CHAPTER–519 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PRACTITIONER SERVICES – INCLUDING PHYSICIANS, PHYSICIAN ASSISTANTS, AND ADVANCED REGISTERED NURSE PRACTITIONERS

CHANGE LOG

Replace	Title	Change Date	Effective Date
Attachment 18	Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners	01/16/12	01/16/12
Section 519.20.1	Prior Authorization for Outpatient Surgeries	01/10/06	02/15/06
Section 519.13.2.1	Immunization for Children	11/21/05	11/30/05
Section 519.19.1	Prior Authorization for Outpatient Surgeries	10/24/05	Postponed
Section 519.12.5	Medicaid Diabetes Disease State Management	10/4/05	10/15/05
Section 519.13.2.2	Immunizations for Adults	10/4/05	10/24/05
Section 519.13.2.1	Immunizations for Children	9/28/05	7/18/05
Section 519.19.1	Prior Authorization for Outpatient Surgeries	9/28/05	11/1/05
Section 519.14.3	Prior Authorization Requirements for Imaging Procedures	9/1/05	10/1/05
Section 519.7.6	Nursing Facility Visits	5/17/05	6/1/05
Section 519.11.3	Psychiatric Services	5/17/05	6/1/05
Section 519.12.1	Caloric Vestibular Testing	5/17/05	6/1/05

Section 519.12.4.1	Colorectal Cancer Screening	5/17/05	6/1/05
Attachment 15	Approved HCPCS J Codes	5/17/05	7/1/05
Attachment 16	Drugs Approved to be Billed with HCPCS Code J3490	5/17/05	7/1/05

January 16, 2012

Attachment 16

Introduction: This is an additional attachment

Change: Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners

Directions: Add attachment to manual.

February 15, 2006

Section 519.20.1

Introduction: The Bureau for Medical Services will require prior authorization beginning February 15, 2006. WVMI will begin prior authorizing services on January 16, 2006 for scheduled procedures on or after February 15, 2006.

Old Policy: All surgeries performed in place of service 22 (Outpatient hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005.

New Policy: Certain surgeries performed in place of services 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. These surgeries are listed in Attachment 17.

Change: First paragraph to read, certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listing in Attachment 17, along with the PA form that may be utilized.

Directions: Replace all affected pages of the current manual.

NOVEMBER 21, 2005

Section 519.13.2.1

Introduction: Coverage changes related to Vaccines for Children Program.

***Old Policy:** CPT 90645, 90646, 90656, and 90698 are provided by Vaccines for Children Program.

Change: Removing CPT 90645, 90646, 90656, and 90698 from the Vaccines for Children Program.

Directions: Replace all affected pages of the current manual.

OCTOBER 24, 2005

Section 519.19.1

The outpatient surgery prior authorization review through WVMI that was to become effective November 1, 2005 has been postponed until further notice. PA for imaging services is still required as of October 1, 2005.

OCTOBER 4, 2005

SECTION 519.12.5

Introduction: Clarification of Diabetes Disease Management Program. To enable providers easier access to the web based modules.

Change From: **(**Under System Process-second sentence)**.** Begin by accessing the course at www.healthywv.org. Under the column listed ~~–P~~revention", locate and click on ~~–D~~iabetes Education for Primary Care Providers". This will take you to the actually program.

Change To: Begin by accessing the course at ~~–w~~www.camcinstitute.org/professional/diabetes/camc.htm."

Change From: (Second to the last paragraph) The automated email that you receive contains a link allowing you access to your electronic certificate for future reference and the option to print additional copies of the certificate.

Change To: The automated email that you receive contains a link allowing you access to your electronic certificate for future reference and the option to print additional copies of the certificate.

Providers will receive a written notice from Unisys stating the provider file has been

updated to allow for reimbursement of Diabetes Educational services with an effective date for billing.

Change From: (Last Paragraph) In the near future, CD's of this program will be available for those who do not have broadband Internet access.

Change To: CD's of this program are available to those who do not have broadband Internet access.

Change From: (Under section Requirements for Becoming a Diabetes Management Provider: 5th paragraph –last sentence). Recertification is required annually.

Change To: Recertification is required annually via Internet web modules and must be renewed by the original calendar date of certification

SECTION 519.13.2.2

Introduction: Tetanus Toxoid, reduced Diptheria Toxoid & Acellular Pertussis vaccine (Adacel) becomes part of the VFC Program effective 10/24/05

Old Policy: CPT 90715 Tetanus Toxoid, reduced Diptheria Toxoid & Acellular Pertussis Vaccine (Adacel) has never been covered by the Vaccines for Children Program

Change: Adding CPT code 90715 for Adolescents ages 11 through 18 years to the Vaccines for Children Program. This will appear as a bullet in Section 519.13.2.1 children's vaccine.

Directions: Replace all affected pages of the current manual.

September 28, 2005

Section 519.13.2.1

Introduction: Meningococcal Conjugate Vaccine (Menactra) CPT 90734 becomes part of the VFC Program effective 7/18/2005

***Old Policy:** CPT 90734 has never been covered by the Vaccines for Children Program

Change: Adding CPT code 90734 Meningococcal Conjugate Vaccine (Menactra) for Adolescents to the Vaccines for Children Program. This will appear as a bullet in Section 519.13.2.1 children's vaccine.

Directions: Replace all affected pages of the current manual.

Section 519.19.1

Introduction: Added Prior Authorization for Outpatient Surgeries.

Change: All surgeries performed in place of service 22 (Out patient hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005.

Directions: Replace pages.

September 1, 2005

Section 519.14.3

Introduction: Deleted all information in Section 519.14.3.

Change: Changed to **PRIOR AUTHORIZATION REQUIREMENTS FOR IMAGING PROCEDURES**

Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic

Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Requests for prior authorization can be sent to: West Virginia Medical Institute, Radiology/Nuclear Medicine Review, 3001 Chesterfield Avenue SE, Charleston, West Virginia 25304. All phone requests can be routed to: (304) 346-9167, or toll free 1-800-982-6334. Fax transmissions can be sent to (304) 346-3669 or toll free 1-800-298-5144.

Directions: Replace pages.

MAY 17, 2005

Section 519.7.6

Introduction: Changed 2nd paragraph to provide more clarity.

Change: Deleted 2nd sentence in the 2nd paragraph, ~~T~~treatment of an acute condition within the 30-day cycle is paid, based on an unlisted E&M code (CPT 99499) with a report attached outlining the reasons for the services." Replaced with the following, ~~E~~emergency treatment provided within the 30-day cycle will be considered for payment based on using the appropriate nursing facility procedure code with documentation of the emergency nature of the visit".

Directions: Replace all affected pages of current manual.

Section 519.11.3

Introduction: Revision being made to include statement that Masters Level Social Worker and Counselors must be in the employ of the psychiatrist.

Change: Changed 1st paragraph from, ~~O~~utpatient psychiatric services must be registered with BMS' contracted agent for Behavioral Health Services prior to services being rendered. All outpatient psychiatric services provided by the psychiatrist, Master's Level Social Worker, or Master's Level counselor must also be registered and assigned an authorization number by the contracted agent. Telephone numbers for this agent are located in the Behavioral Health Services section of Appendix M" to ~~O~~utpatient psychiatric services must be registered with BMS' contracted agent for Behavioral Health Services prior to services being rendered. All outpatient psychiatric services provided by the psychiatrist, or Master's Level Social Worker, or Master's Level counselor in their employ must also be registered and assigned an authorization

number by the contracted agent.

Directions: Replace all affected pages of current manual.

Section 519.12.1

Introduction: There was a typographical error in this section.

Change: In the 4th sentence in this section, changed code 92546-TC to 92543-TC.

Directions: Replace all affected pages of current manual.

Section 519.12.4.1

Introduction: Procedure code G0120 was omitted.

Change: Added procedure code G0120 as bullet 10 in this section.

Directions: Replace all affected pages of current manual.

Attachment 15

Introduction: This is an additional attachment

Change: Approved HCPCS J Codes.

Directions: Add attachment to manual.

Attachment 16

Introduction: This is an additional attachment

Change: Drugs approved to be billed with HCPCS Code J3490.

Directions: Add attachment to manual.

CHAPTER 519—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR PRACTITIONERS SERVICES

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Attachment 12: Responsibilities for Licensed Practitioner to get Extended Office Visit Medicaid Reimbursement

Attachment 13: Diagnostic Codes Covered for Bone Density Scans

Attachment 14: Instructions for Completing the CMS 1500 Claim Form

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CHAPTER 519–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PRACTITIONER SERVICES – INCLUDING PHYSICIANS, PHYSICIAN ASSISTANTS, AND ADVANCED REGISTERED NURSE PRACTITIONERS

INTRODUCTION

The West Virginia (WV) Medicaid Program covers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers acting within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise, in writing, by the Bureau for Medical Services (BMS).

WV Medicaid covers a broad scope of Practitioner Services subject to medical necessity, appropriateness, and prior authorization requirements. Covered Practitioner Services must be provided in settings appropriate for each specific type of practitioner. Medical records must substantiate that any Practitioner Service billed to WV Medicaid was actually provided to an eligible WV Medicaid member by an appropriately credentialed practitioner.

The policies and procedures herein are issued as regulations governing the provision of Practitioner Services in the Medicaid Program administered by the WV Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the WV State Code. BMS is the single State agency responsible for administering the WV Medicaid Program.

519.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200.

519.2 MEDICAL NECESSITY

All services must be medically necessary and appropriate to the member‘s needs in order to be eligible for payment. The medical records of all members receiving Practitioner Services must contain documentation that establishes the medical necessity of the service.

Important: The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider‘s responsibility to verify Medicaid eligibility and obtain appropriate authorizations before services are rendered.

519.3 PROVIDER ENROLLMENT REQUIREMENTS

In order to participate in the WV Medicaid Program and receive payment from BMS, practitioners must meet all enrollment criteria as described in Chapter 300, as well as the specific requirements outlined below.

To participate as a practitioner, providers must submit a completed and signed application form to the

Provider Enrollment Unit of the BMS' fiscal agent. This application form can be obtained by calling provider services at the following telephone numbers:

- (888) 483-0793 - In-state and border providers
- (304) 348-3360 - Out-of-state and Charleston, WV providers

The address for Provider Enrollment is:

Unisys
Post Office Box 625
Charleston, WV 25322-0625

The address for Provider Services and Member Services is:

Unisys
Post Office Box 2002
Charleston, WV 25322-2002

Providers must meet all of the provider requirements of the WV Medicaid Program and their practices must be fully operational before they may enroll as Medicaid providers.

519.3.1 ENROLLMENT: PHYSICIAN

All physicians whether in a private practice, a member of a group practice, or an employee of a medical services entity, must enroll with WV Medicaid in order to receive reimbursement for services rendered to Medicaid members. BMS evaluates the following credentials and circumstances when reviewing applications submitted by physicians who wish to participate in the Program:

- Current license issued by the WV Board of Medicine, Board of Osteopathy, or by the regulatory entity in the state of the practice location
- In a medical specialty:
  - Current board or board eligible certification by a Member Board of the American Board of Medical Specialties
  - Certification of satisfactory completion of a residency program accredited either by the Liaison Committee of Graduate Medical Education or by the appropriate Residency Review Committee of the American Medical Association (AMA)
  - Current board certification or board eligibility by a Specialty Board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association
  - Documented qualifications and training to take examinations of the appropriate Member Board of the American Board of Medical Specialties, if the residency program was completed in a foreign country.

519.3.2 ENROLLMENT: PHYSICIAN ASSISTANT

Physician assistants cannot be enrolled as direct Medicaid providers. However, WV Medicaid allows enrolled physicians to bill for covered services rendered to Medicaid members by physician assistants in their employ and/or under their supervision. Supervising physicians must follow the regulations established in WV Code 30-3-1 et seq. Physicians are not required to be physically present on the premises in order to bill for physician assistant services performed under their supervision.

519.3.3 ENROLLMENT: ADVANCED REGISTERED NURSE PRACTITIONER

For purposes of this manual, an Advanced RN practitioner is an individual licensed and certified as an Advanced nurse practitioner by the WV Board of Registered Nurses, or the appropriate regulatory body in the state of the practice location, with certification in one of the following specialties: (See Chapter 30, Title 19, Series 7-8 of WV Code.)

- Certified nurse midwife
- Certified registered nurse anesthetist
- Family nurse practitioner
- Pediatric nurse practitioner
- Geriatric nurse practitioner
- Adult nurse practitioner
- Women's health nurse practitioner
- Psychiatric nurse practitioner

The Advanced RN practitioner must be enrolled as a provider in order to bill for the provision of WV Medicaid services. Prescriptive authority is not required to be enrolled as a provider.

An Advanced Nurse Practitioner must have a signed collaborative agreement for prescriptive authority with a physician who is enrolled with BMS. This collaborative agreement (which must be on file at the BMS) must document the professional relationship between the Advanced RN practitioner and the physician. The Advanced RN practitioner must notify BMS immediately, and if necessary submit a replacement document, if the collaborative agreement is cancelled, changed, or not renewed.

519.3.4 ENROLLMENT: GROUP/PAY-TO PRACTICES

Providers whose practice is incorporated under the same tax identification number or have an employer-employee relationship must enroll as a Medicaid group/pay-to provider. To receive Medicaid payments, each provider employed by or directing payment to the group/pay-to must be enrolled as an individual provider and designate that payment for rendered services is to be made to the group/pay-to entity. Individuals can participate in multiple groups and all such relationships must be documented with provider enrollment in order that payments may be appropriately made to the correct entity and reported to the correct tax identification number.

Termination of the corporation or the employer- employee relationship must be reported in writing, on office letterhead stationery, to the Provider Enrollment Unit. The notice must include the effective date of the termination. Failure to report these changes will result in incorrect routing of payments and invalid filings with the Internal Revenue Service.

519.3.5 ENROLLMENT: OTHER PRACTITIONERS

Enrollment requirements of other practitioners, e.g. chiropractors, podiatrists, and therapists, are discussed in the Chapters which corresponds to those specific providers.

519.3.6 ENROLLMENT: DOCUMENTATION

Documentation including required license, certifications, proof of completion of training, contracts between physicians and physician assistants, collaborative agreements for prescriptive authority, if applicable, between certified nurse practitioners and physicians, and any other materials substantiating an individual's eligibility to perform as a practitioner with the application for enrollment.

Renewals of license or certification must be maintained in a current status and the documentation must be submitted to Provider Enrollment for inclusion in the provider record.

In order to be paid for services related to skills attained after the initial enrollment, an individual must submit documentation of the new capabilities and request an addition of the specialty or service group to his/her provider profile.

519.4 PRACTITONER SERVICES: OVERVIEW

Practitioner Services are medical services rendered by one of the following:

- A doctor of medicine or osteopathy within the scope of a professional license issued under State law,
- A qualified non-physician practitioner who may provide care under the direction or supervision of a licensed doctor, e.g. a physician assistant or a nurse first assistant,
- An Advanced RN practitioner enrolled and practicing independently.
- Or a Masters Level Social Worker and Masters Level Counselor employed by a participating psychiatrist.

Practitioner Services furnished in federally qualified health centers or rural health centers are included in the facility's reimbursement and are therefore not separately billable.

519.4.1 PHYSICIAN SUPERVISION OF EMPLOYED NON-PHYSICIAN PRACTITIONERS

With certain specific exceptions, physicians must be onsite when WV Medicaid covered services are provided in order to bill for services furnished by physician assistants, clinical nurse specialists, employed nurse practitioners (other than those specialties listed in Section 519.3.3), or other qualified non-physician practitioners. The physician may not bill for services furnished by any employee who is enrolled, or eligible to be enrolled, as a Medicaid provider.

Exception to physician supervision of employees:

- Physician Assistants - The supervising physician must be available for consultation and must review all records, but does not need to be on the premises.
- Advanced Nurse Practitioners – The supervising physician must be available for consultation and must review all records, but does not need to be on the premises.
- Masters Level Social Worker or Masters Level Licensed Professional Counselors – The supervising physician must be available for consultation, but does not need to be on the premises.

Following are some of the provisions governing the activities of physician assistants in WV. They apply to all practice settings in which physician assistants are employed:

- Physician assistants must be supervised by a designated licensed, qualified physician. No physician may supervise more than three physician assistants.
- Physician assistants must have job descriptions approved by the WV Board of Medicine.
- Physician assistants are prohibited from billing directly for their professional services.
- Physician assistant's authority is limited by the following:
  - The supervisory physician's authority

- The physician assistant's license, national certification, and job description
- The employing facility's policies and procedures
- And all applicable statutes and regulations (See WV Code 30-3-1 et seq.)

The employing physician may also bill WV Medicaid for covered services furnished by a registered nurse first assistant acting as an assistant surgeon. See Section 519.4.5 for the requirements of this service.

519.4.2 PHYSICIAN SUPERVISION IN A TEACHING SETTING

Teaching physicians may bill for services provided by residents under their supervision. The teaching physician must be present when the service is rendered unless the individual is licensed to practice medicine and the service is within the scope of his/her license. The level of the service billed must reflect the complexity of the evaluation or treatment need; not the work effort required by the resident.

Residents in an approved graduate medical education program, who have received their license to practice, may be enrolled as Medicaid providers, but they may not bill Medicaid for physician services provided within the scope of the education program. Services related to that program are billed by the supervising physician with the following criteria:

- The teaching physician must be present for a key portion of the time during the performance of the service.
- The teaching physician must be present during the critical portion of a surgical, complex, or dangerous procedure, and be immediately available to furnish care during the entire service or procedure.

EXCEPTION: With regard to the requirement of the teaching physician's presence, there is a special exception to the physician presence requirement for mid-level evaluation and management services furnished through a family practice type of residency program that functions outside an inpatient hospital setting. The exception applies when Current Procedural Terminology (CPT) codes 99201-99203 or 99211-99213 are rendered within a specific residency program in an ambulatory care center. **This does not apply to preventive medicine codes.**

For this exception to apply, all of the following requirements must be met:

- Residents who provide services without a teaching physician present must have completed more than six months of an approved residency program.
- The teaching physician may not supervise more than four residents concurrently and must be immediately available to render care or answer questions.
- The members must be an identifiable group of individuals who use the outpatient setting for their usual and continuing source of care.
- Residents may, within the scope of their training, furnish acute care, chronic care, comprehensive care not limited by organ system or diagnosis, or coordination of care furnished by multiple providers
- The outpatient center must be located in a setting that includes the resident's time in the full-time equivalency count used for direct graduate medical education costs.

WV Medicaid does not apply this exception to preventive medicine. In other words, the teaching physician must be present to supervise the resident in order for Medicaid to pay the teaching physician for supervising the resident while the latter provided a covered preventive service.

519.4.3 RESIDENTS AND FELLOWS

Residents in an approved graduate medical education program may not bill Medicaid for physician services provided within the scope of the education program. Medicaid reimburses these services as hospital services rather than physician services. The reimbursement is in the direct graduate medical contracted education payments WV Medicaid makes to the hospital. (This is true for both teaching and non-teaching hospitals.)

Licensed/enrolled residents may bill WV Medicaid directly for physician services provided to members under the following circumstances:

- In non-approved teaching programs may bill Medicaid for covered services they provide in hospital settings and within the scope of their license
- They may also bill for physician services provided in freestanding skilled nursing facilities or home health agencies.
- They may bill for physician services provided in non-institutional settings, such as freestanding clinics not part of the hospital if the non-institutional setting is not part of the teaching program. **This does not apply to Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC). Services provided at a FQHC/RHC are not separately billable.**

Fellows may not bill separately for services when care is provided through a teaching program, even if a fellow supervises interns and residents. In other words, physician services furnished by fellows within an approved graduate medical education program are hospital services and are not therefore separately billable as physician services.

"Moonlighting" residents may receive separate Medicaid payments for physician services provided in the outpatient or emergency department of a teaching hospital. These are residents who are providing physician services separately identifiable from services required in their graduate medical education program. Separate payment may be made if a contractual arrangement between the resident and the hospital exists and all of the following conditions are met:

- The resident is fully licensed to practice medicine in the State where the services are provided.
- The services are identifiable physician services.
- ~~"~~Moonlighting" services can be differentiated from services provided as part of the approved graduate medical education program.

In these instances, a resident can be paid for covered physician services provided to the Medicaid member.

519.4.4 ADVANCED REGISTERED NURSE PRACTITIONER

WV Medicaid pays specified Advanced RN practitioners (See Section 519.3.3) separately for medically necessary and appropriate services rendered to Medicaid eligible individuals. The services must be rendered in accordance with the provisions of WV State Code, his/her State license, and within the scope of practice defined by that license. Advanced RN practitioners must meet all requirements of the WV Board of Nursing in order to obtain prescriptive authority.

Services provided by an Advanced RN practitioner may include incidental services and supplies that are included as part of another service or procedure. The cost of incidental services is not separately reimbursable.

Advanced RN practitioners cannot bill for nursing home visits, inpatient visits, or observation services.

519.4.5 REGISTERED NURSE FIRST ASSISTANT

WV Medicaid covers services provided by a registered nurse first assistant acting as the assistant surgeon for an employing physician. The employing physician may bill assistant at surgery provided by an employed RN if the following criteria are met:

- The RN first assistant has a current, active RN license
- The RN is certified in peri-operative nursing
- The RN has successfully completed and holds a degree or certificate from a program which consists of the following criteria:
  - The Association of Operating Room Nurses, Inc., Care Curriculum for the Registered Nurse First Assistant and
  - One year of post basic nursing study, which shall include at least 45 hours of didactic instruction and 120 hours of clinical internship or its equivalent of two college semesters, or
  - Was certified by the Certification Board of Perioperative Nursing prior to 1997

Procedures for which Medicaid will reimburse an RN first assistant at surgery are indicated in Appendix 1 of the Resource Based Relative Value Scale (RBRVS) Policy and Procedures Manual. Specific information is given in the discussion of Modifiers 80, 81, 82, and AS.

In billing for the RN first assistant services, the employing physician must repeat the appropriate surgical procedure used for billing his/her service with addition of the modifier ~~–~~AS." WV Medicaid covers only one assistant at surgery per surgical encounter. Also, an Assistant at Surgery is not reimbursable when co-surgeons or team surgery is billed.

519.4.6 OUT-OF-STATE PHYSICIAN SERVICES

WV Medicaid will reimburse **emergency** out-of-state physician services. The submitted claim must clearly indicate an emergency situation existed and the emergency room record must be submitted with the claim. Out-of-state physicians are subject to the same fee and payment regulations as in-state physicians and must enroll with WV Medicaid in order to receive reimbursement for services rendered.

Non-emergency outpatient services provided to WV Medicaid members by out-of-state physicians must be prior authorized by the BMS. (For information concerning provision of inpatient services, see Chapter 510 Hospital Services.) The exceptions to this rule are approved border providers and Medicaid-eligible children who have been placed in an out-of-state foster care home or out-of-state residential treatment center.

A physician who practices in WV and wishes to refer a member to an out-of-state physician must submit a request to the Out-of-State Unit in the BMS. The request must include the reason for the out-of-state referral, member's diagnosis, the expected treatment (including duration and plan for follow-up treatment by that provider), why the treatment cannot be provided in-state, and any other information deemed pertinent for the circumstances.

All claims submitted by out-of-state physicians for non-emergency medical services will be denied unless the physician is a border provider or the service is approved in advance.

519.4.7 WV MEDICAID MUST PAY PROVIDER OF SERVICE

The provider of a service to WV Medicaid-eligible members must bill directly to the WV Medicaid Program for the service. If certain criteria are met, payment may be made to the employer of the provider. (e.g., Payment may be made to the employer of the practitioner if the practitioner is required, as a condition of employment, to turn over his fees to the employer or to the facility in which the service is provided if the practitioner has a contract under which the facility submits the claim.) Information regarding group enrollment may be obtained from the Provider Enrollment Unit.

519.5 SERVICE DESCRIPTIONS IN OTHER MANUALS

Various medical services that may complement or augment the Practitioner Services described in this chapter may be rendered to WV Medicaid members by enrolled WV Medicaid providers. The policies and procedures covering the provision of those services may be found in the appropriate Chapters as listed below:

- Chapter 504: Chiropractic Services
- Chapter 505: Dental Services
- Chapter 506: Durable Medical Equipment
- Chapter 508: Home Health
- Chapter 510: Hospital Services
- Chapter 512: Laboratory & Radiology
- Chapter 515: Occupational/Physical Therapy
- Chapter 518: Pharmacy Services
- Chapter 520: Podiatry Services
- Chapter 524: Transportation
- Chapter 525: Vision Services

Policies and procedures regarding Organ Transplant Services are found in Chapter 510 of the Hospital Services Manual.

519.6 INDEX OF COVERED SERVICES

519.7 EVALUATION AND MANAGEMENT SERVICES

Evaluation and Management (E&M) Services involve face-to-face contacts between members and practitioners. Contacts may occur in a hospital setting, the member's home, the practitioner's office or other ambulatory setting, emergency room, or long-term care facility.

WV Medicaid coverage of E&M Services is outlined below:

- Only one E&M procedure code is covered on the same date of service per member per practitioner.
- Only one E&M procedure may be billed when more than one practitioner in the same specialty and same group provides a service to the same member on the same date of service, unless the E&M services are for unrelated problems.
- When multiple E&M visits occur on the same date of service, the practitioner must bill with the E&M procedure code that best represents the combined level of services.
- The E&M code must reflect the content of the service.
- The member's medical record must support the level of care provided and document, at a minimum, all of the following information:
  - The billed procedure code's components, based on CPT guidelines
  - The time the practitioner spent with the member for medical decision making
  - The coordination of care or counseling provided, including direct fact-to-face contact time when time is the key component for code selection.

WV Medicaid does not cover:

- Hospital visits related to a procedure that WV Medicaid does not cover
- Visits covered by a global surgical fee
- Visits by an RN practitioner in a hospital or nursing home.

In addition, WV Medicaid does not pay separately for manual or automated urine, hemoglobin, and hematocrit tests performed as part of the visit.

519.7.1 OFFICE VISITS AND OTHER OUTPATIENT SERVICES

WV Medicaid covers medical services rendered to the member for the prevention or diagnosis and treatment of illness, accident, and injury. Except for CPT 99211, face-to-face contact must occur. (e.g., the practitioner must examine the member and provide medical services in order to bill a visit.) CPT 99211 indicates an office or other outpatient visit for an established member that does not require the presence of a practitioner. The presenting problem is usually minimal and the practitioner typically spends five minutes performing or supervising this E&M service.

An office visit associated with a covered procedure or minor surgery performed in a practitioner‘s office is considered part of the procedure and is not payable by Medicaid. The visit may be billed separately, with the appropriate modifier, provided the visit is for a distinctly different reason.

A visit to a practitioner‘s office or outpatient department of a hospital solely for a diagnostic service does not qualify for coverage or payment as an E&M procedure. Medicaid payment will be made for the diagnostic service but not for the visit as it is bundled with the payment for the diagnostic service.

A preoperative office visit and uncomplicated follow-up care are bundled with the payment for the surgery and are not separately reimbursed.

Telephone contacts are not considered to be practitioner visits. Therefore, WV Medicaid does not reimburse for telephone contacts with the member or on the member‘s behalf.

519.7.2 PREVENTIVE CARE FOR MEMBERS

WV Medicaid covers well child, preventive medicine examinations for children based on the recommended frequency established by the American Pediatric Association and adopted by the WV Early and Periodic Screening, Diagnostic, and Treatment Program. For adult members, WV Medicaid covers one annual physical examination in a 12 month period. The annual examination must be reported with a preventive medicine code reflective of the member‘s age (CPT 99381-99387 or CPT 99391-99397).

- The annual physical examination is separate and distinct from treatment or diagnosis for a specific illness, symptom, complaint, or injury. If during the examination an abnormality is found or a preexisting condition requires significant additional work to perform the key components of a problem-oriented E&M service, that service may be billed with Modifier 25. Documentation in the medical record must support the provision of this service. Clinical laboratory services, radiology procedures, and other diagnostic services must be reported and billed separately.

WV Medicaid does not cover the following types of physical examinations:

- Sport physicals
- Camp physicals

- Physicals for inpatients in nursing facilities, hospitals, residential treatment facilities, and other such facilities
- Physicals required by third parties, such as insurance companies, Government agencies, and businesses as a condition of employment
- Daycare

Eligibility examinations requested by the county DHHR office are not annual physicals. See Section 519.7.10 for coverage information.

519.7.2.1 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

WV Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program offers screenings and other preventive health services at regularly scheduled intervals to Medicaid members less than 21 years of age. (WV Medicaid EPSDT coverage is through the month in which the member turns 21 years of age.) These services target early detection of disease and illness and provide referral of members for necessary diagnostic and treatment services.

If the Medicaid member is a member of the Physician Assured Access System (PAAS) Program, a referral from the primary care physician (PCP) must be obtained prior to performing an EPSDT exam for reimbursement if the provider administering the exam is not the member's PAAS PCP. If the Medicaid member is a member of a Health Maintenance Organization (HMO), the HMO is responsible for reimbursement for the services when the HMO's requirements have been met.

Providers must make reasonable efforts for every member under 21 years of age to determine whether a visit to the provider's office stems from an EPSDT referral by asking the referring provider, clinic, or member. If the visit is the result of an EPSDT screening, the appropriate space on the claim must be marked "yes" to indicate a referral was the source of the visit. Likewise, the appropriate space on the claim must be marked ~~no~~" if the information cannot be obtained or is not the result of a screening.

519.7.3 HOSPITAL VISITS

All hospital admissions must be prior authorized based on the determination of medical necessity and appropriateness by BMS' contracted utilization management agent in order for WV Medicaid to reimburse for services rendered. Visits by physicians in conjunction with denied or non-covered inpatient services are non-reimbursable. Hospital admissions for diagnostic procedures may be reimbursed only when there is adequate documentation the procedure cannot be performed on an outpatient basis.

As with other E&M services, only one hospital visit per date of service is covered regardless of how many times the physician sees the member on that date. Payment for the hospital visit is included in the global fee paid for surgical/diagnostic procedures, depending on the global period for the procedure. Global periods for procedures are listed in the RBRVS table.

519.7.3.1 EMERGENCY DEPARTMENT SERVICES

WV Medicaid covers emergency department visits rendered by the onsite practitioner using CPT codes 99281-99285. If a practitioner is called in to the emergency department to treat a member, the services must be billed over the appropriate level office/outpatient procedure code. Additional billing of codes for after-hour visits or non-scheduled visits is not covered.

Surgical procedures performed in an emergency room are billable. However, the physician will not be

reimbursed for an emergency room visit in addition to the surgical procedure performed in the emergency room.

519.7.3.2 OBSERVATION SERVICES

Observation services are defined as the use of a bed and periodic monitoring by hospital nursing or other indicated staff at the level and frequency necessary to evaluate the member's condition to determine the need for inpatient admission. Medicaid limits the coverage of observation services to a maximum of 48 hours. Even if the 48 hours extends over three calendar days, only two observation visits are covered: the initial observation care and the observation care discharge services.

In addition to documentation in order to support the medical necessity of the service, the observation record must contain dated and timed physician's admitting orders specifying the care the member is to receive while in observation, admitting history and physical, nursing notes, dated and timed progress notes written by the physician, laboratory and other diagnostic test results, active treatment protocol, and documentation to justify the level of the observation code billed. **This record must be maintained in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.**

When a member is admitted to the hospital for observation, the admitting physician must be physically present on the hospital premises.

If a member is examined by a practitioner other than the admitting physician while in observation, that practitioner must bill the outpatient E&M code appropriate for the service provided.

519.7.4 REFERRALS

A referral involves the transfer of the total or a specific part of the care and treatment of a member from one physician to another physician. A referral does not qualify as a consultation. The care provided during the course of treatment subsequent to such a referral is therefore not considered a consultation for payment purposes and therefore should not bill the consultation E&M procedure codes.

519.7.5 CONSULTATIONS

A consultation is a service provided by a physician whose opinion or advice regarding the evaluation or management of a member's condition is requested by the attending physician or another appropriate provider. A consultant may initiate diagnostic or therapeutic services at the time of the consultation. The consultant must document in the member's record that the member was seen at the request of the referring provider and that the findings, recommendations, and treatment (if initiated) were communicated to the referring practitioner. If the consultant assumes responsibility for the member's continuing care, any subsequent service provided does not qualify as a consultation and should be billed with the appropriate CPT code. The physician must not bill a consultation if the member was self-referred for services, except in the case of a confirmatory consultation which may be requested by the member and/or family.

WV Medicaid applies a service limitation of one consultation per procedure code per consultant per six months to office or other outpatient consultations, initial inpatient consultations, and confirmatory consultations. This limitation applies to the following consultations performed by an individual physician: CPT 99241-99245, 99251-99255, and 99271-99275. In other words, a member may receive only one Medicaid–covered consultation of each specific level from the same physician over a

six month period. The member may receive consultations from different physicians within the same six month period, regardless of whether the physicians provide the same or different levels of service, unless the consultants are in the same group practice or partnership. WV Medicaid covers follow-up consultations (CPT 99261-99263) with no service limitation other than billing with other consultation codes or hospital/office visits.

Consultations are disallowed if and of the following criteria are met:

- They are provided in conjunction with other services furnished by the same physician on the same date to the same member, such as office visits, home visits, or hospital visits,
- They are provided by a surgeon immediately prior to the procedure and resulted in the initial decision to perform surgery with the use of modifier 57,
- When billed by a member of the same group and specialty as the physician performing the surgery.

Gathering of the member's medical history and/or performance of a physical examination prior to a member's admission for surgery is the responsibility of the admitting/operating surgeon under the global surgical package. This may not be billed as a consultation.

Pre-operative evaluations for anesthesia are not considered to be consultations and may not be billed as consultations. Payment for these evaluations is included in the fee for the administration of the anesthesia.

When the consultant assumes responsibility for the management of a portion or all of the member's care subsequent to the consultation, then consultation codes are no longer appropriate. There is a difference between consultations and referrals. See Section 519.7.4 for information on referrals.

519.7.5.1 SECOND OPINIONS FOR ELECTIVE SURGERY

Second opinions (Confirmatory consultations) are covered for elective/non-emergency surgery. The second opinion concept is to be a member oriented service that allows an individual member to make better informed decisions about a physician's recommendation on the need for surgery. However, a physician may also request a second opinion.

The consulting physician must document the type of surgery, the name of the member or physician requesting the second opinion, and must bill an appropriate confirmatory consultation procedure code.

519.7.5.2 TELEHEALTH SERVICES

A teleconsultation is an interactive member encounter that meets specific criteria. This service requires the use of ~~"i~~nteractive telecommunications systems" defined as multimedia communication equipment that involves at least audio and video equipment that permits two-way consultation among the member, consultant and referring provider. Telephones, facsimile machines, and electronic mail systems do not qualify as interactive telecommunication systems. WV Medicaid covers teleconsultations subject to the following criteria:

- The consultation must involve real time consultation as appropriate for the member's medical needs and as needed to provide information to and at the direction of the consulting physician.
- Medicaid coverage of teleconsultations is limited to members in non-metropolitan statistical professional shortage areas as defined by CMS. The referring provider must be located in the non-metropolitan area.

- The referring provider may bill for an office, outpatient, or inpatient E&M service that precedes the consultation and for other Medicaid-covered services the consultant orders, or for services unrelated to the medical problem for which the consultation was requested. However, the referring provider may not bill for a second visit for activities provided during the teleconsultation.
- The consultant must be in control of the member's medical examination, with the referring provider participating, as needed, to complete the examination. The member must be present in real time, and telecommunication technology must allow the consultant to conduct a medical examination of the member.
- The consultant's findings must be documented in a written report given to the referring physician.
- Payment for a teleconsultation does not include any separate reimbursement for telephone line charges or facility fees, and a member may not be billed any amount for these charges/fees.
- Separate payment is not made for the review and interpretation of medical records.
- Medicaid coverage is limited to professional consultations that meet the criteria specified for consultation service in the CPT Manual. Covered services include initial follow-up or confirming consultations in hospitals, outpatient facilities, or medical offices, that is: CPT 99241-99245, 99251-99255, 99261-99263, and 99271-99275. These are subject to the same service limits discussed in the consultation section of this chapter, Section 519.7.5.

Modifier GT must be used with the proper consultation code in order for a physician to bill for a teleconsultation.

519.7.6 NURSING FACILITY VISITS

WV Medicaid covers one nursing facility visit per 30 days when made by the member's primary care physician. The appropriate E&M code (CPT 99301-99313) must be used to bill for the visit. WV Medicaid does not reimburse a nursing facility visit if the same physician provides another E&M visit to the same member on the same date of service.

WV Medicaid does not cover daily, weekly, or routine nursing facility visits. Emergency treatment provided within the 30-day cycle will be considered for payment based on using the appropriate nursing facility procedure code with documentation of the emergency nature of the visit.

Specialists called by an attending physician must bill the code appropriate for their services, such as a procedure code for a consultation or minor surgery. The service must be provided based on a specific request of the primary care physician. **Standing orders are not acceptable.**

Nursing discharge orders, CPT 99315 – 99316, are not covered by WV Medicaid.

There is no coverage for nurse practitioner visits.

519.7.7 CARE PLAN OVERSIGHT SERVICES

Care plan oversight (CPO) consists of physician supervision of members under either home health or hospice care when the member requires complex or multidisciplinary care modalities with ongoing physician involvement. WV Medicaid provides payment for only one CPO service per calendar month, per member, per provider. CPT 99375 and 99378 are the only procedure codes that may be used to bill CPO services. CPO coverage is subject to the following rules:

- The member must be receiving medically necessary home health services or hospice care.
- The physician who bills for CPO services must be the same physician who signed the home health or hospice plan of care.

- A face-to-face encounter between the physician and member must occur at some time during the six months prior to the first month for which CPO services are billed, and every six months afterwards.
- Payment for CPO services may not be made to physicians having a significant ownership interest in or financial relationship with a home health agency or hospice.
- Only the attending physician may bill or receive payment for CPO services. **Exception:** The attending physician may not bill or receive payment for CPO services if he/she is the medical director or a physician employed by, or having a contractual relationship with, the home health agency or hospice.
- Physicians may not bill for CPO during the postoperative period of a global surgery period unless the service is unrelated to the procedure.
- CPT 99375 and 99378 are the only procedure codes that may be used to bill for CPO services.
- The physician must furnish at least 30 minutes of CPO services within the calendar month that is being billed. Medicaid allows multiple CPO encounters during the month on multiple days, but the total time must add up to 30 or more minutes, and can be billed only once.

CPO services for Medicaid members in nursing facilities are not covered. CPO services are not payable to physicians having a significant ownership interest in or financial relationship with a home health agency or hospice.

519.7.8 CRITICAL CARE VISITS

As circumstances warrant, physicians should bill for critical care, regardless of whether the associated visit was an initial or subsequent one, and regardless of the site if the level of care fulfills the criteria for critical care. However, physicians may not bill for procedures and services the CPT Manual defines as ~~-a~~ttendant to critical care management". These services are listed in the CPT Manual.

519.7.9 PROLONGED PHYSICIAN ATTENDANCE

WV Medicaid covers prolonged services only if the physician provides a prolonged direct, face-to-face service to the member that equals or exceeds the threshold time for the E&M service provided (typical time of the service plus 30 minutes). Time spent by office staff with the member or time the member was unaccompanied in the office is not counted toward the total time and may not be counted nor billed. For hospital-prolonged services, time spent waiting for certain events to occur, such as test results, changes in the member's condition, therapy to end, or use of facilities, may not be billed.

The member's medical record must document the duration and content of the billed E&M code and document that the physician personally furnished at least 30 minutes of direct service after the typical time of the E&M service had been exceeded by at least 30 minutes. (This time does not need to be continuous; however, it must be provided on the same date of service.)

Physicians may bill for prolonged services using CPT 99354-99357. These codes require billing of companion E&M codes when the same physician provides both types of services on the same date of service to the same member. CPT 99354 and 99356 are used for the first 30-60 minutes and 99355 and 99357 for each additional 30 minutes. The prolonged service codes are billed in addition to the appropriate visit code.

- The companion E&M codes for CPT 99354 are 99201-99205, 99212-99215, or 99241-99245.
- The companion E&M codes for CPT 99355 are 99354 and its related E&M code.
- The companion E&M codes for CPT 99356 are 99221-99223, 99231-99233, 99251-99255,

99261-99263, 99301-99303, or 99311-99313.

- The companion E&M codes for CPT 99357 are 99356 and its related E&M code.

All these procedure codes are subject to Medicaid coverage rules and CPT definitions.

519.7.10 ELIGIBILITY EXAMINATIONS

The local DHHR office requests physical examinations, consultations, and reports on pending applications for the purpose of determining Medicaid eligibility. These requests are made by letter, defining the service to be provided and the member identification number to be used in billing. These services must be billed on paper with a copy of the authorizing letter. (These services are not reimbursable by Managed Care Organizations.)

Based on Social Security disability regulations, eligibility examinations may only be performed by an MD or DO.

The specific codes that must be used when billing eligibility examinations are:

- 99450 General physical examinations,
- 99456 Specialist exams (including eye exams), and
- S9981 Medical records.

Only one of these procedure codes can be billed per provider and no other E&M code may be billed.

In addition to the procedure codes listed above, diagnostic services may also be ordered by the examining physician if medically necessary to complete the examination and/or consultation. Diagnostic procedures that may be covered for eligibility determination are:

- Diagnostic Eligibility
  - Diagnostic Colonoscopy 45378
  - Diagnostic Radiology 70010-76499
  - Diagnostic Ultrasound 76506-76886, 76977
  - Nuclear Medicine Diagnostic 78000-78999
  - Laboratory 80000-86804, 87001-87999, 88104-88299, 88342-88349, 88400-89060, 89160-89240
- Medicine Codes
  - Therapeutic or Diagnostic Infusions 90780-90781
  - Therapeutic, Prophylactic, or Diagnostic Injections 90782-90799
  - Gastroenterology 91000-91100, 91110, 91122, 91132-91133, 91299
  - Ophthalmology 92015-92060, 92081-92287
  - Otorhinolaryngology 92502-92506, 92511-92520
  - Vestibular Function 92541-92548, 92551-92589, 92610-92617
- Cardiovascular
  - Cardiography 93000-93278
  - Echocardiography 93303-93350
  - Electrophysiological 93660,93701-93722, 93875-93990

– Pulmonary	94010, 94060, 94200, 94375, 94720, 94760, 94761, 94772, 94799
– Neurology and Neuromuscular	95805-95811, 95812-95822, 95827, 95830, 95831-95904, 95920-95967
– Physical Medicine	97001,97003,97750
– A Codes	A9500-A9503, A9505, A9700
– G Codes	G0001, G0030-G0047, G0102-G0107, G0120, G0125, G0210-G0230, G0236, G0253-G0254
– P Codes	P7001,P9612

Documentation for medical necessity is required for all services. The documentation of the authorization, examination, medical necessity for diagnostic procedures, and diagnostic findings must be maintained in the member's record.

519.8 ANESTHESIA SERVICES

Anesthesia services covered by WV Medicaid include general, regional, and labor epidural. These services are primarily reimbursed using the American Society of Anesthesiologist's (ASA) ~~0~~" CPT codes. Supportive services rendered in order to afford the member the necessary anesthesia care are also covered.

Anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) are the only providers that may be reimbursed for general and monitored anesthesia services.

519.8.1 BASE AND TIME UNITS

Two distinct unit values apply to anesthesia services. Base units are defined by the ASA Uniform Relative Value Guide. These units are part of the procedure and may not be billed separately.

The other value is the time unit. WV Medicaid defines a time unit as 15 minutes which must be rounded to the nearest whole unit. (Eight minutes or more, round up. Seven minutes or less, round down.) Only time units may be billed.

Payment is determined by the sum of the ASA base units plus time units multiplied by the anesthesia conversion factor. There is a limit of 40 units (10 hours) on each anesthesia Zero ~~0~~" code, except for maternity-related anesthesia services. (See Section 519.8.3.) If anesthesia is provided longer than 10 hours, the claim must be billed on paper and submitted with documentation that would justify the additional anesthesia used.

519.8.2 COVERAGE POLICIES

WV Medicaid applies the following policies for coverage and reimbursement of anesthesia services:

- Payment for multiple anesthesia procedures is based on the procedure with the highest base unit value and the actual anesthesia time of the multiple procedures. Only one zero code may be billed (the highest value). Exception: Procedures performed at the same time as a delivery are included in the maternity service and must be billed with the maternity anesthesia CPT codes listed in Section 519.8.3.
- Anesthesia time begins when the CRNA or anesthesiologist begins to prepare the member for anesthesia care in the operating room or an equivalent area, and ends when the CRNA or the anesthesiologist is no longer in personal attendance.

- Preoperative evaluations for anesthesia are included in the fee for the administration of anesthesia and may not be billed as an E&M service.
- Regional IV anesthesia (e.g., 01995) is not based on time units; the base unit is covered. Therefore, only one unit of service may be billed. CPT 01995 is used only in situations involving the application of a tourniquet to a limb and injection of an agent for regional anesthesia.
- CPT surgical procedure codes (e.g., 62311 and 62319) are used for regional anesthesia. No base units or time units of anesthesia may be billed. Instead, one unit of service (an injection) is billed.
- Epidural for pain management other than the three stages of delivery (labor, delivery, and postpartum) must be billed with CPT 62311 and 62319. Time units may not be billed.
- CPT 01996 (Daily Management of Epidural or Subarachnoid Drug Administration) is not payable on the same day as the insertion of an epidural catheter or a general anesthesia service. The service unit for this procedure is one base unit.
- Epidural anesthesia for surgical procedures must be billed with the appropriate ~~"0~~" anesthesia code with time units.
- Medications for pain relief given during the time of the epidural anesthesia are inclusive and must not be billed as a separate procedure.
- Local anesthesia and IV (conscious) sedation are bundled into the procedure being provided and must not be billed as separate services.
- Anesthesia services rendered during a hysterectomy or sterilization require completion, submission, and acceptance of the appropriate acknowledge/consent forms.
- Occasionally a procedure which is usually requires no anesthesia or local anesthesia, because of unusual circumstances, must be rendered under general anesthesia. A written description of the reason for using modifier 23 is required, and the claim will be sent for review.
- Modifiers defining the CRNA or anesthesiologist participation are used in processing to allocate payments. (e.g., AD,QK,QX,QY, and QZ) The supervising/medical directing anesthesiologist/ CRNA must bill the same procedure code.
- Physical status modifiers are not used for processing by WV Medicaid. The billing of additional base units for physical status is prohibited.

519.8.3 MATERNITY-RELATED ANESTHESIA

The CPT codes listed below are for reporting maternity-related anesthesia services. WV Medicaid limits payment for maternity anesthesia to eight ~~T~~ime Units". (A maximum of two hours) Base units may not be billed separately.

- 01960 - Anesthesia for vaginal delivery only
- 01961 - Anesthesia for cesarean delivery only
- 01967 - Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or necessary replacement of an epidural catheter during labor)
- 01968 - Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed) (Must be used with 01967.)
- 01969 - Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed) (Must be used with 01967.)

If the Medicaid member is a recipient of a documented emergency cesarean section, the anesthesia

provider may receive reimbursement for up to two additional units of anesthesia. (See Section 519.8.4 for further details on billing emergency anesthesia.)

WV Medicaid's payment policy for labor epidural is as follows:

- Labor epidural provided by the surgeon must be billed with the appropriate delivery anesthesia code and modifier 97. Labor epidural provided by the anesthesiologist and/or CRNA must be billed with the appropriate ~~-0~~" anesthesia code
- CPT surgical codes 62311 and 62319 are not to be used to bill pain management for the three stages of delivery.
- Medications for pain relief given during the time of the epidural anesthesia are not covered as a separate procedure.
- Only one provider or team will be paid for epidural services.
- Emergency anesthesia is not allowed with the provision of epidural anesthesia or vaginal deliveries.
- The labor epidural procedures covered by WV Medicaid are inclusive of labor, delivery, and postpartum care. Additional procedure codes used for pain management are not covered.

519.8.4 EMERGENCY ANESTHESIA

Additional payment is allowed to anesthesiologists and non-medically directed certified registered nurse anesthetists for providing anesthesia for surgery on an emergency basis. The ASA recommended payment policy of two additional base units is followed. CPT code 99140 must be billed one unit in order to receive payment for this service.

519.8.5 MONITORED ANESTHESIA CARE

Monitored anesthesia care involves the intra-operative monitoring of the member's physiological signs in anticipation of the need for administration of general anesthesia or the development of adverse reactions to the procedure.

It must be performed at the request of the attending physician, made known to the member, and performed according to the facility's policies and procedures. If medically necessary, monitored anesthesia care is paid on the same basis as other anesthesia services.

WV Medicaid reimburses an anesthesiologist or CRNA for monitored anesthesia care only if they meet all of the following requirements:

- Performs a pre-anesthetic examination and evaluation of the member
- Prescribes the required anesthesia
- Participates personally in the entire plan of care
- Is continuously physically present when participating in the case
- Observes all facility regulations pertaining to anesthesia services
- Furnishes all the usual services an anesthetist usually performs.

The modifiers which are to be used for monitored anesthesia care are G8, G9, and QS.

519.8.6 OTHER ANESTHESIA SERVICES

Anesthesiologists and non-medically directed CRNAs (within the scope of their license) may bill for the following additional services: Swan-Ganz placement or any other central venous pressure line, critical care visits, emergency intubations, spinal puncture, and blood patch. Payment for these

specific services is based on the RBRVS payment system. Time units are not billable for these services.

They may also bill for cardiopulmonary resuscitation performed in conjunction with the anesthesia procedure or outside the operating suite.

519.8.7 ANESTHESIOLOGIST DIRECTED ANESTHESIA

Medical direction may apply to a single anesthesia service furnished by a CRNA or up to four concurrent anesthesia services. A physician who is directing the administration of anesthesia to four surgical members is not expected to be involved routinely in furnishing any additional services to other members. Addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic rather than continual monitoring of an obstetrical member would not substantially diminish the physician's capacity to direct the CRNA services.

The medical directing anesthesiologist must document in the member's medical record that all medical direction requirements have been met, including:

- Perform the pre-anesthetic examination and evaluation
- Prescribe the anesthesia plan
- Participate personally in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence
- Ensure a qualified individual performs any procedure in the anesthesia plan he/she does not perform personally
- Monitor the course of anesthesia administration at frequent intervals
- Remain physically present and available for immediate diagnosis and treatment of emergency that may develop
- Provide indicated post-anesthesia care.

A physician may appropriately receive members entering the operating suite for the next surgery while directing concurrent anesthesia procedures. However, checking or discharging members in the recovery room and handling scheduling matters are not compatible with reimbursement to the physician for directing concurrent anesthesia procedures.

519.8.8 ANESTHESIA TEAMS

An anesthesia team is defined as one directing anesthesiologist and one CRNA providing services to a member. The payment split between the anesthesiologist and medically directed CRNA equals 100 percent of the payment level for an individually performing anesthesiologist with the anesthesiologist receiving 60 percent and the medically directed CRNA 40 percent.

Only one provider or anesthesia team will be paid for epidural anesthesia.

519.9 SURGICAL SERVICES

WV Medicaid covers medically necessary surgical procedures. No surgical procedure will be covered on an inpatient basis if the procedure can be performed appropriately and safely in a physician's office or other outpatient setting, unless the procedure is performed secondarily to another necessary inpatient procedure.

If the Medicaid member is a participant in the PAAS Program, surgical services will require a referral

from the PCP prior to rendering the service.

Under Medicaid RBRVS payment rules, physicians are paid a single global fee for all necessary services. Payments are not made for individual components of a complete or bundled procedure.

In global billing, all expenses for surgical care must be dated the day the surgery occurred.

The following services are typically bundled into the global surgery period and are; therefore, covered by the global surgery fee and are not paid separately:

- Visits to/by the surgeon the day before or the day of the surgery (Neither hospital nor office visits)
- Visits to a member in intensive care or critical care unit
- Services normally a part of the surgery itself (e.g., use of an operating microscope)
- Services for any complications not requiring an additional trip to the operative room
- Preoperative and postoperative medical care. Only the surgical procedure code is necessary for billing purposes, using the date of the surgery as the date of service.
- Ninety days of postoperative care for major surgery and zero to 10 days for minor surgery.
- Biopsy procedures performed concurrently with a major surgical procedure

When multiple surgeries are performed during the same operative session, payment is based on the full amount for the primary procedure and 50 percent of the fee for all other necessary and appropriate procedures performed during the session. RBRVS coverage guidelines for bilateral surgery, assistant surgeon, co-surgeon, team surgery, and site of service differential also apply to all procedures.

519.9.1 RECONSTRUCTIVE SURGERY

The following types of reconstructive surgery must be medically necessary and require prior authorization prior to rendering the service:

- Eyelid surgery **(Attachment 1)**
- Breast reconstruction following cancer surgery **(Attachment 2)**
- Reduction mammoplasty **(Attachment 3)**
- Panniculectomy (request for panniculectomies must include written documentation demonstrating medical necessity) **(Attachment 4)**

The attachments listed above are copies of the forms that must be completed and submitted to request prior authorization for reconstructive surgery. Each form must be completed in full.

Photographs may be necessary when submitting documentation for medical necessity. However, HIPAA guidelines must be followed to ensure the privacy of Medicaid members.

Questions regarding reconstructive surgery and prior authorization requests must be addressed to BMS' Case Management Unit at (304) 558-1700 or fax number (304) 558-1776. Services must not be provided before any necessary prior authorization is received. The member must be informed he/she may be financially liable for services provided without the requisite authorization.

519.9.2 INTEGUMENTARY SERVICES

WV Medicaid applies multiple surgery rules to most dermatological procedures (e.g., CPT 11400, 11600, and 17260). Multiple surgery payment rules do not apply to selected dermatological services that are, by definition, multiple procedures.

WV Medicaid defines simple and intermediate repairs as follows:

- Simple repair procedure code must be used if the wound involves the skin and subcutaneous tissue.
- Intermediate repair must be used to close one or more of the deeper fascial layers in addition to the skin and subcutaneous tissue.

Services provided to PAAS Program members require a referral from the PCP for reimbursement prior to rendering services.

Procedures must be medically necessary and not for cosmetic purposes. (i.e., Scar revisions/excisions will only be covered for documented medically necessary reasons.)

519.9.3 BARIATRIC SURGICAL PROCEDURES

The West Virginia Medicaid Program covers bariatric surgery procedures subject to the following conditions.

519.9.3.1 MEDICAL NECESSITY REVIEW AND PRIOR AUTHORIZATION

The patient's primary care physician or the bariatric surgeon may initiate the medical necessity review and prior authorization by submitting a request, along with all the required information, to the West Virginia Medical Institute (WVMI), 3001 Chesterfield Place, Charleston, West Virginia 25304. The West Virginia Medical Institute (WVMI) will perform medical necessity review and prior authorization based upon the following criteria:

- A Body Mass Index (BMI) greater than 40 must be present and documented for at least the past 5 years. Submitted documentation must include height and weight.

- The obesity has incapacitated the patient from normal activity, or rendered the individual disabled. Physician submitted documentation must substantiate inability to perform activities of daily living without considerable taxing effort, as evidenced by needing to use a walker or wheelchair to leave residence.

- Must be between the ages of 18 and 65. (Special considerations apply if the individual is not in this age group. If the individual is below the age of 18, submitted documentation must substantiate completion of bone growth.)

- The patient must have a documented diagnosis of diabetes that is being actively treated with oral agents, insulin, or diet modification. The rationale for this criteria is taken from the Swedish Obese Subjects (SOS) study, *International Journal of Obesity and Related Metabolic Disorders*, May, 2001

- Patient must have documented failure at two attempts of physician supervised weight loss, attempts each lasting six months or longer. These attempts at weight loss must be within the past two years, as documented in the patient medical record, including a description of why the attempts failed.

- Patient must have had a preoperative psychological and/or psychiatric evaluation within the six months prior to the surgery. This evaluation must be performed by a psychiatrist or psychologist, independent of any association with the bariatric surgery facility, and must be

specifically targeted to address issues relative to the proposed surgery. A diagnosis of active psychosis; hypochondriasis; obvious inability to comply with a post operative regimen; bulimia; and active alcoholism or chemical abuse will preclude approval.

- The patient must demonstrate ability to comply with dietary, behavioral and lifestyle changes necessary to facilitate successful weight loss and maintenance of weight loss. Evidence of adequate family participation to support the patient with the necessary lifelong lifestyle changes is required.

- Patient must be tobacco free for a minimum of six months prior to the request.

- Documentation of a current evaluation for medical clearance of this surgery performed by a cardiologist or pulmonologist, must be submitted to ensure the patient can withstand the stress of the surgery from a medical standpoint.

519.9.3.2 PHYSICIAN CREDENTIALING REQUIREMENTS

In order to be eligible for reimbursement for bariatric surgery procedures, physicians must: submit the following to the provider enrollment unit:

- Evidence of credentials at an accredited facility to perform gastrointestinal and biliary surgery.

- Documentation that the physician is working within an integrated program for the care of the morbidly obese that provides ancillary services such as specialized nursing care, dietary instruction, counseling, support groups, exercise training and psychological/psychiatric assistance as needed.

- Assurances that surgeons performing these procedures will follow the guidelines established by the American Society for Bariatric Surgery including:

    - Credentials to perform open and laporoscopic bariatric surgery

    - Document at least 25 open and/or laporoscopic bariatric surgeries within the last three years

519.9.3.3 PHYSICIAN PROFESSIONAL SERVICES

Professional services which will be required of the physician performing bariatric surgery include the surgical procedure, the 90-day global post-operative follow-up, and a 12 month assessment period which includes the following: medical management of the patient‘s bariatric care, nutritional and personal lifestyle counseling, and a written report at the end of the 12 month period consisting of: an assessment of the patient‘s weight loss to date, current health status and prognosis, and recommendations for continuing treatment. That 12 month assessment report must be submitted to the patient‘s attending or primary care physician, as well as to the Bureau for Medical Services.

While the bariatric surgeon‘s association with the patient may end following the required 12 month

follow-up, the patient's continuing care should be managed by the primary care or attending physician throughout the patient's lifetime.

519.9.3.4 REIMBURSEMENT

The physician performing the bariatric surgery procedure will be reimbursed through the existing RBRVS payment methodology for the surgical procedure. Reimbursement includes a post-operative follow-up for the global period of 90 days. For the remainder of the required 12 month follow-up period and assessment, the bariatric surgeon may submit claims using the appropriate evaluation and management procedure code. After completion of the required 12 month evaluation period, the patient may be followed-up and medically managed either by the surgeon or primary care physician utilizing appropriate E & M procedure codes.

519.9.3.5 COVERED BARIATRIC PROCEDURES

43842 Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty.

43843 Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty.

43846 Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy.

43847 Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption.

43848 Revision of gastric restrictive procedure for morbid obesity (separate procedure). (This is only for correction of serious complications caused by the procedure within the first 6 months postoperatively, and is not meant to indicate that a patient can have a second procedure due to failure to lose weight from a prior procedure.)

Note: Only one procedure will be covered per lifetime. Those failing to lose weight from a prior procedure will not be approved for a second one.

519.3.6 NON-COVERED BARIATRIC PROCEDURES

The following procedures will not be covered by West Virginia Medicaid Program:

- Mini-gastric bypass surgery
- Gastric balloon for treatment of obesity
- Laparoscopic adjustable gastric banding

519.9.4 EXCLUDED SURGICAL PROCEDURES

Following the guidelines of the Correct Coding Initiative, procedures that would be billable when they are the only billed services become non-covered when billed in conjunction with other surgical procedures. Examples of these situations are:

- Surgical procedures incidental to the primary procedure. Examples of incidental surgeries are appendectomies, lyses of adhesions, and scar revisions. If incidental surgeries are billed and subsequently paid, the physician must return the payment to the BMS.
- Exploratory laparotomies performed at the same time as another surgical procedure in the same anatomical region. The exploratory laparotomy is included in the fee paid for the surgical procedure.
- Surgical destruction during a procedure. Payment for surgical destruction is included in the global fee for the surgery. Under special circumstances, where methods of destruction substantially alter

the standard management of the member's condition, consideration will be given for separate coverage. These special circumstances would require prior authorization.

WV Medicaid does not cover elective cosmetic surgery (surgery that has as its primary purpose the improvement of the member's appearance and is not medically necessary). Many of these procedures may be covered when provided for treatment of congenital anomalies, traumatic injury, or a disease process. Documentation supporting the medical necessity for the procedure must be maintained in the member's record. Examples of cosmetic surgery are otoplasty, rhinoplasty (except to correct internal nasal deformity and must be approved in advance), nasal reconstruction, excision of keloids, fascioplasty, osteoplasty for prognathism or micrognathia, malar augmentation, dermabrasion, certain skin grafts, lipectomy, mastopathy, liposuction, breast augmentation, replacement of breast implants used for purposes other than reconstruction due to cancer, and removal of tattoos.

WV Medicaid does not cover Stretta procedure, lung volume reduction surgery, pancreatic islet cell transplant, and living donor hepatic transplant.

WV Medicaid does not cover experimental, research, or investigational medical and surgical procedures, including those identified by the United States Department of Health and Human Services, nor transportation for any of these services. Minimally, the following criteria are considered in determining whether a procedure is experimental, research, or investigational:

- The current and historical judgment of the medical community as evidenced by medical research, studies, journals, or treaties
- The extent to which Medicare and private insurers recognize and cover the procedure
- The current judgment of experts and specialists in the medical specialty in which the procedure is applicable or performed
- The effectiveness of the procedure as predicated by the number of times the procedure has been performed, the mortality rate, the long-term prognosis, the reputation of the physicians and hospitals performing the procedure, among other factors.

519.10 OBSTETRICAL AND GYNECOLOGICAL SERVICES

A wide range of Obstetrical and gynecological services are covered under WV Medicaid including preventive, pregnancy related, and disease related services.

519.10.1 MATERNITY SERVICES

The practitioner may provide all or a portion of antepartum care, delivery, and/or postpartum care.

Antepartum care includes the initial and subsequent history, physical examinations, monitoring of weight, blood pressure, fetal growth and development, heart tones, and routine chemical urinalysis. During a normal pregnancy, prenatal visits are monthly up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Procedure code 99213TH must be billed for each individual pre-natal visit. Adjustments to the frequency may be made based on documentation of maternal and fetal risk factors.

Delivery services include admission to the hospital, admission history and physical examination, management of labor, vaginal delivery with or without episiotomy and with or without forceps, or cesarean delivery and postpartum care provided in the hospital. Postpartum care during the confinement for delivery is not separately billable.

Postpartum care is normally included in the payment for the delivery unless performed by a

practitioner other than the delivering practitioner. Postpartum care cannot be billed using 99213TH.

Visits or services for medical conditions unrelated to prenatal care may be billed using the appropriate procedure code along with the appropriate modifier: -25, -59, or -79. The diagnosis code reflecting the unrelated condition must appear on the claim and the description of the services must be related in the member's medical record.

WV Medicaid covers the following CPT codes for maternity services:

- 59409 - Vaginal delivery only (with or without episiotomy and/or forceps)
- 59410 - Vaginal delivery only, including postpartum care
- 59412 - External cephalic version, with or without tocolysis
- 59414 – Delivery of placenta (separate procedure)
- 59430 - Postpartum care only (separate procedure for six to eight weeks post-delivery)
- 59514 - Caesarean delivery only
- 59515 - Cesarean delivery only, including postpartum care
- 59612 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
- 59614 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy, and/or forceps) including postpartum care
- 59620 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
- 59622 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care

WV Medicaid will not reimburse for the following global maternity-related procedure codes or the following bundled services codes:

- 59400 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- 59425 - Antepartum care only; 4-6 visits
- 59426 - Antepartum care only; seven or more visits
- 59510 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- 59610 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- 59618 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

  The preceding bundled maternity codes are not reimbursed because Medicaid members often change physicians or managed care entities during maternity care, which greatly complicates or precludes the use of global codes to pay for maternity care.

59414 will only be reimbursed when an infant is delivered by someone other than the provider (i.e., nurse or paramedic) and the provider delivers the placenta and reviews the case. This code cannot be billed along with a vaginal or cesarean section delivery code.

The following multiple surgical rules govern the coding of, and reimbursement for, deliveries involving multiple babies:

- Both babies delivered vaginally: CPT 59409 (Twin A) and 59409-51 (Twin B)
- One twin delivered vaginally and one twin delivered by C-section: CPT 59409-51 (Twin A) and

59514 (Twin B)

- Multiple babies delivered by C-section (CPT 59514). This code must be used only once because only one caesarian procedure was performed.

CPT 99440 is used for newborns requiring life support following delivery; specifically, when providing positive pressure ventilation and/or chest compressions in the presence of inadequate ventilation and/or cardiac output.

Attendance at ―delivery" (when requested by the delivery physician) and initial stabilization of newborn (CPT 99436) is covered by WV Medicaid. The delivering physician must document the request in the member's medical record and explain the reasons for the request. The statement ―high risk delivery" is **not** sufficient to document the procedure's necessity.

Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output (CPT 99440) cannot be billed with 99436.

519.10.1.1 OBSTETRICAL ULTRASOUNDS/FETAL NON-STRESS TESTS

WV Medicaid covers obstetrical ultrasounds and fetal non-stress tests when medically necessary and in accordance with the criteria for high risk pregnancies established by the American College of Obstetrics and Gynecology (ACOG). Obstetrical ultrasounds on a routine basis or for determining the gender of the fetus are not covered.

Documentation of medical necessity for all ultrasounds and fetal non-stress tests is required. An office visit on the same date of service as an ultrasound or fetal non-stress test performed in the physician's office is billable only if a distinct, separately identifiable reason for the visit is documented in the member's medical record. The E&M procedure code must be billed with modifier 25.

If an ultrasound or fetal non-stress test in the physician's office, a separate interpretation of the results must be documented in the member's medical record in order to obtain reimbursement.

Any ultrasound performed before the 17th week of pregnancy must have documentation of medical necessity since there is a high false negative rate (Guidelines for Ultrasound as Part of Routine Prenatal Care, Journal of the Society of Obstetricians and Gynecologists of Canada, No. 28, 1999).

Medicaid follows ACOG Guidelines for fetal non-stress testing. Since testing prior to 28 weeks is not accurate, such testing will require documentation of medical necessity. Documentation of medical necessity must be retained in the member's medical record. ***These tests will be monitored for over utilization or inappropriate use.***

A referral from the PAAS PCP is not required for maternity services provided to PAAS members.

519.10.2 PREGNANCY TERMINATION

WV Medicaid covers pregnancy termination when the attending physician determines, in consultation with the member, that termination is medically advisable. Before making the determination, the physician must discuss the possible pregnancy termination with the member in light of her age, physical, emotional, psychological, and familial circumstances.

Certification by the physician is required for payment. A copy of the certification form to terminate a pregnancy can be accessed through the Unisys webpage which is located at www.wvmmis.com. The completed and signed form must accompany all claim forms for pregnancy terminations.

Attachment 5 lists the CPT codes physicians must use to report pregnancy termination procedures

and summarizes the services represented by these codes.

519.10.2.1 DRUG RU-486 (MIFEPREX)

WV Medicaid covers pregnancy termination using the drug RU-486 subject to the physician's compliance with all of the federal and manufacturer's requirements listed below. An appropriately executed physician certification for pregnancy termination form must be submitted for this service. The physician is required to maintain, on file at their practice location and available for review upon request, a copy of the order form/prescriber's agreement, certifying compliance with all manufacturer's prescribing requirements, including guidelines for use of this product, and an agreement, signed by the Medicaid member prior to the treatment, acquiescing to the procedure.

Reimbursement for pregnancy termination utilizing RU-486 includes:

- A visit for administration of three Mifepristone pills
- A second visit two days later for administration of Misprostol, if termination of the pregnancy cannot be confirmed
- A follow-up visit within two weeks to ensure and document that the abortion is complete.

Under federal law, Mifeprex must be provided by or under the supervision of a physician who meets the following qualifications:

- Ability to assess the duration of pregnancy accurately
- Ability to diagnosis ectopic pregnancies
- Ability to provide surgical intervention in cases of incomplete abortion or severe bleeding, or have made plans to provide such care through others, and are able to assure member access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.

Following completion of the pregnancy termination service, the physician may bill using CPT codes S0190, S0191, and/or S0199.

Payment for S0199 includes laboratory services and ultrasounds. If these services are referred by a physician, the physician must pay the provider of the service and Medicaid cannot be billed.

If it is decided during the first visit that the member is not a candidate for this type of pregnancy termination, the physician may bill the appropriate E&M code.

519.10.3 STERILIZATION

Based on Federal Social Security Act requirements, WV Medicaid covers the sterilization of a male or female member if the following conditions are met:

- The member is at least 21 years of age at the time consent is given; i.e., when he/she signs and dates the consent form.
- At least 30 days, but not more than 180 days, have elapsed since the date of informed consent and the date of sterilization.
- The two exceptions to these conditions are:
  - Premature Delivery - A member may be sterilized at the time of premature delivery if informed consent was obtained at least 30 days before the expected date of delivery AND at least 72 hours have passed from the time the consent form was signed to the time of sterilization.
  - Emergency Abdominal Surgery - A member may be sterilized at the time of emergency abdominal surgery if at least 72 hours have passed since the informed consent was given (Cesarean sections are not emergency abdominal surgery for purposes of this exception).

In order to establish the 72-hour period, the specific time of the signing of the consent form is necessary. If premature delivery is indicated on the consent form, the member's expected delivery date must be indicated. If emergency abdominal surgery is indicated, the circumstances of the emergency must be explained. If both cases, the space for the condition that does not occur must be crossed out.

Informed consent is the voluntary assent from an individual that he/she has been informed orally of, and given the opportunity to, question and receive satisfactory answers concerning sterilization. Informed consent may not be obtained while the member is in any one of the following conditions:

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol or other substance that affects the individual's awareness
- Under anesthesia.

The consent form previously prescribed and distributed by the United States Department of Human Services (DHHS) should be used. The "State Agency Copy" of the consent form must be submitted to P.O. Box 2254, Charleston, WV 25328-2254. WV Medicaid uses the sterilization consent form deve1oped/approved by the Federal DHHS. A copy of the sterilization consent form can be accessed through the Unisys webpage which is located at www.wvmmis.com. It must be signed and dated by the:

- Member who wants to be sterilized
- Interpreter, if applicable
- Person who obtained the consent
- Physician who performed the sterilization procedure.

On the sterilization consent form:

- The interpreter's statement must be completed only if the member does not understand the language on the consent form or the language used by the person obtaining consent and needs an interpreter. If this section is used, the interpreter must sign and date the consent form, using the date informed consent was given.
- The physician must fully complete the ~~"P~~hysician's Statement" section.
- The ~~"D~~ate of Surgery" must list the specific date; "to be scheduled" and "after delivery" is not acceptable.
- The ~~"D~~ate of Physician's Signature" must occur within one day of the date of surgery.

The person who obtains the informed consent must answer any questions the member may have concerning the procedure and provide orally the following information to the member who is considering sterilization:

- Advise the member he/she may withhold or withdraw consent at any time prior to the procedure without affecting his/her right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which he/she may otherwise be entitled,
- Explain alternate methods of family planning with emphasis that sterilization is considered to be irreversible,
- Explain thoroughly all forms of sterilization procedures with special emphasis on the specific procedure being planned for this individual,
- Explain thoroughly the specific sterilization procedure to be performed and describe fully its advantages and disadvantages, including a thorough discussion of the discomforts and risks that

may accompany or follow the procedure. The explanation must include a description of the effects of the anesthetic to be used,
- Advise that the sterilization will not be performed for at least 30 days unless an exception (i.e., premature delivery or emergency abdominal surgery) applies,
- Make a copy of the consent form available to the individual,
- Make suitable arrangements to ensure the above information is effectively communicated to any individual not understanding the language on the consent form and to any individual who is handicapped in any way that would prevent a full understanding of the procedure (i.e., deaf or blind). If necessary, make arrangements for an interpreter prior to the consent form being signed. The individual must also be permitted to have a witness of his/ her choice present when consent is given,
- Follow any additional State or Local laws.

The sterilization consent may be sent with the claim or separately. Photocopies or faxes of the Sterilization Consent Form are acceptable. The photocopy or fax must be an exact copy of the actual form in the member's record. If the consent form is not attached or on file, all claims with a sterilization diagnosis and/or a sterilization procedure will ~~p~~end" for review. If a consent form is not received within 60 days, the claim will deny.

Procedures may have been done unilaterally, but did not render the member sterile because the other tube/ovary had not been previously removed. These must be billed on paper with the patient history, physical exam, pathology report and operative report attached to the claim and sent to P.O. Box 2254, Charleston, WV 25328-2254.

No Medicaid payments will be made unless the member has voluntarily given informed consent. WV Medicaid does not cover sterilizations under any of the following situations:

- Member is under 21 years of age at the time the consent form is signed
- Member is mentally incompetent
- Member is institutionalized
- Sterilization by court order
- Hysterectomy solely to achieve sterilization.

Attachment 6 lists the CPT codes physicians must use to report sterilization procedures and summarizes the services represented by these codes.

The requirements in this section also apply to Managed Care entities which provide services to Medicaid members.

519.10.4 HYSTERECTOMY

WV Medicaid covers hysterectomies performed for medical reasons regardless of the member's age. Federal regulations ensure that women can make informed and voluntary choices and emphasize a hysterectomy is not an appropriate or acceptable means of sterilization. A medically necessary hysterectomy is covered when:

- The person who performs the hysterectomy has informed the member and her representative, if any, orally and in writing the hysterectomy will render the member permanently incapable of reproduction
- The member or her representative has signed and dated the hysterectomy acknowledgment form.

The hysterectomy acknowledgment form will be accepted by WV Medicaid regardless of whether it

was signed by the member before or after the procedure. However, when the member signs the acknowledgment form after the surgery, the member's records must contain language which clearly states she was informed before surgery of the consequences of the surgery (i.e., it would render her sterile) and that the member was competent to sign.

WV Medicaid does not cover a hysterectomy that was performed solely to render a member incapable of reproduction; even when there are other indicators for a hysterectomy.

The physician who performs a medically necessary hysterectomy must complete and sign an acknowledgment form except under the two following conditions:

- The member was already sterile when the hysterectomy was to be performed
- The member requires a hysterectomy because of a life-threatening emergency (e.g., the member is in imminent danger of loss of life) for which the physician determines prior acknowledgment is not possible.

The physician who performs the hysterectomy must certify in writing on the Physician's Certification Form that the exception conditions are met. If the member was already sterile at the time of the hysterectomy the physician must indicate the cause of the sterility. If the hysterectomy was performed under a life-threatening emergency in which the physician determined prior acknowledgment was not possible, the nature of the emergency must be documented. An example of a life-threatening emergency that does not require an acknowledgment statement is a hysterectomy necessitated by a perforated uterus or an uteroplacental apoplexy.

WV Medicaid accepts photocopies or faxes of the Hysterectomy Acknowledgement Form as acceptable documentation. A photocopy or fax must be an exact copy of the actual signed form and contain all the required signatures. The provider must retain the original copy of the Hysterectomy Acknowledgement Form. This form, as well as the Physician's Certification Form to perform a hysterectomy, can be accessed through the Unisys webpage which is located at www.wvmmis.com.

The acknowledgment form or physician certification may be submitted with the claim or separately. If the appropriate form is not on file or submitted with the claim, it will suspend for review. No service related to the hysterectomy will be reimbursed unless appropriate documentation is received. If the documentation is not received within 60 days, the claim will deny.

If a physician performs a hysterectomy on an individual who later becomes eligible for Medicaid and Medicaid eligibility is retroactive to the date on or before the date which the hysterectomy was performed, the physician may bill Medicaid for the surgery if he/she certifies in writing:

- The member was informed before the operation the hysterectomy would make her permanently incapable of reproduction
- The member was already sterile and the cause of the sterility
- The hysterectomy was performed under a life-threatening emergency for which he/she determined prior acknowledgment was not possible. The physician must describe the nature of the emergency.

Attachment 7 lists the CPT codes physicians must use to report a hysterectomy and summarizes the services represented by these codes.

519.10.5 FAMILY PLANNING SERVICES

Family Planning services may be provided as part of the practitioner's routine care. If the practitioner does not wish to provide these services, the member must be informed they may go to any participating practitioner offering these services.

WV Medicaid does not make separate payment for obtaining a Pap smear. This is included in the E&M service. Laboratory services for Pap smears and other medically necessary tests are covered with payment to the performing pathologist and laboratory respectively.

Attachment 8 contains charts listing diagnostic and procedure codes covered for family planning services.

519.11 SPECIALTY SERVICES

Specialty Services refers to services provided to Medicaid members by specialists in a specific field of medicine.

519.11.1 PAIN MANAGEMENT

WV BMS covers a variety of pain management treatment modalities. Prior authorization is required if more than three months of treatment is necessary. Regardless of the treatment for pain management, the following information must be submitted with the physician‘s order and request for prior authorization:

- Number of additional visits and weeks of treatment requested, such as three visits a week for four weeks
- Progress the member has already made toward short-term and long-term goals since therapy began
- Reasons for short-term and long-term goals requiring extended services
- Treatment plan to reach goals
- Estimated number of visits to reach goals

WV Medicaid does not cover hypnosis, acupuncture, prolotherapy, any treatment not approved by the FDA or therapy not accepted as effective by the medical community for chronic pain managment.

DOCUMENTATION REQUIREMENTS

Documentation in the hospital‘s records and/or the therapist's records must contain the following information about the pain management a member received:

- Diagnosis – The diagnosis must document the member‘s need for pain management. A brief description of the member‘s medical condition may be necessary.
- Date of injury or onset of illness, if applicable.
- Name and Medicaid provider number of the physician prescribing the pain management and the physician's order itself.

Documentation of the service provided on the date billed must substantiate fully the amounts charged to WV Medicaid. The documentation must be clear, concise, demonstrate medical necessity and be made available upon request to the BMS or its representative.

519.11.1.1 OSTEOPATHIC MANIPULATIONS

WV Medicaid covers the following osteopathic manipulative services:

- 98925 Osteopathic manipulative treatment, one to two body regions involved
- 98926 Osteopathic manipulative treatment, three to four body regions involved
- 98927 Osteopathic manipulative treatment, five to six body regions involved
- 98928 Osteopathic manipulative treatment, seven to eight body regions involved
- 98929 Osteopathic manipulative treatment, nine to ten body regions involved.

Body regions include head, cervical, thoracic, lumbar, sacral, pelvic, lower and upper extremities, rib cage, abdomen, and viscera.

An E&M code cannot be billed with any manipulative service unless it is related to a distinctly separate service. However, if the manipulative service is distinctly a separate service, then modifier 25 must be used and the service documented in the patient's record.

Medicaid coverage is limited to a combined total of 40 manipulative treatments (not per procedure code) in a 12-month period.

519.11.1.2 PARAVERTEBRAL FACET JOINT BLOCK AND DENERVATION

Prior authorization is required if treatment is required more often than every three months. Treatment of more than three levels per side is considered excessive and will be denied. Use the LT and RT modifiers to indicate a unilateral procedure at any level. If both sides of any level are treated, use the -50 modifier. The fluoroscopy code, CPT 76005 may be used with these procedures. When more than one drug, i.e. anesthetic or steroid, is injected into the same site, only one injection codes is allowed.

The following chart lists the covered services in this pain management modality.

Procedure Code	Description	Coverage
64470	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level	One unit per date of service
64472	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	Two units per date of service
64475	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level	One unit per date of service
64476	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	Two units per date of service
64622	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level MED:CIM 35-17	One unit per date of service

Procedure Code	Description	Coverage
64623	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) MED:CIM 35-17	Two units per date of service
64626	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level MED:CIM 35-17	One unit per date of service
64627	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure) MED:CIM 35-17	Two units per date of service
All of the above listed procedure codes are subject to the bilateral modifier (50).		

519.11.2 WOUND THERAPY

WV Medicaid covers a variety of modalities for wound care. Wound care encompasses local treatment such as topical medications, dressings, pressure relief, tissue healing therapies or debridement. This may also involve systemic treatment to improve underlying nutritional needs, infections, circulatory limitations or management of other contributory factors. Wounds are classified according to the following:

- Stage I Non-blanchable erythema or superficial redness with skin intact
- Stage II Partial thickness skin loss involving epidermis and/or dermis
- Stage III Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia
- Stage IV Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures.

Indications and Limitations of Coverage/Medical Necessity

The following criteria must be met for wound care to qualify for reimbursement by WV Medicaid:

- The services must be medically necessary in the treatment of the member‘s condition. Medical necessity is defined as:
  - The status of the dermal surface and/or wound is such that the treatment will make a significant improvement in the wound in a reasonable and generally predictable period of time.
  - There is an expectation that treatment will substantially effect tissue healing and viability, reduce or control tissue infection, remove necrotic tissue or prepare that tissue for surgical management.
  - The member‘s expected restoration potential must be significant in relation to the extent and duration of treatment required to achieve that potential. If wound closure is not a goal then the expectation is to optimize recovery and establish an appropriate non-skilled maintenance program.
- For criteria not otherwise listed, the BMS follows Medicare‘s criteria for the specified service.

Clinical Indicators

Some clinical indicators that may be used to determine medical necessity are:

- A history of slow-to –heal wounds
- Significant health factors that impair recovery
- Multiple, severe or extensive soft tissue injuries and/or wounds
- Increasing severity of tissue impairment, infection, or necrosis, undermining or an increase in size.

Documentation

Medical records should include the following information:

- Practitioner‘s order: Services may only be provided on the basis of a practitioner‘s written, signed and dated order
- Evaluation: The purpose of a wound care evaluation is to determine both the medical necessity and the appropriate type of skilled service. The evaluation should demonstrate the following:

- The type of tissue involvement; the severity of tissue destruction; undermining or tunneling, necrosis, infection, or evidence of reduced circulation. If infection has developed, the member's response to this infection should be described.
- The size and depth of tissue involvement and its location
- The medical and mental condition and all health factors that may influence the member's ability to heal tissue
- The prior response to other therapies
- A determination of the appropriate treatment plan and therapeutic goal(s) including specific objectives, goal-specific treatment plan and the expected frequency and duration of the skilled treatment
- If the wound therapy is being performed by other than a physician, (e.g., home health agency, physical therapist), an evaluation must be performed by a licensed practitioner who must see the member at least once every thirty days during treatment.

- Treatment Plan: This plan must include specific functional goals and a reasonable estimate of when they will be reached. The modalities/procedures, frequency, and duration of treatment must be defined in the plan. This plan must be reviewed and recertified by the ordering practitioner every 30 days. If this therapy is performed by other than the attending practitioner, the plan must be reviewed and recertified by the attending provider every 30 days and should be completed by licensed professional only.
- Treatment Notes: Documentation for each treatment should specify date and time, types of treatment, status of the member's contributory factors to the wound (i.e., status of infection or level of diabetic control), member and wound/or tissue status and the response to the treatment.
- Progress Reports: Weekly and monthly summaries should systematically describe the need for skilled service. Each progress report should describe changes in risk, severity or size of the wound with a comparison to the previous week or month. If the goals for that week or month are not met, or the wound status has worsened, then describe or detail any associated factors that may account for this condition. If the wound has worsened, there should also be documentation that the physician has been informed and any needed changes in the wound care protocol have been made. A photograph or wound drawing may be useful in reporting the status of the wound. There should be documentation that the provider has been informed if the therapy is administered by other than the attending provider.
- Discharge Summary: The final report that provides the measurement(s) and description of the dermal surface/wound at the time of admission or initiation of treatment and at the time of discharge, and the reason(s) skilled services are no longer required. The summary specifies all the discharge recommendations, the member's or caregiver's capability to care for the residual wound, and prevent further dermal lesions.

The following modalities for wound treatment are not covered by BMS:

- Procuren and other platelet releasate
- Topical Hyperbaric Oxygen Therapy
- Non-contact Normothermic Wound Therapy (NNWT). NNWT promotes wound healing by warming a wound to a predetermined temperature. (A6000, E0231, E0232)
- Maggot therapy
- Alloderm, Biobrane (considered a dressing), Celaderm (not FDA approved), Epicel, EZ Derm, Integra (non-human dermal template, Q0182), Laserskin (available in Europe only), Oasis collagen dressings (A6021-A6024)
- Electrical stimulation and electromagnetic therapy (G0281, G0282, G0283, G0295, G0329) for

wound care are not covered by BMS. (97014 and 97032 are not covered procedure codes for wound therapy.)

- Monochromatic Infrared Therapy (the Anodyne Therapy System) is not covered (E0221 and 97026).

Covered Services

- Wound repairs – local anesthesia is included in reimbursement of this service.
  - Wound closure using tissue adhesives only
  - Wound repair – The CPT procedure used to report the repair is dependent on the location of the wound, classification of the repair and length of the repair. WV Medicaid has not adopted CPT Manual definition of simple intermediate and complex repair, but follows those of CMS. WV Medicaid defines these as follows:
    - Simple repair procedure code should be used if the wound involves the skin and subcutaneous tissue
    - Intermediate repair should be used to close one or more of the deeper fascial layers in addition to the skin and subcutaneous tissue.
  - Wound closure with steri-strips or butterfly band aids is included in the E&M service and not separately billable.
  - Wound repairs of specific anatomic parts such as lips or eyelids have pertinent specific codes, as do repairs of internal structures.
- Debridement
  - Debridement performed by licensed physical therapists should be coded with 97597 and 97598 which represent non-surgical debridement, not requiring anesthesia. This service can also be provided by the attending provider.
    - CPT 97597- Removal of devitalized tissue from wound(s), selective debridement, without anesthesia, (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps) with or without topical application (s), wound assessment, and instructions for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters.
    - CPT 97598- Removal of devitalized tissue from wound(s), selective debridement , without anesthesia,(e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps) with or without topical application (s), wound assessment, and instructions for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters.
  - The status of the wound(s) including size should be adequately documented.
  - Debridement in this sense is covered only to promote wound therapy, and should not be reported in the same claim with the surgical debridement codes, 11040 – 11044.
  - Debridement during a repair procedure is bundled with the repair procedure.
  - Debridement of the wound is included in all repair codes. If in rare cases there is greater amounts of devitalized tissue removed, significant and extensive debridement performed in addition to the wound repair, modifier 59 could be added to the debridement code. Documentation in the member‘s record must substantiate the use of a debridement code with the 59 modifier in addition to the repair code.

- Codes 11010 – 11012 are used only for debridement associated with open fractures and open dislocations. These codes are not used for treatment of ulcers or wounds that are not associated with open fractures/open dislocations. Documentation must substantiate the medical necessity for the use of debridement codes in these situations.

- Negative pressure vacuum pump for wound healing – WV Medicaid follows Medicare criteria for the medical necessity of this modality.
- Regranex:
  - This agent is prescribed to the member when:
    - There is a diagnosis of a diabetic neuropathic ulcer, extending into the subcutaneous tissue, on the lower extremity
    - There is no evidence of infection in the wound and anti-infective therapy is being employed
    - The wound is full thickness (Stage III or IV)
    - The wound is free of necrotic debris
    - The member has adequate circulation in the area of the wound
    - Off-loading of pressure to the wound has been accomplished
    - Member and/or caregiver have been instructed on the appropriate application, storage and cost of Regranex
    - Regranex is prescribed appropriately (once-daily application, with no concomitant topical medications).
  - Prior authorization for quantities of Regranex that exceed 3 tubes in a 90-day period or therapy that extends beyond 12 weeks will be granted only if:
    - The above conditions have been met, and
    - The wound size requires additional quantities of gel to provide adequate coverage, as directed by the manufacturer. (Each square centimeter of ulcer surface requires 0.25 – centimeter length of gel)

      or

    - There is evidence of healing in the initial 90-day period and additional application is required for complete healing.
- Hyperbaric Oxygen Therapy (HBOT). Systemic HBOT is covered for the treatment of non-infected diabetic ulcers when the criteria are met. See Section 519.12.2 of this chapter for information on HBOT.
- Engineered skin – Apligraf and Dermigraft are covered for the treatment of diabetic ulcers. WV Medicaid follows CMS criteria for medical necessity and reimbursement of these agents. Orcel and Transcyte are analogues used for burns.
- Miscellaneous dressings are covered when listed as covered in the DME manual. Dressings and supplies for office procedures are part of the global fee for the procedure and not separately billable.

519.11.3 PSYCHIATRIC SERVICES

Outpatient psychiatric services must be registered with BMS' contracted agent for Behavioral Health Services prior to services being rendered. All outpatient psychiatric services provided by the psychiatrist, or Master's Level Social Worker, or Master's Level counselor in their employ must also be registered and assigned an authorization number by the contracted agent.

Psychiatric services are not the responsibility of the managed care organization, nor do they require PAAS approval prior to rendering services. Claims must be billed to Medicaid for reimbursement.

See **Attachment 9** for policies and regulations related to outpatient psychiatric services.

519.11.4 LABORATORY AND PATHOLOGY SERVICES

WV Medicaid covers various pathology services and offers a comprehensive scope of basic and extended clinical laboratory services to Medicaid members, subject to medical necessity and appropriateness criteria and prior authorization requirements.

519.11.4.1 LABORATORY SERVICES

A practitioner may bill for laboratory services if the practitioner owns a CLIA certified lab, or if the practitioner has CLIA certification to perform CLIA waived testing. CLIA waived tests (a list of which are available on the CMS CLIA website) are tests that can be performed within an office laboratory setting, but for which a CLIA certification is still necessary. Provider-performed Microscopy Services (PPM) also require certification. These tests include pin worms preps, koh scrapings etc. Physicians billing waived laboratory tests or PPM tests must have CLIA certification on file with the Medicaid Program.

Separate charges made by practitioners for drawing or collecting specimens are allowable whether or not the specimens are referred to outside laboratories. Payment is made only to those extracting the specimen. Only one collection fee is allowed for each type of specimen (e.g., blood, urine) for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter. A specimen collection fee is allowed when drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.

NONCOVERED LABORATORY RELATED SERVICES:

- Routine reflex testing is not covered. Reflex testing occurs when initial test results are positive or outside normal parameters and indicate that a second related test is medically appropriate. This is covered only when specifically ordered by the physician, that a second test would be performed only under conditions clearly indicated on the requisition.
- Separate payment will not be made for obtaining a blood sample through a finger, heel or ear stick.
- Separate charge for collecting a Pap smear or throat smear are not covered, as these services are included in the E&M visit.
- A practitioner may not bill an office visit if the sole purpose of the visit was to obtain laboratory work.
- A practitioner may not bill a laboratory fee for conveying or interpreting the laboratory results to the patient. This is considered part of the E&M visit for which the patient sought medical care.

519.11.4.2 PATHOLOGY SERVICES

A pathologist will only be paid for the professional component of physician pathology services. For those procedure codes that do not have a technical and professional component, do not bill modifier 26. The CPT code for the procedure with modifier 26 is paid according to the RBRVS fee schedule. Medicaid payment for the professional component of consultative anatomical and surgical pathology

services must be requested by an attending practitioner regarding an abnormal condition and results in a written report by the pathologist. Covered consultative services may be billed with CPT 80500 Clinical pathology consultation; limited, without review of the member's history and medical records and CPT 80502 Clinical pathology consultation; comprehensive, for a complex diagnostic problem with review of member's history and medical records.

NONCOVERED PATHOLOGY SERVICES

- Separate payment for reviews of laboratory services for quality assurance purposes.
- Autopsies - West Virginia Medicaid does not pay for autopsies and/or supervisory pathology services.
- Fertility services such as embryo/sperm collections and banking.

519.12 MEDICAL SERVICES

WV Medicaid covers the following medical services.

519.12.1 CALORIC VESTIBULAR TESTING

WV Medicaid covers up to four irrigations provided to a member on a single date of service. The procedure code for this service, 92543, is divided into technical and professional components. A physician must both perform and interpret the ear irrigation(s) in order to bill the total service. When performing only one component, the physician must bill 92543-TC for the irrigation or 92543-26 for the interpretation. **When providing both, this service must not be unbundled.**

519.12.2 HYPERBARIC OXYGEN THERAPY (HBOT)

WV Medicaid covers hyperbaric oxygen therapy provided in an inpatient or outpatient hospital setting for certain medical conditions identified below.

For WV Medicaid to reimburse hyperbaric oxygen therapy, the physician must be in constant attendance during the entire procedure and carefully monitor the member during therapy and be immediately available if a complication develops. (The physician must be on site during the entire treatment.) In general, hyperbaric oxygen does not require prior authorization, but a physician's order and documentation for the treatment's medical necessity must be kept in the member's medical record. Hyperbaric oxygen therapy must not be indefinite in duration. If HBOT is medically necessary beyond two months, prior authorization is required from BMS' contracted agent regardless of the member's condition. The physician's order and medical documentation that substantiates medical necessity must be faxed or mailed to BMS' contracted agent.

Coverage of hyperbaric oxygen therapy is limited to members with the following medical conditions and diagnosis codes:

- Acute carbon monoxide intoxication (ICD-9-CM diagnosis 986)
- Decompression illness (ICD-9-CM diagnosis 993.2, 993.3)
- Gas embolism (ICD-9-CM diagnosis 958.0, 999.1)
- Gas gangrene (ICD-9-CM diagnosis 040.0)
- Acute traumatic peripheral ischemia. Hyperbaric oxygen therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb or life is threatened. (ICD-9-CM diagnosis 902.53, 903.01, 903.1, 904.0, 904.41)
- Crush injuries and suturing of severed limbs. As in the previous condition, hyperbaric oxygen therapy would be an adjunctive treatment when loss of function, limb or life is threatened. (ICD-9-

CM diagnosis 927.00-927.03, 927.09-927.11, 927.20-927.21, 927.8-927.9, 928.00-928.01, 928.10-928.11, 928.20-928.21, 928.3, 928.8-928.9, 929.0-929.9, 996.90-996.99).

- Progressive necrotizing infections (necrotizing fasciitis) (ICD-9CM diagnosis 728.86). Meleney ulcers (necrotizing soft tissue infections that are a result of clostridium or synergistic aerobic-anaerobic infection).
- Acute peripheral arterial insufficiency (ICD-9-CM diagnosis codes 444.21, 444.22, and 444.81).
- Preparation and preservation of compromised skin grafts (not for primary management of wounds) (ICD-9-CM diagnosis 996.52; excludes artificial skin graft). Hyperbaric oxygen therapy use is limited to the loss of viability of full thickness, free vascular, or pedicle flap grafts. Hyperbaric oxygen therapy must be used after signs and/or symptoms indicate compromise of graft. It is not covered for split thickness grafts or the initial preparation of the body site for a graft.
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management (ICD-9-CM diagnosis 730.1).
- Osteoradionecrosis as an adjunct to conventional treatment (ICD-9-CM diagnosis 526.89).
- Soft tissue radionecrosis as an adjunct to conventional treatment (ICD-9-CM diagnosis 990).
- Cyanide poisoning (ICD-9-CM diagnosis 987.7, 989.0).
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment, (ICD-9-CM diagnosis 039.0-039.4, 039.8, 039.9).
- Lower extremity diabetic wound if the following criteria are met:
  - The member has type 1 or 2 diabetes and has a lower extremity wound that is due to diabetes. (ICD-9 diagnoses codes 250.70-250.73, 250.80-250.83, 707.0, 707.10, 707.12-707.14, and 707.19);
  - The member has a wound classified as Wagner grade III or higher; and
  - The member has failed an adequate course of standard wound therapy. The use of HBOT will be covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care. Standard wound care in members with diabetic wounds includes:
    - Assessments of a member's vascular status and correction of any vascular problems in the affected limb if possible,
    - Optimization of nutritional status,
    - Optimization of glucose control,
    - Debridement by any means to remove devitalized tissue,
    - Maintenance of clean, moist bed of granulation tissue with appropriate moist dressings,
    - Appropriate off-loading,
    - Necessary treatment to resolve any infection that might be present,

    Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBOT. Continued treatment with HBOT is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

The only WV Medicaid-covered indications for HBOT are those specified above. No program payment may be made for any conditions other than those listed above.

The provider must code to the highest level specified in the ICD-9-CM, (e.g., fourth or fifth digit). However, correct use of an ICD-9 code does not assure coverage of a service.

BILLING CODES

The following procedure codes are used to bill for hyperbaric oxygen therapy:

- Physician - 99183 Physician attendance and supervision of hyperbaric oxygen therapy, per session. (Physician billing is per session, not per minute.)
- Hospital - C1300 Hyperbaric oxygen under pressure, full body chamber, per 30-minute intervals. Separate payment for inpatient hyperbaric oxygen therapy is not made because payment is in the Diagnosis Related Group (DRG) payment rate.

The amount of time billed includes only the time the member spends in therapeutic pressure. Billed time must not include descent or ascent time or air-break time.

DOCUMENTATION REQUIREMENTS

Medical documentation to support the conditions for which hyperbaric oxygen therapy is provided must include:

- An initial assessment including a detailed medical history and physical exam
- Physician progress notes
- Any communication between physicians detailing past or proposed treatments
- Treatment records for hyperbaric oxygen therapy
- Culture reports to confirm the infection status of the member
- Definitive x-ray findings and positive culture to confirm the diagnosis of osteomyelitis
- Definitive x-ray findings to establish the diagnosis of osteoradionecrosis
- For soft tissue radionecrosis, clinical photographs of the necrotic site must be available in the medical record
- Documentation must support the continued efficacy and need for treatment.

The need for more than one service daily will be reviewed.

PHYSICIAN CREDENTIALS

A physician must be credentialed by the hospital in which the therapy is being performed, including hyperbaric medicine, management of acute cardiopulmonary emergencies, and placement of chest tubes.

Credentialing includes the following minimum requirements:

- Training, experience, and privileges within the institution to manage acute cardiopulmonary emergencies, including advanced cardiac life support and emergency myringotomy.
- Completion of a recognized hyperbaric medicine training program as established by either the American College of Hyperbaric Medicine or the Undersea and Hyperbaric Medical Society with a minimum of 40 hours of training and documented by a certificate of completion
- Continuing medical education in hyperbaric medicine of a minimum of 16 hours every two years after initial credentialing.

The hospital must keep documentation of the physician‘s credentials on file.

Since hyperbaric therapy requires the physician be ACLS certified with adequate support staffing and equipment, reimbursement of this service will be restricted to the inpatient or outpatient hospital setting. **Exception: Free standing facilities must meet all credentialing requirements listed above.**

Team coverage for cardiopulmonary resuscitation must be immediately available during the operational hours of the hyperbaric chamber.

EXCLUSIONS

Hyperbaric oxygen therapy is not covered to treat the conditions listed below. No exceptions or prior authorizations are available for any of the listed conditions.

- Cutaneous, decubitus, and stasis ulcers
- Congenital conditions, such as cerebral palsy, autism, mental retardation. Chronic peripheral vascular insufficiency
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility
- Myocardial infarction
- Cardiogenic shock
- Sickle cell anemia
- Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency
- Acute or chronic cerebral vascular insufficiency
- Hepatic necrosis
- Aerobic septicemia
- Nonvascular causes of chronic brain syndrome (Pick‘s Disease, Alzheimer‘s Disease, Korsakoff‘s Disease)
- Tetanus
- Systemic aerobic infection
- Organ transplantation
- Organ storage
- Pulmonary emphysema
- Exceptional blood loss anemia
- Multiple sclerosis
- Arthritic disease
- Acute cerebral edema
- Mental retardation
- Traumatic brain injury

Topical application of oxygen does not meet the definition of hyperbaric oxygen therapy. No Medicaid payment will be made for the topical application of oxygen.

519.12.3 HIGH FREQUENCY CHEST WALL OSCILLATION, AIRWAY CLEARANCE THERAPY: RESPIRATORY VEST SYSTEM

WV Medicaid covers respiratory vest systems for eligible members including Medicaid-eligible children in the Children‘s Specialty Care Program. This devise must be prior authorized before its use can commence.

All of the following criteria must be met before consideration will be given to coverage of the airway clearance therapy/respiratory vest system:

- The devise must be prescribed by a physician (MD/DO) specializing in pulmonary or critical care medicine
- The letter requesting prior authorization and the physician‘s prescription for the devise must be in the physician‘s own words and on his/her letterhead/prescription pad. No request from the

manufacturer's reimbursement specialist or patient advocate will be accepted. The original letter and prescription with the physician's original signature must be submitted to BMS' contracted agent.

- A diagnosis of cystic fibrosis, neuromuscular disease, or broncheictasis must be documented and associated with at least three of the following:
  - Peak flow <300 LPM
  - Sputum production of at least 30 ml per day
  - FEV1 <80% of predicted
  - FVC <50% of predicted
  - 25% decrease in small airway score (FEF 25-75%) over past year
  - For bronchiectasis, radiologic evidence of the diagnosis must be provided in addition to the three other measurements
- Failure with flutter valve and manual chest physiotherapy
- Pattern of at least yearly hospitalizations for respiratory illnesses.

Exclusions/contraindications – The respiratory vest system will not be covered if any of the following exist:

- Unstable head or neck injury
- Subcutaneous emphysema
- Bullous emphysema
- Recent skin grafts to chest
- Recent transvenous or subcutaneous pacemaker
- Chest wall pain
- Uncontrolled hypertension
- Intracranial pressure
- Pleural effusions or emphysema
- Active or gross hemoptysis
- Susceptibility to pneumothorax, pneumomediastinum, or cardiovascular instability
- Diagnosis of COPD
- Distended abdomen
- Suspected pulmonary tuberculosis
- Recent spinal injury or surgery (within the past year)
- Rib fractures
- Hemodynamic instability
- Pulmonary edema/congestive heart failure
- Bronchopleural fistula
- Bronchospasm
- Recent esophageal injury (within the past year)
- Recent epidural anesthesia (within the past year)
- Recent spinal infusion (within the past year)
- Surgical wounds
- Burns of chest wall
- Osteoporosis
- Lung contusion
- Osteomyelitis

- Coagulopathy
- Uncontrolled airway at risk for aspiration

Other provisions:

- Only one generator per family can be covered.
- No other respiratory therapy services will be approved after approval of the respiratory airway clearance system.
- Approval of the respiratory airway clearance system will transpire only if other methods of therapy have failed. Documentation of therapies tried and the reason for failure must be kept.
- This devise will not be covered for individuals who are less than two years of age.

Covered diagnoses- The following ICD-9 diagnosis codes will be covered if they are accompanied by documentation of medical necessity and documentation that manual techniques do not work. (Use of this devise will not be covered merely because there is no one available to perform manual techniques.)

- 277.0 Cystic fibrosis
- 335.20 Amyotrophic lateral sclerosis
- 358.0 Myasthenia gravis
- 359 Muscular dystrophies
- 494 Bronchiectasis
- 518.81 Respiratory failure
- 748.61 Congenital bronchiectasis

The diagnoses listed above are the only diagnoses covered. All other diagnoses are not covered for this service.

If approved, this devise will be rented for three months (payment to go towards the purchase price or lease purchase). If applicable, modifier RR will be used to bill the rental period. Continued coverage will be dependant on a follow-up report which must include:

- The outcome – What expected goals were met?
- The number of times used daily and the duration of each treatment
- An assessment of compliance

The only billable procedure code for this service is:

- E0483 High frequency chest wall oscillation air-pulse generator system (includes hoses and vest), each.

Payment for this service will be according to WV Medicaid Program guidelines for Durable Medical Equipment.

Questions regarding this service should be directed to WV Medicaid's contracted agent for Durable Medical Equipment.

519.12.4 CANCER SCREENING

WV Medicaid covers various types of cancer screening.

519.12.4.1 COLORECTAL CANCER SCREENING

WV Medicaid covers colorectal cancer screening tests for high risk members and for members aged 50 and over. Characteristics of the High Risk Individual at high risk for developing colorectal cancer:

- Close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp.
- Family history of familial adenomatous polyposis.
- Family history of hereditary nonpolyposis colorectal cancer.
- Personal history of adenomatous polyps.
- Personal history of colorectal cancer:
- Inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

The following Healthcare Common Procedure Coding System (HCPCS) codes are used to report the service:

- G0104 - Colorectal cancer screening; flexible sigmoidoscopy (service limit: one in 48 months for members age 50 and over)
- G0105 - Colorectal cancer screening; colonoscopy for an individual at high risk (service limit: one in 24 months for members at high risk)
- G0106 - Colorectal cancer screening; (alternative to G0104, screening sigmoidoscopy) barium enema (service limit: one in 48 months for members age 50 and over)
- G0107 - Colorectal cancer screening; fecal-occult blood test, one to three simultaneous determinations (service limit: one in 12 months for members age 50 and over) Screening fecal-occult blood test means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. Fecal occult testing can only be billed by providers who have certification to perform CLIA waived tests.
- G0120 – Colorectal cancer screening; (alternative to G0105, screening colonoscopy) barium enema (high risk). (1 in 24 months/high risk members).

G0106 and G0120 are covered as alternatives to (but not in addition to) G0104 and G0105. G0104 and G0106 cannot be billed for the same episode of care, nor can G0105 and G0120.

Additionally, the preceding ~~"G~~" codes cannot be billed with their equivalent CPT codes. For example:

- G0106 and G0120 may not be billed with CPT 74280
- G0107 may not be billed with CPT 82270
- G0104 may not be billed with CPT 45330
- G0105 may not be billed with CPT 45378.

If during the course of performing a screening procedure, a condition is discovered that warrants further service, the code for the diagnostic procedure must be billed rather than the screening code. Stool DNA analysis as a part of colorectal screening is not covered by WV Medicaid.

519.12.4.2 PROSTATE CANCER SCREENING

West Virginia Medicaid covers yearly digital rectal examination of the prostate for cancer screening, but makes no separate payment for this exam, as it is included as part of the E&M service. PSA (prostate specific antigen testing) is covered for susceptible populations when the appropriate counseling regarding the potential for over diagnosis has been discussed with the patient.

519.12.4.3 BREAST AND CERVICAL CANCER SCREENING

The Breast and Cervical Cancer Screening Program (BCCSP), administered by the West Virginia Department for Health and Human Resources' Bureau for Public Health, provides statewide screening services free of charge or at a minimal fee to low income and uninsured or underinsured women. Women at or below 200 percent of the Federal Poverty Level qualify for services. The BCCSP offers screening mammography and diagnostic services for breast abnormalities to women age 50 and older. Diagnostic services for breast abnormalities are available for women under the age of 50. Cervical cancer screening services are available for women 25 and older. Cervical cancer screening services are also available for women under age 25 with Pap test results of HGSIL.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) effective October 1, 2000, gives states the option to provide medical assistance through Medicaid to eligible women who were screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and found to have breast or cervical cancer, including pre-cancerous conditions. Qualifying patients are eligible for Medicaid benefits while the cancer condition is undergoing active treatment.

The West Virginia Medicaid program covers yearly pap smears for cervical cancer screening in susceptible populations. A separate reimbursement for obtaining the Pap smear is not allowed, as this is considered part of the E&M service and examination. Billing for a pap smear with a laboratory (8000) code is only paid to the pathology facility actually reading the smear. In addition, a separate specimen handling charge is also not covered.

519.12.4.4 MAMMOGRAPHY

West Virginia Medicaid covers yearly screening mammograms for any aged female (according to the guidelines established by the American Cancer Society.) The order must come from the treating provider. If the physician who is performing the test (ordered by a patient‘s doctor) decides the patient needs additional testing procedures based upon the findings of screenings, the testing physician may proceed with appropriate diagnostic testing. The testing provider should receive authorization from the ordering physician (either by phone or fax) for the additional tests believed to be necessary if possible. If this cannot be obtained while the patient is present for the mammography, the testing physician may order those tests necessary as a result of abnormal findings of the screening.

Mammography services are regulated by the Food and Drug Administration. Therefore, a physician who meets the qualification requirements for an interpreting physician may order a diagnostic mammogram based upon the findings.

519.12.5 DIABETES DISEASE STATE MANAGEMENT

The concept of the Medicaid Diabetes Disease State Management Program is based upon the premise that eligible Medicaid members will benefit from a patient-centered health care approach that is responsive to the unique needs and conditions of people living with diabetes.

The program provides for a coordinated approach to the treatment of Medicaid members who have been diagnosed with Type 1, Type 2, or gestational diabetes mellitus. The essential program components of Medicaid‘s disease management program have been developed from the American Diabetes Association Guidelines (ADA), which aim to prevent the development of serious complications from diabetes. Not only will the member‘s PCP or provider (doctor, nurse practitioner) agree to manage the member‘s medical treatment, but will also ensure that self-management skills and diabetes educational needs are met. Practitioners will provide diabetes education or refer

individuals with diabetes to a Certified Diabetes Educator who is enrolled in the Diabetes Disease Management Program. This policy does not change the requirement for PAAS primary care referral.

The components of Diabetes Disease State Management are:

- Evaluation and education, which includes a comprehensive assessment of the member's clinical status, including health care needs, risks, hygiene, and diet, etc.
- A drug therapy evaluation of the member's oral or injectable medication requirements and their ability to self-monitor blood glucose, to recognize emergency conditions, etc.
- Diet management/education including education on diet restrictions, eating patterns, diet and medication interactions, etc.
- Referral to other providers to meet identified health care needs, such as skin and/or wound care, eye or renal care, etc.
- Comprehensive diabetes assessment using a Diabetes Managing Provider Care Tool. (See **Attachments 10 &11**)

  Medicaid members with diabetes will benefit from a patient-centered health care approach that is responsive to their unique needs and conditions. Because the care is patient centered, the most effective treatment options can be implemented that will ultimately prove cost-effective with outcomes and results that are quantifiable and measurable. The evaluation form to be used for initial and ongoing screening for members is the Diabetes Managing Provider Care Tool, which is included with the instructions for this program, and provides for the ADA Guidelines for appropriate treatment of members with diabetes. This form, which is to be completed by the member's Managing Provider, will define the health care and health related support needs of the member.

Requirements for Becoming a Diabetes Management Provider:

Managing providers may be any of the following licensed practitioners:

- Physicians (MD, D.O.)
- Medicaid Enrolled Nurse Practitioners
- Certified Diabetic Educators

In order to be reimbursed for diabetes management extended visits and for comprehensive educational services, Medicaid providers are required to meet the following criteria:

- enroll as a Medicaid provider
- Certified Diabetes Educators may only enroll with West Virginia Medicaid for the provision of diabetes education and self-management skills. Along with the provider enrollment information found in Chapter 300, the CDE must submit a copy of credentials showing current, unrestricted certification as a Certified Diabetes Educator issued by the National Certification Board for Diabetes Educators.
- Demonstrate successful completion of the six hours of web-based training provided by the Bureau for Medical Services and the Diabetes Prevention and Control Program by submitting the provider's Medicaid number via the web upon completion of the training program. This will provide the documentation necessary for BMS to enroll the provider as a provider of diabetes disease management and will allow reimbursement for diabetes disease management service codes. Recertification is required annually via Internet web modules and must be renewed by the original calendar date of certification.

- Document care utilizing the tools provided
- Submit documents for outcome monitoring as required by BMS
- Demonstrate a capacity to provide all core elements of disease state management services, which includes:

    - Comprehensive client assessment and service plan development
    - Assisting the client to access needed services, i.e., assuring that services are appropriate for the client's needs and that they are not duplicative or overlapping.
    - Monitoring and periodically reassessing the client's status and needs.

System Process

The following are directions for completing the on-line course for ~~"~~Diabetes Education for Primary Care Providers":

Begin by accessing the course at www.camcinstitute.org/professional/diabetes/camc.htm. On the course ~~"o~~pening page", click the button labeled ~~"C~~*lick here to begin program*". Fill in your 10-digit Medicaid number, (Physician Assistants will use their employing physician's Medicaid number and personal 4-digit identifier). These number(s) will track your participation. When you access this course the first time, you will be asked to submit your personal demographic information. This information will be retained for you. If necessary, you may edit the information at a later time. Provide valid credit card information for a one-time Credit Processing fee of $30.00 for six hour of continuing education credit. Complete and submit the program pre-test. From the Program Menu Page, you will find a listing of the six module titles. Complete the modules in any sequence you choose.

When all modules have been completed, a link will become available at the bottom of the Program Menu Page for a post course evaluation form and Certificate of Completion processing. Complete Post Course Evaluation form and submit. At this point, a Certificate of Completion is displayed and an automated email is sent to WV Medicaid advising them that you have successfully completed the course. Another automated email is sent to the email address you provided in your demographic information. You may print the Certificate of Completion for your personal records. The automated email that you receive contains a link allowing you access to your electronic certificate for future reference and the option to print additional copies of the certificate. Providers will receive a written notice from Unisys stating the provider file has been updated to allow for reimbursement of Diabetes Educational services with an effective date for billing.

CD's of this program will be available for those who do not have broadband Internet access. However, to use CD version of the course, the computer you use must have dial-up access to the Internet. CDs will be provided upon request, at no charge by contacting CAMC Health Education and Research Institute at 304-388-9960 or email tera.kirk@camc.org.

Reimbursement

Medical care that is covered by Medicaid and provided will be reimbursed at the Medicaid fee schedule. Diabetes disease management service codes are only reimbursable if the requirements previously noted for becoming a diabetes disease management provider have been met. In addition, reimbursement for the managing provider's extended office visit is a billable service based on the completion of the Diabetes Managing Provider Care Tool. This service is reimbursable, separate

from, and in addition to, the evaluation and management services rendered on the same date of service. Modifier 25 must be used to indicate that a significant separately identifiable EM service was required by the same provider on the same day of a procedure or other service. Reimbursement for diabetes education and self-management training is a separate service from the extended office visit, and payable to either managing providers or Certified Diabetes Educators. Billing should be submitted on the HCFA-1500 claim form or through electronic transmission. Claims which exceed the service limits spelled out in this program instruction will not be reimbursed.

If a Diabetes Managing Provider determines that a patient may benefit from diabetes education beyond extended office visits, a referral may be made to a Certified Diabetes Educator or provided by the practitioner. Certified Diabetes Educators and Diabetes Managing Providers who choose to provide diabetes education must define the educational support needs and develop an educational plan of care. Certified Diabetes Educators must develop and implement a plan of care and supply a copy of this plan to the patient‘s Diabetes Managing Provider, as well as maintaining documentation for services rendered and billed to Medicaid for audit purposes. For your convenience, a Diabetes Educational Provider Care Tool is included with this manual. The provider of diabetes education and self-management training will monitor and re-assess the patient periodically. It is the responsibility of those submitting claims to inquire whether these services have been previously received from other entities, so that service limits are not exceeded. The member may not be held liable for payment of claims which are not reimbursed by Medicaid.

Disease State Management services are reimbursed on a fee-for-service basis with limitations as follows:

HIPAA Compliant Code 7/01/04	Explanation	Previous Code
S0315	Disease management program; Managing Provider Extended Office Visit Limits - 2 visits per year	**W1875**
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes replaces Certified Diabetes Educator Contact Visit and Certified Diabetes Educator Brief Visit (1 unit = 30 minutes) Combination of G0108 and G0109 Limits - 8.5 hours per year (17 units)	**W1870** **W1874**
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes replaces Certified Diabetes Educator Group Service. (1unit = 30 minutes) Combination of G0108 and GO109 Limits - 8.5 hours per year (17 units)	**W1871**
S0316	Follow-Up/reassessment replaces Certified Diabetes Educator Follow-Up Visit Limits - 2 visits per year	**W1873**

519.12.6 PULMONARY FUNCTION TESTS

WV Medicaid covers the following pulmonary function tests:

- 94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
- 94060 Bronchospasm evaluation; spirometry as in 94010, before and after bronchodilator (aerosol or parenteral)
- 94200 Maximum breathing capacity, maximal voluntary ventilation
- 94375 Respiratory flow volume loop
- 94642 Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis
- 94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
- 94720 Carbon monoxide diffusing capacity (e.g., single breath, steady state)
- 94772 Carbon dioxide, expired gas determination by infrared analyzer
- 94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination
- 94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determination (e.g., during exercise)

Separate payment for 94760 and 94761 is made only when the services are medically necessary and there are no other covered services provided on the same date by the same physician.

No other pulmonary function tests are covered by WV Medicaid.

519.12.7 HEMOPHILIA SERVICES

Diagnostic, treatment and prophylactic blood factor therapy are covered for members with hemophilia and other hemorrhagic conditions.

Blood factor supplied to a member with a crisis episode is covered without restriction as needed to control the bleeding.

519.12.8 TOBACCO CESSATION PROGRAM

West Virginia Medicaid operates a tobacco cessation program in cooperation with the Public Employees Insurance Agency and the Bureau for Public Health. In order for members to have access to drugs and other tobacco cessation services, they are required to enroll in the program through the YNOTQUIT Line at 1-877-966-8784. Participants are screened for their readiness to quit the use of tobacco. Written materials and phone coaching are available through the quit line program. Additional information regarding the YNOTQUIT Line can be accessed through the Partners in Corporate Health website, www.ynotquit.com.

All tobacco cessation products must be prescribed by a licensed practitioner within the scope of his/her license under West Virginia law. Prior authorization is required for coverage of tobacco cessation medications and is coordinated through the tobacco quit line.

Members are limited to one 12-week treatment period per year. Pregnant females are eligible for additional course(s) of treatment, if appropriate. Drug products are limited to:

- Nicotine gum – 24 pieces per day
- Nicotine patches – 1 patch per day
- Nicotine lozenges – 20 lozenges per day
- Nicotine inhalers – 168 inhalers per 30 days

- Nicotine nasal spray – 4 spray bottles per 30 days (This therapy is reserved for those who have failed other forms of nicotine replacement therapy.)
- Buproprion – 2 tablets per day

519.13 MEDICATION SERVICES

Medication Services involve drugs and their administration to Medicaid members.

519.13.1 INJECTIONS

Therapeutic, prophylactic or diagnostic injection (CPT 90782) is not covered by WV Medicaid when billed in conjunction with an E&M code. Reimbursement for the drug is covered. If the injection is the primary purpose for the visit, an E&M service is not allowed.

Appropriate HCPCS ~~"J~~ Codes" are used to bill for the provision of the medication injected. If there is not a specific code for the medication, a non-specific ~~"J~~ Code" (J3490 or J9999) is used. These claims must be billed on a paper claim with the name, NDC, and quantity of the medication written on the claim on the line below the billed line or in ~~"F~~ield 19".

When an unlisted drug is billed using a J-code, the following information is required:

- The name of the drug
- National Drug Code (NDC)
- Exact dosage administered
- Strength of the drug administered
- Method of administration (i.e., subcutaneous, intramuscular, etc.)
- A cost invoice for the drug

When an HMO is the member's provider, the HMO is responsible for the cost of the drug and injection fees when the service is provided in the practitioner's office during the office visit. The requirements of the HMO must be followed for reimbursement.

The following injected substances have specific coverage and reporting requirements:

- Intra-articular and intra-bursal injections must be appropriate for the diagnosis; type, NDC, and quantity of steroid or other medication must be reported on the claim with the appropriate CPT code.
- Medications available in parenteral form, only; i.e., gold salts are covered for psoriasis or rheumatoid arthritis and cancer chemotherapy.

WV Medicaid covers Vitamin B-12 injections for particular illnesses and injuries. Following are the medical conditions covered for Vitamin B-12 injections:

- Anemia
  - Pernicious
  - Megaloblastic
  - Macrocytic
  - Fish tapeworm.
- Gastro-intestinal disorder
  - Gastrectomy
  - Malabsorption syndrome
  - Surgical and mechanical disorders resulting from resection of small intestine, strictures, anastomosis, and blind loop syndrome.
- Neuropathy
  - Neuropathy associated with pernicious anemic
  - Severe or acute neuropathy due to malnutrition
  - Severe or acute neuropathy due to alcoholism.

Importantly, diagnoses such as "vitamin deficiency," "secondary anemia," "neuritis," and "menopause" are not sufficient for Medicaid coverage.

WV Medicaid does not cover injections for uses other than those approved by the United States Food and Drug Administration.

519.13.1.1 PALIVIZUMAB/SYNAGIS

Palivizumab (Synagis®) is a humanized monoclonal antibody produced by recombinant DNA technology. It is used to help prevent serious lower respiratory tract disease caused by respiratory syncytial (RSV) in pediatric members at high risk of RSV disease. This antibody is usually administered intramuscularly on a monthly basis even though the RSV season usually spans October

through March in WV.

Prior authorization through the Rational Drug Therapy Program is required for all orders for Palivizumab (Synagis®). This program may be reached at 1-800-847-3859 or faxed at 1-800-531-7787. Its mailing address is:

Rational Drug Therapy Program
West Virginia University, School of Pharmacy
Robert C. Byrd Health Sciences Center
PO Box 9511
Morgantown, West Virginia 26506-9511

Medicaid coverage of Palivizumab (Synagis®) is limited to members who meet one of the following criteria:

- Member is under 24 months of age at the start of therapy and has chronic lung disease and needs oxygen chronically, or has been off oxygen use for less than 3 -6 months.
- Member is under one year of age at the start of therapy with a gestational age of under 28 weeks.
- Member is under 6 months at the start of therapy with a gestational age of 28-32 weeks or 32-36 week gestational age with concomitant medical problems/risk factors.
- Member is under 3 months of age at the start of therapy with gestational age of 32-36 weeks.

Requests must include the information needed to make a coverage determination, including medical documentation supporting the factors placing the child at high risk of RSV, past or present use of oxygen, current medication, or exposure to risk factors in the American Academy of Pediatric (AAP) guidelines. A diagnosis of bronchopulmonary dysplasia alone is insufficient.

Palivizumab (Synagis®) will not be approved for members currently exhibiting RSV infection or receiving immunoglobulin infusions.

Pharmacies may submit claims for Palivizumab (Synagis®) through the pharmacy point-of-sale (POS) system or appropriate manual form using the National Drug Code.

Physicians and outpatient hospitals may bill using CPT 90378 per 50mg, which equals 1 unit. No separate claim for inpatients must be submitted for Palivizumab (Synagis®) provided to hospital inpatients because payment for the drug is included in the DRG payment rate.

519.13.2 IMMUNIZATIONS

WV Medicaid covers medically necessary immunizations provided to members.

519.13.2.1 IMMUNIZATIONS FOR CHILDREN

Routine vaccines to Medicaid members less than 19 years of age are provided free-of-charge through the Vaccines for Children (VFC) Program, which the WV Department of Health administers. When these vaccines are provided, the practitioner is reimbursed only for the administration.

The following list of CPT codes and modifiers must be used for reimbursement of vaccinations using VFC supplies:

- 90647 Hemophilus influenza B vaccine (Hib)
- 90648 Hemophilus influenza B vaccine (Hib)
- 90655 Influenza virus vaccine 6-35 months
- 90657 Influenza virus vaccine 6-35 months
- 90658 Influenza virus vaccine three years and above (to age 19)

- 90669 Pneumococcal conjugate vaccine
- 90700 Diphtheria, tetanus toxoids, acellular pertussis vaccine (DtaP)
- 90702 Diphtheria and tetanus toxoids, (seven years old or less)
- 90707 Measles, mumps, and rubella vaccine (MMR)
- 90713 Poliovirus vaccine (IPV)
- 90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), for use in individuals seven years or older, for intramuscular use
- 90716 Varicella virus vaccine
- 90718 Tetanus and diphtheria toxoids (Td), seven years or older (to age 19)
- 90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and poliovirus vaccine (DtaP - HepB - IPV)
- 90732 Pneumococcal polysaccharide vaccine
- 90734 Meningococcal Conjugate Vaccine (Menactra)
- 90744 Hepatitis B vaccine, pediatric/adolescent dosage

90660 is not a covered service.

In order to assist Medicaid in the accurate identification of the vaccine administered, the appropriate CPT code must be billed. In addition to the specific CPT vaccine codes, an ‗SL' (state supplied) modifier must be placed on the claim to indicate the vaccine was provided by VFC. The appropriate administration CPT codes, 90471 or 90472, must be billed with the appropriate CPT code. Administration codes will not be reimbursed if the corresponding VFC code is not billed.

To bill a single vaccine, bill the CPT vaccine code with the ‗SL' modifier and CPT code 90471 for administration reimbursement.

To bill multiple VFC or subsequent vaccines itemize each CPT vaccine code using the ‗SL' modifier and bill 90472 with the number of additional administrations in the units block.

For vaccines administered to adults >19 years of age, or for vaccines not supplied by VFC, bill the appropriate CPT code. Do not bill the ‗SL' modifier or the administration codes 90471 or 90472. Reimbursement will include the serum and the associated administration.

Coverage of Influenza Vaccine

VFC has restricted coverage due to limited stocks of influenza virus vaccine. Medicaid members must meet one of the CDC's defined criteria for at-risk populations as follows:

- All children aged 6-23 months
- Adults aged 65 years and older
- Persons aged 2-64 years with underlying chronic medical conditions
- All women who will be pregnant during influenza season
- Residents of nursing homes and long-term care facilities
- Children 6 months-18 years of age on chronic aspirin therapy
- Health-care workers with direct patient care who are Medicaid eligible
- Out-of-home caregivers and household contacts of children aged <6 months.

Medicaid will reimburse for influenza vaccine if VFC's serum is depleted if BMS has been notified by VFC that serum supply has been depleted.

According to the National Immunization Program at the CDC, states' immunization programs should

have enough influenza vaccine to meet the demands. However, in the case that VFC's serum is depleted, WV Medicaid will reimburse providers for private stock of vaccine. WV Medicaid will review for inappropriate use and billing of vaccines. A member's high risk status and VFC depletion must be documented or reimbursement will be recouped.

If VFC depletion occurs, bill the appropriate CPT code without modifiers and without the administration code.

WV Medicaid will reimburse practitioners for the administration of vaccine through VFC using specific billing methodologies outlined in this chapter.

519.13.2.2 IMMUNIZATIONS FOR ADULTS

The provision of many immune globulins and vaccines/toxoids for adults is covered by WV Medicaid when prescribed and provided by their practitioner. When this occurs, the appropriate CPT code must be billed. Reimbursement for this service includes the serum and the associated administration. Do not bill 90471 or 90472 when providing immunizations to adults. The vaccine must be billed by the practitioner. WV Medicaid does not reimburse pharmacies for Medicaid members' vaccines.

The following CPT codes are covered for adult WV Medicaid members:

- 90281 Immune globulin (Ig), human, for intramuscular use
- 90283 Immune globulin (IgIV), human, for intravenous use
- 90288 Botulinum immune globulin, human, for intravenous use
- 90291 Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use
- 90296 Diphtheria antitoxin, equine, any route
- 90371 Hepatitis B immune globulin (HBIg), human, for intramuscular use
- 90375 Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use
- 90376 Rabies immune globulin, heat treated (RIg-HT), human, for intramuscular and/or subcutaneous use
- 90384 Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use
- 90385 Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use
- 90386 Rho(D) immune globulin (RhIg), human, for intravenous use
- 90389 Tetanus immune globulin (TIg), human, for intramuscular use
- 90393 Vaccinia immune globulin, human, for intramuscular use
- 90396 Varicella-zoster immune globulin, human, for intramuscular use
- 90399 Unlisted immune globulin
- 90581 Anthrax vaccine, for subcutaneous use
- 90585 Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
- 90586 Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, for intravesical use
- 90632 Hepatitis A vaccine, adult dosage, for intramuscular use
- 90656 Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
- 90658 Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
- 90665 Lyme disease vaccine, adult dosage, for intramuscular use
- 90675 Rabies vaccine, for intramuscular use
- 90676 Rabies vaccine, for intradermal use
- 90703 Tetanus toxoid absorbed, for intramuscular use
- 90704 Mumps virus vaccine, live, for subcutaneous use

- 90705 Measles virus vaccine, live, for subcutaneous use
- 90706 Rubella virus vaccine, live, for subcutaneous use
- 90707 Measles, mumps and rubella virus vaccine (MMR), live , for subcutaneous use
- 90707 Measles, mumps and rubella virus vaccine (MMR), live , for subcutaneous use
- 90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), for use in individuals seven years or older, for intramuscular use
- 90717 Yellow fever vaccine, live, for subcutaneous use
- 90718 Tetanus and diphtheria toxoids (Td), absorbed for use in individuals seven years or older, for intramuscular use
- 90720 Diptheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
- 90721 Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Haemophilus influenza B vaccine (DtaP - Hib) , for intramuscular use
- 90725 Cholera vaccine for injectable use
- 90727 Plague vaccine, for intramuscular use
- 90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
- 90733 Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
- 90734 Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
- 90735 Japanese encephalitis virus vaccine, for subcutaneous use
- 90740 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
- 90746 Hepatitis B vaccine, adult dosage, for intramuscular use
- 90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
- 90749 Unlisted vaccine/toxoid

519.13.3 ANTIGEN/ALLERGY SERVICES

WV Medicaid covers diagnostic services, antigen desensitization, and allergen immunotherapy in accordance with Medicare‘s policies, as described below.

- A dose is defined as the total amount of antigen to be administered to the member during one encounter/treatment session whether mixed or in separate vials.
- Members selected for covered immunotherapy must have significant life-threatening symptomatology (e.g., anaphylaxis) or a chronic allergic state (e.g., allergic rhinitis, asthma), which has not responded to conservative measures, such as environmental control or judicious use of pharmacological agents. Immunotherapy has been shown to be effective in stinging insect hypersensitivity, inhalant allergies, and allergic asthma, but has not been shown to be effective for food allergies and non-allergic rhinitis.
- Desensitization, not immunotherapy, is the procedure of choice for drug allergies.
- The length of immunotherapy depends on the demonstrated clinical efficacy. A presumption of failure can be made when the member does not experience a noticeable decrease of symptoms after 12 months of therapy, there is no evident increase in tolerance to the offending allergen, and no reduction occurs in medication usage. Long-term treatment will not be reimbursed when it has no apparent clinical benefit.
- Whole body extract of biting insect or other arthropod is indicated for use for fire ant allergy only.

- Antigens prepared for sublingual administration are not covered as they have not been proven to be safe and effective. Antigens are covered only if they are administered by injection.
- Very low dose immunotherapy or continued submaximal dose immunotherapy has not been shown to be effective and will be denied as not medically necessary.
- Immunotherapy is not covered for food allergies as it has not been shown to be effective. Strict elimination of the offending allergen is the only proven effective treatment of food hypersensitivity.

- Oral desensitization therapy has not been shown to be effective and is not covered by Medicaid, as it is not considered reasonable and necessary.

WV Medicaid **does not** cover allergen immunotherapy for the following antigens: newsprint, tobacco smoke, dandelion, orris root, phenol formalin, alcohol, sugar, yeast, grain mill dust, goldenrod, pyrethrum, marigold, soybean dust, honeysuckle, wood, fiberglass, green tea, or chalk.

Only physicians who have training and experience in the specialty of allergy and clinical immunology are paid to perform allergy testing and for antigen extract or allergy serum. Follow-up immunotherapy can be referred to a practitioner other than an allergist.

There are no restrictions on the services for acute anaphylaxis whether related to the source of reaction (Allergen, venom, etc.) or the practitioner providing the care.

An E&M service is covered on the same day as allergy testing or immunotherapy if a significantly identifiable E&M service is performed (and billed with modifier 25); that is, the primary purpose of the visit was not the allergy service. Preparation and provision of the antigens for the therapy is separately billable. The global codes are not covered.

WV Medicaid's payment for antigen services is included in the corresponding RBRVS fee. No separate payment is made for antigen services. An allergist must bill two codes when preparing and administering an antigen. WV Medicaid does not allow allergists to bill for a global service (i.e., injection and extract/extract preparation). Injections must therefore be billed using the following codes:

- 95115 Professional services for allergen immunotherapy, not including provision of allergenic extracts; single injection
- 95117 Two or more injections.

The antigen extract and the physician's professional service for preparing the extract must be billed using one of the following codes:

- 95144 Professional services for supervision and provision of antigens for allergen immunotherapy, single or multiple antigens, single dose vials; specify number of vials
- 95145 Professional services for supervision and provision of antigens for allergen immunotherapy; (specify number of does); single stinging insect venom
    - 95146 Two single insect venoms
    - 95147 Three single stinging insect venoms
    - 95148 Four single stinging insect venoms
    - 95149 Five single stinging insect venoms
- 95165 Professional services for supervision and provision of antigens for allergen immunotherapy, single or multiple antigens; specify number of doses
- 95170 Whole body extract of biting insect or other arthropod; specify number of doses.

CPT codes 95120 through 95134 are not valid for payment purposes.

HMOs are responsible for reimbursing for allergy injections and the cost of serum when the service is provided in an office setting to an HMO member. Requirements of the HMO must be followed for reimbursement. PAAS PCP referrals are required prior to rendering the service if the servicing provider is not the PCP.

MULTIPLE DOSE VIALS

Allergists must produce multiple dose vials rather than the more expensive single dose vials, unless another physician will inject the antigen. Therefore, CPT 95144 (single dose vial) is not covered when injection code 95115 or 95117 is billed.

Payment is based on a maximum of 10 doses per multiple dose vial. Medicaid can only be billed for a maximum of 10 doses per vial, even if more than 10 doses are obtained from the vial (e.g., if the physician administered 0.5 cc doses, instead of one cc dose). If fewer than 10 doses are prepared from a vial, the smaller number must be billed.

Medicaid must not be billed any additional amount for diluted doses, for example, by taking a one cc aliquot from a multi-dose vial and mixing it with nine cc of diluent in a new multi-dose vial.

If the number of doses is subsequently adjusted (perhaps because of a member‘s reaction) and a different number of doses are provided than was originally anticipated, the physician may not change the number of doses billed. In other words, the number of doses anticipated when the antigen was prepared is the number that must be billed because the CPT codes require the number of prospectively planned doses. The physician will not be required to refund any payments if fewer doses are provided than were originally planned.

The practice of reducing the amount of antigen provided in a ~~“~~dose” in order to increase the number of doses from a multiple dose vial so that the payment would be increased for the same amount will be monitored.

When a provider bills allergen immunotherapy (CPT 95115, 95117, 95144-95180) and an E&M code on the same date of service, Modifier 25 must be used with the E&M code to indicate the member‘s condition required a significant, separately identifiable service above and beyond allergen immunotherapy. Supporting documentation is required in the member‘s medical record.

The member‘s medical record must confirm that allergen immunotherapy is clinically reasonable and necessary and show that indications for immunotherapy were determined by the appropriate diagnostic procedures coordinated with clinical judgment. The number of vials or doses and injection schedule must be maintained in the member‘s medical record. Documentation must be made available upon request to the BMS.

519.13.4 CHEMOTHERAPY ADMINISTRATION

WV Medicaid covers chemotherapy administration. This service includes refilling and maintenance of a portable or implantable pump, chemotherapy injection, and provision of the chemotherapy agent. The preparation of the chemotherapy agent is included in the payment for administration of the agent and; therefore, is not separately reimbursable. An office visit on the same date of service as the chemotherapy administration may be covered if it is for a separately identifiable service documented in the member‘s medical record.

Chemotherapy drugs administered in the office are reimbursed using the appropriate HCPCS code. If no code is available, CPT 96545 may be billed and the appropriate medical documentation and an invoice showing the drug‘s actual cost must be attached to the claim.

Separate payment will be made when different chemotherapeutic agents are furnished or administered on the same date of service by different routes. For example, if Adriamycin is administered by "push" on the same date as cisplatin is administered by "infusion," both administrations may be billed to Medicaid. Each chemotherapeutic agent must be billed with a separate code for each method of administration.

HMOs are responsible for reimbursing for chemotherapy administration to HMO members regardless of the setting. Requirements of the member's HMO must be followed in order to be reimbursed. A PAAS PCP referral is required if an oncologist or other specialist provides the chemotherapy services.

519.14 RADIOLOGY SERVICES

WV Medicaid covers diagnostic and therapeutic radiology and nuclear medicine services. Specific policies and procedures concerning coverage of radiology services are listed below or found in Chapter 512 of the Laboratory & Radiology Manual.
A signed provider's order listing the service and the appropriate diagnosis is required for Medicaid coverage. West Virginia Medicaid has adopted CMS's policy to cover diagnostic tests only if ordered by the physician or non-physician practitioner who is actively treating and managing the patient. Diagnostic tests ordered by a physician who is not the patient's attending/treating physician, e.g., medical director of a nursing home for a nursing home patient, or a physician in a mobile center, will NOT be covered except in the following situations:

- On call physician who has been given responsibility for a patient's care when the patient's physician is unavailable.
- Specialist who is managing an aspect of the patient's care.
- Non-physician practitioners can order diagnostic test within the scope of their practice. However, supervision of diagnostic testing, such as required by CMS in IDTFs, can only be performed by physicians.

Providers should bill modifier-26 for the professional component only, if only performing radiological supervision and interpretation, and TC only if the provider owns the equipment. Practitioners performing services that require radiological supervision and interpretation may bill for these services. However, oftentimes, the facility also has a radiologist providing another reading. At this time, WV BMS pays for only one reading of a procedure. The provider whose reading results in a decision making process is typically the one that is medically necessary and that is reimbursed. Payment for a second reading interpretation of x-rays for quality assurance/confirmation is NOT covered.

Medicaid will pay for portable x-rays and for low osmolar contrast media. When billing for low osmolar contrast media, use Procedure Code 78990 and attach a manufacturer's or cost invoice. For radiation oncology management services, West Virginia Medicaid requires physicians to bill for weekly treatment management instead of daily treatment management.

Comparison x-rays are not covered routinely. If performed, documentation must substantiate the necessity of the second x-ray. This must be in the patient's record for review.

519.14.1 EMERGENCY ROOM X-RAYS AND ELECTROCARDIOGRAMS

West Virginia Medicaid will only cover one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. The professional component of service must include an interpretation and written report for inclusion in the patient's medical record. Reviewing an x-ray or EKG without providing a written report does not meet the criterion that CMS and public payers have established for separate payment.

CMS' criterion is also used for determining which claim should pay in the event of multiple claims being submitted for the same emergency room visit:

- The interpretation and report that directly led to the diagnosis and treatment of the patient.
- Interpretation of the x-ray or EKG by a radiologist/cardiologist if the interpretation is performed at the same time as the diagnosis and treatment.

Note: When circumstances warrant and are well documented, Medicaid will cover two interpretations. However, in most instances only one interpretation will be covered. Payment for interpretation of x-rays and EKG's for quality assurance is NOT Covered.

519.14.2 BONE DENSITY TESTING

WV Medicaid covers bone density scans in order to prevent the morbidity associated with osteoporosis and osteoporotic fracture. The bone density test is not to be routinely performed for dialysis patients. Routine screening of individuals without symptoms or risk factors is not covered. Criterion for providing bone density testing is: The test must be ordered for the symptoms or disorder associated with the loss of bone density.

- The bone density test is limited to one every two years. More frequent requests will require prior authorization with documentation of the medical necessity. (An exception of the limit would occur if the member had an abnormal screen on a peripheral site and an actual test was necessary to confirm the abnormality.)
- Only axial testing is allowed for monitoring osteoporosis therapy. Photo-densitometry of a peripheral bone and ultrasound bone densitometry are not allowed as part of this monitoring.

Only one scan can be billed regardless of how many sites are tested during the session. For those providers who are also the treating physician, a separate written interpretation of the scan must be included in the ember's chart as the codes include interpretation and report.

A complete list of diagnostic codes covered for bone density scans is found in **Attachment 13.**

519.14.3 PRIOR AUTHORIZATION REQUIREMENTS FOR IMAGING PROCEDURES

Effective 10/01/05, prior authorization will be required on all outpatient Radiological/Nuclear Medicine services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic Services required during an emergency room episode will not require prior authorization.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Requests for prior authorization can be sent to: West Virginia Medical Institute, Radiology/Nuclear Medicine Review, 3001 Chesterfield Avenue SE, Charleston, West Virginia 25304. All phone requests can be routed to: (304) 346-9167, or toll free 1-800-982-6334. Fax transmissions can be sent to (304) 346-3669 or toll free 1-800-298-5144.

519.15 UNLISTED SERVICES, DRUGS, PROCEDURES, OR ITEMS

Unlisted services, drugs, procedures, or items (as defined by HCPCS) are used only when there is no code that describes the service, item, or procedure provided to a Medicaid member. Unlisted codes must always be billed on paper with a description of the service provided, e.g., an operative report or clinical notes.

When billing for other unlisted services, procedures, or items, the claim must be accompanied by all documentation necessary to justify reimbursement (i.e., operative reports, cost invoices, etc).

519.16 NON-COVERED ITEMS – MEDICAL SUPPLIES/DURABLE MEDICAL EQUIPMENT

Payment will not be authorized for non-covered items – medical supplies/durable medical equipment. Details of non-covered items – medical supplies/durable medical equipment are found in the Chapter 506 pertaining to durable medical equipment.

519.17 NON-COVERED SERVICES

Certain services and items are not covered by the Medicaid Program. Non-covered services include, but not limited to, the following:

- Acupressure
- Acupuncture
- Autopsy
- Cardiac rehabilitation programs, pulmonary rehabilitation programs, and other rehabilitation programs
- Chelation therapy
- Claims received more than 12 months after the date of service
- Completion of forms and reports, except for eligibility purposes as specifically requested by the Department of Human Services using ~~"E~~SRT" letters of request
- Cosmetic procedures, medical or surgical, the primary purpose of which is to improve the member's appearance. Such procedures include, but not limited to, otoplasty for protruding ears of lop ears, rhinoplasty (except to correct nasal deformity), nasal reconstruction, excision of keloids, fascioplasty, osteoplasty for prognathism or micrognathism or both, dermabrasion, certain skin grafts, malar augmentation, breast implants for other than breast cancer reconstruction, and lipectomy
- Courtesy Calls (visits in which no identifiable medical service was rendered)
- Dietary (food) supplements, except as provided in a hospital or nursing home
- Direct payments to members (payments are made to the provider of service)
- Domestic or housekeeping services, except to the extent they may be provided under a home health service plan
- Drugs and supplies dispensed by the physician which are acquired by the physician at no cost
- Educational services
- Experimental/Research/Investigational medical or surgical procedures
- Genetic testing
- Hypnosis
- Immunizations required for travel outside the Continental United States
- Incidental surgical Procedures (i.e., incidental appendectomy, lysis of adhesions, excision of previous scar, etc.) performed at the same time as a major surgical procedure
- Infertility services (i.e., artificial insemination, in vitro fertilization, etc.)
- Inhalation Therapy (chronic basis)

- Injections and visits solely for the administration of injections unless medically necessary and the member's inability to take appropriate oral medications are documented in the member's medical record and on the claim form
- Inpatient rehabilitation services for members over 18 years of age
- Items/Services not related to medical care that were provided for the convenience of the member, their custodian, or the provider
- Maintenance services if no progress is being made
- Mass screenings for any condition
- Massage therapy
- Meals-on-Wheels (or similar food service arrangements)
- Naturopathy
- Non-legend Drugs (over-the-counter drugs), except for the following:
  - Family planning supplies
  - Insulin
  - Diabetic syringes/Needles/Testing kits
  - End-Stage Renal Disease (ESRD) Vitamin/Vitamin mineral preparations and other medications related to ESRD services.

  NON-LEGEND DRUGS FOR MEMBERS RESIDING IN LONG-TERM CARE (LTC) FACILITIES (skilled and intermediate nursing homes) are to be furnished by the LTC and are not to be billed to the member or the Department of Health and Human Resources.
- Nutritional (dietary) counseling
- Operating surgeon may not bill for the administration of anesthesia, except epidural anesthesia
- Pain Clinics (Specific medical procedures ordered by the physician for treatment are covered)
- Payment to a physician for laboratory services as payment is made directly to the facility performing these services. (The physician may have a laboratory specifically approved for Medicaid purposes; the laboratory must have a Medicaid laboratory provider number)
- Personal comfort items (items which do not directly contribute to the treatment of an illness or injury or to the functioning of a malformed body part)
- Physician services denied by Medicare as not medically necessary, ineffective, unsafe, or without proven clinical value
- Physician services included as part of the cost of an inpatient facility or hospital outpatient department
- Pre-operative evaluations for anesthesia are included in the fee for administration of anesthesia and the provider may not bill them
- Procedures prohibited by State or Federal statute or regulations
- Pulmonary rehabilitation programs and other similar rehabilitation programs
- Referrals from one physician to another for treatment of specific member problems are not to be billed as consultations
- Reflexology
- Rehabilitation programs such as cardiac, pulmonary, dietary, weight control, etc.
- Respiratory therapy
- Routine Foot Care, except for those members having a metabolic disease such as diabetes and the metabolic disease must be documented
- Services and items under a Workers Compensation law or other payment services
- Services provided as inpatient hospital services if the service could appropriately and safely be

performed on an outpatient basis in an office or outpatient hospital setting unless the procedure is performed as a secondary necessary procedure

- Services provided by students
- Services provided for the purpose of relieving discomfort
- Services which are not medically justified
- Services which are provided at no charge to patients who are not Medicaid members (i.e., services provided free to the general public cannot be billed to Medicaid)
- Sex change surgery (transsexual surgery)
- Sex determination services
- Spectacle (glasses) cases
- Sterilizations when the member is under 21 years of age, institutionalized, or mentally incompetent
- Tai chi
- Telephone contacts with members or on their behalf
- Tempomandibular Joint Syndrome (TMJ) surgery or treatment
- Visits solely for one or more of the following:
  - Prescription pickup
  - Collection of specimens for laboratory procedures
  - Ascertaining members‘ weight.
- Weight reduction (obesity) clinics/programs.
- Yoga

519.18 BILLING AND REIMBURSEMENT

Practitioners must bill WV Medicaid directly for covered services provided to Medicaid members. However, payment may be made to a practitioner‘s employer when the practitioner is required as a condition of employment to turn over his/her fees to the employer or when the facility where a service is rendered has a signed contract with the practitioner that requires the facility to submit the claim. **Chapters 300 and 600** contain additional information.

As is consistent with Federal law prohibiting Medicaid providers from balance billing, (i.e., billing an amount in excess of the Medicaid fee), the practitioner may not bill the member any additional amount regardless of the setting in which a service is rendered.

519.18.1 HCPCS CODES

The Center for Medicare and Medicaid Services (CMS) of the Federal Government has mandated that all States implement the HCPCS codes to identify medical services provided to Medicaid members.

HCPCS is a coding system that uses the AMA‘s Current Procedural Terminology, fourth edition (CPT-4) as its base (Level I codes) and then nationalizes non-standard codes used by various states so all state and federal payers of medical claims use the same coding system (Level II codes).

In an effort to maintain uniformity with National Correct Coding Policies implemented by CMS, the BMS incorporates the National Correct Coding Initiative methodologies for the analysis of standard medical and surgical practice. These policies were developed based on coding conventions defined in the AMA‘s CPT-4 Manual, in national and local policies, in edits and in coding guidelines developed by national societies. They are consistent with federally and state mandated program policies. Incorporating these edits into the review process does not represent new policy or monitoring procedures by the BMS and should not be interpreted as such. These edits represent generally accepted standards of medical and surgical practice. Adherence to these policies will be monitored

through post payment reviews conducted by BMS or its contracted agent.

On a case-by-case basis, WV Medicaid determines whether to cover and pay for unlisted physician services, i.e., procedure codes with the last two digits typically ending in 99. These clinical codes require the physician to submit a detailed report with the claim for payment. These codes cannot be billed electronically because they must be reviewed manually.

519.18.2 CLINICAL CODE MODIFIERS

At times, a physician may have to attach a 2-digit modifier to the end of a CPT code in order to report accurately and completely the services provided to a Medicaid member. WV Medicaid has adopted the definitions of modifiers consistent with the AMA's CPT-4.

519.18.3 PAYMENT FOR ANESTHESIA SERVICES

Medicaid fees for anesthesiology services are calculated somewhat differently from the fees paid for all other physician services. The fee equals the conversion factor for anesthesia services multiplied by the sum of the base units and time units for a service. (There are no relative value units for these services.)

The base units for a given anesthesia service are the same every time the service is provided and have been established by the American Society of Anesthesiologists (ASA). The time units depend on the length of time to provide the service. The time units are expressed in 15-minute blocks and are expressed in whole units. Thus, a service that takes 75 minutes would be assigned five time units.

An example follows:

If an anesthesia service has three base units and five time units and the anesthesia conversion factor is $15.25 per unit, the fee would be $122.00.

Fee = Conversion Factor x Total Units

$122.00 = $15.25 x 8

Base units are in the system and are not billed by the provider.

Time units do not apply to certain anesthesia services. These services are paid using the RBRVS fee schedule. The BMS establishes relative value units for these services so the fee equals the number of units multiplied by the anesthesia conversion factor.

519.18.4 CMS 1500 CLAIM FORM

A physician must submit a completed claim (CMS-1500) in order to be paid for covered services furnished to Medicaid members. **Attachment 14** lists a brief description of the spaces or fields the physician must complete to bill the WV Medicaid Program.

519.19 SOLICITATIONS

It is unlawful for a physician to knowingly solicit, offer, pay, or receive any remuneration including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for furnishing or arranging to furnish any item or service for which payment may be made under the WV Medicaid Program, or in return for obtaining, purchasing, leasing, ordering, or arranging or recommending the provision of a service.

519.20 MEDICAL NECESSITY CERTIFICATION AND PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements of the Provider Manual. In

addition, the following limitations also apply to the requirements for payment of Practitioner Services described in this chapter:

- Requests for medical necessity certification and prior authorization must be submitted to the Bureau for Medical Service's contracted agent.
- Prior authorization requests for Practitioner Services must be submitted within the timelines required by BMS' contracted agent.
- Prior authorization requests must be submitted in a manner specified by BMS' contracted agent.
- Prior authorization numbers will not be issued over the telephone. Practitioners must not render services until an authorization number is received.
- Prior authorization does not guarantee payment. Services must be rendered by approved provider to eligible individual within service limitations in effect on date of service. All provider/member eligibility requirements and service limitations apply.

519.20.1 PRIOR AUTHORIZATION FOR OUTPATIENT SURGERIES

Certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listing in Attachment 17, along with the PA form that may be utilized.

519.21 MANAGED CARE

Unless noted otherwise, services detailed in this manual are the responsibility of the HMO if the Medicaid member is a member of an HMO. Medicaid will not reimburse for services provided when HMO or PAAS requirements are not met for those members.

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ATTACHMENT 1
PRIOR AUTHORIZATION FORM FOR
BLEPHAROPLASTY, UPPER EYELIDS
PAGE 1 OF 3

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Prior Authorization Request for Upper Eyelid Surgery

Member Name: _____

Member ID#: _____ Member Date of Birth: _____

Physician Name: _____ Medicaid Provider ID#: _____

Medical Necessity Criteria

West Virginia Medicaid covers eyelid surgery with documentation of medical necessity according to the following criteria.

ICD-9-CM Code(s): _____ CPT Code(s): _____

Blepharoplasty and repair of blepharoptosis are considered for payment by WV Medicaid when medically necessary.

Symptoms documented by member complaints which may justify functional surgery and are commonly found in patients with: (Check as appropriate and attach required documentation)

_____ Visual impairment with near or far vision due to dermatochalasis, blepharochalasis or blepharoptosis
_____ Sensation of looking through lashes
_____ Symptomatic redundant skin weighing down on upper lashes
_____ Chronic, symptomatic dermatitis of pretarsal skin caused by redundant upper lid skin; prosthesis difficulties in an anophthalmia socket

History:

Myasthenia Gravis
Thyroid Disease
Diabetes
Partial blindness or unilateral blindness

Physical Examination: (Must include a full visual examination to rule out other potential causes of visual disturbance. The presence of any of the following should be documented.)

_____ Ptosis
_____ Dermatochalasis
_____ Pseudoptosis
_____ Chronic blepharitis
_____ Upper eyelid margin approaches to within 2.0 mm of the corneal light reflex
_____ Upper eyelid skin rests on the eyelashes
_____ Upper eyelid indicates the presence of dermatitis
_____ Upper eyelid position contributes to difficulty tolerating prosthesis in an anophthalmia socket
_____ Any significant retinopathy

Documentation: (Attach to Request)

_____ Current photographs: The photographs must be taken with the head perpendicular to the plane of the ground, pointing straight ahead, canthus to canthus. Photos should also be taken from the side to show the excess skin resting on the eyelid.
For requests for blepharoptosis repair, another set of photos with the skin lifted off the lid to show persistent drooping is necessary.

_____ Copies of current visual fields, both taped and untaped, recorded to demonstrate:

_____ Minimum twelve (12) degree or thirty percent (30%) loss of upper field of vision with upper lid skin and/or upper lid margin in natural position and elevated (by taping of the lid) to demonstrate

potential correction by the proposed procedure or procedures. Visual field examination by tangent screen testing is not acceptable.

_____ Visual field testing by either Goldman perimetry or automated perimetry will be accepted. The test object must be indicated with Goldman testing, and the fixation monitor with fixation losses must be listed with the automated testing. The test must show a superior (vertical) extent 50-60 degrees above fixation with targets present at a minimum of 4 degrees vertical separation starting at 24 degrees above fixation while using no wider than a 10 degree horizontal separation.

_____ Demonstration of an improvement of visual field examination with lid (in the case of blepharoptosis) or excess lid skin (for blepharoplasty) elevated is necessary to show that the procedure is medically necessary. The improvement must be at least 30%.

Per National Correct Coding Edits, requests for a blepharoplasty, CPT 15283 with a blepharoptosis repair 67904, will be bundled into the latter.

For the most part, lower eyelid surgery is cosmetic, and medical necessity for entroprion repair must be documented with photos and slit lamp examination.

This procedure must be performed on an outpatient basis by a Board Certified/Eligible plastic surgeon or Board Certified Ophthalmologist with experience with this procedure.

_____ _____

Physician Signature Date

WVDHHR/BMS/PARequest01/10/05

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PRACTITIONER SERVICES
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ATTACHMENT 2
PRIOR AUTHORIZATION FORM FOR
BREAST RECONSTRUCTION
PAGE 1 OF 3

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Prior Authorization Request for Open Periprosthetic Capsulectomy, Periprosthetic Capsulectomy, or Revision of Reconstructed Breast Surgery

Member Name: _____

Member ID#: _____ Member Date of Birth: _____

Physician Name: _____ Medicaid Provider ID#: _____

Medical Necessity Criteria

ICD-9-CM Code(s): _____ CPT Code(s): _____

Reconstruction after cancer:

West Virginia Medicaid covers reconstructive breast surgery for those patients who have had surgical procedures for cancer. A pathology report and operative report is necessary for documentation of breast cancer surgery.

If the patient has elected to undergo reconstruction at the time of breast cancer surgery, a separate prior authorization for the reconstructive process is necessary over and above the authorization for the hospital stay. If any part of staged procedures is performed on an outpatient basis, prior authorization is also necessary.

The reconstructive surgeon must list the proposed procedure(s), and any subsequent procedures if the reconstruction is performed in stages. Reconstructive surgery on the opposite breast, if necessary for symmetry, will also be approved when documentation of medical necessity is submitted.

The following procedures are covered:

Reconstruction with tissue expanders and implants
Latissimus flap reconstruction
Nipple areola reconstruction

Nipple tattooing is not covered as this is not considered medically necessary.

Implants:

If placed for reconstruction after cancer surgery is covered. Replacement of breast implants originally placed for reconstruction after cancer is covered with documentation of medical necessity. (i.e., Baker Class III contracture or implant ruptures.)

Removal of ruptured implants and/or Baker Class III placed for any other reason is also covered. **(Removal due to patient anxiety is not covered.)**

Replacement of implants placed for reasons other than post-cancer reconstruction is not covered.

The following should be documented for revision of a reconstructed breast:

Photos are required only in cases when a revision of a reconstructed breast, or the contralateral breast is requested.

Medical condition that necessitates the surgery:

_____ Pain
_____ Asymmetry
_____ Deformity
_____ Ruptured implant
_____ Infection
_____ Malignancy/tumor

Documentation: (Attach to request)

_____ Current original photographs (Only for revision requests and for requests for surgery on contralateral breast)

_____ Preoperative studies
_____ Preoperative diagnosis
_____ Postoperative studies
_____ Postoperative diagnosis
_____ Operative report
_____ Pathology report
_____ History/physical report

Requests for reconstruction for congenital defects are reviewed on a case-by-case basis, and require photos as part of the documentation process.

These procedures must be performed by Board Eligible/Certified Plastic Surgeons. The procedures may be inpatient or outpatient depending on whether other cancer surgery is performed during the same hospitalization. Prior approval for these procedures is necessary over and above the approval for the hospital admission.

_____ _____

Physician Signature Date

WVDHHR/BMS/PA Request01/10/05

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ATTACHMENT 3

PRIOR AUTHORIZATION FORM FOR BREAST REDUCTION

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Prior Authorization Request for Breast Reduction Mammoplasty Surgery

Member Name: _____

Member ID#: _____ Member Date of Birth: _____

Physician Name: _____ Medicaid Provider ID#: _____

Medical Necessity Criteria

ICD-9-CM Code(s): _____ CPT Code(s): _____

History:

Documentation showing the patient has sought medical attention for any of these conditions must be submitted in support of medical necessity for reduction mammoplasty. (Mark all that apply)

_____ Health problems and/or discomfort related to breast hypertrophy
_____ Postural problems related to breast size (Must be depicted in photo)
_____ Respiratory symptoms related to breast size (Must be documented by need for medications and/or physician/ER visits)
_____ Neurological symptoms related to breast size (e.g., ulnar nerve parasthesia) (Must be documented by EMG and/or neurologic consultation
_____ Refractory skin infections in the inframammary creases (Must be documented by need for medications and/or practitioner visits)

Physical Examination:

_____ Weight _____ Height _____ Bra Size
_____ Right low nipple position (distance of nipple from level of suprasternal notch >21cm)
_____ Left low nipple position (distance of nipple from level of suprasternal notch >21cm)
_____ Right span of distance from inframammary crease to nipple >6.5cm
_____ Left span of distance from inframammary crease to nipple >6.5cm
_____ Right areolar diameter
_____ Left areolar diameter
_____ Refractory candidal rashes beneath breasts
_____ Secondary skeletal effects
_____ Dorsal kyphosis of spine
_____ Supraclavicular bra strap grooves **(Must be shown in photographs. If shoulders are cut off in photographs, the appeal will be returned for lack of documentation of medical necessity.)**
_____ Ulnar nerve compression secondary to descent of coracoid process (Requires documentation by EMG)
_____ Additional information (please attach documentation, if applicable)

Documentation: (Attach to Request)

_____ Copy(ies) of recent mammogram
_____ Current original photographs
_____ Copy(ies) of previous breast operation and pathology reports, if applicable

Other information needed:

(These services can only be performed by Board Certified or Board Eligible Plastic Surgeons.)

_____ Right estimate excess breast tissue weight to be removed
_____ Left estimate excess breast tissue weight to be removed

Will this procedure be performed in an outpatient or inpatient setting? (Circle either inpatient or outpatient)

_____ _____

Physician Signature Date

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ATTACHMENT 4
PRIOR AUTHORIZATION FORM FOR PANNICULECTOMY

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Prior Authorization Request for Panniculectomy Surgery

Member Name: _____

Member ID#: _____ Member Date of Birth: _____

Physician Name: _____ Medicaid Provider ID#: _____

Medical Necessity Criteria

ICD-9-CM Code(s): _____ CPT Code(s): _____

Documentation must show that the patient has significant dermatologic and musculoskeletal problems as a result of large pannus. Panniculectomy solely to improve appearance is not covered by West Virginia Medicaid.

History:

_____ Ulcers and/or intertrigo under surface of panniculus refractory to treatment for at least six months
_____ Antibiotics/antifungals (type used, length of use, and outcome of use)
_____ Hospitalization for infections
Treatments for back pain (List):
Medications: _____
Therapy: _____
Chiropractic: _____
Functional limitations (List): _____
Other medical conditions (List): _____
_____
_____ Previous abdominal surgery (e.g., gastric by-pass/gastroplasty)

Documentation of the above conditions must be attached to this prior authorization request.

Physical Examination:

_____ Weight _____ Height
_____ Approximate weight of panniculus to be removed
_____ Back exam as affected by pannus
_____ Examination of abdomen

Documentation:

_____ Current photographs taken from the front and side which show the full extent of the pannus, hanging to, at least, the pubic bone

Liposuction is not covered.

Abdominoplasty to cover a rectus diastasis is not covered, as this does not represent a true hernia.

This procedure must be performed by a Board certified/Eligible plastic surgeon or a Board Certified general surgeon with experience performing this procedure. This procedure must be performed as an inpatient procedure; therefore, the patient's admission requires a separate authorization from the procedure's prior approval.

_____ _____

Physician Signature Date

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ATTACHMENT 5
CPT CODES TO REPORT PREGNANCY TERMINATION PROCEDURES
PAGE 1 OF 2

ICD-9-CM Diagnosis	Description
635.10	Legally induced abortion - Complicated by delayed or excessive hemorrhage - Unspecified
635.11	Legally induced abortion - Complicated by delayed or excessive hemorrhage - Incomplete
635.12	Legally induced abortion - Complicated by delayed or excessive hemorrhage - Complete
635.20	Legally induced abortion - Complicated by damage to pelvic organs or tissues - Unspecified
635.21	Legally induced abortion - Complicated by damage to pelvic organs or tissues - Incomplete
635.22	Legally induced abortion - Complicated by damage to pelvic organs or tissues - Complete
635.30	Legally induced abortion - Complicated by renal failure - Unspecified
635.31	Legally induced abortion - Complicated by renal failure - Incomplete
635.32	Legally induced abortion - Complicated by renal failure - Complete
635.40	Legally induced abortion - Complicated by metabolic disorder - Unspecified
635.41	Legally induced abortion - Complicated by metabolic disorder - Incomplete
635.42	Legally induced abortion - Complicated by metabolic disorder - Complete
635.50	Legally induced abortion - Complicated by shock - Unspecified
635.51	Legally induced abortion - Complicated by shock - Incomplete
635.52	Legally induced abortion - Complicated by shock - Complete
635.60	Legally induced abortion - Complicated by embolism - Unspecified
635.61	Legally induced abortion - Complicated by embolism - Incomplete
635.62	Legally induced abortion - Complicated by embolism - Complete
635.80	Legally induced abortion - With unspecified complication - Unspecified
635.81	Legally induced abortion - With unspecified complication - Incomplete
635.82	Legally induced abortion - With unspecified complication - Complete
635.90	Legally induced abortion - Without mention of complication - Unspecified
635.91	Legally induced abortion - Without mention of complication - Incomplete
635.92	Legally induced abortion - Without mention of complication - Complete

CPT or HCPCS Code	Description
	(Anesthesia)
01964	Anesthesia for abortion procedures
	(Surgery)
59840	Induced abortion, by dilation and curettage
59841	Induced abortion, by dilation and evacuation
59850	Induced abortion, by one or more intra-amniotic injections (amniocentesis – injections), including hospital admission and visits, delivery of fetus and secundines;
59851	with dilation and curettage and/or evacuation
59852	with hysterotomy (failed intra-amniotic injection)
59855	Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines;
59856	with dilation and curettage and/or evacuation
59857	with hysterotomy (failed medical evacuation)
S0190	Mitepristone, oral, 200 mg (Mifoprex 200 mg oral)
S0191	Misoprostol, oral, 200 mcg
S0199	Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drug

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ATTACHMENT 6
CPT CODES TO REPORT STERILIZATION PROCEDURES

ICD-9-CM Diagnosis	Description
V25.2	Sterilization – Admission for interruption of fallopian tubes or vas deferens

CPT Code	Description
	(Anesthesia)
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection
00921	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral/bilateral
	(Surgery)
58600	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during the same hospitalization (separate procedure)
58611	Ligation or transaction of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

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ATTACHMENT 7
CPT CODES TO REPORT HYSTERECTOMIES

ICD-9-CM

Diagnosis

NA

CPT Code	Description
	(Anesthesia)
00846	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; radical hysterectomy
00848	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; pelvic exenteration
00944	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); vaginal hysterectomy
01962	Anesthesia for urgent hysterectomy following delivery
01963	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care
01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)
	(Surgery)
51925	Closure of vesicouterine fistula; with hysterectomy
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58152	with colpo-urethrocystopexy (e.g., Marshall-Marchetti-Krantz, Burch)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling with or without removal of tube(s), with or without removal of ovary(s)
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)
58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
58260	Vaginal hysterectomy, for uterus 250 grams or less;
58262	with removal of tube(s) and/or ovary(s)
58263	with removal of tube(s) and/or ovary(s), with repair of enterocele
58267	with colpo-urethrocystoplexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy;
58280	with repair of enterocele
58285	Vaginal hysterectomy, radical (Schauta type operation)

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ATTACHMENT 8
DIAGNOSTIC & PROCEDURE CODES FOR COVERED FAMILY PLANNING SERVICES

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FAMILY PLANNING
DIAGNOSTIC CODES

ICD 9	DESCRIPTION
V15.7	Hx of Contraception
V25.01	Prescription of Oral Contraceptives
V25.02	Initiate Contraceptive Measure NEC
V25.03	Emergency Contraceptive Counsel/Rx
V25.09	Contraceptive Management NEC
V25.1	Insertion of IUD
V25.2	Sterilization
V25.3	Menstrual Extraction
V25.4	Contraceptive Surveillance
V25.40	Contraceptive Surveillance NOS
V25.41	Contraceptive Surveillance
V25.42	IUD Surveillance
V25.43	Subderm Contraceptive Surveillance
V25.49	Contraceptive Surveillance NEC
V25.5	Subderm Contraceptive Insertion
V25.8	Contraceptive Management NEC
V25.9	Contractive Management NOS
V26.4	Procreative Management Counseling
V26.8	Procreative Management NEC
V26.9	Procreative Management NOS

FAMILY PLANNING
PROCEDURE CODES

CODE	DESCRIPTION
J1051	Medroxyprogesterone Injection
J1055	Medrxyprogester Acetate, 150 mg, Injection
J1056	MA/EC Contraceptive Injection
J7302	Levonorgestrel IU Contracept
11975	Insert Contraceptive Capsules
11976	Remove Contraceptive Capsules
11980	Subcutaneous Hormone Pellet Implant
57170	Fitting of Diaphragm/Cervical Cap
58300	Insert Intrauterine Device (IUD)
58301	Remove Intrauterine Device (IUD)
58615	Occlude Oviduct(s)

CHAPTER 519

PRACTITIONER SERVICES

OCTOBER 1, 2005

ATTACHMENT 9

APS UTILIZATION MANAGEMENT GUIDELINES (FOR PSYCHIATRIC SERVICES)

PAGE 1 OF 33

APS UTILIZATION MANAGEMENT GUIDELINES

WEST VIRGINIA

PSYCHIATRIC SERVICES - CPT CODES

VERSION 1.0

APS HEALTHCARE, INC.- WEST VIRGINIA

Service Utilization Management Guidelines

Psychiatric Services – CPT Codes

Table of Contents

Psychiatric Services – CPT Codes

APS Healthcare, Inc.
West Virginia Medicaid ASO

The right consumer

receives the right service

at the right time

from the right provider

at the right intensity

for the right duration

with the right outcome

The purpose of the utilization management system is to assure that the "rights" as listed above are in place for every consumer and to assure consistency in level and duration of treatment and support among service providers and throughout regions.

These Service Utilization Management (UM) Guidelines are organized to provide an overview of the approved CPT code services psychiatrists and eligible staff in their practices may provide Medicaid beneficiaries and invoice the WV Bureau for Medical Services for reimbursement. Notice that each service listing provides:

- a definition,
- level of benefit,
- initial authorization limits,
- increments of re-authorization, and
- service exclusions.

In addition, the service listing provides:

- consumer-specific criteria, which discusses the conditions for
  - admission,
  - continuing stay,
  - discharge,
- clinical exclusions, and
- basic documentation requirements.

The elements of these service listings will be the basis for utilization reviews and management by APS Healthcare, Inc. (APS). Additional detail regarding service definitions and documentation requirements can be found in the American Medical Association Current Procedural Terminology (CPT) Manual.

REQUEST FOR PRIOR AUTHORIZATION

APS has developed a tiered system for initial and continuing-stay service authorizations. While most services require the provider submit only minimal information for the initial authorization; others require the provision of more clinical information to establish medical necessity. Continued-stay authorizations most frequently require the additional clinical information be submitted. Admission and continued stay criteria for these services were developed based upon the intensity of the service in question, as consumers are best served when services are tailored to individual needs and are provided in the least restrictive setting.

Status of Request for Prior Authorization

When a prior authorization for service is required, the service provider submits the required information to APS. The provider will be notified if the request is authorized, pended (additional information is needed to make the decision), closed or denied and/or what alternative services may be recommended.

Provider requests for service authorizations failing to meet the medical necessity guidelines are subject to negotiations between the provider and APS. APS strives to assist the provider in developing an appropriate plan of care for each consumer. Typically, the vast majority of discrepancies between the request for service and final status are resolved through discussion and mutual agreement. In the event that a consumer truly does not have a demonstrated behavioral health, or MR/DD diagnosis and/or need that meets the guidelines for care, the request will be denied. In this event, it is the provider's responsibility to share the denial with the consumer and their support system so that alternative arrangements may be made. Please see the APS Provider Manual for additional information regarding the denial process.

MULTIPLE SERVICE PROVIDERS

Each provider is responsible for obtaining authorization for the service(s) they provide an individual. In cases where one provider has already registered or received prior authorization to perform a service and an additional provider(s) attempts to register or request prior authorization that would exceed the client benefit, APS Care Managers will make every effort to determine which provider the consumer chooses to render the service. We are hopeful that providers will continue to coordinate services for consumers to avoid duplication and maximize the therapeutic benefit of interventions.

Note: It is the provider's responsibility to coordinate care and establish internal utilization management processes to ensure consumers meet all medical necessity/service utilization guidelines and to obtain authorization prior to the onset of service when required. In instances where another provider is performing the service requested or the consumer benefit is exhausted, requests will not be authorized.

Medical Necessity

Prior authorization does not guarantee payment for services. Prior authorization is an initial determination that medical necessity requirements are met for the requested service. In the Managed Care position paper, published in 1999, the state of West Virginia introduced the following definition of medical necessity:

"services and supplies that are (1) appropriate and necessary for the symptoms, diagnosis or treatment of an illness; (2) provided for the diagnosis or direct care of an illness; (3) within the standards of good practice; (4) not primarily for the convenience of the plan member or provider; and (5) the most appropriate level of care that can be safely provided."

The CPT code services rendered by psychiatrists more clearly define the services and criteria utilized to meet parts (1) and (2) of the definition above. In determining the appropriateness and necessity of services for the treatment of specific individuals the

- diagnosis,
- level of functioning,
- clinical symptoms and
- stability and available support system are evaluated.

The current role of the ASO is to devise clinical rules and review processes that evaluate these characteristics of individuals, and ensure that psychiatric services requested are medically necessary and to enforce the policies of the Bureau for Medical Services.

The Utilization Management Guidelines published by APS serve to outline the requirements for diagnosis, level of functional impairment and clinical symptoms of individuals who require the specific services.

Part (4) of the definition, in the context of CPT code services rendered by psychiatrists, relates to services requested by the consumer that may be helpful but are not medically necessary, as well as to alternative and complementary services not provided by the psychiatrist but to which the consumer may be referred. This portion of the definition prohibits the utilization of treatment codes to provide service that meets a consumer need but does not meet the medical necessity criteria. Prior authorization review will utilize these guidelines as well as specific clinical requirements for the specific service(s) requested.

Part (5) of the definition which refers to the "most appropriate level of care that can be safely provided", in the context of CPT codes used by psychiatrists, relates to the least restrictive type and intensity of service acceptable to meet the consumer's needs while ensuring that the consumer does not represent a direct danger to himself or others in the community.

PRIOR AUTHORIZATION REQUEST TIERED SYSTEM

The information submitted at the ***"Registration"*** tier is brief and is primarily used to track utilization of various services. Significant clinical review of medical necessity and/or clinical appropriateness is not conducted at the registration level. A registration is allowed as long as the consumer has not exhausted the Medicaid benefit for the service requested.

The information submitted at the second tier (Tier 2) through the West Virginia Behavioral Health Care Connection® provides a clinically relevant summary but it alone is not always sufficient documentation of a consumer's medical necessity. For this reason, APS Care Managers may request additional information to make prior authorization decisions for consumers who do not clearly meet the UM guidelines for the service or do not clearly meet medical necessity requirements. The assessment, plan of care and proposed discharge criteria all serve to document the appropriateness and medical necessity of services provided to a consumer.

RETROSPECTIVE REVIEWS

Retrospective reviews may determine that services as planned and documented do not meet the criteria requirements in the Medicaid manual. Through internal utilization management processes, providers need to ensure that medical necessity documentation is complete and consistent throughout the clinical record.

90801 Psychiatric Diagnostic Interview Examination

Definition: Psychiatric diagnostic interview examination by a psychiatrist includes a history, mental status, and a disposition, and may include communication with family or other sources.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration required for 2 sessions/per consumer/per year from start date of initial service Unit = Session/Event
Re-Authorization	1. Registration required for additional units after one year by any provider previously utilizing the benefit for the same consumer. 2 sessions/per consumer/ per year Unit= Session/Event 2. Tier 2 data submission required to exceed limit of two (2) units per consumer/per year (consumer benefit is two (2) sessions per year from any/all providers). This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. Only one unit (session) can be approved and the need for the additional unit should be described in the free-text field.
Admission Criteria	1. Consumer has, or is suspected of having, a behavioral health condition, **-or-** 2. Consumer is entering or reentering the service system, **-or-** 3. Consumer has need of an assessment due to a change in clinical/functional status, **-or-** 4. Evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Consumer has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	Codes 90862 Pharmacologic Management, 90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes, and 90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes, may not be billed *on the same day as* 90801 Psychiatric Diagnostic Interview Examination.
Clinical Exclusions	None
Documentation Requirement	Documentation must include a written record of findings and recommendations from the interview examination. Documentation must be signed (in practices of five (5) practitioners or less, where

	initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Physician Assistant may also perform this service.

H0031 AJ Mental Health assessment by a non-physician

Definition: Initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status, and/or social history of an individual. Specialty evaluations such as occupational therapy, nutritional, and functional skills assessments are included. The administration and scoring of functional skills assessments are included. This code is to be utilized by Master's Level Licensed Social workers or Licensed Professional Counselors working in a psychiatric practice.

Level of Service	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child & Adult (C&A)
Medicaid Option	Psychiatric Services-CPT Codes
Initial Authorization	Registration required for 1 session/per consumer/per year/per provider from start date of initial service Unit= Session/Event
Re-Authorization	1. Registration required for additional units after one year by any provider previously utilizing the benefit for the same consumer. 1 session/per consumer/ per year/per provider Unit= Session/Event 2. Tier 2 data submission required to exceed the limit of four (4) units per consumer/per year (consumer benefit is four (4) sessions per year from any/all providers). This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. Only one unit (session) can be approved and the need for the additional unit should be described in the free-text field.
Admission Criteria	1. Consumer has, or is suspected of having, a behavioral health condition, **-or-** 2. Consumer is entering or reentering the service system, **-or-** 3. Consumer has need of an assessment due to a change in clinical/functional status, **-or-** 4. Evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Consumer has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for the consumer's treatment have been substantially met.
Service Exclusions	None

Clinical Exclusions	None
Documentation	Documentation must include a written record of findings and recommendations from the interview examination. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. The assessments are evaluative services and standardized testing instruments.

2. The assessments are administered by qualified staff and are necessary to make determinations concerning the mental, physical and functional status of the consumer.

90862 Pharmacologic Management

Definition: Pharmacologic Management by a psychiatrist including prescription, use and review of medication with no more than minimal medical psychotherapy.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration required for 12 sessions/per consumer/per 184 days/per provider 12 sessions for 184 days from start date of initial service Unit = Session/Event
Re-Authorization	1. Registration required for additional units after 184 days by any provider previously utilizing the benefit for the same consumer. 12 sessions for 184 days Unit = Session/Event *2.* Tier 2 data submission required to exceed the limit of twelve (12) sessions per consumer/per provider/per 184 days. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. The total number of additional units/sessions being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit/session will be granted.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. A psychiatrist has determined the need for and prescribed psychotropic medication.
Continuing Stay Criteria	Consumer continues to meet admission criteria.
Discharge Criteria	Consumer no longer needs medication or refuses this service.
Service Exclusions	Services 90801 Psychiatric Diagnostic Interview Examination, 90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes, and 90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes may not be billed *on the same day as* 90862 Pharmacologic Management.
Clinical Exclusions	Service excludes intensive medical psychotherapy.
Documentation Requirement	Psychiatrist must complete a note describing the service provided. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Physician Assistant may also perform this service.

90804 Individual Psychotherapy 20-30 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 20-30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 20-30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	This is an outpatient service. If the consumer is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized, depending

	on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90804 AJ Individual Psychotherapy 20-30 minutes

Definition: Face-to-face structured intervention by a Master's Level Licensed Social Worker or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 20-30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 20-30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts

	and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. This service includes medical evaluation and management services and may include more intensive medical psychotherapy than is allowable under the Pharmacologic Management service.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 20-30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 20-30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	Services 90801 Psychiatric Diagnostic Interview Examination, 90862 Pharmacologic Management, and 90807 Individual Psychotherapy with Medical Evaluation and Management

	Services 45-50 minutes, may not be billed *on the same day as* 90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes. This is an outpatient service. If the consumer is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized depending on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90806 Individual Psychotherapy 45-50 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten (10) additional units/ per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g. 15, 20 etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in

	the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment needs. 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	This is an outpatient service. If the consumer is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized depending on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

2.

1. Physician Assistant may also perform this service.

Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90806 AJ Individual Psychotherapy 45-50 minutes

Definition: Face-to-face structured intervention by a Master's Level Licensed Social Worker or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes

Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. This service includes medical evaluation and management services and may include more intensive medical psychotherapy than is allowable under the Pharmacologic Management service.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis (other than a V-code) which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	Services 90801 Psychiatric Diagnostic Interview Examination, 90862 Pharmacologic Management, and 90805 Individual

	Psychotherapy with Medical Evaluation and Management Services 20-30 minutes, may not be billed *on the same day as* 90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes. This is an outpatient service. If the consumer is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized depending on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.

2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90846 Family Psychotherapy (without patient present)

Definition: Face-to-face structured family intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed limit of ten additional units/per consumer/per year. This level of data is required to exceed authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	*90846 Family Psychotherapy (without patient present) has a combined service limit with 90847 Family Psychotherapy (with patient present) of 10 units/per consumer/per year.*
Clinical Exclusions	1. There is no outlook for improvement with this level of service.

	2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.

2. ***Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.***

90847 Family Psychotherapy (with patient present)

Definition: Face-to-face structured family intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. The identified patient must be present to utilize this code.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	*90847 FAMILY PSYCHOTHERAPY (WITH PATIENT PRESENT) HAS A COMBINED SERVICE LIMIT WITH 90846 FAMILY PSYCHOTHERAPY (WITHOUT PATIENT PRESENT) OF 10 UNITS/PER CONSUMER/PER YEAR.*

Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.

2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not “stand-alone” interventions.

90847 AJ Family Psychotherapy (with patient present)

Definition: Face-to-face structured family intervention by a Master's Level Licensed Social Worker or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. The identified patient must be present to utilize this code.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	*NONE.*
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.

Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90853 Group Psychotherapy 75-80 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. These activities are carried out within a group context where the therapist engages the group dynamics in terms of relationships, common problems focus, and mutual support to promote progress for individual consumers. This code may not be utilized for multiple family group therapy.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 75-80 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/ per year Unit = 75-80 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
ADMISSION CRITERIA	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.

Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90853 AJ Group Psychotherapy 75-80 minutes

Definition: Face-to-face structured intervention by a Master's Level Licensed Social Worker or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. These activities are carried out within a group context where the therapist engages the group dynamics in terms of relationships, common problems focus, and mutual support to promote progress for individual consumers. This code may not be utilized for multiple family group therapy.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = session/75-80 minutes
Re-Authorization	2. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/ per year Unit = session/75-80 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. Additionally, the need for additional units must be described in the free-text field.

ADMISSION CRITERIA	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria: 1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90875 Individual Psychotherapy Biofeedback 20-30 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes individual psychophysiological therapy incorporating biofeedback training by any modality with psychotherapy to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 20-30 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 20-30 minutes

	NOTE: Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Service includes biofeedback training by any modality.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Psychiatrist, Physician Assistant or other qualified professional billing this code must have specific training in biofeedback techniques.

2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90876 Individual Psychotherapy Biofeedback 45-50 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes individual psychophysiological therapy incorporating biofeedback training by any modality with psychotherapy to provide therapeutic change in an outpatient setting.

Service Tier	Registration
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Registration for 10 units/per year/per consumer from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same consumer or continuing the service after one year. 10 additional units/per consumer/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per consumer/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Consumer demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the consumer's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Service includes biofeedback training by any modality.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the consumer's identified treatment need(s). 2. Progress notes document consumer's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Consumer has withdrawn or been discharged from service. 2. Goals for consumer's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must

	be signed (in practices of five (5) practitioners or less, where initials can easily identify the specific practitioner, initials are sufficient) and dated (date of service).

Additional Service Criteria:

1. Psychiatrist, Physician Assistant or other qualified professional billing this code must have specific training in biofeedback techniques.

2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90899 Special Evaluation Services

Definition: Provision of special evaluation services especially those ordered by the court. Services must relate to a consumer's known or suspected behavioral health condition, symptoms or functional impairments and must be either court ordered or specifically requested by Child Protective Services, Adult Protective Services, or Youth Services for purposes related to treatment planning, permanency planning, possible court action and/or removal from the current living situation **and** to make recommendations related to interventions or services that will ameliorate the client's symptoms and/or improve current functioning. Special Evaluation Services include substance abuse evaluation, forensic and/or competency evaluation, sexual victim or perpetrator evaluation or domestic violence/child abuse evaluation (other than sexual abuse). The evaluator must have specific training and expertise in the area of specialty evaluation and evaluation activities must include two (2) or more of the following activities to be considered a special evaluation service: specialized testing or screening relevant to the specialty area (including interpretation of findings), ancillary or collateral interviews, extensive record review or review of court testimony/police reports, special interviewing techniques or videotape review. Documentation must include interpretation and scoring of any testing and a written report of findings and recommendations.

Service Tier	Tier 2 Prior Authorization
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (MR/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Tier 2 Prior Authorization required 1 evaluation/per consumer/per year Unit = 1 hour The number of units requested should be included in the free text field. Units will be approved based on reasonable and customary times and rates for comparable evaluations. Unique circumstances that justify units above reasonable and customary should be noted in the free text field.
Re-Authorization	Tier 2 data submission is required for additional units within one-year of the start date of the authorized Special Evaluation by any provider for the same consumer. 1 evaluation/per consumer/per year Unit = 1 hour The number of units requested should be included in the free text field. Units will be approved based on reasonable and customary times and rates for comparable evaluations. Unique circumstances that justify units above reasonable and customary should be noted in the free text field.
Admission Criteria	1. Consumer has a behavioral health diagnosis which qualifies for Medicaid behavioral health services or a suspected behavioral health condition that requires special evaluation, **- and-**

	2. Consumer requires evaluation for a specific purpose (which is identified and documented), **-and/or-** 3. Evaluation is required to make specific recommendations regarding specialized treatment or services required by the individual.
Continuing Stay Criteria	1. Consumer has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the consumer's progress to the court.
Discharge Criteria	Consumer has withdrawn or been discharged from service.
Service Exclusions	90801 Psychiatric Diagnostic Interview by a Psychologist may not be billed on the same day as 90899. 96100 Comprehensive Evaluation by a Psychologist; 96110 Developmental Testing: Limited; 96111 Developmental Testing: Extended; 96115 Neurobehavioral Status Exam; and 96117 Neuropsychological Testing Battery may not be billed by the psychiatrist during the period 90899 is authorized but referrals may be made to psychologists to provide testing. Requests for authorizations by psychologists for these services will pend if a psychiatrist has authorization for 90899 and will be authorized on a case-by-case basis.
Clinical Exclusions	None.
Documentation Requirement	Documentation must include scoring and/or interpretation of testing, assessments and screenings administered and a written report of findings and recommendations. Documentation must be signed (including the credentials of the individual performing the service) and dated (date of service).

Additional Service Criteria:

1. Service must be provided by a Psychiatrist with specific training and expertise in the type of special evaluation requested;

2. The number of units requested should be based on reasonable and customary evaluations of a similar type **and** the activities required to complete the special evaluation for the specific client.

3. The designated start date will be the service start date and the end date of the request will be negotiated between the provider and the APS Care Manager but will be no more than 45 days from the designated start date.

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ATTACHMENT 10

DIABETES EDUCATION PROVIDER TOOL
PAGE 1 OF 2

Diabetes Education Provider Tool

This tool is based on the "National Standards for Diabetes Self-Management Education" and indicates minimum services to be provided in the continuing care of people with diabetes. It is not intended to replace or preclude clinical judgment or more intensive management where medically indicated. Use it as a reminder to simplify record keeping and as a way to continually improve care to all patients with diabetes.

DEMOGRAPHIC INFORMATION		
Patient Name:		
DOB:	Type of Diabetes: 1 2 GDM (circle one)	Year of Diagnosis:

DIABETES EDUCATION NEEDS	DATE OF VISIT					
Diabetes Disease Process						
Medical Nutrition Therapy						
Physical Activity						
Medication Therapy						
Monitoring						
Acute Complications						
Risk Reduction						
Goal Setting/Problem Solving						
Psychosocial Issues						
Preconception/Pregnancy						
Other Education Needs						

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PRACTITIONER SERVICES
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ATTACHMENT 11
DIABETES MANAGING PROVIDER CARE TOOL
PAGE 1 OF 2

Diabetes Managing Provider Care Tool
(MDs, DOs, FMPs, PNPs)

This tool is based on the 2004 American Diabetes Associations "Clinical Practice Recommendations 2004" and indicates minimum services to be provided in the continuing (initial visits have additional components) care of adults with diabetes. It is not intended to replace or preclude clinical judgment or more intensive management where medically indicated. Use it as a reminder for exams or important tests to simplify record keeping and as a way to continually improve care to all patients with diabetes.

DEMOGRAPHIC INFORMATION		
Patient Name:		
DOB:	Type of Diabetes: 1 2 GDM (circle one)	Year of Diagnosis:
Height	Smoker: YES NO (circle one)	Pneumococcal Vaccine Date (s):

CLINICAL INFORMATION	DATE OF VISIT					
Every Visit						
Weight						
B/P **Goal <130/80**						
A1c (every 3-6 mo.) **Goal: <7%**						
Foot Exam (Visual)						
Annually						
Foot Exam: Sensation, foot structure/biomechanics, vascular, and skin integrity						
Fasting Lipid Profile: • Total Cholesterol **Goal <200**						
• LDL **Goal <100**						
• HDL **Goal: Men >40 Women >50**						
• Triglycerides **Goal <150**						
Microalbumin **Goal: <30**						
Dilated Eye Exam **Referral Date**						
Flu Vaccine						
Counseling						
Self-Management Education **Referral Date**						
Exercise/Physical Activity						
Medical Nutrition Therapy **Referral Date**						
Nephrology **Referral Date**						
Behavioral Health **Referral Date**						
Tobacco Cessation						
Preconception Counseling (women of childbearing age)						
Other						
Review Self-Monitoring Glucose Log						
Assess Need for Aspirin Therapy						
Assess Need for Statin Therapy						

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PRACTITIONER SERVICES

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ATTACHMENT 12
RESPONSIBILITIES FOR LICENSED PRACTITIONER TO GET EXTENDED OFFICE VISIT MEDICAID REIMBURSEMENT
PAGE 1 OF 2

Responsibilities for Licensed Practitioner to get Extended Office Visit Medicaid Reimbursement

A. The provider or a member of the staff (RN, NP, PA, or LPN) must attend a Medicaid/Public Health Session **or receive equivalent training.**

B. Document that a diabetes instructional session of the provider's staff has taken place in the provider's office. (i.e. held a meeting in the practice and reviewed the DSM/Preventive Service manual with the staff, or used the CD ROM [Quick Tips] in the packet to educate the staff to the new diabetes information.)

C. Institute and complete the Flow sheet for each Medicaid patient with diabetes. The sheet includes:

1. Blood Pressure
2. HbA1c
3. Lipid Profile
4. Fasting/random blood glucose
5. EKG
6. Urinalysis
7. 24 hour urine or Microalbuminuria
8. Lytes, H&H, WBC, BUN, Creatinine
9. Aspirin as prevention
10. Immunizations (flu/pneumococcal)
11. Weight
12. Foot Exam
13. Eye referral
14. Nutrition Counseling

D. Complete a Diabetes Assessment (including exercise) and Plan for each **patient (A copy of this assessment is sent with a written referral to the Certified Diabetes Educator)**.

E. Provide written referral for nutrition counseling to **a certified diabetes educator (CDE)**.

F. **A written referral is sent by the provider to a diabetes educator indicating the material to be taught. The provider is responsible for survival skill information for diabetes:**

1. Medication administration with signs and symptoms of adverse effects
2. Monitoring: Glucose & Urine testing for ketones. Ketone testing for type 1 and illness in type
3. What to do in the event of Hypo/Hyperglycemia & sick day management
4. Foot care
5. Exercise Plan
6. Advanced level education: **Acute and chronic complications include** impotence, cardiovascular, nephropathy, neuropathy, pre-pregnancy counseling, pregnancy counseling , gestational diabetes

G. A written individualized diabetes plan of care is given to each patient b**y** the provider. The plan includes meal plan, exercise, medication, monitoring and goal for blood glucose.

H. The Certified Diabetes Educator will send a written report of the items taught and recommendations back to the Provider for review.

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ATTACHMENT 13
DIAGNOSTIC CODES COVERED FOR BONE DENSITY SCANS

Diagnostic Code	Description
242.90-91	Thyrotoxicosis
252.0	Hyperparathyroidism
255.0	Cushing's Syndrome
256.2, 627.2, 627.8	Estrogen deficient states
256.31-256.39	Other ovarian failure
259.3	Ectopic hyperparathyroidism
259.9	Other endocrine disorder, estrogen/testosterone deficiency
268.0-268.9	Osteomalacia, rickets, vitamin D deficiency
275.41	Hypocalcemia
626.0	Absence of menstruation
627.0-627.9	Menopausal disorders
733.00-733.09	Osteoporosis
733.11-733.16	Pathologic fractures
733.90	Disorder of bone and cartilage, unspecified
733.13	Pathologic fracture of vertebrae
756.51	Osteogenesis imperfecta
756.83	Ehlers-Danlos Syndrome
758.6	Gonadal dysgenesis, Turner's Syndrome
759.82	Marfan's Syndrome
805.00-805.9	Fracture of vertebral column, without spinal cord injury
806.00-806.9	Fracture of vertebral column with spinal cord injury
962.0, 995.2	Long-term use of glucocorticoid drugs
E932.0	Drugs causing adverse effects in therapeutic use
V49.81	Post menopausal status
V58.69	Long-term use (current) of other medications
V67.51	Following treatment with high-risk meds, monitoring for response to osteoporosis therapy
V67.59	Following other treatment, for monitoring ongoing therapy for osteoporosis

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PRACTITIONER SERVICES

OCTOBER 1, 2005

ATTACHMENT 14

INSTRUCTIONS FOR COMPLETING THE CMS 1500 CLAIM FORM
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Item 1a. Insured's ID Number

Enter the member's 11 digit identification number (no letters) assigned by the WV DHHR for Medicaid members. The Medical Card may indicate an "M" for Medicare or "P" for private insurance. This is NOT part of the Member I.D. Number.

Item 2. Member's Name

Enter the patent's last name, first name and middle initial.

Item 3. Member's Birth Date and Gender

Indicate the member's date of birth and whether male or female.

Item 4. Insured's Name

Enter the insured's name as listed on the Medicaid (Medical) Card.

Item 5. Member's Address

Enter the member's address in full.

Item 6. Member's Relationship to the Insured

Check "self."

Item 7. Insured's Address

Enter the current address of the member.

Item 8. Member's Status

Not required for Medicaid.

Item 9. Other Insured's Name

Enter policyholder's name if insurance other than Medicaid is covering this member. If no insurance, go to Block 10.

Medicaid is the payer of last resort program. Medicare and all other payers must be billed before Medicaid is billed.

Item 9a. Other Insured's Policy or Group Number

Enter policy or group number of the insurance policy.

Item 9b. Other Insured's Date of Birth

Enter the policyholder's date of birth and gender.

Item 9c. Employer's Name or School Name

Enter the name of the employer through which the policy is held.

Item 9d. Insurance Plan Name or Program Name

Enter the name of the insurance plan or program other than Medicaid.

Item 10. Member's Condition Related to Employment, Auto Accident or Other Accident

If treatment was due to accidental injury, auto accident or was employment-related, enter an "X" in the proper block.

Item 11. Insured's Group Number or FECA Number

Item 11a-11d. Enter insurance information other than listed in Block 9a - 9d.

Item 12. Member's Signature

Not required for Medicaid.

Item 13. Insured's Signature

Not required for Medicaid.

Item 14. Date of Current Illness, Injury and/or Pregnancy

Indicate the date of onset of current illness, injury, or pregnancy.

Item 15. Previous Date of Same or Similar Illness

Indicate the date of initial treatment for the same or similar condition, if known.

Item 16. Dates Member Unable to Work

Desired, but not required.

Item 17. Name of Referring Physician or Other Source

Enter the referring physician's name.

Item 17a. I.D. Number of Referring Physician

Enter the referring physician's UPIN, NPI or Medicaid Provider Number. Leave blank if the member was not referred for treatment.

Item 18. Hospitalization Dates

Admission and discharge dates, if known.

Item 19. Reserved for Local Use

Enter the 10 digit PAAS approval number, if applicable.

Item 20. Outside Lab

Not required for Medicaid.

Item 21. Diagnosis Code

Enter up to four ICD-9-CM diagnosis codes in priority order (primary, secondary, etc.).

The claim will be denied if there is no diagnosis code.

Diagnosis and procedure codes must be consistent.

Item 22. Medicaid Resubmission Code/Original Reference Number

If this is an adjustment for a previous claim, enter the TCN of the original claim.

Item 23. Prior Authorization Number

Enter the 10 digit prior authorization number if applicable for the claim. The claim must be split if more than one prior authorization applies.

Item 24A. Service Period

Enter the date(s) of service in the block (MM, DD, YY).

Item 24B. Place of Service

Enter the appropriate place of service code from the codes listed below.

CODE	Place of Service
11	Office
12	Member’s Home
21	Hospital - Inpatient
22	Hospital - Outpatient
23	Hospital - Emergency Department
24	Ambulatory Surgical Center (ASC)
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility

33	Custodial Care Facility
34	Hospice
41	Ambulance (Land)
42	Ambulance (Air-Water)
51	Psychiatric Facility - Inpatient
52	Psychiatric Facility - Outpatient
53	Community Mental Health Center (CMHC)
54	Intermediate Care Facility
55	Residential Substance Abuse Facility
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic (RHC)
81	Independent Lab
99	Other Unlisted Facility

Item 24C. Type of Service - Defaults to 1 for CMS Services

Item 24D. Procedure Codes

Enter the five-digit code that describes the procedure performed on the date of service. The code will be a CPT-4 (Level I), HCPCS (Level II) or State-Specific (Level III) code.

If service provided requires a modifier, enter up to three modifiers in the spaces provided after the procedure code. If more than three modifiers apply, enter Modifier 99 first.

Two lines on the CMS-1500 cannot be billed with same information. One line will deny as a duplicate.

Procedure code and diagnosis code must match.

Item 24E. Diagnosis Code

Enter the diagnosis code reference numbers from locator 21 (maximum 4). Only specific reference numbers (1, 2, 3, 4) will be accepted.

Item 24F. Charges

Enter the <u>total</u> charges for the procedure code billed on each line.

Item 24G. Days or Units

Enter the number of times the procedure for which you are billing was performed.

For general anesthesia, show the elapsed time in units in Item 24G. Each 15 minutes equals one unit. <u>Base units are programmed in the system and are not to be entered on the claim form</u>. Do NOT bill in minutes.

Item 24H. EPSDT/Family Planning for Providers Participating in EPSDT and Family Planning Programs Only

Valid values include:
Spaces = not applicable
1 = Full screen, with referral
2 = Full screen, no referral
3 = Partial screen, with referral
4 = Partial screen, no referral

5 = Family planning, physician
6 = Family planning, mid-level
7 = Family planning, nurse

Item 24J. Coordination of Benefits (COB)

Indicate whether or not the member has other health coverage. Enter "1" if no other insurance; enter “2" if Medicare; enter "3" if there is any other health insurance.

Item 24K. Reserve for Local Use

Indicate any amounts paid toward these charges by other insurance, or member. If other insurance, attach “Explanation of Benefits” if (1) insurance denied the claim or (2) the insurance company billed is not listed on the medical card or is not the same as the one listed.

Item 25. Federal Tax I.D. Number

Enter Federal Tax I.D. Number.

Item 26. Member’s Account Number

Enter your member account number. Alpha and numeric characters may be used (maximum of 20). It is especially useful in locating files if the case number is incorrect, not on file, all zero numbers, etc. This information will appear on the remittance voucher. If using member's name: Last name first.

Item 27. Accept Assignment

Billing Medicaid indicates acceptance of assignment. (In order for Medicaid to pay the co-insurance and/or deductible owed, assignment must be accepted for Medicare members.)

Item 28. Total Charge

Enter total charge for the claim.

Item 29. Amount Paid

Enter total amount paid by other insurance.

Item 30. Balance Due

Not required for Medicaid.

Item 31. Signature of Physician or Supplier

Signature of person authorized to certify this claim. By signing the BMS Provider Enrollment Agreement (included in the Enrollment/Re-enrollment Packet) you have certified all information listed on a claim for reimbursement from Medicaid is true, accurate, and complete. Therefore, you may endorse your claim with a computer-generated, manual, or stamped signature.

Item 32. Name and Address of Facility Where Services Were Rendered

Enter the name and address of the facility, if a member was in an institutional setting (i.e., hospital, nursing home, etc.).

Item 33. Physician or Supplier Name, Address, Zip Code, Provider Number and Phone Number

Enter name, address, and Medicaid 10 digit provider number.

GRP # (Group Number)

Enter the 10 digit Medicaid group pay to provider number, if applicable.

STATUS CODES

A Active code: These are covered services for which payment is made using Medicaid's

physician fee schedule. Services with “relative value units” covered by Medicaid have an "A" status.

B Bundled code: Payment for covered services is bundled into payment for other unspecified services. Separate payment for the provision of these services is never made.

C Carrier-priced procedure code: Medicaid will establish the “relative value units” services considered unlisted CPT procedure codes, CPT codes that end in "99", and for services for which CMS has not established “relative value units”, typically low-volume services. The "C" is also used to indicate services typically covered by Medicaid, but for which there are no “relative value units” in Medicaid's database.

P Bundled and non-incident services: there are two instances in which no fee schedule payment is made for a covered service, but instead payment for the particular service is bundled into the payment for another covered service. The first instance occurs when a service is considered as incident to a physician service and is furnished on the same date of service, such as the provision of an elastic bandage. Payment for the service is considered bundled into the second service’s payment. The second instance occurs when a service is not considered “incident” to a physician service, such as the provision of colostomy supplies. In this latter case, payment for the service is made under other provisions.

T Injections and other minor services: There services are only paid if there are no other services payable and billed on the same date by the same provider. Services the same provider bills on the same date are bundled into the service for which separate payment is made.

Global Surgery Indicators

The WV Medicaid Program adopted Medicare's pre-operative and post-operative global surgical package windows for surgeries. During these global surgery periods, payment for office visits associated with the surgical procedure will not be made. The Global Indicator Variable indicates the post-operative period.

CODE	EXPLANATION
MMM	Global surgery period does not apply; maternity code
XXX	Global surgery period concept does not apply
YYY	Global surgery period determined by carrier
ZZZ	Code falls within global surgery period for another service
90	Global surgery period includes day before, day of, and 90 days after surgical procedure.
10	Global surgery period includes day of and 10 days after surgery
0	Global surgery period includes day of procedure only.

Payment Policy Indicators

Multiple Surgeries

A "Y" indicates these services may be billed as multiple procedures.

Bilateral Surgery

A "Y" indicates these services may be billed as bilateral procedures. When billing Modifier 50, use "1" in "Days or Units", Block 24G.

Assistant at Surgery

A "Y" indicates payment may be made for assistants at surgery, if medically necessary.

A “D” indicates payment may be made for assistant at surgery if documentation supports medical necessity.

Co-surgeons

A "Y" indicates physicians may bill as co-surgeons for the service, with or without supporting documentation depending on the procedure.

A “D” indicates physicians may bill as co-surgeons with supporting documentation to be reviewed for medical necessity.

Team Surgery

A "Y" indicates physicians may bill as team surgeons for this service, with supporting documentation depending on the procedure.

A “D” indicates physicians may bill as team surgeons for this service with supporting documentation to substantiate medical necessity.

CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 15
APPROVED HCPCS J CODES
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West Virginia Department of Health and Human Resources
Bureau for Medical Services
Office of Healthcare Policy and Managed Care Coordination
HCPCS J Codes
Effective 7/1/05

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J0120	Injection tetracycline up to 250mg	Achromycin Sumycin Panmycin	Antibiotic	None	4 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0128	Injection abarelix 10mg	Plenaxis	Gonado-tropin	68158-0149-51	None	X	X												New code 1/1/05. Maximum dosage 100 mg on days 1, 15 & 29, then maximum 100 mg every 4 weeks thereafter. ICD-9-CM 185 required on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0130	Injection abciximab 10mg	ReoPro	Antiplatelet	00002-7140-01															Not Covered
J0135	Injection adalimumab 20mg	Humira	Antirheu-matic	00074-3799-02															Not Covered
J0150	Injection adenosine 6mg	Adenocard	Antiarrhy-thmic	54569-3745-00															Not covered
J0152	Injection adenosine for diag. use 30mg	Adenocard	Diagnostic agent	00469-0871-20 00469-0871-30	None	X	X									X			Replaces J0151. **Use only for stress testing**. Separate billing when test provided in physician's office or IDTF. Adults only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0170	Injection adrenalin epi-nephprine up to 1ml	Adrenalin Chloride, SusPhrine	Respiratory	54868-1363-00' 54868-2065-00' 54868-2065-01 61570-0418-81	1 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0180	Injection agalsidase beta 1mg	Fabrazyme	Enzyme	58468-0040-01 58468-0041-01	None	X	X											X	New code 1/1/05. **Requires Prior Authorization for children 16<years of age.** Submit copies of physician's medical records, specialist's medical records (as appropriate), member's weight, signs and symptoms and diagnostic test results to confirm diagnosis of ICD-9-CM code 272.7 to BMS Medical Director. Children 16> years of age, do not require prior authorization. ICD-9-CM Code 272.7 must be documented on the CMS 1500 claim form when submitting to Unisys for payment consideration.. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0190	Injection biperiden lactate 5mg	Akineton		None	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0200	Injection alatroflaxacin mesylate 100mg	Trovan Trova-floxacin	Antibiotic	'00049-3890-28 '00049-3900-28															Not Covered
J0205	Injection alglucerase 10U	Ceredase	Enzyme	58468-1060-01	None	X	X												ICD-9-CM code 272.7 required on CMS 1500 claim form. Medical necessity documentation to include member's weight is required in individual's medical record.

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J0207	Injection amifostine 500mg	Ethyol	Antineo-plastic	'58178-0017-01 '58178-0017-03	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0210	Injection methyldopate HCl up to 250mg	Aldomet Aldoril	Antihyper-tensive	00517-8905-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0215	Injection alefacept 0.5mg	Amevive	Monoclonal Antibody	59627-0020-01 59627-0021-03	see Special Instruc-tions	X	X												30 units per week X 12 weeks in a 6 month period per lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0256	Injection alpha 1 protein-ase inhibitor human 10mg	Prolastin	Alpha anti-tripsin I deficiency	00026-0601-30 '00026-0601-35 '49669-5800-01 '49669-5800-02	8 per day	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J0270	Injection alprostadil 1.25mcg	Prostin VR Pediatric	Prostaglan-din	00009-3169-06 '00703-1501-02 '55390-0503-10 '55390-0506-05 '55390-0506-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0275	Alprostadil urethral suppository	Muse	Prostaglan-din	62541-0110-01 '62541-0110-06															Not Covered
J0280	Injection aminophyllin up to 250mg	Phyllocontin	Broncho-dilator	00074-7385-01 '00223-7128-02 '00223-7128-10 '00223-7130-00 '00223-7130-10 '54868-0004-00	None	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0282	Injection amiodarone HCl 30 mg	Cordarone	Antiarrhy-thmic	00008-0814-01 '10019-0131-01 '55390-0057-01 '55390-0058-10 '60505-0722-00 '61703-0241-03 '63323-0616-03 '63323-0616-13															Not Covered
J0285	Injection amphotericinB 50mg		Antibiotic	00003-0437-30 '00013-1405-44 '00703-9785-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0287	Injection amphotericinB lipid complex 10mg		Antibiotic	61799-0101-31 '61799-0101-41	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0288	Injection amphotericinB cholesteryl sulfate com-plex 10mg	Amphotec	Antibiotic	61471-0110-12 '61471-0115-12	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0289	Injection amphotericinB liposome 10mg.	Ambisome	Antibiotic	00469-3051-30	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J0290	Injection ampicillin sodi-um 500mg.	Totacillin-N Omnipen-N	Antibiotic	00015-7403-20 '00015-7403-99 '54868-4047-00 '55045-1204-03 '55045-1204-09 '63323-0388-10	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0295	Injection ampicilllin sodi-um sulbactam sodium 1.5g	Unasyn	Antibiotic	00049-0013-83 '59911-5901-02	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0300	Injection amobarbital up to 125mg.	Amytal	Anticonvul-ant	63304-0303-10 '63304-0303-25	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0330	Injection succinylcholine chloride up to 20mg.	Anectine Quelicin Sucostrin	Neuromus-cular blocker	00052-0445-10 54868-4380-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0350	Injection anistreplase 30U	Eminase		None															Not Covered
J0360	Injection hydralazine HCl up to 20mg	Apresoline	Antihyper-tensive	00517-0901-25 '63323-0614-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0380	Injection metaraminol bitartrate 10mg	Aramine	Adrenergic agonist	00006-3222-10 '54868-3692-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0390	Injection chloroquine HCl up to 250mg	Aralen	Antiinfec-tive	00024-0074-01															Not Covered
J0395	Injection arbutamine HCl 1 mg	GenESA		00703-1105-01	None	X	X									X			Medical necessity documentation of services provided must be maintained in the member's individual file.
J0456	Injection azithromycin 500 mg.	Zithromax	Antibiotic	00069-3150-14 '00069-3150-83 '54868-4527-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0460	Injection atropine sulfate up to 0.3mg	AtroPen	Antichole-nergic	00074-7897-15 '00517-0805-25	3 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0470	Injection dimercaprol 100 mg.	BAL in oil	Antidote	11098-0526-03	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0475	Injection baclofen 10mg	Lioresal	Skeletal muscle relaxant	58281-0560-01 58281-0561-02 '58281-0561-04	4 per day	X	X										X		A4220 bundled into refill/maintenance services. ICD-9-CM 342.1, 343.0 - 344.9, 345.60 - 345.61, 434.91, or 781.0 must be documented on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0476	Injection baclofen 50mg	Lioresal for intrathecal trial	Skeletal muscle relaxant	58281-0562-01	1 per year	X	X										X		For intrathecal trial only. Medical necessity documentation of services provided must be maintained in the member's individual file.

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Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J0500	Injection dicyclomine HCl up to 20mg	Bentyl Antispas Dilomine Dibent DiSpaz Neoquess	Anticholenergic	00068-0809-23	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0515	Injection benztropine mesylate 1mg	Cogentin	Anticholenergic	00006-3275-16 '00006-3275-38 '54868-2429-01	None	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J0520	Injection bethanechol chloride up to 5mg	Urecholine Mytonachol	Cholenergic	00006-7786-29	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0530	Injection penicillinG benzathine & penicillinG procaine up to 600K U	Bicillin CR	Antibiotic	61570-0139-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0540	Injection penicillinG benzathine & penicillinG procaine up to 1.2m U	Bicillin CR	Antibiotic	61570-0140-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0550	Injection penicillinG benzathine & penicillinG procaine up to 2.4m U	Bicillin CR	Antibiotic	61570-0142-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0560	Injection penicillinG benzathine up to 600K U	Bicillin LA Permapen	Antibiotic	54868-0753-00 '54868-0753-01 '61570-0146-10 '61570-0147-10 '61570-0148-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0570	Injection penicillinG benzathine up to 1.2m U	Bicillin LA Permapen	Antibiotic	54868-0753-00 '54868-0753-01 '61570-0146-10 '61570-0147-10 '61570-0148-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0580	Injection pennicillinG benzathine up to 2.4m U	Bicillin LA Permapen	Antibiotic	54868-0753-00 '54868-0753-01 '61570-0146-10 '61570-0147-10 '61570-0148-10	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0583	Injection bivalirudin 1mg	Angiomax	Anticoagulant	65293-0001-01	None	X													Medical necessity documentation of services provided must be maintained in the member's individual file.

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Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J0585	Botulinum toxin type A per unit.	Botox	Neuromus-cular blocker	00023-1145-01 '54868-4123-00	None	X	X											X	**Requires Prior Authorization.** Submit documentation of diagnostic treatment plan, failed therapies, adjunctive/concurrent therapies to BMS Medical Director for review prior to providing services. **Not covered for headache or cosmesis**. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0587	Botulinum toxin type B per 100 U	Myobloc	Neuromus-cular blocker	59075-0710-10 59075-0711-10 '59075-0712-10	None	X	X											X	**Requires Prior Authorization** Submit documentation of diagnostic treatment plan, failed therapies, adjunctive/concurrent therapies to BMS Medical Director for review prior to providing services. **Not covered for headache or cosmesis.** Medical necessity documentation of services provided must be maintained in the member's individual file.
J0592	Injection buprenorphine HCl 0.1mg	Buprenix	Analgesic narcotic	12496-0757-01	6 per day														Close code effective 7/1/05.
J0595	Injection butorphanol tartrate 1mg	Stadol	Analgesic narcotic	00015-5645-15 00015-5645-20 10019-0461-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0600	Injection edetate calcium disodium up to 1000mg.	Calcium Disodium Versenate, Calcium EDTA	Antidote	00089-0510-06	None	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J0610	Injection calcium gluco-nate 10ml	Kaleinate	Electrolyte Supplement	00223-7280-00 '00223-7280-10	3 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0620	Injection calcium glycer-ophosphate & calcium lactate 10ml	Calphosan	Electrolyte Supplement	00516-0060-60	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0630	Injection calcitonin sal-mon up to 400 U	Miacalcin Caalcimar	Antidote	00078-0149-23	1 per day	X	X												Not covered effective 7/1/05
J0636	Injection calcitrol 0.1mcg	Calcijex	Vitamin fat soluble	00074-8110-31 63323-0731-01 '66591-0315-12	30 per day	X	X												Not covered effective 7/1/05
J0637	Injection caspofungin acetate 5mg	Cancidas	Antifungal	00006-3822-10 '00006-3823-10	14 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0640	Injection Leucovorin calcium 50mg	Wellcovorin	Antidote	55390-0051-10	25 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J0670	Injection mepivacine HCL 10ml.	Carbocaine Polocaine Isocaine HCL	Local Anesthetic	00074-1038-50' 00074-2047-50 '00186-0410-01 '00186-0420-01 '54569-4782-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0690	Injection cefazolin sodium 500mg.	Ancef Kefzol Zolicef	Antibiotic	00015-7338-99 '54569-4431-00	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0692	Injection cefepime HCL 500mg	Maxipime	Antibiotic	00003-7731-99 '51479-0053-01 '51479-0053-10	8 per day	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0694	Injection cefoxitin sodium 1g	Mefoxin	Antibiotic	00006-3356-45 '59911-5963-02	1 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0696	Injection ceftriaxone sodium 250mg	Rocephin	Antibiotic	00004-1962-01 '00004-1962-01 '00004-1962-02 '00004-1962-02 '54868-0934-00 '54868-0934-00 '58016-9453-01 '58016-9453-01	8 per day	X	X	X	X								X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0697	Injection sterile cefurox-ime sodium 750mg	Kefurox Zinacef	Antibiotic	00002-5357-25 '00002-7271-01 '00002-7271-25 '00002-8994-25 '00173-0352-31 '00781-3918-96	2 per day	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0698	Cefotaxime sodium per g	Claforan	Antibiotic	00039-0018-10 '00039-0018-25 '00039-0018-50 '54868-3429-00 54868-3429-01 '63323-0331-15	1 per day	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0702	Injection betamethasone acetate & betametha-sone sodium phosphate 3mg	Celestone	Antiinflam-matory	00085-0566-05 '54868-0206-00 '58016-9191-01	9 per day	X	X	X				X							Medical necessity documentation of services provided must be maintained in the member's individual file.
J0704	Injection bemethasone sodium phosphate 4mg.	Celestone Phosphate Betameth Cel-U-Jec Selestoject	Antiinflam-matory	00223-7265-05	2 per day	X	X	X	X			X							Medical necessity documentation of services provided must be maintained in the member's individual file.
J0706	Injection caffeine citrate 5 mg	Cafcit		00597-0060-11 '00597-0061-11	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0710	Injection cephapirin sodium up to 1g	Cefadyl		None	1 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.

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J0713	Injection ceftazidime 500 mg	Fortaz Tazidime	Antibiotic	00173-0377-31 '00173-0377-31															Not Covered
J0715	Injection ceftizoxime sodium 500 mg	Ceflzox	Antibiotic	00469-7251-01 '00469-7253-02 '00469-7255-10	2 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0720	Injection chloramphenicol sodium succinate up to 1 g	Chloromycetin Sodium Succinate	Antibiotic	61570-0405-71	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0725	Injection, chorionic gonadotropin per 1000 USP units	Novarel Profasi Pregnyl	Gonado-tropin	00052-0315-10 '00223-7760-10 '00223-7770-10 44087-8010-03 '52637-0126-10 '54569-1986-00 '54868-3910-00 '55566-1501-01 '63323-0025-10	5 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0735	Injection clonidine HCl 1mg	Catapres	Alpha Adrenergic Agonist	00054-8233-01 '00054-8234-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0740	Injection cidofovir 375mg	Vistide	Antiviral	61958-0101-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0743	Injection cilastatin sodium imipenem 250 mg.	Primaxin	Antiinfec-tive	00006-3514-58	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0744	Injection ciprofloxacin for IV infusion 200mg	Cipro Ciloxan	Antibiotic	00026-8527-36 '00026-8552-36 '00026-8562-20	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0745	Injection codeine phos-phate 30mg		Analgesic-narcotic	00074-1102-02 '00074-1102-32	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0760	Injection colchicine 1mg		Antigout	55390-0605-02	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0770	Injection colistimethate sodium up to 150mg.	Coly-Mycin M	Antibiotic	39822-0615-01 '61570-0414-51	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0780	Injection prochlorperazine up to 10mg	Compazine Compa-Z Contrazine	Antiemetic	00641-0491-25 '54868-0261-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J0800	Injection cotricotropin up to 40U	Cortrosyn ACTH Acthar	Diagnostic agent	63004-7731-01	None		X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0835	Injection cosyntropin 0.25mg	Cortosyn	Diagnostic agent	00548-5900-00	3 per day		X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J0850	Injection cytomegalovirus immune globulin IV (human) per vial	CytoGam	Immune globulin	60574-3101-01															Not covered. Refer to CPT 90291
J0878	Injection daptomycin 1mg.	Cubicin	Antibiotic	67919-0011-01	4 per day X 14 days	X	X												New code 1/1/05. Maximum dose 4mg per day X 14 days. Adults only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0880	Injection darbepoetin alfa 5mcg	Aranesp	Anti-anemic	55513-0010-01 '55513-0011-01 '55513-0011-04 '55513-0012-01 '55513-0012-04 '55513-0013-01 '55513-0013-04 '55513-0014-01 '55513-0014-04 "55513-0015-01 '55513-0054-01 55513-0054-04	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0895	Injection deferoxamine mesylate 500mg	Desferal	Antidote	00083-3801-04	12 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J0900	Injection testosterone enanthate & estradiol valerate up to 1cc	Andro-Estro 90-4 Androgyn LA	Androgen	00314-0786-70	1 every 3 weeks	X	X	X											Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J0945	Injection brompherina-mine maleate10mg	ND Stat		52637-0926-10	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J0970	Injection estradiol valerate up to 40mg	Delestrogen Estradiol LA Valergen Estra-L	Contracep-tive	00223-7607-10 '00314-0784-70 '54569-1394-00 '55553-0244-10 '61570-0182-01	1 every 3 weeks	X	X	X											Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1000	Injection depoestradiol cyplonate up to 5mg	Estradiol Cypionate Estra-D Estra-Cyp Estro-LA	Hormonal Replace-ment	00009-0271-01 '52637-0332-10 '54569-2580-00 '54868-1729-00	1 per 3 weeks	X	X	X											Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1020	Injection methylpredniso-lone acetate 20mg	DepoMedrol	Antiinflam-matory	00009-0274-01	None	X	X	X				X							Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1030	Injection methylpredniso-lone acetate 40mg	DepoMedrol MPrednisol Rep-Pred	Antiinflam-matory	00009-0280-02 '00009-0280-03 '00009-0280-51 '00009-0280-52 '00009-3073-01 '00009-3073-03 '54868-3896-00	None	X	X	X				X							Medical necessity documentation of services provided must be maintained in the member's individual file.
J1040	Injection methylpredniso-lone acetate 80mg	DepoMedrol Medralone Prednisol RedPred	Antiinflam-matory	00009-0306-02 '00009-0306-12 '00009-3475-01 '00009-3475-03 '54868-1185-00 '54868-1994-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1051	Injection medroxyproges-terone acetate 50mg	Depo-Provera	Contracep-tive	00009-0626-01 '00009-0746-30 '00009-0746-35 '54868-3348-01	20 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1055	Injection medroxyproges-terone acetate 150 mg	Depo-Provera	Contracep-tive	None	1 per day	X	X	X	X										Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1056	Injection medrosyproges-terone acetate/estradiol cypionate 5mg/25mg	Lunelle	Contracep-tive	00009-3484-04 00009-3484-05 '54569-5272-00 '54868-4660-00	1 per day	X	X	X	X										Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1060	Injection testosterone cypionate & estradiol cypionate up to 1ml	Depo-Testadiol Andro/Fem	Androgen	00009-0253-02 '54569-4199-00	1 per 3 weeks	X	X	X											Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1070	Injection testosterone cypionate up to 100mg.	Depo-Testoster-one Depotest	Androgen	00009-0347-02	1 per 3 weeks	X	X	X											Male only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1080	Injection testosterone cypionate 1cc 200mg.	Depo-Tester-one Depotest Andro-Cyp 200	Androgen	00009-0417-01 '00009-0417-02	1 per week	X	X	X											Male only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1094	Injection dexamethasone acetate 1mg	Dalalone LA	Antiinflam-matory	00223-7390-05 '25332-0011-05 '54868-3977-00	20 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1100	Injection dexamethosone sodium phosphate 1mg	Cortastat Dalalone	Antiinflam-matory	Too numerous to list	10 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1110	Injection dihydroergota-mine mesylate 1mg	DHE 45	Anti-migraine	66490-0041-01	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1120	Injection acetazolamide sodium up to 500mg	Diamox	Glaucoma	55390-0460-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1160	Injection digoxin up to 0.5 mg	Lanoxin	Antiarrhy-thmic	00173-0260-10 '00173-0260-35 '00641-1410-35 54569-1523-00 '54569-1523-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1165	Injection phenytoin sodi-um 50mg	Dilantin	Anticonvul-ant	00074-1317-01 '00074-1317-02 '00641-0493-25 '00641-2555-45	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1170	Injection hydromorphone up to 4mg	Dilaudid	Analgesic narcotic	00074-2332-11 '00074-2333-11 '00074-2333-26 00074-2334-11 00641-0121-25	12 units per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1180	Injection dyphylline up to 500mg	Lufyllin Diler		00281-1112-31	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1190	Injection dexrazoxane HCl per 250mg	Zinecard	Cardio-protective agent	00013-8715-62	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1200	Injection diphenhydra-mine HCl up to 50mg.	Benadryl	Anti-histamine	00071-4259-03 '54868-0554-00 '54868-2048-00 '54868-2048-01 '54868-3644-00 63323-0664-01	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1205	Injection chlorothiazide sodium 500mg	Diuril Sodium	Antihyper-tensive	00006-3619-32	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1212	Injection DMSO di-methylsulfoxide 50%, 50 ml	Rimso		00433-0433-05 '49072-0433-05	1 per day	X	X												ICD-9-CM code 595.1 (intersitial cystitis) required on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1230	Injection methadone HCl up to 10mg	Dolphine HCL	Analgesic narcotic	00054-1218-42	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1240	Injection dimenhydrinate up to 50mg	Dramamine	Antiemetic	00223-7475-10															Not Covered
J1245	Injection dipyridamole 10 mg	Persantine	Antiplatelet	00703-1652-02 '55390-0555-10 '63323-0613-02	8 per day	X	X									X			Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1250	Injection dobutamine HCl 250mg.	Dobutrex	Adrenergic agonist	00074-2025-20	None	X	X									X			Medical necessity documentation of services provided must be maintained in the member's individual file.
J1260	Injection dolasetron mesylate 10mg	Anzemet	Antiemetic	00088-1206-32	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1270	Injection doxercalciferol 1mcg.	Hectorol	Vitamin D analog	64894-0840-50	20 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1320	Injection amitriptyline HCl up to 20mg	Elavil Enovil	Anti-depressant	00310-0049-10	1 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J1325	Injection epoprostenol 0.5mg.	Flolan	Prostaglan-din	00173-0517-00	None	X	X												Requires ICD-99-CM code 416.XX on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1327	Injection eptifibatide 5mg	Integrillin	Antiplatelet	00085-1136-01 '00085-1177-01 '00085-1177-02	None	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J1330	Injection ergonovine maleate up to 0.2mg	Ergotrate Maleate	Anti-migraine	None	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1335	Injection ertapenem sodium 500mg	Invanz	Antibiotic	00006-3843-71	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1364	Injection erythromycin lactobionate 500 mg		Antibiotic	00074-6365-02 '00074-6482-01	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1380	Injection estradiol valerate up to 10mg	Delestrogen Estradiol Gynogen	Contracep-tive	00223-7606-10 '00223-7607-10 '25332-0117-10 '54569-1394-00 '55553-0244-10 61570-0180-01 '61570-0181-01 '61570-0182-01															Not Covered
J1390	Inection estradiol valerate up to 20mg	Delestrogen Dioval Estradiol Gynogen Valergan Estra L	Contracep-tive	00223-7606-10 00223-7607-10 '00314-0784-70 '25332-0117-10 '54569-1394-00 55553-0244-10 '61570-0180-01 '61570-0181-01 '61570-0182-01	None		X	X	X										Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1410	Injection estrogen conju-gated 25mg	Premarin IV	Estrogen Derivative	00046-0749-05	1 per day	X	X												Female only. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1435	Injection estrone 1mg	Theelin Aqueous Estone 5 Kestrone 5		00223-7660-10 00223-7670-10 '25332-0019-10 '52637-0313-10															Not Covered
J1436	Injection etidronate disod ium 300mg	Didronel	Bone Res-tortive agent	58063-0457-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1438	Injection etanercept 25mg	Enbrel	Antirheu-matic	58406-0425-34 '58406-0425-41	2 per day	X	X												Not covered effective 7/1/05
J1440	Injection filgrastim (G-CSF) 300mcg	Neupogen	Colony stimulating factor	54868-2522-00 '55513-0530-01 '55513-0530-10	5 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1441	Injection filgrastim (G-CSF) 480mcg	Neupogen	Colony stimulating factor	'55513-0546-01 55513-0546-10	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1450	Injection fluconazone 200mg	Diflucan	Antifungal	00049-3371-26 '00049-3435-26 '00049-3437-26	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1452	Injection omivirsen sodi-um intraocculur 1.65mg.	Vitavene		58768-0902-35															Not Covered
J1455	Injection foscarnet sodi-um 1000mg	Foscavir	Antiviral	00186-1905-01 00186-1906-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1457	Injection gallium nitrate 1 mg	Ganite		66657-0301-01 66657-0301-05															Not Covered
J1460	Injection gamma globulin IM 1cc	Gammar Gamastan	Immune globulin	00026-0635-04 00026-0635-12 54569-5275-00 54569-5275-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1470	Injection gamma globulin IM 2cc	Gammar Gamastan	Immune globulin	00026-0635-04 '00026-0635-12 '54569-5275-00 54868-4193-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1480	Injection gamma globulin IM 3cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1490	Injection gamma globulin IM 4cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1500	Injection gamma globulin IM 5cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1510	Injection gamma globulin IM 6cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1520	Injection gamma globulin IM 7cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1530	Injection gamma globulin IM 8cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1540	Injection gamma globulin IM 9cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1550	Injection gamma globulin IM 10cc	Gammar Gamastan	Immune globulin	00026-0635-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1560	Injection gamma globulin IM over 10cc	Gammar Gamastan	Immune globulin	54868-4193-00 54569-5275-00 14362-0115-02 00026-0635-12 00026-0635-04	5 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1563	Injection immune globulin IV 1g		Immune globulin	00026-0648-20 '00026-0648-71 '00053-7486-05 00053-7486-10 00944-2620-03 '00944-2620-04 '44206-0507-56 52769-0268-66 '52769-0471-75 '52769-0471-80 '64193-0250-50	50 per day	X	X												Close code effective 7/1/05 - Replaced with Q9941 and Q9943
J1564	Injection immune globulin IV 10mg		Immune globulin	00026-0635-12 '00026-0646-12 '00026-0646-20 '00026-0646-24 '00026-0646-25 '00026-0646-71 '00026-0648-12 '00026-0648-15 '00026-0648-20 00026-0648-24 '00026-0648-71 49669-1612-01 '49669-1623-01 '49669-1624-01	None	X	X												Close code effective 7/1/05 - replaced with Q9942 and Q9944
J1565	Injection RSV immune globulin IV 50mg	RespiGam	Immune globulin	60574-2101-01	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1570	Injection ganciclovir sodium 500mg	Cytovene	Antiviral	00004-6940-03 '54569-4738-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1580	Injection Garamycin gentamicin up to 80mg	Gentamine Sulfate Jenamicin	Antibiotic	00085-0069-04 '00223-7719-02 '00223-7719-25 00223-7721-02 00641-0395-25 '00641-2331-43 '63323-0010-02 '63323-0010-20	None	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1590	Injection gatifloxacin 10 mg	Tequin Zymar	Antibiotic	00015-1179-80	40 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1595	Injection glatiramer acetate 20mg	Copaxone	Biological Misc	00088-1153-30	1 per day	X	X												Not covered effective 7/1/05
J1600	Injection gold sodium thiomalate up to 50mg	Aurolate Myochrysine	Antirheu-matic	11098-0533-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1610	Injection glucagon HCl 1mg.	Glucagon GlucaGen	Antidote	54569-2239-00 '54569-4734-00 '55390-0004-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1620	Injection gonadorelin HCl 100mcg	Factrel Lutrepulse	Gonado-tropin	00046-0507-05	1 per day	X	X												Not for fertility treatment and diagnosis. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1626	Injection granisetron HCl 100mcg	Kytril	Antiemetic	00004-0239-09 '00004-0240-09	20 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1630	Injection haloperidol up to 5mg	Haldol	Anti-psychotic	00045-0255-01 '00703-7041-03 '54868-3459-00 '55390-0147-10 55390-0447-10 '63323-0474-01 '63323-0474-91	2 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J1631	Injection haloperidol decanoate 50mg	Haldol Decanoate 50	Anti-psychotic	00045-0254-14 '00144-0544-51 '00703-7021-03 '55390-0413-01 55390-0423-01 '63323-0471-01	1 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J1642	Injection heparin sodium (heparin lock flush) 10U.	HepLock HepLock U/P	Anticoagu-lant	00223-7861-01 '00223-7863-02 '00641-0392-25 00641-0393-25 '00641-2438-45 '00641-2442-45 '63323-0544-11 '63323-0544-31	None									X	X				Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1644	Injection heparin sodium 1000U	Heparin Sodium Liqusemin Sodium	Anticoagu-lant	00223-7801-01 '00223-7810-10 00223-7843-10 '00223-7844-30 '00641-0391-25 '00641-2436-45 '00641-2440-45 '00641-2450-45 '11743-0210-02 '49072-0291-30 63323-0540-11 63323-0540-31	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1645	Injection dalteparin sodi-um 2500IU	Fragmin	Anticoagu-lant	00013-2406-91	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1650	Injection enoxaparin sodium 10mg	Lovenox	Anticoagu-lant	00075-0626-03	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1652	Injection fondaparinux sodium 0.5 mg	Atrixtra	Anticoagu-lant	66203-2300-01	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1655	Injection tinzaparin sodium 1000 IU.	Innohep	Anticoagu-lant	00056-0342-08 '00056-0342-53	7 conse-cutive days	X	X	X											Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1670	Injection tetanus immune globulin human up to 250U	BayTet	Immune globulin	00026-0634-02	1 per 10 years	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1700	Injection hydrocortisone acetate up to 25mg	Hydrocortone Acetate	Antiinflam-matory	00463-1036-10	4 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1710	Injection hydrocortisone sodium phosphate up to 50mg	Hydrocortone Phosphate	Antiinflam-matory	00006-7633-04	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1720	Injection hydrocortisone sodium succinate up to 100mg	Solu-Cortef A-Hydrocort	Antiinflam-matory	00009-0825-01 '00009-0825-01 00074-5671-02 '00223-7893-02 '54868-0605-00 '54868-0605-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1730	Injection diazoxide up to 300mg	Hyperstat IV	Antihyper-tensive	00085-0201-05	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1742	Injection ibutilide fumarate 1mg	Corvert	Antiarrhy-thmic	00009-3794-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1745	Injection infliximab 10mg	Remicade	Antirheu-matic	57894-0030-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1750	Injection iron dextran 50 mg	Infed Dexferrum	Iron salt	00517-0134-10	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1756	Injection iron sucrose 1mg IV	Venofer	Iron supple-ment	00517-2340-10	None	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1785	Injection imiglucerase per unit	Cerezyme	Enzyme	58468-1983-01 58468-4663-01	None	X	X												ICD-9-CM code 172.7 required on CMS 1500 claim form. Medical necessity documentation to include member's weight is required in individual's medical record.
J1790	Injection droperidol up to 5mg	Inapsine	Antiemetic	00074-1187-01 00517-9702-25 11098-0010-02	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1800	Injection propranolol HCl up to 1mg.	Inderal	Antianginal	00046-3265-10 '54569-2232-01 '55390-0003-10 '63323-0604-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1810	Injection droperidol & fentanyl cit-rate up to 2ml ampule	Innovar	Antiemetic	00186-1230-03	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1815	Injection insulin 5U	Humalog Humulin Lispo	Antidiabetic	00002-8501-01	20 per day	X	X	X											ICD-9-CM code 250.00 - 250.9X required on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J1817	Insulin for administration thru insulin pump per 50 U.	Humalog	Antidiabetic	Too numerous to list															Not Covered
J1825	Injection interferon beta 1a 33mcg	Avonex	Biological Response Modulator	None	None	X	X												Not covered effective 7/1/05
J1830	Injection interforon beta 1b 0.25mg	Betaseron	Biological Response Modulator	50419-0523-15	2 per day	X	X												Not covered effective 7/1/05
J1835	Injection itraconazole 50 mg.	Sporonox	Antifungal	50458-0298-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1840	Injection kanamycin sul-fate up to 55mg	Kantrex Klebcil	Antibiotic	00015-3503-20 00015-3503-99 '63323-0359-03	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J1850	Injection kanamycin sul-fate up to 75mg	Kantrex Klebcil	Antibiotic	00015-3503-20 63323-0359-03	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1885	Injection ketoralac tro-methamine 15mg	Toradol	Analgesic	00004-6925-06 '55390-0480-01 '60505-0705-00 '63323-0161-01	None	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J1890	Injection cephalothin sodium up to to 1g	Cephalothin Sodium Keflin	Antibiotic	00338-0525-41	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1931	Injection laronidase 0.1 mg	Aldurazyme	Enzyme	58468-0070-01	None	X	X												ICD-9-CM code 277.5 required on CMS 1500 claim form. Medical necessity documentation to include member's weight is required in individual's medical record.
J1940	Injection furosemide up to 20mg.	Lasix Furomide	Antihyper-tensive Diuretic	00074-6101-02 '00223-7700-02 00223-7701-02 52637-0010-10 '63323-0280-02	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1950	Injection leuprolide ace-tate 3.75mg.	Lupron Depot	Antineo-plastic	00300-3641-01 54868-2825-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1955	Injection levocarnitine1g.	Carnitor	Nutritional Supplement	00517-1045-25 '00703-0404-02 54482-0146-09 '54482-0147-01 '55390-0136-05 '55390-0436-05			X												Not Covered
J1956	Injection levoflaxacin 250 mg	Levaquin	Antibiotic	00045-0067-01	3 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1960	Injection levorphanol tartrate up to 2mg	Levo Dromoran	Analgesic narcotic	00004-1911-06 '00187-3072-10	1.5 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J1980	Injection hyoscyamine sulfate up to 0.25mg.	Levsin	Anticholе-nergic	00091-1536-05	2 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J1990	Injection chlordiazepoxide HCL up to 100mg.	Librium	Benzodiaze-pine	00187-3755-74 '54868-2362-01															Not Covered
J2001	Injection lidocaine HCl IV infusion 10mg		Antiarrhy-thmic	00548-1192-00	None	X													Activate code effective 7/1/05. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2010	Injection lincomycin HCl up to 300mg	Lincocin	Antibiotic	00009-0555-01 '00009-0555-02	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2020	Injection linezolid 200 mg	Zyvox	Antibiotic	00009-5137-01	6 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2060	Injection lorazepam 2mg	Ativan	Antianxiety	00008-0581-15 '00074-1985-01 '10019-0102-01 '54868-3566-01	2 per day	X	X	X		X							X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2150	Injection mannitol in 25% in 50ml	Osmitrol	Diuretic	00074-4031-01 '00517-4050-25 '63323-0024-25	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2175	Injection meperidine HCl per 100mg	Demerol	Analgesic narcotic	00074-1180-69 '00074-1201-20 '00074-1256-01 00074-2046-01 '00641-1150-35 '10019-0158-68 '54868-3610-00	2 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2180	Injection meperidine & promethazine HCl up to 50mg	Mepergan	Analgesic combo narcotic	54868-4136-00	2 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2185	Injection meropenem 100 mg	Merrem	Antibiotic	00310-0321-30 00310-0325-20	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2210	Injection methylergonovine maleate up to 0.2mg.	Methergine	Ergot alkaloid & derivative	00078-0053-03	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2250	Injection midazolam HCl per 1mg	Versed	Benzodiaze-pine	10019-0028-05 '10019-0028-10 '59911-5912-02 59911-5913-02 '60505-0711-01 '60505-0711-02 '60505-0711-03 '63323-0411-05 '63323-0411-10 '63323-0411-12															Not Covered
J2260	Injection milrinone lactate 5mg	Primacor	Enzyme	00024-1200-05 '00024-1200-06	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2270	Injection morphine sulfate up to 10mg	Roxanol	Analgesic narcotic	00641-0180-25 '00641-1180-35 '00641-2343-41 '10019-0178-44 '10019-0178-62 '10019-0178-68 '54868-4189-00	5 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2271	Injection morphine sulfate 100mg.	Roxanol	Analgesic narcotic	00641-2343-41 '10019-0178-62	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2275	Injection,morphine sulfate (preservative-free sterile solution)10mg	Astramorph PF Duramorph	Analgesic narcotic	00074-1135-03 '00641-1132-31 '61703-0224-72	None	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2280	Injection moxifloxacin 100 mg	Avelox	Antibiotic	00026-8582-31	5 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2300	Injection nalbuphine HCl per 10mg	Nubain	Analgesic narcotic	00074-1463-01 '54868-3471-00 '54868-3608-00 '54868-3686-00 '54868-3686-01 '58016-9384-01 '63481-0432-10 '63481-0508-05	6 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2310	Injection naloxone HCl per 1mg	Narcan	Antidote	63481-0368-05 '63481-0377-10	None	X	X	X											Activate code effective 7/1/05. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2320	Injection nandrolone decanoate up to 50mg.	Decaduraboli n	Anabolic steroid	00052-0697-02 '00052-0698-01 '00364-6717-47	1 per week	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2321	Injection nandrolone decanoate up to 100mg.	Decaduraboli n Hybolin Decanoate	Anabolic steroid	00052-0697-02	1 per week	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2322	Injection nandrolone decanoate up to 200mg	Decaduraboli n Neo-burabolic	Anabolic steroid	00052-0697-02 '00052-0698-01 00364-2186-46 '00364-6717-47	1 per week	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2324	Injection nesiritid 0.5mg	Natrecor	Vasodilator	65847-0205-25	None	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J2352	Injection octreotide acetate 1mg																		Code deleted 12/31/03
J2353	Injection octreotide depot form for IM 1mg	Sandostatin	Anti-diarrheal	00078-0342-84	None	X	X												Replaced J2352. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2354	Injection onctreotide non-depot form for SQ or IV 25 mcg	Sandostatin	Anti-diarrheal	00078-0180-01 00078-0181-01 00078-0182-01 00078-0183-25 00078-0184-25	7 conse-cutive days	X	X												Replaced J2352. For IV route only. Physician reimbursement for administration is limited to 7 consecutive days per Medicaid member per lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file..
J2355	Injection oprelvekin 5 mg	Neumega	Platelet growth factor	58394-0004-01 '58394-0004-02	2 per day	X	X												ICD-9-CM code 287.4 must be documented on CMS 1500 claim form for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file..

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J2357	Injection omalizumab 5 mg.	Xolair	Anti-asthmatic	50242-0040-62	None	X	X												New code 1/1/05. Requires ICD-9-CM code 493.XX on CMS 1500 claim form for payment consideration.. Age limit 12> years. For children: the first dose may be split into 2 doses the first week. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2360	Injection orphenadrine citrate up to 60 mg.	Norflex	Muscle relaxant	00089-0540-06 '11584-1016-02 '11584-1016-05 '52959-0179-06	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2370	Injection phenylephrine HCl up to 1ml	Neo-Synephrine	Adrenergic agonist	00074-1800-01 '00517-0299-25 '00703-1631-04 '10019-0163-12	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2400	Injection chloroprocaine HCl 30ml	Nesacaine Nesacaine MPF	Local Anesthetic	00074-4169-01 '00074-4170-01 '00186-0971-66 '00186-0972-66	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2405	Injection ondansetron HCl 1mg	Zofran	Antiemetic	00173-0442-00 '00173-0442-02 '54868-4509-00	32 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2410	Injection oxymorphone HCl up to 1 mg	Numorphan	Analgesic-narcotic	63481-0444-10	9 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2430	Injection amidronate disodium 30 mg	Aredia	Antidote	00083-2601-04 '00703-4075-19 '55390-0127-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2440	Injection papaverine HCL up to 60 mg.	Para-Time SR	Vasodilator	00517-4002-05 '00517-4010-01 '55390-0107-10 '60793-0015-02 '60793-0015-10	1 per day	X	X												Not covered effective 7/1/05
J2460	Injection oxytetracycline HCl up to 50 mg	Terramycin	Antibiotic	00049-0750-77	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2469	Injection palonesetron HCl 25mcg	Aloxi	Antiemetic	58063-0797-25	10 units per week	X	X												New code 1/1/05. Requires ICD-9- CM code V58.0, V58.1, 140.0 - 208.91, 230.0, OR 239.9 on CMS 1500 claim form for payment consideration.. Maximum dosage 0.25mg per week. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2501	Injection paricalcitol 1 mcg	Zemplar	Vitamin D analog	00074-4637-01	None	X	X										X		Requires ICD-9-CM 588.XX on CMS 1500 claim form for payment consideration. Medical necessity documentation (including weight of member) of services must be maintained in the member's individual file.
J2505	Injection pegfilgrastim 6mg	Neulasta	Colony stimulating factor	55513-0190-01	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2510	Injection penicillinG pro-caine aqueous up to 600K U	Wycillin Pfizerpen AS	Antibiotic	61570-0085-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2515	Injection pentobarbital sodium per 50 mg.	Nembutal	Anti-convulsant	00074-3778-04 '00074-3778-05	10 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2540	Injection penicillinG pot-assium up to 600K U	Pfizerpen	Antibiotic	00049-0520-83 '00049-0530-28 '00338-1021-41 '00338-1023-41 '00338-1025-41 '00781-6135-95 '00781-6136-94 '54868-3480-00 '54868-4488-00	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2543	Injection piperacillin sodium/tazobacta m sodium 1g/0.125g (1.125 g)	Zosyn	Antibiotic	00206-8452-16 '00206-8454-55 '00206-8455-25 '00206-8620-11	24 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2545	Pentamidine isethionate inhalation solution 300mg	Nebupent Pentam 300	Antibiotic	00074-4548-01 '00074-4548-49 '54868-2528-00 '63323-0113-10 '63323-0877-15															Not Covered
J2550	Injection promethazine HCl up to 50mg	Phenergan Prorex-25	Antiemetic	00008-0746-01 '00223-8394-01 '00641-0929-25 '00641-1496-35 '00703-2201-04 '54868-0262-00 '54868-2695-00	6 per day	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2560	Injection phenobarbital sodium up to 120mg	Luminal Sodium	Anticonvul-ant	00641-0476-25	3 per day	X	X												20/mg/kg for status epilepticus. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2590	Injection oxytocin up to 10U.	Pitocin	Oxytocic agent	60793-0416-05 '61570-0416-03 '61570-0416-05 '63323-0012-01 '63323-0012-10	1 per day	X	X												May increase to maximum 4 units for post partum hemorrhage. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2597	Injection desmopressin acetate 1mcg	DDAVP Stimate		00074-2265-01 '00075-2451-01 '00075-2451-53 '00703-5051-03 '00703-5054-01 '54868-3889-00 '55566-5040-01			X												Not Covered
J2650	Injection prednisolone acetate up to 1ml	AK-Pred Inflammase Forte Pediapred Prelone Key-Pred Predcor Predoject Predalone	Antiinflam-matory	00223-5346-10 '00223-8341-30 '00223-8345-10 00223-8345-30 '00223-8346-10 '00223-8346-30 '00463-1019-30 '00463-1020-10 '52637-0325-10 '55553-0249-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2670	Injection tolazoline HCl up to 25mg	Priscoline	Alpha-adrenergic blocking agent	00083-6733-04	8 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2675	Injection progesterone 50 mg	Crinone Progestasert	Progestin	00591-3128-79 '63323-0261-10	8 per day	X	X	X	X										Not for fertility treatment and diagnosis. For menorrhagia, amenorrhea. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2680	Injection fluphenazine decanoate up to 25mg	Prolixin Decanoate	Anti-psychotic	00003-0569-15 '00144-0644-56 '00703-5003-01 '55390-0465-05 '60505-0664-02 '63323-0272-05 '63323-0272-55	2 per day	X	X	X		X							X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2690	Injection procainamide HCl up to 1g	Pronestyl Procanbid	Antiarrhy-thmic	00074-1902-01 '00074-1903-01	None	X	X												Weight based 50mg/kg/day. Medical necessity documentation of services provided must be maintained in the member's individual file.
J2700	Injection oxacillin sodium up to 250mg	Bactocill Prostaphlin PCN Methylphenyl Isoxazolyl	Antibiotic	00015-7103-28 '00015-7103-98 '00015-7970-20 '00015-7970-99 '00015-7981-20 '00015-7981-99	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2710	Injection neostigmine methylsulfate up to 0.5 mg	Prostigmin	Acetychol-inesterase inhibitor	00187-3101-30 '00517-0033-25 '00517-0034-25 '00703-2711-03 '00703-2714-03 '10019-0271-02 '10019-0271-10 '63323-0382-10	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2720	Injection protamine sul-fate 10mg		Antidote	11743-0250-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2725	Injection protirelin 250 mcg	Relefact TRH Thypi-nome		55566-0081-05	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2730	Injection pralidoxime chloride up to 1g	Protopam Chloride	Antidote	00641-0374-06	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2760	Injection phentolamine mesylate up to 5mg	Regitine	Diagnostic agent	55390-0113-01	1 per day	X	X												Not covered effective7/1/05
J2765	Injection metoclopramide HCl up to 10mg	Reglan	Antiemetic	00074-3413-01 '00703-4502-04 '10019-0450-02 '54868-4167-00	8 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2770	Injection quinupristin/dalfop ristin 500mg (150/350)	Synercid	Antibiotic	00075-9051-10															Non Covered
J2780	Injection ranitidine HCl 25mg	Zantac	Anti-histamine	00173-0362-38 '00173-0363-00 '00173-0363-01	6 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2783	Injection rasburicase 0.5 mg	Elitek	Enzyme	00024-5150-10	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2788	Injection Rhod immune globulin human minidose 50 mcg	BAYRho-D MicrhoGam Hyprho-D	Immune globulin	00562-7808-06 '00562-7808-26															See CPT code 90385
J2790	Injection Rhod immune globuliln human full dose 300 mcg	Gamulin RH	Immune globulin	00026-0631-02 '00562-7807-06 '00562-7807-26															See CPT code 90384
J2792	Injection RhoD immune globulin IV human solvent detergent 100 IU	BAYrho-D Winrho SDF	Immune globulin	60492-0024-01															See CPT code 90386
J2794	Injection Risperidone long acting 0.5mg	Risperdal Consta IM	Anti-psychotic	50458-0308-11 50458-0307-11 50458-0306-11	100 every 2 weeks	X	X	X		X									New code 1/1/05. Requires ICD-9-CM code 295XX.on CMS 1500 claim form for payment consideration. Age limit 18>years. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J2795	Injection ropivacaine HCl 1mg	Naropin	Local Anesthetic	'00186-0859-44 00186-0859-54 '00186-0863-44 '00186-0863-54 '00186-0867-44 '00186-0867-54 '00186-0868-44 '00186-0868-54															Not Covered
J2800	Injection methocarbamol up to 10ml	Robaxin	Skeletal muscle relaxant	00031-7409-87 '00031-7409-94 '00223-8150-10	3 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2810	Injection theophylline 40 mg	Theo-Dur	Broncho-dilator	Too numerous to list															Not Covered
J2820	Injection sargramostim (GM-CSF) 50mcg	Leukine Prokine	Colony stimulating factor	58406-0050-14 '58406-0050-30	20 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2910	Injection aurothioglucose up to 50mg	Solganal		54868-1133-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2912	Injection sodium chloride 0.9% per 2ml			00074-2102-02	None									X	X				Medical necessity documentation of services provided must be maintained in the member's individual file.
J2916	Injection sodium ferric gluconate complex in sucrose injection 12.5mg	Ferriecit	Iron supple-ment	52544-0922-26	20 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J2920	Injection methylprednisolone sodium succinate up to 40mg	SoluMedrol Ametha-Pred	Antiinflam-matory	00009-0113-12 '00009-0113-19 '00074-5684-01 '00223-8160-01 '54868-0768-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2930	Injection methlprednisolone sodium succinate up to 125mg	SoulMedrol Ametha-Pred	Antiinflam-matory	00009-0190-09 '00009-0190-16 '00074-5685-02 '00223-8160-02 '00223-8161-02 '54569-1555-01 '54868-3637-00 '54868-3637-01 '58016-9452-01	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J2940	Injection somatrem 1mg	Protropin		50242-0015-64 50242-0016-65 '50242-0028-49 '50242-0030-50															Not Covered
J2941	Injection somatropin 1mg	Humatrope Genotropin Nutropin		00013-2653-02															Not Covered

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J2950	Injection promazine HCl up to 25mg	Sparine Prozine-50		00223-8397-10	40 per day	X	X			X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J2993	Injection reteplase 18.1 mg	Retavase	Fibrinolytic	57894-0040-01 '57894-0040-02															Not Covered
J2995	Injection streptokinase per 250KIU	Streptase	Fibrinolytic	00053-1770-01	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J2997	Injection alteplase recombinant 1mg	Activase	Fibrinolytic	50242-0041-64 '50242-0041-65															Not Covered
J3000	Injection streptomycin up to 1g	Streptomycin Sulfate	Antibiotic	39822-0706-01 '39822-0706-02	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3010	Injection fentanyl citrate 0.1mg	Sublimaze Duragesic	Analgesic narcotic	00074-9093-32 '11098-0030-02 '54868-3738-00 '54868-3738-01	1 per day	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J3030	Injection sumatriptan succinate 6mg	Imitrex	Anti-migraine	00173-0449-02 '54569-3704-00 '54569-4505-00 '54868-2652-00	1 per day	X	X												Not covered effective 7/1/05
J3070	Injection pentazocine 30 mg	Talwin	Analgesic narcotic	00074-1941-01	12 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3100	Injection tenecteplase 50 mg	TNKase	Fibrinolytic	50242-0038-61	1 per day	X													Medical necessity documentation of services provided must be maintained in the member's individual file.
J3105	Injection terbutaline sulfate up to 1mg	Brethine	Broncho-dilator	00028-7507-01 '00028-7507-23	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3110	Injection teriparatide 10 mcg	Forteo	Parathyroid hormone																Not Covered
J3120	Injection testosterone enanthate up to 100mg	Delatestryl	Androgen	54396-0328-16 '54396-0328-40	1 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3130	Injetion testosterone enanthate up to 200mg	Delatestryl	Androgen	54396-0328-16 '54396-0328-40	2 per week	X	X	X									X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3140	Injection testosterone suspension up to 50mg	Andronaq 50	Androgen	00314-0083-10 '00314-0771-70 '00463-1069-10	3 per week	X	X	X											May increase to 4 doses for post partum breast engorgement. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3150	Injection testosterone propionate up to 100mg	Testex	Androgen	00314-0772-70 '00463-1073-10 '54569-2363-00	3 per week	X	X	X											May increase to 4 doses for post partum breast engorgement. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J3230	Injection chlorpromazine HCl up to 50mg	Thorazine	Anti-psychotic	00223-7325-02 '00223-7334-01 '00641-1398-35	10 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J3240	Injection thyrotropin alpha 0.9 mg provided in 1.1 mg vial	Thyrogen	Diagnostic agent	58468-1849-04	3 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3245	Injection tirofiban HCl 12.5 mg	Aggrastat	Antiplatelet	None		X													Code closed 1/1/05
J3246	Injection tirofiban HCL 0.25mg IV	Aggrastat	Antiplatelet	00006-3739-43 61379-0120-05 00006-3739-96 00006-3739-55	1 per day	X	X												New code 1/1/05. Replaces J3245. Note dosage change. Must be billed daily. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3250	Injection trimeth-obenzamide HCl up to 200mg	Tigan	Antiemetic	54868-0608-00 '61570-0540-02															Not Covered
J3260	Injection tobra-mycin sulfate up to 80mg	Nebcin	Antibiotic	00002-1499-25 '00002-7090-01 '00002-7090-16 '00002-8989-25 '00003-2725-10 '00003-2725-30 '00703-9402-04 '00703-9416-01 '54868-4106-00	2 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3265	Injection torsemide 10mg/ml	Demadex	Antihyper-tensive	00004-0267-06 '00004-0268-06															Not Covered
J3280	Injection thiethylperazine maleate up to 10mg	Torecan Norzine	Antiemetic	54868-4579-00	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3301	Injection triamcinolone acetonide 10mg	Kenalog-10 Kenalog-40 Triam-A	Antiinflam-matory	00003-0494-20 '54868-0234-00	4 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3302	Injection triamcinolone diacetate 5mg	Aristocort Intralesional Aristocort Forte Cinolone Trilone Clinacort	Antiinflam-matory	00469-5116-01 '00469-5116-05 '00469-5117-05 '54868-0926-00	8 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3303	Injection triamcinolone hexacetonide 5mg	Aristoospan Intralesional Aristospan Intra-articular	Antiinflam-matory	00469-5118-05 '00469-5119-01 '00469-5119-05 54868-3344-00	4 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3305	Injection trimetrexate glucoronate 25mg	Neutraxin	Antiinflam-matory	58178-0020-10 '58178-0020-50 '58178-0021-01	None	X	X												Weight based. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J3310	Injection perphenazine up to 5mg	Trilafon	Anti-psychotic		3 per day	X	X	X		X						X			Medical necessity documentation of services provided must be maintained in the member's individual file.
J3315	Injection triptorelin pamoate 3.75mg	Trelstar LA	Luteinizing hormone-releasing hormone	00009-5215-01 00009-7664-01	3 per month	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3320	Injection spectinomycin dihydrochloride up to 2g	Trobicin	Antibiotic	00009-7664-01		OHP	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3350	Injection urea up to 40g	Ureaphil	Diuretic	00009-0566-01															Not Covered
J3360	Injection diazepam up to 5mg	Valium	Benzodiaze-pine	54569-5351-00 '54868-0617-00 '54868-4061-00															Not Covered
J3364	Injection urokinase 5000 IU vial	Abbokinase open cath	Fibrinolytic	00074-6111-01	2 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3365	Injection IV urokinaase 250000 IU vial	Abbokinase	Fibrinolytic	00074-6109-05															Not Covered
J3370	Injection vancomycin HCl 500mg	Varocin Vancocin	Antibiotic	00002-1444-25 '00074-4332-01 '00074-4332-49 '00074-6534-01 '00074-6534-49		X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3395	Injection verteporfin 15mg	Visudyne																	Code close 1/1/05
J3396	Injection, verteporfin 0.1mg	Visudyne		58768-0150-15	None	X	Ophthal-mologist only												New code 1/1/05. Replaces J3395. Requires ICD-9-CM code 115.02, 115.12, 115.92, 360.21, 362.16, OR 362.52 and meter square on CMS 1500 claim form for payment consideration. . Only bill CPT codes 67221 or 67225 with J3396. Must be billed daily. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3400	Injection triflupromazine HCl up to 20mg	Vesprin		None	150mg per day	X	X			X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J3410	Injection hydroxyzine up to 25mg	Vistaril Hyzine-50 Atarax	Antianxiety	00223-7885-01 '00517-4201-25 '54868-0858-00 '63323-0021-01	None	X	X	X		X									Activate code effective 7/1/05. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3411	Injection thiamine HCL 200mg	Thiamilate	Vitamin supplement	63323-0013-02	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J3415	Injection pyridoxine HCl 100mg		Vitamin supplement	00223-8403-10 00223-8404-30 00223-8410-10 25332-0073-30 63323-0180-01	2 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3420	Injection vitamin B-12 cyanocobalamin up to 1000mcg	Sytobex Residol Rubramin PC	Vitamin supplement	00223-8860-30 '00223-8861-01 '00223-8862-25 '00517-0031-25 '00517-0130-01 '49072-0145-30 '52637-0282-10 '52637-0312-30 '54569-2130-00 '63323-0044-01	1 per day	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3430	Injection phytonadione (viatamin K) per 1mg	Aqua Mephyton Konakion	Vitamin supplement	00006-7784-33 '00074-9157-01 '54868-4434-00	25 per day	X	X										X		Medical necessity documentation of services provided must be maintained in the member's individual file.
J3465	Injection voriconazole 10mg	VFEND	Antifungal	00049-3190-28	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3470	Injection hyaluronidase up to 150units	Wydase		None	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J3475	Injection magnesium sulphate 500mg			00074-4075-32 '49072-0475-50 '63323-0064-20 '63323-0064-50															Not Covered
J3480	Injection potassium chloride 2mEq	Kdur Kaon-Cl	Electrolyte Supplement	00074-1513-02 '00074-3907-03 '00074-3934-02 '00223-8322-30 '00223-8330-01 '00223-8330-10 '00223-8331-20 '00223-8332-30 '00264-1940-10 '00264-1940-20 '00338-0318-02 '49072-0571-30 '54868-0767-00	None	X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J3485	Injection zidovudine 10mg	Retrovir	Antiretro-viral	00173-0107-93															Not Covered
J3486	Injection zipraosidone mesylate 10mg	Geodon	Anti-psychotic	00049-3920-83	10 per day	X	X	X		X									Medical necessity documentation of services provided must be maintained in the member's individual file.
J3487	Injection zoledronic acid 1mg	Zometa	Antidote	00078-0350-84	4 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J3490	**Unclassified drugs. Used only if a more specific code is not available.**																		Refer to the list of Approved Drugs Billed with HCPCS Code J3490 by WV Medicaid. Cost invoice may be required. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3520	Edetate disodium 10mg	Endrate Disotate	Antidote		None	X	X												Covered only for treatment for lead poisoning or heavy metal poisoning; duration <2 weeks. Medical necessity documentation of services provided must be maintained in the member's individual file.
J3530	Nasal vaccine inhalation																		Not Covered
J3535	Drug administered thru a metered dose inhaler.																		Not Covered
J3570	Laetrile amygdalin vitamin B-17.																		Not Covered
J3590	**Unclassified biologics. Used only if a more specific code is not available.**																		Close code effective 7/1/05.
J7030	Infusion normal saline solution 1000cc			00074-1583-02 '00074-7983-03 '00074-7983-09 '00074-7983-55 '00264-4000-55 '00264-4001-55 '00338-0044-02 '00338-0044-03 '00338-0049-02 '00338-0049-03		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7040	Infusion normal saline solution sterile (500ml = 1 unit)			00074-1583-02 '00074-7101-02 '00074-7983-02 '00074-7983-03 '00074-7983-09 '00074-7983-55 '00264-4000-55 '00264-4001-55 '00338-0044-02 '00338-0044-03 '00338-0049-02 '00338-0049-03 '00338-0049-04 '54868-0710-00 '54868-0710-01		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7042	5% dextrose/normal saline (500ml - 1 unit)			Too numerous to list		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7050	Infusion normal saline solution 250cc			00074-1583-02 '00074-7983-02 00074-7983-03 '00074-7983-09 '00074-7983-55 '00264-4000-55 '00264-4001-55 '00338-0044-02 '00338-0044-03 '00338-0049-02 '00338-0049-03 '00338-0049-04 '54868-0710-00 '54868-0710-01		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7051	Sterile saline or water up to 5cc			Too numerous to list	1 per day			X						X					Medical necessity documentation of services provided must be maintained in the member's individual file.
J7060	5% dextrose/water (500 ml = 1 unit)			00074-1522-03 '00074-7922-03 '00074-7922-55 '00264-1101-55 '00264-7510-10 '00338-0016-03 '00338-0017-03 '54868-0296-01		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7070	Infusion D-5-W 1000cc			00074-1500-05 '00074-7922-09 '00264-1107-55 '00264-1110-00 '00264-7510-00		X	X	X											Medical necessity documentation of services provided must be maintained in the member's individual file.
J7100	Infusion dextran 40 500ml	Rheomacrodex Gentran 75		00338-0271-03 61563-0212-65 61563-0211-65 00338-0272-03 00074-7419-03 00338-0270-03 00264-1962-10 00264-1963-10	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7110	Infusion dextran 75 500ml	Gentran 75		00338-0265-03 00338-0263-03 00074-1505-03 00074-1507-03	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7120	Ringer's lactate infusion up to 1000cc			00074-7953-09 '00264-3500-55 '00264-7750-00 '00338-0117-04	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7130	Hypertonic saline solution 50 or 100 mEq 20cc vial			Too numerous to list	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7190	Factor VIII human per IU	Monarc-M Koate HP Hemofil-M Alphanate SD Humate P Koate DVI MonoclateP vonWille- brand dise- ase	Antihemo-philic	00026-0664-20 '00026-0664-30 '00026-0664-50 '00026-0664-60 '00026-0665-20 '00026-0665-30 '00026-0665-50 '00053-7656-01 '00053-7656-02 '00053-7656-04 '00944-2935-01 '49669-4600-01 '49669-4600-02 '52769-0460-01	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 - 286.4; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7191	Factor VIII porcine per IU	Hyate-C	Antihemo-philic	55688-0106-02	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 - 286.4; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7192	Factor VIII recombinant per IU	Recombi- nate Kogenate Helixate FS Refacto Advate	Antihemo-philic	00944-2938-01 '00944-2938-02 '00944-2938-03 '58394-0005-01 '58394-0006-01 '58394-0007-01 '58394-0011-01 52769-0464-02 52769-0464-05 52769-0464-10 00026-0372-20 00026-0372-30 00026-0372-50 00944-2940-01 00944-2940-02 00944-2940-03 00944-2940-04 00053-8130-01 00053-8130-02 00053-8130-04	None	X	X				X				X	HS			Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7193	Factor IX purified, non-combinant per IU	AlphaNine SD Mononine	Antihemo-philic	00053-7668-01 '00053-7668-02 '00053-7668-04 '49669-3600-02 68516-3600-02	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claimfor payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7194	Factor IX complex per IU	Bevulin VH Profilnine HT Konyne-80 Proplex T, SX-T	Antihemo-philic	00944-0581-01 '49669-3200-02 '49669-3200-03 '64193-0244-02 58394-0001-01	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 - 286.1; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7195	Factor IX recombinant per IU	Benefix	Antihemo-philic	58394-0001-01 '58394-0002-01 '58394-0003-01	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.1; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC#and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claim for payment consideration.. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7197	Antithrombin III human per IU	Throbate III Atnativ	Antihemo-philic	00026-0603-20 '00026-0603-30	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claimfor payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7198	Anti-inhibitor per IU	Autoplex T FEIBA	Anti-inhibitor coagulant complex	59730-6059-07 '64193-0222-04	None	X	X				X				X				Requires completed CMS 1500 claim form to include documentation of ICD-9-CM code 286.0 - 286.1; dates of service, place of service, appropriate J code, description of code and brand name of factor, total units or mg dispensed, appropriate NDC# and total charges. Physician's order and provider's Rx form documenting units dispensed must be attached to the claimfor payment consideration. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7199	**Hemophilia clotting factor NEC. Used only if a more specific code is not available.**		Antihemo-philic																Close code effective 7/1/05.
J7300	Intrauterine copper contraceptive.	Paragard T380A	Contracep-tive	None	None	X	X	X	X										Medical necessity documentation of services provided must be maintained in the member's individual file.
J7302	Levonorgest releasing intrauterine contraceptive system 52 mg	Minera	Contracep-tive	None	None	X	X	X	X										Medical necessity documentation of services provided must be maintained in the member's individual file.
J7303	Contraceptive supply hormone containing vaginal ring each		Contracep-tive																Not Covered
J7304	Contraceptive supply, hormone containing vaginal patch each		Contracep-tive																Not Covered
J7308	Aminolevulinic acid HCl for topical administra-tion 20%, single unit dosage form (354mg)	Kerastick Levulan	Photosensi-tivity agent	67308-0101-01 '67308-0101-06	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7310	Ganciclovir 4.5 mg long-acting implant	Vitrasert Cytovene	Antiviral	61772-0002-01	None	X	Ophthal-mologist only												One per each eye per 5 months. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7317	Sodium hyaluronate per 20 to 25 mg dose for intra-articular injection	Hyalgan 20 Supartz 25	Osteoarth-ritic	08024-0724-12 '08363-7765-01	1 per week X 5	X	X	X											Requires ICD-9-CM code 715.XX or 716.XX on CMS 1500 claim form for payment consideration. Maximum 10 injections (5 per knee) in a 6 month period. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J7320	Hylan G-F20 16mg/2ml for intra-articular injection	Synvisc	Osteoarth-ritic	00008-9149-01 '00008-9149-02 '66267-0921-03	1 per week X 3	X	X	X											Required ICD-9-CM code 715.XX or 716.XX on CMS 1500 claim form for payment consideration. Maximum 6 inections (3 per knee) in a 6 months period. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7330	Augologous cultured chondrocytes implant	Carticel		63861-1025-01															Not Covered
J7340	Dermal & epidermal tissue human origin with or without bioengineered or processed elements with metabolically active elements per square cm	Dermagraft Dermagraft TC		09978-0001-99 '30170-0000-10	None	X	X					X							Activate code effective 7/1/05. **For diabetes:** ICD-9-CM code 250.XX plus 707.XX for **surgeons**; OR, ICD-9-CM code 250.XX plus 707.13, 707.14, or 707.15 for **podiatrists**. For **venous stasis ulcer**: ICD-9-CM code 454.0, 454.1 or 454.2 plus 707.XX for **surgeons**; OR, ICD-9-CM code 454.0, 454.1 or 454.2 plus 707.13, 707.14, or 707.15 for **podiatrists** required on CMS 1500 claim form. Service limits for diabetic ulcer: 3 applications in 9 weeks per year per ulcer. Service limits for venous stasis ulcer: 3 applications in 12 weeks per year per ulcer. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7342	Dermal tissue human origin with or without other bioengineered or pro-cessed elements with metabolically active elements per square cm.	Applegraft		38172-0202-00	None	X	X					X							Activate code effective 7/1/05. ICD-9-CM code 250.XX plus 707.XX for **surgeons** and ICD-9-CM code 250.XX plus 707.13, 707.14 or 707.15 for **podiatrists** required on CMS 1500 claim form for payment consideration. . Service limits 1 application x 8 weeks per year per ulcer. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7343	Dermal & epidermal tissue nonhuman origin with or without other bioengineered or pro-cessed elements without metabolically active elements per square cm.			84784-0040-02 84784-0040-08 84788-0040-08 84784-0040-06 84788-0040-06 84784-0040-05 84788-0040-05	None	X	X					X							For **surgeons**: ICD-9-CM code(s) 941.30 - 941.39; 941.40 - 941.49; 942.30 - 942.39; 942.40 - 942.49; 943.30 - 943.39; 943.40 - 943.49; 944.30 - 944.38; 944.40 - 944.48; 945.30 - 945.39; 945.40 - 945.49; 946.3; 946.4; 949.3; OR 949.4 required on CMS 1500 claim form for payment consideration. For **podiatrists**: ICD-9-CM code 945.X2 or 945.X3 required on CMS 1500 claim form for payment consideration..

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J7344	Dermal tissue human orgin with or without bio-engineered or processed elements without metabolically active elements per square cm	Dermagraft Dermagraft TC		85600-5X10-10 38172-0001-01 81218-6040-04 86002-X04-04 86004-X07-07 86005-X05-05	None	X	X					X							Not Covered
J7350	Dermal tissue human origin injectable with or without other bioengi-neered or processed elements but without metabolized active elements per 10mg	Dermagraft Dermagraft TC			None	X	X					X							Activate code effective 7/1/05. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7500	Azathioprine oral 50mg	Imuran	Immuno-suppress-ant	00054-4084-25 '00054-8084-25 '00781-1059-01															Not Covered
J7501	Azathioprine parenteral 100mg	Imuran	Immuno-suppress-ant	65483-0551-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7502	Cyclosporine oral 100mg	Neoral Sandimm-une	Immuno-suppress-ant	00078-0241-15 '00078-0248-15 '00185-0933-30 '50111-0920-43															Not Covered
J7504	Lymphocyte immune globulin antihymocyte globulin equine parenteral 250mg	Atgam	Immune globulin	00009-7224-02															Medical necessity documentation of services provided must be maintained in the member's individual file.
J7505	Muromonab-CD3 paren-teral 5mg.	Orthoclone OKT3	Immuno-suppress-ant	59676-0101-01	1 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7506	Prednisone oral per 5mg	Deltasone Meticorten Orasone	Immono-suppress-ant	Too numerous to list	None	X	X												Not Covered
J7507	Tacrolimus oral per 1mg	Prograf	Immuno-suppress-ant	00469-0617-11 '00469-0617-73															Not Covered
J7509	Methylprednisolon e oral per 4mg	Medrol	Immuno-suppress-ant	Too numerous to list															Not Covered
J7510	Prednisolone oral per 5mg	Deltacortef	Immono-suppress-ant	00223-1512-01 '00223-1512-02															Not Covered

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J7511	Lymphocyte immune globulin antithymocyte globulin rabbit parenteral 25mg	Thymoglobulin	Immune globulin	62053-0534-25		X	X												Weight based. Medical necessity documentation of services provided must be maintained in the member's individual file.
J7513	Daclizumab parenteral 25 mg	Zenapax	Immuno-suppress-ant	00004-0501-09	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7515	Cyclosporine oral 25mg	Neoral Sandimm-une	Immuno-suppress-ant	00078-0240-15 '00078-0246-15 '00185-0932-30 '50111-0909-43															Not Covered
J7516	Cyclosporine parenteral 250mg	Neoral Sandimm-une	Immuno-suppress-ant	00078-0109-01 55390-0122-10	6 per day	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7517	Mycophenolate mofetil oral 250mg	CellCept	Immuno-suppress-ant	00004-0259-01 '00004-0259-05 '00004-0259-43															Not Covered
J7518	Mycophenolic acid oral 180mg	Myfortic	Immuno-suppress-ant	00078-0386-66 00078-0385-66															Not Covered
J7520	Sirolimus oral 1mg	Rapamune	Immuno-suppress-ant	00008-1031-05 '00008-1031-10															Not covered
J7525	Tacrolimus parenteral 5 mg	Prograf	Immuno-suppress-ant	00469-3016-01	None	X	X												Medical necessity documentation of services provided must be maintained in the member's individual file.
J7599	**Immunosuppressive drug NOS. Used only if a more specific code is not available**																		Not Covered
J7608	Acetylcysteine inhalation solution unit dose form per g	Mucomyst Mucosil		00087-0570-07 '00087-0572-03															Not Covered
J7611	Albuterol inhalation concentrated form 1mg	Albuterol Sulfate Proventil Ventolin	Broncho-dilator	Too numerous to list															Not Covered
J7612	Levalbuterol inhalation solution concentrated form 0.5mg	Xopenex	Broncho-dilator	63402-0515-30															Not Covered
J7613	Albuterol inhalation solution unit dose 1mg	Albuterol Sulfate Airet Proventil Accuneb	Broncho-dilator	Too numerous to list															Not Covered

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J7614	Levalbuterol inhalation solution unit dose 0.5mg	Xopenex	Broncho-dilator	54868-4409-00 54569-4748-00 63402-0511-24 63402-0512-24 63402-0513-24															Not Covered
J7616	Albuterol up to 5 mg and Ipratropin bromide up to 1 mg compounded inhalation solution	Duoneb	Broncho-dilator	54569-5432-00 49502-0672-60 49502-0672-30															Not Covered
J7617	Levalbuterol up to 2.5 mg and Ipratropin bromide up to 1 mg. compounded in-halation solution		Broncho-dilator	None															Not Covered
J7618	Albuterol all formulations including separated isomers inhalation solutions concentrated form per 1mg. (Albuteral) or per 0.5 mg (Levalbuterol)		Broncho-dilator	00085-0208-02 '00182-6014-65 '00472-0832-20 '00603-1006-43 '50383-0741-20 '52959-0589-00 '54569-3900-00 '54868-3407-00 '54868-3479-00 '59930-1647-02 '63874-0708-20															Code closed 1/1/05
J7619	Albuterol all formulations including separated isomers inhalation solution unit dose per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)		Broncho-dilator	00054-8063-11 '00054-8063-13 '00054-8063-21 '00603-1005-40 '49502-0697-03 '49502-0697-33 '49502-0697-60 '50383-0742-25 '54569-3899-00 '59930-1517-01 '59930-1517-02															Code closed 1/1/05
J7621	Albuterol all formulations including separated isom-ers up to 5mg (albuterol) or 2.5 mg (levoalbuterol) and ipratropium bromide up to 1 mg compounded inhalation solution		Broncho-dilator	49502-0672-30 49502-0672-60															Code closed 1/1/05

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J7622	Bethamethasone inhalation solution unit dose form per mg			38779-0364-01 '38779-0364-03 '38779-0364-06 '49452-0802-01 '49452-0802-02 '49452-0802-03															Not Covered
J7624	Bethamethasone inhalation solution unit dose form per mg																		Not Covered
J7626	Butesonide inhalation solution unit dose form 0.25mg to 0.5mg	Pulmicort Respules		54569-5163-00 00186-1988-04 00186-1989-04															Not Covered
J7628	Bitolterol mesylate inhalation solution con-centrated form per mg	Tornalate		None															Not Covered
J7629	Bitolterol mesylate inhalation solution unit dose form per mg	Tornalate		None															Not Covered
J7631	Cromolyn sodium inhaltion solution unit dose form per 10mg	Gastrocrom Intal Nasalcrom	Antiallergic	00054-8167-21 '00054-8167-23 '00172-6406-49 '00172-6406-59 '00472-0750-21 '00472-0750-60 '49502-0689-02 '49502-0689-12															Not Covered
J7633	Budesonide inhalation solution concentrated form per 0.25mg	Pulmicort	Cortico-steroid	38779-0198-00 '38779-0198-03 '38779-0198-06 '49452-1291-01 '49452-1291-02 '49452-1291-03 '51552-0668-01															Not Covered
J7635	Atropine inhalation solution concentrated form per mg.																		Not Covered
J7636	Atropine inhalation solution administered through DME unit dose form per mg			10019-0250-20															Not Covered

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J7637	Dexamethasone inhalation solution concentrated form per mg			00223-7401-25 '00223-7402-30 '00223-7403-01 '00223-7404-05 '00223-7406-25 '00223-7407-01 '00223-7408-10 '00314-0896-30 '00314-0896-70 '00314-0896-75 '00517-4901-25 '00517-4905-25 '00517-4930-25 '00641-0367-25 '00703-3524-01 '00703-3524-03 '25332-0010-05															Not Covered
J7638	Dexamethasone inhalation administered through DME unit dose form per mg			Too numerous to list															Not Covered
J7639	Dornase alpha inhalation solution unit dose form per mg	Pulmozyme		50242-0100-39 '50242-0100-40															Not Covered
J7641	Flunisolide inhalation solution unit dose per mg			38779-0406-00 38779-0406-06 '38779-0406-09 '51552-0611-01 '51552-0611-05															Not Covered
J7642	Glycopyrrolate inhalation solution concentrated form per mg			00031-7890-06 '00031-7890-83 00223-7722-05 '00223-7723-20 '00517-4605-25 '00517-4620-25 '10019-0016-54 10019-0016-63															Not Covered
J7643	Glycopyrrolate inhalation solution unit dose form per mg			00031-7890-06 00031-7890-83 '00223-7722-05 '00223-7723-20 00517-4605-25 00517-4620-25 '10019-0016-54 '10019-0016-63															Not Covered

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J7644	Ipratropium bromide inhalation solution unit dose form per mg	Atrovent		00054-8402-11 '00054-8402-13 00054-8402-21 '00054-8404-11 '00054-8404-13 '00054-8404-21 '00472-0751-23 '00472-0751-30 '00472-0751-60 '00597-0080-62 '49502-0685-03 '49502-0685-33 '49502-0685-60															Medical necessity documentation of services provided must be maintained in the member's individual file.
J7648	Isoetharine HCl inhalation solution concentrated form per mg																		Not Covered
J7649	Isoetharine HCl inhalation solution unit dose form per mg																		Not Covered
J7658	Isoproterenol HCl inhalation solution con-centrated form per mg	Isuprel HCl Medihaler-150		00641-1438-35															Not Covered
J7659	Isoproterenol HCl inhalation solution unit dose form per mg	Isuprel HCl Medihaler-150		00641-1438-35															Not Covered
J7668	Metaproterenol sulfate inhalation solution con-centrated form per 10mg	Alupent																	Not Covered
J7669	Metaproterenol sulfate inhalation solution unit dose form per 10 mg	Alupent																	Not Covered
J7674	Methacholine chloride as inhalation solution through a nebulizer per 1mg	Provocho-line		64281-0100-12 64281-0100-06															Not Covered
J7680	Terbutaline sulfate inhalation solution con-centrated form per mg	Brethine Bricanyl																	Not Covered

Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J7681	Terbutaline sulfate inhalation solution unit dose form per mg	Brethine Bricanyl																	Not Covered
J7682	Tobramycin unit dose form 300mg inhalation solution	Tobi		53905-0065-01															Not Covered
J7683	Triamcinolone inhalation solution concentrated form per mg	Azmacort		00003-0293-05 '00003-0293-20 '00003-0293-28															Not Covered
J7684	Triamcinolone inhalation solution unit dose form per mg	Azmacort		00003-0293-05 '00003-0293-20 '00003-0293-28															Not Covered
J7699	**NOC drugs inhalation drugs. Used only if a more specific code is not available.**																		Not Covered
J7799	**NOC drugs other than inhalation drugs. Used only if a more specific code is not available**																		Not Covered
J8499	**Prescription drug oral non-chemotherapeutic NOS**																		Not Covered
J8501	Aprepitant oral 5mg	Emend Emend Tri-Fold	Antiemetic	00006-0462-30 00006-0461-30 00006-0462-05 00006-0461-05 00006-3862-03															Not Covered
J8510	Bulsulfan oral2 mg	Myleran	Anti-neoplastic	00173-0713-25															Not Covered
J8520	Capecitabine oral 150mg	Xeloda	Anti-neoplastic	00004-1100-51 00004-1100-20															Not Covered
J8521	Capecitabine oral 500mg	Xeloda	Anti-neoplastic	00004-1101-16 00004-1101-50															Not Covered
J8530	Cyclophosphamide oral 25mg	Cytoxan Procytox	Anti-neoplastic	00015-0503-01 00015-0503-02 00015-0504-01 00054-4129-25 00054-4130-25 00054-8089-25 00054-8130-25															Not Covered

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J8560	Etoposide oral 50mg	VePesid	Anti-neoplastic	00015-3091-45 00378-3266-94 51079-0965-05															Not Covered
J8565	Gefitnib oral 250mg	Iressa	Anti-neoplastic																Not Covered
J8600	Melphalan oral 2mg	Alkeran		00173-0045-35 59572-0302-50															Not Covered
J8610	Methotrexate oral 2.5mg	Rheumatrex Dose Pack		00005-4507-04 00005-4507-05 00005-4507-07 00005-4507-09 00005-4507-91 00054-4550-15 00054-4550-25 00054-8550-25 00378-0014-01 00378-0014-50 00555-0572-02 00555-0572-35 00555-0572-45 00555-0572-46 00555-0572-47 00555-0572-48 00555-0572-49 00555-0927-01 00555-0928-01 00555-0929-01 00555-0945-01 00603-4499-21 00904-1749-60 51079-0670-05	N/C													Not Covered
J8700	Temozolomide oral 5mg	Temodar		00085-1244-01 00085-1244-02 00085-1248-01 00085-1248-02 00085-1252-01 00085-1252-02 00085-1259-01 00085-1259-02															Not Covered
J8999	**Prescription drug oral chemotherapeutic NOS. Used only if a more specific code is not available.**																		Not Covered

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J9000	Doxorubicin HCl 10mg	Adriamycin	Anti-neoplastic	00703-5043-03 '55390-0231-10 '55390-0235-10 '55390-0241-10 '55390-0245-10	20 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9001	Doxorubicin HCl all lipid formulation 10mg	Doxil	Anti-neoplastic	17314-9600-01 '17314-9600-02	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9010	Alemtuzumab 10mg	Campath	Anti-neoplastic	50419-0355-10	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9015	Aldesleukin per single use vial.	Proleukin	Biological Response Modulator	53905-0991-01	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9017	Arsenic trioxide 1mg	Trisenox	Anti-neoplastic	60553-0111-10	15 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9020	Asparaginase 10000U	Elspar	Anti-neoplastic	00006-4612-00 00247-1289-10	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9031	BCG live (intravesical) per instillation	TheraCys Tice BCG	Biological Response Modulator	00052-0602-02 49281-0880-01 00052-0603-02	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9035	Injection bevacizumab 10 mg	Avastin		50242-0061-01 50242-0060-02 50242-0060-01	None	X	X												New code 1/1/05. Requires ICD-9-CM code 153.0 - 154.8 on CMS claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9040	Bleomycin sulfate 15U	Blenoxane	Anti-neoplastic	00015-3010-20 '00703-3154-01 '00703-3154-91 '61703-0332-18 61703-0323-22 55390-0006-01 00703-3155-91 00703-3155-01 55390-0005-01	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9041	Injection bortezomib 0.1 mg	Velcade	Proteasome Inhibitor	63020-0049-01	None	X	X												New code 1/1/05 Activate 1/1/05. Must have ICD-9-CM code 203.00 on CMS claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9045	Carboplatin 50mg	Paraplatin	Anti-neoplastic	00015-3213-30	18 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9050	Carmustine 100mg	BICNU	Anti-neoplastic	00015-3012-38	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9055	Injection Cetuximab 10 mg	Erbitux		66733-0948-23	None	X	X												Code opened 1/1/05. Must have ICD-9-CM code 153.0-154.8 on CMS 1500 claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9060	Cisplatin powder or solution per 10mg	Plantinol AQ	Anti-neoplastic	00703-5747-11 '00703-5748-11 '10019-0910-01 '10019-0910-02 '55390-0112-50 '55390-0112-99 '55390-0414-50 '55390-0414-99 '63323-0103-91 '63323-0103-95	18 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9062	Cisplatin 50mg	Plantinol AQ	Anti-neoplastic	00703-5747-11 '10019-0910-01 '55390-0112-50 '55390-0414-50 '63323-0103-91	6 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9065	Injection cladribine per 1 mg	Leustatin	Anti-neoplastic	55390-0115-01 '55390-0124-01 '59676-0201-01	40 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9070	Cyclophosphamide 100mg	Cytoxan Neosar	Anti-neoplastic	00013-5606-93	68 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9080	Cyclophosphamide 200 mg	Cytoxan Neosar	Anti-neoplastic	00013-5616-93	34 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9090	Cyclophosphamide 500 mg	Cytoxan Neosar	Anti-neoplastic	00013-5626-93 '00015-0547-41	14 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9091	Cyclophosphamide 1g	Cytoxan Neosar	Anti-neoplastic	00013-5636-70 '00015-0548-41	7 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9092	Cyclophosphamide 2g	Cytoxan Neosar	Anti-neoplastic	00013-5646-70 '00015-0549-12	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9093	Cyclophosphamide lyophilized 100mg	Cytoxan Lyophilized	Anti-neoplastic	00015-0546-41	68 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9094	Cyclophosphamide lyophilized 200 mg	Cytoxan Lyophilized	Anti-neoplastic	00015-0546-41	34 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9095	Cyclophosphamide lyophilized 500 gm	Cytoxan Lyophilized	Anti-neoplastic	00013-5626-93 '00015-0547-41	14 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9096	Cyclophosphamide lyophilized 1g	Cytoxan Lyophilized	Anti-neoplastic	00013-5636-70 '00015-0548-41	7 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9097	Cyclophosphamide lyophilized 2g	Cytoxan Lyophilized	Anti-neoplastic	00015-0549-12 '00015-0549-41	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9098	Cytarabine liposome 10 mg	DepoCyt	Anti-neoplastic	53905-0331-01	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9100	Cytarabine 100mg	Cytosar-U	Anti-neoplastic	00009-0373-01	75 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9110	Cytarabine 500mg	Cytosar-U	Anti-neoplastic	00009-0473-01 '55390-0132-10 '55390-0807-10	15 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9120	Dactinomycin 0.5mg	Cosmegen	Anti-neoplastic	00006-3298-22	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9130	Dacarbazine 100mg	DTIC-Dome	Anti-neoplastic	63323-0127-10	9 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9140	Dacarbazine 200mg	DTIC-Dome	Anti-neoplastic	00026-8151-20 '00703-5075-01 '00703-5075-03 '55390-0090-10 '63323-0128-12 '63323-0128-20	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9150	Daunorubicin HCl 10mg	Cerubidine	Anti-neoplastic	55390-0281-10 '55390-0805-10	11 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9151	Daunorubicin citrate liposomal formulation 10 mg	Daunoxome	Anti-neoplastic	61958-0301-01	11 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9160	Denileukin diftitox 300mcg	Ontak	Anti-neoplastic	64365-0503-01															Not Covered
J9165	Diethylstilbestrol diphosphate 250 mg	Stilphostrol			4 per day	X	X												Cannot bill with 96545. Only for cancer diagnosis. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9170	Docetaxel 20mg	Taxotere	Anti-neoplastic	00075-8001-20	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9178	Injection epirubicin HCl 2 mg	Ellence	Anti-neoplastic	00009-5091-01 00009-5093-01	None	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9181	Etoposide 10mg	VesPesid Toposar	Anti-neoplastic	00013-7336-91 '00013-7346-94 '00013-7356-88 '00015-3061-20 '00015-3062-20 '00015-3084-20 '00015-3095-20 '10019-0930-01 '55390-0291-01 '55390-0292-01 '55390-0293-01 '55390-0491-01 '55390-0492-01 '55390-0493-01 '63323-0104-05 '63323-0104-25 '63323-0104-50	25 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9182	Etoposide 100mg	VesPesid Toposar	Anti-neoplastic	00013-7336-91 '00015-3095-20 '55390-0291-01 '55390-0491-01 '63323-0104-05	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9185	Fludarabine phosphate 50mg	Fludara	Anti-neoplastic	50419-0511-06	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9190	Fluorouracil 500 mg	Adrucil	Anti-neoplastic	00013-1036-91 '00187-3953-64	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9200	Floxuridine 500 mg	FUDR	Anti-neoplastic	55390-0135-01 '55390-0435-01 '61703-0331-09 '63323-0145-07	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9201	Gemcitabine HCl 200mg	Gemzar	Anti-neoplastic	00002-7501-01	None	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9202	Goserelin acetate implant per 3.6mg	Zoladex	Anti-neoplastic	00310-0960-36 00310-0951-30 00310-0950-35	1 per month	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9206	Irinotecan 20mg	Camptosar	Anti-neoplastic	00009-7529-01 '00009-7529-02	35 per day	X	X												Requires ICD-9-CM code 153.0 - 154.8.on CMS 1500 claim form for payment consideratin. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9208	Ifosfamide per 1g	Ifex	Anti-neoplastic	00015-0556-05 '63323-0142-10 '63323-0142-12 00015-0557-41	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9209	Mesna 200mg	Mesnex	Anti-neoplastic	00015-3563-02 '00015-3563-03 '00703-4805-03 '63323-0733-10 '63323-0733-11 '63323-0733-12	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9211	Idarubicin HCl 5mg	Idamycin Pfs	Anti-neoplastic	00703-4154-11	12 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9212	Injection interferon alfa-con1 recombinant 1mcg	Infergen	Antiviral	'55513-0562-01 55513-0562-06 '64116-0031-01 '64116-0031-06	1 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9213	Interferon alfa-2A recombinant 3 million U	Roferon-A	Antiviral	00004-2015-07 '00004-2015-09	1 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9214	Interferon alfa-2B recombinant 1 million U	Intron-A	Antiviral	00085-0539-01 '00085-0571-02 '00085-1110-01	19 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9215	Interferon alfo-n3 human leukocyte derived 250,000 IU	Alferon-N	Biological Response Modulator	54746-0001-01	1 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9216	Interferon gamma 1B 3 million U	Actimmune	Biological Response Modulator	64116-0011-01 '64116-0011-12	2 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9217	Leuprolide acetate for depot suspension 7.5mg	Lupron Depot Eligard Lupron Depot Ped	Anti-neoplastic	00024-0597-07 '00300-3642-01	None	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9218	Leuprolide acetate 1mg	Lupron	Anti-neoplastic	00182-3154-99 '00185-7400-14 '00185-7400-85 '00300-3612-24 '00300-3612-28 '00703-4014-18 '00703-4014-19	1 per day	X	X												Physician reimbursement for administraton is limited to 7 consecutive days per Medicaid member for lifetime. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9219	Leuprolide acetate implant 65mg	Viadur	Anti-neoplastic	00026-9711-01	1 per 3 months	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9230	Mechlorethamine HCl nitrogen mustard 10mg	Mustargen	Anti-neoplastic	00006-7753-31	5 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9245	Injection melphalan HCl 50mg	Alkeran Lphenylalanine mustard	Anti-neoplastic	00173-0130-93	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9250	Methotrexate sodium 5mg	Rheumatrex Trexall Methotrexate sodium Lpf	Anti-neoplastic	54569-4983-00 '63323-0123-02 '63323-0123-10 '66479-0137-21 '66479-0139-29	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9260	Methotrexate sodium 50mg	Rheumatrex Trexall Methotrexate sodium Lpf	Anti-neoplastic	63323-0123-02	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9263	Injection oxaliplatin 0.5mg	Eloxatin	Anti-neoplastic	00024-0596-02 00024-0597-04	None	X	X												Requires ICD-9-CM code 153.0 - 154.8 on CMS 1500 claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9265	Paclitaxel 20mg	Taxol Onxol	Anti-neoplastic	00015-3475-30 '00015-3479-11 '00172-3753-77 '00172-3753-96 '00172-3754-73 '00172-3754-94 '00172-3756-75 '00172-3756-95 '51079-0961-01 '51079-0962-01 '51079-0963-01 '55390-0114-05 '55390-0114-20 '55390-0114-50	20 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9266	Pegaspargase per single dose vial	Oncaspar	Anti-neoplastic	57665-0002-02	8 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9268	Pentostatin per 10mg	Nipent	Anti-neoplastic	62701-0800-01	1 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9270	Plicamycin 2.5mg	Mithracin Mithramycin	Anti-neoplastic	00026-8161-15	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9280	Mitomycin 5mg	Mutamycin	Anti-neoplastic	00015-3001-20 '55390-0251-01 '55390-0451-01 '62701-0010-01	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9290	Mitomycin 20mg	Mutamycin	Anti-neoplastic	00015-3002-20 '55390-0252-01 '55390-0452-01 '62701-0011-01 '63323-0191-40	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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J9291	Mitomycin 40mg	Mutamycin	Anti-neoplastic	00015-3059-20 '55390-0253-01 '55390-0453-01		X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9293	Injection mitaxan-trone HCl 5mg	Navatrone	Anti-neoplastic	58406-0640-03 '58406-0640-05 '58406-0640-07	6 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9300	Gemtuzumab ozogamicin 5mg	Mylotarg	Anti-neoplastic	00008-4510-01	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9305	Injection pemetrexed 10mg	Alimta	Anti-neoplastic	00002-7673-01	None	X	X												New code 1/1/05. Must have ICD-9-CM code 162-163.9 on CMS 1500 claim form for payment consideration. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9310	Rituximab 100mg	RituXan	Anti-neoplastic	50242-0051-21 50242-0053-06	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9320	Streptozocin 1g	Zanosar	Anti-neoplastic	00247-1394-01 00703-4636-01	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9340	Thiotepa 15mg	Thioplex	Anti-neoplastic	00703-4301-02 '55390-0030-10 '58406-0662-01 58406-0662-36	10 per day	X	X												For Bone Marrow Transplants. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9350	Topotecan 4mg	Hycamtin	Anti-neoplastic	00007-4201-01 '00007-4201-05															Not Covered
J9355	Trastuzumab 10mg	Herceptin	Anti-neoplastic	50242-0134-60	40 per day	X	X												Canot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9357	Valrubicin intravesical 200mg	Valstar	Anti-neoplastic	53014-0216-04 '53014-0216-24	6 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9360	Vinblastine sulfate 1mg	Vinblastine Sulfate Velban	Anti-neoplastic	63323-0278-10 61703-0310-18 55390-0091-10	46 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9370	Vincristine sulfate 1mg	Oncovin Vincasar Pfs	Anti-neoplastic	00013-7456-86 '00703-4402-11	7 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9375	Vincristine sulfate 2mg	Oncovin Vincasar Pfs	Anti-neoplastic	00013-7466-86 '00703-4412-11	4 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9380	Vincristine sulfate 5mg	Vincasar Pfs	Anti-neoplastic	00013-7456-86 '00013-7466-86 '00703-4402-11 '00703-4412-11	2 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9390	Vinorelbine tartrate 10mg	Navelbine	Anti-neoplastic	00173-0656-01 '00703-4182-01 '00703-4183-01 '59911-5958-01	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9395	Injection fulvestrant 25mg	Faslodex	Antineo-plastic	00310-0720-25 00310-0720-50	10 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

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Code	Description	Brand Name	Category	NDC #	Service Limits	OPH	Physician	NP	MW	MH/R	HS	POD	OPTH	H-IV	Phar	IDTF	Dial-ysis	PA	Special Instructions
J9600	Porfimer sodium 75mg	Photofrin	Antineo-plastic	58914-0155-75	3 per day	X	X												Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.
J9999	**NOC antineoplastic drug. Used only if a more specific code in not available.**					X	X											X	Requires Prior Authorization effective 7/1/05. Submit medical documentation of failed therapy(ies) and confirmation of diagnosis to BMS Medical Director for review prior to providing services. Cannot bill with 96545. Medical necessity documentation of services provided must be maintained in the member's individual file.

CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 16
DRUGS APPROVED TO BE BILLED WITH
HCPCS CODE J3490
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West Virginia Department of Health and Human Resources
Office of Healthcare Policy Managed Care Coordination
Unlisted J3490 Medications
July 1, 2005

Description	Brand Name	Dosage	Reimbursable To	Special Instruction
Allopurinal Sodium	Aloprim Zyloprim	500mg	Outpatient Hospital and Physician	ICD-9-CM 174.9 or 790.6 plus ICD-9-CM for Neoplasm and NDC# required on claim. Drug must be billed with the code for Chemotherapy.
Amikacin Sulfate	Amikin	50mg	Physician and Nurse Practitioner	NDC# required on claim form.
Azacitidine	Vidaza	1mg	Outpatient Hospital and Physician	ICD-9-CM 238.7 and NDC# required on claim.
Aztreonam	Azactam	500mg	Physician and Nurse Practitioner	NDC# required on claim.
Bretylium	Tosylate	5mg	Physician and Nurse Practitioner	NDC# required on claim.
Bumetanide	Bumex	0.25mg	Physician and Nurse Practitioner	NDC# required on claim.
Bupivicaine 0.75%, 1ml	Marcaine Sensorcaine	1ml	Physician and Nurse Practitioner	0.75%/10ml allowed when billed with 62310, 62311, 62318, 62319, 64400 - 64484, 64505 - 64530. Not payable when billed with other procedures. NDC# required on claim.
Cimetidine HCl	Tagamet	150mg	Physician and Nurse Practitioner	ICD-9-CM 787.01, 787.02 OR 787.03 and NDC# required on claim.

Clavulanate Potassium/Ticarcillin Disodium	Timentin	0.1-3G	Physician and Nurse Practitioner	NDC# required on claim.
Clindamycin Phosphate	Cleocin Clindamax	150mg	Physician and Nurse Practitioner	NDC# required on claim.
Dantrolene Sodium	Dantrium	20mg	Physician and Nurse Practitioner	NDC# required on claim.
Dextrose 50%		50%	Physician and Nurse Practitioner	NDC# required on claim.
Diltiazem HCl	Cardizem	5mg	Physician and Nurse Practitioner	NDC# required on claim.
Edrophonium Chloride	Tensilon Reverso	10mg	Physician and Nurse Practitioner	ICD-9-CM 358.0 and NDC# required on claim.
Esmolol HCl	Brevibloc	10mg	Physician and Nurse Practitioner	ICD-9-CM 427.89 and NDC# required on claim.
Ethacrynate Sodium	Edecrin	50mg	Physician and Nurse Practitioner	NDC# required on claim.
Famotidine	Pepcid	10mg	Physician and Nurse Practitioner	NDC# required on claim.
Flumazenil	Romazicon Mazicon	0.1mg	Physician and Nurse Practitioner	ICD-9-CM 977.9 and NDC# required on claim.
Folic Acid	Folate	5mg	Physician and Nurse Practitioner	NDC# required on claim.

Glycopyrrolate	Robinul	0.2mg	Physician and Nurse Practitioner	NDC# required on claim.
Heparin Sodium		100U	Physician and Nurse Practitioner	NDC# required on claim.
Histrelin Implant	Vantas	5mg	Physician	ICD-9-CM code 185 and NDC# required on claim. Service limits 1 per year. Males only.
Isoproterenol HCl	Isuprel	0.2mg	Physician and Nurse Practitioner	NDC# required on claim.
Labetalol HCl	Trandate Normodyne	20mg	Physician and Nurse Practitioner	Covered for IV in office only with ICD-9-CM 401.0 and NDC# required on claim.
Lidocaine		1ml	Physician	Covered separately when billed on same day as 62310, 62311, 62318, 62319, 64400-64484, 64505-64530. Not payable when billed with other procedures. NDC# required on claim.
Metoprolol Tartrate	Lopressor	1mg	Outpatient Hospital, Physician, IDTF	Covered only when given IV with Dobutamine J1250 during Dobutamine Stress Test. Bill with both J3490 & J1250. NDC# required on claim.
Metronidazole in NACL	Flagyl	500mg	Physician and Nurse Practitioner	NDC# required on claim.
Minocycline HCl	Dunacin Minocin	100mg	Physician and Nurse Practitioner	NDC# required on claim.

Nafcillin Sodium	Unipen Nallpen	lG	Physician and Nurse Practitioner	NDC# required on claim.
Nitroglycerin	Nitrostat	5mg	Physician and Nurse Practitioner	NDC# required on claim.
Paclitaxel protein-bound particles	Abraxane	1mg	Outpatient Hospital and Physician	New code 04/01/05. Mjust be billed with Chemo. NDC# required on claim.
Pantoprazole Sodium	Protonix	40mg	Physician and Nurse Practitioner	NDC# required on claim.
Pegaptanib Sodium	Macugen	0.3mg	Ophthalmol-ogist ONLY	ICD-9-CM 362.52 and NDC# required on claim. Service limit 1 every 6 weeks. Must be billed with CPT 67028-RT or CPT 67028-LT
Potassium Acetate	Klor-Con	2mEq	Physician and Nurse Practitioner	NDC# required on claim.
Rifampin	Rifacin Rimactane	600mg	Physician and Nurse Practitioner	NDC# required on claim.
Sodium Acetate		2mEq	Physician and Nurse Practitioner	NDC# required on claim.
Sodium Bicarbonate		8.4% in 50ml	Physician and Nurse Practitioner	NDC# required on claim.
Sodium Hyaluronate for Intra-Articular Injection	Orthovisc	30mg	Outpatient Hospital and Physician	ICD-9-CM 715.16, 715.26, 715.36 OR 715.96 and NDC# required on claim. Must be billed with CPT 20610. Service limit 1 injection per knee per week x 6months.

Valproate Sodium	Depacon	100mg	Physician and Nurse Practitioner	ICD-9-CM code 345.00-345.91 and NDC# required on claim.
Vasopressin	Pitressin	20U	Physician and Nurse Practitioner	NDC# required on claim.
Verapamil HCl	Calan Calan SR IsoptinSR	2.5mg	Physician and Nurse Practitioner	NDC# required on claim.

CHAPTER 519
PRACTITIONER SERVICES
OCTOBER 1, 2005

ATTACHMENT 17
OUTPATIENT SURGERY PA REQUIREMENTS
PAGE 1 OF 15

Confidential

WVMI Medicaid Outpatient Services Authorization Request Form

Fax: 304- 344-2580 **or** 1-800- 891-0016 **Phone:** 304-414-2551 or (Toll Free) 1-800-296-9849

Request Date: _____ Member's Medicaid ID #:_____

A. **Member** Name: _____ Date of Birth: _____
Last First MI
Member Address: _____
Street City State Zip

B. **Surgical Procedure** Requested: _____
CPT Code **(Required)**: _____ ICD-9-CM Code **(Required)**: _____ Assistant surgeon? ☐ Yes ☐ No

Diagnosis Related to Surgical Procedure: _____

C. **Facility** Performing Surgical Procedure: _____
Facility ID # (10 digits): _____ Facility is: □ In WV □ Outside WV

Referring Physician Name: _____
Mailing Address: _____
Street City State Zip
Surgeon Name: _____
Mailing Address: _____
Street City State Zip

Contact Name: _____ Phone# (_____)_____-_____ Ext: _____
Fax # (_____)_____-_____

D. **Clinical Reasons for Surgery:** (e.g. signs and symptoms): _____
_____
_____
_____ Date of Onset: _____

E. **Relative Diagnostic and Outpatient Studies: (Include results of studies and attach photographs if** indicated):_____
_____
_____

F. **Related Medications, Treatments, and Therapies (include duration): _____**
_____
_____
_____

G. If procedure routinely performed in office, please document need for OP surgical setting: _____
_____

*****THIS FORM WILL BE RETURNED TO ORDERING PHYSICIAN WITH DETERMINATION*****

For <u>WVMI Use Only:</u>
Approved: ___ Authorization Number: _____ Date*: _____

***(Authorization expires 90 days from this date)**

Denied: ____ Detailed letter to follow

***** REMINDER: Preauthorization for medical necessity does not guarantee payment***

CPT/ HCPCS	Description	Medical Necessity	Place of Service
10040	Acne surgery	X	
10060	Drainage of skin abscess		X
10061	Drainage of skin abscess		X
10080	Drainage of pilonidal cyst	X	X
10081	Drainage of pilonidal cyst	X	X
10120	Remove foreign body		X
10121	Remove foreign body		X
10140	Drainage of hematoma/fluid	X	X
10160	Puncture drainage of lesion	X	X
10180	Complex drainage, wound	X	X
11055	Trim skin lesion	X	X
11056	Trim skin lesions, 2 to 4	X	X
11057	Trim skin lesions, over 4	X	X
11100	Biopsy, skin lesion	X	X
11101	Biopsy, skin add-on	X	X
11200	Removal of skin tags	X	X
11201	Remove skin tags add-on	X	X
11300	Shave skin lesion	X	X
11301	Shave skin lesion	X	X
11302	Shave skin lesion	X	X
11303	Shave skin lesion	X	X
11305	Shave skin lesion	X	X
11306	Shave skin lesion	X	X
11307	Shave skin lesion	X	X
11308	Shave skin lesion	X	X
11310	Shave skin lesion	X	X
11311	Shave skin lesion	X	X
11312	Shave skin lesion	X	X
11313	Shave skin lesion	X	X
11400	Exc tr-ext b9+marg 0.5 < cm	X	X
11401	Exc tr-ext b9+marg 0.6-1 cm	X	X
11402	Exc tr-ext b9+marg 1.1-2 cm	X	X
11403	Exc tr-ext b9+marg 2.1-3 cm	X	X
11404	Exc tr-ext b9+marg 3.1-4 cm	X	X
11406	Exc tr-ext b9+marg > 4.0 cm	X	X
11420	Exc h-f-nk-sp b9+marg 0.5 <	X	X
11421	Exc h-f-nk-sp b9+marg 0.6-1	X	X
11422	Exc h-f-nk-sp b9+marg 1.1-2	X	X
11423	Exc h-f-nk-sp b9+marg 2.1-3	X	X
11424	Exc h-f-nk-sp b9+marg 3.1-4	X	X
11426	Exc h-f-nk-sp b9+marg > 4 cm	X	X
11440	Exc face-mm b9+marg 0.5 < cm	X	X
11441	Exc face-mm b9+marg 0.6-1 cm	X	X
11442	Exc face-mm b9+marg 1.1-2 cm	X	X
11443	Exc face-mm b9+marg 2.1-3 cm	X	X
11444	Exc face-mm b9+marg 3.1-4 cm	X	X
11446	Exc face-mm b9+marg > 4 cm	X	X
11450	Removal, sweat gland lesion	X	X
11451	Removal, sweat gland lesion	X	X
11462	Removal, sweat gland lesion	X	X
11463	Removal, sweat gland lesion	X	X
11470	Removal, sweat gland lesion	X	X

11471	Removal, sweat gland lesion	X	X
11600	Exc tr-ext mlg+marg 0.5 < cm	X	X
11601	Exc tr-ext mlg+marg 0.6-1 cm	X	X
11602	Exc tr-ext mlg+marg 1.1-2 cm	X	X
11603	Exc tr-ext mlg+marg 2.1-3 cm	X	X
11604	Exc tr-ext mlg+marg 3.1-4 cm	X	X
11606	Exc tr-ext mlg+marg > 4 cm	X	X
11620	Exc h-f-nk-sp mlg+marg 0.5 <	X	X
11621	Exc h-f-nk-sp mlg+marg 0.6-1	X	X
11622	Exc h-f-nk-sp mlg+marg 1.1-2	X	X
11623	Exc h-f-nk-sp mlg+marg 2.1-3	X	X
11624	Exc h-f-nk-sp mlg+marg 3.1-4	X	X
11626	Exc h-f-nk-sp mlg+mar > 4 cm	X	X
11640	Exc face-mm malig+marg 0.5 <	X	X
11641	Exc face-mm malig+marg 0.6-1	X	X
11642	Exc face-mm malig+marg 1.1-2	X	X
11643	Exc face-mm malig+marg 2.1-3	X	X
11644	Exc face-mm malig+marg 3.1-4	X	X
11646	Exc face-mm mlg+marg > 4 cm	X	X
11719	Trim nail(s)		X
11720	Debride nail, 1-5		X
11721	Debride nail, 6 or more		X
11730	Removal of nail plate		X
11732	Remove nail plate, add-on		X
11740	Drain blood from under nail		X
11750	Removal of nail bed		X
11752	Remove nail bed/finger tip		X
11755	Biopsy, nail unit		X
11760	Repair of nail bed		X
11762	Reconstruction of nail bed		X
11765	Excision of nail fold, toe		X
11900	Injection into skin lesions	X	X
11901	Added skin lesions injection	X	X
11960	Insert tissue expander(s)	X	X
11970	Replace tissue expander	X	X
11971	Remove tissue expander(s)	X	X
11975	Insert contraceptive cap		X
11976	Removal of contraceptive cap		X
11980	Implant hormone pellet(s)		X
12001	Repair superficial wound(s)	X	X
12002	Repair superficial wound(s)	X	X
12004	Repair superficial wound(s)	X	X
12011	Repair superficial wound(s)	X	X
12013	Repair superficial wound(s)	X	X
12014	Repair superficial wound(s)	X	X
12015	Repair superficial wound(s)	X	X
12031	Layer closure of wound(s)	X	X
12032	Layer closure of wound(s)	X	X
12041	Layer closure of wound(s)	X	X
12042	Layer closure of wound(s)	X	X
12051	Layer closure of wound(s)	X	X
12052	Layer closure of wound(s)	X	X
12053	Layer closure of wound(s)	X	X
14000	Skin tissue rearrangement	X	

14001	Skin tissue rearrangement	X	
14020	Skin tissue rearrangement	X	
14021	Skin tissue rearrangement	X	
14040	Skin tissue rearrangement	X	
14041	Skin tissue rearrangement	X	
14060	Skin tissue rearrangement	X	
14061	Skin tissue rearrangement	X	
15786	Abrasion, lesion, single	X	X
15787	Abrasion, lesions, add-on	X	X
15823	Blepharoplasty, upper eyelid; with extensive skin weighting down lid	X	
15831	Excise excessive skin tissue	X	
15850	Removal of sutures		X
15851	Removal of sutures		X
15852	Dressing change not for burn		X
17000	Destroy benign/premlg lesion	X	
17003	Destroy lesions, 2-14	X	
17004	Destroy lesions, 15 or more	X	
17106	Destruction of skin lesions	X	
17107	Destruction of skin lesions	X	
17108	Destruction of skin lesions	X	
17110	Destruct lesion, 1-14	X	
17111	Destruct lesion, 15 or more	X	
17250	Chemical cautery, tissue	X	
17260	Destruction of skin lesions	X	
17261	Destruction of skin lesions	X	
17262	Destruction of skin lesions	X	
17263	Destruction of skin lesions	X	
17264	Destruction of skin lesions	X	
17266	Destruction of skin lesions	X	
17270	Destruction of skin lesions	X	
17271	Destruction of skin lesions	X	
17272	Destruction of skin lesions	X	
17273	Destruction of skin lesions	X	
17274	Destruction of skin lesions	X	
17276	Destruction of skin lesions	X	
17280	Destruction of skin lesions	X	
17281	Destruction of skin lesions	X	
17282	Destruction of skin lesions	X	
17283	Destruction of skin lesions	X	
17284	Destruction of skin lesions	X	
17286	Destruction of skin lesions	X	
17304	1 stage mohs, up to 5 spec	X	X
17305	2 stage mohs, up to 5 spec	X	X
17306	3 stage mohs, up to 5 spec	X	X
17307	Mohs addl stage up to 5 spec	X	X
17310	Mohs any stage > 5 spec each	X	X
19140	Mastectomy for gynecomastia	X	
19180	Prophylactic, simple, complete	X	
19182	Mastectomy, subcutaneous	X	
19316	Mastopexy	X	
19318	Reduction mammaplasty	X	
19324	Mammaplasty, augmentation; without prosthetic implant	X	
19325	Mammaplasty, augmentation; with prosthetic implant	X	
19328	Removal intact mammary implant	X	

19330	Removal mammary implant material	X	
19340	Immediate insertion breast prosthesis after reconstruction	X	
19342	Delayed breast prosthesis	X	
19350	Nipple/areola reconstruction	X	
19355	Correction of inverted nipples	X	
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	X	
19361	Breast reconstruction with lat. flap	X	
19364	Breast reconstruction with free flap	X	
19366	Breast reconstruction other technique	X	
19367	Breast reconsturction with TRAM	X	
19368	with microvascular anastaomosis	X	
19369	with TRAM double pedicle	X	
19370	Open periprosthetic capsulotomy, breast	X	
19371	Periprosthetic capsulectomy, breast	X	
19380	Revision of reconstructed breast	X	
19396	Prep for custom implant	X	
19499	Unlisted procedure, breast	X	
21060	Meniscectomy TMJ (<21)	X	
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft	X	
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft	X	
21143	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, without bone	X	
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	X	
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)	X	
21147	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)	X	
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)	X	
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	X	
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts) with LeFort I	X	
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); with LeFort I	X	
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	X	
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	X	
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	X	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	X	

21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	X	
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	X	
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	X	
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	X	
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	X	
21198	Osteotomy, mandible, segmental	X	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	X	
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)	X	
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	X	
21209	Osteoplasty, facial bones; reduction	X	
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	X	
21215	Graft, bone; mandible (includes obtaining graft)	X	
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	X	
21240	Arthroplasty, temporomandibular joint (TMJ), with or without autograft (includes obtaining graft) for <21 years.	X	
21240	Reconstruction of jaw joint	X	
21242	Arthroplasty, temporomandibular joint (TMJ), with allograft for <21 years	X	
21242	Reconstruction of jaw joint	X	
21243	Arthroplasty, temporomandibular joint (TMJ), with prosthetic joint replacement for <21 years	X	
21243	Reconstruction of jaw joint	X	
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)	X	
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	X	
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	X	
21247	Reconstruction of mandibular condyle with bone and cartilage autogra fts (includes obtaining grafts) (e.g. for hemifacial microsomia)	X	
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial	X	
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete	X	
21270	Malar augmentation, prosthetic material	X	
21280	Medial canthopexy (separate procedure)	X	
21282	Lateral canthopexy	X	
21299	Unlisted craniofacial and maxillofacial procedure	X	
21310	Treatment of nose fracture	X	
21315	Treatment of nose fracture	X	
21320	Treatment of nose fracture	X	
21325	Treatment of nose fracture	X	
21330	Treatment of nose fracture	X	
21335	Treatment of nose fracture	X	
21499	Unlisted musculoskeletal procedure, head	X	
21685	Hyoid myotomy and suspension	X	
21740	Reconstructive repair of pectus excavatum or carinatum; open	X	
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) without thoracoscopy	X	
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) with thoracoscopy	X	
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	X	

22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar	X	
22522	Each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure	X	
22523	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); thoracic	X	
22524	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); lumbar	X	
22525	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure)	X	
22899	Unlisted procedure, spine (to be used for kyphoplasty with dates of service prior to 01/01/2006)	X	
23412	Release shoulder joint	X	
23415	Drain shoulder lesion	X	
23420	Drain shoulder bursa	X	
23450	Exploratory shoulder surgery	X	
23455	Biopsy shoulder tissues	X	
23460	Biopsy shoulder tissues	X	
23462	Removal of shoulder lesion	X	
23470	Reconstruct shoulder joint	X	
23472	Reconstruct shoulder joint	X	
24351	Release elbow joint	X	
24352	Biopsy arm/elbow soft tissue	X	
24354	Biopsy arm/elbow soft tissue	X	
24356	Remove arm/elbow lesion	X	
24360	Reconstruct elbow joint	X	
24361	Reconstruct elbow joint	X	
24362	Reconstruct elbow joint	X	
24363	Replace elbow joint	X	
24365	Reconstruct head of radius	X	
24366	Reconstruct head of radius	X	
25000	Incision of tendon sheath	X	
25001	Incise flexor carpi radialis	X	
25111	Remove wrist tendon lesion	X	
25112	Reremove wrist tendon lesion	X	
25332	Revise wrist joint	X	
25441	Reconstruct wrist joint	X	
25442	Reconstruct wrist joint	X	
25443	Reconstruct wrist joint	X	
25444	Reconstruct wrist joint	X	
25445	Reconstruct wrist joint	X	
25446	Wrist replacement	X	
25447	Repair wrist joint(s)	X	
26010	Drainage of finger abscess		X
26055	Incise finger tendon sheath	X	
26121	Release palm contracture	X	
26123	Release palm contracture	X	
26125	Release palm contracture	X	
26160	Remove tendon sheath lesion	X	
26530	Revise knuckle joint	X	
26531	Revise knuckle with implant	X	

26531	Revise knuckle with implant	X	
26535	Revise finger joint	X	
26535	Revise finger joint	X	
26536	Revise/implant finger joint	X	
26536	Revise/implant finger joint	X	
26560	Repair of web finger	X	
26561	Repair of web finger	X	
26562	Repair of web finger	X	
26568	Lengthen metacarpal/finger	X	
26580	Repair hand deformity	X	
26587	Reconstruct extra finger	X	
26590	Repair finger deformity	X	
26989	Hand/finger surgery	X	
27096	Inject sacroiliac joint	X	
27200	Treat tail bone fracture	X	
27332	Removal of knee cartilage	X	
27333	Removal of knee cartilage	X	
27403	Repair of knee cartilage	X	
27405	Repair of knee ligament	X	
27407	Repair of knee ligament	X	
27409	Repair of knee ligament	X	
27437	Revise kneecap	X	
27437	Revise kneecap	X	
27438	Revise kneecap with implant	X	
27438	Revise kneecap with implant	X	
27440	Revision of knee joint	X	
27440	Revision of knee joint	X	
27441	Revision of knee joint	X	
27441	Revision of knee joint	X	
27442	Revision of knee joint	X	
27442	Revision of knee joint	X	
27443	Revision of knee joint	X	
27443	Revision of knee joint	X	
27445	Arthroplasty of knee	X	
27445	Revision of knee joint	X	
27446	Revision of knee joint	X	
27446	Revision of knee joint	X	
27447	Total knee arthroplasty	X	
27487	Revise/replace knee joint	X	
27613	Biopsy lower leg soft tissue	X	
27700	Arthroplasty, ankle	X	
27700	Ankle arthroplasty	X	
27702	With implant	X	
27703	Revision, total ankle	X	
27704	Removal of ankle implant	X	
28035	Decompression of tibia nerve	X	
28070	Removal of foot joint lining	X	
28072	Removal of foot joint lining	X	
28080	Removal of foot lesion	X	
28108	Removal of foot lesions	X	
28110	Part removal of metatarsal	X	
28111	Part removal of metatarsal	X	
28112	Part removal of metatarsal	X	
28113	Part removal of metatarsal	X	

28114	Removal of metararsal heads	X	
28116	Revision of foot	X	
28118	Removal of heel bone	X	
28119	Removal of heel spur	X	
28190	Removal of foot foreign body	X	
28192	Removal of foot foreign body	X	
28193	Removal of foot foreign body	X	
28238	Revision of foot tendon for medical necessity	X	
28240	Release of big toe	X	
28250	Revision of foot fascia	X	
28280	Fusion of toes	X	
28285	Repair of hammertoe	X	
28286	Repair of hammertoe	X	
28288	Partial removal of foot bone	X	
28289	Repair hallux rigidus	X	
28290	Correction of bunion	X	
28292	Correction of bunion	X	
28293	Correction of bunion	X	
28293	Correction of bunion with implant	X	
28294	Correction of bunion	X	
28296	Correction of bunion	X	
28297	Correction of bunion	X	
28298	Correction of bunion	X	
28299	Correction of bunion	X	
28300	Incision of heel bone	X	
28310	Revision of big toe	X	
28312	Revision of toe	X	
28313	Repair deformity of toe	X	
28315	Removal of sesamoid bone	X	
29800	Jaw arthroscopy/surgery	X	
29806	Shoulder arthroscopy/surgery	X	
29807	Shoulder arthroscopy/surgery	X	
29819	Shoulder arthroscopy/surgery	X	
29822	Shoulder arthroscopy/surgery	X	
29823	Shoulder arthroscopy/surgery	X	
29824	Shoulder arthroscopy/surgery	X	
29826	Shoulder arthroscopy/surgery	X	
29827	Arthroscop rotator cuff repr	X	
29848	Wrist endoscopy/surgery	X	
29855	Tibial arthroscopy/surgery	X	
29856	Tibial arthroscopy/surgery	X	
29870	Knee arthroscopy, dx	X	
29871	Knee arthroscopy/drainage	X	
29873	Knee arthroscopy/surgery	X	
29874	Knee arthroscopy/surgery	X	
29875	Knee arthroscopy/surgery	X	
29876	Knee arthroscopy/surgery	X	
29877	Knee arthroscopy/surgery	X	
29879	Knee arthroscopy/surgery	X	
29880	Knee arthroscopy/surgery	X	
29881	Knee arthroscopy/surgery	X	
29882	Knee arthroscopy/surgery	X	
29883	Knee arthroscopy/surgery	X	
29885	Knee arthroscopy/surgery	X	

29886	Knee arthroscopy/surgery	X	
29887	Knee arthroscopy/surgery	X	
29888	Knee arthroscopy/surgery	X	
29889	Knee arthroscopy/surgery	X	
29893	Scope, plantar fasciotomy	X	
29999	Arthroscopy of joint	X	
30150	Rhinectomy; partial	X	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	X	
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	X	
30420	Rhinoplasty, primary; including major septal repair	X	
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	X	
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	X	
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	X	
30465	Repair of nasal stenosis	X	
30520	Repair of nasal septum	X	
30540	Repair nasal defect	X	
30545	Repar nasal defect	X	
31299	Unlisted procedure, accessory sinuses	X	
31513	Injection into vocal cord	X	
31570	Laryngoscopy with injection	X	
31571	Laryngoscopy with injection	X	
36299	Unlisted procedure, vascular injection	X	
36468	Inj. Sclerosing solution	X	
36469	face	X	
36470	single vein	X	
36471	multiple veins, same leg	X	
37204	Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	X	
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	X	
37501	Unlisted vascular endoscopy procedure	X	
37700	Ligation and division long saphenous vein at saphenofemoral junction, or distal interruptions	X	
37718	Ligation division and stripping short saphenous vein	X	
37722	Ligation divisin and stripping , long greater saphenous viens from saphenofemoral junction to knee or below	X	
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg with excision of deep fascia	X	
37760	Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open	X	
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions	X	
37766	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions	X	
37780	Ligation and division of short saphenous vein at saphenopopliteal junction	X	
37785	Ligation, division, and/or excision of varicose vein cluster(s), one leg	X	
37799	Unlisted procedure, vascular surgery	X	
39502	Repair paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, exceptional	X	
40806	Incision of lip fold	X	
40819	Excise lip or cheek fold	X	
41520	Reconstruction, tongue fold	X	
42145	Repair palate, pharynx/uvula	X	
42810	Excision of nect cyst	X	

42815	Excision of nect cyst	X	
42820	Remove tonsils and adenoids	X	
42821	Remove tonsils and adenoids	X	
42825	Removal of tonsils	X	
42826	Removal of tonsils	X	
42830	Removal of adenoids	X	
42831	Removal of adenoids	X	
42835	Removal of adenoids	X	
42836	Removal of adenoids	X	
43201	Esophagoscopy with injections	X	
43280	Lap, esophagus	X	
43289	Lap, esophagus	X	
43644	Lap, gastric bypass	X	
43645	Lap, gastric bypass	X	
43651	Lap, vagotomy	X	
43652	Lap, vagotomy	X	
43659	Lap, gastric, unlisted	X	
44970	Lap, appendectomy	X	
44979	Lap, appendix unlisted	X	
46505	Chemodenervation of internal and sphincter if coupled with J0585 pr K0587	X	
47562	Lap cholecystectomy	X	
47563	Lap cholecystectomy	X	
47564	Lap cholecystectomy	X	
47570	Lap cholecystoenterostomy	X	
47579	Lap, unlisted biliary	X	
49250	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure	X	
49329	Lap, abd, peritoneum, omen, unlisted	X	
49560	Repair initial incisional or rentrel hernia	X	
49561	Incarcerated or strangulated	X	
49565	Repair recurrentincisional or rentrel hernia, reducible	X	
49566	Incarcerated or strangulated	X	
49568	Hernia repair with mesh	X	
49569	Lap, hernia, unlisted	X	
49570	Repair epigashric hiernia, reducible	X	
49572	Repair epigashric hiernia, blocked	X	
49585	Repair umbilical hernia, reducible > 5 years	X	
49587	Repair umbilical hernia, blocked+C379+C411 > 5 years	X	
49650	Lap, inguinal hernia	X	
49651	Lap, inguinal hernia	X	
49904	Omental flap, extra-abdominal (e.g., for reconstruction of sternal and chest wall defects)	X	
51999	Lap, bladder, unlisted	X	
51999	Lap, bladder, unlisted	X	
53440	Correct bladder function	X	
53442	Remove perineal prosthesis	X	
53445	Insert uro/ves nck sphincter	X	
53447	Remove/replace ur sphincter	X	
53448	Removal/replacement of sphincter pump	X	
53505	Repair of urethra injury no pa--no pink	X	
54400	Insert semi-rigid prosthesis	X	
54401	Insert self-contd prosthesis	X	
54405	Insert multi-comp penis pros	X	
54406	Removal of inflatable penile prosthesis	X	
54409	Removal of inflatable penile prosthesis	X	

54410	Remove/replace penis prosth	X	
54416	Remv/repl penis contain pros	X	
54699	Lap, testicle unlisted	X	
55550	Lap, ligation spermatic veins	X	
55559	Lap, spermatic cord, unlisted	X	
55866	Lap. Prostatectomy	X	
57265	Extensive repair of vagina	X	
57284	Repair paravaginal defect	X	
57287	Revise/remove sling repair	X	
57288	Repair bladder defect	X	
57425	Lap colpopexy	X	
58150	Hyst and BSO	X	
58180	Hyst and BSO	X	
58200	Hyst and BSO	X	
58260	Vag Hyst	X	
58262	removal of tubes/ovaries	X	
58263	Vag Hyst	X	
58267	Vag Hyst	X	
58270	Vag Hyst	X	
58275	Vag Hyst	X	
58280	Vag Hyst	X	
58285	Vag Hyst	X	
58290	Vag Hyst	X	
58291	Vag Hyst	X	
58292	Vag Hyst	X	
58293	Vag Hyst	X	
58294	Vag Hyst	X	
58550	Laparoscopy, surgical with vaginal hysterectomy	X	
58552	Laparoscopy, surgical with vaginal hysterectomy	X	
58553	Laparoscopy, surgical with vaginal hysterectomy	X	
58554	Laparoscopy, surgical with vaginal hysterectomy	X	
58555	Hysteroscopy, diagnostic	X	
58558	Hysteroscopy, surgical	X	
58559	With lysis of cohesions	X	
58560	With division or resection of intrauterine septum	X	
58561	With removal of leiomyoma	X	
58562	With removal of impacted foreign body	X	
58563	With endometrial ablation	X	
58565	Hysteroscopy, sterilization	X	
58578	Lap, uterus unlisted	X	
58579	Unlisted hysteroscopy procedure, uterus	X	
58679	Lap, ovary unlisted	X	
59898	Lap, unlisted, maternity	X	
61885	Implant neurostim one array	X	
61886	Implant neurostim arrays	X	
62360	Implantation or replacement of device for intrathreal or epidural drug infusion; subcutaneous.	X	
62361	Implant spine infusion pump	X	
62362	Implant spine infusion pump	X	
63650	Implant neuroelectrodes	X	
63655	Implant neuroelectrodes	X	
63685	Implant neuroreceiver	X	
64553	Implant neuroelectrodes	X	
64555	Implant neuroelectrodes	X	

64560	Implant neuroelectrodes	X	
64561	Implant neuroelectrodes	X	
64565	Implant neuroelectrodes	X	
64573	Implant neuroelectrodes	X	
64575	Implant neuroelectrodes	X	
64577	Implant neuroelectrodes	X	
64580	Implant neuroelectrodes	X	
64581	Implant neuroelectrodes	X	
64585	Revision or removal of peripheral stimulator electrodes	X	
64590	Implant neuroreceiver	X	
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)	X	
64613	Chemodenervation, neck muscles	X	
64614	Extremity or trunk	X	
64650	Chemodenervation of eccrineglands	X	
64653	Other areas when coupled with J0585 or J0587	X	
65772	Corneal relaxing incision for correction of surgically induced astigmatism	X	
65775	Corneal wedge resection for correction of surgically inducted astigmatism	X	
67345	Chemodenervation of extraocular muscle	X	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	X	
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material	X	
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)	X	
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	X	
67904	Repair of blepharoptosis; (tarso) Levator resection or advancement, external approach	X	
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	X	
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)	X	
67909	Reduction of overcorrection of ptosis	X	
67911	Correction of lid retraction	X	
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)	X	
67914	Repair of ectropion, suture	X	
67915	Repair of ectropion; thermocauterization	X	
67916	Repair of ectropion; excision tarsal wedge	X	
67917	Repair of ectropion; extensive (e.g., tarsal strip operations)	X	
67921	Repair of entropion; suture	X	
67922	Repair of entropion; thermocauterization	X	
67923	Repair of entropion; excision tarsal wedge	X	
67924	Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)	X	
67950	Canthoplasty	X	
67999	Unlisted eyelid procedure	X	
69300	Otoplasty	Not covered	
69399	Unlisted procedure, external ear	X	
69420	Incision of eardrum	X	
69421	Incision of eardrum	X	
69610	Repair of eardrum	X	
69620	Repair of eardrum	X	
69631	Repair eardrum structures	X	
69632	Rebuild eardrum structures	X	

69633	Rebuild eardrum structures	X	
69635	Rebuild eardrum structures	X	
69636	Rebuild eardrum structures	X	
69637	Rebuild eardrum structures	X	
69650	Release middle ear bone	X	
69660	Revise middle ear bone	X	
69661	Revise middle ear bone	X	
69662	Revise middle ear bone	X	
69930	Cochlear device implantation, with or without mastoidectomy	X	
69949	Unlisted procedure, inner ear	X	
76012	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body	X	
76013	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body, under CT guidance	X	
76499	Unlisted diagnostic radiographic procedure (to be used for dates of service prior to 01/01/2006 for radiological sueprvision and interpretation, kyphoplasty under fluoroscopic or CT guidance).	X	
91110	GI tract imaging, capsulte endoscopy	X	
95873	Electrical stimulation/chemodenervation	X	
13100-13152	Keloid Revision	X	
21182-21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g. fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	X	
43770-43774	Lap, gastric band	X	
47560-47561	Lap, transhepatic cholangiography	X	
49320-49323	Lap, abd, peritoneium, omentum	X	
51990-51992	Lap, for stress incontinence	X	
54690-54692	Lap, testicle	X	
58545-58546	Lap myomectomy	X	
58550-58554	Lap hysterectomy	X	
58660-58673	Lap, ovary	X	
58970-58976	Lap, in vitro	X	
67971-67975	Reconstruction of eyelid	X	
68320-68340	Conjunctivoplasty	X	
69310-69320	Reconstruction external auditory canal	X	

CHAPTER 519

PRACTITIONER SERVICES

JANUARY 16, 2012

ATTACHMENT 18

INFANT AND CHILD ORAL HEALTH FLUORIDE VARNISH PROGRAM FOR PRIMARY CARE PRACTITIONERS

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Cabinet Secretary

Bureau for Medical Services
Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners
Coverage Criteria

Physician fluoride varnish (FV) services are defined as preventive procedures provided by or under the supervision of a physician. This includes caries screening, recording of notable findings in the in the oral cavity, preventive oral health and dietary counseling, and administration of topical fluoride varnish. Such services shall maintain a high standard of quality and shall be within the reasonable limits of services customarily available and provided to most persons in the community with the limitations specified below in this document. The American Dental Association (ADA) expert panels have reviewed evidence-based (class 1a) studies and concluded that "Fluoride varnish applied every six months is effective in preventing caries in the primary and permanent dentition of children and adolescents." Please see JADA executive Summary 2006 recommendations attached.

Fluoride varnish is a thin coating of resin that is applied to the tooth surface to protect it from decay. According to the Food & Drug Administration (FDA), fluoride varnish falls under the category of "drugs and devices" that presents minimal risk and is subject to the lowest level of regulation. The purpose of applying fluoride varnish is to retard, arrest, and reverse the process of cavity formation.

Fluoride varnish is easy to apply, does not require special dental equipment or a professional cleaning prior to application. It also requires minimal training, and is inexpensive. Fluoride varnish dries immediately upon contact with saliva and is safe and well tolerated by infants, young children, and individuals with special needs.

Effective January 16, 2012, the Bureau for Medical Services (BMS) will start reimbursing primary care providers who have been certified through a face-to-face training for fluoride varnish application offered through the West Virginia University School of Dentistry for the application of fluoride varnish to children ages 6 months to 36 months (3 years) who are at high risk of developing dental caries. The application of the fluoride varnish should include communication with and counseling of the child's caregiver, including a referral to a dentist.

A child is considered at high risk of developing cavities if he or she:

- ✓ Has had cavities in the past or has white spot lesions and stained fissures
- ✓ Continues to use the bottle past one year of age or sleeps with a bottle containing liquids other than water
- ✓ Breastfeeds on demand at night
- ✓ Has a developmental disability
- ✓ Chronically uses high sugar oral medications
- ✓ Has family members with histories of caries
- ✓ Engages in prolonged or ad lib use throughout the day of a bottle or "sippy" cup containing liquids other than water

Who is not Covered:

- ✓ Children with a low risk of cavity formation who consume optimally fluoridated water or children who receive routine fluoride treatments through a dental office.

BMS recognizes the following types of primary care providers to be eligible for payment of this service:

- ✓ Pediatricians
- ✓ General and Family Practice Doctors
- ✓ Nurse Practitioners
- ✓ Physician Assistants (in FQHC settings only)

Provider Eligibility to Bill for Program Services

Providers must have completed a certified training course from the WVU School of Dentistry prior to performing and billing for these services. The WVU School of Dentistry will provide a list of all current certifications monthly in 2011 and thereafter to BMS and its fiscal agent in order to create a file of reimbursable providers. Information about this course is available at www.hsc.wvu.edu/sod/oral-health.

Reimbursement for the Services

BMS allows coverage of two fluoride varnish applications per year (one every six months). The first application must be provided and billed in conjunction with a comprehensive well-child exam as reported under the CPT codes listed in the table below. The second fluoride varnish application can be reimbursed during the 12-month subsequent period, and may be billed in conjunction with the HCPCS code outlined in the table below.

BMS will use the following codes to reimburse primary care providers for fluoride varnish application:

Code	Description	Comments
99381-99382 99391-99392	Comprehensive well-child exam codes for children less than 1 year and up to age 4 (note FV coverage under this program is only through age 3)	Oral evaluation and counseling are components of comprehensive well –child exams
T1503	Administration of medication, other than oral and/or injectable by a health care agency/professional, per visit Note: Use this code to bill for the topical fluoride varnish; therapeutic application for moderate to high caries risk patients. By mid-2012, updates to the BMS Fiscal Agent's claim processing system will allow this code to be replaced by D1206-Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	Covered 2 times per year for children up to age 3; 1st application must be billed in conjunction with one of the comprehensive well child exam codes listed above
T1503-DA	Use Code T1503 with modifier-DA (Oral health assessment by a licensed health professional other than a dentist) to bill for oral evaluation of patient under three years of age and counseling with primary caregiver. Note: By mid-2012, updates to the BMS Fiscal Agent's claim processing system will allow this code to be replaced by D0145 – Oral Evaluation for patient under three years of age and counseling with primary caregiver.	Covered once per year in conjunction with 2nd fluoride varnish application; cannot be covered when comprehensive well-child exam is billed on the same day and at least 180 days after billing for the comprehensive well child-exam
V20.2	Routine infant or child health check	Primary diagnosis used when billing well-child exam
V82.89	Special screening for other specified conditions	Secondary diagnosis used when billing comprehensive well-child exam
V72.2	Dental Exam	Primary diagnosis used when billing D0145 – dental exam; cannot report in combination with V20.2

Reimbursement will be made using the dental fee schedule effective on the date of service. The current fee for T1503 (D1206) will be $20.00 and T1503-DA (D0145) will be $25.00.