics.

Certified Nurse-Midwife

A certified 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. Per 848 IAC 3-1-2 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 additional details on the scope of practice for nurse-midwives, see 848 IAC 3-3-1.

The following are standards for each nurse-midwife:

• Assess clients by using advanced knowledge and skills to:
  - Identify abnormal conditions;
  - Diagnose health problems;
  - Develop and implement nursing treatment plans; and
  - Evaluate patient outcomes.
- Use advanced knowledge and skills in teaching and guiding clients and other health care team members.

- Use appropriate critical thinking skills to make independent decisions, commensurate with the autonomy, authority, and responsibility of the practice of nurse-midwifery.

- Function within the legal boundaries of the practice of nurse-midwifery and shall have and utilize knowledge of the statutes and rules governing the practice of nurse-midwifery, including the following:
  - State and federal drug laws and regulations.
  - State and federal confidentiality laws and regulations.
  - State and federal medical records access laws.

- Consult and collaborate with other members of the health care team as appropriate to provide reasonable client care.

- Recognize the limits of individual knowledge and experience, and consult with or refer clients to other health care providers as appropriate.

- Retain professional accountability for any delegated intervention, and delegate interventions only as authorized by IC §25-23-1 and 848 IAC 3-3.

- Maintain current knowledge and skills in the practice of nurse-midwifery.

- Manage and provide health care services in the practice of nurse-midwifery.

- Provide individual and group counseling and teaching throughout the life cycle.

- Participate in periodic and joint evaluation of services rendered, including, but not limited to, the following:
  - Chart reviews.
  - Case reviews.
  - Client evaluations.
  - Outcome statistics.

- Conduct and apply research findings appropriate to the area of practice.

- Participate, when appropriate, in the joint review and revision of written guidelines involving the plan of care.

Please note: Nurse midwives may not provide services to members with medically high-risk pregnancies.
CRNAs

Medicaid reimbursement is available for services rendered by CRNAs when acting under the direction of and in the immediate presence of a physician.

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.

CRNAs are registered nurses who are:

- Graduates of a nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or its predecessor;
- Properly certified by successfully completing the certification examination administered by the Council on Certification of Nurse Anesthetists or its predecessor; and
- Properly certified and in compliance with criteria for biennial recertification, as defined by the Council on Recertification of Nurse Anesthetists.

CRNAs are not eligible for prescriptive authority; however, CRNAs may administer anesthesia without this authorization per IC § 25-23-1-30.

Prior Authorization Requirements

For PA criteria, refer to medical policy guidelines regarding specific services provided by nursing professionals.

Billing Requirements

Nurse Practitioners

Reimbursement is available for medically necessary services or preventative healthcare services provided by a nurse practitioner enrolled either as a billing, group, or dual provider. Chapter 8 of the IHCP Provider Manual 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, and clinical nurse specialists), except CRNAs.

- Independently practicing nurse practitioners are reimbursed at 75 percent of the rate on file. The nurse practitioner NPI number is included in field 24J of the CMS-1500 Claim Form. The billing NPI will also be entered in 33A, and the LPI may be entered in 33B with a qualifier of 1D on the CMS-1500 claim form (optional).
- 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 rendering NPI in field 24J of the
CMS-1500. The billing NPI will also be entered in 33A, and the LPI may be entered in 33B with a qualifier of 1D on the CMS-1500 claim form (optional). The IHCP reimburses them at 100 percent of the Medicaid allowed amount.

- Nurse practitioners with individual provider numbers who are employed by physicians should bill using their rendering NPIs in field 24J of the CMS-1500. The NPI will also be entered in 33A, and the LPI may be entered in 33B with a qualifier of 1D on the CMS-1500 claim form (optional). The IHCP reimburses them at 100 percent of the Medicaid allowed amount.

- Providers cannot bill separately for nurse practitioner services in outpatient hospital settings and should include these services in the hospital outpatient reimbursement rate.

Additional information for billing nurse practitioner services are found in Chapter 8 of the IHCP Provider Manual.

CRNA

CRNAs must use anesthesia CPT® codes (00100-01999) and bill with the appropriate modifier. CRNAs that bill with their individual rendering provider numbers must not use modifiers listed below. Anesthesia procedure code modifiers listed in Table 1 must be reported to identify services rendered by CRNAs not enrolled in the IHCP and the anesthesiologist who is providing medical direction.

One of the anesthesia procedure code modifiers listed 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. See Chapter 8 of the IHCP Provider Manual for additional instructions for billing CRNA services.

Table 1 – Modifiers for Current Procedural Terminology Anesthesia Codes

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QS</td>
<td>Monitored anesthesia care services</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service with medical direction by a physician</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service without medical direction by a physician</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals</td>
</tr>
</tbody>
</table>

Nurse Practitioners and Clinical Nurse Specialists in Mental Health

The IHCP provides reimbursement for mental health services provided by a nurse practitioner or clinical nurse specialist under the supervision of a physician, psychiatrist, or HSPP. Providers should use the rendering NPI of the supervising practitioner (physician or HSPP) to bill.
psychiatric and clinical nurse specialist services. Providers must use these modifiers with the appropriate procedure code. Nurse practitioners and clinical nurse specialists should bill utilizing modifiers HE in conjunction with SA.

Additional information regarding billing nurse practitioner and clinical nurse specialist services for mental health services are found in Chapter 8 of the IHCP Provider Manual.

**Rules, Citations and Sources**

*IC § 25-23-1-1.1 – Additional definitions*

*IC § 25-23-1-1.2 – “Licensed practical nurse” defined*

*IC § 25-23-1-1.3 – “Practical nursing” defined*

*IC § 25-23-1-19.6 - Advanced practice nurses; prescriptions; identification numbers*

*IC § 25-23-1-30 - Administration of anesthesia by certified registered nurse anesthetist*

*405 IAC 5-22 – Nursing and Therapy Services*

*405 IAC 5-10 – Anesthesia Services*

*848 IAC 2-2 – Registered Nursing*

*848 IAC 2-3 – Licensed Practical Nursing*

*848 IAC 3-1-2 - “Practice of nurse-midwifery” defined*

*848 IAC 4-1-3 - "Advanced practice nurse" defined*

*848 IAC 4-2-1 - Competent practice of nurse practitioners*

*848 IAC 4-3-1-: Competent practice of clinical nurse specialists*

*848 IAC 5-1-: Prescriptive authority*

IHCP Banner Pages

BR200420

BR200351

*IHCP Provider Newsletter*

NL200406

*IHCP Provider Manual*
Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp)

**Related Medical Topics**

Anesthesia Services

Home Health Services

Mental Health/Behavioral Health – Outpatient Services
Obstetric Care

Introduction

This section serves as a general summary of the IHCP’s policies regarding obstetric care. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, , or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Obstetric care includes the care of and services provided to a member during pregnancy and childbirth (including the immediate postpartum period).

Reimbursement Requirements

The IHCP provides reimbursement for various obstetrical services for the following pregnancy-related services:

- Antepartum care
- Other outpatient office visits
- Normal pregnancy
- High-risk pregnancy
- Pregnancy services billing procedures

Antepartum Services

The IHCP utilizes guidelines from the American College of Obstetricians and Gynecologists (ACOG), which separates antepartum care from delivery and postpartum care. This enables the IHCP to more effectively encourage antepartum care and track its impact on reducing poor pregnancy outcomes.

The IHCP reimburses up to 14 visits for normal antepartum care. 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.

Other Outpatient Office Visits

Providers may bill CPT® procedure codes 99211–99215 or 99241-99245 for outpatient office visits rendered to pregnant members, if the service is related to a concurrent medical condition requiring medical care or consultative referral.

Normal Pregnancies

A normal pregnancy is one in which the physician determines 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V22.0</td>
<td>Supervision of normal first pregnancy</td>
</tr>
<tr>
<td>V22.1</td>
<td>Supervision of other normal pregnancy</td>
</tr>
</tbody>
</table>

High-Risk Pregnancies

A pregnant woman may be considered high-risk if at least one medical or psychosocial reason is identified in her current pregnancy or obstetrical history which places her at risk for preterm birth or a poor pregnancy outcome. The provider should utilize the IHCP Prenatal Risk Assessment Form as a tool for identifying pregnant members at risk of preterm births or poor pregnancy outcomes. Providers may refer members identified as having high-risk pregnancies only to appropriate physicians. Referrals to non-physicians for high-risk pregnancy-related services are not covered.

The IHCP does not determine conditions which may or may not complicate a pregnancy. Therefore, if a physician determines an illness or injury could complicate a pregnancy or have an adverse effect on the pregnancy’s outcome, the IHCP allows billing for covered services provided to treat the illness or injury. Refer to Chapter 8 of the IHCP Provider Manual for a list of medically high-risk pregnancy ICD-9-CM diagnosis codes.

Additional information regarding the Prenatal Risk Assessment Form is located in Chapter 8 of the IHCP Provider Manual. The form can be printed from the Forms section of the IHCP Web site at www.indianamedicaid.com.

Medically High-Risk Pregnancies

Medically high-risk pregnancy is defined as pregnant members who have medical complications which, if not adequately addressed, may adversely affect the pregnancy’s outcome. 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. Members identified as having medically high-risk pregnancies may receive additional antepartum care visits beyond the maximum of 14 allowed for a normal pregnancy. The IHCP recognizes the care of pregnant women in the medically high-risk category requires greater physician management.

Psychosocially High-Risk Pregnancies

Reimbursement is available for high-risk pregnancies identified for psychosocial reasons. These visits 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. Pregnant women with psychosocial factors identified that may affect the pregnancy may require care coordination.

Ultrasound/Sonography/Echography

Ultrasound/Sonography/Echography services performed during pregnancy are covered by the IHCP when indicated by one or more of the following conditions:

- Early diagnosis of ectopic or molar pregnancy
- Placental localization associated with abnormal bleeding
- Fetal postmaturity syndrome
- Suspected multiple births
- Suspected congenital anomaly
- Polyhydramnios or oligohydramnios
- Guide for amniocentesis
- Fetal age determination if necessitated by:
  - Discrepancy in size versus fetal age
  - Lack of fetal growth or suspected fetal death

In addition, reimbursement is available for US guidance to perform a procedure that improves fetal status.

Reimbursement is available for ultrasounds for fetal age determination prior to therapeutic, non-elective abortions when the age of a fetus cannot be determined by the patient’s H&P 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.
First Trimester Fetal Nuchal Translucency Ultrasound

The first-trimester fetal nuchal translucency ultrasound does not require prior authorization. However, the first-trimester fetal nuchal translucency ultrasound must be performed in conjunction with maternal serum-free beta human chorionic gonadotropin (hCG) and pregnancy-associated plasma protein A for the detection of chromosomal defects. The IHCP does not cover first-trimester fetal nuchal translucency testing when performed alone for the detection of chromosomal defects, as it is considered investigational. For optimal test results, the first-trimester fetal nuchal translucency ultrasound should be performed between 11 and 13 weeks of pregnancy. First-trimester fetal nuchal translucency ultrasounds are subject to the requirements found in 405 IAC 5-27-6.

The IHCP does not provide reimbursement for routine ultrasounds or ultrasounds performed for gender determination. The diagnosis of a normal pregnancy does not substantiate the medical necessity for an ultrasound to be performed. Documentation must be maintained in the patient’s medical record to support the medical need for an ultrasound.

Reimbursement is not available for CPT® code 59072 – Fetal umbilical cord occlusion, including US guidance as this procedure is designed to terminate a fetus.

Home Tocolytic Infusion Therapy

The IHCP coverage is available for home tocolytic infusion therapy utilizing a home uterine monitoring device. 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 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 require only home uterine monitoring devices do not qualify for tocolytic infusion therapy. For additional information, please refer to the IHCP Provider Manual.

Early Elective Deliveries
The IHCP does not cover early elective deliveries (EEDs). Deliveries that are not medically indicated prior to 39 weeks and 0 days, known as EEDs, are noncovered. Deliveries that meet one of the approved medical indications for a medically necessary delivery prior to 39 weeks in Table 69.2 are covered.

The medical indications listed in Table 2 are compiled from lists released by the Indiana Perinatal Quality Improvement Collaborative (IPQIC), ACOG, and The Joint Commission as indications for a medically necessary delivery prior to 39 weeks. The comprehensive list of medical indications in Table 2 is intended to ensure all medically indicated deliveries prior to 39 weeks remain covered. The IHCP will continue to evaluate the list of approved medical indications to ensure that all medically necessary indications are covered.

Table 2 – Approved medical indications for a medically necessary delivery prior to 39 weeks and 0 days

<table>
<thead>
<tr>
<th>Maternal Indications</th>
<th>Fetal Indications</th>
<th>Obstetric Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiphospholipid Syndrome</td>
<td>ABO Isoimmunization</td>
<td>Abruptio Placenta</td>
</tr>
<tr>
<td>Chronic Hypertension</td>
<td>Abnormal Fetal Heart Rate</td>
<td>Abruption</td>
</tr>
<tr>
<td>Cardiovascular Diseases</td>
<td>Chorioamnionitis</td>
<td>Antepartum Hemorrhage/Bleeding</td>
</tr>
<tr>
<td>Chronic Pulmonary Disease</td>
<td>Congenital Heart Defect/Heart Disease</td>
<td>Chronic Hypertension with Super Imposed Preeclampsia</td>
</tr>
<tr>
<td>Coagulopathy Defect</td>
<td>Fetal Abnormality</td>
<td>Chorioamnionitis</td>
</tr>
<tr>
<td>Coagulopathy Disorders</td>
<td>Fetal Chromosomal Anomaly</td>
<td>Gestational Diabetes</td>
</tr>
<tr>
<td>Congenital Heart Defect/Heart Disease</td>
<td>Fetal CNS Anomaly</td>
<td>Gestational Hypertension</td>
</tr>
<tr>
<td>Current Cancer</td>
<td>Fetal Damage due to Disease</td>
<td>Hypertensive Disorder</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>Fetal Damage due to Drugs</td>
<td>Maternal/Fetal Hemorrhage</td>
</tr>
<tr>
<td>Epilepsy/Seizure Disorder</td>
<td>Fetal Damage due to Radiation</td>
<td>Mild Preeclampsia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe Preeclampsia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preeclampsia/HELLP/Eclampsia</td>
</tr>
<tr>
<td>Gastroenteric Diseases/Disorders</td>
<td>Fetal Damage due to Virus</td>
<td>Multiple Gestation/ Multiple Gestation with Loss</td>
</tr>
<tr>
<td>Hematological Disorder</td>
<td>Fetal Demise-Singleton</td>
<td>Oligohydramnios</td>
</tr>
<tr>
<td>HIV; Asymptomatic HIV Infection Status</td>
<td>Fetal Distress</td>
<td>Placenta Previa</td>
</tr>
<tr>
<td>Hypertension Non-Specified</td>
<td>Fetal/Maternal Hemorrhage</td>
<td>Placental Previa Hemorrhage</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>Intrauterine Growth</td>
<td>Polyhydramnios</td>
</tr>
<tr>
<td>Restriction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal/Fetal Hemorrhage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous Stillborn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Classical Cesarean Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Myomectomy Entering Endometrial Cavity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Reassuring Fetal Antepartum Testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RH Isoimmunization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prolonged Rupture of Membranes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ruptured Membranes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstable Lie; Multiple Gestation with Malpresentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vasa Previa</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Anesthesia for Vaginal or Cesarean Delivery**

The IHCP provides reimbursement for anesthesia services for a vaginal or cesarean delivery. Refer to Section 3 of this manual, *Anesthesia Services*, for additional 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.

**Postpartum**

The IHCP allows up to two postpartum visits within 60 days post-delivery. The IHCP may reimburse the provider for up to two inpatient or outpatient postpartum visits when billing for postpartum care only. Providers may be reimbursed for one (1) additional postpartum visit when the delivery and postpartum care are billed under one procedure code.

**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 childbearing age do not require copayments.

**Transportation Services**

No copayment is required for transportation provided to pregnant members; however, transportation exceeding the 50-mile one-way trip limitation is subject to PA. Refer to Section 94 of this manual, *Transportation Services*, for additional information.

**Prior Authorization Requirements**

For PA information pertaining to specific obstetrical care services, please refer to the *IHCP Provider Manual.*
Billing Requirements

Pregnancy Services

The IHCP limits payment for pregnancy-related services to the following ICD-9-CM diagnoses, subject to PA restrictions and in accordance with IAC. The primary diagnosis codes are V22.0 through V25.2 and V60.0 through V62.9. Providers must indicate a pregnancy-related diagnosis code as the primary diagnosis when billing for pregnancy-related services for members not covered under Traditional Medicaid.

The IHCP does not process for payment any claims for pregnancy-related services submitted without a record of a last menstrual period (LMP). Providers must indicate the LMP in a MM/YY/DD format in field 14 for paper claim filing and in a CCYYMMDD format in the LMP date, Data Element 1251, for electronic claim filing.

Antepartum Visits

The IHCP allows providers to bill antepartum care for pregnant members separately from delivery and postpartum visits. Providers must individually list each antepartum visit on the claim. In addition, providers may submit claims:

- After each individual visit or at the end of the respective trimester
- Bill the required antepartum tests and screenings for each trimester along with the trimester visits; or
- Bill antepartum services within a trimester within 30 days of the end of the trimester

Providers must bill each antepartum visit separately using CPT® procedure codes 59425 or 59426. Submit visits two through six with the procedure code 59425 at each visit. Submit the seventh, and all subsequent visits, with procedure code 59426 at each visit. Providers may use a new or established patient E/M code (99201–99215) for the first antepartum visit to accommodate the greater amount of work involved with the first visit. However, providers should use the appropriate antepartum care code to bill all subsequent antepartum visits. If providers report an E/M code for the first visit, they must use the appropriate trimester modifier and expected date of delivery.

Table 3 – Antepartum Visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59425</td>
<td>Antepartum Care only; 4-6 visits</td>
</tr>
<tr>
<td>59426</td>
<td>Antepartum Care 7 or more visits</td>
</tr>
<tr>
<td>99201-99215</td>
<td>New or Established Patient - Evaluation and Management (first through third antepartum visit)</td>
</tr>
</tbody>
</table>
To identify antepartum visits in each trimester, providers must bill the appropriate modifier in Table 3 in conjunction with CPT® procedure codes 59425, 59426, or 99201-99215 (if used for the first antepartum visit) with each specific date of service. Place the modifier following the CPT® code in field 24D of the CMS-1500.

Use the modifiers in Table 4 in conjunction with 59425 and 59426, to denote the appropriate trimester.

**Table 69.4 – Modifiers – Antepartum Visits**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>Trimester one – 0 through 14 weeks, 0 days</td>
</tr>
<tr>
<td>U2</td>
<td>Trimester two – 14 weeks, one day through 28 weeks, 0 days</td>
</tr>
<tr>
<td>U3</td>
<td>Trimester three – 28 weeks, one day, through delivery</td>
</tr>
</tbody>
</table>

The IHCP allows up to eight antepartum visits during the third trimester for a normal pregnancy, and providers can bill them along with delivery and postpartum services on the same CMS-1500 claim form or 837P transaction.

In addition to the schedule for antepartum visits, the OMPP has developed a schedule of tests and screenings highly recommended for pregnant members within each respective trimester. Providers should render other tests and screenings, such as those defined as optional, only when the person providing the service determines that the procedure is necessary. Providers can bill the tests and screenings with the appropriate antepartum care visit code on the same CMS-1500 or 837P transaction.

The trimester schedules are uniform with standards established by the ACOG and the American Academy of Pediatrics (AAP).

**Table 5 – Antepartum Tests and Screenings Schedule**

**Trimester One (Three Total Visits)**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>59425*</td>
<td>First trimester visits = three</td>
</tr>
<tr>
<td>59426*</td>
<td>Chorionic villa sampling (CVS), optional for women older than 35</td>
</tr>
<tr>
<td>59015</td>
<td>UA by dipstick, performed each visit; using the automated UA is based on medical necessity, as determined by the physician</td>
</tr>
<tr>
<td>81000 (includes microscopy for suspected UT infection); or 81002 (without microscopy); or 81001 (UA, automated with microscopy); or 81003 (UA, automated without microscopy)</td>
<td>Cytomegalovirus (CMV) antibody titer</td>
</tr>
<tr>
<td>Code</td>
<td>Test</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>86694</td>
<td>Herpes simplex test</td>
</tr>
<tr>
<td>86701</td>
<td>HIV test (optional)</td>
</tr>
<tr>
<td>86777</td>
<td>Toxoplasma antibody titer</td>
</tr>
<tr>
<td>88150, 88152-88155</td>
<td>Cervical cytology (Pap smear)</td>
</tr>
<tr>
<td>80055</td>
<td>Total obstetrical panel includes:</td>
</tr>
<tr>
<td></td>
<td>- Complete blood count (CBC) with complete differential</td>
</tr>
<tr>
<td></td>
<td>- HBsAg</td>
</tr>
<tr>
<td></td>
<td>- Rubella antibody titer</td>
</tr>
<tr>
<td></td>
<td>- Syphilis test</td>
</tr>
<tr>
<td></td>
<td>- Antibody screen, RBC</td>
</tr>
<tr>
<td></td>
<td>- Blood typing (ABO)</td>
</tr>
<tr>
<td></td>
<td>- Blood typing (RhD)</td>
</tr>
<tr>
<td>85025</td>
<td>CBC with complete differential</td>
</tr>
<tr>
<td>87340</td>
<td>HBsAg</td>
</tr>
<tr>
<td>86762</td>
<td>Rubella antibody titer</td>
</tr>
<tr>
<td>86592</td>
<td>Syphilis test; non treponemal antibody, qualitative (e.g., VDRL, RPR, ART)</td>
</tr>
<tr>
<td>86850</td>
<td>Antibody screen, RBC</td>
</tr>
<tr>
<td>86900</td>
<td>Blood typing (ABO)</td>
</tr>
<tr>
<td>86901</td>
<td>Blood typing (RhD)</td>
</tr>
</tbody>
</table>

* Use the appropriate CPT® code for the number of antepartum visits:

<table>
<thead>
<tr>
<th>Code</th>
<th>Antepartum care only; four to six visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>59425</td>
<td></td>
</tr>
<tr>
<td>59426</td>
<td></td>
</tr>
</tbody>
</table>
Table 6 – First Trimester Fetal Nuchal Translucency Ultrasound

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76813**</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation; optional</td>
</tr>
<tr>
<td>76814**</td>
<td>Ultrasound, Each additional gestation - list separately in addition to code for primary procedure</td>
</tr>
<tr>
<td>84163***</td>
<td>Pregnancy Associated Plasma Protein A (PAPP-A)</td>
</tr>
<tr>
<td>84702-84704***</td>
<td>Maternal serum free beta Human Chorionic Gonadotropin (hGC)</td>
</tr>
</tbody>
</table>

**The IHCP does not cover 1st Trimester Fetal Nuchal Translucency testing when performed alone for the detection of chromosomal defects.

*** The nuchal translucency sonography must be performed in conjunction with maternal serum free beta human chorionic gonadotropin (hCG) and pregnancy-associated plasma protein A (PAPP-A) for the detection of chromosomal defects.

For optimal test results the First Trimester Fetal Nuchal Translucency Ultrasound should be performed between 11 and 13 weeks of pregnancy.

Reimbursement is available for sonography services performed during pregnancy when indicated by one or more of the following conditions:

1. Early diagnosis of ectopic or molar pregnancy.
2. Placental localization associated with abnormal bleeding.
3. Fetal postmaturity syndrome.
4. Suspected multiple births.
5. Suspected congenital anomaly.
6. Polyhydramnios or oligohydramnios.
7. Fetal age determination if necessitated by:
   A. discrepancy in size versus fetal age; or
   B. lack of fetal growth or suspected fetal death.
### Table 7 – Antepartum Tests and Screenings Schedule Trimester Two (Three Total Visits)

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>59425*</td>
<td>Second trimester visits = three</td>
</tr>
<tr>
<td>59426*</td>
<td></td>
</tr>
<tr>
<td>59000</td>
<td>Amniocentesis, optional for women older than 35</td>
</tr>
<tr>
<td>81000</td>
<td>UA by dipstick, performed each visit; using automated UA is based on medical necessity, as determined by the physician</td>
</tr>
<tr>
<td>81000 (includes microscopy for suspected UT infection); or 81002 (without microscopy); or 81001 (UA, automated with microscopy); or 81003 (UA, automated without microscopy)</td>
<td></td>
</tr>
<tr>
<td>82105</td>
<td>Serum alpha-fetoprotein</td>
</tr>
<tr>
<td>82947</td>
<td>Diabetic screening</td>
</tr>
<tr>
<td>82951</td>
<td>Glucose tolerance test</td>
</tr>
<tr>
<td>86644</td>
<td>CMV antibody titer</td>
</tr>
<tr>
<td>86694</td>
<td>Herpes simplex test</td>
</tr>
<tr>
<td>86777</td>
<td>Toxoplasma antibody titer</td>
</tr>
<tr>
<td>80055</td>
<td>Total obstetrical panel includes:</td>
</tr>
<tr>
<td></td>
<td>• CBC with complete differential</td>
</tr>
<tr>
<td></td>
<td>• HBsAg</td>
</tr>
<tr>
<td></td>
<td>• Rubella antibody titer</td>
</tr>
<tr>
<td></td>
<td>• Syphilis test</td>
</tr>
<tr>
<td></td>
<td>• Antibody screen, RBC</td>
</tr>
<tr>
<td></td>
<td>• Blood typing (ABO)</td>
</tr>
<tr>
<td></td>
<td>• Blood typing (RhD)</td>
</tr>
<tr>
<td>85025</td>
<td>CBC with complete differential</td>
</tr>
<tr>
<td>87340</td>
<td>HBsAg</td>
</tr>
<tr>
<td>86762</td>
<td>Rubella antibody titer</td>
</tr>
<tr>
<td>86592</td>
<td>Syphilis test; non treponemal antibody, qualitative (e.g., VDRL, RPR, ART)</td>
</tr>
<tr>
<td>86850</td>
<td>Antibody screen, RBC</td>
</tr>
<tr>
<td>86900</td>
<td>Blood typing (ABO)</td>
</tr>
<tr>
<td>86901</td>
<td>Blood typing (RhD)</td>
</tr>
</tbody>
</table>

* Use the appropriate CPT® code for the number of antepartum visits:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>59425</td>
<td>Antepartum care only; one to six visits</td>
</tr>
</tbody>
</table>
Table 8 – Antepartum Tests and Screenings Schedule
Trimester Three (Eight Total Visits)

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>59425*</td>
<td>Third trimester visit = 8</td>
</tr>
<tr>
<td>59426*</td>
<td>UA by dipstick, performed each visit; using automated UA is based on medical necessity, as determined by the physician</td>
</tr>
<tr>
<td>81000</td>
<td>(includes microscopy for suspected UT infection); or 81002 (without microscopy); or 81001 (UA, automated with microscopy); or 81003 (UA, automated without microscopy)</td>
</tr>
<tr>
<td>81000</td>
<td>UA by dipstick, performed each visit; using automated UA is based on medical necessity, as determined by the physician</td>
</tr>
<tr>
<td>85025</td>
<td>CBC with differential</td>
</tr>
<tr>
<td>86592</td>
<td>Syphilis test; repeat test for patients who tested positive in first trimester</td>
</tr>
<tr>
<td>86850</td>
<td>Antibody test; repeat for patients who tested negative in first trimester</td>
</tr>
<tr>
<td>86644</td>
<td>CMV antibody titer</td>
</tr>
<tr>
<td>86694</td>
<td>Herpes simplex test</td>
</tr>
<tr>
<td>86777</td>
<td>Toxoplasma antibody titer</td>
</tr>
<tr>
<td>80055</td>
<td>Total obstetrical panel includes:</td>
</tr>
<tr>
<td></td>
<td>• CBC with complete differential</td>
</tr>
<tr>
<td></td>
<td>• HBsAg</td>
</tr>
<tr>
<td></td>
<td>• Rubella antibody titer</td>
</tr>
<tr>
<td></td>
<td>• Syphilis test</td>
</tr>
<tr>
<td></td>
<td>• Antibody screen, RBC</td>
</tr>
<tr>
<td></td>
<td>• Blood typing (ABO)</td>
</tr>
<tr>
<td></td>
<td>• Blood typing (RhD)</td>
</tr>
<tr>
<td>85025</td>
<td>CBC with complete differential</td>
</tr>
<tr>
<td>87340</td>
<td>HBsAg</td>
</tr>
<tr>
<td>86762</td>
<td>Rubella antibody titer</td>
</tr>
<tr>
<td>86592</td>
<td>Syphilis test; non treponemal antibody, qualitative (e.g., VDRL, RPR, ART)</td>
</tr>
<tr>
<td>86850</td>
<td>Antibody screen, RBC</td>
</tr>
<tr>
<td>86900</td>
<td>Blood typing (ABO)</td>
</tr>
<tr>
<td>86901</td>
<td>Blood typing (RhD)</td>
</tr>
</tbody>
</table>
* Use the appropriate CPT® code for the number of antepartum visits:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59425</td>
<td>Antepartum care only; one to six visits</td>
</tr>
<tr>
<td>59426</td>
<td>Antepartum care only; seven or more visits</td>
</tr>
</tbody>
</table>

**Ultrasound/Sonography/Echography**

Ultrasounds performed to detect fetal malformations or intrauterine growth retardation should have an ICD-9-CM code from the V22 series as the primary diagnosis and an ICD-9-CM diagnosis code from the V28 series (antenatal screening 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:

**Table 9 – Secondary ICD-9 Codes for Echography**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V28.0</td>
<td>Screening for chromosomal anomalies by amniocentesis</td>
</tr>
<tr>
<td>V28.1</td>
<td>Screening for raised alpha-fetoprotein levels in amniotic fluid</td>
</tr>
<tr>
<td>V28.2</td>
<td>Other antenatal screening based on amniocentesis</td>
</tr>
<tr>
<td>V28.3</td>
<td>Screening for malformation using ultrasonics</td>
</tr>
<tr>
<td>V28.4</td>
<td>Screening for fetal growth retardation using ultrasonics</td>
</tr>
<tr>
<td>V28.5</td>
<td>Antenatal screening for isoimmunization</td>
</tr>
<tr>
<td>V28.6</td>
<td>Antenatal screening for streptococcus b</td>
</tr>
<tr>
<td>V28.8</td>
<td>Other specified antenatal screening</td>
</tr>
<tr>
<td>V28.9</td>
<td>Unspecified antenatal screening</td>
</tr>
</tbody>
</table>

**Table 10 – Ultrasound/Sonography/Echography CPT® Procedure Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76801</td>
<td>Ultrasound, pregnant uterus, first trimester, transabdominal approach</td>
</tr>
<tr>
<td>76802</td>
<td>Each additional gestation</td>
</tr>
<tr>
<td>76805</td>
<td>Ultrasound, pregnant uterus, after first trimester, transabdominal approach</td>
</tr>
<tr>
<td>76810</td>
<td>Each additional gestation</td>
</tr>
<tr>
<td>76811</td>
<td>Ultrasound, pregnant uterus; single or first gestation</td>
</tr>
<tr>
<td>76812</td>
<td>Each additional gestation</td>
</tr>
<tr>
<td>76815</td>
<td>Ultrasound, pregnant uterus, limited, 1 or more fetuses</td>
</tr>
<tr>
<td>76816</td>
<td>Ultrasound, pregnant uterus, follow-up, per fetus</td>
</tr>
<tr>
<td>76817</td>
<td>Ultrasound, pregnant uterus, transvaginal</td>
</tr>
</tbody>
</table>
**Table 11 - First Trimester Fetal Nuchal Translucency Ultrasound
CPT® Procedure Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76813*</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation; optional</td>
</tr>
<tr>
<td>76814*</td>
<td>Ultrasound, Each additional gestation - list separately in addition to code for primary procedure</td>
</tr>
<tr>
<td>84163**</td>
<td>Pregnancy Associated Plasma Protein A (PAPP-A)</td>
</tr>
<tr>
<td>84702-84704**</td>
<td>Maternal serum free beta Human Chorionic Gonadotropin (hGC)</td>
</tr>
</tbody>
</table>

*The IHCP does not cover 1st Trimester Fetal Nuchal Translucency testing when performed alone for the detection of chromosomal defects.

** The nuchal translucency sonography must be performed in conjunction with maternal serum free beta human chorionic gonadotropin (hCG) and pregnancy-associated plasma protein A (PAPP-A) for the detection of chromosomal defects.

For optimal test results the First Trimester Fetal Nuchal Translucency Ultrasound should be performed between 11 and 13 weeks of pregnancy.

**Home Tocolytic Infusion Therapy**

Home Health Agencies (HHA) may bill all three components of home tocolytic infusion therapy when utilizing the proper billing forms and appropriate codes if the HHA maintains multiple enrollments as an HHA, Pharmacy and DME, or HME provider.

CPT® procedure codes 99601 and 99602 are used if a member meets the criteria for home tocolytic infusion therapy and the agency is providing the home uterine monitoring and skilled nursing components of the therapy only (rather than the entire package noted in S9349). When the home health agency bills 99601 and 99602, the tocolytic drugs and other supplies must be supplied and billed separately through another provider. The home health agency should provide only the home uterine monitor and the skilled nursing components of the home tocolytic infusion therapy. The home health agency may bill 99601 for the first two hours of therapy and bill 99602 for each additional hour of therapy, up to 22 additional hours for each 24-hour period.

HHAs may bill for S9349, 99601, and 99602 using standard home health care billing guidelines. All supplies for each therapy are bundled into a daily rate, and HHAs are not allowed to bill separately for any supplies associated with these therapies and are not allowed to bill an overhead charge when daily infusion services do not include an actual encounter in the home.

Providers are allowed to bill one unit of service daily and should use revenue code 559 when billing S9349, 99601, and 99602.
For additional information regarding billing, please refer to Chapter 8 of the IHCP Provider Manual.

**Table 12 – Home Tocolytic Infusion Therapy CPT® procedure codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| S9349  | Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, per diem. (Total global package of services provided by HHAs for all the components of Home Tocolytic Infusion Therapy.) Covers the following items:  
  - Home uterine monitor  
  - Skilled nursing services that include the following:  
    - Initial nursing assessment  
    - Instructions given to the patient about the proper use of the monitoring equipment  
    - Home visits as needed to monitor signs and symptoms of preterm labor  
    - Twenty-four-hour telephone support for troubleshooting on the monitoring equipment, for pharmacological support, and for patient symptoms  
  - Ambulatory infusion pump  
  - Tocolytic drugs  
  - All other supplies necessary to maintain a patient at home on this therapy including the following:  
    - Conductive paste or gel  
    - Dressings  
    - Extra batteries for infusion pump  
    - Sharps container  
    - Site kits  
    - Syringes  
    - Tubing  
    - Other supplies  
  This global package also includes any costs involved in transmitting reports to the physician electronically, such as a fax or telephone modem. |
| 99601  | Home infusion/specialty drug administration, per visit (up to two hours)                                                                                                                                      |
| 99602  | Home infusion/specialty drug administration, per visit (up to two hours) each additional hour  
  Codes 99601 and 99602 cover the following items:  
  - Home uterine monitor |
• Skilled nursing services that include the following:
  ➢ Initial nursing assessment
  ➢ Instructions given to the patient about the proper use of the monitor
  ➢ Home visits to monitor signs and symptoms of preterm labor
  ➢ Twenty-four hour telephone support for troubleshooting the monitoring equipment and for reporting patient symptoms
• Also includes any costs involved in transmitting reports to the physician electronically, such as fax or telephone modem

**Delivery Code Modifiers**

The following modifiers are required on the *CMS-1500* claim form when billing fee-for-service (FFS) claims with Current Procedural Terminology (CPT®) delivery codes 59409, 59514, 59612, and 59620.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>UB</td>
<td>Medically necessary delivery prior to 39 weeks of gestation: Deliveries resulting from:</td>
</tr>
<tr>
<td></td>
<td>• Members presenting in labor and subsequently delivering before 39 weeks of gestation.</td>
</tr>
<tr>
<td></td>
<td>• Inductions or cesarean sections that meet the IHCP’s approved medical indications for a medically necessary delivery prior to 39 weeks and 0 days. Documentation of the gestational age of the fetus and the medical indication for an early delivery must be completed and maintained in the member’s file. Suggested forms for documentation are the ACOG Patient Safety Checklists on the ACOG website at acog.org or the IPQIC Scheduling form on the ISDH website at in.gov/isdh.</td>
</tr>
<tr>
<td>UC</td>
<td>Delivery at 39 weeks of gestation or later: Delivery at 39 weeks of gestation or later regardless of method (induction, cesarean section, or spontaneous labor)</td>
</tr>
<tr>
<td>UA</td>
<td>Nonmedically necessary delivery prior to 39 weeks of gestation: Deliveries at less than 39 weeks of gestation that do not meet the IHCP’s stated guidelines for approved medically necessary deliveries</td>
</tr>
</tbody>
</table>

The following condition codes are required on the *UB-04* claim form when billing for FFS obstetric delivery services. Condition codes are to be placed in fields 18-24 of the *UB-04* claim form.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81</td>
<td>C-sections or inductions performed at less than 39 weeks’ gestation for medical</td>
</tr>
</tbody>
</table>
necessity
82  C-sections or inductions performed at less than 39 weeks’ gestation electively
83  C-sections or inductions performed at 39 weeks’ gestation or greater

### Anesthesia for Vaginal or Cesarean Delivery

Providers billing anesthesia services for labor and delivery use the anesthesia CPT® vaginal or cesarean delivery CPT® codes. This method of billing is the same for any other surgery and for obstetrical anesthesia, regardless of the type of anesthesia provided (such as general or regional), including epidural anesthesia. When the anesthesiologist starts an epidural for labor, and switching to a general anesthetic for the delivery becomes necessary, combine and bill the total time for the procedure performed, such as vaginal delivery or cesarean section (C-section).

When a provider, other than the surgeon or obstetrician, bills for epidural anesthesia, the IHCP reimburses that provider in the same manner as for general anesthesia Table 125 is a list of applicable vaginal and cesarean delivery CPT® codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01960</td>
<td>Anesthesia for vaginal delivery only</td>
</tr>
<tr>
<td>01961</td>
<td>Anesthesia for cesarean delivery only</td>
</tr>
<tr>
<td>01962</td>
<td>Anesthesia for urgent hysterectomy following delivery</td>
</tr>
<tr>
<td>01963</td>
<td>Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia</td>
</tr>
<tr>
<td>01965</td>
<td>Anesthesia for incomplete or missed abortion procedures</td>
</tr>
<tr>
<td>01966</td>
<td>Anesthesia for induced abortion procedures</td>
</tr>
<tr>
<td>01967</td>
<td>Anesthesia for induced abortion procedures Neuraxial labor analgesia or</td>
</tr>
<tr>
<td></td>
<td>anesthesia for planned vaginal delivery (this includes any repeat sub</td>
</tr>
<tr>
<td></td>
<td>arachnoid needle placement and drug injection and/or any necessary</td>
</tr>
<tr>
<td></td>
<td>replacement of an epidural catheter during labor</td>
</tr>
<tr>
<td>01968</td>
<td>Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (list separately in addition to code for primary procedure performed)</td>
</tr>
<tr>
<td>01969</td>
<td>Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (list separately in addition to code for primary procedure performed)</td>
</tr>
</tbody>
</table>

### Postpartum

The IHCP reimburses for up to two postpartum visits within 60 days post-delivery. The IHCP may reimburse the provider for up to two inpatient or outpatient postpartum visits using CPT®
code 59430, which is postpartum care only. However, if providers use CPT® codes 59410 or 59515 (which include delivery plus postpartum care) when billing, the provider may bill one additional postpartum visit using procedure code 59430.

**High-Risk Pregnancy (Illness or Injury)**

When billing for an illness or injury that could complicate a pregnancy or have an adverse effect on the pregnancy’s outcome, physicians may bill for the covered services provided to treat that illness or injury. The physicians must use the appropriate diagnosis codes as the primary diagnosis on the claim. (Refer to *Chapter 8 of the IHCP Provider Manual*, for a list of medically high-risk pregnancy ICD-9-CM diagnosis codes.) 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.

**Medical 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.

Higher reimbursement is available when providers bill with prenatal office visit procedure codes (CPT® 59425 and 59426) and an appropriate ICD-9-CM diagnosis code.

**Psychosocially High-Risk Pregnancies**

ICD-9-CM diagnosis codes range from V60.0 through V62.9 are used to indicate a high-risk pregnancy for psychosocial reasons.

**Multiple Births**

Multiple birth deliveries are subject to the multiple surgery reimbursement methodology. The current reimbursement policy can be found in 405 IAC 5-28-1(g) for pricing multiple surgical procedures.

**Cesarean Delivery**

The IHCP reimburses only for one cesarean procedure, regardless of the number of babies delivered during the cesarean section. When billing for multiple births, only one detail line with one unit of service is billed for cesarean delivery procedure codes. Please note, the IHCP reimburses only 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 all births are cesarean, the cesarean births are billed using the appropriate procedure code and one unit of service.

**Table 16 – Cesarean Delivery CPT® Procedure Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59514</td>
<td>Cesarean delivery only</td>
</tr>
<tr>
<td>59620</td>
<td>Cesarean delivery only, following attempted V-BAC</td>
</tr>
</tbody>
</table>

Additional information on billing requirements can be found in Chapter 8 of the IHCP Provider Manual.

**Vaginal Delivery**

When billing for multiple births when all births are vaginal deliveries, providers bill the first birth using the appropriate procedure code listed below. In addition, the second birth and any subsequent births are billed using procedure codes 59409 or 59612 with modifier 51 – *Multiple procedures*.

**Table 17 – Vaginal Delivery CPT® Procedure Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59409</td>
<td>Vaginal delivery only (with or without episiotomy and/or forceps);</td>
</tr>
<tr>
<td>59612</td>
<td>Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps),</td>
</tr>
</tbody>
</table>

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*, 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 births are billed on one detail line with one unit of service using procedure code 59514 or 59515. The vaginal births are billed as separate details using procedure code 59409 or 59612 with modifier 51.

**Other Outpatient Office Visits**

CPT® procedure codes 99211-99215 or 99241-99245 may be billed for outpatient office visits rendered to pregnant members if the visits are 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.

**Rules, Citations and Sources**

*405 IAC 5-22-3 – Nursing and Therapy Services – Certified Nurse Midwife Services*
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

IHCP Bulletins
BT201421

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Abortion
Anesthesia Services
Chiropractic
Family Planning
Gynecology Services
Home Health Services
Laboratory Services – Human Immunodeficiency Virus (HIV) Testing
Laboratory Services – Salivary Estriol Test for Preterm Labor Risk Assessment
Screening Services – Newborn Screening
Transportation Services
Oncology

Introduction

This section serves as a general summary of the IHCP’s policies regarding oncology. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

As defined in the MacMillan dictionary, 2011, “oncology” is the study and treatment of cancer. 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.

Reimbursement Requirements

Oncology services are covered if the services are medically necessary and reasonable, 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. Per 405 IAC 5-28-10, outpatient administration of chemotherapy and costs related to this therapy, including catheterization, physician’s visits, cost of drugs and solutions, pump regulators, and servicing, will be covered and do not require PA.

Prior Authorization Requirements

PA is required for bone marrow or stem cell transplants. Chemotherapy services provided by a home health agency are subject to the PA criteria. PA is not required for parenteral infusion pumps when used in conjunction with parenteral hyperalimentation, including central venous catheters.

Billing Requirements

Billing Requirements for Chemotherapy and Radiation Treatment Services

All outpatient hospital chemotherapy and radiation treatment services are billed on the UB-04 claim form. When chemotherapy and radiation treatment services are rendered on the same day, all applicable components should be billed.
Chemotherapy

Chemotherapy services consist of four components: treatment room services, administration of chemotherapy agent, chemotherapy agent, and IV solution and equipment. Each of these four components is separately reimbursable when chemotherapy is administered. To bill for chemotherapy services, providers should adhere to the following guidelines:

- Treatment room services – Bill using revenue codes 45X, 483, 51X, 52X, or 76X. Treatment room reimbursement is limited to one unit per day, per member, per provider.

- Administration of chemotherapy agent – Bill using revenue codes 331, 332 or 335. The appropriate CPT® chemotherapy administration codes (96401 – 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) CPT® 2002]

- Chemotherapy agent – Bill using revenue code 636 (Drugs requiring detailed coding) along with the appropriate covered HCPCS J code(s) (J9000 – J9390).

- IV 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

Radiation treatment consists of two components: treatment room services and administration of radiation treatment. To bill for radiation treatment services, providers should adhere to the following guidelines:

- Treatment room services – Bill using revenue codes 45X, 483, 51X, 52X, or 76X. Treatment room reimbursement is limited to one unit per day, per member, per provider.

- Administration of radiation treatment – Bill using revenue codes 330, 333, or 339 along with the appropriate CPT® radiation treatment codes (77261-77799).

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
IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Not Applicable
Oncology – Breast and Cervical Cancer Program

Introduction

This section serves as a general summary of the IHCP’s policies regarding oncology – breast and cervical cancer program. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

USC 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 Breast and Cervical Cancer Mortality Prevention Act of 1990 established the Centers for Disease Control and Prevention’s National Breast and Cervical Cancer Early Detection Program (NBCCEDP), providing breast and cervical screening exams to underserved women.

On October 24, 2000, the Breast and Cervical Cancer Prevention and Treatment Act of 2000 was signed into law, giving states the option to provide medical assistance through Medicaid to eligible women screened for and found to have breast or cervical cancer through the NBCCEDP. 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 IC 12-15-2-13.5.

Reimbursement Requirements

To be eligible for Medicaid while receiving treatment for breast or cervical cancer, a woman must meet the following criteria:

- Not eligible for Medicaid under any other section of IC 12-15
- Less than 65 years of age
- 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.
• Not otherwise covered under credible coverage, as defined in 42 U.S.C. 300gg(c)
• Family income does not exceed 200 percent 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

Requirements for PA are contingent on each service rendered to participants of the Breast and Cervical Cancer Program. Please refer to Chapter 6 of the IHCP Provider Manual for PA requirements for each service rendered.

Billing Requirements

IHCP providers are responsible for following correct coding procedures in accordance with standard billing practices. Please refer to the Fact Sheet which corresponds to each service rendered for more information on billing requirements.

Rules, Citations and Sources

IC 12-15-2-13.5
IC 12-15-2.3
IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Not Applicable
Ophthalmological Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding ophthalmological services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

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.

Reimbursement Requirements

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 20 years old and younger, per rolling calendar year
- One routine vision care examination and refraction is covered for members 21 years old and older every two years.
- The member must meet the following medical necessity guidelines, in at least one eye, for the provision of eyeglasses. The documentation 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
Initial Examinations

IHCP coverage for vision examinations is limited to specific criteria. An initial examination is the initial vision care service performed for the determination of the need for additional vision care services. Medical necessity will determine which type of initial exam will be given. 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 services and provider should not bill them separately:

- 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.

The frequency of vision care services is subject to the following limitations:

- Reimbursement for the initial vision care examination will be limited to one examination per year for a recipient under 21 years old.
- One examination every two years for a recipient 21 years old or older.

If medical necessity dictates more frequent examination or care, documentation of such medical necessity must be maintained in the provider’s office.

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
• Neutralization of contact lenses
• Extended ophthalmoscopy
• Serial tonometry
• Refractions
• Out-of-office visit
• Office visit
• Consultation
• Visual skills testing

Screening services (excluding Early and Periodic Screening, Diagnosis, and Treatment – EPSDT) for recipients are not covered by Medicaid, and payment will not be made for such care. All services provided to recipients in long-term care (LTC) facilities must be documented in the recipient medical record maintained by the facility.

**Prior Authorization Requirements**

Most vision care services do not require PA; however, PA is required for the following services:

• Blepharoplasty for a significant obstructive vision problem
• Prosthetic device, except eyeglasses
• Reconstructive or plastic surgery
PA is required for all vision services provided to 590 members when an amount greater than $500.00 per procedure is billed, regardless of whether the services require PA in the traditional Medicaid program.

**Billing Requirements**

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 CPT® 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 progressive lenses, transitional lenses, anti-reflective coating, or tint numbers other than 1 or 2, 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 if 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. The IHCP may reimburse for only tints 1 and 2. Table 1 lists the covered codes for tints.

**Table 1—Covered Codes for Tints**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2745 U1</td>
<td>Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens, plastic, rose 1 or 2, per lens</td>
</tr>
<tr>
<td>V2745 U2</td>
<td>Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens, glass, rose 1 or 2, per lens</td>
</tr>
</tbody>
</table>

Table 2 lists non-covered HCPCS codes for lenses.

**Table 2—Non-covered Vision Codes**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2702</td>
<td>Deluxe lens feature</td>
</tr>
<tr>
<td>V2744</td>
<td>Tint, photochromatic, per lens</td>
</tr>
</tbody>
</table>
Non-covered services for lens include:

- Lenses with decorative designs
- Fashion tints, gradient tints, sunglasses, or photochromatic lenses
- Except when medical necessity is documented, lenses larger than size 61 millimeters

**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 frames may not bill the member for any additional cost that is more than the IHCP reimbursement.

The IHCP does not cover any portion of a deluxe or fancy frame purchase, except when medically necessary. The maximum amount reimbursed for frames is $20 per pair except when medically necessity requires a more expensive frame. Charges for medically necessary deluxe frames must be submitted with procedure code V2025 – Deluxe frame. All Medicaid claim forms submitted for more expensive frames 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
- Specific lens prescription requirements
- Frames with special modifications, such as a ptosis crutch
- Infant or child where special size frames must be prescribed that are unavailable for $20 or less

If a member chooses to upgrade to a deluxe frame without medical necessity, the entire frame is considered 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 or frames can be repaired. The following information describes instances that support medical necessity for replacement of eyeglasses:

- Members younger than 21 years of age that have met the medical necessity for replacement of eyeglasses may be eligible for a new pair of eyeglasses one year from the date the replacement eyeglasses were provided.
- Members 21 years old and older that have met the medical necessity for replacement of eyeglasses may be eligible for a new pair of eyeglasses five years from the date the replacement eyeglasses were provided.
- If a member needs replacement eyeglasses loss, theft, or damage beyond repair, prior to the established limitations, the U8 modifier to bill for the replacement lenses or frames.*
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.

The minimum prescription or change meets the following criteria:

- For one eye, a minimum initial prescription or, for a subsequent pair of glasses, a change of seventy-five hundredths (.75) diopters for a patient aged 6 to 42 years old; and fifty-hundredths (.50) diopters prescription or change for a patient older than 42 years old.

- An axis change of at least 15 degrees.

- 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 needed only on claims for replacement of frames or lenses within the one- or five 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 includes but is not limited to members with severe facial deformities who are physically unable to wear eyeglasses; or to members who have severe allergies 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 extended-wear lenses is necessary, as well. Providers can bill with CPT codes 92310 through 92326, which are not part of the general ophthalmology services.

Effective December 20, 2012, for dates of service on or after November 1, 2012, CPT codes 92071 – *Fitting of contact lens for treatment of ocular surface disease* – and 92072 – *Fitting on contact lens for management of keratoconus, initial fitting* – was linked to provider specialty 180 – optometrist.

**Ophthalmologic Surgeries**

Documentation must be maintained in the member’s medical records to support medical necessity for all ophthalmologic surgeries, including Argon and Krypton laser-beam therapy, yttrium aluminum garnet (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 Section 90 Surgery – Surgical Services - and Section 91 Surgery – Transplants of this manual.

Argon and Krypton Light Amplification by Stimulated Emission of Radiation (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 it may be used to incise tissue to provide a new avenue for the aqueous humor to drain as part of glaucoma treatment.

IOLs and NTIOLs

IOLs and NTIOLs are intraocular lenses that are implanted to replace the natural lenses following procedures such as cataract surgery. Other diagnoses supporting 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 CPT® codes 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 DME provider number.

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. The treatment 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, that is, brain tumors, hemorrhoids, and chondylmata. When used in conjunction with a surgery not specific to ophthalmological treatments, it should be included in the global fee billing schedule when filing a claim.

Vision Procedures

Vision care reimbursement is not available for more than one unit for eye exams and other ophthalmologic procedures. IHCP providers may bill only one unit, per member, per day for the procedures indicated in Table 72.3. Claims having more than one unit per day for these codes will automatically pay for one unit. Examinations in which counseling and coordination of care are the dominant services may be coded with the appropriate 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. All Medicaid claim forms submitted for vision materials must be accompanied by valid copies of laboratory invoices.

Ophthalmologic Surgeries

Providers furnishing optical or ophthalmology services to members enrolled in MCE delivery systems must contact the appropriate organization and refer to the appropriate manual for specific guidelines for surgical services.

Table 3—Ophthalmologic Services
<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92002</td>
<td>Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient</td>
</tr>
<tr>
<td>92004</td>
<td>Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits</td>
</tr>
<tr>
<td>92012</td>
<td>Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient</td>
</tr>
<tr>
<td>92014</td>
<td>Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits</td>
</tr>
<tr>
<td>92018</td>
<td>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</td>
</tr>
<tr>
<td>92019</td>
<td>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</td>
</tr>
<tr>
<td>92020</td>
<td>Gonioscopy with medical diagnostic evaluation (separate procedure)</td>
</tr>
<tr>
<td>92060</td>
<td>Sensorimotor examination with multiple measurements of ocular deviation (i.e., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)</td>
</tr>
<tr>
<td>92065</td>
<td>Orthoptic and/or pleoptic training, with continuing medical direction and evaluation</td>
</tr>
<tr>
<td>92081</td>
<td>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)</td>
</tr>
<tr>
<td>92082</td>
<td>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)</td>
</tr>
<tr>
<td>92083</td>
<td>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 perimeter, Octopus programs G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)</td>
</tr>
<tr>
<td>92100</td>
<td>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)</td>
</tr>
<tr>
<td>92140</td>
<td>Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>92250</td>
<td>Fundus photography with medical diagnostic evaluation</td>
</tr>
<tr>
<td>92260</td>
<td>Ophthalmoscopy, with medical diagnostic evaluation with ophthalmodynametry</td>
</tr>
<tr>
<td>92265</td>
<td>Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with medical diagnostic evaluation</td>
</tr>
<tr>
<td>92270</td>
<td>Electro-oculography with medical diagnostic evaluation</td>
</tr>
<tr>
<td>92275</td>
<td>Electroretinography with medical diagnostic evaluation</td>
</tr>
<tr>
<td>92284</td>
<td>Dark adaptation examination, medical diagnostic evaluation</td>
</tr>
<tr>
<td>92285</td>
<td>External ocular photography with medical diagnostic evaluation for documentation of medical progress</td>
</tr>
<tr>
<td>92286</td>
<td>Special anterior segment photography with medical diagnostic evaluation with specular endothelial microscopy</td>
</tr>
<tr>
<td>92287</td>
<td>Special anterior segment photography with interpretation and report; with fluorescein angiography</td>
</tr>
<tr>
<td>92311</td>
<td>Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye</td>
</tr>
<tr>
<td>92312</td>
<td>Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes</td>
</tr>
<tr>
<td>92313</td>
<td>Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens</td>
</tr>
<tr>
<td>92315</td>
<td>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</td>
</tr>
<tr>
<td>92316</td>
<td>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</td>
</tr>
<tr>
<td>92317</td>
<td>Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneoscleral lens</td>
</tr>
</tbody>
</table>

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
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 must 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 be physically available at the time and location the vision therapy services are rendered.
- All documentation of directly supervised vision therapy services rendered by staff must be cosigned in the medical record by the supervising optometrist or physician.

Rules, Citations and Sources

42 CFR § 440.120, Subpart A – Definitions
42 CFR § 441.30, Subpart A – General Provisions – Optometric services
405 IAC 5-9-1 – E/M services
405 IAC 5-3-1 – Prior Authorization
405 IAC 5-16 – 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 – Reimbursement Limitations
405 IAC 5-36 – Diabetes Self Management Treatment

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.
Related Medical Topics

Not Applicable
Osteogenic Bone-Growth Stimulator

Introduction

This section serves as a general summary of the IHCP’s policies regarding osteogenic bone-growth stimulators. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Osteogenic bone-growth stimulators are devices that use electrical currents to promote bone growth and healing. Electrical stimulation produces calcification and mineralization of the fibrocartilage repair tissue (bone growth) at a fracture site and helps increase vascularity. Electrical stimulators are used for non-healing or hard to heal fractures, usually of the long bones, and also for spinal fusions.

At this time, the IHCP covers four different types of bone-growth stimulators with PA. There are several types of bone-growth stimulators available to deliver therapy by different methods:

- Implantable direct current stimulators – These are used for spinal fusions, for use at the time of the surgical procedure, or to be implanted surgically for bone grafting of non-union 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. Implantable stimulators allow constant current treatment and increased patient compliance.

- Non-invasive external device – Electrodes 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. The unit may be operated up to 24 hours per day.

- External device – Coil 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 for no more than 10 hours per day.

- Ultrasonic (US) osteogenic stimulator – This is a non-invasive unit applied directly to the skin. This produces pulsed US, which increases vascularity to speed healing. The US 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.

**Reimbursement Requirements**

The IHCP provides reimbursement for covered osteogenic bone-growth stimulators (listed in Table 1) when the service is considered medically necessary and provided in compliance with all IHCP guidelines, including obtaining prior authorization.

**Prior Authorization Requirements**

This policy relates to nonunion fractures, which must meet the following criteria:

- Serial radiographs must have confirmed that the healing of the fracture has ceased for three or more months prior to starting treatment with an osteogenic stimulator.
- 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.

Once the above criteria are met, the PA criteria are as follows:

- **Non-invasive Stimulators (E0747 and E0748)** – The noninvasive stimulator devices are covered only for the following indications:
  - Non-union of long bone fractures
  - Congenital pseudoarthrosis
  - As an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site, or for those undergoing multiple level fusions. A multiple level fusion involves three 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:
  - Non-union of long bone fractures
  - As an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site; or for those undergoing multiple level fusions. A multiple level fusion involves three or more vertebrae (e.g. L3-L5, L4-S1, etc.).

- **Ultrasound Stimulator (E0760)** – The US stimulator is covered for the following indications:
  - Non-union of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the US stimulator; radiographs must be separated by a minimum of 90 days, and each must include multiple views of the fracture site. Written interpretation by a
physician must state that there has been no clinically significant evidence of
the fracture healing between the two sets of radiographs.

- The ultrasonic osteogenic stimulator may not be used concurrently with other
  non-invasive osteogenic devices.

Non-unions of the skull and vertebrae, and those that are tumor-related are excluded from
coverage. Treatment for fresh fractures and non-union associated with osteomyelitis is not
covered.

Billing Requirements

The IHCP covers osteogenic stimulators with PA under the following codes:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0747</td>
<td>Osteogenesis stimulator, electrical, noninvasive, other than spinal applications</td>
</tr>
<tr>
<td>E0748</td>
<td>Osteogenesis stimulator, electrical, noninvasive, spinal applications</td>
</tr>
<tr>
<td>E0749</td>
<td>Osteogenesis stimulator, electrical, surgically implanted</td>
</tr>
<tr>
<td>E0760</td>
<td>Osteogenesis stimulator, low intensity ultrasound, noninvasive</td>
</tr>
</tbody>
</table>

Rules, Citations and Sources

405 IAC 5-3-5 – Written requests for prior authorization
405 IAC 5-17-1 – Reimbursement; limitations
405 IAC 5-17-2 – Prior authorization; generally
405 IAC 5-19-1 – Medical supplies
405 IAC 5-19-2 – “Durable medical equipment” or “DME” defined
405 IAC 5-19-3 – Reimbursement parameters for durable medical equipment
405 IAC 5-19-6 – Durable medical equipment subject to prior authorization
405 IAC 5-19-7 – Prior authorization criteria
405 IAC 5-19-8 – Ownership of durable medical equipment

IHCP Banner Page

BR200838 – Medicaid Changes Prior Authorization Requirements for Osteogenic Bone-
Growth Stimulators

IHCP Provider Manual
Related Medical Topics

Evaluation and Management Services

Medical Supplies and Durable Medical Equipment – Overview

Hospital Inpatient Services

Hospital Outpatient Services

Surgery – Surgical Services
Out-of-State Services

Introduction
This section serves as a general summary of the IHCP’s policies regarding out-of-state services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service
Members of the IHCP may require healthcare services when they are outside the state of Indiana under specifically defined circumstances. If an Indiana Health Coverage Program member requires healthcare services, he or she should inquire, if possible before receiving services, whether the organization is enrolled as an IHCP provider. Out-of-state healthcare providers must enroll in the IHCP.

Reimbursement Requirements
Per 405 IAC 5-5-1, IHCP reimbursement is available for following specified services provided outside the state of Indiana:
- Acute general hospital care
- Chiropractic services
- Dental services
- Diagnostic services, including genetic testing
- Durable medical equipment and supplies Physican services
- Hospice services, subject to the conditions in 405 IAC 5-34-3
- Pharmacy services
- Physician services
- Podiatry services
- Therapy services
- Transportation services
The above services may be rendered to the member while outside the state of Indiana or under the following specifically defined circumstances:

- The service is not available in Indiana. Care provided by out-of-state VA and Shriners Hospitals for Children 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 member, to the member’s family, or to 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.

Enrolled out-of-state hospital providers are reimbursed for inpatient acute care services at DRG in-state rates or through 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.

**Prior Authorization Requirements**

PA is required for the above services when they are provided to IHCP members with the following exceptions:

- Emergency services provided out-of-state are exempt from PA; however, continuation of inpatient treatment and hospitalization is subject to the PA requirements of Indiana and must be requested within 48 hours of admission.
- Recipients of the adoption assistance program placed outside of Indiana will receive approval for all routine medical and dental care provided out-of-state.

PA may be granted for any time period from one day to one year for out-of-state medical services listed above as long as the service meets the criteria for medical necessity, and any one of the above criteria is also met.

PA will not be approved for the following services outside Indiana and are not covered when provided by any out-of-state provider or designated out-of-state providers:

- Nursing facilities, Intermediate Care Facilities for the Intellectually Disabled (ICFs/ID), or home health agency services.
- Any other LTC 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.
Designated Out-of-State Areas

Members may receive services in the following designated out-of-state areas, subject to the PA requirements as in-state service providers.

<table>
<thead>
<tr>
<th>State</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td>Chicago</td>
</tr>
<tr>
<td></td>
<td>Danville</td>
</tr>
<tr>
<td></td>
<td>Watseka</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Louisville</td>
</tr>
<tr>
<td></td>
<td>Owensboro</td>
</tr>
<tr>
<td>Michigan</td>
<td>Sturgis</td>
</tr>
<tr>
<td>Ohio</td>
<td>Cincinnati</td>
</tr>
<tr>
<td></td>
<td>Hamilton</td>
</tr>
<tr>
<td></td>
<td>Harrison</td>
</tr>
<tr>
<td></td>
<td>Oxford</td>
</tr>
</tbody>
</table>

Members may 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 member or the member’s family.
- The service is not available in the immediate area.
- The member’s physician complies with all the criteria set forth in this article, in accordance with the state plan and 42 CFR 456.3.

out-of-State Suppliers of Medical Equipment

To be treated as an in-state provider, any out-of-state supplier of medical equipment must comply with the following:

- Maintain an Indiana business office, staffed during regular business hours, with telephone service.
- Provide service, maintenance, and replacements for Indiana Medicaid members whose equipment has malfunctioned.
- Qualify with the Indiana Secretary of State as a foreign corporation.
Billing Requirements

Pharmacy Claims for Members in the Restricted Card Program

For pharmacy claims to pay for restricted members, prescriptions must be written by the lock-in provider or a valid referring doctor, and must be presented at the lock-in pharmacy. Claims can be submitted via point of sale (POS), electronic batch, or paper. If a member in the Restricted Card Program is locked-in to a pharmacy and presents a prescription from a prescriber that is not the primary lock-in provider or a valid referral, the claim will deny.

If the pharmacy does receive a denial indicating the prescriber is not a valid lock-in provider (EOB 7501), and the member insists he or she has a valid referral from that prescriber, the lock-in pharmacy should contact the appropriate vendor associated with the member’s Restricted Card Program.

Rules, Citations and Sources

42 CFR 456.3
405 IAC 5-5 – Out-of-State Services
405 IAC 5-13-5 – Prior authorization for services rendered outside of large state ICF/IID

IHCP Bulletins

   BT 200317
   BT 200625

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp

Related Medical Topics

Transportation Services
Physician Administered Drugs

Introduction

This section serves as a general summary of the IHCP’s policies regarding physician administered drugs. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Physician administered drugs, commonly referred to as J-codes, include drugs that ordinarily cannot be self administered, chemotherapy drugs, immunosuppressives, inhalation solutions, and other miscellaneous drugs and solutions. This section summarizes policy for physician administered drugs only. For immunizations and vaccines, refer to the Immunizations and Vaccines and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Healthwatch Program sections of this manual.

Reimbursement Requirements

The IHCP generally provides coverage for all physician administered drugs for medically necessary conditions. However, reimbursement is not available to a physician for injecting medications that can be self-administered unless justified by the patient’s condition. Possible noncompliance by a recipient to oral medications is insufficient justification to administer injections.

It is the provider’s responsibility to ensure the treatment is appropriate based on FDA approved indications, peer reviewed journals, and standards of practice. IHCP reserves the right to place diagnosis restrictions on physician administered drugs when deemed appropriate. One such group of drugs is the botulinum toxins; refer to the section Physician Administered Drugs – Botulinum Toxin Injections for approved diagnosis criteria.

With the exception of vaccines available through the Vaccines for Children (VFC) Program, the IHCP calculates the maximum allowable amount for reimbursement for physician office-administered injectable drugs, using HCPCS J codes and CPT® immunization codes, on the basis of the most cost-effective, current, reimbursement for an appropriate NDC, identified as the benchmark NDC. The maximum allowable reimbursement is equal to Wholesale Acquisition Cost (WAC) plus 5 percent (WAC+5%) of the benchmark NDC or, if no WAC data is available, CMS’ reimbursement, which is currently Average Sales Price (ASP) plus 6 percent (ASP+6%). The maximum allowable cost corresponds to the dose in the narrative description of the HCPCS
or CPT® code. When the provider specifies no dose in the narrative, the reimbursement rate is set by the contractor responsible for updating the rates based on what corresponds to a typical dose for the particular code. The IHCP notifies providers through bulletins or banner pages about reimbursement rates for codes that have no dose or are dose-unspecified.

All procedure coded physician administered drugs are priced by using submitted procedure code and procedure code units. IHCP reviews pricing for physician administered drugs quarterly. Pricing updates are based on relating the HCPCS code to the corresponding classification of NDC from the First DataBank (FDB) drug file. The benchmark NDC price should meet the criteria of being non-terminated by CMS or less than three years obsolete by CMS, from a labeler with a federal rebate agreement in place, and the lowest Wholesale Acquisition Cost within the FDB classification. Some codes use manual pricing in place of the benchmark process. Manual pricing will apply in situations where there is no benchmark NDC available.

When a provider cannot use an existing CPT® or HCPCS code to bill for a new injectable drug because a specific code has not been assigned, the provider should use an appropriate nonspecific CPT® or HCPCS code such as J3490 – Unclassified drugs or 90749 – Unlisted immunization procedure to bill. Providers can use a nonspecific CPT® or HCPCS code only when no code is available with a narrative that accurately describes the drug being administered or the drug’s route of administration.

The IHCP limits joint injections to four injections per joint site, per provider, per month. Claims submitted for more than three injections per joint site in a one-month period must have supporting documentation attached to indicate the medical necessity of the fourth injection per joint site. Additionally, providers billing for more than four joint injections per provider in a one month period must have supporting documentation to indicate that the injections involve different joint sites and that no more than four injections were administered to a single joint.

The IHCP limits Vitamin B12 injections to one per 30 days per member.

For injectable drugs, vaccines that are not part of the VFC program, and vaccines typically part of the VFC program but supplied out of private stock, providers may separately bill an appropriate CPT® administration code, 96372-96373, in addition to the HCPCS J-code or CPT® code for the injectable drug. If an Evaluation and Management (E&M) code is billed with the same date of service as a physician administered drug, separate reimbursement is not available for the administration of the drug since the administration is already included in the E&M code allowed amount. However, if documentation supports that the E&M visit is a separate identifiable event, the provider may receive reimbursement for both the E&M visit and the administration by billing modifier 25. If no E&M code is billed and more than one injection is given on the same date of service, providers may bill a separate administration fee for each injection using the appropriate administration code.

When administering an infusion, providers should bill the appropriate HCPCS J-code or CPT® drug infusion code. An E&M code may be billed on the same date as infusion therapy if the physician’s documentation supports such a code and the E&M service is reasonable and
necessary. While both services may be billed, the physician is not entitled to bill an E&M code on each occasion of infusion therapy.

**Prior Authorization Requirements**

Prior authorization (PA) is generally not required for physician administered drugs. An exception is Krystexxa (pegloticase) which does require prior approval.

**Billing Requirements**

The Federal Deficit Reduction Act of 2005 mandates that IHCP require the submission of National Drug Codes (NDCs) on claims submitted with certain procedure codes for physician administered drugs. Thus, when billing physician administered drugs, the procedure code, the NDC, and the procedure code units must be submitted. Providers should ensure that the number of units billed is supported by the HCPCS code or CPT® code narrative description and the patient’s medical record. The NDC administered is required on the CMS-1500 paper claim form, UB-04 paper claim form, Web InterChange, the 837P electronic transactions, and the 837I electronic transactions. Refer to Chapter 8 of the IHCP Provider Manual for detailed billing instructions.

The procedure code billing units, as well as the NDC quantity, are required. To report the NDC on the CMS-1500 claim form, enter the following information into the shaded portion of fields 24A to 24H:

- Enter the NDC qualifier of N4
- Enter the NDC 11-digit numeric code
- Enter the drug description
- Enter the NDC Unit qualifier
  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN – Unit
- Enter the NDC Quantity (Administered Amount) in the format 9999.99

The procedure code billing units and NDC quantity do not always have a one-to-one relationship. The NDC quantity is based on the strength of the drug administered per unit, and the designated strength of the procedure code. The NDC quantity billed must be reflective of the procedure code quantity billed on the claim. When billing NDCs that have one procedure code but that involve multiple NDCs, providers will no longer need to use the KP and KQ modifiers. Providers will bill the claim with the appropriate NDC for the drug they are dispensing on separate detail lines. For example, if a provider administers 150 mg of Synagis, most likely a 50 mg vial plus a 100 mg vial would be used. These two vials have different NDCs but one
procedure code; therefore, the item would be billed with two detail lines for the same procedure
code and the corresponding NDCs. This change includes crossover claims as well.

When billing any compound drugs that require an NDC, providers must bill the appropriate NDC
for each procedure code. Providers will receive payment for all valid NDCs included in the
compounded drug.

The IHCP manually prices drugs billed with a nonspecific CPT® or HCPCS code, and providers
must submit them with an attachment. For all CMS-1500 claims or 837P transactions billed with
a nonspecific code, providers must write the NDC qualifier, NDC, NDC unit of measure, and
number of units administered on the claim itself; otherwise, the IHCP must deny the claim. The
IHCP reimburses nonspecific codes at the WAC+5% (or ASP+6% if no WAC data is available)
of the National Drug Code (NDC) indicated on the claim form, multiplied by the number of units
administered. For electronic 837 transactions, providers can indicate the NDC for the drug
dispensed in the NDC field. The NDC quantity and unit of measure must also be provided.

Rules, Citations and Sources

405 IAC 5-25-4 – Injections administered by physicians

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins,
and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) HealthWatch
Program

Immunizations and Vaccines

Physician Administered Drugs - Pegloticase Injections.
Physician Administered Drugs – Botulinum Toxin Injections

Introduction

This section serves as a general summary of the IHCP’s policies regarding botulinum toxin injections. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Currently, the FDA has approved four types of botulinum toxin injections – onabotulinumtoxinA (Botox), rimabotulinumtoxinB (Myobloc), abobotulinumtoxinA (Dysport), and incobotulinumtoxinA (Xeomin). These injections are approved for symptomatic treatment of certain neuromuscular conditions. Botulium toxin injects are neurotoxins that interfere with neuromuscular transmission. Providers should be aware that the potency units of these products are not interchangeable with each other and, therefore, units of biological activity of one product cannot be compared to or converted into units of other botulinum toxin products.

Botulinum toxins are injected directly into the affected muscle, through a procedure called chemodenervation, to paralyze temporarily 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). Botulinum toxin injections 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 PT.

Reimbursement Requirements

Treatment with botulinum toxin injections provides temporary relief of symptoms and is indicated for use when conventional treatment has failed or in conjunction with PT or other therapeutic techniques. IHCP provides reimbursement for chemodenervation using botulinum toxins for treating certain neuromuscular conditions, including cervical dystonia, cerebral palsy, multiple sclerosis, and other muscular and neurological conditions that cause excessive muscle contractions.

Reimbursement is available only when administered in a physician’s office, consistent with IHCP policy concerning reimbursement for injectable pharmaceutical products. Reimbursement
is limited to one injection, per member, every three months. The IHCP does not provide reimbursement for botulinum toxins for cosmetic purposes, as indicated in 405 IAC 5-24-3.

**Prior Authorization Requirements**

PA is not required for botulinum toxin injections.

**Billing Requirements**

The HCPCS codes that are available for billing botulinum toxins are included in Table 1.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0585</td>
<td>Injection, onabotulinumtoxina, 1 unit (Botox)</td>
</tr>
<tr>
<td>J0586</td>
<td>Injection, abobotulinumtoxina, 5 units (Dysport)</td>
</tr>
<tr>
<td>J0587</td>
<td>Injection, rimabotulinumtoxinb, 100 units (Myobloc)</td>
</tr>
<tr>
<td>J0588</td>
<td>Injection, incobotulinumtoxina, 1 unit (Xeomin)</td>
</tr>
</tbody>
</table>

IHCP reimbursement for botulinum toxin must include one of the following CPT® codes available for billing chemodenervation, listed in Table 2.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>42699</td>
<td>Unlisted procedure, salivary glands or ducts</td>
</tr>
<tr>
<td>43201</td>
<td>Esophagoscopy, rigid or flexible; with directed submucosal injections, any substance</td>
</tr>
<tr>
<td>43236</td>
<td>Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance</td>
</tr>
<tr>
<td>46505</td>
<td>Chemodenervation of internal anal sphincter</td>
</tr>
<tr>
<td>52287</td>
<td>Cystourethroscopy, with injection(s) for chemodenervation of the bladder</td>
</tr>
<tr>
<td>53899</td>
<td>Unlisted procedure, urinary system</td>
</tr>
<tr>
<td>64612</td>
<td>Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)</td>
</tr>
<tr>
<td>64614</td>
<td>Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis)</td>
</tr>
<tr>
<td>64616</td>
<td>Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)</td>
</tr>
</tbody>
</table>
Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed

Chemodenervation of one extremity; 1-4 muscle(s)

Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s) (List separately in addition to code for primary procedure)

Chemodenervation of one extremity; 5 or more muscle(s)

Chemodenervation of one extremity; each additional extremity, 5 or more muscle(s) (List separately in addition to code for primary procedure)

Chemodenervation of trunk muscle(s); 1-5 muscle(s)

Chemodenervation of trunk muscle(s); 6 or more muscle(s)

Chemodenervation of eccrine glands; both axillae

Chemodenervation of eccrine glands; other area(s) (eg., scalp, face, neck), per day

Chemodenervation of extraocular muscle

Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)

Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)

To ensure that the injections are medically necessary, IHCP reimbursement for botulinum toxin injections is limited to specific diagnosis codes. Table 3 shows the ICD-9-CM codes that are available for reimbursement of botulinum toxin injections.

Table 3 – ICD-9-CM Codes Available for Reimbursement of Botulinum Toxin Injections

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>333.6</td>
<td>Genetic torsion dystonia</td>
</tr>
<tr>
<td>333.71</td>
<td>Athetoid cerebral palsy</td>
</tr>
<tr>
<td>333.79</td>
<td>Other acquired torsion dytonia</td>
</tr>
<tr>
<td>333.81</td>
<td>Blepharospasm</td>
</tr>
<tr>
<td>333.82</td>
<td>Orofacial dyskinesia</td>
</tr>
<tr>
<td>333.83</td>
<td>Spasmodic torticollis</td>
</tr>
<tr>
<td>333.84</td>
<td>Organic writers’ cramp</td>
</tr>
<tr>
<td>333.89</td>
<td>Other fragments of torsion dystonia</td>
</tr>
<tr>
<td>334.1</td>
<td>Hereditary spastic paraplegia</td>
</tr>
<tr>
<td>340</td>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>341.0</td>
<td>Neuromyelitis optica</td>
</tr>
<tr>
<td>341.1</td>
<td>Schilder's disease</td>
</tr>
<tr>
<td>341.22</td>
<td>Idiopathic transverse myelitis</td>
</tr>
<tr>
<td>341.8</td>
<td>Other demyelinating diseases of central nervous system</td>
</tr>
<tr>
<td>341.9</td>
<td>Demyelinating disease of central nervous system, unspecified</td>
</tr>
<tr>
<td>342</td>
<td>Hemiplegia and hemiparesis</td>
</tr>
<tr>
<td>342.10</td>
<td>Spastic hemiplegia and hemiparesis affecting unspecified side</td>
</tr>
<tr>
<td>342.11</td>
<td>Spastic hemiplegia and hemiparesis affecting dominant side</td>
</tr>
<tr>
<td>342.12</td>
<td>Spastic hemiplegia and hemiparesis affecting nondominant side</td>
</tr>
<tr>
<td>343.0</td>
<td>Diplegic</td>
</tr>
<tr>
<td>343.1</td>
<td>Hemiplegia</td>
</tr>
<tr>
<td>343.2</td>
<td>Quadriplegic</td>
</tr>
<tr>
<td>343.3</td>
<td>Monoplegic</td>
</tr>
<tr>
<td>343.4</td>
<td>Infantile hemiplegia</td>
</tr>
<tr>
<td>343.8</td>
<td>Other specified infantile cerebral palsy</td>
</tr>
<tr>
<td>343.9</td>
<td>Infantile cerebral palsy, unspecified</td>
</tr>
<tr>
<td>344.00</td>
<td>Quadriplegia unspecified</td>
</tr>
<tr>
<td>344.01</td>
<td>Quadriplegia c1-c4 complete</td>
</tr>
<tr>
<td>344.02</td>
<td>Quadriplegia c1-c4 incomplete</td>
</tr>
<tr>
<td>344.03</td>
<td>Quadriplegia c5-c7 complete</td>
</tr>
<tr>
<td>344.04</td>
<td>Quadriplegia C5-C7 Incomplete</td>
</tr>
<tr>
<td>344.09</td>
<td>Other quadriplegia</td>
</tr>
<tr>
<td>344.1</td>
<td>Paraplegia</td>
</tr>
<tr>
<td>344.2</td>
<td>Diplegia or upper limbs</td>
</tr>
<tr>
<td>344.30</td>
<td>Monoplegia or lower limb affecting unspecified side</td>
</tr>
<tr>
<td>344.31</td>
<td>Monoplegia of lower limb affecting dominant side</td>
</tr>
<tr>
<td>344.32</td>
<td>Monoplegia of lower limb affecting nondominant side</td>
</tr>
<tr>
<td>344.40</td>
<td>Monoplegia of upper limb affecting unspecified side</td>
</tr>
<tr>
<td>344.41</td>
<td>Monoplegia of upper limb affecting dominant side</td>
</tr>
<tr>
<td>344.42</td>
<td>Monoplegia of upper limb affecting nondominant side</td>
</tr>
<tr>
<td>346.70</td>
<td>Chronic migraine without aura, without mention of intractable migraine without mention of status migrainosus</td>
</tr>
<tr>
<td>346.71</td>
<td>Chronic migraine without aura, with intractable migraine, so stated, without</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>346.72</td>
<td>Chronic migraine without aura, without mention of intractable migraine with status migrainosus</td>
</tr>
<tr>
<td>346.73</td>
<td>Chronic migraine without aura, with intractable migraine, so stated, with status migrainosus</td>
</tr>
<tr>
<td>351.8</td>
<td>Other facial nerve disorders</td>
</tr>
<tr>
<td>374.03</td>
<td>Spastic entropion</td>
</tr>
<tr>
<td>374.13</td>
<td>Spastic ectropion</td>
</tr>
<tr>
<td>378.00</td>
<td>Esotropia, unspecified</td>
</tr>
<tr>
<td>378.01</td>
<td>Monocular esotropia</td>
</tr>
<tr>
<td>378.02</td>
<td>Monocular esotropia with A pattern</td>
</tr>
<tr>
<td>378.03</td>
<td>Monocular esotropia with V pattern</td>
</tr>
<tr>
<td>378.04</td>
<td>Monocular esotropia with other noncomitancies</td>
</tr>
<tr>
<td>378.05</td>
<td>Alternating esotropia</td>
</tr>
<tr>
<td>378.06</td>
<td>Alternating esotropia with A pattern</td>
</tr>
<tr>
<td>378.07</td>
<td>Alternating esotropia with V pattern</td>
</tr>
<tr>
<td>378.08</td>
<td>Alternating esotropia with other noncomitancies</td>
</tr>
<tr>
<td>378.10</td>
<td>Exotropia, unspecified</td>
</tr>
<tr>
<td>378.11</td>
<td>Monocular exotropia</td>
</tr>
<tr>
<td>378.12</td>
<td>Monocular exotropia with A pattern</td>
</tr>
<tr>
<td>378.13</td>
<td>Monocular exotropia with V pattern</td>
</tr>
<tr>
<td>378.14</td>
<td>Monocular exotropia with other noncomitancies</td>
</tr>
<tr>
<td>378.15</td>
<td>Alternating exotropia</td>
</tr>
<tr>
<td>378.16</td>
<td>Alternating exotropia with A pattern</td>
</tr>
<tr>
<td>378.17</td>
<td>Alternating exotropia with V pattern</td>
</tr>
<tr>
<td>378.18</td>
<td>Alternating exotropia with other noncomitancies</td>
</tr>
<tr>
<td>378.20</td>
<td>Intermittent heterotropia, unspecified</td>
</tr>
<tr>
<td>378.21</td>
<td>Intermittent esotropia, monocular</td>
</tr>
<tr>
<td>378.22</td>
<td>Intermittent esotropia, alternating</td>
</tr>
<tr>
<td>378.23</td>
<td>Intermittent exotropia, monocular</td>
</tr>
<tr>
<td>378.24</td>
<td>Intermittent exotropia, alternating</td>
</tr>
<tr>
<td>378.30</td>
<td>Heterotropia, unspecified</td>
</tr>
<tr>
<td>378.31</td>
<td>Hypertropia</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>378.32</td>
<td>Hypotropia</td>
</tr>
<tr>
<td>378.33</td>
<td>Cyclotropia</td>
</tr>
<tr>
<td>378.34</td>
<td>Monofixation syndrome</td>
</tr>
<tr>
<td>378.35</td>
<td>Accommodative component in esotropia</td>
</tr>
<tr>
<td>378.40</td>
<td>Heterophoria, unspecified</td>
</tr>
<tr>
<td>378.41</td>
<td>Esophoria</td>
</tr>
<tr>
<td>378.42</td>
<td>Exophoria</td>
</tr>
<tr>
<td>378.43</td>
<td>Vertical heterophoria</td>
</tr>
<tr>
<td>378.44</td>
<td>Cyclophoria</td>
</tr>
<tr>
<td>378.45</td>
<td>Alternating hyperphoria</td>
</tr>
<tr>
<td>378.50</td>
<td>Paralytic strabismus, unspecified</td>
</tr>
<tr>
<td>378.51</td>
<td>Third or oculomotor nerve palsy, partial</td>
</tr>
<tr>
<td>378.52</td>
<td>Third or oculomotor nerve palsy, total</td>
</tr>
<tr>
<td>378.53</td>
<td>Fourth or trochlear nerve palsy</td>
</tr>
<tr>
<td>378.54</td>
<td>Sixth or abducens nerve palsy</td>
</tr>
<tr>
<td>378.55</td>
<td>External ophthalmoplegia</td>
</tr>
<tr>
<td>378.56</td>
<td>Total ophthalmoplegia</td>
</tr>
<tr>
<td>378.60</td>
<td>Mechanical strabismus, unspecified</td>
</tr>
<tr>
<td>378.61</td>
<td>Brown’s (tendon) sheath syndrome</td>
</tr>
<tr>
<td>378.62</td>
<td>Mechanical strabismus from other musculofascial disorders</td>
</tr>
<tr>
<td>378.63</td>
<td>Limited duction associated with other conditions</td>
</tr>
<tr>
<td>378.71</td>
<td>Duane’s syndrome</td>
</tr>
<tr>
<td>378.72</td>
<td>Progressive external ophthalmoplegia</td>
</tr>
<tr>
<td>378.73</td>
<td>Strabismus in other neuromuscular disorders</td>
</tr>
<tr>
<td>378.81</td>
<td>Palsy of conjugate gaze</td>
</tr>
<tr>
<td>378.82</td>
<td>Spasm of conjugate gaze</td>
</tr>
<tr>
<td>378.83</td>
<td>Convergence insufficiency or palsy</td>
</tr>
<tr>
<td>378.84</td>
<td>Convergence excess or spasm</td>
</tr>
<tr>
<td>378.85</td>
<td>Anomalies of divergence</td>
</tr>
<tr>
<td>378.86</td>
<td>Internuclear ophthalmoplegia</td>
</tr>
<tr>
<td>378.87</td>
<td>Other dissociated deviation of eye movements</td>
</tr>
<tr>
<td>378.9</td>
<td>Unspecified disorder of eye movements</td>
</tr>
<tr>
<td>478.75</td>
<td>Laryngeal spasm</td>
</tr>
</tbody>
</table>
527.7 Disturbance of salivary secretion
530.0 Achalasia and cardiospasm
565.0 Anal fissure
596.54 Neurogenic bladder NOS
596.55 Detrusor sphincter dyssynergia
705.21 Primary focal hyperhydrosis
723.5 Torticollis, unspecified
754.1 Certain congenital musculoskeletal deformities of sternocleidomastoid muscle

Due to the short shelf life of botulinum toxin products, providers may bill the units injected in a single treatment AND the units discarded and not used for another patient. Both the amount of the agent actually administered and the amount discarded should be documented in the patient’s medical chart. If a vial is split between two or more members, the provider must bill the amount used for each member and the bill the unused amount as wastage on the claim for the last member injected.

Rules, Citations and Sources

405 IAC 5-24 – Pharmacy Services

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Not applicable
Physician Administered Drugs – Histrelin Implant (Supprelin LA)

Introduction

This section serves as a general summary of the IHCP’s policies regarding Supprelin LA histrelin implant (Supprelin LA). Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their policies and PA procedures.

Description of Service

Supprelin LA implant is approved by the FDA for the treatment of central precocious puberty (CPP). Children with CPP have an early onset of secondary sexual characteristics before age eight (8) in females and age nine (9) in males. They also show significantly advanced bone age that can result in diminished adult height attainment.

The work-up for precocious puberty should include both physical and laboratory diagnostic confirmatory steps before treatment are initiated. Physical diagnostic documentation should include the following:

- A record of growth, Tanner stages, and height and weight percentiles
- External genitalia changes
- Abdominal, pelvic, neurologic examinations
- Signs of androgenization
- Other conditions such as McCune-Albright and hypothyroidism

Laboratory diagnostic studies include:

- Bone age x-rays
- Head MRI, ultrasonography of abdomen and pelvis
- FSH, LH, hCG assays
- Thyroid hydroxyprogesterone
- Inhibin levels
- GnRH testing
Reimbursement Requirements

Supprelin LA is considered medically necessary when ALL of the following criteria are met:

- The diagnosis of Central Precocious Puberty is made before the age of 8 years in girls and 9 years in males; **AND**
- The diagnosis of Central Precocious Puberty is documented in clinical records (history, physical findings and laboratory analysis); **AND**
- A pediatric endocrinologist has been consulted and is in agreement with the diagnosis and treatment plan; **AND**
- Documented inability to tolerate leuprolide acetate (Lupron Depot Ped) intramuscularly (not due to pain) once every 4 weeks due to recurrent sterile fluid collections at the sites of injections; **AND**
- Documentation that subcutaneous injections of aqueous leuprolide, given once or twice daily (total dose 60 mg/kg/24hr), or intranasal administration of the GnRH agonist nafarelin (Synarel) 800 mg bid would not be tolerated or complied with.

Prior Authorization Requirements

This service does not require PA.

Billing Requirements

Supprelin LA implant is designed to deliver approximately 65 mcg of histrelin per day over 12 months. The recommended dose of histrelin is one 50 mg implant inserted subcutaneously for 12 months. The implant must be removed 12 months after insertion. At the time the implant is removed, another implant may be inserted to continue therapy. Table 1 below lists the HCPCS code for Supprelin LA.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9226</td>
<td>Histrelin implant (Supprelin LA), 50 mg</td>
</tr>
</tbody>
</table>

Supprelin LA will only be reimbursed when billed with the one of the following ICD-9-CM diagnosis codes listed in Table 2 below.

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>259.1</td>
<td>Precocious sexual development and puberty, not elsewhere classified</td>
</tr>
</tbody>
</table>
Rules, Citations and Sources

405 IAC 5-24 – Pharmacy Services

IHCP Provider Bulletin

BT200827

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Physician Administered Drugs – Histrelin Implant (Vantas)
Physician Administered Drugs – Histrelin Implant - Vantas

Introduction

This section serves as a general summary of the IHCP’s policies regarding Histrelin Implant (Vantas). Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their policies and PA procedures.

Description of Service

Vantas is a drug-delivery system that contains the medicine histrelin and is placed under the skin. After it is placed under the skin, Vantas delivers histrelin continuously for 12 months. Vantas is a sterile, non-biodegradable, diffusion-controlled Hydron polymer reservoir containing histrelin acetate, a synthetic nonapeptide analog of the naturally occurring gonadotropin releasing hormone (GnRH), also known as luteinizing hormone releasing hormone (LH-RH), possessing a greater potency than the natural sequence hormone. Vantas is used to help relieve the symptoms of advanced prostate cancer; it is not a cure.

Vantas, an LH-RH agonist, acts as a potent inhibitor of gonadotropin secretion when given continuously in therapeutic doses.

Administration of Vantas results in an initial increase in circulating levels of luteinizing hormone (LH) and follicle-stimulating hormone (FSH), leading to a transient increase in concentration of gonadal steroids (testosterone and dihydrotestosterone in males). With continued administration for more than one to three weeks, the pituitary gland down-regulates and desensitizes GnRH receptors, reducing FSH and LH secretion. Although the physiologic effects are complicated, the end result of continuous GnRH use is chemical castration, or markedly reduced testosterone levels in males. In men, testosterone increases transiently during the first week after the initial dose and then falls to castrate levels after two to four weeks of continued therapy.

Reimbursement Requirements

Vantas is considered medically necessary for the palliative treatment of advanced prostate cancer when all of the following criteria are met:

- A medical need for the implant (e.g. mobility or compliance issues, inability to receive daily injects) is determined.
- A documented diagnosis of cancer of the prostate is made.
- A demonstrated response to luteinizing hormone-releasing hormone (LHRH) agonists is confirmed by periodic measurement of testosterone and prostate-specific antigen (PSA) levels.
- The member has a life expectancy of more than one year
- The member has not had a bilateral orchiectomy

The IHCP does not reimburse for J9225 if a member is hypersensitive to gonadotropin releasing hormone (GnRH), GnRH analogs, or any of the components of Vantas.

Prior Authorization Requirements

This service does not require PA.

Billing Requirements

Vantas is designed to deliver approximately 50 mcg histrelin per day over 12 months. The recommended dose of histrelin is one 50 mg implant inserted subcutaneously for 12 months. The implant must be removed 12 months after insertion. At the time the implant is removed, another implant may be inserted to continue therapy. Table 1 below lists the HCPCS code for Vantas.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9225</td>
<td>Histrelin implant (Vantas), 50 mg</td>
</tr>
</tbody>
</table>

Vantas will only be reimbursed when billed with the one of the following ICD-9-CM diagnosis codes listed in Table 2 below.

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>185</td>
<td>Malignant neoplasm of prostate</td>
</tr>
<tr>
<td>V10.46</td>
<td>Personal history of malignant neoplasm of prostate</td>
</tr>
</tbody>
</table>

Vantas is limited to males and to one unit per member per month.

Rules, Citations and Sources

405 IAC 5-24 – Pharmacy Services
Bulletins

BT201363 – The IHCP provides coverage and billing guidelines for HCPCS code J9225 – Histrelin implant (Vantas)

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics
Physician Administered Drugs – Histrelin Implant (Supprelin LA)
Physician Administered Drugs – Pegloticase Injections

Introduction

This section serves as a general summary of the IHCP’s policies regarding pegloticase injections. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Pegloticase (Krystexxa) is an intravenous medication that breaks down uric acid. It is used for the treatment of chronic gout.

Gout is thought to be caused by deposition of urate crystals in joints, which is often due to elevated levels of uric acid (also called hyperuricemia). Patients with gout experience recurrent attacks of painful inflamed joints, often involving the toes, knees, and fingers. Sometimes urate crystals accumulate at joints along with red, painful tissue. These are called tophi. They can cause significant pain and limit the use of affected joints.

Lowering uric acid levels in the blood is the primary approach to prevention of gout and acute gouty attacks. Pegloticase (Krystexxa) is an alternative to oral medications to lower uric acid when other therapies have not worked or have not been tolerated. Pegloticase works by breaking down uric acid in the blood.

Reimbursement Requirements

Reimbursement is available only when administered in a physician’s office, consistent with IHCP policy concerning reimbursement for injectable pharmaceutical products. Reimbursement is limited to those members who met the prior authorization criteria.

Prior Authorization Requirements

Pegloticase may be considered medically necessary in patients with gout when criteria A, B, AND C are met.

Criteria A – Symptomatic gout with one or more of the following:

- Three (3) gouty flares or more in previous 18 months OR
- Presence of one or more tophi OR
- Chronic gouty arthritis

**Criteria B – Serum Uric Acid Level**
- Serum uric acid level greater than eight (8) mg/dL

**Criteria C – Treatment with oral xanthine oxidase inhibitors**
- A 90-day course each of two xanthine oxidase inhibitors alternatives (example allopurinol and febuxostat) is ineffective in normalizing serum uric acid levels to less than six (6) mg/DL OR
- Intolerance to two xanthine oxidase inhibitors alternatives (example allopurinol and febuxostat) OR
- Use of two xanthine oxidase inhibitors alternatives (example allopurinol and febuxostat) is contraindicated

Pegloticase is considered investigational when used for all other conditions, including but not limited to hyperuricemia not associated with gout and asymptomatic hyperuricemia.

When prior authorization is approved, pegloticase may be authorized in quantities of one eight (8) mg infusion every two (2) weeks, not to exceed 26 infusions in one year.

**Billing Requirements**
The HCPCS code for billing pegloticase is in Table 1.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>J2507</td>
<td>Injection, pegloticase, 1 mg</td>
</tr>
</tbody>
</table>

As with all injectables, providers may separately bill an appropriate CPT® administration code in addition to the HCPCS or CPT® code for the injectable drug. If an Evaluation and Management (E&M) code is billed with the same date of service as a physician administered drug, separate reimbursement is not available for the administration of the drug since the administration is already included in the E&M code allowed amount. However, if documentation supports the E&M visit as a separate identifiable event, the provider may receive reimbursement for both the E&M visit and the administration by billing modifier 25. If no E&M code is billed and more than one injection is given on the same date of service, providers may bill a separate administration fee for each injection using the appropriate administration code.

**Rules, Citations and Sources**

405 IAC 5-25-4
Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics
Not Applicable
Plasmapheresis

Introduction
This section serves as a general summary of the IHCP’s policies regarding plasmapheresis. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service
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 (6) to 10 treatments over a two (2) to 10-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).

Reimbursement Requirements
Plasmapheresis is covered when performed in a hospital setting (either inpatient or outpatient); or in a non-hospital 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 non-physician 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 Requirements**

PA is not required for plasmapheresis.

**Billing Requirements**

The IHCP reimburses plasmapheresis services when IHCP providers bill on a CMS-1500 claim form with CPT® code 36514 – *Therapeutic apheresis; for plasmapheresis*. The appropriate ICD-9-CM procedure code is 99.71 – *Therapeutic plasmapheresis*. PA is not required. Plasmapheresis services are subject to postpayment review. Providers must maintain documentation in the member’s medical record indicating the IHCP coverage criteria has been met.

**Rules, Citations and Sources**

405 IAC 5-3-13 – Services Requiring Prior Authorization

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**Note:** For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp)
Related Medical Topics

Evaluation and Management Services
Hospital Inpatient Services
Hospital Outpatient Services
Podiatry

Introduction

This section serves as a general summary of the IHCP’s policies regarding podiatry. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

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.

Reimbursement Requirements

The IHCP provides reimbursement for podiatric services performed within the scope of the practice of the podiatric profession as defined by Indiana law. Covered services shall include:

- Diagnosis of foot disorders and
- Mechanical, medical, or surgical treatment of these disorders,

Podiatry services are subject to the restrictions and limitations identified in 405 IAC 5-26.

General Restrictions

- In an emergency situation, for services requiring PA, the authorization must be obtained within 48 hours, not including Saturdays, Sundays, and legal holidays.
- Any podiatrist services rendered during inpatient days that are not appropriately prior authorized 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.
- Any podiatrist services rendered during an outpatient visit that were not appropriately prior authorized or were subsequently found not to be medically necessary will not be reimbursed.
- Consultation services rendered by a podiatrist in a NF are not covered when performed on members on a routine basis for screening purposes, except in cases where a specific foot ailment is involved.
Podiatric Office Visits

The IHCP covers podiatric office visits, subject to the following restrictions:

- Reimbursement is limited to one (1) office visit, per 12 months.
- Reimbursement for a new patient office visit is limited to one (1) office visit, per member, per provider, within the last three (3) years.

Reimbursement is not available for the following types of extended or comprehensive office visits:

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

A new patient is “one who has not received professional services from the provider or another provider of the same specialty who belongs to the same practice within the last three years.”

Routine Foot Care Restrictions

The IHCP covers routine foot care only if a medical doctor or doctor of osteopathy has seen the patient for treatment or evaluation of a systemic disease during the six-month period prior to rendering routine foot care services.

The IHCP may provide reimbursement for a maximum of six (6) routine foot care services per year only when the member:

- Has a systemic disease of sufficient severity that unskilled performance of the procedure would be hazardous; and
- The systemic condition has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet.

Routine foot care 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 is routine foot care only when:
  - Clinical evidence of infection of the toenail is present; and
  - Compelling medical evidence exists documenting that the member has either marked limitation of ambulation requiring active treatment of the foot or, in the case of non-ambulatory members, has a condition that is likely to result in significant medical complications in the absence of such treatment.
Doppler Evaluations

The IHCP may provide reimbursement for ultrasonic measurement of blood flow (Doppler evaluation) providing prior authorization has been obtained for the proposed medical procedure and is subject to the following limitations:

- There is a preoperative diagnosis of diabetes mellitus, peripheral vascular disease, or peripheral neuropathy.
- The measurement is for preoperative podiatric evaluation.
- The measurement cannot be used for routine screening.
- The measurement cannot be used as an evaluation of routine foot care procedures, including such services as removal or trimming of corns, calluses, and nails.
- The preoperative Doppler evaluation is limited to one per year.

Surgical Procedures

The IHCP may reimburse for the following podiatric surgical procedures without PA:

- 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
- The IHCP allows surgical procedures other than those mentioned above, performed within the scope of the podiatrist’s license, subject to PA, as specified in 405 IAC 5-26. For covered, paid claims, the IHCP pays 100 percent of the IHCP allowance for the major procedure and 50 percent of the IHCP allowance for subsequent procedures.

Second Opinions

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, 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 surgical setting in which the surgery is performed, including ambulatory surgical centers, hospitals, clinics, or offices.
Laboratory or X-Ray Services

The IHCP may reimburse for laboratory or X-ray services provided by a podiatrist only if the services are rendered by or under the personal supervision of the podiatrist. Services ordered by a podiatrist, but performed by a laboratory or X-ray facility, will be billed directly to the IHCP by the laboratory or X-ray facility. The podiatrist may be reimbursed for handling or conveyance of a specimen sent to an outside laboratory in accordance with 405 IAC 5-18. Reimbursement is not available for comparative foot x-rays, unless prior authorized. The IHCP may reimburse for the following lab and X-ray services billed by a podiatrist:

- Cultures for foot infections and mycotic (fungal) nails for diagnostic purposes
- Sensitivity studies for treatment of infection processes
- Medically necessary pre-surgical testing

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 may be available, subject to the PA requirements of 405 IAC 5-3.

Orthopedic or Therapeutic Footwear

The IHCP may reimburse when a podiatrist renders orthotic services covered by Medicare for all eligible members receiving Medicare and Traditional Medicaid.

- With a physician’s written order, the IHCP may provide reimbursement for the following for members of all ages: Corrective features built into shoes such as heels, lifts, wedges, arch supports, and inserts
- Orthopedic footwear, such as, shoes, boots, and sandals
- Orthopedic shoe additions

If a member currently has a brace, the IHCP covers the shoes and supportive devices if providers document continued medical necessity. The IHCP also provides coverage for therapeutic shoes for members with severe diabetic foot disease.

Prior Authorization Requirements

PA for routine foot care is not required. However, no more than six visits per year are covered. The patient must have been seen by a MD or doctor of osteopathy for treatment or evaluation of the systemic disease during the six-month period prior to the rendering of routine foot care services.

PA is required for the following services:

- Hospital stays, as outlined in 405 IAC 5-17
When a podiatrist prescribes or supplies corrective features built into shoes, such as heels, lifts, and wedges, for a recipient under 21 years old

When a podiatrist fits or supplies orthopedic shoes for a recipient with severe diabetic foot disease, subject to the restrictions and limitations outlined in 405 IAC 5-19

Comparative foot X-rays

Billing Requirements

For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.

Podiatric Office Visits

Providers may bill a visit separately only on the initial visit. For subsequent visits, the procedure performed on that date includes the reimbursement for the visits, and providers do not bill them separately. However, if a second, significant problem is addressed on a subsequent visit, the provider can report the visit code along with supporting documentation indicating why the subsequent visit was required.

- Reimbursement is limited to one (1) office visit, per 12 months, per member.
- Reimbursement for a new patient office visit is limited to one (1) office visit, per member, per provider, within the last three (3) years.

Tables 1 and 2 include the CPT® codes which should be utilized when billing Podiatric Office Visits.

Table 1 Established Podiatric Office Visit

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.</td>
</tr>
<tr>
<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem</td>
</tr>
</tbody>
</table>
focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

Table 2 New Podiatric Office Visit

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
</tbody>
</table>

Routine Foot Care

The IHCP covers a maximum of six routine foot care services per year only when the member:

- Has a systemic disease of sufficient severity that unskilled performance of the procedure would be hazardous; and
- The systemic condition has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet.

Table 3 includes CPT and HCPCS codes that can be billed for routine foot care.
### Table 3 – CPT and HCPCS Codes for Routine Foot Care

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11055</td>
<td>Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion</td>
</tr>
<tr>
<td>11056</td>
<td>Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions</td>
</tr>
<tr>
<td>11057</td>
<td>Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions</td>
</tr>
<tr>
<td>11719</td>
<td>Trimming of nondystrophic nails, any number</td>
</tr>
<tr>
<td>11720</td>
<td>Debridement of nail(s) by any method(s); 1 to 5</td>
</tr>
<tr>
<td>11721</td>
<td>Debridement of nail(s) by any method(s); 6 or more</td>
</tr>
<tr>
<td>G0127</td>
<td>Trimming of dystrophic nails, any number</td>
</tr>
</tbody>
</table>

Table 4 includes ICD-9 diagnosis codes which represent those systemic conditions that would justify coverage for routine foot care.

### Table 4 – ICD-9-CM Codes for Routine Foot Care

<table>
<thead>
<tr>
<th>ICD-9-CM Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.00-250.03</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>250.10-250.13</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>250.20-250.23</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>250.30-250.33</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>250.40-250.43</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>250.50-250.53</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>250.60-250.63</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>250.70-250.73</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>250.80-250.83</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>250.90-250.93</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>356.0-356.9</td>
<td>Hereditary and idiopathic peripheral neuropathy</td>
</tr>
<tr>
<td>357.0-357.7</td>
<td>Polyneuropathy of the feet</td>
</tr>
<tr>
<td>357.81-357.9</td>
<td>Polyneuropathy of the feet</td>
</tr>
<tr>
<td>440.20-440.29</td>
<td>Arteriosclerotic vascular disease of the lower extremities</td>
</tr>
<tr>
<td>443.1</td>
<td>Thromboangiitis obliterans (Buerger’s disease)</td>
</tr>
<tr>
<td>459.10-459.19</td>
<td>Post-phlebitis syndrome</td>
</tr>
</tbody>
</table>
Providers must submit documentation of the treatment or evaluation which occurred within six months prior to routine foot care with the claim, as well as documentation of the nature of the systemic condition and the foot condition being treated. Providers must include the name and provider number of the physician in the CMS-1500 in fields 17 and 17A, respectively. Providers should include the nature of the foot condition being treated on the claim form, include the diagnosis in field 21 of the CMS-1500, and refer to the diagnosis in field 24E of the CMS-1500.

Surgical Procedures
Podiatric surgical procedures, including diagnostic surgical procedures, cannot be fragmented and billed separately. These procedures are generally included in the major procedure. Such procedures include, but are not limited to, the following:

- Arthroscopy or arthrotomy procedures in the same area as a major joint procedure, unless the claim documents that a second incision was made
- Local anesthesia administered to perform the surgical or diagnostic procedure
- Scope procedures used for the surgical procedure approach

Rules, Citations and Sources
405 IAC 5-3 – Prior Authorization
405 IAC 5-5 – Out of State Services
405 IAC 5-8 – Second Opinions
405 IAC 5-17 – Hospital Services
405 IAC 5-19-10 – Restrictions and Limitations
405 IAC 5-26 – Podiatric Services

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp

Related Medical Topics
Not applicable.
Radioimmunotherapy

Introduction

This section serves as a general summary of the IHCP’s policies regarding radioimmunotherapy. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Radioimmunotherapy utilizes a tumor-killing dose of radioactive substance that is linked to a monoclonal antibody, which targets and binds selectively to a malignant tumor. The ability of the antibody to bind to a tumor-associated antigen ensures that the tumor receives a high dose of radiation, killing the targeted cancer cells, while normal tissue receives only a minimal dose. Radioimmunotherapy may result in significant tumor shrinkage while avoiding larger full body doses of radiation.

Currently, the IHCP reimburses for radioimmunotherapy for the treatment of refractory low-grade B-cell non-Hodgkin’s lymphoma utilizing Zevalin® and Bexxar®. Zevalin® and Bexxar® are monoclonal antibodies that target lymphocytes, including malignant B-cells involved in the disease. Additional radioimmunotherapy regimens will be evaluated by the IHCP as they are approved by the FDA.

Reimbursement Requirements

Radioimmunotherapy utilizing Zevalin® and Bexxar® are covered by the IHCP for the treatment of low-grade B-cell non-Hodgkin’s lymphoma in patients that have not responded to or have failed other chemotherapy treatments. Radioimmunotherapy should not be used as the first line of treatment. The patient’s medical record must support the medical necessity of the radioimmunotherapy regimen.

The radioimmunotherapy regimen is administered in two separate steps – the diagnostic step and the therapeutic step. The purpose of the diagnostic step is to determine the radiopharmaceutical biodistribution of 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. The therapeutic step is
characterized by the administration of targeted radiolabeled antibodies. Rituximab and its infusion prior to the administration of Zevalin®, and the infusion of tositumomab prior to the administration of Bexxar®, are separately reimbursable. Likewise, the radiopharmaceutical is separately reimbursable from the nuclear scanning procedure.

Currently, radioimmunotherapy is not a procedure typically performed more than once. Therefore, codes specific to the radioimmunotherapy procedure are limited to one unit per lifetime. The IHCP will re-examine the policy if future research determines that multiple dosing of the radioimmunotherapy regime is appropriate.

**Prior Authorization Requirements**

PA is not required for radioimmunotherapy services.

**Billing Requirements**

The radiopharmaceutical (Zevalin® and Bexxar®) is separately reimbursable from the nuclear medicine scanning procedure. Providers should bill the diagnostic and therapeutic supply of Bexxar® (A9544 and A9545, respectively), and the infusion and supply of tositumomab (G3001) in the Bexxar® regimen. Similarly, providers should bill codes for the diagnostic and therapeutic supplies of Zevalin® (A9542 and A9543, respectively), and the infusion and supply of Rituximab (J9310) in the Zevalin® regime.

**Billing for Outpatient Facility Setting or Physician’s Office**

The outpatient facility or physician’s office should bill the TC of the procedure using CPT® code 78804 (diagnostic component) and 79403 (therapeutic component); the radiopharmaceutical using the appropriate HCPCS code (A9544, A9545, A9542, or A9543), and the appropriate revenue code on the UB-92 claim form or 837I transaction.

Rituximab (J9310) and its infusion (Q0084, 96413, 96416, 96422, or 96425) 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. The physician should bill the professional component with the code-modifier combination 78804-26 or 79403-26 on a CMS-1500 claim form or 837P transaction. Billing codes for outpatient facilities and physicians’ offices are summarized in Table 82.1.
<table>
<thead>
<tr>
<th>Code</th>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78804* (outpatient facility)</td>
<td>341</td>
<td>Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging (Diagnostic)</td>
</tr>
<tr>
<td>79403* (outpatient facility)</td>
<td>340, 342</td>
<td>Radiopharmaceutical therapy, radiolabeled monoclonal antibody by IV infusion (Therapeutic)</td>
</tr>
<tr>
<td>78804-26* (physician)</td>
<td>N/A</td>
<td>Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging (Diagnostic)</td>
</tr>
<tr>
<td>79403-26* (physician)</td>
<td>N/A</td>
<td>Radiopharmaceutical therapy, radiolabeled monoclonal antibody by IV infusion (Therapeutic)</td>
</tr>
<tr>
<td>A9544* (Bexxar®) or A9542* (Zevalin®)</td>
<td>343</td>
<td>Iodine, I-131 tositumomab, diagnostic, per study dose Indium, IN-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries</td>
</tr>
<tr>
<td>A9545* (Bexxar®) or A9543* (Zevalin®)</td>
<td>344</td>
<td>Iodine, I-131 tositumomab, therapeutic, per treatment dose Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries</td>
</tr>
<tr>
<td>J9310 (Zevalin® regime)</td>
<td>636</td>
<td>Injection, rituximab, 100 mg</td>
</tr>
</tbody>
</table>

Also use one of the following administration codes, as appropriate

<table>
<thead>
<tr>
<th>Code</th>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q0084</td>
<td>335</td>
<td>Chemotherapy administration by infusion technique only, per visit</td>
</tr>
<tr>
<td>96413</td>
<td>335</td>
<td>Chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug</td>
</tr>
<tr>
<td>96416</td>
<td>335</td>
<td>Chemotherapy administration, intravenous infusion technique, initiation of prolonged chemotherapy infusion (more than 8 hours), requiring the use of a portable or implantable pump</td>
</tr>
<tr>
<td>96422</td>
<td>335</td>
<td>Chemotherapy administration, intra-arterial; infusion technique, up to one hour</td>
</tr>
<tr>
<td>96425</td>
<td>335</td>
<td>Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump</td>
</tr>
<tr>
<td>G3001 (Bexxar® regimen)</td>
<td>333, 34x</td>
<td>Administration and supply of tositumomab, 450 mg</td>
</tr>
</tbody>
</table>
*Limited to one unit per lifetime

**Rules, Citations and Sources**

*IHCP Bulletins*

BR200716  
BR200446  
BR200513


**Related Medical Topics**

Not applicable.
Radiology

Introduction

This section serves as a general summary of the IHCP’s policies regarding radiology. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Radiology is the branch of medicine that uses radioactive substances, electromagnetic radiation, and sound waves to create images of the body, its organs, and structures for diagnosis and treatment. Radiology can be classified broadly into diagnostic radiology and therapeutic radiology. Diagnostic radiology is the interpretation of images of the human body to aid in the diagnosis or prognosis of disease. Therapeutic radiology utilizes radiation to treat cancer and other diseases.

Reimbursement Requirements

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.

Criteria for the use of radiological services include consideration of the following:

- Evidence that this radiological procedure is necessary for the appropriate treatment of illness or injury.
- X-rays of the spinal column are 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 or 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

Providers must document all services related to radiological examinations in the patient’s record.

CT 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 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 more than 20 cuts is not reimbursed, except in staging cancer for treatment evaluation.

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 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 pre-operative 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 allows for separate reimbursement of non-hospice related radiological treatment in these circumstances. Medicaid providers billing for the treatment of non-terminal conditions are reminded that they are responsible for obtaining Medicaid PA for any non-hospice services that require PA.

**Positron Emission Tomography (PET) Scans**

If the member is an inpatient, the IHCP covers the PET scan in the DRG payment to the hospital. All claims for reimbursement must include an appropriate ICD-9-CM diagnosis code. Please refer to Section 82 of this manual, *Radiology – Positron Emission Tomography (PET) Scans*, for specific guidelines.

**Stereotactic Radiosurgery (SRS)**

IHCP covers three types of non-robotic cranial and total body SRS: particle beam (proton), cobalt-60 (gamma, photon), and linear accelerator (linac).

**Prior Authorization Requirements**

Per 405 IAC 5-27-1, IHCP requires PA for any radiological services that exceed the use parameters set out in this document.

Radiology services are available to *Care Select* and RBMC members on a self-referral basis. RBMC member claims should be submitted to the member’s MCE for payment. Services that require PA furnished to members enrolled in RBMC must be prior authorized by the member’s MCE, in accordance with the MCE’s guidelines.

**Billing Requirements**

Reimbursement is available to radiology inpatient and outpatient facilities, freestanding clinics, and surgical centers for services provided to members subject to the following limitations:

- 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 physicians or other practitioners 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 TC, Modifier TC – Technical component must be used with the appropriate CPT® code. When billing for both professional and TCs 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 CABG
  - Peripheral, percutaneous transluminal angioplasty procedures

Provider Type and Specialty Type

The provider types and specialties that are authorized to bill radiology services to the IHCP are summarized in Table 1. Radiology clinics can be enrolled as billing providers or as groups with members. A radiology group with rendering members is enrolled with provider type 31 – Physician with provider specialty 341 – Radiologist. Radiology clinics can be enrolled as freestanding clinics or as mobile X-ray clinics.

Table 1 – Authorized Billers of Radiology Services

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Provider Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 – Radiology Provider</td>
<td>290 – Freestanding X-ray clinic</td>
</tr>
<tr>
<td></td>
<td>291 – Mobile X-ray clinic</td>
</tr>
<tr>
<td>31 – Physician</td>
<td>341 – Radiologist</td>
</tr>
</tbody>
</table>

Radiology providers are required to submit copies of their Registration Certificates, ISDH Notices 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 Notices of Compliance.

Out-of-state mobile radiology providers performing services in Indiana must be certified in Indiana and possess Notices of Compliance in Indiana. All operators must be certified in the state of Indiana.

Transportation of Portable ECGs and X-ray Machine

When one patient is served, providers should bill using 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. Modifiers UN, UP, UQ, UR, and US must not be reported with HCPCS code R0070. One unit should 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 indicating the number of patients served. Modifiers are summarized below in Table 81.2. 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 percentage of the fee schedule amount that each modifier will reimburse when reported with HCPCS code R0075 is summarized in Table 2.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Fee Schedule Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>UN</td>
<td>Two patients served</td>
<td>50 percent</td>
</tr>
<tr>
<td>UP</td>
<td>Three patients served</td>
<td>33 percent</td>
</tr>
<tr>
<td>UQ</td>
<td>Four patients served</td>
<td>25 percent</td>
</tr>
<tr>
<td>UR</td>
<td>Five patients served</td>
<td>20 percent</td>
</tr>
<tr>
<td>US</td>
<td>Six or more patients served</td>
<td>16 percent</td>
</tr>
</tbody>
</table>

**SRS**

Reimbursement is available for both the technical and the professional components, as well as pre-operative planning services. Providers must bill with revenue code 333 on the UB-04 claim form or 837I transaction.

**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]

**Related Medical Topics**

Not applicable
Radiology – Positron Emission Tomography (PET) Scans

Introduction

This section serves as a general summary of the IHCP’s policies regarding positron emission tomography (PET) scans. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

PET is a non-invasive 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.

Reimbursement Requirements

The IHCP reimburses radiology inpatient and outpatient facilities and freestanding clinics for services provided to members. The following criteria apply:

- There must be sufficient evidence that the radiological procedure is necessary for the appropriate treatment of illness or injury.
- For a radiological service, a physician or other practitioner authorized to do so under state law must order the service in writing.
- The IHCP does not reimburse for radiology examinations of any body part as a routine study not necessary for the diagnosis or treatment of a medical condition.
- Providers must document all services related to radiological examinations in the patient’s records.

Prior Authorization Requirements

PA is not required for PET scans.
Billing Requirements

All claims for reimbursement of PET scans must include an appropriate ICD-9-CM diagnosis code (Table 1) supporting medical necessity and a CPT® code. Claims for PET scans that do not include the appropriate ICD-9-CM diagnosis code will be denied.

Inpatient

If the member is an inpatient, the IHCP covers the PET scan in the DRG payment to the hospital. The CPT® codes for PET scans represent the global service. Providers performing just one component of the test should appropriately use modifier TC (technical component) or 26 (professional component).

Outpatient

If the member is an outpatient and has services performed in the outpatient area of the hospital or in a freestanding facility, the provider should bill for the PET scan as follows:

- Reimbursement for professional services, reported with the appropriate CPT code, modifier 26 (professional services), and the appropriate ICD-9-CM code (Table 84.1), and billed on a CMS-1500 or 837P electronic transaction, reimburse from the resource-based relative value scale (RBRVS) fee schedule.
- Reimbursement for the appropriate CPT code, billed with the technical component (TC) and appropriate ICD-9-CM code on a UB-04 claim form, reimburse based on the statewide max rate.

Table 1 – ICD-9-CM Codes Supporting Medical Necessity

<table>
<thead>
<tr>
<th>Pet Scan Imaging</th>
<th>CPT® Code</th>
<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>78811, 78812, 78814, 78815</td>
<td>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</td>
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<tr>
<td>Myocardial perfusion imaging</td>
<td>78459, 78491, 78492</td>
<td>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</td>
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<tr>
<td>Refractory seizures</td>
<td>78608, 78609</td>
<td>345.01, 345.11, 345.2, 345.3, 345.41, 345.51, 345.61, 345.71, 345.81, 345.91</td>
</tr>
<tr>
<td>Description</td>
<td>CPT Codes</td>
<td>ICD-10 Codes</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Regional or whole body, for single pulmonary nodule</td>
<td>78811, 78812, 78813, 78814, 78815, 78816</td>
<td>235.7, 239.1, 793.1, V71.1</td>
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<tr>
<td>Thyroid cancer</td>
<td>78811, 78812, 78814, 78815</td>
<td>193</td>
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<tr>
<td>Whole body, for colorectal cancer</td>
<td>78813, 78815, 78816</td>
<td>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</td>
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<tr>
<td>Whole body, for esophageal cancer</td>
<td>78813, 78815, 78816</td>
<td>150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, V10.03, V71.1</td>
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<tr>
<td>Whole body, for melanoma</td>
<td>78813, 78816</td>
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</tr>
<tr>
<td>Whole body, for non-small cell lung carcinoma</td>
<td>78811, 78812, 78813, 78815, 78816</td>
<td>162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 196.1, V10.11, V71.1</td>
</tr>
<tr>
<td>Whole body, or regional, for head and neck cancer</td>
<td>78811, 78812, 78813, 78815, 78816</td>
<td>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</td>
</tr>
</tbody>
</table>
Rules, Citations and Sources

405 IAC 5-27-1 – Reimbursement limitations

Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Not applicable
Robotic Therapy

Introduction

This section serves as a general summary of the IHCP’s policies regarding robotic therapy. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Traditionally, a physical therapist will assist in the treatment of movement dysfunction and enhance physical and functional abilities of persons with neuromuscular diseases. The intention of physical therapy is to restore and promote optimal physical function, wellness, fitness and quality of life as it relates to movement. In addition, physical therapists may assist in the prevention of the progression of impairments, functional limitation and disability. An occupational therapist will apply their specific knowledge to enable people to engage in activities of daily living that have personal meaning and value. The intention of the occupational therapist is to develop, improve, sustain, or restore independence to a person with neuromuscular diseases. Occupational therapy will focus on fine motor skills, visual motor integration, visual processing, visual memory, visual perceptual abilities that assist in improving physical, and social development and sensory integration. Use of robotic therapy will facilitate and enhance traditional rehabilitation therapy. Robotic therapy offers an alternate modality to traditional physical and occupational therapy services.

The robots may be used for either upper or lower extremities. These robots serve as a tool that the therapist can utilize to develop, evaluate, and measure outcomes of individually designed therapy programs. Upper extremity therapy entails the use of a robot that attaches to the arm and measures the person’s ability to manipulate a cursor on a computer screen. Systems can be developed to provide incentives for younger children to move the cursor in a directed manner. An example of this would be a video game which encourages the child to move an animal through a maze. The upper extremity robot can either assist the person to move in the proper direction, or as the person improves, provide some resistance to strengthen the muscles.

The lower extremity robots attach to the leg and can be used to facilitate movement or provide resistance to build strength. The lower extremity robots can be adjusted to provide a more normal gait pattern, speed, and force.
Reimbursement Requirements

Reimbursement is available for robotic therapy once the determination has been made it is medically reasonable and necessary and the prior authorization criteria has been met. Robotic therapy may be provided by professionally trained staff, within the scope of their professional license and/or credentials. A screening will be completed at the clinic. The results are to be reviewed by a Board Certified Neurodevelopmental Disabilities physician who will aid in determining eligibility of the member in question. To be considered for robotic therapy, children must be between the ages of 3 and 12. Individuals must have the diagnosis of Cerebral Palsy to be considered for robotic therapy. Listed in Table 1 are the appropriate diagnoses codes indicative of Cerebral Palsy.

Table 1 – ICD-9-CM Codes for Cerebral Palsy

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>343</td>
<td>Infantile Cerebral Palsy</td>
</tr>
</tbody>
</table>

The IHCP will provide coverage of robotic therapy for a total of 6 weeks. The program will consist of 3-1 hour treatments per week, for a total of eighteen treatments for the duration of the program. The treatment regimen can be adjusted with a different frequency of treatments, but the requirement of eighteen treatments remains the expectation.

Coverage of robotic therapy will require a temporary interruption in other forms of therapy or treatment of neuromuscular disorders. Upon completion of the 6 week course of therapy, the person may return to their regular intermittent therapy treatments.

Robotic therapy that has been determined to meet criteria is covered by the IHCP under the Healthcare Common Procedural Coding System (HCPCS) code 97039-Physical Medicine treatment to one area; Unlisted modality (Specify) in conjunction with the modifier GP-Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care. Of note, when utilizing code 97039 GP, 1 unit is equal to 15 minutes of therapy. Motion analysis will be done at both the beginning and end of therapy to monitor outcome and provide recommendations for further traditional therapy. Motion analysis is indicated using HCPCS code 96000-Comprehensive-computer based motion analysis by video-taping and 3-D Kinematics.

Prior Authorization Requirements

PA is required for robotic therapy and motion analysis. The following documentation must be submitted for consideration of the services of robotic therapy and motion analysis;

- Written evidence of physician involvement and personal member evaluation will be required to document medical needs. Therapy must be ordered by a physician.
- A current plan of treatment, including clearly stated and measurable goals and progress.
• 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.
• Medicaid reimbursement is available only for medically reasonable and necessary therapy.
• Therapies which duplicate other services provided to a patient will not be authorized.
• Therapy rendered 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 not covered by Medicaid.
• Therapy services will not be approved for more than one (1) hour per day per type of therapy.

Prior Authorization criteria for upper extremity robotic therapy:
• Diagnosis of mild to moderate Cerebral Palsy
• Cognitive level of the individual will reflect an understanding of expectations and ability to follow directions to allow for completion of the therapy process
• Ages three (3) to twelve (12) years
• Vision - Able to identify shapes and colors on monitor screen
• No more than moderate spasticity at the time of training in the upper limb, as demonstrated by a Modified Ashworth Score of two (2) or less in the shoulder, elbow, and forearm and three (3) or less in the wrist or fingers (no restriction regarding use of botox)
• Adequate passive range of motion to engage in robotic therapy with a passive range of motion in elbow extension of +/−25 degrees or better and wrist extension of neutral or better.
• Capable of understanding and completing two (2) step commands and maintain attention during a 60-minute evaluation session (with frequent breaks allowed).

Prior Authorization criteria for lower extremity robotic therapy:
• Diagnosis of mild to moderate Cerebral Palsy
• Cognitive level of the individual will reflect an understanding of expectations and ability to follow directions to allow for completion of the therapy process
• Ages three (3) to twelve (12) years
• Height 1.1 to 1.90m
- Head stability minimally required
- Capable of understanding and completing two (2) step commands and maintain attention during a 60-minute evaluation session (with frequent breaks allowed).
- Children who can take one (1) to two (2) steps with a walker with assistance

Of note, if the determination is made that the individual in question meets criteria for robotic therapy of both the upper and lower extremities, a separate prior authorization request is required for each modality. Robotic therapy of the upper and lower extremities will not be approved together within the same 6 week time frame.

**Billing Requirements**

As previously mentioned, prior authorization (PA) is required for robotic therapy and motion analysis. Claims for these services may be submitted using CMS 1500.

**Rules, Citations and Sources**

IC § 25-23.5-1-4
IC § 25-23.5-1-5
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

405 IAC 5-3-5 – Written requests for prior authorization; contents
405 IAC 5-5 – Out of State 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 5-25-3 – Physician's written order, plan of treatment; when required
405 IAC 5-32 – Rehabilitation Unit

IHCP Provider Manual
Related Medical topics

Therapy Services

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.
Screening Services - Newborn Screening

Introduction

This section serves as a general summary of the IHCP’s policies regarding newborn screening. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

IC § 16-41-17-2 and IAC 410-3-3-3, require newborn blood screening tests for at least 47 conditions for every infant before discharge from the hospital. This is a required procedure for every infant not earlier than 48 hours after birth and not before the infant has been on a protein diet for at least 24 hours; and no later than 120 hours after birth. This usually occurs before discharge from the hospital.

Babies born at home must have a newborn screening within one week of birth. 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.

The newborn screening test screens for the following:

- Phenylketonuria (PKU)
- Galactosemia
- Hypothyroidism
- Homocystinuria
- Maple syrup urine disease (MSUD)
- Hemoglobinopathies (which includes sickle-cell anemia)
- Congenital adrenal hyperplasia
- Biotinidase deficiency
- Cystic fibrosis
- 34 other amino acid defects, fatty acid oxidation defects and/or organic acidemias
- Medium chain acyl-coenzyme A dehydrogenase (MCAD) deficiency
- Congenital heart disease
- Hearing Impairment
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
  - Tandem mass spectrometry (MS/MS)
  - High volume radioimmunoassay
  - Hemoglobin electrophoresis
  - Isoelectric focusing.
  - Bacterial inhibition assays.
  - Immunoreactive trypsin (IRT).
  - DNA testing.

The hospital collects all blood samples on a filter paper card that must also contain information to identify the infant, the physician, the time of birth, the time of first feeding, and the time of the blood draw. The hospital sends the blood sample to the Indiana University (IU) Newborn Screening Laboratory. In addition, IC § 16-41-17-2(c) requires that every infant shall be given a physiologic hearing screening examination at the feasible time for the detection of hearing loss.

IC § 16-41-17-2(d) identifies religious belief exception from this requirement. Any parent or guardian who objects to the testing for reasons pertaining to religious beliefs only shall indicate by signing a statement or informed refusal. Such objection shall become part of the medical record and the infant shall be exempted from the testing.

**Reimbursement Requirements**

The Indiana State Department of Health (ISDH) has a contract with IU Laboratory to perform laboratory analysis for newborn screening. Providers using laboratories other than the IU Laboratory to perform newborn screening analysis must discontinue the practice. To ensure that the IU Laboratory performs all newborn screening, the ISDH must coordinate all newborn screenings.

Primary care providers can access newborn screening results online through the Indiana Newborn Screening Tracking & Education Program (INSTEP). For registration instructions, please send an e-mail to Bob Bowman, director of Genomics and Newborn Screening (BobBowman@isdh.IN.gov).

Other healthcare professionals who are not primary care providers can obtain newborn screening results by contacting the IU Newborn Screening Laboratory. A fax must be sent on office letterhead with the patient’s name, date of birth (DOB), patient’s mother’s name, and birthing facility to (317) 491-6679. Healthcare professionals with any questions may call 1-800-
Parents or other individuals requesting newborn screening results can contact the ISDH Genomics and Newborn Screening Program by calling 1-888-815-0006.

If the IU Laboratory has obtained a valid test and the results are normal, the IHCP requires no further testing. If the laboratory needs to rescreen due to invalid or abnormal results, the provider must contact the ISDH to work out the best method of accomplishing the rescreening. Because hospitals are more frequently releasing newborns before the 48 hours needed to obtain valid newborn screen results, an increasing number of newborns require a second screen. Providers should ask families to bring the newborn back to the birth hospital as an outpatient, or the hospital may request a nurse to make a follow-up visit to obtain the sample for the newborn screening. In either case, the possibility arises that the hospital could bill separately for newborn screening that is already included in the DRG that the IHCP pays for the newborn hospitalization.

If the IU Laboratory has obtained a valid test and the results are normal, the IHCP requires no further testing. If the laboratory needs to rescreen due to invalid or abnormal results, the provider must call the ISDH at (888)-815-0006 to work out the best method of accomplishing the rescreening. Because hospitals are more frequently releasing newborns prior to the 48 hours needed to obtain valid newborn screen results, an increasing number of newborns require a second screen.

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 to detect HIV or the antibody or antigen to HIV. The test must be ordered at the earliest feasible time, not exceeding 48 hours after the infant’s birth.

Newborn screening results must be recorded in the patient record for infants younger than one year old.

**Prior Authorization Requirements**

PA is not required for newborn screening.

**Billing Requirements**

The IHCP does not permit hospitals to bill separately for newborn screening. The IHCP pays the newborn hospitalization under the DRG that includes the newborn screening. The IHCP does not require HealthWatch/EPSDT providers to report newborn screening on the CMS-1500 or 837P. Newborns should be screened at the birth hospital or the hospital of closest proximity. To avoid being charged by the IU Laboratory for a second screen, a hospital screening a newborn who was born in another Indiana hospital must indicate the name of the birth hospital on the filter paper card. If the newborn’s name or birth date has been changed, the hospital must include the original name and date of birth in the information sent to the IU Laboratory to facilitate a match and avoid a charge by the lab.
Rules, Citations and Sources

IC § 16-41-6 – Communicable Disease: Mandatory Testing of Individuals with Communicable or Dangerous Diseases

IC § 16-41-17-2 – Prevention and Treatment Programs: Examination of Infants for PKU, Hypothyroidism, and Other Disorders

405 IAC 5-15 – Early and Periodic Screening, Diagnostic, and Treatment Services

410 IAC 3-3-3 – Maternal and Child Health

Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) HealthWatch Program

Laboratory Services

Obstetric Care
Smoking Cessation

Introduction

This section serves as a general summary of the IHCP’s policies regarding smoking cessation. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Smoking cessation refers to a course of treatment designed to assist individuals in decreasing or stopping the use of tobacco products.

Reimbursement Requirements

The IHCP provides reimbursement for smoking cessation available for one 12-week course of treatment per member per calendar year. Treatment may include prescription of any combination of smoking cessation products and counseling. Providers may prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment.

Treatment services must be prescribed by a licensed practitioner within the scope of license under Indiana law. Practitioners ordering smoking cessation services must maintain documentation about the order in the same manner used for other covered services.

Smoking Cessation Products

Reimbursement is available to pharmacy providers for smoking cessation products under the following conditions:

- When prescribed by a licensed practitioner within the scope of his or her license under Indiana law.
- Over-the-counter smoking cessation products must be prescribed by licensed practitioners.
- A licensed practitioner must prescribe all smoking cessation products for use, along with counseling, within the 12-week treatment time frame.
- Pharmacies should bill for reimbursement according to the normal procedures.
Only patients who agree to participate in smoking cessation counseling will receive prescriptions for smoking cessation products. The prescribing practitioner may request 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 smoking cessation products will serve as documentation the prescribing practitioner has prescribed or obtained assurance from the patient 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
- Varenicline tartrate tablets (Chantix)
- Nicotine replacement drug products (patch, gum, inhaler)

**Smoking Cessation Counseling**

Counseling services must be prescribed by a licensed practitioner within the scope of his or 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 30 minutes (two units) and a maximum of 150 minutes (10 units) within the 12 weeks. Counseling will be billed in 15-minute increments.

**Prior Authorization Requirements**

PA is not required for reimbursement for smoking cessation products or counseling.

**Hoosier Healthwise:**

Providers of smoking cessation treatment services must obtain the PMP certification for Hoosier Healthwise enrollees.

**Billing Requirements**

The IHCP reimburses for smoking cessation treatment subject to the following requirements.
- Reimbursement is available for one (1) twelve (12) week course of treatment, per member, per calendar year.
- Treatment may include any prescription of any combination of smoking cessation products and counseling.
- Providers may prescribe one (1) or more modalities of treatment.
- Providers **must** include counseling in any combination of treatment.
- Providers must order smoking cessation treatment services in order for the IHCP to reimburse for the services.
- All smoking cessation products must be prescribed within the 12-week treatment time frame.
- Counseling must be provided within the 12-week course of treatment and must be a minimum of 30 minutes (two units) and a maximum of 150 minutes (10 units).
- There is a limit of 84 days of smoking cessation therapy in 365 calendar days.
- Over-the-counter smoking cessation products must be prescribed by licensed practitioners in order for the pharmacy to be reimbursed by Medicaid.
- Providers/practitioners are reminded that they are **not** entitled to Medicaid reimbursement for services they provide to the public at no charge, including smoking cessation counseling services.
- Fractional units of service cannot be billed on the *CMS-1500* form.
- Providers and practitioners should accumulate billable time equivalent to whole units prior to billing.
- Pharmacies will bill for reimbursement according to the normal procedures outlined in the *IHCP Provider Manual*.
- 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.

Providers and practitioners of counseling services must utilizing the HCPCS procedure and ICD 9 diagnosis code in Table 1.

### Table 1 Smoking Cessation Codes

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>HCPCS Procedure Code</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>305.1 – Tobacco use disorder</td>
<td>99407 U6 – Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes;</td>
<td>1 Unit = 15 minutes*</td>
</tr>
</tbody>
</table>
per 15 minutes

*Providers should not round up to the nearest 15 minutes.

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.

Rules, Citations and Sources

405 IAC 5-37 – Smoking Cessation Treatment Policies
405 IAC 5-37-1 – Limitations
405 IAC 5-37-2 – Smoking Cessation Products
405 IAC 5-37-3 – Smoking Cessation Counseling
405 IAC 5-24-7 – Copayment for Legend and Nonlegend drugs

Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Not applicable
Substance Abuse

Introduction

This section serves as a general summary of the IHCP’s policies regarding substance abuse. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Substance abuse services include services for inpatient detoxification, rehabilitation, and aftercare for chemical dependency and outpatient services for individuals who have substance-related disorders. Substance abuse, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-V-TR), describes two primary substance use disorders – substance abuse and substance dependence. A person receives a diagnosis of alcohol and/or drug abuse if he or she experiences at least one of four abuse symptoms (i.e., role impairment, hazardous use, legal problems, or social problems) leading to “clinically significant impairment or distress.”

Substance dependence is defined as the constellation of symptoms related to physical dependence as well as compulsive and pathological patterns of drug use. To qualify for a DSM-V-TR diagnosis of substance dependence, a person must exhibit within a 12-month period at least three of the six following dependence symptoms: (1) tolerance; (2) withdrawal or drinking/using to avoid or relieve withdrawal; (3) drinking larger amounts or for a longer period than intended; (4) unsuccessful attempts or a repeated desire to quit or cut down on use; (5) much time spent using alcohol/drugs; and (6) reduced social or recreational activities in favor of alcohol/drug use. In this section, the terms substance abuse and substance dependence are used interchangeably under alcohol use disorders.

Reimbursement Requirements

The IHCP provides reimbursement for covered inpatient and outpatient substance abuse services when the services are provided in compliance with all IHCP guidelines including obtaining prior authorization

Inpatient substance abuse treatment is available, subject to PA. Outpatient substance abuse services are available to members enrolled in the Medicaid Rehabilitation Option (MRO) who meet the substance-related disorder guidelines.
Inpatient Detoxification

Detoxification is defined as treatment requiring a physician’s 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:

- Evidence of symptoms of withdrawal that require close medical monitoring or continuous observation. Three 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)

- Or one of the following conditions:
  - Seizures
  - Hallucinations of recent onset
  - Disorientation or confusion

- History of severe withdrawal reaction, such as seizures, delirium tremens, or psychotic episode

- Intoxicated with a history of recent, severe idiosyncratic intoxication, such as violence or blackouts while under the influence

- In addition to alcohol/drug condition, member has a co-existing medical and/or psychiatric condition which requires medical and psychiatric services

- 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.

- 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

Inpatient Substance Abuse Services

The IHCP reimburses for inpatient psychiatric services provided to eligible individuals between 22 and 65 years old only in certified psychiatric hospitals of 16 beds or fewer. If the member is
22 years old and began receiving inpatient psychiatric services immediately before the member’s 22nd birthday, inpatient psychiatric services are available.

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.

According to 405 IAC 5-17-5 – Inpatient detoxification, rehabilitation, and aftercare for chemical dependency, Medicaid reimbursement is available when services are prior authorized, subject to IAC requirements. Admission to a general hospital floor is not indicated unless the medical services are required for life support and cannot be rendered in a substance abuse treatment unit or facility.

PA for inpatient detoxification, rehabilitation, and aftercare for chemical dependency includes consideration of the following:

- All requests for PA will be reviewed on a case-by-case basis by the contractor
- Treatment, evaluation, and detoxification are based on the stated medical condition
- The need for safe withdrawal from alcohol or other drugs
- A history of recent convulsions or poorly controlled convulsive disorder
- Reasonable evidence that detoxification and aftercare cannot be accomplished in an outpatient setting

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. MCEs 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 PMP, or any other specialty not enrolled as a psychiatrist, health services provider in psychology, or mental health services provider.

**MRO Services**

MRO services are clinical behavioral health services provided to consumers and families of consumers living in the community who need aid intermittently for emotional disturbances, mental illness, and addiction. Services may be provided in individual or group settings, and in the community. For the purposes of MRO, a “day” is a calendar day, unless otherwise specified. The IHCP provides reimbursement for the following MRO outpatient mental health services:

- AIRS
- Addiction Counseling (Individual, group setting)Behavioral Health Counseling and Therapy (Individual, group setting)
- Behavioral Health Level of Need Redetermination
- Case Management Services
• CAIRS
• Crisis Intervention
• Individual Outpatient Treatment (IOT)
• Medication Training and Support (Individual, group setting)
• Peer Recovery Services
• Psychiatric Assessment and Intervention
• Skills Training and Development (Individual, group setting)

MRO services are designed to assist in the rehabilitation of the consumer’s optimum functional ability in daily living activities. This is accomplished by assessing the consumer’s needs and strengths, developing an IICP that outlines objectives of care, including how MRO services assist in reaching the consumer’s rehabilitative and recovery goals, and delivering appropriate MRO services to the consumer.

According to 405 IAC 5-21.5-2, The Office of Medicaid Policy and Planning (OMPP) will reimburse MRO services for consumers who meet specific diagnosis and level of need criteria under the approved DMHA assessment tool. The listing of diagnostic and level of need criteria approved for reimbursement shall be as follows:

• Will be listed and published in a provider manual by the OMPP.
• May be updated by the OMPP as needed.

Services are provided:

• through a behavioral health service provider that is an enrolled as a Medicaid provider that offers a full continuum of care as defined under IC § 12-7-2-40.6 and 440 IAC 9. These providers may subcontract for services as appropriate; and
• by personnel who meet appropriate federal, state, and local regulations for their respective disciplines or are under the supervision or direction of a licensed professional or QBHP.

Reimbursement for MRO services is restricted to providers enrolled as CMHCs (provider type 11, specialty 111) that meet the requirements for DMHA approval under IC 12-29, in accordance with 440 IAC 4. For additional information regarding MRO services, please see the Medicaid Rehabilitation Option Manual located at www.indianamedicaid.com.

**Prior Authorization Requirements**

IHCP requires PA for all psychiatric, rehabilitation, and substance abuse stays. IHCP does not reimburse providers for days that are not approved for PA.

PA for inpatient detoxification, rehabilitation, and aftercare for chemical dependency include consideration of the following information:
- Review on a case-by-case basis for inpatient detoxification, rehabilitation, and aftercare.
- Treatment, evaluation, and detoxification, 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

Admission to a general hospital floor is not indicated unless medical services are required for life support and cannot be rendered in a substance abuse treatment unit or facility.

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 10 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 the form does not meet the requirements, any claims associated with the admission will be denied.

MRO Services, as defined in the IAC, require PA in certain circumstances. PA is not required for MRO case management services except when requesting additional units of the service.

For additional information regarding PA, please see the IHCP Provider Manual located at www.inianamedicaid.com.

**Billing Requirements**

**Inpatient Services**

The IHCP reimburses 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.

According to 405 IAC 5-20-3, a psychiatric hospital must meet the following conditions to be reimbursed for inpatient mental health services:

- The facility must be enrolled in the IHCP.
- The facility must maintain special medical records for psychiatric hospitals, as required by 42 CFR § 482.61.
- The facility must provide services under the direction of a licensed physician.
- The facility must meet federal certification standards for psychiatric hospitals.
- The facility must meet utilization review requirements.
Direct care services of physicians, including psychiatric evaluations, are excluded from the *per diem* rate and are billable separately by the rendering provider on the CMS-1500 claim form or 837P transaction. The *per diem* rate includes all other supplies and services provided to patients in inpatient psychiatric facilities, including services of HSPPs, clinical psychologists, and clinical social workers, regardless of whether salaried, contracted, or independent providers. Providers cannot bill these supplies and services separately.

**Outpatient Services**

Providers must bill all professional services associated with outpatient mental health services on the CMS-1500 claim form or 837P transaction.

**MRO Services**

For additional information regarding MRO services, please refer to the Medicaid Rehabilitation Option Provider Manual located at www.indianamedicaid.com.

**Rules, Citations and Sources**

405 IAC 5-17 – Hospital Services

405 IAC 5-20 – Mental Health Services

405 IAC 5-21 – Community Mental Health Rehabilitation Services

IC ch 12-29-2

IHCP Bulletin

BT201023

IHCP Provider Manual

Medicaid Rehabilitation Option Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp)

**Related Medical Topics**

Mental Health/Behavioral Health – Outpatient Services
Surgery - Plastic and Reconstructive Surgery – Facial and Maxillofacial

Introduction

This section serves as a general summary of the IHCP’s policies regarding plastic and reconstructive facial and maxillofacial surgery. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

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 and who have completed an approved residency in oral surgery. They must be eligible for certification by the Board of Oral and Maxillofacial Surgery, or they must be physicians who have completed residency training in plastic surgery who are eligible for certification by the American Board of Plastic Surgery.

Reimbursement Requirements

Facial Plastic and Reconstructive Surgeries

IHCP reimburses 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 resulting in anatomical changes.
Reimbursement is available through the IHCP when PA is obtained for medically necessary surgical procedures to remove excess skin from the face and tighten the muscles of the face to correct a facial abnormality caused by functional impairments, disease, or injury-related facial changes – for example, following burn injury or facial palsy from neurologic disease.

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 mid-face. Members with these craniofacial mid-face diseases often require long-term monitoring of the ears, nose, and throat for occurrence of the following conditions 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)

Coverage Criteria for Rhinoplasty and Septoplasty

Nasal deformities may be congenital or acquired. Rhinoplasty that changes 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.
Rhinoplasty

Rhinoplasty may be required to treat a cleft lip or cleft palate. PA is not required for members receiving rhinoplasty surgery related to a documented, primary diagnosis of cleft lip and/or cleft palate. 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
- H&P, including any problems/congenital deformities that could potentially affect the outcome of the requested procedure
- Documented evidence of family/caregiver education about the POC and special health care needs of the member, pre and post op
- Statement that the requested surgery is expected to correct a specified portion of the deformity
- Statement that the requested surgery is expected to improve the member’s functional status

Septoplasty

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 a functional impairment does not respond to medical management treatment. Documentation must support failed conservative, medical interventions for severe airway obstruction.

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 CPAP for treatment of obstructive sleep disorder
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 that 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. (For coverage criteria regarding hearing aids, please see Section 26 in this manual, Hearing Services.)

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
- Re-innervation techniques
- Regional muscle transfers
Free muscle transfers

Physical Therapy (PT) will improve functional outcomes allowing surgical repair of facial nerves, especially for patients requiring tissue transfer. PT utilizes facial neuromuscular retraining to optimize the motor control of facial muscles.

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 loss of visual field or to reconstruct deformity due to trauma or disease. Reimbursement is not provided for blepharoplasties to enhance the appearance of the eyes.

Maxillofacial Services

Coverage Criteria for Maxillofacial Services

The IHCP provides coverage for maxillofacial surgery services. Providers may be required, based on 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 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
Orthognathic (Jaw Realignment) Surgery

Coverage Criteria for 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.

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:

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 (SD) from published norms.

Vertical discrepancies
- Presence of a vertical facial skeletal deformity which is two or more SDs 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

Transverse discrepancies
- A transverse skeletal discrepancy which is two or more SDs 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

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 and/or 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 have not been improved by ST or orthodontia.
  - Malnutrition must be related to the inability to masticate; significant weight loss must be documented over four months, and a low serum albumin exists that is related to malnutrition.
  - Intra-oral trauma while chewing related to malocclusion or recurrent damage to the soft tissues of the mouth during mastication.
  - Documentation of significant OSA 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 ASC.

• Anesthesia for orthognathic surgery may be performed by an anesthesiologist or certified nurse anesthetist, as medically appropriate.

**Temporomandibular Joint Syndrome (TMJ)**

**Coverage Criteria for Treatment of TMJ**

TMJ syndrome or TMJ disorder is a condition resulting from macro-trauma or micro-trauma to the temporomandibular jaw joint and the 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

The IHCP will cover both non-surgical and surgical treatments for TMJ. There are several approaches to treat 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**

Before being evaluated for surgical 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 without adequate relief for a total of three to six months:

- Medical Management
- Physical Therapy
- Psychiatric/psychological therapy
- 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.

**Medical Management**

Medical management may include nonopiate analgesics and nonsteroidal 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. Medical management may be prescribed by a dentist, an orthodontist, an ear, nose, and throat (ENT) specialist, a psychiatrist, or an oral surgeon.

**Physical Therapy for TMJ**

Physical Therapy (PT) for TMJ may include active and passive jaw exercises, thermal modalities, manipulation modalities, electrogalvanic stimulation, and TENS. Cranial manipulation, continuous passive motion, diathermy, infrared, and US treatment, hydrotherapy, myofunctional therapy, iontophoresis, and neuromuscular re-education are not considered medically necessary PT treatments for TMJ.
Per 405 IAC 5-22-8 physical therapy services must be performed by a licensed physical therapist or certified therapist assistant under the direct, on-site supervision of a licensed physical therapist.

**Psychiatric/Psychological Therapy for TMJ**

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, or jaw misalignment) should be evaluated for psychosomatic causes and treated appropriately.

**Surgical Treatment of TMJ**

Treatment of TMJ by maxillofacial surgery will be covered if the following conditions are met:

- A physical exam, diagnostic X-rays, arthrography, or orthopantogram and diagnostic imaging (CT, MRI, or arthroscopy) indicate an intra-articular cause of TMJ.
- 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 PA for surgery.

**Anesthesia for the Surgical Treatment of TMJ**

Local anesthesia is usually adequate for 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.

**Cleft Lip and Cleft Palate**

**Coverage Criteria for Cleft Lip and Cleft Palate**

Cleft lip and cleft palate are congenital defects that 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 do 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

The IHCP stipulates the treatment of cleft lip and cleft palate must be provided by a craniofacial IDT of healthcare 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 are not 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 cleft lip and cleft palate deformities. Depending on the member’s condition, secondary surgical procedures may be required involving the lip, nose, palate, and jaw. These procedures usually are staged over a period of several years.

**Orthodontic Services**

**Coverage Criteria for Orthodontic Services**

The member 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, such as patients with cleft lip and palates, for orthodontic services. Otolaryngologists, plastic surgeons, and oral surgeons usually recommend surgery to correct left lip and cleft palate deformities. Depending on the member’s condition, secondary surgical procedures may be required involving the lip, nose, palate, and jaw. These procedures usually are staged over a period of several years.

The IHCP covers orthodontic procedures only for members younger than 21 years old. PA is required for all orthodontic services. Orthodontic services are covered for members with documentation of one or more 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. The diagnoses or conditions appropriate for orthodontic services are listed below.

**Diagnoses or Conditions Appropriate for Orthodontic Services**

**Category I**

The following diagnoses and/or conditions are appropriate for orthodontic services (patients in Category I and Category II do not require additional information for approval of PA requests):

• Cleft lip and palate and facial clefts
• Oculoauriculovertebral dysplasia
• Mandibulofacial dysostosis (Treacher Collins Syndrome)
• Pierre Robin
• Cleidocranial dysplasia
• Frontonasal malformation
• Crouzon Syndrome
• Apert Syndrome
• Pfeiffer’s Syndrome
• Ectodermal dysplasia
• Hemifacial microsomia
• Amniotic Band Syndrome
• Neurofibromatosis of the facial region
• Holoprosencephaly
• Gorlin Syndrome
• Beckwith-Weidemann Syndrome
• Klippel-Feil Syndrome

Category II

The following conditions, when accompanied by moderate to severe malocclusions, are appropriate for orthodontic services:

• Fetal Alcohol Syndrome
• Encephalocele
• Down Syndrome
• Werdnig-Hoffman Disease
• Spina bifida
• Developmental disturbances related to oncology radiation
• Cerebral palsy
• Achondroplasia
• Osteogenesis imperfecta
• Arthrogryposis of the TMJ (congenital contractures)
• Ankylosis of the mandibular condyles
• VATER Association
• Hemimandibular hypertrophy
• Condylar hyperplasia
• Condylar hypoplasia
• Arcofacial dysostosis
• Rieger Syndrome
Category III

For patients in Category III – Severe Atypical Craniofacial Skeletal Pattern, accompanied by moderate to severe malocclusion – the following listed documentation must be submitted for approval of PA requests. (Patients in this category will likely have a secondary diagnosis of a maxillary or mandibular skeletal problem, such as maxillary vertical hyperplasia, mandibular hypoplasia, maxillary excess, vertical maxillary deficiency, and so forth.)

Documentation is by special report and must include:

- Frontal and lateral photographs of the face
- Photographs of the occlusion,
- A panoramic film,
- A lateral cephalometric film (with tracing)

For Category III members with vertical skeletal problems, the practitioner must enclose a posterior-anterior cephalometric film.

The following is a list of guidelines for defining moderate to severe malocclusion as a medical problem for Categories II and III:

- Cleft lip and palate, and other craniofacial anomalies with severe functional compromise of the occlusion
- Hypodontia or malalignment (one tooth or more per quadrant) precluding routine restorative dentistry
- Overjet greater than six millimeters (mm)
- Reverse overjet (underbite) less than one mm
- Anterior or posterior crossbite with greater than two mm discrepancy
- Lateral or anterior openbite greater than four mm
- Severe overbite with gingival or palatal trauma
- Impaction or impeded eruption of teeth (other than third molars)
- Dysplasia of the vertical dimension of occlusion, LFH greater than 59 percent or less than 52 percent
- Facialskeletal vertical asymmetry greater than two SDs from the norm for menton-zygoma (left or right) or gonion-zygoma (left or right)
Prior Authorization Requirements

Prior Authorization is required for plastic or reconstructive surgery per 405 IAC 5-3-13. In addition, plastic or reconstructive surgery is non-covered unless related to disease or trauma deformity per 405 IAC 5-29-1.

Craniofacial Deformities

PA Criteria for Facial Disorders

The IHCP will provide reimbursement for members with mid-face disorders, nasal deformities, external ear disorders, and facial disorders. Providers are advised to report the most appropriate code for the procedure performed. The PA requirement is indicated for each CPT® codes listed in Table 1. The following information 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, which could include, for example:
  - A suppressed immune system
  - A current infection unresponsive to medical management
  - Medical instability following illness or injury

PA for Rhinoplasty and Septoplasty:

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 information in this section regarding 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. Cleft nasal deformity is 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.

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/turbinectomy 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 CPAP for treatment of obstructive sleep disorder

The IHCP PA requirement for services related to rhinoplasty and septoplasty is noted in Table 2.

**PA for External Ear Disorders**

PA will be granted based on documentation of medical necessity maintained in the member’s medical record. Documentation must include:

- History of the etiology of the external ear deformity
- Any other medical documentation that supports the member’s need of this service and 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.

**PA Criteria for Blepharoplasty**

PA is required for all blepharoplasties, and documentation must support the medical necessity to improve abnormal function, which has resulted in significant visual field loss or to reconstruct...
deformity due to trauma or disease. 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 preclude 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)

The IHCP PA requirement for services related to blepharoplasty is noted in Table 3.

**Maxillofacial Services**

**PA 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 4 for orthognathic surgery and related procedures necessary for facial aesthetic surgery and includes PA requirements.

**TMJ Services**

**PA for Physical Therapy Procedures for TMJ**

PA is required for Physical Therapy as designated below. Refer to the Therapy Services section for additional information regarding PT.
The IHCP PA requirement for services for physical therapy procedures for TMJ is noted in Table 5.

**PA for Psychiatric/Psychological Therapy**

PA is required for mental health services provided in an outpatient or office setting that exceeds twenty (20) units per recipient, per provider, per rolling twelve (12) month period of time.

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, or jaw misalignment) should be evaluated for psychosomatic causes and treated appropriately.

**PA for the Surgical Treatment of TMJ**

PA is required for a diagnostic arthroscopy and an arthrotomy of the TMJ joint. Table 6 lists radiology codes for evaluation of TMJ that are covered by the IHCP. Table 7 lists the codes for reporting treatment of TMJ that are covered by the IHCP. PA requirements are noted in both tables.

PA will be granted for surgical treatment of TMJ under the following circumstances. Documentation must be maintained in the member’s medical record and submitted for PA of these procedures:

- **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

- **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

- **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

- 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 that is not responsive to other modes 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

The IHCP PA requirement for surgical treatment of TMJ is noted in Table 9

**PA for Cleft Lip and Cleft Palate Services**

PA is not required for cleft lip and cleft palate services, except orthodontic services related to cleft palate (for additional information see orthodontic services listed below).

**PA of Orthodontic Services for Craniofacial Deformity or Cleft Palate**

The Office of Medicaid Policy and Planning (OMPP) requires PA for all orthodontic services. Orthodontic PA requests must be submitted on the *Indiana Prior Review and Authorization Request Form*, not on 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 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 on the time remaining in the treatment rendered by a new practitioner, the first practitioner must prorate the amount to be refunded to the program.

All 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.

• The diagnosis must include 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.

The IHCP PA requirement for orthodontic services is noted in Table 11

**Non-covered Services**

The IHCP does not provide reimbursement for the following services:

• Blepharoplasties when not related to significant obstructive vision problems

• 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
  - Member’s 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 50 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

**Billing Requirements**

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs. Providers must bill utilizing the appropriate procedure code. 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. For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.

PA does not guarantee reimbursement for services. Documentation supporting medical necessity must be maintained in the medical records. Reimbursement for cleft lip, cleft palate, and orthodontic services for craniofacial deformity is determined by 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.

Billing for Mid-Face Disorders, Nasal Deformities, External Ear Disorders and Facial Disorders

The IHCP will provide reimbursement for mid-face disorders, nasal deformities, external ear disorders and facial disorders when billed utilizing the appropriate procedure code listed in Table 1.

Table 1 – PA Requirement for Mid-face Disorders, Nasal Deformities, External Ear Disorders, and Facial Disorders

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>21137</td>
<td>Reduction forehead; contouring only</td>
<td>Yes</td>
</tr>
<tr>
<td>21138</td>
<td>Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)</td>
<td>Yes</td>
</tr>
<tr>
<td>21139</td>
<td>Reduction forehead; contouring and setback of anterior frontal sinus wall</td>
<td>Yes</td>
</tr>
<tr>
<td>21230</td>
<td>Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)</td>
<td>Yes</td>
</tr>
<tr>
<td>21235</td>
<td>Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)</td>
<td>Yes</td>
</tr>
<tr>
<td>21244</td>
<td>Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)</td>
<td>Yes</td>
</tr>
<tr>
<td>21245</td>
<td>Reconstruction of mandible or maxilla, subperiosteal implant; partial</td>
<td>Yes</td>
</tr>
<tr>
<td>21246</td>
<td>Reconstruction of mandible or maxilla, subperiosteal implant; complete</td>
<td>Yes</td>
</tr>
<tr>
<td>21247</td>
<td>Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)</td>
<td>Yes</td>
</tr>
<tr>
<td>21248</td>
<td>Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial</td>
<td>Yes</td>
</tr>
<tr>
<td>21249</td>
<td>Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Billing for Rhinoplasty and Septoplasty

The IHCP will provide reimbursement for rhinoplasty and septoplasty when billed utilizing the appropriate procedure code listed in Table 2.

Table 2 – Rhinoplasty and Septoplasty Procedure Codes and PA Requirements

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>30400</td>
<td>Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip</td>
<td>Yes</td>
</tr>
<tr>
<td>30410</td>
<td>Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip</td>
<td>Yes</td>
</tr>
<tr>
<td>30420</td>
<td>Rhinoplasty, primary; including major septal repair</td>
<td>Yes</td>
</tr>
<tr>
<td>30430</td>
<td>Rhinoplasty, secondary; minor revision (small amount of nasal tip work)</td>
<td>Yes</td>
</tr>
<tr>
<td>30435</td>
<td>Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)</td>
<td>Yes</td>
</tr>
<tr>
<td>30450</td>
<td>Rhinoplasty, secondary; major revision (nasal tip work and osteomyses)</td>
<td>Yes</td>
</tr>
<tr>
<td>30460</td>
<td>Rhinoplasty for nasal deformity secondary to congenital</td>
<td>No</td>
</tr>
<tr>
<td>30462</td>
<td>Rhinoplasty for nasal deformity secondary to congenital cleft</td>
<td>No</td>
</tr>
<tr>
<td>30520</td>
<td>Septoplasty with or without cartilage implant</td>
<td>No</td>
</tr>
<tr>
<td>30620</td>
<td>Reconstruction, functional, nose (septal or other intranasal dermatoplasty (does not include obtaining graft)</td>
<td>No</td>
</tr>
</tbody>
</table>

Billing for Blepharoplasty

The IHCP will provide reimbursement for blepharoplasty when billed utilizing the appropriate procedure code, listed in Table 3.
### Table 3 – Codes for Reporting Blepharoplasty

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid</td>
<td>Yes</td>
</tr>
<tr>
<td>15821</td>
<td>Blepharoplasty, lower eyelid; with extensive herniated fat pad</td>
<td>Yes</td>
</tr>
<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid</td>
<td>Yes</td>
</tr>
<tr>
<td>15823</td>
<td>Blepharoplasty, upper eyelid; with excessive skin weighting down lid</td>
<td>Yes</td>
</tr>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
<td>Yes</td>
</tr>
<tr>
<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)</td>
<td>Yes</td>
</tr>
<tr>
<td>67902</td>
<td>Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)</td>
<td>Yes</td>
</tr>
<tr>
<td>67903</td>
<td>Repair of blepharoptosis; (tarso) levator resection, internal approach</td>
<td>Yes</td>
</tr>
<tr>
<td>67904</td>
<td>Repair of blepharoptosis; (tarso) levator resection, external approach</td>
<td>Yes</td>
</tr>
<tr>
<td>67906</td>
<td>Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)</td>
<td>Yes</td>
</tr>
<tr>
<td>67908</td>
<td>Removal of tissue, muscle, and membrane to correct eyelid drooping or paralysis</td>
<td>Yes</td>
</tr>
<tr>
<td>67909</td>
<td>Reduction of overcorrection of ptosis</td>
<td>No</td>
</tr>
<tr>
<td>67911</td>
<td>Correction of lid retraction</td>
<td>Yes</td>
</tr>
<tr>
<td>67912</td>
<td>Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)</td>
<td>Yes</td>
</tr>
<tr>
<td>67914</td>
<td>Repair of ectropion; suture</td>
<td>No</td>
</tr>
<tr>
<td>67915</td>
<td>Repair of ectropion; thermocauterization</td>
<td>No</td>
</tr>
<tr>
<td>67916</td>
<td>Repair of ectropion; excision tarsal wedge</td>
<td>No</td>
</tr>
<tr>
<td>67917</td>
<td>Repair of ectropion; extensive (eg, tarsal strip operations)</td>
<td>No</td>
</tr>
<tr>
<td>67921</td>
<td>Repair of entropion; suture</td>
<td>No</td>
</tr>
<tr>
<td>67922</td>
<td>Repair of entropion; thermocauterization</td>
<td>No</td>
</tr>
<tr>
<td>67923</td>
<td>Repair of entropion; excision tarsal wedge</td>
<td>No</td>
</tr>
<tr>
<td>67924</td>
<td>Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)</td>
<td>No</td>
</tr>
</tbody>
</table>

**Billing Orthognathic (Jaw Realignment) Surgery**

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...
Anesthesia for orthognathic surgery 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.

The IHCP provides reimbursement for the codes listed in Table 4 for orthognathic surgery and related procedures necessary for facial aesthetic surgery.

**Table 4 – Orthognathic Surgery Codes**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>21110</td>
<td>Application of interdental fixation device for conditions other than fracture or dislocation, includes removal</td>
<td>Yes</td>
</tr>
<tr>
<td>21120</td>
<td>Genioplasty; augmentation (autograft, allograft, prosthetic material)</td>
<td>Yes</td>
</tr>
<tr>
<td>21121</td>
<td>Genioplasty; sliding osteotomy, single piece</td>
<td>Yes</td>
</tr>
<tr>
<td>21122</td>
<td>Genioplasty: 2 or more osteotomiesleg, wedge reversal for asymmetrical chin</td>
<td>Yes</td>
</tr>
<tr>
<td>21123</td>
<td>Geniplasty; sliding, augmentation with interpositional bone grafts (inc. obtaining autografts)</td>
<td>Yes</td>
</tr>
<tr>
<td>21125</td>
<td>Augmentation, mandibular body or angle; prosthetic material</td>
<td>Yes</td>
</tr>
<tr>
<td>21127</td>
<td>Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (include obtaining autograft)</td>
<td>Yes</td>
</tr>
<tr>
<td>21141</td>
<td>Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft</td>
<td>No</td>
</tr>
<tr>
<td>21142</td>
<td>Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft</td>
<td>No</td>
</tr>
<tr>
<td>21143</td>
<td>Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft</td>
<td>No</td>
</tr>
<tr>
<td>21145</td>
<td>Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)</td>
<td>No</td>
</tr>
<tr>
<td>21146</td>
<td>Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)</td>
<td>No</td>
</tr>
<tr>
<td>21147</td>
<td>Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)</td>
<td>No</td>
</tr>
<tr>
<td>21150</td>
<td>Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)</td>
<td>No</td>
</tr>
<tr>
<td>21151</td>
<td>Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)</td>
<td>No</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Coverage</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>21154</td>
<td>Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (including obtaining autografts); without LeFort I</td>
<td>No</td>
</tr>
<tr>
<td>21155</td>
<td>Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (including obtaining autografts); with LeFort I</td>
<td>No</td>
</tr>
<tr>
<td>21159</td>
<td>Reconstruction midface, LeFort III; (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I</td>
<td>No</td>
</tr>
<tr>
<td>21160</td>
<td>Reconstruction midface, LeFort III; (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I</td>
<td>No</td>
</tr>
<tr>
<td>21188</td>
<td>Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (inc. obtain autograft)</td>
<td>No</td>
</tr>
<tr>
<td>21193</td>
<td>Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft</td>
<td>No</td>
</tr>
<tr>
<td>21194</td>
<td>Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)</td>
<td>No</td>
</tr>
<tr>
<td>21195</td>
<td>Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation</td>
<td>No</td>
</tr>
<tr>
<td>21196</td>
<td>Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation</td>
<td>No</td>
</tr>
<tr>
<td>21198</td>
<td>Osteotomy, mandible, segmental;</td>
<td>No</td>
</tr>
<tr>
<td>21199</td>
<td>Osteotomy, mandible, segmental; with genioglossus advancement</td>
<td>Yes</td>
</tr>
<tr>
<td>21206</td>
<td>Osteotomy for prognathism, micrognathism, or apertognathism; maxilla, segmental</td>
<td>Yes</td>
</tr>
<tr>
<td>21208</td>
<td>Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)</td>
<td>No</td>
</tr>
<tr>
<td>21209</td>
<td>Osteoplasty, facial bones; reduction</td>
<td>Yes</td>
</tr>
<tr>
<td>21210</td>
<td>Graft, bone, nasal, maxillary, or malar areas (includes obtaining graft)</td>
<td>Yes</td>
</tr>
<tr>
<td>21215</td>
<td>Graft, bone; mandible (includes obtaining graft)</td>
<td>Yes</td>
</tr>
<tr>
<td>21244</td>
<td>Reconstruction of mandible, extraoral, with transosteal bone plate, (eg, mandibular staple bone plat)</td>
<td>Yes</td>
</tr>
<tr>
<td>21245</td>
<td>Reconstruction of mandible or maxilla, subperiosteal implant, partial</td>
<td>Yes</td>
</tr>
<tr>
<td>21246</td>
<td>Reconstruction of mandible or maxilla, subperiosteal implant, complete</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Billing for Non-Surgical Treatment - TMJ Services

Billing for Physical Therapy Codes for TMJ

PT for TMJ may include active and passive jaw exercises, thermal modalities, manipulation modalities, electrogalvanic stimulation, and TENS. Table 5 lists appropriate codes to report PT for TMJ. Cranial manipulation, continuous passive motion, diathermy, infrared, and US treatment, hydrotherapy, myofunctional therapy, iontophoresis, and neuromuscular re-education are not considered medically necessary PT treatments for TMJ.

Table 5 – PT Codes for TMJ

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>64550</td>
<td>Application of surface (transcutaneous) neurostimulator</td>
<td>No</td>
</tr>
<tr>
<td>97010</td>
<td>Physical medicine treatment to one area; hot or cold packs</td>
<td>Yes</td>
</tr>
<tr>
<td>97032</td>
<td>Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes</td>
<td>Yes</td>
</tr>
<tr>
<td>97110</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility</td>
<td>Yes</td>
</tr>
<tr>
<td>97140</td>
<td>Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Billing for Psychiatric Codes for TMJ Therapy

The IHCP provides reimbursement for the psychiatric codes listed in Table 6 in relation to treatment of TMJ when services are provided by a:

- Licensed Physicians
- Licensed Psychiatric
- Psychologists endorsed as a health service provider in psychology (HSPP).

Outpatient mental health services rendered by a medical doctor, doctor of osteopathy, or HSPP are subject to the following limitations:

- Outpatient mental health services rendered by a medical doctor or doctor of osteopathy are subject to the limitations set out in 405 IAC 5-25.
Subject to prior authorization by the office or its designee, Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when the services are provided by one (1) of the following practitioners:

- A licensed psychologist.
  - A licensed independent practice school psychologist.
  - A licensed clinical social worker.
  - A licensed marital and family therapist.
  - A licensed mental health counselor.
  - A person holding a master’s degree in social work, marital and family therapy, or mental health counseling,
  - An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

### Table 6 – Psychiatric Codes for TMJ Therapy

<table>
<thead>
<tr>
<th>CPT® Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791-90792</td>
<td>Psychiatric diagnostic evaluation</td>
</tr>
<tr>
<td>90832-90838</td>
<td>Psychotherapy</td>
</tr>
<tr>
<td>90846-90853</td>
<td>Family and group psychotherapy</td>
</tr>
</tbody>
</table>

### Mechanical Therapy for Treatment of TMJ

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 provides reimbursement for intra-oral appliances, when billed utilizing the procedure codes in Table 7. PA is not required. Intra-oral appliances may be provided by a dentist, ENT specialist, orthodontist, or oral surgeon.

### Table 7 – CPT® Codes for Mechanical Therapy for TMJ

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1700</td>
<td>Jaw motion rehabilitation system</td>
<td>No</td>
</tr>
<tr>
<td>E1701</td>
<td>Replacement cushions for jaw motion system, pkg. of 6</td>
<td>No</td>
</tr>
<tr>
<td>E1702</td>
<td>Replacement measuring scales for jaw motion rehabilitation system, pkg of 200</td>
<td>No</td>
</tr>
</tbody>
</table>
Radiology Services for Evaluation of TMJ

The IHCP provides reimbursement for radiology services for the evaluation of TMJ when billed utilizing the procedure codes listed in Table 8.

Table 8 – Radiology Codes for Evaluation of TMJ

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>70328</td>
<td>Radiology examination, temporomandibular joint, open and closed mouth; unilateral</td>
<td>No</td>
</tr>
<tr>
<td>70330</td>
<td>Radiology examination, temporomandibular joint, open and closed mouth; bilateral</td>
<td>No</td>
</tr>
<tr>
<td>70332</td>
<td>Temporomandibular joint arthrography, supervision and interpretation only</td>
<td>No</td>
</tr>
<tr>
<td>70336</td>
<td>Magnetic resonance (e.g., proton) imaging, temporomandibular joints</td>
<td>No</td>
</tr>
<tr>
<td>70450</td>
<td>Computed tomography, head or brain; without contrast material</td>
<td>No</td>
</tr>
<tr>
<td>70460</td>
<td>Computed tomography, head or brain; with contrast material(s)</td>
<td>No</td>
</tr>
<tr>
<td>70470</td>
<td>Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections</td>
<td>No</td>
</tr>
<tr>
<td>70486</td>
<td>Computed tomography, maxillofacial area; without contrast material</td>
<td>No</td>
</tr>
<tr>
<td>70487</td>
<td>Computed tomography, maxillofacial area; with contrast material(s)</td>
<td>No</td>
</tr>
<tr>
<td>70488</td>
<td>Computed tomography, maxillofacial areas; without contrast material, followed by contrast material(s) and further sections</td>
<td>No</td>
</tr>
</tbody>
</table>

Billing for 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 in an outpatient or ASC setting. The remaining procedures may be performed in an inpatient hospital, outpatient hospital, or ASC setting. The IHCP provides reimbursement for the codes listed in Table 9 for the surgical treatment of TMJ.
## Table 9 – Surgery Codes for the Treatment of TMJ

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20605</td>
<td>Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa)</td>
</tr>
<tr>
<td>21010</td>
<td>Arthrotomy, temporomandibular joint</td>
</tr>
<tr>
<td>21050</td>
<td>Condylectomy temporomandibular joint (separate procedure)</td>
</tr>
<tr>
<td>21060</td>
<td>Meniscectomy, partial or complete, temporomandibular joint (separate procedure)</td>
</tr>
<tr>
<td>21070</td>
<td>Coronoidectomy (separate procedure)</td>
</tr>
<tr>
<td>21110</td>
<td>Application of interdental fixation device for conditions other than fracture or dislocation, includes removal</td>
</tr>
<tr>
<td>21116</td>
<td>Injection procedure for temporomandibular joint arthrography</td>
</tr>
<tr>
<td>21240</td>
<td>Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>21242</td>
<td>Arthroplasty, temporomandibular joint, with allograft</td>
</tr>
<tr>
<td>21243</td>
<td>Arthroplasty, temporomandibular joint, with prosthetic joint replacement</td>
</tr>
<tr>
<td>21247</td>
<td>Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)</td>
</tr>
<tr>
<td>21480</td>
<td>Uncomplicated treatment of temporomandibular dislocation; initial or subsequent</td>
</tr>
<tr>
<td>21485</td>
<td>Complicated manipulative treatment of temporomandibular dislocation, initial or subsequent</td>
</tr>
<tr>
<td>21490</td>
<td>Open treatment of temporomandibular dislocation</td>
</tr>
<tr>
<td>29800</td>
<td>Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)</td>
</tr>
<tr>
<td>29804</td>
<td>Arthroscopy, temporomandibular joint, surgical</td>
</tr>
</tbody>
</table>

### Billing Anesthesia for Surgical Treatment of TMJ

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 Cleft Lip or Cleft Palate Services

The IHCP provides reimbursement for services for the treatment of cleft lip or cleft palate when billed utilizing the procedure codes listed in Table 10.
### Table 10 – CPT® Codes for Cleft Lip or Cleft Palate Services

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>30460</td>
<td>Rhinoplasty for nasal deformity secondary to congenital cleft lip</td>
<td>No</td>
</tr>
<tr>
<td>30462</td>
<td>Rhinoplasty for nasal deformity secondary to congenital cleft</td>
<td>No</td>
</tr>
<tr>
<td>40700</td>
<td>Plastic repair of cleft lip; primary, partial or complete, unilateral</td>
<td>No</td>
</tr>
<tr>
<td>40701</td>
<td>Plastic repair of cleft lip; primary bilateral, 1-stage procedure</td>
<td>No</td>
</tr>
<tr>
<td>40702</td>
<td>Plastic repair of cleft lip; primary bilateral, 1 of 2 stages</td>
<td>No</td>
</tr>
<tr>
<td>40720</td>
<td>Plastic repair of cleft lip; secondary, by recreation of defect and re-closure</td>
<td>No</td>
</tr>
<tr>
<td>40761</td>
<td>Plastic repair of cleft lip; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle</td>
<td>No</td>
</tr>
<tr>
<td>42200</td>
<td>Palatoplasty for cleft palate, soft and/or hard palate only</td>
<td>No</td>
</tr>
<tr>
<td>42210</td>
<td>Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge</td>
<td>No</td>
</tr>
<tr>
<td>42215</td>
<td>Palatoplasty for cleft palate; major revision</td>
<td>No</td>
</tr>
<tr>
<td>42220</td>
<td>Palatoplasty for cleft palate; secondary lengthening procedure</td>
<td>No</td>
</tr>
<tr>
<td>42225</td>
<td>Palatoplasty for cleft palate; attachment pharyngeal flap</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Billing for Orthodontic Services for Craniofacial Deformity or Cleft Palate

Table 11 contains the appropriate orthodontic HCPCS codes and descriptions for craniofacial services.

### Table 11 – Craniofacial Orthodontic HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>PA Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8010</td>
<td>Limited orthodontic treatment of the primary dentition</td>
<td>Yes</td>
</tr>
<tr>
<td>D8020</td>
<td>Limited orthodontic treatment of the transitional dentition</td>
<td>Yes</td>
</tr>
<tr>
<td>D8030</td>
<td>Limited orthodontic treatment of the adolescent dentition</td>
<td>Yes</td>
</tr>
<tr>
<td>D8040</td>
<td>Limited orthodontic treatment of the adult dentition</td>
<td>Yes</td>
</tr>
<tr>
<td>D8050</td>
<td>Interceptive orthodontic treatment of the primary dentition</td>
<td>Yes</td>
</tr>
<tr>
<td>D8060</td>
<td>Interceptive orthodontic treatment of the transitional dentition</td>
<td>Yes</td>
</tr>
<tr>
<td>D8070</td>
<td>Comprehensive orthodontic treatment of the transitional dentition</td>
<td>Yes</td>
</tr>
<tr>
<td>D8080</td>
<td>Comprehensive orthodontic treatment of the adolescent dentition</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Rules, Citations and Sources

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 5-25 – Physician Services

405 IAC 5-28 – Medical and Surgical Services

405 IAC 5-29-1 – Services Not Covered by Medicaid

### IHCP Provider Banner Page

BR200519

BR201345

### IHCP Bulletins

BT19909

BT200208

BT200230

BT200321

BT200360

BT200362

### IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp)

## Related Medical Topics

Anesthesia Services

Dental Services
Hearing Services
Mental Health/Behavioral Health – Outpatient Services
Surgery – Surgical Services
Therapy Services
Surgery – Plastic and Reconstructive Surgery – Genitourinary and Breast

Introduction
This section serves as a general summary of the IHCP’s policies regarding genitourinary and breast plastic and reconstructive surgery. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service
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 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.

Reimbursement Requirements
The IHCP will provide reimbursement for reconstructive or plastic surgery for congenital defects, developmental anomalies, trauma, infection, tumors, or disease. The primary goal of reconstructive surgery is to improve function, but may also be performed to reshape abnormal structures of the body, and/or to allow a person to have a more normal appearance.

Breast Plastic and Reconstructive Surgery
Breast reconstruction is defined as those surgical procedures designed to restore the normal appearance of the breast (male and female) after surgery, accidental injury, or trauma. The most common indication for reconstructive breast surgery is a prior mastectomy.

Reduction mammoplasty is defined as the surgical removal of a substantial portion of the breast(s), including the skin and underlying glandular tissue, in order to obtain a clinically normal size breast(s). Bilateral surgery is usually performed; however, when there is significant hypertrophy of one breast, resulting in an abnormal difference in 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 in order to:
• Reshape the normal structure to improve appearance or self-esteem, or
• For conditions not related to congenital defects, developmental anomalies, trauma, infection, tumors, or disease.

IHCP reimbursement is not available for:
• Cosmetic symptoms including ptosis, poorly fitting clothing, unacceptable appearance, or nipple-areolar distortion.
• The use of liposuction to perform breast reduction is considered investigational.

Genitourinary System Plastic and Reconstructive Surgery

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. PA is required for reconstructive surgery.

The IHCP does not provide reimbursement for the following:
• Scar removal or tattoo removal by excision or abrasion
• Penile implants
• Perineoplasty for sexual dysfunction
• 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 resulting 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.

Prior Authorization Requirements

PA is required for plastic or reconstructive surgery per 405 IAC 5-3-13. In addition, plastic or reconstructive surgery is non-covered unless related to disease or trauma deformity per 405 IAC 5-29-1.

Breast Reduction in Females

The IHCP will provide reimbursement for breast reduction surgery in females. Documentation must be maintained in the member’s medical record.

PA criteria:
• 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)

- Asymmetry of the breasts will not be authorized unless it is performed to achieve symmetry of the contralateral side when the opposite breast has been reconstructed after mastectomy for cancer.

- Specific weight guidelines vary with the height and weight of the member. Table 1 displays the height and weight categories indicating the minimum amount of breast tissue expected to be removed. Variances may occur which may not be accommodated by this table; these variances will be reviewed on an individual basis.

Table 1 – Expected Minimum Amount of Breast Tissue to Be Removed

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Expected Amount of Breast Tissue to Be Removed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5’</td>
<td>Less than 140 lbs</td>
<td>300 gm per breast</td>
</tr>
<tr>
<td>5’ – 5’4”</td>
<td>Up to 180 lbs</td>
<td>350 gm per breast</td>
</tr>
<tr>
<td>5’4” – 5’7”</td>
<td>Up to 220 lbs</td>
<td>400 gm per breast</td>
</tr>
<tr>
<td>5’7” and up</td>
<td>211 lbs and greater</td>
<td>500 gm per breast</td>
</tr>
</tbody>
</table>

Breast Reduction in Males

The IHCP will provide reimbursement for breast reduction surgery in males older than 18 or 18 months after the end of puberty, for gynecomastia, when medically necessary.

PA criteria:

- 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.

- 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 lists the codes for reporting breast reduction and reconstruction surgeries, as well as PA requirements for individual codes.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>PA Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>19300</td>
<td>Mastectomy for gynecomastia</td>
<td>Yes</td>
</tr>
<tr>
<td>19316</td>
<td>Mastopexy</td>
<td>No</td>
</tr>
<tr>
<td>19318</td>
<td>Reduction mammoplasty</td>
<td>Yes</td>
</tr>
<tr>
<td>19325</td>
<td>Mammaplasty, augmentation; with prosthetic implant</td>
<td>Yes</td>
</tr>
<tr>
<td>19328</td>
<td>Removal of intact mammary implant</td>
<td>No</td>
</tr>
<tr>
<td>19330</td>
<td>Removal of implant material</td>
<td>No</td>
</tr>
<tr>
<td>19340</td>
<td>Immediate insertion of breast prosthesis following mastectomy, mastectomy, or in reconstruction</td>
<td>Yes</td>
</tr>
<tr>
<td>19350</td>
<td>Nipple/areola reconstruction</td>
<td>No</td>
</tr>
<tr>
<td>19361</td>
<td>Breast reconstruction, immediate or delayed, with tissue</td>
<td>No</td>
</tr>
<tr>
<td>19364</td>
<td>Breast reconstruction with free flap</td>
<td>No</td>
</tr>
<tr>
<td>19366</td>
<td>Breast reconstruction with other technique</td>
<td>No</td>
</tr>
<tr>
<td>19367</td>
<td>Breast reconstruction with transverse rectus abdominis myocutaneous (TRAM) flap, single pedicle, including closure of donor site</td>
<td>No</td>
</tr>
<tr>
<td>19368</td>
<td>Breast reconstruction with TRAM flap single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)</td>
<td>No</td>
</tr>
<tr>
<td>19369</td>
<td>Breast reconstruction with TRAM flap, double pedicle, including closure of donor site</td>
<td>No</td>
</tr>
<tr>
<td>19370</td>
<td>Open periprosthetic capsulotomy, breast</td>
<td>No</td>
</tr>
</tbody>
</table>
Periprosthetic capsulectomy, breast
Revision of reconstructed breast
Breast reconstruction with GAP flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral
Breast reconstruction of a single breast with stacked deep inferior epigastric perforator flap(s) and/or gluteal artery perforator flap(s), including harvesting of the flap(s), microvascular transfer, closure of donor site(s)
Breast reconstruction with deep inferior epigastric perforator flap or superficial inferior epigastric artery flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast

Genitourinary Surgery

IHCP reimburses for female reconstructive surgery with PA for one of the following conditions. Documentation supporting medical necessity must be maintained in the medical record:

- Agenesis of the vagina
- Post-trauma
- Post-cancer therapy

IHCP reimburses for male reconstructive surgery with PA in the following circumstances. Documentation supporting medical necessity must be maintained in the medical record:

- Absence of testicle as a result of illness, injury, or congenital anomaly.
- No evidence of active infection, malignancy, or current treatment for malignancy.

Intersex Surgery

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 reflects codes for reporting female and male reconstructive surgery and intersex surgeries, as well as PA requirements for each code.

Table 3 – CPT® Codes for Reporting Reconstructive Genitourinary Surgery

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>PA Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>54660</td>
<td>Insertion of testicular prosthesis (separate procedure)</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Billing Requirements

All Plastic and Reconstructive Surgery – Genitourinary and Breast are to be billed utilizing the appropriate CPT® procedure codes.

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 claims.

### Rules, Citations, and Sources

405 IAC 5-3-13 – Services requiring prior authorization

405 IAC 5-29-1 – Non-covered services

**IHCP Bulletins**

BT200208

**IHCP Provider Manual**

*Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp)*

### Related Medical Topics

Consultations – Second Opinions

Hospital Inpatient Services

Hospital Outpatient Services
Introduction

This section serves as a general summary of the IHCP’s policies regarding panniculectomies. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Panniculectomy is the surgical removal of a redundant, large and/or long overhanging apron of skin and subcutaneous fat located in the lower abdominal area. The condition may accompany significant overstretching of the lax anterior abdominal wall and, therefore, often occurs in morbidly obese individuals or following substantial weight loss.

The panniculectomy is similar to an abdominoplasty; however, the abdominoplasty may include muscle placation, neoumbilicoplasty or flap evaluation and is typically performed for cosmetic purposes.

Reimbursement Requirements

The IHCP provides reimbursement for a panniculectomy when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization and appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

Obesity is a predisposing factor for this condition. 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 massive overhanging apron of fat and skin may cause chronic and persistent local skin conditions in the abdominal folds.

These conditions may include intertrigo, intertriginous dermatitis, cellulitis, ulcerations or tissue necrosis, or they may lead to painful inflammation of the subcutaneous adipose tissue (i.e., panniculitis).

When panniculitis is severe, it may interfere with activities of daily living, such as personal hygiene and ambulation. In addition to excellent personal hygiene practices, treatment of these
skin conditions generally involves topical or systemic corticosteroids, topical antifungals, and topical or systemic antibiotics. The American Society of Plastic Surgeons grades the severity of abdominal deformities as follows:

Grade 1: panniculus covers hairline and mons pubis but not the genitals
Grade 2: panniculus covers genitals and upper thigh crease
Grade 3: panniculus covers upper thigh
Grade 4: panniculus covers mid-thigh
Grade 5: panniculus covers knees and below

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

Prior Authorization Requirements

PA is required for a panniculectomy. Providers must submit a PA request with the appropriate clinical summary and physician's documentation supporting medical necessity.

The following information must be included with the PA request:

- Member's diagnosis
- The member's current weight and height
- Preoperative photographs, front and lateral views
- H&P, 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
There are numerous surgeries which require PA. Per IAC 405 IAC 5-3, PA for multiple surgeries performed on the same day does not override the restrictions of 405 IAC 5-28.

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, HIP-ESP Plan, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their PA procedures.

Non-Covered

Panniculectomy following gastric bypass procedures performed for cosmetic reasons, even if performed incidentally to a ventral herniorrhaphy, is a non-covered service.

Billing Requirements

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs. Providers must bill utilizing the appropriate procedure code. 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. For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.

Table 1 includes CPT® codes which should be utilized when billing a panniculectomy.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15830</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen, inframamillary panniculectomy</td>
</tr>
<tr>
<td>15847</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial placation) (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>00802</td>
<td>Anesthesia for procedures on lower anterior abdominal wall; panniculectomy</td>
</tr>
</tbody>
</table>

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

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.
Related Medical Topics

Anesthesia Services
Bariatric Surgery and Revisions
Consultations – Second Opinions
Gastroenterology
Surgery – Surgical Services
Surgery – Surgical Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding surgical services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

Surgical services are services for a member requiring or seeking medically necessary perioperative care. These include, but are not limited to, pre-operative preparation, the operating room, recovery room, outpatient admitting and discharge. 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 may occur in the physician’s office, in the emergency room, in the outpatient surgery area, or an Ambulatory Surgical Center (ASC).

Reimbursement Requirements

Reimbursement for most surgical procedures is based on the global concept that includes three parts: preoperative management, intraoperative (surgical) care, and postoperative management.

Preoperative Office Visits

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. Office visits made with the surgeon prior to the scheduling of surgery are billed under the global surgery payment billing rules.

Separate reimbursement is available for preoperative care when the provider performing the surgery has never seen the patient, or the decision to perform surgery was made during the preoperative visit. All levels of medical care, prior to surgical procedures, are reimbursed individually based on documentation of the patient’s medical condition.

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 the surgery is made during the evaluation of the
patient. 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 separately billed.

**Post-operative Care**

The postoperative care days for a surgical procedure include 90 days following a major surgical procedure and 10 days following a minor surgical procedure. Separate reimbursement is available for care provided during the global postoperative period unrelated to the surgical procedure, or for care not considered routine, and postoperative care for surgical complications. All levels of medical care, before surgical procedures, are reimbursed individually based on documentation of the patient’s medical condition.

If the patient’s condition requires additional medical or surgical care outside the scope of the operating surgeon – for example, an additional surgery performed by a different specialist for a different diagnosis – on the same day, reimbursement for the medical care is considered individually. Medical visits for surgical complication are reimbursed only if medically indicated and no other physician has billed for the same or related diagnosis. The claim must indicate the specific complications, and providers should attach documentation that clearly supports the medical necessity for the care provided. The medical visits are billed separately from the surgical fee. Such complications may include but are not limited to the following:

- 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
- Nausea and vomiting persisting more than 24 hours
- 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 must 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 fee billed for the office visit.

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. Each surgeon may bill as primary surgeon for that portion of surgery for which he/she was responsible.

IHCP reimbursement is available for a physician as an assistant surgeon with the following restrictions:

• If extenuating circumstances require an assistant surgeon when customarily one is not required:
  ➢ The circumstances must be well documented in the hospital record; and
  ➢ Documentation must be attached to the claim form.

• Reimbursement is not available for a surgical assistant who assists in diagnostic surgical procedures or for minor surgical procedures.

• Reimbursement is limited to the procedures that generally require the skills and services of an assistant surgeon as set out in HCPCS.

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. Secondary closure after the initial surgical procedure may be considered part of the initial surgery and part of the global fee schedule.

However, when a dehiscence occurs in the immediate post-operative period, the patient may return to the operating room for suturing as an emergency procedure. Dehiscence of a wound is considered a complication of the primary procedure. As an emergency procedure, the rules pertaining to emergency procedures will apply.
Split Care

Reimbursement for most surgical procedures is based upon three parts: preoperative management, intraoperative (surgical) care, and postoperative management. Split care occurs when a component of the global surgery is rendered by a physician other than the physician performing the surgical service. Although there are three components, the Indiana Health Coverage Programs (IHCP) only recognizes split billing for two of the components, intraoperative and postoperative care. It is expected the physician performing the intraoperative portion will perform the preoperative service.

The IHCP requires a written agreement when the global surgical procedure is split among multiple providers. The conditions are the same as those for Medicare and are illustrated as follows:

- Providers billing for split care must have a written agreement outlining the date care is to be turned over and the name of the provider receiving the patient.
- The agreement must become part of the patient's file.
- The agreement must be submitted with any review or hearing request about the split-care payment.
- Modifier 54 must not be billed unless a written agreement exists.
- Physician must bill the appropriate CPT code without modifier 54 or 55 if a written agreement does not exist.

Same Group Practice Physicians

If more than one physician in the same group participates in a portion of the patient's care, included in the global surgery package, only the physician who performs the surgery may submit a bill. Split care modifiers are not applicable and the surgeon's claim must only include the surgical procedure. Although other physicians participated in the care, all are within the same group practice. There is no need to split the reimbursement because the physician group is reimbursed the global fee.

Maxillofacial Surgery

Medicaid providers are 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 or conditions of the jaws and contiguous structures. The second opinion is required regardless of the surgical setting in which the surgery is to be performed. For a complete list of coverage criteria, prior approval, and billing requirements for Maxillofacial surgical procedures, please refer to the Surgery - Facial and Maxillofacial section of this manual.
Anesthesia

Local anesthesia (therapeutic or regional blocks) will be reimbursed as a surgical procedure. Time units or modifying factors associated with local anesthesia are not reimbursable. Reimbursement for local anesthesia (therapeutic or regional blocks) administered by the surgeon in conjunction with a surgical procedure is included in the fee for the surgical procedure.

If reimbursement for a surgical procedure has been disallowed due to lack of prior approval, reimbursement for the anesthesia service will also be disallowed.

Podiatric Surgery

Podiatric surgical procedures, including diagnostic surgical procedures, cannot be fragmented and billed separately. Such procedures generally are included in the major procedure. For a complete list of coverage criteria, prior approvals, and billing requirements for Podiatric surgical procedures, please refer to the Podiatric section of this manual.

Prior Authorization Requirements

Per 405 IAC 5-17-2 PA is required for all nonemergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. This applies to medical and surgical inpatient admissions. Emergency admissions, routine vaginal deliveries, C-section deliveries, and newborn stays do not require PA. This applies to members of all ages served by Traditional Medicaid, those in the Care Select program, and in some cases, dually eligible members.

The IHCP follows Milliman guidelines for all nonemergent and urgent care inpatient admissions. If IHCP criteria already exist, that criteria are used first when determining if admissions are appropriate. If criteria are not available within Milliman or IHCP policy, the IHCP relies on medical necessity determination of current evidence-based practice. To ensure a 48-hour turnaround, the PA request should be made by a clinical staff person. For nonemergent and urgent care admissions that occur outside normal business hours, including weekends and holidays, providers have 48 hours from the time of admission to request PA.

Reimbursement for the inpatient admission is determined by the appropriate DRG, but may be subject to retrospective review of the medical necessity for the inpatient stay. Days that are not prior authorized under the LOC methodology will not be covered by Medicaid. 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.

Services furnished to patients enrolled in RBMC must be prior authorized by the MCE in accordance with the MCE guidelines.

In addition to the prior authorization requirements set forth in 405 IAC 5-17-2, prior authorization is also required for the procedures listed in 405 IAC 5-3-13. Additional information regarding PA criteria for the following services can be located in the corresponding sections of this manual. Currently, PA is required for the following surgical procedures.
- Hysterectomy (Refer to Gynecology section of this manual)
- 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 (TMJ) 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 (405 IAC 5-5-2)

For surgeries normally scheduled as outpatient and are scheduled as inpatient, the following criteria are 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.
Billing Requirements

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs. Providers must bill utilizing the appropriate procedure code(s). 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. For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.

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.

Office Visits

Certain modifiers may be used to distinguish the type of office visit performed, including a pre-operative 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 for claim payment of these services. Documentation must be maintained in the medical record.

Post-operative Care

Separate reimbursement is available for care provided during the global postoperative period unrelated to the surgical procedure, or for care not considered routine, and postoperative care for surgical complications. All levels of medical care, prior to surgical procedures, are reimbursed individually based on documentation of the patient’s medical condition.

To calculate post-operative care units, one unit is equal to one day of post-operative care. Post-operative management claims must not be submitted until the physician managing the post-operative care sees the patient for the first time.
Bi-lateral Procedures

Providers submitting CMS-1500 claims or 837P transactions using modifier 50, indicating bilateral procedure, must enter only one unit in field 24G on the CMS-1500. The use of modifier 50 ensures that the procedure code is priced at the lower of 150% of the billed charge or the rate on file. Providers should note that if the CPT code description specifies the procedure as bilateral, modifier 50 should not be used on the CMS-1500 or 837P.

Assistant Surgeon

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.

Co-surgeons

Co-surgeons must append modifier 62 to the surgical service. Modifier 62 cuts the reimbursement rate to 62.5 percent of the rate on file.

Split Care

When the provider who performed the surgery does not provide any postoperative care, the provider must bill the surgical procedure code with modifier 54 – surgical care only, and the actual date of the surgery.

If the primary care physician is rendering the pre-operative or post-operative care only, this information must be indicated on the claim form and the name and address of the operating physician.

Post-operative care must be billed using the surgical procedure code 55 – post-operative management only. The dates of service must reflect the date care was assumed and relinquished and the units filed must include the total number of post-operative days furnished. To ensure appropriate reimbursement when billing with modifier 55, the number of days within the DOS range must equal the number of units (days) reported on the claim. Physician must bill the appropriate CPT® code without modifier 54 or 55 if a written agreement does not exist.

Postoperative management claims must not be submitted until the physician managing the postoperative care sees the patient for the first time.

Exceptions and Special Billing Considerations

If more than one physician in the same group practice participates in a portion of a patient’s care, included in a global surgery package, only the physician who performs the surgery can submit a bill. Split-care modifiers are not applicable, and the surgeon’s claim must include only the surgical procedure. Although other physicians participated in the care, all are within the
same group practice. There is no need to split the reimbursement because the physician group is reimbursed the global fee.

If a transfer of care does not occur, occasional post-discharge services for a physician other than the surgeon are reported with the appropriate E/M code. Modifiers are not required.

If the transfer of care occurs immediately after surgery, the physician who provides the postoperative care while the patient remains in the hospital bills using subsequent hospital care codes. Once the patient is released from the hospital, the physician responsible for postoperative care bills using the surgical procedure code with modifier 55. The surgeon should bill the appropriate surgical procedure code with modifier 54. This situation can occur when an itinerant (traveling) surgeon is used.

If a physician provides follow-up services during the postoperative period for minor procedures performed in the emergency department, the physician must bill the appropriate level of office visit code. The emergency department physician who performed the surgical service bills the surgical procedure code without a modifier.

If the services of a physician, other than the surgeon, are required during a postoperative period for an underlying condition or medical complication, the other physician reports the appropriate E/M code, and split-care modifiers are not required on the claim. For example, a cardiologist may manage the underlying cardiovascular condition during the postoperative period for a cardiovascular procedure that was performed by a cardiothoracic surgeon.

If a patient is returned to surgery for a related procedure during the postoperative period and billed using modifier 78, the IHCP-allowed amount is calculated by multiplying the RBRVS fee amount by the surgical care only (intraoperative) percentage on the Medicare fee schedule database (MFSDB). In these situations, the preoperative percentage is not added to the intraoperative percentage for calculating the allowed amount described in the first example. In addition, a new postoperative period is not allowed for the related procedure. The number of postoperative days allowed following the return to surgery is equal to the number of postoperative days remaining from the original procedure. Billing certain modifiers on the same detail is restricted as follows to avoid processing issues:

Modifier 54 (intraoperative) cannot be billed on the same detail as modifiers 55, 78, 80, 81, 82, AA, P1 through P5, QJ, QK, QX, QZ, QQ, X6, and W5 through W7, or the detail denies for an invalid modifier combination.

Billing certain modifiers on the same detail is restricted as follows, to avoid processing issues:

- Modifier 54 (intraoperative) cannot be billed on the same detail as modifiers: 55, 78, 80, 81, 82, P1 through P5, QK, QX, and QZ, or the detail denies for an invalid modifier combination.
• Modifier 55 (postoperative) cannot be billed on the same detail as modifiers: 54, 78, 80, 81, 82, P1 through P5, QK, QX, and QZ, or the detail denies for an invalid modifier combination.

Return to Surgery

If a patient is returned to surgery for a related procedure during the post-operative period it should be billed using modifier 78. The number of post-operative days allowed following the return to surgery is equal to the number of post-operative days remaining from the original procedure.

Additional Documentation 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 DOS

To explain the above situations, the IHCP requires that the provider submit the following documentation.

• Medical reason and unusual circumstances for the separate 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

Rules, Citations and Sources

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
405 IAC 5-1-5 – Global Fee Billing
405 IAC 5-3 – Prior Authorization
405 IAC 5-10 – Anesthesia Services
405 IAC 5-14-21 – Maxillofacial Surgery
405 IAC 5-17-2 – Prior Authorization; Generally
405 IAC 5-25 – Physician Services
405 IAC 5-26-9 – Surgical Procedures; Reimbursement
405 IAC 5-28 – Medical and Surgical Services
405 IAC 5-28-9 – Hysterectomy

Bulletins

BT201060

IHCP Provider Manual


Related Medical Topics

Not applicable
Surgery - Transplants

Introduction

This section serves as a general summary of the IHCP's policies regarding transplants. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

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.

Reimbursement Requirements

The IHCP provides reimbursement for the following transplants (listed in Table 1) when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization.

Table 1 – Transplant List

<table>
<thead>
<tr>
<th>Bone Marrow and Stem Cell</th>
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<tr>
<td>Liver, cadaver, and live donor</td>
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Donor Hospital and Surgical Expenses

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.

**Corneal Tissue Transplantation**

Corneal tissue transplant, also known as keratoplasty, replaces the patient's damaged cornea utilizing the cornea from the eye of a human cadaver. Corneal transplant is used when vision is lost in an eye due to damage to the cornea by disease or traumatic injury. Eye banks acquire and store eyes from donor individuals largely to supply the need for transplant corneas.

The IHCP provides reimbursement for corneal tissue transplantation when medically necessary without PA for services provided in-state.

**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)
- Potential for corneal perforation

The IHCP provides reimbursement 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 descemetocele formation

The IHCP provides reimbursement for transplantation of new tissue to the cornea for the treatment of severe corneal surface disease, reported with ocular surface reconstruction 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

**Bone Marrow and Stem Cell Transplantations for Breast Cancer**

Bone marrow transplantation (BMT) and stem cell transplantation is a procedure in which bone marrow that is diseased or damaged is replaced with healthy bone marrow. The bone marrow to be replaced may be deliberately destroyed by high doses of chemotherapy and/or radiation therapy. Bone marrow is the soft, sponge-like material found inside bones. It contains immature cells known as hematopoietic or blood-forming stem cells.

The IHCP will provide bone marrow transplants with PA for confirmed cancer of the breast, Stage II with >10 positive auxiliary nodes, Stage III B, or Stage IV, for individuals diagnosed with Breast Cancer. PA criteria may be found under the prior authorization requirements heading.

The IHCP advises providers to report the appropriate CPT® code, as listed in Table 93.2 for bone marrow and stem cell transplants for breast cancer.

**Bone Marrow or Stem Cell Transplantations (Other than for Breast Cancer)**

The IHCP will provide reimbursement for autologous or allogenic bone marrow or stem cell transplants 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 Prior Authorization 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 Prior Authorization 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

**Lung Transplantation**

Lung transplantation involves removal of one or both diseased lungs from a patient and the replacement of the lungs with healthy organs from a donor. Lung transplantation may refer to single, or double.

The IHCP provides reimbursement for three components of lung transplantation, when medical necessary and with Prior Authorization.

• Harvesting of the lung includes cold preservation
• 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
• Recipient transplantation includes transplanting a single lung or both lungs into the patient (see CPT® codes 32851-32854)

**Heart Transplantation**

Cardiac transplantation is a therapeutic modality for individuals with end-stage heart disease, characterized by cardiac failure that does not respond to standard, optimal medical or surgical treatments.

The IHCP reimburses for the following three components of heart transplantation (with or without lung transplant) when considered medically necessary with prior authorization.
Providers are advised to report the appropriate CPT® code from Table 93.5 for reimbursement of heart transplants.

- Cadaver donor cardiectomy consists of harvesting and cold preservation of the graft prior to transport
- 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
- Recipient transplantation includes transplanting the heart/lungs into the patient

Heart/Lung Transplantation

Cardiopulmonary transplantation (heart and lung transplantation) is the simultaneous surgical replacement of the heart and lungs in patients with end-stage cardiac and pulmonary disease.

The IHCP provides reimbursement for the following three components of heart/lung transplantation, with Prior Authorization. Table 93.7, lists the codes to report for reimbursement of heart/lung transplantation:

- Cadaver donor cardiectomy with pneumonectomy consists of harvesting and cold preservation of the graft prior to transport
- 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
- Recipient transplantation includes transplanting the heart/lungs into the patient

Hepatic (Liver) Transplantation

A liver transplant is a surgical procedure to remove a diseased liver and replace it with a healthy liver from a donor. Liver transplantation is performed for individuals with end-stage liver disease.

The IHCP provides reimbursement for the following three components of Hepatic (Liver) Transplantation, with Prior Authorization. Table 93.9, lists the codes to report for reimbursement of a 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
- 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
Recipient transplantation includes transplanting the liver into the patient and care of the recipient.

Renal Transplantation

Renal (Kidney) transplantation is a surgical procedure to remove a healthy, functioning kidney from a living or brain-dead donor and implant it into a patient with non-functioning kidneys. Kidney transplantation is performed on patients with chronic kidney failure, or end-stage renal disease (ESRD). ESRD occurs when a disease or disorder damages the kidneys so that they are no longer capable of adequately removing fluids and wastes from the body or of maintaining the proper level of certain kidney-regulated chemicals in the bloodstream. Without long-term dialysis or a kidney transplant, ESRD is fatal.

The IHCP provides reimbursement for the following three different components of renal transplantation. Table 93.10 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.
- Backbench work consists of preparation of the donor kidney prior to transplantation. This includes removal of perinephritic 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.
- Recipient transplantation includes transplanting the kidney into the patient.

Pancreatic Transplantation

A pancreas transplant is a surgical procedure to place a healthy pancreas from a donor into a person whose pancreas no longer functions properly.

The IHCP provides reimbursement for three different components of pancreatic transplants with Prior Authorization. Pancreatic transplantation which is performed at the same time as kidney transplantation is to be reported with the appropriate CPT® code for each organ transplanted. Table 93.11 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.
- 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.
Recipient transplantation includes transplanting the pancreas into the patient

**Islet Cell Transplantation**

Islet cell transplantation is a procedure which is performed to prevent diabetes or reduce the severity of diabetes after removal of the pancreas (pancreatic resection). When the pancreas is removed, the body loses its ability to produce insulin causing diabetes. Typically, the form of diabetes that occurs after pancreas resection is very severe and difficult to control.

The IHCP provides reimbursement for islet cell transplantation when considered medically necessary and with Prior Authorization.

**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.

**Intestinal (or Small Bowel) Transplantation**

The IHCP provides reimbursement for three different components of intestinal (or small bowel) transplantation with Prior Authorization. Table 93.14 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
- Backbench work consists of preparation of donor intestine prior to transplantation. This includes mobilizing and developing the superior mesenteric artery and vein. Also included is any additional reconstruction of graft including venous and arterial anastomosis(es) prior to transplantation.
- Recipient transplantation includes transplanting the intestine into the patient
Indications for Intestinal Transplantation

The IHCP considers intestinal transplant medically necessary with Prior Authorization for members with irreversible intestinal failure who can no longer be maintained on TPN. Prior Authorization may be given for small bowel or intestinal transplantation for the indications listed in Table 15, below. Clinical indications of TPN failure are listed in Table 16.

Multi-Visceral Transplantation

A visceral organ is defined as any organ within the chest or abdomen. A multi-visceral transplantation includes transplantation of the intestine, pancreas, and liver. Additional organs could include the stomach and colon.

The IHCP provides reimbursement for the three components (removal of donor organ, backbench work and recipient transplantation) for each organ included in the multi-visceral transplant when medically necessary and with Prior Authorization:

- 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

Removal of Transplanted Organs

Certain organs may require removal following transplantation due to organ rejection. Removal of a transplanted organ does not require PA. Transplantation of another organ does require a new PA request.

Prior Authorization Requirements

PA is required for transplant surgeries per 405 IAC 5-3-13. The IHCP does not reimburse providers for any services requiring Prior Authorization unless Prior Authorization is obtained first. Please refer to the Prior Authorization requirements indicated within each transplant type.

Corneal Tissue Transplantation

Corneal tissue transplants do not require Prior Authorization (PA).

Bone Marrow and Stem Cell Transplantations for Breast Cancer

Prior authorization criteria for bone marrow or stem cell transplantation for indications of breast cancer are as follows:

The IHCP will provide bone marrow transplants with PA 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

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

Bone Marrow or Stem Cell Transplantations (Other than for Breast Cancer)

Prior authorization criteria for bone marrow or stem cell transplantation for indications other than for breast cancer are as follows:
• 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 post-operative 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.

**Contraindications to Bone Marrow or Stem Cell Transplantations (Other Than Breast Cancer)**

PA 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 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 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 ribonucleic acid (RNA) undetectable
  - Stable anti-retroviral therapy for more than 90 days
  - No other complications from AIDS (e.g., opportunistic infection, including aspergilus, 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
Lung Transplantation

The IHCP considers lung transplants medically necessary with PA 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

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
- 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, coccidiodomycosis, antimicrobial resistant fungal infections, or Kaposi’s sarcoma or other neoplasms)

Heart Transplantation

The IHCP considers heart transplants medically necessary with PA 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 MI 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. (NYHA 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

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)
• Uncontrolled 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 condition (e.g., cerebral vascular accident)
• 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
- 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

Heart/Lung Transplantation

The IHCP considers heart/lung transplants medically necessary with PA if criteria for both heart and lung transplantation are met.

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.

Hepatic (Liver) Transplantation

The IHCP considers Hepatic (liver) transplants medically necessary with PA 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

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., cerebral vascular accident)
- An active extrahepatic malignancy
- 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

Renal Transplantation

The IHCP considers Renal (Kidney) transplantation medically necessary with PA 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

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
• 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, coccidiodomycosis, antimicrobial resistant fungal infections, or Kaposi’s sarcoma or other neoplasms)

Pancreatic Transplantation

The IHCP considers pancreatic transplantation medically necessary with PA when ONE of the following criteria is met:

• 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

**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 central nervous system condition (e.g., cerebral vascular accident)
• 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
• 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)
Islet Cell Transplantation

The IHCP considers Islet Cell Transplantation medically necessary as an adjunct to a total or near total pancreatectomy in patients with chronic pancreatitis.

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

Intestinal Transplantation (TPN)

The IHCP considers intestinal transplant medically necessary with PA for members with irreversible intestinal failure who can no longer be maintained on TPN. PA may be given for small bowel or intestinal transplantation for the indications listed in Table 93.3, below. Clinical indications of TPN failure are listed in Table 93.4.

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 3 - Indications for Intestinal Transplantation

<table>
<thead>
<tr>
<th>Pediatric</th>
<th>Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aganglionosis (Hirschsprung’s disease)</td>
<td>Crohn’s disease</td>
</tr>
<tr>
<td>Congenital epithelial mucosal disease (microvillus inclusion disease, tufting enteropathy)</td>
<td>Desmoid tumors</td>
</tr>
<tr>
<td>Gastrochisis</td>
<td>Gardner’s syndrome/familial polyposis</td>
</tr>
<tr>
<td>Intestinal atresia</td>
<td>Ischemia</td>
</tr>
<tr>
<td>Necrotizing enterocolitis</td>
<td>Trauma</td>
</tr>
<tr>
<td>Pseudo-obstruction</td>
<td>Volvulus</td>
</tr>
<tr>
<td>Volvulus</td>
<td>Surgical adhesions</td>
</tr>
<tr>
<td>Radiation enteritis</td>
<td>Hollow visceral myopathy</td>
</tr>
<tr>
<td>Short gut syndrome</td>
<td>Inflammatory bowel disease</td>
</tr>
</tbody>
</table>
### Table 4 – Clinical Indications of TPN Failure

<table>
<thead>
<tr>
<th>Clinical Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impending or overt liver failure due to TPN. Symptoms include:</td>
</tr>
<tr>
<td>• Elevated bilirubin and/or liver enzymes</td>
</tr>
<tr>
<td>• Gastroesophageal varices</td>
</tr>
<tr>
<td>• Coagulopathy</td>
</tr>
<tr>
<td>• Splenomegaly</td>
</tr>
<tr>
<td>• Thrombocytopenia</td>
</tr>
<tr>
<td>• Stomal bleeding</td>
</tr>
<tr>
<td>• Hepatic fibrosis/cirrhosis</td>
</tr>
<tr>
<td>Central line access failure as evidenced by:</td>
</tr>
<tr>
<td>• Thrombosis of two or more of the major central channels (jugular, subclavian, and</td>
</tr>
<tr>
<td>femoral veins)</td>
</tr>
<tr>
<td>• Pulmonary embolism</td>
</tr>
<tr>
<td>• Superior vena cava syndrome</td>
</tr>
<tr>
<td>• Chronic venous insufficiency</td>
</tr>
<tr>
<td>Two or more episodes of systemic sepsis due to line infection per year that requires</td>
</tr>
<tr>
<td>hospitalization or a single episode of line-related fungemia, septic shock or acute</td>
</tr>
<tr>
<td>respiratory distress syndrome</td>
</tr>
<tr>
<td>Frequent episodes of severe dehydration despite IV fluid supplementation</td>
</tr>
</tbody>
</table>

### 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
AIDS as defined by a CD4 count of less than 200 cells/mm³ unless all of the following are noted
- CD4 count greater than 200 cells/mm³ for greater than 5 months
- 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, 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 SDs from mean or a Z-score greater than 2 SDs 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

Multi-Visceral Transplantation
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: 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.

Providers should refer to the intestinal transplantation criteria for indication 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.

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
- AIDS as defined by a CD4 count of less than 200 cells/mm³ unless all of 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, coccidiodomycosis, 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 SDs from mean or a Z-score greater than 2 SDs 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

Removal of Transplanted Organs

The IHCP does not require PA for removal of a transplanted organ. Prior Authorization is required for transplantation of another organ.

Billing Requirements

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs. Providers must bill utilizing the appropriate procedure code. 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. For specific billing guidelines, please refer to Chapter 8 of the IHCP Provider Manual.

Corneal Tissue Transplantation

Corneal Tissue

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. Submit claims for this item on the CMS-1500 claim form or through the 837P transaction. Attach a copy of the invoice from the eye bank or organ procurement organization showing the actual cost of acquiring the tissue.
Providers must follow current policy for submitting paper attachments with the 837P transaction. HCPCS code V2785 is reimbursed 100 percent of the cost invoice. When submitting paper attachments with an 837P transaction, providers must follow the instructions in Chapter 8 of the IHCP Provider Manual.

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.

Table 5 lists the covered CPT® codes for the reimbursement of corneal tissue transplants.

**Table 5 – CPT® Codes for Reporting Corneal Transplantations**

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>65710</td>
<td>Keratoplasty (corneal transplant); anterior lamellar</td>
</tr>
<tr>
<td>65730</td>
<td>Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)</td>
</tr>
<tr>
<td>65750</td>
<td>Keratoplasty (corneal transplant); penetrating (in aphakia), inc. autografts and fresh or preserved</td>
</tr>
<tr>
<td>65755</td>
<td>Keratoplasty (corneal transplant); penetrating (in pseudophakia)</td>
</tr>
<tr>
<td>65756</td>
<td>Keratoplasty (corneal transplant); endothelial</td>
</tr>
<tr>
<td>65757</td>
<td>Backbench preparation for corneal endothelial allograft prior to transplantation (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>65780</td>
<td>Ocular surface reconstruction; amniotic membrane transplantation, multiple layers</td>
</tr>
<tr>
<td>65781</td>
<td>Ocular surface reconstruction; limbal stem cell allograft (e.g. cadaveric or living donor)</td>
</tr>
<tr>
<td>65782</td>
<td>Ocular surface reconstruction; limbal conjunctival autograft (includes obtaining graft)</td>
</tr>
</tbody>
</table>

**Bone Marrow or Stem Cell Transplantations**

The IHCP will provide reimbursement for autologous or allogenic bone marrow or stem cell transplants. Table 6 lists the covered CPT® codes for reimbursement of bone marrow or stem cell transplants. These codes should be used for bone marrow or stem cell transplants with or without the diagnosis of breast cancer.
# Table 6 – CPT® Codes for Bone Marrow or Stem Cell Transplantations

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>38204</td>
<td>Management of recipient hematopoietic progenitor cell donor search and cell acquisition</td>
</tr>
<tr>
<td>38205</td>
<td>Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic</td>
</tr>
<tr>
<td>38206</td>
<td>Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous</td>
</tr>
<tr>
<td>38230</td>
<td>Bone marrow harvesting for transplantation, allogeneic</td>
</tr>
<tr>
<td>38240</td>
<td>Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor</td>
</tr>
<tr>
<td>38241</td>
<td>Hematopoietic progenitor cell (HPC); autologous transplantation</td>
</tr>
<tr>
<td>38242</td>
<td>Allogeneic lymphocyte infusions</td>
</tr>
</tbody>
</table>

## 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 examination signed by a physician that includes the member’s height, weight and gender. Additionally, the history and physical examination 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** computerized tomography (CT)
- Bone scan
- Chest X-ray, posteroanterior view
- Bone marrow aspirate and bilateral ischial bone biopsy and cellularity (pathology reports)
- Pulmonary function, including Carbon Monoxide Diffusing Capacity (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, HBV, HCV, syphilis and CMV serologies
• Laboratory values
  ➢ Complete blood count (CBC)
  ➢ CMT
  ➢ Creatinine clearance (CC)
  ➢ UA
  ➢ Carcinoembryonic antigen (CEA)
  ➢ Prothrombin time/international normalized ratio (PT/INR), partial thromboplastin time (PTT)
  ➢ Creatine kinase (CK)
  ➢ Lactic Acid Dehydrogenase

Documentation for Bone Marrow Transplantations (Other than Breast Cancer):
The following documentation must be maintained in the member’s medical record:
• H&P examination 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 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), 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 ABGs and pulmonary function tests if member was (is) a smoker or has a history of lung disease. FEV less than 60% of normal and 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

**Lung Transplant**

The IHCP will provide reimbursement for lung transplantation. Table 7 lists the covered CPT® codes for reimbursement lung transplants.

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>32851</td>
<td>Lung transplant, single; without cardiopulmonary bypass</td>
</tr>
<tr>
<td>32852</td>
<td>Lung transplant, single; with cardiopulmonary bypass</td>
</tr>
<tr>
<td>32853</td>
<td>Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass</td>
</tr>
<tr>
<td>32854</td>
<td>Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass</td>
</tr>
<tr>
<td>32855</td>
<td>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</td>
</tr>
<tr>
<td>32856</td>
<td>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</td>
</tr>
</tbody>
</table>

**Documentation for Lung Transplantation**

Documentation must indicate the following information was obtained within a medically reasonable timeframe prior to the request:

- 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

Computerized tomography (CT) scan 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 ABGs and carboxyhemoglobin, and pulmonary function, including a FEV of 25% normal and decreasing FVC of 40% normal or less.

HIV, HBV, HCV, syphilis, and CMV serologies

Lab values within normal limits
  ➢ Complete blood count, urine, CEA, CMP
  ➢ Plasma ammonia
  ➢ CK
  ➢ Serum magnesium
  ➢ Lactic Acid Dehydrogenase
  ➢ Serum phosphate
  ➢ Platelet count

Dental evaluation with treatment of any significant dental disease

Heart Transplantation

The IHCP will provide reimbursement for Heart transplantation. Table 8 lists the covered CPT® codes for reimbursement Heart transplants.
Table 8 – CPT® Codes for Reporting Heart Transplantations

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33940</td>
<td>Donor cardiectomy (including cold preservation)</td>
</tr>
<tr>
<td>33944</td>
<td>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</td>
</tr>
<tr>
<td>33945</td>
<td>Heart transplant, with or without recipient cardiectomy</td>
</tr>
</tbody>
</table>

Repair or resection procedures of the donor heart should be reported using CPT® codes listed in Table 9, as appropriate.

Table 9 – CPT® Codes for Reporting Repair and Resection of Donor Heart

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>*33310</td>
<td>Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); without bypass</td>
</tr>
<tr>
<td>*33320</td>
<td>Suture repair of aorta or great vessels; without bypass</td>
</tr>
<tr>
<td>*33400</td>
<td>Valvuloplasty, aortic valve; open with bypass</td>
</tr>
<tr>
<td>*33463</td>
<td>Valvuloplasty, tricuspid valve, without ring insertion</td>
</tr>
<tr>
<td>*33464</td>
<td>Valvuloplasty, tricuspid valve, with ring insertion</td>
</tr>
<tr>
<td>*33510</td>
<td>Coronary artery bypass, vein only; single coronary venous graft</td>
</tr>
<tr>
<td>*33641</td>
<td>Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch</td>
</tr>
<tr>
<td>*35216</td>
<td>Repair blood vessel or A-V fistula, direct; intrathoracic, without bypass</td>
</tr>
<tr>
<td>*35276</td>
<td>Repair blood vessel or A-V fistula with graft or other than vein; intrathoracic, without bypass</td>
</tr>
<tr>
<td>*35685</td>
<td>Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (list separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

*These procedures do not require PA.

**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.
• 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

• Complete blood count (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, HBV, HCV, syphilis, and CMV serologies

• Results of EKG, multiple gate acquisition (MUGA) scan, heart catheterization(s), or EP studies

• Results of ABGs and pulmonary function tests if member was (is) a smoker or has a history of lung disease. FEV less than 60% of normal and FVC less than 50% of normal may be a contraindication to transplant.

• Dental evaluation with treatment of any significant dental disease

Heart/Lung Transplantation

The IHCP will provide reimbursement for Heart/Lung transplantation. Table 10 lists the covered CPT® codes for reimbursement of Heart/Lung transplants.

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33930</td>
<td>Donor cardiectomy-pneumonectomy (including cold preservation)</td>
</tr>
<tr>
<td>33933</td>
<td>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</td>
</tr>
<tr>
<td>33935</td>
<td>Heart-lung transplant with recipient cardectomy-pneumonectomy</td>
</tr>
</tbody>
</table>

Repair or resection procedures of the donor heart should be reported using CPT® codes listed in Table 11, as appropriate.
### Table 11 – CPT® Codes for Reporting Repair and Resection of Donor Heart

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>*33300</td>
<td>Repair of cardiac wound without bypass</td>
</tr>
<tr>
<td>*33310</td>
<td>Cardiotomy, exploratory (includes removal of foreign body, atrial or ventricular thrombus); without bypass</td>
</tr>
<tr>
<td>*33320</td>
<td>Suture repair of aorta or great vessels; without shunt or cardiopulmonary bypass</td>
</tr>
<tr>
<td>*33400</td>
<td>Valvuloplasty, aortic valve; open with cardiopulmonary bypass</td>
</tr>
<tr>
<td>*33463</td>
<td>Valvuloplasty, tricuspid valve, without ring insertion</td>
</tr>
<tr>
<td>*33464</td>
<td>Valvuloplasty, tricuspid valve, with ring insertion</td>
</tr>
<tr>
<td>*33510</td>
<td>Coronary artery bypass, vein only; single coronary venous graft</td>
</tr>
<tr>
<td>*33641</td>
<td>Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch</td>
</tr>
<tr>
<td>*35216</td>
<td>Repair blood vessel or A-V fistula, direct; intrathoracic, without bypass</td>
</tr>
<tr>
<td>*35276</td>
<td>Repair blood vessel or A-V fistula with graft or other than vein; intrathoracic, without bypass</td>
</tr>
<tr>
<td>*35685</td>
<td>Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (list separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

*These procedures do not require PA

**Documentation for Heart/Lung Transplantation**

The IHCP requires documentation for heart lung transplantation meet the same criteria required for both heart and lung transplantation.

**Hepatic (Liver) Transplantation**

The IHCP will provide reimbursement for Liver transplantation. Table 12 lists the covered CPT® codes for reimbursement of Liver transplants.

### Table 12 – CPT® Codes for Hepatic Transplantations

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>47133</td>
<td>Donor hepatectomy (including cold preservation), from cadaver donor</td>
</tr>
<tr>
<td>47135</td>
<td>Liver transplant, with or without recipient hepatectomy</td>
</tr>
<tr>
<td>47136</td>
<td>Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age</td>
</tr>
</tbody>
</table>
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 (i.e., left lateral segment (segments II and III) and right trisegment (segments 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 (i.e., 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

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:

- 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.

- Complete blood count, UA, CMP, and EKG
### Renal (Kidney) Transplantation

The IHCP will provide reimbursement for Renal transplantation. Table 13 lists the covered CPT® codes for reimbursement of Renal transplants.

#### Table 13 – CPT® Codes Renal Transplantations

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>50300</td>
<td>Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral;</td>
</tr>
<tr>
<td>50320</td>
<td>Donor nephrectomy (including cold preservation); open, from living donor</td>
</tr>
<tr>
<td>50323</td>
<td>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</td>
</tr>
<tr>
<td>50325</td>
<td>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</td>
</tr>
<tr>
<td>50327</td>
<td>Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each</td>
</tr>
<tr>
<td>50328</td>
<td>Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each</td>
</tr>
<tr>
<td>50329</td>
<td>Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each</td>
</tr>
<tr>
<td>50340</td>
<td>Recipient nephrectomy (separate procedure)</td>
</tr>
</tbody>
</table>
Renal allotransplantation, implantation of graft; without recipient nephrectomy

Renal allotransplantation, implantation of graft; with recipient nephrectomy

Renal autotransplantation, reimplantation of kidney

**Documentation for Renal Transplantation**

Documentation must indicate that the following information was obtained within a medically reasonable timeframe prior to the request:

- 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.
- Complete blood count (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, HBV, HCV, syphilis, and CMV serologies
- Dental evaluation with treatment of any significant dental disease

Results of ABGs and pulmonary function tests if member was (is) a smoker or has a history of lung disease. FEV less than 60% of normal and FVC less than 50% of normal may be a contraindication to transplant.

**Pancreatic Transplantation**

The IHCP will provide reimbursement for Pancreatic Transplantation. Table 14 lists the covered CPT® codes for reimbursement of Pancreatic Transplants.

**Table 14 – CPT® Codes for Pancreatic Transplantation**

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>48550</td>
<td>Donor pancreatotomy, (including cold preservation), with or without duodenal segment for transplantation</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>48551</td>
<td>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</td>
</tr>
<tr>
<td>48552</td>
<td>Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation, venous anastomosis, each</td>
</tr>
<tr>
<td>48554</td>
<td>Transplantation of pancreatic allograft</td>
</tr>
</tbody>
</table>

**Documentation for Pancreas Transplantation**

Documentation must indicate the following information was obtained within a medically reasonable timeframe prior to the request:

- 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
- Complete blood count (CBC), UA, CMP, and EKG
- HIV, HBV, HCV, syphilis, and 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 ABGs and pulmonary function tests if member was (is) a smoker or has a history of lung disease. FEV less than 60% of normal and FVC less than 50% of normal may be a contraindication to transplant.
- Dental evaluation with treatment of existing caries
Islet Cell Transplantation

The IHCP will provide reimbursement for Islet Cell Transplantation. Table 15 lists the covered CPT® codes for reimbursement of Islet Cell Transplants.

Table 15 – CPT® Codes for Islet Cell Transplantation

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>48160</td>
<td>Pancreatectomy, total or subtotal, with transplantation</td>
</tr>
</tbody>
</table>

Table 16 – Non-Covered CPT® Codes for Allogenic Islet Cell Transplantation

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0341</td>
<td>Percutaneous islet cell transplantation, includes portal vein catheterization and infusion</td>
</tr>
<tr>
<td>G0342</td>
<td>Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion</td>
</tr>
<tr>
<td>G0343</td>
<td>Laparotomy for islet cell transplant, includes portal vein catheterization and infusion</td>
</tr>
</tbody>
</table>

Allogenic islet cell transplantation, reported with HCPCS codes G0341, G0342, and G0343, are noncovered services, and are considered investigational.

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 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, HBV, HCV, syphilis, and 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

Intestinal and Small Bowel Transplantation

The IHCP will provide reimbursement for intestinal and small bowel transplantation. Table 17 lists the covered CPT® codes for reimbursement of intestinal and small bowel transplants.
### Table 17 – CPT® Codes for Reporting Intestinal and Small Bowel Transplantation

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44132</td>
<td>Donor enterectomy (including cold preservation), open; from cadaver donor</td>
</tr>
<tr>
<td>44133</td>
<td>Donor enterectomy (including cold preservation), open; partial, from living donor</td>
</tr>
<tr>
<td>44135</td>
<td>Intestinal allotransplantation; from cadaver donor</td>
</tr>
<tr>
<td>44136</td>
<td>Intestinal allotransplantation; from living donor</td>
</tr>
<tr>
<td>44715</td>
<td>Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein</td>
</tr>
<tr>
<td>44720</td>
<td>Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; venous anastomosis, each</td>
</tr>
<tr>
<td>44721</td>
<td>Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation; arterial anastomosis, each</td>
</tr>
</tbody>
</table>

### 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 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 complete blood count (CBC), CMP, UA and creatinine clearance (if creatinine is greater than 2.0)
- Lipid and hepatic function panels
- HIV, HBV, HCV, syphilis, and 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 EKG and chest X-ray, posteroanterior view
- Psychosocial evaluation, performed at the transplant center
- Dental evaluation with treatment of any significant dental disease
Multi-Visceral Transplantation

The IHCP will provide reimbursement for Multi-Visceral Transplantation. Table 18 lists the covered CPT® codes for reimbursement of Multi-Visceral Transplants.

**Table 18 - Codes for Reporting Multi-Visceral Transplantation**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>44132-44133</td>
<td>Donor enterectomy (including cold preservation), open</td>
<td></td>
</tr>
<tr>
<td>44135-44136</td>
<td>Intestinal allotransplantation</td>
<td></td>
</tr>
<tr>
<td>44715, 44720-44721</td>
<td>Backbench work – intestine allograft</td>
<td></td>
</tr>
<tr>
<td>47133, 47140-47142</td>
<td>Donor hepatectomy</td>
<td></td>
</tr>
<tr>
<td>47135-47136</td>
<td>Liver transplantation</td>
<td></td>
</tr>
<tr>
<td>47143-47147</td>
<td>Backbench work – liver graft</td>
<td></td>
</tr>
<tr>
<td>48550</td>
<td>Donor pancreatectomy</td>
<td></td>
</tr>
<tr>
<td>48554</td>
<td>Pancreatic transplant</td>
<td></td>
</tr>
<tr>
<td>48551-48552</td>
<td>Backbench work – pancreas allograft</td>
<td></td>
</tr>
</tbody>
</table>

**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:

- 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, HBV, HCV, syphilis, and 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 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
The IHCP will provide reimbursement for removal of transplanted organs. Table 19 lists the covered CPT® codes for reimbursement of removal of transplanted organs.

Table 19 – CPT® Codes for Reporting Removal of Transplanted Organs

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44137</td>
<td>Removal of transplanted intestinal allograft, complete</td>
</tr>
<tr>
<td>48556</td>
<td>Removal of transplanted pancreatic allograft</td>
</tr>
<tr>
<td>50370</td>
<td>Removal of transplanted homograft (eg, infected or rejected kidney)</td>
</tr>
</tbody>
</table>

Transportation
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
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.

Hoosier Healthwise Package C
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.

**Rules, Citations and Sources**

*IC § 29-2-16-12 – Donation Costs*

*405 IAC 5-3-13 – Services Requiring Prior Authorization*

*405 IAC 5-29-1 – Services not Covered by Medicaid; Non-covered Services*

**IHCP Banner Page**

*BR200506 – Corneal Tissue Reimbursement*

**IHCP Bulletins**

BT199928
BT200018
BT200231
BT200420

**IHCP Provider Manual**

**Note:** For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp)

**Related Medical Topics**

Hospital Inpatient Services
Hospital Outpatient Services
Out-of-State Services
Surgery – Surgical Services
Transportation Services
Telehealth

Introduction
This section serves as a general summary of the IHCP's policies regarding Telehealth services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCO or plan administrator for more specific guidelines regarding their policies and PA procedures.

Description of Service
Telehealth services are defined as the scheduled remote monitoring of clinical data through technologic equipment in the member's home. Data is transmitted from the member's home to the home health agency to be read and interpreted by a registered nurse (RN). The technologic equipment allows the home health agency to detect minute changes in the member's clinical status that allow home health agencies to intercede before the member's condition advances and requires emergency intervention or inpatient hospitalization.

Reimbursement Requirements
The IHCP provides reimbursement for telehealth services when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization (PA). Telehealth services are considered medically necessary for individuals with uncontrolled chronic conditions, as evidenced by emergency room visits and inpatient hospital stays directly related to the chronic condition.

In any telehealth services encounter, a licensed RN must read the transmitted health information provided from the member, in accordance with the written order of the physician. The nurse must review all data on the day the ordered data is received or, in cases when the data is received after business hours, on the first business day following receipt of the data. Transmitted data must meet Health Insurance Portability and Accountability Act (HIPAA) compliance standards.

The home health agency will follow the monitoring criteria and interventions for the treatment of the member's qualifying condition, as outlined in the plan of treatment. Any potential medical concerns should be communicated to the ordering physician and, for individuals enrolled in Hoosier Healthwise or Care Select, to the member's health plan. Members who are unable or unwilling to use the telehealth equipment appropriately will be disenrolled from telehealth services.
Prior Authorization Requirements

PA is required for all for telehealth services, per Indiana Administrative Code 405 IAC 1-4.2-3 and 405 IAC 5-16-3. Telehealth services are indicated for members who require scheduled remote monitoring of data related to the member’s qualifying chronic diagnoses that are not controlled with medications or other medical interventions.

Per 405 IAC 5-16-3.1, to initially qualify for telehealth services, the member must have had two or more of the following events within the previous 12 months:

- Emergency room visits
- Inpatient hospital stays

An emergency room visit that results in an inpatient hospital admission does not constitute two separate events. The two qualifying events must be for the treatment of one of the following diagnoses:

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Diabetes

Additionally, to qualify for telehealth services, the member must be receiving or approved for other IHCP home health services. The PA request for telehealth services must be submitted separately from other home health service PA requests. Once initially qualified, to continue receiving telehealth services, the member must have a current diagnosis of one of the previous qualifying diagnoses and continue to receive other home health services. Services may be authorized for members for up to 60 days per PA request.

The telehealth PA request form must include a physician’s written order that is signed and dated by the physician. The PA request must also include an attestation from the home health agency that the telehealth equipment to be placed in the member’s home is capable of monitoring any data parameters included in the plan of treatment, and that the transmission process meets HIPAA compliance standards.

A plan of treatment must be signed and dated by the physician and submitted with the PA request. Monitoring criteria and interventions for the treatment of the member’s qualifying conditions must be developed collaboratively between the member’s physician and the home health agency and included in the member’s plan of treatment. The plan of treatment must clearly outline the patient’s health data and information to be monitored and measured, and the circumstances under which the ordering physician should be contacted to address any potential health concerns. The monitoring criteria and interventions should be directly related to the member’s qualifying diagnoses. Other monitoring criteria and interventions may be developed for other conditions the member may have, but the primary criteria and interventions must be for treatment of the qualifying diagnoses. The plan of treatment must also indicate how often an RN must perform a reading of transmitted health information.
Billing Requirements

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for members enrolled in IHCP managed care programs. Home health agencies must bill using the appropriate procedure codes using the UB-04 claim form.

Per 405 IAC 1-4.2-6, the IHCP will cover the Current Procedural Terminology (CPT®1) codes with the appropriate modifiers and revenue codes in Table 1. This information will be reflected on the next monthly update to the Fee Schedule at indianamedicaid.com.

Table 1 – Telehealth procedure codes covered for DOS on or after December 1, 2014

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Rate</th>
<th>Revenue Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>99600 U1</td>
<td>Unlisted home visit service or procedure; one-time initial face-to-face visit necessary to train the member or caregiver to appropriately operate the telehealth equipment.</td>
<td>$14.45</td>
<td>780</td>
</tr>
<tr>
<td>99600 U2 TD</td>
<td>Unlisted home visit service or procedure; remote skilled nursing visit to monitor and interpret telehealth reading; RN</td>
<td>$9.84</td>
<td>780</td>
</tr>
</tbody>
</table>

Approved telehealth services are reimbursed separately from other home health services. The initial visit is limited to a one-time visit to educate the member or caregiver about how to properly operate the telehealth equipment. A remote skilled nursing visit cannot be billed on the same DOS that a member received a skilled nursing visit in the home. The telehealth reading should be included in the skilled nursing home visit when the reading and the home visit are performed on the same day.

All equipment and software costs associated with the telehealth services must be separately identified on the home health provider’s annual cost report, so that the equipment and software costs may be removed from the calculation of overhead costs. The home health agency cost report forms and instructions have been revised to accommodate the changes for telehealth services.
Rules, Citations and Sources

405 IAC 1-4.2-2 – Definitions

405 IAC 1-4.2-3 – Home health care services; general information

405 IAC 1-4.2-6 – Telehealth services

405 IAC 5-2-28 – "Telemedicine services" defined

405 IAC 5-16-2 – Home health agency services

405 IAC 5-16-3.1 – 405 IAC 5-16-3.1 – Home health agency services; limitations

Related Medical Topics

Home Health Services

Telemedicine
Telemedicine Services

Introduction
This section serves as a general summary of the IHCP’s policies regarding telemedicine. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP
For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service
The American Telemedicine Association defines telemedicine as “the use of medical information exchanged from one site to another via electronic communications to improve patients' health status.” The terms "telemedicine" and "telehealth" are often used interchangeably, although "telehealth" is intended to include a broader range of services such as videoconferencing and transmission of still images. The main proposed advantage of telemedicine is the capability of delivering medical services to distant areas with low access to medical specialists.

Telemedicine services refer to a specific method of delivery of certain services, including medical exams and consultations, which are already reimbursed by Medicaid. Telemedicine uses videoconferencing equipment to allow a medical provider to deliver an exam or other services to a patient at a distant location.

In any telemedicine service, there will be a hub site, a spoke site, an attendant to connect the patient to the specialist at the hub site, a computer or television so that the patient has real-time, interactive, and face-to-face communication with the hub specialist/consultant via the interactive television technology. These services may be offered in an inpatient, outpatient, or office setting.

Telemedicine is not the use of the following:
- Telephone transmitter for transtelephonic monitoring; or
- Telephone or any other means of communication for consultation from one provider to another.

Definitions
Hub Site – Location of the physician or provider rendering consultation services.
Spoke Site – Location where the patient is physically located when services are provided.
Interactive Television (IATV) – Videoconferencing equipment at the hub and spoke sites that allows real-time, interactive, and face-to-face consultation.

Store and Forward – Electronic transmission of medical information for subsequent review by another health care provider

Reimbursement Requirements

The IHCP will provide reimbursement for the telemedicine when the services are medically necessary and provided in compliance with all applicable IHCP guidelines and per 405 IAC 5-38.

Telemedicine shall be limited to the following conditions:

- Telemedicine is reimbursable for the following services or provider types (specific codes eligible for reimbursement are identified in the “Billing Requirements” section of this policy):
  - Consultations,
  - Office visits,
  - Psychotherapy
  - Psychiatric diagnostic interview
  - End-stage renal disease (ESRD) services
  - Pharmacologic management
- The member must be:
  - physically present at the spoke site; and
  - must participate in the visit.
- The physician or practitioner who will be examining the patient from the hub site must determine if it is medically necessary for a medical professional to be at the spoke site.
- Separate reimbursement for a provider at the spoke site is payable only if that provider's presence is medically necessary. Documentation must be maintained in the patient's medical record to support the need for the provider's presence at the spoke site during the visit.
- Reimbursement for telemedicine services is available only when the hub and spoke sites are greater than twenty (20) miles apart. Effective December 1, 2014, this requirement does not apply to the following provider types:
  - Federally Qualified Health Centers (FQHCs)
  - Rural Health Clinics (RHCs)
Federally Qualified Health Centers and Rural Health Clinics

Reimbursement is available to Federally Qualified Health Centers (FQHCs) and rural health centers (RHCs) for telemedicine services when the service rendered meets both the definition of a valid encounter and is consistent with the IHCP telemedicine policy.

Subject to the following criteria, reimbursement is available to FQHCs and RHCs when they are serving as either the hub site or the spoke site for telemedicine services.

When serving as the hub site (the location of the physician or provider rendering services), the service provided at the FQHC or RHC must meet both the requirements of a valid encounter and an approved telemedicine service as defined in the IHCP’s telemedicine policy.

Reimbursement is based on the prospective payment system (PPS) rate specific to the FQHC or RHC facility.

When serving as the spoke site (the location where the patient is physically located), an FQHC or RHC may be reimbursed if it is medically necessary for a medical professional to be with the member, and the service provided includes all components of a valid encounter code.

Reimbursement is based on the PPS rate specific to the FQHC or RHC facility.

Please note all components of the service must be provided and documented, and the documentation must demonstrate medical necessity. All documentation is subject to post-payment review.

Separate reimbursement for merely serving as the spoke site is not available to FQHCs and RHCs. Neither the originating site facility fee, as billed by Healthcare Common Procedure Coding System (HCPCS) code Q3014, nor the facility-specific PPS rate is available, because the requirement of a valid encounter is not met. Pursuant to the Code of Federal Regulations at 42 CFR 405.2463, an encounter is defined by the Centers for Medicare & Medicaid Services (CMS) as a face-to-face meeting between an eligible provider and a Medicaid member during which a medically necessary service is performed. Consistent with federal regulations, for an FQHC or RHC to receive reimbursement for services, including those for telemedicine, the criteria of a valid encounter must be met. For a list of valid encounter codes, see the Myers and Stauffer website at in.mslc.com.

FQHC and RHC providers are reminded that their facility-specific PPS rate, which is calculated based on an FQHC’s or RHC’s operating costs, is an all-inclusive enhanced rate that covers any ancillary services that are not billable as valid encounters. FQHC and RHC providers may request an increase in their facility-specific PPS rate when the scope of services changes.
Special Considerations

- When ongoing services are provided, the member should be seen by a physician for a traditional clinical evaluation at least once a year, unless otherwise stated in policy. In addition, the hub physician should coordinate with the patient's primary care physician.

- The existing service limitations for office visits are applicable. All telemedicine consultations billed using the codes listed in the *Hub Site Services and Billing Requirements* section are counted against the office visit limit. Third-party liability (TPL), spend-down, managed care, and all other considerations apply.

- Reimbursement for ESRD-related services under HCPCS codes 90951 – 90970 is permitted in the telemedicine setting. The IHCP requires at least one monthly visit for ESRD-related services to be a traditional clinical encounter to examine the vascular access site.

Telemedicine is not reimbursable for the following services or provider types:

- Ambulatory surgical centers.
- Outpatient surgical services.
- Home health agencies or services.
- Radiological services.
- Laboratory services.
- Long term care facilities, including nursing facilities, intermediate care facilities, or community residential facilities for the developmentally disabled.
- Anesthesia services or nurse anesthetist services.
- Audiological services.
- Chiropractic services.
- Care coordination services.
- DME, medical supplies, hearing aids, or oxygen.
- Optical or optometric services.
- Podiatric services.
- Services billed by school corporations.
- Physical or speech therapy services.
- Transportation services.
- Services provided under a Medicaid waiver.
Documentation Standards

- Documentation must be maintained at the hub and spoke locations to substantiate the services provided. Documentation must indicate the services were rendered via telemedicine.
- Documentation must clearly indicate the location of the hub and spoke sites.
- All other IHCP documentation guidelines for services rendered via telemedicine apply, for example chart notes and start and stop times.
- Documentation is subject to post-payment review.

Providers must have written protocols for circumstances when the member must have a hands-on visit with the consulting provider. The member should always be given the choice between a traditional clinical encounter versus a telemedicine visit. Appropriate consent from the member must be obtained by the spoke site and maintained at the hub and spoke sites.

Prior Authorization Requirements

Please refer to the appropriate section of the medical policy manual for each service covered under telemedicine. Telemedicine is the method by which a service is delivered, all services which are available for reimbursement under telemedicine are still subject to the same limitations and restrictions as services not delivered by telemedicine.

Billing Requirements

Hub Site Services and Billing Requirements

The following Current Procedural Terminology (CPT®) codes are reimbursable for providers that render services via telemedicine at the hub site. Modifier GT – Via interactive audio and video telecommunications system must be used to denote telemedicine services. The payment amount is equal to the current fee schedule amount for the services listed in Table 1:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241 – 99245 and 99251 – 99255</td>
<td>Consultations</td>
</tr>
<tr>
<td>99201 – 99205 and 99211 – 99215</td>
<td>Office or other outpatient visit</td>
</tr>
<tr>
<td>90832 – 90834, 90836-90840, 90846-9084 and 90853</td>
<td>Psychotherapy</td>
</tr>
<tr>
<td>90791 and 90792</td>
<td>Psychiatric diagnostic interview</td>
</tr>
<tr>
<td>90951 – 90970</td>
<td>End-stage renal disease (ESRD) services</td>
</tr>
</tbody>
</table>
Spoke Site Services and Billing Requirements

The following Healthcare Common Procedure Coding System (HCPCS) code and revenue code are reimbursable for providers that render services via telemedicine at the spoke site. Modifier GT – *Via interactive audio and video telecommunications system* must be used to denote telemedicine services. The payment amount is equal to the current fee schedule amount for HCPCS code Q3014 *Telehealth originating site facility fee.*

- Spoke services are reimbursed using HCPCS code Q3014 *Telehealth originating site facility fee.* The GT modifier must be used to denote telemedicine services.
- Revenue code 780 represents telemedicine services. If a different, separately reimbursable treatment room revenue code is provided on the same day as the telemedicine consultation; the appropriate treatment room revenue code should also be included on the claim. Documentation must be maintained in the patient’s record to indicate that services were provided separate from the telemedicine visit.
- If spoke site services are provided in a physician’s office and other services are provided on the same date as the spoke service, the medical professional should bill Q3014 as a separate line item from other professional services.

*If a health care provider’s presence at the spoke site is medically necessary, billing of the appropriate evaluation and management code is permitted.*

Rules, Citations and Sources

42 CFR 410.78 - Telehealth services.
405 IAC 5-38 - Telemedicine Services

IHCP Provider Bulletins
- BT200802

IHCP Provider Banners
- BR201409

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit [http://www.indianamedicaid.com/ihcp/index.asp](http://www.indianamedicaid.com/ihcp/index.asp)

Related Medical Topics

Not applicable.
Therapy Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding therapy services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Description of Service

The IHCP covers therapy services for its members. Therapy services, as described in this section, encompass occupational, speech, and physical therapy.

Reimbursement Requirements

Acute Condition

Reimbursement is available only for medically reasonable and necessary therapy services provided by professionally trained staff, within the scope of the staff’s professional license 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 member’s medical condition. Therapy services may be provided in inpatient and outpatient settings, such as the home, outpatient clinics, rehabilitation hospitals, inpatient hospitals, LTC facilities, ICF/IIDs.

Chronic Condition (Ongoing Need)

Chronic medical condition or rehabilitation condition means any injury or insult with onset and sequelae extending past one year, according to 405 IAC 5-22-1. Ongoing therapy services may be approved when the therapist is able to supply documentation that supports the determination that the recipient’s functional abilities would not be maintained without therapy, and that the skills of a therapist are required to perform the service.

This supporting documentation will be reflected in the progress notes related to the recipient’s current POC. Further, there must be documentation by the therapist or any other therapist
identifying the member as receiving any other therapy. Duplication of services must be identified in the progress notes.

**Occupational Therapy (OT)**

OT, as defined in *IC § 25-23.5-1-5*, is 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.

OT is reimbursed when performed by an OT or by a certified OT assistant under the direct, on-site supervision of a registered OT. Reimbursement for OT evaluations is available only when the therapy is performed by a registered OT. OT psychiatric services are non-covered.

**Speech Therapy (ST)**

ST services are provided for 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. A speech pathologist or audiologist is someone who meets the licensing requirements under *IC § 25-35.6-3*.

**Physical Therapy (PT)**

PT, 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.

**Prior Authorization Requirements**

**Therapy services limitations**

Effective January 1, 2011, new limits were imposed on PT, OT, and ST; however effective June 30, 2011, these limitations were eliminated and PT, OT, and ST require PA for dates of service on or after June 30, 2011.

**General Therapy Service Limitations**

**For Dates of Service January 1, 2011 to June 29, 2011**

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 ST services:

- Initial evaluations.
• For members under the age of twenty-one (21) years, any combination of occupational, physical, and speech 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 days with PA.

• For members ages twenty one years (21) and older, any combination of OT, PT and ST, ordering in writing prior to a recipient’s discharge from inpatient hospital care may continue for a period not to exceed 25 hours/sessions/visits in 25 days with PA of a rolling calendar year.

• Deductible and copayment for services covered by Medicare Part B.

PT, ST, and OT 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, 405 IAC 5-22-10, and 405 IAC 5-22-11).

• PT services ordered in writing by a physician in an outpatient setting may continue for a period not to exceed 12 hours/sessions/or visits within 30 calendar days without PA. This includes the provision of splints, crutches, and canes. Additional services require PA.

• OT services ordered in writing by a physician may continue for a period not exceeding 12 hours/sessions/or visits within 30 calendar days without PA. This includes the provision of splints, crutches, and canes.

• ST services can be received by the member without PA through an initial evaluation, which is conducted during the initial 30 days after hospital discharge. The discharge orders must include speech pathology orders.

The following criteria must be met for PA of physical, speech, and OT when it is provided outside the exceptions previously stated:

• Therapy must be ordered by a physician.
• Written evidence of physician involvement and personal member evaluation will be required to document acute medical needs.
• A current POC, developed 60 to 90 days from the date of the PA submission, must include clearly stated and measurable goals and progress.
• Therapies must be provided by qualified therapists or qualified assistants under direct supervision of a therapist, as appropriate.
• Therapy must be complex enough to require the judgment, knowledge, and skills of a qualified therapist.
• Therapy for diversional, recreational, vocational purposes, for the remediation of learning disabilities, or for developmental activities which can be conducted by nonmedical personnel is non-covered.
Therapy Services

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 may be approved.

Therapies which duplicate other services provided to a patient will not be authorized (e.g., nursing services).

Therapy services provided by a NF, or by a large private or small ICF/IID, are included in the facility’s per diem rate. Therapy services provided in these settings are not separately reimbursable. OT 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 of physical, speech, or OT does not require PA; 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. Those orders must include physical or OT. Re-evaluations will be authorized only one time per year, unless the provider submits documentation showing a significant change in the member’s condition.

General Therapy Service Limitations

For Dates of Service On or After June 30, 2011

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 ST services:

- Initial evaluations.
- Any combination of OT, PT, and ST, 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 days with PA.
- Deductible and copayment for services covered by Medicare Part B.

PT, ST, and OT 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, 405 IAC 5-22-10, and 405 IAC 5-22-11).

- PT services ordered in writing by a physician in an outpatient setting may continue for a period not to exceed 12 hours/sessions/or visits within 30 calendar days without PA. This includes the provision of splints, crutches, and canes. Additional services require PA.
- OT services ordered in writing by a physician may continue for a period not exceeding 12 hours/sessions/or visits within 30 calendar days without PA. This includes the provision of splints, crutches, and canes.
• ST services can be received by the member without PA through an initial evaluation, which is conducted during the initial 30 days after hospital discharge. The discharge orders must include speech pathology orders.

The following criteria must be met for PA of physical, speech, and OT when it is provided outside the exceptions previously stated:

• Therapy must be ordered by a physician.
• Written evidence of physician involvement and personal member evaluation will be required to document acute medical needs.
• A current POC, developed 60 to 90 days from the date of the PA submission, must include clearly stated and measurable goals and progress.
• Therapies must be provided by qualified therapists or qualified assistants under direct supervision of a therapist, as appropriate.
• Therapy must be complex enough to require the judgment, knowledge, and skills of a qualified therapist.
• Therapy for diversional, recreational, vocational purposes, for the remediation of learning disabilities, or for developmental activities which can be conducted by nonmedical personnel is non-covered.
• 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 may be approved.
• Therapies which duplicate other services provided to a patient will not be authorized (e.g., nursing services).

Therapy services provided by a NF, or by a large private or small ICF/IID, are included in the facility’s per diem rate. Therapy services provided in these settings are not separately reimbursable. OT 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 of physical, speech, or OT does not require PA; 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. Those orders must include physical or OT. Re-evaluations will be authorized only one time per year, unless the provider submits documentation showing a significant change in the member’s condition.

Hippo Therapy

The IHCP has initiated coverage of hippo therapy for PT. To be covered, services must be provided by a licensed PT and should be billed using the appropriate CPT® codes. Services must be ordered by a physician and included in the patient’s POC. Existing PA requirements for PT apply to hippo therapy.
Home Health Care (405 IAC 5-6-1)

Home health services for therapies require PA, except in the following circumstance:

- Any combination of therapy services which has been ordered in writing by a physician prior to the member’s hospital discharge that does not exceed 30 units in 30 calendar days does not require PA. These services may not continue beyond 30 days following discharge unless PA is received.

The PA request for home health services must contain information required for all PAs, 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 periods 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 care for the member, including consideration of whether the caregiver works outside the home or attends school. 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 to utilize the 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, therapists, 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 problems 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.

**Billing Requirements**

The IAC 405 IAC 5-22-8 allows for the reimbursement of services provided by a certified physical therapist assistant (PTA). This rule clarifies supervision requirements for services provided by a certified PTA. 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 PT daily to review treatment. The consultation can be either face to face or by telephone.

Therapy assistants may perform only 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 members in preparation for, as necessary during, and at the conclusion of the treatment
- Assembling and disassembling equipment
- Assisting the PT 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
Covered Procedures for PTAs

The IHCP has identified procedures that may be performed by PTAs 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 PT.

Table 1 lists the PT services PTAs may perform. Evaluation and testing codes are excluded from this list, as PTAs may not administer tests or perform evaluations.

**Table 1 – PT Services That May Be Performed by PTAs – Current Procedural Terminology**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>29200</td>
<td>Strapping; thorax</td>
</tr>
<tr>
<td>29240</td>
<td>Strapping; shoulder (eg, Velpeau)</td>
</tr>
<tr>
<td>29260</td>
<td>Strapping; elbow or wrist</td>
</tr>
<tr>
<td>29280</td>
<td>Strapping; hand or finger</td>
</tr>
<tr>
<td>29505</td>
<td>Application of long leg splint (thigh to ankle or toes)</td>
</tr>
<tr>
<td>29515</td>
<td>Application of short leg splint (calf to foot)</td>
</tr>
<tr>
<td>29520</td>
<td>Strapping; hip</td>
</tr>
<tr>
<td>29530</td>
<td>Strapping; knee</td>
</tr>
<tr>
<td>29540</td>
<td>Strapping; ankle and/or foot</td>
</tr>
<tr>
<td>29550</td>
<td>Strapping; toes</td>
</tr>
<tr>
<td>29580</td>
<td>Strapping; Unna Boot</td>
</tr>
<tr>
<td>97012</td>
<td>Application of a modality to 1 or more areas; traction, mechanical</td>
</tr>
<tr>
<td>97014</td>
<td>Application of a modality to 1 or more areas; electrical stimulation (unattended)</td>
</tr>
<tr>
<td>97016</td>
<td>Application of a modality to 1 or more areas; vasopneumatic devices</td>
</tr>
<tr>
<td>97018</td>
<td>Application of a modality to 1 or more areas; paraffin bath</td>
</tr>
<tr>
<td>97022</td>
<td>Application of a modality to 1 or more areas; whirlpool</td>
</tr>
<tr>
<td>97024</td>
<td>Application of a modality to 1 or more areas; diathermy (eg, microwave)</td>
</tr>
<tr>
<td>97026</td>
<td>Application of a modality to 1 or more areas; infrared</td>
</tr>
<tr>
<td>97028</td>
<td>Application of a modality to 1 or more areas; ultraviolet</td>
</tr>
<tr>
<td>97032</td>
<td>Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes</td>
</tr>
<tr>
<td>97033</td>
<td>Application of a modality to 1 or more areas; iontophoresis, each 15 minutes</td>
</tr>
<tr>
<td>97034</td>
<td>Application of a modality to 1 or more areas; contrast baths, each 15 minutes</td>
</tr>
<tr>
<td>97035</td>
<td>Application of a modality to 1 or more areas; ultrasound, each 15 minutes</td>
</tr>
<tr>
<td>97036</td>
<td>Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes</td>
</tr>
</tbody>
</table>
Inpatient Rehabilitation Services

IHCP reimburses for medically necessary inpatient rehabilitation services provided by licensed, certified, or registered staff members. All rehabilitation center services require PA. A written POC is required for all rehabilitation services. The therapist or psychologist and attending physician must cooperatively develop the POC.

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 LOC 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 pre-morbid 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97110</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility</td>
</tr>
<tr>
<td>97112</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities</td>
</tr>
<tr>
<td>97113</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercise</td>
</tr>
<tr>
<td>97116</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)</td>
</tr>
<tr>
<td>97124</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)</td>
</tr>
<tr>
<td>97140</td>
<td>Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes</td>
</tr>
<tr>
<td>97150</td>
<td>Therapeutic procedure(s), group (2 or more individuals)</td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes.</td>
</tr>
<tr>
<td>97760</td>
<td>Orthotic(s) management and training, (including assessment and fitting when not otherwise reported), upper extremity(s) and/or trunk, each 15 minutes</td>
</tr>
<tr>
<td>97761</td>
<td>Prosthetic training, upper and/or lower extremity(s), each 15 minutes</td>
</tr>
</tbody>
</table>
• 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.
• PT must be provided in conjunction with OT and/or ST.
• Participation in a rehabilitation program must be under the direction of a qualified physician.
• Daily skilled rehabilitative nursing care or supervision.

**Hippo Therapy**

In order for hippo therapy to be reimbursed, services should be billed utilizing the CPT® codes listed in Table 2.

**Table 2 – Hippo Therapy CPT® Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97110</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility</td>
</tr>
<tr>
<td>97112</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities</td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve performance), each 15 minutes</td>
</tr>
<tr>
<td>97533</td>
<td>Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes</td>
</tr>
</tbody>
</table>

HCPCS code S8940 – *hippo therapy per person, equestrian, hippo therapy, per session* is not covered by the IHCP.
Home Health Services

In order for home therapy services to be reimbursed, providers should utilize the HCPCS codes listed in Table 3.

Table 3 – Home Therapy Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0151</td>
<td>Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G0152</td>
<td>Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>G0153</td>
<td>Services performed by a qualified speech language pathologist in the home health or hospice setting, each 15 minutes</td>
</tr>
</tbody>
</table>

The OMPP has determined reimbursement for therapy evaluations should be billed using one of the following CPT® codes, in conjunction with the appropriate revenue code:

Table 4 – CPT® Codes for Reimbursement of Therapy Evaluations in Home Settings

<table>
<thead>
<tr>
<th>Therapy</th>
<th>CPT®/Description</th>
<th>Revenue Code/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
<td>97001-97002 – Physical Therapy Evaluation</td>
<td>424 – PT Evaluation or Re-Evaluation</td>
</tr>
<tr>
<td>OT</td>
<td>97003-97004 – Occupational Therapy Evaluation</td>
<td>434 – OT Evaluation or Re-Evaluation</td>
</tr>
<tr>
<td>ST</td>
<td>92521-92523 – Evaluation of speech</td>
<td>444 – Speech Pathology Evaluation or Re-Evaluation</td>
</tr>
</tbody>
</table>

Rules, Citations and Sources

Indiana Code Title 25

405 IAC 5-22-6 – Prior Authorization; exceptions
405 IAC 5-16 – Home Health Agency and Clinic Services
405 IAC 5-16-4 – Rehabilitation center services; limitations
405 IAC 5-17-4 – Physical rehabilitation services
405 IAC 5-22 – Nursing and Therapy Services
405 IAC 5-22-8 – Certified Physical Therapist ‘s Assistants
405 IAC 5-32-1 – Rehabilitation Unit
IHCP Bulletin

BT 201126
BT 201058
BT 200611

IHCP Banner Pages

BR200845
BR200832
BR201338

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp

Related Medical Topics

Not applicable.
Transportation Services

Introduction

This section serves as a general summary of the IHCP’s policies regarding transportation services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member’s MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Package C Transportation Services

Hoosier Healthwise Package C members are eligible to receive emergency ambulance services, subject to the prudent layperson’s definition of emergency found in 407 IAC 1-1-6. Non-emergency ambulance transportation between medical facilities is a covered service when ordered by the treating physician.

Description of Service

This section serves as a general summary of the IHCP’s policies regarding transportation services. More specific information may be found in the IHCP Provider Manual, program notices, the IAC, or other sources, as appropriate.

Transportation services enable IHCP members to get to and from medically necessary services. General categories within this section include types of transportation services; definition of a trip; PA requirements and exemptions; covered services; provider requirements; and the transportation code set.

Reimbursement Requirements

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 copies of 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 OFC (contact caseworker).
- Providers must keep a copy of the authorization letter for their records.

**Air Ambulance**

- Providers must have an 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.

The IHCP reimburses transportation services to and from IHCP-covered services. The IHCP defines a trip as transporting a member from the initial point of pick-up to the drop-off point at the final destination. The member being transported 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.
Additionally, providers are expected to transport members along the shortest, most efficient route to and from a designation. IHCP reimbursement is available for emergency and non-emergency transportation services, subject to program restrictions. The limitations and restrictions, set out in the IC, the IAC, and IHCP newsletters, bulletins, and banners, are summarized in this section.

**Covered Transportation Services**

**Advanced Life Support**

The IHCP provides coverage for medically necessary emergency and nonemergency advanced life support (ALS) ambulance services when the level of services rendered meets the Indiana Emergency Medical Services Commission’s (EMSC) definition for advanced life support. The EMSC and *Title 836* of the *IAC* define 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.”

Thus, advanced life support may include any of the following acts of care:

- Defibrillation
- Endotracheal intubation
- Parenteral injection of appropriate medications
- Electrocardiogram (ECG) interpretation
- Emergency management of trauma and illness

ALS services are covered only when the level of service is medically necessary, and basic life support (BLS) services are not appropriate due to the medical conditions of the member being transported. Base rate, mileage, and wait time are reimbursed. The codes for the base rate include reimbursement for supplies and oxygen and, thus are not separately reimbursed.

In accordance with IC 16-31, vehicles and staff that provide emergency services must be certified by the EMSC to be eligible for reimbursement for transports involving either ALS or BLS services.

**Basic Life Support**

The IHCP provides coverage for medically necessary emergency and nonemergency BLS ambulance services when the level of services rendered meets the EMSC definition of basic life support. The EMSC defines BLS as the following:

- Assessment of emergency patients
- Administration of oxygen
- Use of mechanical breathing devices
- Application of anti-shock trousers
- Performance of CPR
- Application of dressings and bandage materials
- Application of splinting and immobilization devices
- Use of lifting and moving devices to ensure safe transport
- Use of an automatic or semiautomatic defibrillator
- Administration of epinephrine through an auto-injector
- An emergency medical technician-basic advanced may perform the following:
  - ECG interpretation
  - Manual external defibrillation
  - IV fluid therapy

Thus, basic life support 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. Base rate, mileage, wait time, and oxygen are separately reimbursable.

**Commercial or Common Ambulatory Service**

The IHCP provides reimbursement for transportation of ambulatory (walking) members to or from an IHCP-covered service. Common Ambulatroy 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. Thus, 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.

**Non-Ambulatory Services (NAS) (Wheelchair Van)**

Non-Ambulatory Services (NAS) or wheelchair services are reimbursable when a member must travel in a wheelchair to or from an IHCP-covered service. Providers must bill all transportation services according to the level of services rendered. Thus, 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.
Taxi Transportation

The IHCP provides reimbursement for transportation of a member to or from an IHCP-covered service via taxi. Taxi providers may operate under authority from a local governing body (city taxi or delivery 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. Mileage is not reimbursable.

Family Member Transportation

Family members enrolled as transportation providers under 405 IAC 5-4-3 are eligible for reimbursement for mileage only. Reimbursement is determined by the actual loaded mileage multiplied by the rate per mile established by the Indiana legislature for state employees. The local county office of the Division of Family Resources (DFR) in which the member resides must authorize all family member transportation.

Other Transportation Services

Medicaid reimbursement is available for other transportation services, including but not limited to intrastate bus or train transportation. Medicaid payment for other transportation services will be the fee usually and customarily charged the general public, subject to federal, state, or local law, rule, or ordinance. Intrastate bus or train services (including services provided in designated areas) require authorization by the county office, and interstate bus or train services require authorization from the contractor. Authorization may be given for use of monthly bus passes in situations where a recipient has an ongoing medical need, so that purchase of the bus pass is cost effective when compared to the cost of other modes of transportation. Such authorization shall be given only if the recipient has agreed to use this mode of transportation. To be reimbursed, the bus or train company providing services must be enrolled as a Medicaid provider.

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 medical 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 a place of storage or from a 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

Prior Authorization Requirements

PA is required for the following transportation services:

- Trips exceeding 20 one-way trips per member, per rolling 12-month period, with certain exceptions.
- 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 require PA.
- Airline or air ambulance services require PA.

PA requests must include a brief description of the anticipated care and description of the clinical circumstances necessitating the need for the transportation. PA requests are reviewed and a PA decision letter is sent to the member and the requesting provider.

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. 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. However, some services, listed below, are exempt from the 20 one-way trip limitations:

- Emergency transportation services
- Hospital admission or discharge
- Members on renal dialysis
- Members residing in nursing home
- Accompanying parent or attendant
- Additional attendant

**Emergency Transportation Services**

Emergency ambulance transportation is exempt from the 20 one-way trip limitations. 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. However, air ambulance and interstate transportation services do require PA. Additionally, any transportation service provided by a provider located in an out-of-state, non-designated area requires PA.

**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 limitations. 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. However, 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.

When a Medicaid recipient is admitted to a hospital, it may become necessary to transport the patient to another hospital for specialized services while the patient maintains inpatient status with the original hospital. Transportation of the patient in this instance is not a separately billable Medicaid transportation service. Payment for the transportation of a patient while still in inpatient status is not payable apart from the inpatient payment for the original inpatient hospital stay. For billing and cost reporting purposes, the admitting hospital should record the services obtained at the other hospital, including transport of the patient, in the appropriate ancillary cost center relating to the services obtained. Do not use revenue code 54X (Ambulance).

**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 limitations. Claims for members undergoing dialysis or members in nursing homes must be filed with one of the ICD-9-CM diagnosis codes listed in Table 1. The ICD-9-CM 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. ICD-9-CM diagnosis codes for transportation renal dialysis patients and patients residing in nursing homes are summarized in Table 1.

### Table 1 – ICD-9-CM Diagnosis Codes for Transportation of Renal Dialysis Patients and Patients Residing in Nursing Homes

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>V56.0, V56.1, or V56.8</td>
<td>Patient undergoing renal dialysis</td>
</tr>
<tr>
<td>V70.5</td>
<td>Patient residing in nursing facility</td>
</tr>
</tbody>
</table>

**Accompanying Parent/Attendant**

Procedure codes for an accompanying parent or attendant are not applied to the member’s 20 one-way trip limitations. PA 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. PA is required for procedure codes A0424 and A0130 U6 when the trip exceeds 50 miles one-way.

**Billing Requirements**

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*. If the member is transported to multiple points in succession, the provider may not bill for a trip between each point of the destination. A stop along the way is not considered a separate trip. Some examples are included below:

**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.

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.

Additionally, 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 trip 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.

When submitting claims, providers must ensure that each claim is supported with the following documentation on the driver’s ticket or run sheet:

- Complete date of service, including day, month, and year of service in the format MM/DD/YY
- Complete member name and address of pick-up, including street address, city, county, state, and zip code
- Member ID number
- Member signature – if the member is unable to sign, the driver should document that “the patient was unable to sign” and state the reason for the inability.
- Waiting time, including the actual start and stop time of the waiting period, such as wait time from 1 to 3:20 p.m.
- Service providers complete name and address, including street address, city, county, state, and zip code. 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 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. 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 the mileage code billed.
- Indication whether the trip was one-way or round trip
• Indication of CAS or NAS transportation
• The name and relationship of any accompanying parent or attendant to support the accompanying parent or attendant code billed, if applicable. When an attendant or parent is billed as part of the transport, the parent or attendant must also sign the driver's ticket.

If the provider makes a round trip for the same member, on the same date of service, and at the 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 at 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.

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.

A transportation modifier must be used to indicate the place of origin and destination for each service. The first character indicates the transport’s place of origin, while the second character indicates the designation. Modifiers are summarized in Table 2.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD</td>
<td>From diagnostic or therapeutic site to diagnostic or therapeutic site</td>
</tr>
<tr>
<td>DE</td>
<td>From diagnostic or therapeutic site to residential, domiciliary or custodial facility</td>
</tr>
<tr>
<td>DG</td>
<td>From diagnostic or therapeutic site to hospital-based dialysis facility</td>
</tr>
<tr>
<td>DH</td>
<td>From diagnostic or therapeutic site to hospital</td>
</tr>
<tr>
<td>DI</td>
<td>From diagnostic or therapeutic site to site of transfer between modes of ambulance transport</td>
</tr>
<tr>
<td>DJ</td>
<td>From diagnostic or therapeutic site to non-hospital-based dialysis facility</td>
</tr>
<tr>
<td>DN</td>
<td>From diagnostic or therapeutic site to skilled nursing facility</td>
</tr>
<tr>
<td>DP</td>
<td>From diagnostic or therapeutic site to physician’s office</td>
</tr>
<tr>
<td>DR</td>
<td>From diagnostic or therapeutic site to residence</td>
</tr>
<tr>
<td>DX</td>
<td>From diagnostic or therapeutic site to intermediate stop at physician’s office en route to the hospital</td>
</tr>
<tr>
<td>ED</td>
<td>From residential, domiciliary, custodial facility to diagnostic or therapeutic site</td>
</tr>
<tr>
<td>EE</td>
<td>From residential, domiciliary, custodial facility to residential, domiciliary or custodial facility</td>
</tr>
</tbody>
</table>

Table 2 – Transportation Modifiers
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EG</td>
<td>From residential, domiciliary, custodial facility to hospital-based dialysis facility</td>
</tr>
<tr>
<td>EH</td>
<td>From residential, domiciliary, custodial facility to hospital</td>
</tr>
<tr>
<td>EI</td>
<td>From residential, domiciliary, custodial facility to site of transfer between modes of ambulance transport</td>
</tr>
<tr>
<td>EJ</td>
<td>From residential, domiciliary, custodial facility to non-hospital-based dialysis facility</td>
</tr>
<tr>
<td>EN</td>
<td>From residential, domiciliary, custodial facility to skilled nursing facility</td>
</tr>
<tr>
<td>EP</td>
<td>From residential, domiciliary, custodial facility to physician’s office</td>
</tr>
<tr>
<td>ER</td>
<td>From residential, domiciliary, custodial facility to residence</td>
</tr>
<tr>
<td>EX</td>
<td>From residential, domiciliary, custodial facility to intermediate stop at physician’s office en route to the hospital</td>
</tr>
<tr>
<td>GD</td>
<td>From hospital-based dialysis facility to diagnostic or therapeutic site</td>
</tr>
<tr>
<td>GE</td>
<td>From hospital-based dialysis facility to residential, domiciliary or custodial facility</td>
</tr>
<tr>
<td>GG</td>
<td>From hospital-based dialysis facility to hospital-based dialysis facility</td>
</tr>
<tr>
<td>GH</td>
<td>From hospital-based dialysis facility to hospital</td>
</tr>
<tr>
<td>GI</td>
<td>From hospital-based dialysis facility to site of transfer between modes of ambulance transport</td>
</tr>
<tr>
<td>GJ</td>
<td>From hospital-based dialysis facility to non-hospital-based dialysis facility</td>
</tr>
<tr>
<td>GN</td>
<td>From hospital-based dialysis facility to skilled nursing facility</td>
</tr>
<tr>
<td>GP</td>
<td>From hospital-based dialysis facility to physician’s office</td>
</tr>
<tr>
<td>GR</td>
<td>From hospital-based dialysis facility to residence</td>
</tr>
<tr>
<td>GX</td>
<td>From hospital-based dialysis facility to intermediate stop at physician’s office en route to the hospital</td>
</tr>
<tr>
<td>HD</td>
<td>From hospital to diagnostic or therapeutic site</td>
</tr>
<tr>
<td>HE</td>
<td>From hospital to residential, domiciliary or custodial facility</td>
</tr>
<tr>
<td>HG</td>
<td>From hospital to hospital-based dialysis facility</td>
</tr>
<tr>
<td>HH</td>
<td>From hospital to hospital</td>
</tr>
<tr>
<td>HI</td>
<td>From hospital to site of transfer between modes of ambulance transport</td>
</tr>
<tr>
<td>HJ</td>
<td>From hospital to non-hospital-based dialysis facility</td>
</tr>
<tr>
<td>HN</td>
<td>From hospital to skilled nursing facility</td>
</tr>
<tr>
<td>HP</td>
<td>From hospital to physician’s office</td>
</tr>
<tr>
<td>HR</td>
<td>From hospital to residence</td>
</tr>
<tr>
<td>HX</td>
<td>From hospital to intermediate stop at physician’s office en route to the hospital</td>
</tr>
<tr>
<td>ID</td>
<td>From site of transfer between modes of ambulance transport to diagnostic or therapeutic site</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>IE</td>
<td>From site of transfer between modes of ambulance transport to residential, domiciliary or custodial facility</td>
</tr>
<tr>
<td>IG</td>
<td>From site of transfer between modes of ambulance transport to hospital-based dialysis facility</td>
</tr>
<tr>
<td>IH</td>
<td>From site of transfer between modes of ambulance transport to hospital</td>
</tr>
<tr>
<td>II</td>
<td>From site of transfer between modes of ambulance transport to site of transfer between modes of ambulance transport</td>
</tr>
<tr>
<td>IJ</td>
<td>From site of transfer between modes of ambulance transport to non-hospital-based dialysis facility</td>
</tr>
<tr>
<td>IN</td>
<td>From site of transfer between modes of ambulance transport to skilled nursing facility</td>
</tr>
<tr>
<td>IP</td>
<td>From site of transfer between modes of ambulance transport to physician’s office</td>
</tr>
<tr>
<td>IR</td>
<td>From site of transfer between modes of ambulance transport to residence</td>
</tr>
<tr>
<td>IX</td>
<td>From site of transfer between modes of ambulance transport to intermediate stop at physician’s office en route to the hospital</td>
</tr>
<tr>
<td>JD</td>
<td>From non-hospital-based dialysis facility to diagnostic or therapeutic site</td>
</tr>
<tr>
<td>JE</td>
<td>From non-hospital-based dialysis facility to residential, domiciliary or custodial facility</td>
</tr>
<tr>
<td>JG</td>
<td>From non-hospital-based dialysis facility to hospital-based dialysis facility</td>
</tr>
<tr>
<td>JH</td>
<td>From non-hospital-based dialysis facility to hospital</td>
</tr>
<tr>
<td>JI</td>
<td>From non-hospital-based dialysis facility to site of transfer between modes of ambulance transport</td>
</tr>
<tr>
<td>JJ</td>
<td>From non-hospital-based dialysis facility to non-hospital-based dialysis facility</td>
</tr>
<tr>
<td>JN</td>
<td>From non-hospital-based dialysis facility to skilled nursing facility</td>
</tr>
<tr>
<td>JP</td>
<td>From non-hospital-based dialysis facility to physician’s office</td>
</tr>
<tr>
<td>JR</td>
<td>From non-hospital-based dialysis facility to residence</td>
</tr>
<tr>
<td>JX</td>
<td>From non-hospital-based dialysis facility to intermediate stop at physician’s office en route to the hospital</td>
</tr>
<tr>
<td>ND</td>
<td>From skilled nursing facility to diagnostic or therapeutic site</td>
</tr>
<tr>
<td>NE</td>
<td>From skilled nursing facility to residential, domiciliary or custodial facility</td>
</tr>
<tr>
<td>NG</td>
<td>From skilled nursing facility to hospital-based dialysis facility</td>
</tr>
<tr>
<td>NH</td>
<td>From skilled nursing facility to hospital</td>
</tr>
<tr>
<td>NI</td>
<td>From skilled nursing facility to site of transfer between modes of ambulance transport</td>
</tr>
<tr>
<td>NJ</td>
<td>From skilled nursing facility to non-hospital-based dialysis facility</td>
</tr>
<tr>
<td>NN</td>
<td>From skilled nursing facility to skilled nursing facility</td>
</tr>
<tr>
<td>NP</td>
<td>From skilled nursing facility to physician’s office</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>NR</td>
<td>From skilled nursing facility to residence</td>
</tr>
<tr>
<td>NX</td>
<td>From skilled nursing facility to intermediate stop at physician’s office en route to the hospital</td>
</tr>
<tr>
<td>PD</td>
<td>From physician’s office to diagnostic or therapeutic site</td>
</tr>
<tr>
<td>PE</td>
<td>From physician’s office to residential, domiciliary or custodial facility</td>
</tr>
<tr>
<td>PG</td>
<td>From physician’s office to hospital-based dialysis facility</td>
</tr>
<tr>
<td>PH</td>
<td>From physician’s office to hospital</td>
</tr>
<tr>
<td>PI</td>
<td>From physician’s office to site of transfer between modes of ambulance transport</td>
</tr>
<tr>
<td>PJ</td>
<td>From physician’s office to non-hospital-based dialysis facility</td>
</tr>
<tr>
<td>PN</td>
<td>From physician’s office to skilled nursing facility</td>
</tr>
<tr>
<td>PP</td>
<td>From physician’s office to physician’s office</td>
</tr>
<tr>
<td>PR</td>
<td>From physician’s office to residence</td>
</tr>
<tr>
<td>PX</td>
<td>From physician’s office to intermediate stop at physician’s office en route to the hospital</td>
</tr>
<tr>
<td>RD</td>
<td>From residence to diagnostic or therapeutic site</td>
</tr>
<tr>
<td>RE</td>
<td>From residence to residential, domiciliary or custodial facility</td>
</tr>
<tr>
<td>RG</td>
<td>From residence to hospital-based dialysis facility</td>
</tr>
<tr>
<td>RH</td>
<td>From residence to hospital</td>
</tr>
<tr>
<td>RI</td>
<td>From residence to site of transfer between modes of ambulance transport</td>
</tr>
<tr>
<td>RJ</td>
<td>From residence to non-hospital-based dialysis facility</td>
</tr>
<tr>
<td>RN</td>
<td>From residence to skilled nursing facility</td>
</tr>
<tr>
<td>RP</td>
<td>From residence to physician’s office</td>
</tr>
<tr>
<td>RR</td>
<td>From residence to residence</td>
</tr>
<tr>
<td>RX</td>
<td>From residence to intermediate stop at physician’s office en route to the hospital</td>
</tr>
<tr>
<td>SD</td>
<td>From scene of accident or acute event to diagnostic or therapeutic site</td>
</tr>
<tr>
<td>SE</td>
<td>From scene of accident or acute event to residential, domiciliary or custodial facility</td>
</tr>
<tr>
<td>SG</td>
<td>From scene of accident or acute event to hospital-based dialysis facility</td>
</tr>
<tr>
<td>SH</td>
<td>From scene of accident or acute event to hospital</td>
</tr>
<tr>
<td>SI</td>
<td>From scene of accident or acute event to site of transfer between modes of ambulance transport</td>
</tr>
<tr>
<td>SJ</td>
<td>From scene of accident or acute event to non-hospital-based dialysis facility</td>
</tr>
<tr>
<td>SN</td>
<td>From scene of accident or acute event to skilled nursing facility</td>
</tr>
<tr>
<td>SP</td>
<td>From scene of accident or acute event to physician’s office</td>
</tr>
</tbody>
</table>
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 or level of service being billed. Ambulance providers must bill the most appropriate codes for the level of service provided. Thus, if the level of service does not meet the EMSC definition of ALS or BLS services, ambulance providers must bill using the appropriate CAS or NAS codes. However, ambulance providers are still permitted to bill HCPCS A0425 U1 or A0425 U2 to be reimbursed for mileage.
- CAS and NAS providers are reimbursed for loaded mileage when the member is transported more than 10 miles one way.
- Taxi providers are not separately reimbursed for mileage and are not required to submit mileage with their claims. However, mileage must be documented on the driver’s ticket using odometer readings or mapping software.
- 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 HCPCS 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 3.

**Table 3 – Mileage Codes and Descriptions**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425 U1</td>
<td>ALS ground mileage, per statute mile</td>
</tr>
</tbody>
</table>
Authorized family members may be reimbursed for actual loaded mileage multiplied by the rate per mile established by the Indiana legislature for state employees.

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 HCPCPS code 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's vehicles. Additional reimbursement is not available for multiple passengers when the billing provider does not bill non-IHCP customers for these services. The correct billing codes for multiple passengers are summarized in Table 4.

<table>
<thead>
<tr>
<th>Type of Transportation</th>
<th>First Member</th>
<th>Second and Subsequent Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taxi, non-regulated, 6 to ten miles</td>
<td>T2003 for base rate</td>
<td>T2004 for base rate</td>
</tr>
<tr>
<td></td>
<td>A0425 U3 for mileage</td>
<td>No reimbursement for mileage</td>
</tr>
<tr>
<td></td>
<td>T2007 U3 for waiting time, if applicable</td>
<td>No reimbursement for waiting time</td>
</tr>
<tr>
<td>NAS</td>
<td>A0130 for base rate</td>
<td>A0130 TT for base rate</td>
</tr>
<tr>
<td></td>
<td>A0425 U5 for mileage</td>
<td>No reimbursement for mileage</td>
</tr>
<tr>
<td></td>
<td>T2007 U5 for waiting time, if applicable</td>
<td>No reimbursement for waiting time</td>
</tr>
<tr>
<td>Taxi, non-regulated, zero to five miles</td>
<td>A0100 UA (no mileage)</td>
<td>A0100 TT UA (no mileage)</td>
</tr>
<tr>
<td>Taxi, non-regulated, six to 10 miles</td>
<td>A0100 UB (no mileage)</td>
<td>A0100 TT UB (no mileage)</td>
</tr>
</tbody>
</table>
Taxi, non-regulated, 11 or more miles | A0100 UC (no mileage) | A0100 TT UC (no mileage)

Prior approval 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 Accompanying Attendant

When members younger than 18 years old need an adult to accompany them to a medical service or 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, as listed below. The provider must bill both the base code and the accompanying parent or attendant code using the member’s information.

<table>
<thead>
<tr>
<th>Table 5 – HCPCS Codes for Accompanying Parent or Attendant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Transportation</strong></td>
</tr>
<tr>
<td>Commercial ambulatory services</td>
</tr>
<tr>
<td>NAS</td>
</tr>
<tr>
<td>Taxi, non-regulated, zero to five miles</td>
</tr>
<tr>
<td>Taxi, non-regulated, six to 10 miles</td>
</tr>
<tr>
<td>Taxi, non-regulated, 11 or more miles</td>
</tr>
</tbody>
</table>

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 the 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 relationship of the accompanying parent or attendant to the member.

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 a wheelchair-bound member lives upstairs, and the residence has no wheelchair ramp. This code is not subject to the 20-trip limit; however, if the trip exceeds 50
miles one-way, PA 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. Billing codes for additional attendants are summarized in Table 6.

<table>
<thead>
<tr>
<th>Type of Transportation</th>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-ambulatory or wheelchair van transportation</td>
<td>A0130 U6</td>
<td>Non-ambulatory transportation; wheelchair van, U6 = additional attendant</td>
</tr>
<tr>
<td>Ambulance transportation (ALS and BLS)</td>
<td>A0424</td>
<td>Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged) (requires medical review)</td>
</tr>
</tbody>
</table>

**Waiting Time**

Waiting time in excess of 30 minutes is reimbursable only when the vehicle is parked outside the office of the medical service provider, when it is awaiting the return of the member to the vehicle, and when 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 and 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 10 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.

**Emergency Transportation Services**

Providers must bill emergency services by using the Y indicator in Field 24C on the CMS-1500 or in the Emergency Indicator on the 837P to indicate that the service rendered was an emergency service. 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.

**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 Co-payments**

Transportation services require a copayment. According to 42 CFR 447.15, providers may not deny services to any member due to the member’s inability to pay the co-payment 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 co-payment. It is the member’s responsibility to inform the provider that he or she cannot afford to pay the co-payment on the date of service. The provider may bill the member for co-payments not paid on the date of service. Providers are advised to review 405 IAC 5-30-2 for complete co-payment information.

The determination of the member’s co-payment 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 co-payment amount from the IHCP member equal to those listed in Table 7.

**Table 7 – Transportation Copayments**

<table>
<thead>
<tr>
<th>Transportation Service</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation services that pay $10.00 or less</td>
<td>$0.50 each one-way trip</td>
</tr>
<tr>
<td>Transportation services that pay $10.01 to $50.00</td>
<td>$1.00 each one-way trip</td>
</tr>
<tr>
<td>Transportation services that pay $50.01 or more</td>
<td>$2.00 each one-way trip</td>
</tr>
</tbody>
</table>

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, NFs, ICF/IID s, or other medical institutions. This includes instances where members are being transported for admission or discharge.
- Transportation services provided under a MCE to its Hoosier Healthwise enrollees

**Transportation Code Sets**

A complete list of ambulance transportation codes is included in Table 8.

**Table 8 – 264 Commercial Ambulatory Service (CAS) Provider Code Set – 264 CAS Provider**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425 U3</td>
<td>Ground mileage, per statute mile, CAS</td>
</tr>
<tr>
<td>T2003</td>
<td>Non-emergency transportation, encounter/trip (CAS)</td>
</tr>
<tr>
<td>T2004</td>
<td>Non-emergency transportation, commercial carrier, multi-pass (CAS)</td>
</tr>
<tr>
<td>T2001</td>
<td>Non-emergency transportation, patient attendant/escort (CAS)</td>
</tr>
<tr>
<td>T2007 U3</td>
<td>Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments, CAS</td>
</tr>
</tbody>
</table>

**Table 9 – Non-Ambulatory Service (NAS) Provider Code Set – 265 NAS Provider**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425 U5</td>
<td>Ground mileage, per statute mile, NAS</td>
</tr>
<tr>
<td>A0130</td>
<td>Non-emergency transportation, wheel chair van base rate</td>
</tr>
<tr>
<td>A0130 TK</td>
<td>Non-emergency transportation, wheel chair van base rate; extra patient or passenger, non-ambulance</td>
</tr>
<tr>
<td>A0130 TT</td>
<td>Non-emergency transportation, wheel chair van base rate; individualized service provided to more than one patient in same setting</td>
</tr>
<tr>
<td>A0130 U6</td>
<td>Non-emergency transportation, wheel chair van base rate; additional attendant</td>
</tr>
<tr>
<td>T2007 U5</td>
<td>Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; NAS</td>
</tr>
<tr>
<td>A0425 U3</td>
<td>Ground mileage, per statute mile; CAS</td>
</tr>
<tr>
<td>T2003</td>
<td>Non-emergency transportation, encounter/trip (CAS)</td>
</tr>
<tr>
<td>T2004</td>
<td>Non-emergency transportation, commercial carrier, multi-pass (CAS)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>T2001</td>
<td>Non-emergency transportation, patient attendant/escort (CAS)</td>
</tr>
<tr>
<td>T2007 U3</td>
<td>Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; CAS</td>
</tr>
</tbody>
</table>

**Reminder:** 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. Thus, CAS codes are included in the NAS provider code set.
### Table 10 – Ambulance Provider Code Set – 260 Ambulance (ALS and BLS) Providers

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0422</td>
<td>Ambulance (ALS and BLS) oxygen and oxygen supplies, life-sustaining situation</td>
</tr>
<tr>
<td>A0425 U1</td>
<td>Ground mileage, per statute mile; ALS</td>
</tr>
<tr>
<td>A0425 U2</td>
<td>Ground mileage, per statute mile; BLS</td>
</tr>
<tr>
<td>A0420 U1</td>
<td>Ambulance waiting time ALS, one-half (1/2) hour increments</td>
</tr>
<tr>
<td>A0420 U2</td>
<td>Ambulance waiting time BLS, one-half (1/2) hour increments</td>
</tr>
<tr>
<td>A0426</td>
<td>Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)</td>
</tr>
<tr>
<td>A0427</td>
<td>Ambulance service, advanced life support, emergency, level 1 (ALS1-emergency)</td>
</tr>
<tr>
<td>A0428</td>
<td>Ambulance service, basic life support, non-emergency transport; (BLS)</td>
</tr>
<tr>
<td>A0429</td>
<td>Ambulance service, basic life support, emergency transport, (BLS-emergency)</td>
</tr>
<tr>
<td>A0433</td>
<td>Advanced ALS (Level 2)</td>
</tr>
<tr>
<td>A0225</td>
<td>Ambulance service, neonatal transport, base rate, emergency transport, one-way</td>
</tr>
<tr>
<td>A0999</td>
<td>Unlisted ambulance service</td>
</tr>
<tr>
<td>A0424</td>
<td>Extra ambulance attendant, ground (ALS or BLS) or air (rotary and fixed wing)</td>
</tr>
<tr>
<td>T2003</td>
<td>Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); CAS</td>
</tr>
<tr>
<td>A0130</td>
<td>Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); NAS</td>
</tr>
<tr>
<td>T2003</td>
<td>Ambulance service, basic life support, non-emergency transport; CAS</td>
</tr>
<tr>
<td>T2003</td>
<td>Ambulance service, basic life support, non-emergency transport; NAS</td>
</tr>
<tr>
<td>T2003</td>
<td>Non-emergency transportation, encounter/trip (CAS)</td>
</tr>
<tr>
<td>A0130</td>
<td>Non-emergency transportation, wheel chair van base rate (NAS)</td>
</tr>
<tr>
<td>T2007 U3</td>
<td>Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; CAS</td>
</tr>
<tr>
<td>A0130 U6</td>
<td>Non-emergency transportation, wheel chair van base rate; additional attendant</td>
</tr>
<tr>
<td>T2007 U5</td>
<td>Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; NAS</td>
</tr>
</tbody>
</table>

**Reminder:** 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.
### Table 11 – Air Ambulance Code Set – 261 Air Ambulance

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0140</td>
<td>Non-emergency transportation and air travel (private or commercial), intra or interstate</td>
</tr>
<tr>
<td>A0430</td>
<td>Ambulance service, conventional air service transport, one way (fixed wing)</td>
</tr>
<tr>
<td>A0431</td>
<td>Ambulance service, conventional air service, transport, one way (rotary wing)</td>
</tr>
<tr>
<td>A0999</td>
<td>Unlisted ambulance service</td>
</tr>
</tbody>
</table>

### Table 12 – Taxi Code Set – 263 Taxi Provider

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0100 UA</td>
<td>Taxi, rates non-regulated, 0-5 miles</td>
</tr>
<tr>
<td>A0100 UB</td>
<td>Taxi, rates non-regulated, 6-10 miles</td>
</tr>
<tr>
<td>A0100 UC</td>
<td>Taxi, rates non-regulated, 11 or more miles</td>
</tr>
<tr>
<td>A0100 TK UA</td>
<td>Taxi, rates non-regulated, 0-5 miles for accompanying parent/attendant</td>
</tr>
<tr>
<td>A0100 TK UB</td>
<td>Taxi, rates non-regulated, 6-10 miles for accompanying parent/attendant</td>
</tr>
<tr>
<td>A0100 TK UC</td>
<td>Taxi, rates non-regulated, 11 or more miles for accompanying parent/attendant</td>
</tr>
<tr>
<td>A0100 TT UA</td>
<td>Taxi, rates non-regulated, 0-5 miles for multiple passengers</td>
</tr>
<tr>
<td>A0100 TT UB</td>
<td>Taxi, rates non-regulated, 6-10 miles for multiple passengers</td>
</tr>
<tr>
<td>A0100 TT UC</td>
<td>Taxi, rates non-regulated, 11 or more miles for multiple passengers</td>
</tr>
<tr>
<td>A0100 U4</td>
<td>Non-emergency transportation; taxi, suburban territory</td>
</tr>
</tbody>
</table>

### Table 13 – Family Member Transportation Provider Code Set – 266 Family Member Provider

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0090</td>
<td>Non-emergency transportation, per mile-vehicle provided by individual (family member, self, neighbor) with vested interest</td>
</tr>
</tbody>
</table>

### Table 14 – Bus Provider Code Set – 262 Bus Provider

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0110</td>
<td>Non-emergency transportation and bus, intra or interstate carrier</td>
</tr>
</tbody>
</table>

### Rules, Citations and Sources

- **405 IAC 5-3-9(4)** – Prior authorization after services have begun
- **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 5-5-1 – Out-of-state services; general

405 IAC 5-5-2 – Prior authorization requirements for out-of-state services

405 IAC 5-30 – Transportation Services

IHCP Provider Banners

BR201216

IHCP Provider Manual

Note: For the most updated information regarding the IHCP Provider Manual, bulletins, and banners, please visit http://www.indianamedicaid.com/ihcp/index.asp.

Related Medical Topics

Transportation Services – Rotary Wing Air Transportation
Transportation Services – Rotary Wing Air Transportation

Introduction

This section serves as a general summary of the IHCP’s policies regarding rotary wing air transportation services. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

For members enrolled in the Hoosier Healthwise RBMC program, the HIP, or any other plan, providers must contact the member's MCE or plan administrator for more specific guidelines regarding their specific policies and PA procedures.

Package C Transportation Services

Hoosier Healthwise Package C members are eligible to receive emergency ambulance services, subject to the prudent layperson’s definition of emergency found in 407 IAC 1-1-6. Non-emergency ambulance transportation between medical facilities is a covered service when ordered by the treating physician.

Description of Service

Rotary air ambulance is furnished when the member’s medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.

Generally, transport by rotary wing air ambulance may be necessary because the member’s condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery by ground transport to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the member is inaccessible by a ground or water vehicle.

Transportation by air ambulance is only covered for transport to a hospital. Air ambulance services are not covered for transport to a facility that is not an acute care hospital. Transport to a nursing facility, a physician’s office, or a beneficiary’s home by rotary air ambulance is not reimbursable.

Reimbursement Requirements

Registration Requirements

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.

**Base Rate, Mileage, and Wait Time**

The Indiana Health Coverage Programs (IHCP) provides reimbursement for both a base rate and mileage. The base rate is an all inclusive rate including coverage of processes, treatments, and services that are an integral part of care while in transit, including but limited to, oxygen, drugs, supplies, and extra attendants. The air ambulance mileage rate is calculated to the nearest suitable hospital per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles). Wait time is not separately reimbursable.

**Medical Necessity**

Rotary air ambulance transport is a covered service when the member has a potentially life-threatening condition that does not permit the use of another form of transportation. IHCP reimburses rotary air transportation services to a hospital facility under medical appropriate circumstances. Medical necessity is only established when the member’s condition is such that the time needed to transport a member by ground, or the instability of transportation by ground, poses a threat to the member’s survival or seriously endangers the member’s health. The list below includes examples of medical conditions in which rapid transport may be necessary. This list does not guarantee reimbursement nor is it intended to be all inclusive. Diagnosis only does not serve as justification for reimbursement.

- Intracranial bleeding requiring neurosurgical intervention
- Cardiogenic shock
- Burns requiring treatment in a burn center
- Conditions requiring treatment in a Hyperbaric Oxygen Unit
- Multiple severe injuries
- Life-threatening trauma

Air transport must be to the nearest suitable hospital. If the air transport was medically necessary but the member could have been treated at a nearer hospital than one to which they were transported, the air transportation mileage reimbursement is limited to the rate for the distance from the point of pickup to the nearer hospital.

**Severe Weather**

If the flight is aborted due to bad weather, or other circumstance beyond the pilot’s control, any time before the beneficiary is loaded onboard, i.e. prior to or after take-off to point of pick up, IHCP will not reimburse for the flight. If the flight is aborted after the beneficiary is loaded, the appropriate air base mileage and rural adjustment is available.
Member Death

If the member dies before being transported, then no Medicaid payment may be made. Thus, in a situation where the member dies, whether any payment is made depends on the time at which the member is pronounced dead by an individual authorized by the State to make such pronouncements. If the time of death pronouncement is prior to take-off to point of pick-up with notice to dispatcher and time to abort the flight, no payment is made. This included scenarios in which the air ambulance has taxied to the runway, and/or has been cleared for takeoff, but has not actually taken off. If member is pronounced after takeoff to point of pickup, but before the member is loaded, the appropriate air base rate with no mileage is reimbursed. The provider should use the QL modifier when submitting such a claim. When the member is pronounced after the member is loaded onboard, but prior to or upon arrival at the receiving facility, reimbursement is such as if the member had not died.

Multiple Patients

Additional reimbursement is not available for multiple passengers in a rotary air ambulance.

Hospital to Hospital Transfer

Air ambulance transport is covered for transfer of a patient from one hospital to another if the medical appropriateness criteria is met, i.e. transportation by ground ambulance would endanger the member’s health, and the transferring hospital does not have adequate facilities to provide the medical services needed by the patient. Example of such specialized medical services that are generally not available at all types of facilities may include, but are not limited to, burn care, cardiac care, trauma care, and critical care. A patient transported from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Reimbursement is not available for transport from a hospital capable of treating the patient because the patient and/or family prefer a specific hospital or physician.

Accompanying Parent/ Attendant

Separate reimbursement is not available for an accompanying parent/ attendant in a rotary air ambulance.

Prior Authorization Requirements

Prior authorization (PA) is required for airline or air ambulance services. A PA request must include a brief description of the care and description of the clinical circumstances necessitating the need for the transportation. 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 24C on the CMS-1500 or in the Emergency Indicator on the 837P.
Billing Requirements

When submitting a claim, providers must ensure that each claim is supported with the following documentation on the driver’s ticket or run sheet:

- Complete date of service, including day, month, and year of service in the format MM/DD/YY
- Complete member name and address of pick-up, including members street address, city, county, state, and zip code
- 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
- Complete service provider name and address, including street address, city, county, state, and zip code. 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, including the date the transportation service was provided and the specific starting and destination address.
- Indication of a one-way trip

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.

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. Air ambulance transportation services require PA. In addition, any transportation services provided by a provider located in an out-of-state, non-designated area require PA.

Base Rate

The IHCP reimburses a base rate for rotary air ambulance transportation given the necessary criteria are met. Providers should bill A0431 - Ambulance service, conventional air service, transport, one way (rotary wing).

Mileage

Providers should bill A0436 - Rotary wing air mileage, per statute mile. Transportation providers are expected to transport members along the shortest most efficient route to the nearest suitable hospital. All rotary air transportation providers must document mileage on the driver’s ticket using odometer readings. Rotary air ambulance providers are reimbursed for loaded
mileage for each statute mile of the trip. Providers must bill 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.

**Rotary Air Transport Code Set**

Providers should bill the appropriate codes for the base rate and mileage as summarized in Table 1 below.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0431</td>
<td>Ambulance service, conventional air service, transport, one way (rotary wing)</td>
</tr>
<tr>
<td>A0436</td>
<td>Rotary wing air mileage, per statute mile</td>
</tr>
</tbody>
</table>

**Member Co-Pays**

Emergency rotary air transportation is exempt from the co-payment requirement.

**Rules, Citations and Sources**

405 IAC 5-3-9(4) – Prior authorization after services have begun

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 5-5-1 – Out-of-state services; general

405 IAC 5-5-2 – Prior authorization requirements for out-of-state services

405 IAC 5-30 – Transportation Services

**IHCP Provider Manual**

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**Related Medical Topics**

Transportation Services
Traumatic Brain Injury Program

Introduction

This section serves as a general summary of the IHCP’s policies regarding traumatic brain injury (TBI) program. Additional information specific to this topic may be found in the IHCP Provider Manual, program notices, or the IAC.

IHCP

TBI providers will need to contact ADVANTAGE Health Solutions (800-269-5720) when they have an MCE member who is going to be admitted. Members enrolled in an IHCP MCE must disenroll and will be assigned to the most appropriate Medicaid program. Disenrollment is necessary for the TBI authorization to be completed. Members become eligible for TBI services the business day following disenrollment from the MCE.

When the member is discharged from the TBI, he or she will be re-enrolled immediately into the most applicable Medicaid program.

Description of Service

TBI is an injury sustained after birth from physical trauma, an anoxia or hypoxic episode, allergic conditions, toxic substances, or other acute medical clinical incidents resulting in psychological, neurological or anatomical changes in brain functions. Traumatic brain injury does not include:

- Strokes that can be treated in nursing facilities providing routine rehabilitation services;
- Spinal cord injuries for which there are no known or obvious injuries to the intracranial central nervous system;
- Progressive dementias and other mentally impairing conditions;
- Depression and psychiatric disorders in which there is no known or obvious central nervous system damage;
- Mental retardation and birth defect related disorders of long standing nature; or
- Neurological degenerative, metabolic, and other medical conditions of a chronic, degenerative nature.

Each brain injury is unique. A brain injury may be mild, with a brief change in mental status, moderate, with a loss of consciousness, or severe, causing a prolonged coma. Mild, moderate and severe brain injuries can lead to long-term symptoms and the potential for permanent disability. The outcome following a brain injury depends on several factors including:

- Nature and severity of the brain injury
- Type and degree of any resulting impairments and disabilities
• Overall health of the patient
• Family support
• Quality of the rehabilitation care

TBI services are provided based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive and behavioral function.

Reimbursement Requirements

The IHCP provides reimbursement for TBI services when the services are provided in compliance with all IHCP guidelines, including obtaining prior authorization, for members who have been determined to meet eligibility.

Reimbursement for TBI services is determined based upon the member’s level of need in each of the ten (10) domains listed in Table 1 - Domains and the total score of the 10 domains. Based upon the domain total the member will fall within one (1) of four (4) levels of service reimbursement categories which are described in the Level of Service section of this policy.

<table>
<thead>
<tr>
<th>Domains:</th>
<th>Level of Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential</td>
<td>• Low: basic residential services</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate assist with residential living</td>
</tr>
<tr>
<td></td>
<td>• High: significant assistance with residential needs</td>
</tr>
<tr>
<td>Case Management</td>
<td>• Low: minimal logistical assistance</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate coordination of care and family engagement</td>
</tr>
<tr>
<td></td>
<td>• High: significant management of complex medical and social issues</td>
</tr>
<tr>
<td>Medical Management</td>
<td>• Low: routine medical care</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate basic medical services and care delivery</td>
</tr>
<tr>
<td></td>
<td>• High: significant and complex medical services</td>
</tr>
<tr>
<td>Speech/Language Therapy</td>
<td>• Low: maintenance services for speech and language skills</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate frequency of speech therapy with progress to goals</td>
</tr>
<tr>
<td></td>
<td>• High: intensive speech therapy for language, speech, and receptive skills</td>
</tr>
<tr>
<td>Productive Activity/Physical Therapy</td>
<td>• Low: basic activity that does not require skilled staff</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate individualized therapy with progress to goals</td>
</tr>
<tr>
<td></td>
<td>• High: intensive and frequent services requiring skilled professional</td>
</tr>
</tbody>
</table>
Table 2 – Scoring of Domains

<table>
<thead>
<tr>
<th></th>
<th>staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy</td>
<td>• Low: basic activity that does not require skilled staff</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate individualized therapy with progress to goals</td>
</tr>
<tr>
<td></td>
<td>• High: intensive and frequent services requiring skilled professional</td>
</tr>
<tr>
<td>Rehabilitation Therapy</td>
<td>• Low: basic activity that does not require skilled staff</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate individualized therapy with progress to goals</td>
</tr>
<tr>
<td></td>
<td>• High: intensive and frequent services requiring skilled professional</td>
</tr>
<tr>
<td>Vocational Therapy</td>
<td>• Low: basic activity that does not require skilled staff</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate individualized therapy with progress to goals</td>
</tr>
<tr>
<td></td>
<td>• High: intensive and frequent services requiring skilled professional</td>
</tr>
<tr>
<td>Neuro-cognitive Therapy</td>
<td>• Low: basic activity that does not require skilled staff</td>
</tr>
<tr>
<td></td>
<td>• Medium: moderate individualized therapy with progress to goals</td>
</tr>
<tr>
<td></td>
<td>• High: intensive and frequent services requiring skilled professional</td>
</tr>
<tr>
<td>Behavioral Health/Psychiatric</td>
<td>• Low: basic activity that does not require skilled staff</td>
</tr>
<tr>
<td>Therapy</td>
<td>• Medium: moderate individualized therapy with progress to goals</td>
</tr>
<tr>
<td></td>
<td>• High: intensive and frequent services requiring skilled professional</td>
</tr>
</tbody>
</table>

An assessment is utilized to review each case based upon ten domains of service and the intensity of service within each discipline as well as services provided to that member during the review process. Services will be rated on a 1 to 3 scale, e.g.

1------------2-------------3

Low       Medium       High

Level of Service Reimbursement Categories

The goal of TBI rehabilitation is re-integration into the community. The member’s ability to live at home and/or in the community is related to the severity of the illness (SI) and intensity of services (IS). The member’s needs must be balanced with the resources available in the recovery environment. These resources include:

- Physical health care needs
• Behavioral health care needs
• Cognitive Impairments
• Safety needs, and
• Other support needs

The IHCP has developed four (4) levels of service reimbursement categories utilizing the ten domains of service, identifying the severity of the illness and the intensity of services required by each member. The four levels of service are described below.

**Level I – Intense NeuroRehabilitation/NeuroBehavioral Programming**

Level I is assigned to members who require immediate admission into a TBI program in order to receive intensive therapy and may be appropriate for up to the first four (4) months of intervention. Members requiring additional days after the first four (4) months for level 1 services will be reviewed on a case-by-case basis.

Members must demonstrate needs in the following areas:

**Cognitive/Behavioral Needs**

- Cognition – memory, impulsivity, poor judgment, lack of initiation, poor problem solving, poor social skills which significantly impact safety and well being
- Unwanted behaviors – including demonstration of, frequency and intensity of high risk behaviors secondary to the brain injury
- Non-compliance with traditional therapies due to cognitive/behavioral barriers.
- Crisis intervention and ultra high risk support

**Safety Needs**

- Supervision – may require additional one on one supervision for behaviors
- Environment – may require durable, secure, highly supervised living environment to decrease risk to self or others.

**Physical Health Care Needs**

- Medical needs requiring daily nursing availability to ensure safety/wellbeing
- Medication management
- Coordination of physician specialists and/or any orthotic/prosthetic devices
- Pharmacological intervention through psychiatrist consults and medically necessary therapeutic interventions in all of the areas listed below.
- Residential
Other Needs

- Transportation/Escort
- Interagency communication/coordination
- Family/Caregiver Training
- Available continuum of treatment/environmental options to practice skill acquisition and simulate discharge environment.
- Begin discharge planning as part of the program to match home community based services in Indiana

Requires therapeutic interventions in the following areas

- Residential
- Case Management
- Medical Management
- Speech Language Therapy
- Productive Activity/Physical Therapy
- Occupational Therapy
- Rehabilitation Therapy
- Vocational Therapy
- Neuro-cognitive Therapy
- Mental/Behavioral Health

Level I may be appropriate for up to the first 4 months of intervention.

<table>
<thead>
<tr>
<th>Billing Level</th>
<th>Total Score of Domains</th>
<th>Corresponding per diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>30</td>
<td>$ 567</td>
</tr>
<tr>
<td>Level I</td>
<td>28 – 29</td>
<td>$ 541</td>
</tr>
<tr>
<td>Level I</td>
<td>26 – 27</td>
<td>$ 509</td>
</tr>
</tbody>
</table>

Members at level 1 will have a total domain score between 26 and 30.

**Level II – Active NeuroRehabilitation/NeuroBehavioral Step-Down Program**

Level II offers individualized support needed at any time, specifically during times of crisis, and a member may require or be provided additional residential and programmatic support. The team may change the intensity of assistance from time to time, while taking advantage of certain
“therapeutic windows”. Regardless of the setting or type of program, rehabilitation interventions are intended to help members practice strategies to remain free from harm and attain personal goals that are durable over time. Discharge planning efforts continue to be geared toward exploring and securing living environments, therapeutic services, and productive activities that match the needs and desires of the member with a focus on returning to the home community.

Level II members’ have made progress in active rehabilitation and exhibit the following needs:

- Training in self-management of behavioral, cognitive, and/or medical/physical challenges
- Continues to require specialized therapeutic intervention in the following areas although at a reduced frequency and duration
  - Residential
  - Case Management
  - Medical Management
  - Speech Language Therapy
  - Productive Activity/Physical Therapy
  - Occupational Therapy
  - Rehabilitation Therapy
  - Vocational Therapy
  - Neuro-cognitive Therapy
  - Mental/Behavioral Health
- Still unable to access their home environment, independent living options, or transitional supported living due to the continual unwanted behaviors or the significant cognitive/physical challenges.
- Ready to engage in therapeutic interventions geared toward maintaining the durability of goals achieved as well as continued work on upgraded objectives

Table 4 – Level II Per Diem Rates

<table>
<thead>
<tr>
<th>Billing Level</th>
<th>Total Score of Domains</th>
<th>Corresponding per diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level II</td>
<td>25</td>
<td>$ 477</td>
</tr>
<tr>
<td>Level II</td>
<td>23 – 24</td>
<td>$ 445</td>
</tr>
<tr>
<td>Level II</td>
<td>21 – 22</td>
<td>$ 413</td>
</tr>
</tbody>
</table>

Members at level II will have a total domain score between 21 and 25.
Level III: NeuroRehabilitation/NeuroBehavioral Step Down Program

Level III members’ have made progress in more intensive, active rehabilitation and require reduced formal clinical service delivery. Members who are appropriate for this level of program will transition into a residential and programmatic continuum designed to replicate the type of support the person will experience once they return to their home community. Members will continue to practice strategies to increase independence, safety, and behavioral self management while pursuing discharge placement in the discharge community. During times of crisis, a member may require or be provided additional residential and programmatic support. If the crisis maintains, the member may need to move to Level I or II with the corresponding rate until stabilized.

Level III places strong emphasis on discharge planning as the member continues to practice skills attained and prepares for transfer to an alternative environment or to reside in the most independent environment possible.

Level III members’ exhibit the following needs:

- Additional experience and feedback with a variety of daily living situations to ensure self-management skills are effective and risk is minimized
- Supported living skill training and supervision with feedback
- Productive activity and community involvement with therapeutic intervention and feedback provided
- Supported practice with individualized cognitive, behavioral, or medical strategies to minimize health and safety risk.
- Continues to require specialized therapeutic intervention in the following areas although at a reduced frequency and duration:
  - Residential
  - Case Management
  - Medical Management
  - Speech Language Therapy
  - Productive Activity/Physical Therapy
  - Occupational Therapy
  - Rehabilitation Therapy
  - Vocational Therapy
  - Neuro-cognitive Therapy
  - Mental/Behavioral Health
Table 5 – Level III Per Diem Rates

<table>
<thead>
<tr>
<th>Billing Level</th>
<th>Total Score of Domains</th>
<th>Corresponding per diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level III</td>
<td>20</td>
<td>$381</td>
</tr>
<tr>
<td>Level III</td>
<td>16 – 19</td>
<td>$349</td>
</tr>
</tbody>
</table>

Members at level III will have a total domain score between 16 and 20.

**Level IV: NeuroRehabilitation/Neurobehavioral Step-Down Support Services**

Level IV members’ have made progress in more intensive, active rehabilitation and are appropriate for step down services to maintain goals achieved through supportive services. Members who are appropriate for this level of step down support services will attempt to replicate the type of interventions the individual will experience once they return to their home community. Members will continue to practice learned strategies to increase independence, safety, and behavioral self management while pursuing discharge placement in the appropriate community. During times of crisis, members may require or be provided additional residential and programmatic support. If the crisis maintains, the member will be recommended to a move to Level I, II, or III with the corresponding rate until stabilized.

Level IV places a strong emphasis on discharge planning as the member continues to practice skills attained and maintain those skills designed to meet future placement needs in the home community.

Level IV members’ exhibit the following needs:

- Additional experience and feedback with a variety of daily living situations to ensure self-management skills are effective and risk is minimized
- Supported living skill training and supervision with feedback
- Productive activity and community involvement with therapeutic intervention and feedback provided
- Supported practice with individualized cognitive, behavioral, or medical strategies to maintain current health and overall functioning level.
- Continues to require specialized therapeutic intervention at a moderate level in the following areas although at a reduced frequency and duration:
  - Residential
  - Case Management
  - Medical Management
  - Speech Language Therapy
  - Productive Activity/Physical Therapy
Traumatic Brain Injury Program

- Occupational Therapy
- Rehabilitation Therapy
- Vocational Therapy
- Neuro-cognitive Therapy
- Mental/Behavioral Health

**Table 6 – Level IV Per Diem Rates**

<table>
<thead>
<tr>
<th>Billing Level</th>
<th>Total Score of Domains</th>
<th>Corresponding per diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level IV</td>
<td>15</td>
<td>$ 317</td>
</tr>
<tr>
<td>Level IV</td>
<td>10 – 14</td>
<td>$ 285</td>
</tr>
</tbody>
</table>

Members at this level will have a total domain score between 10 and 15.

**Per Diem Rates**

The total score of the domains determines the billing level and reimbursement rate. Rates are adjusted according to the level of intensity, on a scale of 1-3, as evidenced by medical necessity based upon the member’s individual needs. All reimbursement rates are directly communicated to the facility via the Notice of Action (Admission or Extension) letter. Each member’s reimbursement rate is reviewed at the time of the clinical reassessment and the extension request. Table 7 – *TBI Per Diem Rates* is utilized to determine the rate for reimbursement for the prospective period. Level assignment and rate determinations will be based upon the information supplied by the TBI facility from documentations submitted for review and dialogue from collaborative case rounds with the Prior Authorization Vendor.

The per diem rates include the following services:

- Room and board
- Staffed residence
- Therapeutic interventions

**Table 7 – TBI Per Diem Rates**

<table>
<thead>
<tr>
<th>Billing Level</th>
<th>Total Score of Domains</th>
<th>Corresponding per diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>30</td>
<td>$ 567</td>
</tr>
<tr>
<td>Level I</td>
<td>28 – 29</td>
<td>$ 541</td>
</tr>
<tr>
<td>Level I</td>
<td>26 – 27</td>
<td>$ 509</td>
</tr>
<tr>
<td>Level II</td>
<td>25</td>
<td>$ 477</td>
</tr>
<tr>
<td>Level II</td>
<td>23 – 24</td>
<td>$ 445</td>
</tr>
<tr>
<td>Level II</td>
<td>21 – 22</td>
<td>$ 413</td>
</tr>
</tbody>
</table>
Prior Authorization Requirements

Prior Authorization is required for TBI services per 405 IAC 5-5. The IHCP does not reimburse providers for any services requiring prior authorization unless prior authorization is obtained first.

Admission Requests

Placement within a TBI facility is available to members who have been determined to meet eligibility. Qualifications for enrollment in the TBI program include (but are not limited to) the following:

- Diagnosis of Traumatic Brain Injury
  - The injury resulted from an acute anoxic event or brain injury caused by external trauma
- Medical need for long term neuro-cognitive rehabilitation
- Therapeutic benefit from rehabilitation services proposed is reasonable
- Acute services for brain injury and other services within Indiana must have been considered and utilized when available
- Formal clinical assessment for need of long term rehabilitation has been conducted by brain injury specialists within Indiana
- Member must be 18 years of age or older.
  - Requests for admission for members under age 18 will be reviewed on a case-by-case basis

Consideration of admission includes submission of documentation to support the following criteria:

- Diagnosis of Traumatic Brain Injury
- Rancho Los Amigos Levels of Cognitive Functioning level of V or greater and/or
- Mayo-Portland Adaptability Inventory (MPAI-4)
- The member’s current residence/living situation
- Summary of the member’s complete medical history, including

<table>
<thead>
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<th>$381</th>
</tr>
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<tr>
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<tr>
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<td>15</td>
<td>$317</td>
</tr>
<tr>
<td>Level IV</td>
<td>10 – 14</td>
<td>$285</td>
</tr>
</tbody>
</table>
- past hospitalizations
- rehabilitation services
- initial date of any head injury
- history of previous head injury or cerebral harm
- history of pre-injury behavior and social condition (including history of drug abuse, abuse, or police arrests)

- Evidence of behavioral problems including
  - aggressiveness
  - sexual inappropriateness
  - danger to self or others

- Neuropsychiatric evaluation (if completed)
- Psychiatric history (including depression, suicide, etc)
- Ability to participate in a minimum of 3 hours of therapy per day
- Free of mental illness or illicit drug use
- Medically stable
- A reasonable expectation for improvement with therapy
- A reasonable expectation that the member would be eligible to return to his/her community for ongoing services upon completion of program
- Head injury that is no more than 4 years old; exceptions include
  - Member has had no previous treatment for their TBI
- Cannot be placed and adequately cared for in any in-state facility
- The member must meet one of the four (4) levels of need

All TBI admission requests are reviewed by the Prior Authorization (PA) Vendor on a case-by-case basis. The PA vendor determines the medical necessity for placement and if appropriate services are available to address the member’s needs within Indiana. When members qualify for placement, the level of services provided is reviewed as submitted by the requesting facility.

**Extension Requests**

Providers must submit a re-assessment of the member’s functional status along with the extension request. The re-assessment is utilized to review each case based upon the ten domains of service, the intensity of service within each discipline, as well as services provided to the member during the review process, and initial or ongoing discharge planning efforts.
Each domain will be evaluated by the Prior Authorization Vendor as documented in the extension request and a determination will be made based upon the member’s level of need in each of the ten (10) domains.

**Hearing & Appeals Procedures**

Requests for the Administrative Review, Appeals, & Hearing process are consistent with the procedures as outlined in *Chapter 6 of the IHCP Provider Manual.*

**Billing Requirements**

Once a member’s stay has been authorized for admission or an extension, the authorization will be approved with one of the 10 HCPCS procedure codes listed in Table 98.8. Providers must bill on the UB-04 claim form utilizing the authorized HCPCS procedure code along with the usual and customary charges. Billing, payment, and enrollment is contingent upon member’s Medicaid eligibility.

**Table 8 – TBI HCPCS Codes and Rates**

<table>
<thead>
<tr>
<th>HCPC Code</th>
<th>Rate</th>
<th>Billing Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2013 UB</td>
<td>$567</td>
<td>Level I</td>
</tr>
<tr>
<td>H2013 UA</td>
<td>$541</td>
<td>Level I</td>
</tr>
<tr>
<td>H2013 U9</td>
<td>$509</td>
<td>Level I</td>
</tr>
<tr>
<td>H2013 U8</td>
<td>$477</td>
<td>Level II</td>
</tr>
<tr>
<td>H2013 U6</td>
<td>$445</td>
<td>Level II</td>
</tr>
<tr>
<td>H2013 U5</td>
<td>$413</td>
<td>Level II</td>
</tr>
<tr>
<td>H2013 U4</td>
<td>$381</td>
<td>Level III</td>
</tr>
<tr>
<td>H2013 U3</td>
<td>$349</td>
<td>Level III</td>
</tr>
<tr>
<td>H2013 U2</td>
<td>$317</td>
<td>Level IV</td>
</tr>
<tr>
<td>H2013 U1</td>
<td>$285</td>
<td>Level IV</td>
</tr>
</tbody>
</table>

The following services are included in the per diem rate:

- Room and board
- Staffed residence
- Therapeutic interventions

**Member Leave Days**

The IHCP no longer covers “bed hold” days in a TBI facility as a member benefit. This change impacts all IHCP members receiving long term neuro-cognitive rehabilitation in the TBI facilities.
Facilities must make members aware of their policies and that members cannot be charged for services that they do not request or that are not provided.

**Rules, Citations and Sources**

405 IAC 5-5-1 – Services; General

405 IAC 5-3 – Prior Authorization

**IHCP Bulletins**

BT 201061

BT 201127

**IHCP Provider Manual**


**Related Medical Topics**

Not Applicable
Appendix A

Eliminated Policies

Case Management - Pregnant Women
Effective July 1, 2011, the IHCP eliminated reimbursement for targeted case management (TCM) services for Prenatal Care Coordination. Please refer to IHCP Bulletin BT201127.

HIV/AIDS Care Coordination
Effective July 1, 2011, the IHCP eliminated reimbursement for targeted case management (TCM) services for Prenatal Care Coordination. Please refer to IHCP Bulletin BT201127.

Medical Supplies and Equipment – Prothrombin Time (PT) Self-Management Monitors
Effective September 6, 2011, the IHCP eliminated reimbursement for medical supplies and equipment – prothrombin time (PT) self-management monitors.

Laboratory Services – Salivary Estriol Test for Preterm Labor Risk Assessment
Effective October 1, 2012, the IHCP eliminated reimbursement for laboratory services – salivary estriol test for preterm labor risk assessment. Please refer to IHCP Banner BR20131

Pharmacy – Synagis®
For dates of service on or after October 1, 2011, Synagis must be billed by a pharmacy provider. All claims submitted on a medical claim form for dates of service on or after October 1, 2011, with Current Procedural Terminology (CPT®) code 90378 – Respiratory syncytial virus, antibody, recombinant, for intramuscular use, 50 mg, each will be denied. Medical offices may request Synagis from a specialty pharmacy vendor and have the product shipped to the office for administration. If providers require assistance locating a participating specialty pharmacy provider, they may contact the Affiliated Computer Services (ACS) Clinical Call Center at 1-866-879-0106. Please refer to IHCP Bulletin BT 201143.

Physician Administered Drugs – 17P Injections
Effective June 1, 2011, 17P is no longer covered on medical claims. This must be billed on pharmacy claims. Please refer to IHCP Bulletin BT 201110.