CHAPTER 510 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR HOSPITAL SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 510.8.1	Prior Authorization Requirements For Outpatient Services	01/12/06	02/15/06
Section 510.8.1	Prior Authorization Requirements For Outpatient Services	10/24/05	Postponed
Section 510.8.1	Prior Authorization Requirements For Outpatient Services (Surgeries-Place of Service 22 and 24)	09/28/05	11/01/05
Section 510.8.1	Prior Authorization Requirements For Outpatient Services	09/28/05	10/01/05 Policy clarification
Section 510.8.1	Prior Authorization Requirements for Outpatient Services	09/01/05	10/01/05
Section 510.8.1	Prior Authorization Requirements for Outpatient Services	02/14/05	05/01/05
Section 510.8.2	Non-covered Services - Outpatient	02/14/05	05/01/05
Attachment 1	Special Coverage Considerations and Billing Instructions	02/14/05	05/01/05

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CHAPTER 510 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR HOSPITAL SERVICES

JANUARY 12, 2006

SECTION 510.8.1

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 services 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 3.

Change: Number 4 should 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 listed in Attachment 3, along with the PA form that may be utilized.

Directions: Replace pages.

OCTOBER 24, 2005

SECTION 510.8.1

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.

SEPTEMBER 28, 2005

Section 510.8.1

Introduction: Policy clarification for Critical Access Hospitals regarding diagnostic imaging PA requirements.

Introduction: Prior Authorization required for surgeries preformed in place of service 22 and 24.

Change: Critical Access Hospitals (CAHs) who have chosen encounter, as well as those who bill Fee For Service, must obtain a prior authorization for certain diagnostic imaging testing. Reimbursement for diagnostic imaging services are considered part of the encounter and cannot be billed separately. CAHs will be required to obtain a PA from WVMI and document this information in the patient's medical record for audit purposes.

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

Directions: Replace pages.

SEPTEMBER 1, 2005

Section 510.8.1

Introduction: Implementing changes in policy for imaging procedures effective 10/01/05.

Change: 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.

Directions: Replace pages.

MAY 1, 2005

Section 510.8.1

Introduction: Corrected the number of physical therapy visits to 20 from 10.

Directions: Replace this section.

Change: Replace page

Section 510.8.2

Introduction: 5th bullet - Corrected the number of physical therapy visits to 20 from 10. Added Enhanced Extracorporeal Counterpulsation (EECP), Stretta, and Cosmetic Surgery to the list of noncovered services.

Directions: Replace this section.

Change: Page

Attachment 1

Introduction: Added section relating to new condition code which allows inpatient admission to be changed to outpatient.

Directions: Insert this section.

Change: Attachment 1

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CHAPTER 510—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR HOSPITAL SERVICES

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CHAPTER 510–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR HOSPITAL SERVICES

INTRODUCTION

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

This chapter sets forth requirements of the BMS regarding coverage, payment and processing for Hospital Services provided to eligible WV Medicaid members by acute care, psychiatric and medical rehabilitation hospitals.

Inpatient and outpatient hospital services, including tests furnished by participating hospitals, are covered only when ordered by a licensed medical practitioner for the care and treatment indicated in the management of illness, injury, or maternity care, or for the purpose of determining existence of an illness or disease. All Medicaid covered items and services must be medically necessary. The physician's order and appropriate documentation of medical necessity must be on file in the patient's record. The fact that a provider has prescribed, recommended, or approved medical care, goods, or a service, does not in itself make such care, goods or services medically necessary or a covered service. For definition of medically necessary, refer to Chapter 200, Definitions.

There must be documentation in the patient's record for all services billed to the West Virginia Medicaid Program, which substantiates the medical necessity for covered items or services. For Medicaid covered services or items requiring prior authorizations, the physician's order and documentation must be submitted prior to the provision of the service.

This Chapter outlines or describes the allowable services which may be rendered within each of the three categories of hospital providers, acute care, psychiatric, and medical rehabilitation.

510.1 DEFINITIONS

Definitions governing the provision of WV Medicaid services will apply pursuant to Chapter 200, Definitions. In addition, the following definitions apply specifically to the requirements for payment of Hospital Services as described in this chapter.

Critical Access Hospital (CAH) – Critical Access Hospital is defined in the code of federal regulations at CFR 42, Chapter 4, Section 400.2.2, as "a facility designated by the Centers for Medicare and Medicaid Services as meeting the applicable requirements of Section 1820 of the Act and of Subpart F of Part 485 of this chapter. Characteristics of critical access hospitals include:

- Special reimbursement status, consisting of 100 percent cost reimbursement as determined by Medicare fiscal intermediary (for Medicaid reimbursement methodology see Attachment 1.)

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- Number of beds: Except as permitted for CAHs having swing bed agreements (with Medicare) under Section 485.645 of this chapter, the CAH maintains no more than 15 inpatient beds.
- Length of stay. The CAH provides acute inpatient care for a period that does not exceed on an annual average basis 96 hours per patient.

Eligible Medicaid Patient – An individual with a valid identification card receiving financial and/or medical assistance from the DHHR and children in foster care under Department supervision.

Regulating Agency – The unit in the Department of Health that is responsible for Medicaid certification of all participating laboratory and radiology providers in accordance with the standards set forth in Title XIX laboratory and radiology services regulations.

510.2 PROVIDER PARTICIPATION

Refer to Chapter 300 for enrollment requirements for Hospital providers.

510.3 MEMBER ELIGIBILITY

Reimbursement for medically necessary Hospital Services is available on behalf of all WV Medicaid-eligible members, subject to the conditions and limitations applicable to these services. Additional information on member eligibility is located in Chapter 400.

510.4 HOSPITAL INPATIENT SERVICES

An inpatient admission is defined as a person who has been admitted to an inpatient facility for bed occupancy for purposes of receiving inpatient hospital facility services. Inpatient care is covered under the Medicaid Program when it is reasonable and medically necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body part. The services must be consistent with the diagnosis or treatment of the patient's condition, and must be rendered in accordance with standards of good medical practice to be considered medically necessary. Inpatient care which does not contribute meaningfully to the treatment of an illness or injury, or to improve the functioning of a malformed body part, is not covered. Nursing and other related services, such as use of hospital facilities, medical and social services, and transportation furnished by the hospital during an inpatient stay are included in the rate of reimbursement. Covered services are limited to those admissions which are certified by the Bureau's utilization management agency in accordance with the procedures and admission criteria utilized by the agency and approved by BMS. Refer to Attachment I for additional information. Additionally, admissions must be effected upon the written order of a physician who is licensed in the practice of medicine and surgery in the state in which he/she is located, and authorized to admit patients to the facility in which the service is rendered.

510.4.1 Acute Care Hospital – Inpatient Services (This category of hospital is intended to include both acute care general and critical access hospitals)

The WV Medicaid Program reimburses hospitals for medically necessary inpatient services provided to eligible members within coverage limitations in effect on the date of service. Coverage and benefit limitations may be revised periodically as necessary due to changes in Federal regulations, fiscal constraints, or WV Medicaid policies.

Covered inpatient services include general acute care admissions and critical access admissions, as well as admissions to Medicare certified distinct part psychiatric and medical

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rehabilitation inpatient units. Services rendered in the distinct part psychiatric unit are covered for both children and adults. Coverage for services rendered in the distinct part rehabilitation inpatient unit is limited to children through age 20 or under age 21.

A member admitted to a psychiatric distinct part must have a mental health DSM IV diagnosis as the primary diagnosis. If during the distinct part inpatient stay, the treatment emphasis changes to, or shifts to a physical health diagnosis or condition, the hospital cannot bill the distinct part rate but must bill the appropriate DRG. In these instances the patient must be discharged from the distinct part unit and if medically necessary and appropriate and following medical necessity review and certification by the Bureau's utilization management agency, readmitted as an acute care medical admission.

Inpatient services are primarily for treatment indicated in the management of acute or chronic illness, injury, impairment, or for maternity care. The member's hospital records and the hospital's utilization review mechanism must document that the care and services rendered were medically necessary; that the services rendered could only be provided on an inpatient basis (i.e. could not be provided on an outpatient basis or in a lower level of care facility); and that the services rendered were necessary for each day of inpatient care billed to the program. Outpatient charges including observation services incurred with 24 hours of admission must be made a part of the inpatient claim.

510.4.2 Psychiatric Inpatient Facilities

Members who are admitted to distinct part psychiatric units must have an admission diagnosis of a mental illness. If however, during the course of the stay, treatment changes from psychiatric care to physical care, the hospital shall bill the appropriate DRG. These admissions will be subject to audit and cost settlement.

510.4.2.1 Inpatient Psych Facility Acute Psych Under 21

Services rendered in this setting include inpatient acute care psychiatric services for individuals under 21 (Professional services rendered to members who would be admitted to a psych under 21 facility must be billed separately under the practitioner's provider number. Those charges are not included in the facility's invoice). Such facilities may also render all of the outpatient services for which they meet applicable federal and state regulatory requirements (Outpatient services are reimbursed on a procedure specific fee for service utilizing appropriate HCPCS and CPT codes just as for outpatient services rendered in any other approved setting). Services rendered in the outpatient setting may also include partial hospitalization services in Medicaid approved Partial Hospitalization Programs, as further defined in Attachment 1. These facilities are reimbursed based on costs and are subject to audit and cost settlements.

Services rendered to Medicaid members enrolled in an HMO are not the responsibility of the HMO and must be billed to Medicaid. If the Medicaid recipient is a member of the PAAS Program, PAAS PCP referrals are not required.

510.4.2.2 Inpatient Psychiatric Residential Treatment Facility

Services rendered in this setting are available only to Medicaid eligible individuals under age 21. PRTFs may only render inpatient services, which are inclusive of any medical, pharmaceutical or psychiatric professional services rendered in the facility. PRTFs are not authorized to render

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outpatient hospital services. These facilities are reimbursed based on costs and are subject to audit and cost settlements.

Services rendered to Medicaid members enrolled in an HMO are not the responsibility of the HMO and must be billed to Medicaid. If the Medicaid recipient is a member of the PAAS Program, PAAS PCP referrals are not required.

510.4.2.3 Adult Psychiatric Services

Medicaid program coverage for inpatient psychiatric services rendered to adults is limited as follows:

a. Medicaid covers such services when rendered to Medicaid eligible individuals in Medicare certified distinct part psychiatric units of acute care general hospitals when such individuals are admitted following medical necessity review and admission certification by the Bureau's utilization management contractor

b. For those individuals 65 and over who are both Medicare and Medicaid eligible, the Medicaid program provides coverage of coinsurance and deductible payments subject to Medicaid's upper payment limits for individuals admitted to facilities designated as institutes for mental disease (IMD). Psychiatric facilities classified as IMD are defined in federal regulation at CFR 42, Section 435.1009, IMD. In general, this designation includes all JACHO approved psychiatric inpatient facilities

510.4.3 Medical Inpatient Rehabilitation Facility

Services covered in this setting are medical inpatient rehabilitation services for Medicaid eligible individuals under 21, and general medical outpatient services which meet certification requirements of the Office of Facility, Licensure and Certification. These facilities are reimbursed based on costs and are subject to audit and cost settlements.

Medicaid covers inpatient rehabilitation services in facilities that are certified as rehabilitation hospitals or rehabilitation units of a general acute care hospital. The facility must also have a current provider agreement for rehabilitation services.

510.5 SERVICE LIMITS INPATIENT SERVICES

Medicaid Program coverage places limits on certain categories of facilities with regard to admission review procedures and characteristics of members they may serve. The following sections outline those limitations and program exclusions:

510.5.1 Prior Authorization Requirements For Inpatient Services

All inpatient admissions, with the exception of those related to labor and delivery, are subject to medical necessity review and certification of admission by the Bureau for Medical Services Utilization Management Agency. (See Attachment 2 for further information.)

General requirements by category of provider are as follows:

1. Acute Inpatient. Admissions to both general and critical access acute care facilities are subject to medical necessity review and preadmission certification. Retrospective review is available for admissions occurring on weekends and holidays, or at times when the utilization management agency review process is unavailable. Additionally, retrospective

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review is permitted for admissions of Medicaid members whose eligibility has been determined retroactively. Retrospective review must be requested within 12 months of discharge date.

2. Admissions to Medicare certified distinct part psychiatric and rehabilitation units of acute care facilities are subject to both preadmission and continued stay review.
3. Psychiatric inpatient facility and PRTF admissions are subject to admission and continued stay review by the Bureau's utilization management contractor.
4. Inpatient Medical Rehabilitation Facility admissions are subject to both admission and continued stay review by the Bureau's utilization management contractor. Members who are inpatients, upon reaching the age of 21, may continue to receive services through age 21, as long as they continue to meet medical necessity criteria for continued stay.

510.5.2 Inpatient Non-Covered Services (Exclusions)

The following inpatient services are excluded from coverage by the West Virginia Medicaid Program:

1. Admissions which are not authorized by the Bureau's utilization management contractor in accordance with Medicaid Program Policy in effect as of the date of service.
2. Admissions other than emergency to out-of-state facilities for services which are available in-state or in border area facilities
3. Admissions for experimental or investigational procedures
4. Admissions and/or continued stays which are strictly for patient convenience and not related to the care and treatment of a patient
5. Inpatient psychiatric or medical rehabilitation facility admissions of individuals age 21 or over
6. Inpatient admission for services which could be performed in an outpatient setting

510.6 REIMBURSEMENT METHODOLOGY FOR INPATIENT SERVICES

Reimbursement methodologies for hospital services vary depending on the type of service at issue. The following describes various inpatient services and their corresponding reimbursement methodologies.

Service	Reimbursement Methodology
Inpatient Acute Care Services – General	Diagnosis related group (DRG)
Acute Care Hospital – Critical Access	Per diem rate established by Medicare fiscal intermediary
Distinct Part	Cost based
Inpatient Psych Facility – Acute Psych Under 21	Interim per diem for in-state facilities and border facilities. Must submit cost reports subject to audit and cost settlement

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Inpatient Psychiatric Residential Treatment Facilities (PRTF)	Interim per diem for facilities in-state, out-of-state is percentage of charge. Must submit cost reports subject to audit and cost settlement.
Medical Inpatient Rehabilitation Facility	Per diem

510.7 ACUTE CARE HOSPITAL OUTPATIENT SERVICES

The following outlines those outpatient hospital services which are covered by the West Virginia Medicaid Program. These services are reimbursable for all Medicaid eligible members.

- **Lab, radiology, and other diagnostic procedures including pulmonary function testing**

  Medicaid coverage rules require that lab, radiology, and other diagnostic services rendered in the outpatient department of the hospital must be performed by facilities which meet all applicable professional and regulatory certification. Reimbursement may be made only for medically necessary tests ordered by a physician or other practitioner acting within the scope of his/her license for the care and treatment indicated in the management of illness, injury, impairment, maternity care, or for the purpose of determining the existence of an illness or disease process. Medicaid does not reimburse for clinical laboratory tests or radiology procedures performed for quality assurance, paternity determination, or routine drug screening. Refer to Medicaid Lab and Radiology Services Manual.

- **Emergency room services**

  Medicaid covers five levels of emergency room services. Those levels of service are further defined in Attachment 1. There are five CPT procedure codes available for billing emergency room services. The reimbursement is an all-inclusive fee, which is considered to include the following items:

  - Use of emergency room
  - Routine supplies (such as sterile dressings)
  - Minor supplies (bandages, slings, finger braces, etc.)
  - Pharmacy charges
  - Suture, catheter, and other trays
  - IV fluids and supplies
  - Routine EKG monitoring
  - Oxygen administration and O_2 saturation monitoring

Diagnostic procedures including lab and radiology may be billed separately and in addition to the emergency room services. See Attachment I for further information.

- **Outpatient surgery**

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Outpatient surgery procedures are those which can safely be performed in the outpatient department of the hospital or freestanding ambulatory surgery center. Procedures in which both the surgery and recovery can be accomplished on a date of service, do not normally require the nursing services support and care of an inpatient hospital admission.

- **Radiation and cobalt therapy**
- **Chemotherapy**
- **Outpatient physical therapy**
- **Observation Services**

Observation services are those furnished on a hospital's premises, including use of a bed and periodic monitoring by hospital nurses or other staff. The services must be reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered when provided by the order of a physician and within the limitations defined in Medicaid Program policy. (See Attachment 1)

- **Partial hospitalization**

Partial hospitalization is an outpatient hospital service rendered in a treatment setting, where an interdisciplinary program of medical therapeutic services is provided for the treatment of psychiatric and substance abuse disorders. The interdisciplinary program of medical therapeutic services may be delivered through one of the two following program formats (services may not be provided under both formats concurrently):

Medicaid Program policy defines partial hospitalization services to include a 4 hour structured treatment program, which may be offered either during the day or evening hours. The second covered service format is a short-term intensive program for those individuals whose needs can be met through an intensive outpatient program consisting of 6 to 10 hours of group therapy per week, delivered in 2 hour per day group therapy sessions. (See Attachment 1 for further details regarding treatment scheduling and reimbursement options.)

- **Infusion Therapy**
- **Transfusion**

510.8 OUTPATIENT SERVICE LIMITATIONS

Partial hospitalization services may only be rendered in settings authorized by the Bureau for Medical Services and subject to all prior authorization requirements and limitations. Physical and occupational therapy rendered in the hospital outpatient setting are also subject to prior authorization by the Bureau's utilization management contractor. All outpatient services must be medically necessary for the diagnosis and/or treatment of an illness or injury and ordered by a physician or other practitioner acting within their licensure and/or scope of practice as defined by state law.

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510.8.1 Prior Authorization Requirements For Outpatient Services

Medicaid covered outpatient services which require medical necessity review and prior authorization are:

1. Partial hospitalization
2. Physical therapy exceeding twenty (20) sessions or units per year.

Refer to Medicaid Physical and Occupational Therapy Services Manual at www.wvdhhr.org.

3. 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.

   Critical Access Hospitals (CAHs) who have chosen encounter, as well as those who bill Fee For Service, must obtain a prior authorization for certain diagnostic imaging testing. Reimbursement for diagnostic imaging services are considered part of the encounter and cannot be billed separately. CAHs will be required to obtain a PA from WVMI and document this information in the patient's medical record for audit purposes.

   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.

4. 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 listed in Attachment 3 along with the PA form that may be utilized.

   (See **Attachment 2** for utilization management agency information.)

510.8.2 Non-Covered Services (Exclusions) Outpatient

The following are excluded from coverage in the outpatient service department:

- Any charges incurred by a Medicaid member who was not eligible on the date of service
- Charges related to use of hospital facilities by attending physician
- Services which are denied as not medically necessary

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- Partial hospitalization services which are not authorized by the Bureau's utilization management contractor
- Physical or occupational therapy services exceeding twenty (20) sessions which are not authorized by the Bureau's utilization management contractor
- Services known as alternative therapies, including but not limited to acupressure, acupuncture, chelation therapy, massage therapy, naturopathy, reflexology, tai chi, and yoga
- Mass screenings for any condition whether for outpatients or inpatients
- Convenience items or services; items or service for the convenience of the patient or caregiver that are not related to medical care or treatment
- Infertility services
- Seat lift chairs and/or comparable items
- Prenatal sex determination services
- Maintenance services provided when a persons highest level of function has been reached and no progress is being made
- Experimental/investigational/research studies on medical or surgical procedures/services, treatment and/or therapies
- Free Service – Medicaid funds cannot be used to reimburse for services that are provided free of charge to other individuals, or groups of individuals
- Outpatient observation on the same date as discharge from inpatient facility
- Observation services billed in conjunction with therapeutic services such as chemotherapy, or labor and delivery
- Observation which extends into hospital admission
- Educational services or nutritional counseling
- Injections or visits solely for the administration of injections unrelated to a medical encounter in emergency room or observation area
- Preoperative testing performed on the same date as surgery in the hospital outpatient department, or preoperative monitoring during a normal recovery period
- Enhanced Extracorporeal Counterpulsion (EEC)
- Stretta
- Cosmetic Surgery

510.9 REIMBURSEMENT METHODOLOGY FOR OUTPATIENT SERVICES

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With the exception of services rendered in a critical access hospital setting, outpatient hospital services are all reimbursed fee-for-service specific to the procedure. These services are listed below with the corresponding reimbursement method. (Additional information is in Attachment 1.)

- Lab, radiology, and other diagnostic procedures including pulmonary function testing. Reimbursement is fee-for-service/CPT code.
- Emergency room services – CPT codes, see Attachment 1

  Each of five levels of emergency room services is reimbursed using an all-inclusive fee.
- Day surgery procedures are reimbursed with CPT codes. These are surgical procedures that generally do not require admission. Payment includes usual supplies such as local anesthesia, dressing trays, and other surgical supplies.
- Radiation and cobalt therapy – Reimbursement is CPT codes.
- Chemotherapy use CPT codes
- Outpatient physical therapy – CPT codes – PA after 20 visits
- Observation services – CPT codes, see Attachment 1
- Partial hospitalization – CPT and HCPCS codes, see Attachment 1
- Infusion therapy – Reimbursed CPT codes
- Transfusion – Reimbursed CPT codes
- Casting – Reimbursed CPT codes

510.10 MANAGED CARE

If a Medicaid recipient is a member of an HMO, the HMO is responsible for the services in this manual, excluding the behavioral health services. Prior authorization requirements of the HMO must be followed prior to rendering the service. If the recipient is a member of the PAAS Program, a referral from the PCP must be obtained prior to rendering the service, excluding behavioral health services, and Medicaid prior authorization requirements must be followed. If the requirements of the MCO/PAAS are not followed, Medicaid will not reimburse for services rendered.

510.11 INTERFACILITY TRANSPORTS VIA AMBULANCE

Ambulance transportation from one hospital to a more distant hospital <u>must</u> be for specialized care that is not available at the sending facility. In addition, the patient's current medical condition must meet the medical necessity criteria established in Chapter 524 of the Transportation Services Provider Manual.

Reimbursement for same day, round trip transportation by ambulance for services not available at sending facility is the responsibility of the sending facility, not the Medicaid member or Program. The hospital or Medicaid member requesting ambulance transport is responsible for reimbursing the ambulance agency if the reason for transport does not meet the criteria listed above.

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510.12 MATERNITY RELATED SERVICES

A newborn child whose mother is Medicaid eligible at the time of birth, and who resides with the mother, is eligible for Medicaid services up to 1 year from the date of birth. Whether or not the mother is on Medicaid, the service must be billed with the newborn's Medicaid identification number. Payment is determined by DRG for maternity related services.

For managed care members, the managed care entity is responsible for claims incurred by a newborn. The MCO responsible is the one the mother was enrolled in at the time of the birth. The MCO is responsible for the newborn up to 2 months after birth.

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CHAPTER 510

HOSPITAL SERVICES

NOVEMBER 1, 2004

ATTACHMENT I

SPECIAL COVERAGE CONSIDERATIONS AND BILLING INSTRUCTIONS

WEST VIRGINIA MEDICAID PROGRAM HOSPITAL REGULATIONS

MEDICAID COVERAGE FOR OUTPATIENT PARTIAL HOSPITALIZATION PROGRAMS

I. SERVICE DESCRIPTION

Partial hospitalization is an outpatient hospital service rendered in a treatment setting, where an interdisciplinary program of medical therapeutic services is provided for the treatment of psychiatric and substance abuse disorders. The interdisciplinary program of medical therapeutic services may be delivered through any one of the following program formats (services may not be provided under multiple program formats concurrently):

1. Day programming, which must provide at a minimum, twenty (20) hours of scheduled treatment, delivered in sessions of 4 hours duration and extending over a minimum of five (5) days per week; or

2. Evening hours programming must provide a minimum of sixteen (16) hours of scheduled programming, extending over a minimum of four (4) days per week; or

3. A short term intensive program for those individuals whose needs can be met through an intensive outpatient program consisting of six to ten hours of group therapy per week, delivered in two (2) hour per day group therapy sessions.

   Some flexibility in billing is made possible through the availability of an abbreviated treatment session procedure code. The abbreviated treatment session is a one (1) hour unit of service limited to a maximum of three (3) units per date of service. This one (1) hour service unit may be billed for individuals who have been approved for either a four (4) hour day or evening programming or the two (2) hour short term intensive program in instances when the patient is unable to complete the full four (4) hour or two (2) hour treatment session. This abbreviated treatment session is not intended to replace either the four (4) hour day or evening program, or the two (2) hour intensive outpatient modality. It is intended only for use in those instances when the patient is unable to complete either a four (4) hour evening or day program, or a two (2) hour intensive outpatient session. It may not be billed in addition to or with either the evening/day program or the intensive outpatient procedure code.

II. PROVIDER ELIGIBILITY

Partial hospitalization programs may be operated by psychiatric acute inpatient facilities and acute care general hospitals with a Medicare certified distinct part substance abuse and/or psychiatric unit, which is accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO). Additionally, the partial hospitalization program must meet the standards and guidelines for such programs as defined by a national accreditation or standard setting organization recognized by the West Virginia Medicaid Agency.

III. PROGRAM COVERAGE AND LIMITATIONS

All partial hospitalization services require medical necessity review and prior authorization through the Bureau's utilization management contractor. Services may not exceed 40 units in a calendar year.

IV. REIMBURSEMENT RATES

Both the twenty (20) hour per week day program, and the sixteen (16) hour per week evening program, will be reimbursed on a per diem basis, at the rate of $125.00 per day, thirty (30) days per individual per calendar year. The intensive outpatient Partial Hospitalization Units Program, which consists of three (3) to five (5) two hour group sessions (units) per week, will be reimbursed at the rate of $50.00 per session.

The abbreviated treatment session one (1) hour service unit will be reimbursed at the rate of $25.00 per one (1) hour unit, to a maximum of three (3) units for a date of service. This procedure may not be billed in combination with any other treatment modality for that date of service.

Services must be reported using CPT codes as follows:

Partial Hospitalization, per diem (Minimum - 4 hours)	H0035
Partial Hosp. Intensive Group Therapy (two hour session)	90853
Partial Hosp. Treatment Session, per hour (maximum - 3 hours)	H0015

The Medicaid Program will not be responsible for reimbursement of any services provided prior to issuance of an authorization, nor for any dates of service which exceed the authorization.

WEST VIRGINIA MEDICAID PROGRAM

COVERAGE BARIATRIC SURGERY PROCEDURES

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

- 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:

1. 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.

2. 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.

3. 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.)

4. 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.

5. 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 attempt failed.

6. 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.

7. 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.

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

9. Contraindications: Three (3) or more prior abdominal surgeries; history of failed bariatric surgery; current cancer treatment; Crohn's disease; End Stage Renal Disease (ESRD); prior bowel resection; ulcerative colitis; history of cancer within prior 5 years that is not in remission; prior history of non-compliance with medical or surgical treatments.

10. 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.

PHYSICIAN CREDENTIALING REQUIREMENTS

In order to be eligible for reimbursement for bariatric surgery procedures, physicians must:

- Provide evidence of credentials at an accredited facility to perform gastrointestinal and biliary surgery.
- Provide 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.
- Provide 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 bariatic surgery
    - Document at least 25 open and/or laporoscopic bariatic surgeries within the last three years

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.

REIMBURSEMENT:

Hospital

Participating hospitals will be reimbursed for approved admissions through the DRG reimbursement methodology.

The hospital must be a facility in which the procedures are performed on a regular basis, and that has the proper equipment and appropriately trained staff for this specialized surgery, as outlined by the American College of Surgeons for facilities performing bariatric surgery . WVMI reserves the right to deny the request based on the appropriateness of the facility involved.

Physicians

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.

CPT Codes/Covered 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.)

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.

Non-Covered Procedures

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

A. Mini-gastric bypass surgery

B. Gastric balloon for treatment of obesity

C. Laparoscopic adjustable gastric banding

INPATIENT ADMISSION CHANGED TO OUTPATIENT

I. General Information

A. Background

The Center for Medicare and Medicaid Services (CMS) has issued directions on how to bill when a physician orders a member to be admitted to an inpatient bed, but upon reviewing the case later, the hospital's utilization review committee determines that an inpatient level of care does not meet the hospital's or State Medicaid Utilization Management's admission criteria.

For these purposes, CMS implemented a condition code obtained from the National Uniform Billing Committee (NUBC):

> Condition Code 44 - - Inpatient admission changed to outpatient – For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its or Medicaid's Utilization Management inpatient criteria.

B. Policy

1. In cases where a hospital utilization review committee determines that an inpatient admission does not meet inpatient criteria, the hospital may change the member's status from inpatient to outpatient and submit an outpatient claim (TOBs 13x, 85x) for medically necessary Medicaid covered services that were furnished to the member, provided all of the following conditions are met:
    a. The hospital has not submitted a claim to Medicaid for the inpatient admission;
    b. A physician concurs with the utilization review committee's decision; and
    c. The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.
2. When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.
3. When the hospital submits a 13x or 85x bill for services furnished to a member whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 in one of Form Locators 24-30, or in the ANSIX12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim.

OUTPATIENT BILLING
SURGERY, RECOVERY, OBSERVATION,
AND EMERGENCY DEPARTMENT

The following information defines the billing methodology for hospital based outpatient surgery, recovery, observation, partial hospitalization and Emergency Department visits.

BACKGROUND:

Surgical procedures must be billed with the appropriate CPT or HCPCS code and revenue code. Surgical procedures previously reported using W1546, W1547 and W1548 must now be reported using the specific CPT Code for the service. Units are reported in fifteen (15) minute time increments. Charges and total time units for the procedure(s) must be rolled to the primary, most complex procedure and billed on one line. If you wish to report multiple procedures, bill all additional lines with zero units and zero charges. The maximum number of payable units is 16, but several procedures, including those previously billed with W codes, allow fewer units. The maximum rate is one hundred ninety-six dollars ($196.00) per unit.

Appropriate Revenue codes for billing out patient surgical procedures (procedure codes 10021 through 69979) are:

- 036X Operating Room Services
- 0391 Blood Administration (36430 – 36460)
- 045X Emergency Room
- 049X Ambulatory Surgical Care
- 051X Clinic
- 072X Labor Room/Delivery (59400 – 59899)
- 075X Gastro – Intestinal Services (Endoscope Procedures)
- 079X Extra Corporeal Shock Therapy

Some procedures in the surgical range are divided into technical and professional components (e.g. 59025 Fetal non-stress test) and must be billed with the TC modifier.

Recovery must be billed with Revenue Code 710. Payment will be made based on the combination of Revenue Code and units billed. Units are reported in fifteen (15) minute time increments. The maximum units allowed are twenty-four (24). For minor procedures and those not requiring anesthesia the billing of recovery is not appropriate. The rate is sixty dollars and ninety cents ($60.90) per unit. No procedure code is required.

Observation

Observation is billed using Revenue Codes 760 and 762 and time units reported in one (1) hour increments. The maximum number of units allowed for an episode of care is 48. The rate is ten dollars ($10.00) per unit (hour).

Observation is defined as, "The use of a bed and periodic monitoring, by hospital nursing or other staff which are reasonable and necessary, to evaluate an outpatient's condition to determine the need for inpatient admission."

The criteria for observation services include the following basic provisions:

- Observation services are covered only upon written order of a physician. This order must document the medical necessity for the services and is retained as part of the patient's medical record. Documentation requirements for admission to observation are essentially the same as for inpatient admission; however the medical necessity criteria are less stringent.
- Observation does not require prior authorization.
- Coverage of observation may not exceed 48 hours.
- Charges for observation services which result in an inpatient admission are deemed to be part of the admission and not separately billable.
- Ancillary services, laboratory, x-ray and other diagnostic procedures, performed during the observation period, may be billed separately.
- Observation services are appropriate for labor and delivery monitoring when the medical necessity criteria are met.

Emergency Department Services

Emergency Department services must be reported using CPT codes as follows:

Minimal ER Service	99281
Brief ER Service	99282
Intermediate ER Service	99283
Extended ER Service	99284
Emergent ER Service	99285

The following definitions and descriptions are representative of the treatment provided at various levels within the Emergency Department. The specific criteria are intended as guidelines for the determination of charges.

Minimal

General Description:

The individual's chief complaint upon presentation is minimal. That is, the individual requires only the most minimal treatment or could go without treatment and present little affect to his/her general health.

Specific Requirements:

1. Multiple Trauma/Surgical

   A. Cleansing of the wound or band-aide therapy
   B. Sprains or strains requiring only advice or elastic wrap
   C. No instrument trays required

2. Medical

   A. Medication orders received by telephone prior to patient's arrival
   B. Minimal physician examination
   C. No instrument trays required

3. OB-GYN

   A. Individual arrives in the Emergency Department for a consultation with their private physician
   B. No instrument trays required

4. Behavioral Medicine

   A. Individual requires a simple interview only (no medication)

<u>Brief</u>

General Description:

This individual requires treatment; however, treatment could possibly be delayed 24 hours with little effect to his/her general condition. Individuals in this classification rarely require admission to the hospital.

Specific Requirements:

1. Multiple Trauma/Surgical

   A. Simple orthopedic injuries requiring splints, slings, crutches, etc.
   B. Simple lacerations not requiring sutures

C. First degree burns

D. Minor eye injuries, including corneal abrasions

E. Post operative complications not requiring hospital admission

2. Medical

A. Medical evaluation without intravenous therapy or medication

B. Urinary tract infections requiring catheterization

C. Evaluation of sore throat with medication dispensed

D. Evaluation of headache with medication

E. Evaluation of neck vein distention without intravenous therapy/medication administration

F. Allergic reaction requiring only oral or injectable medication

G. Evaluation of conjunctivitis

3. OB-GYN

A. Obstetrical evaluation which may include urinary catheterization or vaginal exam

B. Evaluation of simple pelvic inflammatory disease

4. Behavioral Medicine

A. Individual requires a simple interview with medication administration

Intermediate

General Description:

This individual requires medical intervention today in order to prevent an impact on his/her general well-being. Oxygen and/or intravenous therapy may be required; however, hospital admission is indeterminate. Extensive monitoring is not required.

Specific Requirements:

1. Multiple Trauma/Surgical:

A. Minor lacerations requiring suturing

B. Simple fractures reduced and cast within the confines of the Emergency Department

C. Orthopedic injuries requiring major splinting

D. Partial thickness burns less than 20% body surface are that do not require follow-up

E. Removal of foreign body requiring incision

2. Medical

A. Evaluation of renal calculus requiring intravenous therapy

B. Dehydration requiring fluid replacement

C. Evaluation of simple chest pain not requiring cardiac monitoring or intravenous therapy

D. General medical evaluation requiring medication administration and/or intravenous therapy

E. Evaluation of minor GI bleeding requiring aspiration of gastric contents

F. Evaluation and monitoring of potential seizure activity

3. OB-GYN

A. Evaluation of pelvic inflammatory disease requiring multiple vaginal examinations and/or intravenous therapy and medication administration

B. Incision and drainage of Bartholin cyst

C. Removal of foreign body

4. Behavioral Medicine

A. Drug overdosage requiring induced emesis and not more than one liter of intravenous fluid administration

B. Evaluation and uncomplicated admission to a state psychiatric or other similar facility

<u>**Extended**</u>

General Description:

The individual presents to the Emergency Department with an injury or illness/disease process requiring prompt medical evaluation and intervention, the result of which is usually admission to the hospital.

Specific Requirements:

1. Multiple Trauma/Surgical

A. Requires periodic vital signs, neurological evaluations, or cardiac monitoring

B. Lacerations requiring major suturing

C. Partial thickness burns greater than 20% body surface area

D. Motor vehicle crash requiring evaluation but on invasive diagnosis or therapeutic measures except intravenous fluid administration

2. Medical

A. G.I. Bleeding requiring fluid replacement

B. Medical evaluation requiring cardiac monitoring

C. Evaluation and treatment of epiglottitis

D. Lumbar puncture for diagnostics

E. Evaluation and treatment of altered states of consciousness without other injury

3. OB-GYN

A. Evaluation and treatment of the following:

1) Profuse vaginal bleeding

2) Ectopic pregnancy

3) Placenta previa

4) Septic shock

B. Delivery in the Emergency Room

C. Rape examination

4. Behavioral Medicine

A. Individuals requiring suicidal or homicidal precautions

B. Individuals presenting as disruptive enough to require physical restraint and/or observation by the security department

C. Drug overdose requiring gastric lavage and intravenous therapy

Emergent

General Description:

The individual presents with an injury or disease process significant enough as to require immediate evaluation and intervention in order to prevent continued deterioration.

Specific Requirements:

1. Multiple Trauma Surgery
   - A. Individuals presenting with moderate shock requiring intravenous fluid and/or blood replacement
   - B. Trauma team activations that require no invasive therapeutic and/or diagnostic procedures (excluding urinary catheterization)
   - C. Individuals presenting with significant neurologic insult or injury

2. Medical
   - A. G.I. Bleeding requiring blood replacement and/or endoscopy performed in the Emergency Department for evaluation
   - B. Evaluation of chest pain requiring cardiac monitoring and intravenous nitroglycerin therapy
   - C. Cardiac arrest requiring CPR of less than 30 minute duration
   - D. Individuals presenting with chronic obstructive pulmonary disease requiring endotracheal intubation and complex intravenous and medication therapy

3. Behavioral Medicine
   - A. Drug overdose or suicide attempt requiring resuscitation but without CPR

Payment for two (2) Emergency Department visits on the same day, to the same facility, for the same problem is not allowed. When more than one visit occurs in a day, the charges must be rolled to the highest level appropriate to the visits. To request special consideration, submit the claim on paper with documentation to support the uniqueness of the visits for review to:

BMS Exception Review
350 Capitol Street, Room 251
Charleston, WV 25301-3707

Charges for surgical procedures, diagnostic procedures, casting supplies and certain drugs may be billed separately. Unusual and/or high cost drugs and supplies may be covered by exception following review of documentation. Such requests should be addressed as above.

ORGAN TRANSPLANT SERVICES

WV Medicaid covers certain types of organ transplants performed in a Medicare-approved transplant facility.

Organ transplant services are covered when generally considered safe, effective, and medically necessary when no alternative medical treatment as recognized by the medical community is

available. The intended transplant must be performed to manage a disease consistent with recognized standards in the medical community Investigational, research, or experimental procedures are not covered.

Member selection criteria are based on critical medical need for transplantation and a maximum likelihood of successful clinical outcome. All other medical and surgical therapies that might be expected to affect short-and long-term survival must have been tried or considered. At a minimum, member selection criteria include the following:

- Current medical therapy has failed and the member has failed to respond to appropriate therapeutic management
- The member is not in an irreversible terminal state
- The transplant is likely to prolong life and restore a range of physical and social function to activities of daily living

Prior authorization is required for all transplants. BMS' contracted agent reviews requests for prior authorization.

The following types of transplants are covered with prior authorization:

- Heart Transplant
- Bone Marrow Transplant
- Adult Liver Transplant
- Pediatric Liver Transplant
- Kidney Transplant
- Pancreas/Kidney Transplant
- Lung Transplant – single and double
- Heart/Lung Transplant
- Small Intestine Transplant
- Cornea

Transplants are not covered when two of them are performed together, except under the following circumstances:

- If the primary organ defect caused damage to a second organ and transplant of the primary organ will eliminate the disease process
- If the damage to the second organ will compromise the outcome of the transplant of the primary organ, multiple organ transplantation may be considered

Reimbursement for the hospital admission in which the transplant is performed is standard DRG reimbursement with a maximum or a cap of $75,000. Additionally, the hospital will be reimbursed the organ procurement cost at the CORE standard organ procurement cost for each category of organ plus any additional transportation cost associated with the organ acquisition. Donor cost, if not reimbursed by the donors insurance, may be reimbursed by the Medicaid Program under the Medicaid eligible members ID number.

CRITICAL ACCESS HOSPITAL OUTPATIENT REIMBURSEMENT

The outpatient component of critical access reimbursement is per diem as determined by Medicare fiscal intermediary. Claims must be filed on the UB-92 claim form or the ASC X12N 837 (004010X096A1) electronic claim format utilizing procedure code T1015, bill type 851, and appropriate revenue code.

CAH/Medicaid Reimbursement of Title XVIII Medicare Crossovers:

Medicare crossover claims must be submitted on paper with a copy of the Medicare EOB attached. It is necessary that CAHs submit claims to Medicaid, because the Medicare fiscal intermediaries which process CAH claims do not cross over those claims automatically to Medicaid.

Cost Reporting:

Critical Access Hospital (CAH) reimbursement is subject to audit and year-end reconciliation to cost. The reconciliation is performed by an accounting firm, employed by the Bureau for Medical Services. The information utilized in the calculation of cost settlements are the Medicare cost report and Medicaid Program encounter data from claims history.

CHAPTER 510

HOSPITAL SERVICES

NOVEMBER 1, 2004

ATTACHMENT 2

PRIOR AUTHORIZATION

PAGE 1 OF 2

PRIOR AUTHORIZATION

The utilization management contractor which performs medical necessity review and prior authorization of services for the Bureau for Medical Services is the West Virginia Medical Institute (WVMI).

The West Virginia Medical Institute maintains a website, http://www.wvmi.org/Priorauthcriteria.asp, which contains information regarding procedures for requesting prior approval, as well as criteria for all the different services for which they perform review for the Bureau for Medical Services. It also includes contact names and telephone numbers for key individuals and functions performed for BMS by WVMI.

If you have problems accessing the website or for some reason are unable to obtain information needed electronically, you may contact WVMI by telephone at (304) 346-9167 or 1-800-982-6334.

CHAPTER 510

HOSPITAL SERVICES

NOVEMBER 1, 2004

ATTACHMENT 3

OUTPATIENT SURGERY PA REQUIREMENTS

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 WVMI Use Only:
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	