

2018 Administrative Guide

Physician, Health Care Professional, Facility and Ancillary
KanCare Program
Chapter 8: Hospital Services

Welcome

Welcome to the UnitedHealthcare Community Plan care provider manual. This complete and up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as processing a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Operational policy changes and other electronic tools are ready on our website at UHCprovider.com.

Click the following links to access different manuals:

- [UnitedHealthcare Administrative Guide](#) for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual – go to UHCCommunityPlan.com, click For Health Care Professionals at the top of the screen. Select the desired state.

Easily find information in this manual using the following steps:

1. Select CTRL+F.
2. Type in the key word.
3. Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF.

If you have any questions about the information or material in this manual or about any of our policies, please call Provider Services.

We greatly appreciate your participation in our program and the care you offer our members.

Important Information Regarding the Use of This Guide

In the event of a conflict between your agreement and this care provider manual, the manual controls unless the agreement dictates otherwise. In the event of a conflict between your agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

We amend the manual as policies change.

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Chapter 8: Hospital Services

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to hospital providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendices.

The Billing Instructions subsection provides directions on how to complete and submit the billing forms applicable to hospital services

The Benefits and Limitations subsection defines aspects of the scope of hospital services.

HIPAA Compliance

You are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. You are required to furnish the Department of Health and Human Services all information required by the department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 amendments thereto.

If you receive such a request for access to or inspection of documents and records, you must promptly and reasonably comply with access to the records and facility at reasonable times and places. You must not obstruct any audit, review or investigation, including the relevant questioning of your employees. You shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

8.1 Hospital Billing Instructions

Introduction to the UB-04 Claim Form

Hospital providers must use the UB-04 red paper claim form or the electronic equivalent when requesting payment for medical services and supplies provided under KanCare. Any UB-04 claim not submitted on the red claim form (original form only, no copies) will be returned. An example of the UB-04 claim form is available on the [KMAP website](#).

Instructions for completing this claim form are included in the following pages. UnitedHealthcare will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

The following numbered form locators (FL) are to be completed when required or if applicable.

Completing the UB-04 claim form:

To submit claims electronically: have your office software vendor make connections to our clearinghouse OptumInsight, OptumInsight.com. Be sure to use our electronic payer (ID 96385) to submit claims to us. For more information, contact your vendor or our Electronic Data Interchange (EDI) unit at 800-210-8315. You may also submit claims online at UHCCommunityPlan.com.

If you do not have access to Internet services, you may mail the completed claim to:

UnitedHealthcare
P.O. Box 5270
Kingston, NY 12402

- FL 1 Billing Provider Name, Address and Telephone Number –Required.** Enter the name and address of the billing provider.
- FL 3A Patient Control No. Enter a patient account number if desired.** This number is referenced on the remittance advice (RA).
- FL 3B Medical Record No.- Desired. Enter the patient’s medical record number.** This number appears on the care provider’s RA.
- FL 4 Type of Bill - Required.** Enter the three-digit number specific to the type of claim.

Note: Only the codes in bold below are applicable to NF’s

- 1st digit indicates facility.
- 2nd digit indicates location within facility.
- 3rd digit indicates the frequency of the claim billed.

Medicaid allowed codes:

- 1st digit: **1 Hospital (IP/OP)**
2 Skilled Nursing
6 Intermediate Care
8 Outpatient – Critical Access
- 2nd digit: 1 Inpatient
3 Outpatient
5 Level I
6 Level II
8 Swing bed NF
- 3rd digit: 0 Nonpayment/zero claim
1 Admit through discharge claim
2 Interim - first claim
3 Interim - continuing claim
4 Interim - last claim(thru date is discharge date)
7 Placement of a Prior Claim
8 Void/Cancel of Prior Claim
**State has verified as valid pass thru for those claims.

FL 5 Federal Tax Number – Required.

FL 6 Statement Covers Period – From/Through -Required. Enter inpatient dates of admission and discharge or outpatient from and through dates in MM/DD/YY format.

FL 7 Reserved for assignment by NUBC.

FL 8 Patient Name/Identifier – Required. Enter patient’s last name, first name, and middle initial exactly as it appears on the ID card. If patient is a newborn, enter “newborn”, “baby boy”, or “baby girl” in the first name field and enter the last name.

FL 9 Patient Address – Required.

FL 10 Birth date – Required. Enter patient’s date of birth in MM/DD/YYYY format. If newborn, enter baby’s date of birth (not mother’s).

FL 11 Sex – Required. Enter “M” for male or “F” for female. If newborn services, enter “M” or “F” for the baby.

FL 12 Admission/Start of Care Date – Required. Enter date patient was admitted as inpatient or date of outpatient care in MM/DD/YY format.

FL 13 Admission Hour – Required – Inpatient Only. Enter treatment hour using the continental time system (i.e., 6:00 p.m. equals 1800 hours).

FL 14 Priority Type of Visit – Required – Inpatient Only. Enter a one-digit code to indicate type of admission.

- | | | |
|------------------|--------------|-------------------------------|
| 1 – Emergency | 3 – Elective | 5 – Trauma |
| 2 – Urgent, etc. | 4 – Newborn | 9 – Information not available |

FL 15 Point of Origin for Admission or Visit – Required.

Enter a code to indicate admission source.

- 1 – Non-health care facility point of origin
- 2 – Clinic
- 3 – Reserved for assignment by NUBC
- 4 – Transfer from hospital
- 5 – Transfer from skilled nursing facility
- 6 – Transfer from another healthcare facility
- 7 – Emergency room
- 8 – Court/law enforcement
- 9 – Information not available
- A – Reserved for assignment by NUBC
- B – Transfer from another home health facility
- C – Readmission to same home health agency
- D – Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in separate claim to the payer

- E – Transfer from ambulatory surgery center
- F – Transfer from hospice and is under a hospice plan of care or enrolled in a hospice program
- G-Z – Reserved for assignment by NUBC

Code structure for newborn

- 1-4 – Reserved
- 5 – Born inside this hospital
- 6 – Born outside of this hospital
- 7-9 – Reserved

FL 16 Discharge Hour – Required on inpatient claims with a frequency code of 1 or 4 except Type of Bill 021X.

FL 17 Patient Status – Required – Inpatient Only. Enter a two-digit code to indicate status of patient:

- 01 Discharged to home or self-care (routine discharge)
- 02 Discharged/transferred to another short-term general hospital for inpatient care
- 03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification
- 04 Discharged/transferred to a facility that provides custodial or supportive care
- 05 Discharge/transfer to a designated cancer center or children’s hospital
- 06 Discharged/transferred to a home under care of organized home health service organization
- 07 Left against medical advice or discontinued care
- 08 Discharged/transferred to home under care of a home IV drug therapy provider (This is not a certified Medicare provider.)
- 09 Admitted as an inpatient to this hospital (for use on Medicare Outpatient Hospital claims only)
- 20 Expired (or did not recover - Christian Science Patient)
- 21 Discharged/transferred to court/law enforcement
- 30 Still patient
- 40 Expired at home (Hospice claims only)
- 41 Expired in a medical facility, such as a hospital, SNF, ICF, or freestanding hospice (Hospice claims only)
- 42 Expired - place unknown (Hospice claims only)
- 43 Discharge/transferred to a Federal Health Care Facility
- 50 Discharge to hospice – home
- 51 Discharge to hospice - medical facility
- 61 Discharged/transferred within this institution to a hospital-based, Medicare-approved, swing bed
- 62 Discharged/transferred to another rehabilitation facility an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
- 63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
- 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- 66 Discharged/transferred to a Critical Access Hospital (CAH) for discharge dates on or after January 1, 2006
- 70 Discharged/transferred to another type of health care institution not defined elsewhere in the code list

Note: Hospitals will be eligible for full DRG reimbursement when a discharge occurs using discharge code 01, 03, 04, 05, 06, 07, 08, 20, 50, or 51. Distinct claim forms must be submitted for each discharge. In the case of transfers to same specialty providers (discharge code 02), the transferring hospital's reimbursement may be reduced, based upon a transfer prorated reimbursement determination, and the receiving hospital will be eligible to receive a full DRG reimbursement.

FL 18-28 Condition Codes – Enter one of these two-digit codes to indicate a condition(s) relating to inpatient or outpatient claims, special programs or procedures **Note:** This is not a complete list. For a complete list of Condition Codes, contact Customer Service.

- 01 Military service related
- 02 Condition is employment related
- 03 Patient covered by insurance not reflected here
- 67 Beneficiary elects not to use lifetime reserve (LTR) days

Note: This will now replace the Z1 Medicare Part A benefits exhausted condition code. The verbiage in the explanation of condition code 67 means the patient's benefits are exhausted.

- 80 Home Dialysis – Nursing Facility
- A4 Family Planning
- AA Abortion performed due to rape
- AB Abortion performed due to incest
- AI Sterilization
- D9 Any other change

Note: This will now replace the XO swing bed condition code.

FL 31-34 Occurrence Codes/Dates: OCCURRENCE CODES CAN ONLY BE SUBMITTED ON LINE A.

The following occurrence codes must be indicated if reporting information on type of accident, crime victim, other insurance denial or date of TPR termination, or aborted surgery, false labor or non-delivery claim where associated services are indicated.

- 01 Accident/medical coverage
- 02 No fault insurance involved – including auto accident/other
- 03 Accident/tort liability
- 04 Accident/employment related
- 05 Accident/no medical or liability coverage
- 06 Crime victim
- 24 Date insurance denied
- 25 Date benefits terminated by primary payer
- A3 Benefits exhausted, Payer A
- B3 Benefits exhausted, Payer B
- C3 Benefits exhausted, Payer C

FL 35-36 Occurrence span codes and dates.

FL 37 Reserved for assignment by NUBC.

FL 38 Responsible party name and address (claim addressee) – situational.

FL 39-41 Value Codes/Amount – Required if applicable.

- Enter D3 for non-patient obligation as the value code. Enter the non-patient obligation dollar amount in the “Amount” field. Examples of non-patient obligation are Parental, Spousal, and Trust.
- Enter 80 for covered days and enter the number of covered days in the Amount field.

Note: Count the date of admission but not the date of discharge.

FL 42 Revenue Code – Required. Enter the three-digit number identifying the type of accommodation and ancillary service(s).

FL 43 Revenue Description/IDE Number/Medicaid Drug Rebate – Required on paper bills only.

FL 44 HCPCS/Accommodation Rates/HIPPS Rates Code – Required – Outpatient Only. List the HCPCS procedure code for each specific outpatient procedure.

FL 45 Serv. Date – Required – Outpatient Only. Enter the date services were provided in MM/DD/YY format.

FL 46 Serv. Units – Required. Enter number of days for each accommodation revenue code or appropriate units for

FL 47 Total Charges – Required. Enter total charges for each coded line item. List each outpatient procedure with a specific (itemized) charge.

Enter the total claim charge on the last line of this detail section with a revenue code of 001 in FL 42 and total charges in

FL 48 Non-covered Charges – Situational. Enter non-covered charges.

FL 49 Reserved.

FL 50 Payer Name – Required. Indicate all third party resources (TPR). If TPR does exist, it must be billed first. Lines B and C should indicate secondary and tertiary coverage. Medicaid will be either the secondary or tertiary coverage and the last payer. When B and C are completed, the remainder of this line must be completed as well as FL 58-62. Medicare needs to always be the last entry.

FL 51 Health Plan Identification Number.

- Line A – Required
- Line B & C – Situational

FL 52 Release of Information Certification Locator – Required.

FL 53 Assignment of Benefits Certification Indicator – Required.

FL 54 Prior Payments Payer – Required if other insurance is involved. Enter amount paid by other insurance. Medicare needs to be the last entry (do not enter spend-down amount as these reductions are made automatically during claim processing).

- FL 55 Estimated Amount Due Payer – Situational.**
- FL 56 NPI.** Enter the billing provider’s NPI.
- FL 57 Other Provider ID:** Enter either qualifier “1D” or qualifier “ZZ” and the taxonomy code.
- FL 58 Insured’s Name – Required.**
- FL 59 Patient’s Relationship to Insured.**
- Line A – Required
 - Line B & C – Situational
- FL 60 Insured’s Unique ID – Required.** Enter the 11-digit beneficiary number from patient’s medical ID card on line C. If newborn services, use mother’s beneficiary number if newborn’s ID number is unknown.
- FL 61 Insured’s Group Name – Required if group name is available and FL 62 is not used.** Enter the primary insurance information on line A and Medicare on line C.
- FL 62 Insured’s Group Number – Required when insured’s identification card shows a group number.**
- FL 63 Treatment Authorization Codes – Leave blank.** (This number, if applicable, is system generated.)
- FL 64 Document Control Number – Required when TOB code (FL 04) indicates this claim is a replacement or void to a previously adjudicated claim.**
- FL 65 Employer Name (of the Insured) – Situational.**
- FL 66 Diagnosis and Procedure Code Qualifier – Qualifier code 9 required.**
- FL 67 Principal Diagnosis Code and Present on Admission Indicator – Principal Diagnosis Code – Required.**
Present on Admission Indicator – Required. Follow the official coding guidelines for ICD reporting.
- FL 67A-Q Other Diagnoses Codes and Present on Admission Indicator – Required when other conditions coexist or develop during the patient’s treatment. Present on Admission Indicator – Required when other diagnoses included.**
- FL 68 Reserved for Assignment by the NUBC.**
- FL 69 Admitting Diagnosis Code – Required when claim involves an inpatient admission.**
- FL 71 Prospective Payment System (PPS) Code.**
- FL 72A-C External Cause of Injury (ECI) Code and Present on Admission Indicator – Required when an injury, poisoning or adverse effect is cause for seeking medical treatment or occurs during medical treatment.**
Present on Admission Indicator – Required for UB04. See FL 67.

FL 74 Principal Procedure Code and Date – Required on inpatient claims. Enter the ICD-10-CM procedure code for the primary procedure and date of service.

FL 74A-E Other Procedure Codes and Dates – Required – Inpatient. Enter other procedures performed, using ICD

FL 76 Attending Provider Name and Identifiers – Required.

- a. Enter attending physician's NPI, or the appropriate qualifier or taxonomy code.
- b. Enter attending physician's Medicaid provider name as last name and then first name.

Note: DO NOT ENTER A GROUP PROVIDER NUMBER.

FL 77 Operating Physician Name and Identifiers – Required if applicable.

- a. Enter attending physician's NPI, or the appropriate qualifier or taxonomy code.
- b. Enter attending physician's Medicaid provider name as last name and then first name.

FL 78-79 Other Provider (Individual) Names and Identifiers – Required if applicable.

- a. Enter attending physician's NPI, or the appropriate qualifier or taxonomy code.
- b. Enter attending physician's Medicaid provider name as last name and then first name.

FL 80 Remarks Field – Specify additional information as necessary.

Submission of Claim

UnitedHealthcare
P.O. Box 5270
Kingston, NY 12402

8.2 Hospital Specific Billing Information

Inpatient

Accommodation and Ancillary Charges

If the individual accommodation and ancillary services exceed the detail lines on the UB-04 claim form, you may combine all similar revenue code charges together (e.g. lab, radiology) when necessary. Accommodation codes may also be “lumped” together when necessary. This will not affect the reimbursement of the claim.

Admission and Readmission (Same Day)

Admission

An inpatient admission starts when you write an order for an inpatient admission. It is not considered inpatient until the order has been written. Documented verbal admission orders are considered the same as written orders.

- Scenario #1: A patient is sent to the medical floor on September 23 at 11:00 p.m. The care provider writes an order to admit the patient on September 24 at 3:00 a.m. According to KanCare, the inpatient admission starts on September 24 at 3:00 a.m.

- Scenario #2: A care provider writes an order for a patient to be admitted inpatient on September 23 at 11:00 p.m. The patient arrives on the medical floor on September 24 at 3:00 a.m. According to KanCare, the inpatient admission starts on September 23 at 11:00 p.m.
- Scenario #3: A care provider contacts a hospital on September 23 at 11:00 p.m. about a direct admission and gives a verbal order for admission once the patient arrives at the hospital. The patient arrives at the hospital on September 24 at 3:00 a.m. According to KanCare, the inpatient admission starts on September 24 at 3:00 a.m.

Readmission (Same Day)

When a patient is discharged or transferred from an inpatient hospital and is readmitted to the same inpatient hospital on the same day for symptoms related to or for evaluation and management of the prior stay's medical condition, hospitals must adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

When a patient is discharged or transferred from an inpatient hospital and is readmitted to the same inpatient hospital on the same day for symptoms unrelated to and not for evaluation and management of the prior stay's medical condition, hospitals must bill for two separate stays on two separate claims.

Attending Provider

The attending care provider's National Provider Identifier (NPI) and name are required on all institutional claims. All institutional claims submitted on paper, through provider electronic services (PES), electronically, or through the KMAP web portal must have both the attending provider's NPI and name. You are required to submit this information correctly in order for the institutional claim to be accepted for processing.

Donor Human Breast Milk

Effective with dates of service on and after July 1, 2016, Kansas Medicaid reimburses a medical care facility for prescribed medically necessary donor human breast milk for a critically ill infant under the age of 3 months who is in a neonatal intensive care unit of a hospital.

- A person who is licensed to practice medicine and surgery will order the donor human milk using established medical necessity guidelines. The parent or legal guardian of the beneficiary must sign and date an informed consent form indicating the risks and benefits of using banked human donor breast milk.
- The human donor breast milk must be obtained from a milk bank accredited by the Human Milk Banking Association of North America (HMBANA) or a milk bank in compliance with federal regulations governing the production and labeling of such items as covered by statutes in 21 CFR 100-169, in particular, parts 105-107 dealing with infant foods.
- The milk must not be altered in composition (other than pooling with multiple donor mothers' milk to achieve target energy or protein goals) and should provide a nutritionally complete product for a term infant (does not have to be mixed with human milk to make it safe to feed). The milk must be pasteurized and remain in a frozen state.

Emergency Renal Dialysis

Inpatient emergency renal dialysis must be billed using revenue code 809 in FL 42 of the UB-04 claim form.

End Stage Renal Disease

You may enroll to perform end-stage renal disease (ESRD) services with KanCare as a provider type and specialty 30/300 (Renal Dialysis Center).

Hospice

Payment for services related to the terminal illness or related conditions is the responsibility of the hospice care provider. If the inpatient stay was not related to the terminal illness, submit a claim with a copy of the admission and discharge summary. If the beneficiary is only assigned to a hospice care provider for a portion of the inpatient stay, submit a claim for the entire stay. The claim and documentation will be reviewed to determine if KanCare can reimburse for all or a portion of the stay, or if the stay is the responsibility of the hospice care provider.

Interim Billing

Interim inpatient hospital billing is restricted to a frequency of no more than one interim claim every 30 days. Providers can bill less frequently if desired. Interim bills received more frequently than 30 days will be denied. When interim billing, be sure to enter the appropriate 'Type of Bill' code (e.g. 112, 113, 114). A 'Patient Status' code of 30 (still a patient) must be indicated when 'Type of Bill' is 112 or 113.

Medicare A Exhaustion of Benefits

- Once Medicare Part A regular inpatient benefits are exhausted, dual-eligible beneficiaries (those who have both Medicaid and Medicare) can only receive a Medicaid payment if they have already used their Life Time Reserve (LTR) days or they elect to use their LTR days. A KanCare beneficiary must make a written election not to use LTR days and cannot be "deemed" to have elected not to use LTR days. If a beneficiary makes a written election not to use LTR days after the regular inpatient days are exhausted, Medicaid will not issue payment for any part of the inpatient stay which would have been covered if the beneficiary had elected to use LTR days. After making a written election not to use LTR days, a beneficiary can still decide to use LTR days.
- If benefits were exhausted prior to hospital admission, LTR days are available for the entire stay, and the beneficiary elects not to use LTR days, submit a no pay bill (third-digit of TOB is zero).
- If benefits were exhausted during the hospital stay and the beneficiary elects not to use available LTR days:
 - Bill condition code 67.
 - Bill the number of covered days for which benefits were available.
 - Bill the number of non-covered days for which the beneficiary elected not to use LTR days.
- If benefits were exhausted during the hospital stay and the beneficiary elects to use LTR days:
 - Bill all days as covered as long as there were sufficient LTR days for the stay.
 - If LTR days are available for only a portion of the stay, bill occurrence code A3 with the from date indicating the day all benefits (including LTR days) were exhausted.
 - Bill all days as covered for Medicaid.
- If all benefits are exhausted (including LTR days):
 - Bill occurrence code A3 with the from date indicating the day benefits were exhausted.
 - Bill all days as covered for Medicaid.

Medicare B Services

When Medicare B payment is made on an inpatient claim, indicate the amount paid as Prior Payment in FL 54 on the UB-04 claim form.

Newborn Services (When the Mother is in an Managed Care Organization (MCO))

Notify the MCO that the mother is assigned to at the time of birth. The MCO will provide further instructions if the care provider is part of that MCO's network. The mother's MCO will notify KanCare and the fiscal agent of the birth.

Newborn Services (When the Mother is NOT in an MCO)

- Only procedure codes which specifically state newborn in the code description according to the CPT® code book are considered newborn services. These services can be paid under the mother's beneficiary ID number for the first 45 days after the baby's date of birth. These services must be billed with a newborn diagnosis code in order to receive payment.
- When billing for a newborn who does not have a beneficiary ID number, use "Newborn", "Baby Girl", or "Baby Boy" in the first name field and enter the last name. Use the newborn's date of birth and the mother's beneficiary ID number. The claim will suspend in the claims processing system for up to 45 days pending the fiscal agent's receipt of the newborn's beneficiary ID number from the eligibility system.
- If the newborns ID number is received within 45 days, the claim will be denied. The hospital will need to resubmit a new claim using the newborns Medicaid ID number.
- If the newborn's ID number is not received within 45 days and the date of service is not within 45 days of the newborn's date of birth, the claim will be denied.

Outpatient/Inpatient

- All outpatient procedures (including, but not limited to, surgery, X-rays, and EKGs) provided within three days of a hospital admission for the same or similar diagnosis are considered content of service and must be billed on the same inpatient hospital claim. The statement covers period should encompass all services on the claim. Critical Access Hospitals are exempt from this requirement and must bill services prior to the point of admission as outpatient.

Note: There is one exception to this policy: complications from an outpatient sterilization resulting in an inpatient admission. In this instance, the outpatient charges and the inpatient charges should be billed on two separate claims. This is necessary in order for the service dates on the claim form to match the service dates on the Sterilization Consent Form.

Outpatient Services Provided During Inpatient Admission

Outpatient services provided during an inpatient hospital stay must be included by the hospital on the UB-04 claim form and reimbursed through the DRG. The outpatient care provider should receive reimbursement from the hospital. Outpatient services provided to residents of state institutions must be billed by the hospital providing the outpatient service.

Present on Admission Indicators

- Effective with dates of service on and after October 01, 2008, all claims involving inpatient admissions to general acute care hospitals will require submission of present on admission (POA) indicator(s). POA is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA.
- Effective with dates of service on and after July 01, 2012, POA and Health Care Acquired Conditions (HCAC) requirements apply to all inpatient settings, including critical access, long-term care, cancer and children's hospitals as well as freestanding psychiatric and rehabilitation facilities.
- The POA indicator is assigned to principal and secondary or other diagnoses (as defined in Appendix I of the Official Coding Guidelines for Coding and Reporting) and the external cause of injury codes. The validity of the POA indicator will be edited and claims are subject to denying when the POA indicator is invalid. The hospital will need to supply the correct POA indicator(s) and resubmit the claim. A POA indicator for the external cause of injury code is not required unless it is being reported as an "other diagnosis" on the UB-04.

- POA Indicators and Definitions
 - Y (for yes): Present at the time of inpatient admission.
 - N (for no): Not present at the time of inpatient admission.
 - U (for unknown): The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
 - W (for clinically undetermined): You were unable to clinically determine whether the condition was present at the time of inpatient admission or not.
 - Effective with dates of service on and after January 01, 2011, for those exempt from POA reporting: For a 4010A1 claim billing an exempt diagnosis code, use POA indicator 1. For a 5010 claim billing an exempt diagnosis code, leave the POA indicator field blank. For a hardcopy claim billing an exempt diagnosis, use POA indicator 1.
- For dates of service on and before December 31, 2010, for those exempt from POA reporting, a blank space or a 1 were considered synonymous for the purpose of claims processing.

Note: The ICD-10-CM Official Guidelines for Coding and Reporting includes a list of diagnoses codes that are exempt from POA reporting.
- KanCare will not pay the complication comorbidity/major complication comorbidity (CC/MCC) DRG for those selected hospital acquired conditions (HACs) that are coded as “U” for the POA indicator. KanCare will not pay the CC/MCC for those selected HACs that are coded as “1” for the POA indicator or those left blank. The “1” or blank POA indicator should not be applied to any codes on the HAC list. These claims will deny as ungroupable, and you will need to correct and resubmit the claim for reimbursement. HAC information is available on the Centers for Medicare & Medicaid Services (CMS) website at: cms.hhs.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp#TopOfPage.
- These POA guidelines are not intended to replace any found in the ICD-10-CM Official Guidelines for Coding and Reporting nor are they intended to provide guidance on when a condition should be coded. They should be used in conjunction with the UB-04 Data Specifications Manual and the ICD-10-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the POA indicator for each “principal” diagnosis and “other” diagnoses codes reported on claim forms (UB-04 and 837 Institutional).

Transfers

When billing medically necessary incoming transfers, enter “direct transfer from (hospital, city)” in FL 80 under “Remarks” on claims for incoming transfers from other hospitals.

Swing Bed Nursing Facility

When billing for a swing bed nursing facility (NF), the following must be observed:

- Your hospital must be certified as a swing bed NF hospital.
- The facility retains the original MS-2126 and submits a copy to the KanCare Clearinghouse. Submission of the MS-2126 is not required as a prerequisite for a hospital “reserve day.” However, the MS-2126 must be retained in the beneficiary’s file for documentation. Completion of the MS-2126 is not required for payment of a therapeutic reserve day. The KanCare Clearinghouse will notify the facility when payment is approved or denied. The facility will also be notified of the effective date and any applicable patient liability.
- Providers must bill the full amount and patient liability will be deducted during processing. When billing for a swing bed, a separate claim must be submitted for each calendar month.

Note: Do not attach a copy of either the MS-2126 or Notice of Action to your claim form.

- Bill all NF days for eligible Medicare patients to Medicare first. Medicaid can be billed for any remaining amounts using the inpatient Medicare claim crossover method. (Refer to Section 3200 of the General Third Party Liability Payment Manual.) If Medicare will not pay for the NF days, a copy of either the Medicare Report of Eligibility (ROE) or a Medicare denial must be attached to the Medicaid billing supporting nonpayment by Medicare.
- Before a transfer to a swing bed NF occurs, the patient must be discharged from the inpatient unit. Use the appropriate three-digit type of bill code in FL 4 on the UB-04 claim form. Remember, the inpatient unit is not reimbursed for the date of discharge since the swing bed NF will be reimbursed for the date of admission.
- The appropriate accommodation revenue code applicable to the patient's level of care must be entered in FL 42. Bill the total number of days in FL 46 (units). In FL 47, place the total charge of days billed. For further information on per diem supplies and services, including durable medical equipment, pharmacy, therapy, transportation, and miscellaneous items, refer to Section 8400 of the Nursing/Intermediate Care Facility Provider Manual.

Ancillary charges: Cannot be billed on the swing bed NF claim. Any ancillary services received by the patient while in a swing bed NF, must be billed on a UB-04 claim form using the outpatient type of bill code (FL 4) and the correct HCPCS code and revenue code for the ancillary services provided. Indicate condition code D9 (any other change) in FL 18-28, and enter the from and through dates of service in FL 6 on the UB-04 claim form. When multiple dates of service are being billed, enter only the first date of service in FL 45 on the UB-04 claim form.

Pharmacy: Pharmacy services for swing bed claims need to be billed on a pharmacy claim form from a Medicaid-enrolled outpatient pharmacy. Refer to the Pharmacy Provider Manual for billing instructions and coverage information.

Supplies: When billing for supplies provided by the swing bed facility over and above the supplies included in the reimbursement rate, use procedure code 99070 - bill one unit per day. Claims must include both revenue codes and HCPCS codes.

- With the exception of the billing guidelines addressed above, the remainder of the claim form is to be completed in the same manner as an inpatient submission.

Outpatient

Note: Outpatient hospital claims which require medical necessity documentation may be billed electronically. Medical necessity documentation must be retained in your file and made available for review on a post-pay basis.

It is not required for you to roll-up charges into the covered code you are billing. You may bill the code you are providing, and the processing system will allow the covered charges and deny the services content or non-covered.

Revenue codes should not be indicated for outpatient services. Use appropriate Current Procedural Terminology (CPT) and HCPCS codes. Enter the time of day using the continental time system if the services are provided between 6:00 p.m. and 8:00 a.m. (1800 and 0800 hours) in FL 13, admission hour.

Attending Provider

The attending provider's National Provider Identifier (NPI) and name are required on all institutional claims. All institutional claims submitted on paper or electronically, must have both the attending provider's NPI and name. Providers are required to submit this information correctly in order for the institutional claim to be accepted for processing.

Bilateral Procedures

Bilateral procedures performed during the same operative session shall be billed with the appropriate code. To be consistent with Medicare, if a procedure is identified in the CPT® codebook as one that should have modifier 50 added when performed bilaterally, bill the procedure as a single line item with modifier 50. For example, to bill the excision of bilateral nasal polyps, you should indicate code 3011050 on one detail line on the claim. Reimbursement will be made for the bilateral procedure.

DME Purchase/Rental

All DME services are covered for in-home use only. DME services (purchase or rental) are non-covered in nursing facilities, swing bed facilities, state institutions, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IID), psychiatric residential treatment facilities (PRTF), traumatic brain injury (TBI) facilities, rehab facilities, and hospitals.

Emergency Renal Dialysis

Outpatient emergency renal dialysis must be billed using the following diagnosis codes in FL 67 of the UB-04 claim form: O084, T795XXA, N170, N171, N172, N178, N179, O0382, O0732, O904.

Emergency Room/Department Services

- Enter the time of day (using the continental time system, such as 0000-2300) in FL 13, admission hour.
- Emergency services provided in the emergency department must be billed using the appropriate evaluation and management (E&M) emergency department or critical care procedure code from the CPT® codebook.
- Reference the CPT® codebook for information on the CMS and American Medical Association (AMA) documentation guidelines as well as directions for assigning codes for emergency services. Copies of “detailed” documentation guidelines have been published by CMS.
- E&M procedure codes applicable to emergency department services include: 99281, 99282, 99283, 99284, 99285, 99291, and 99292. For dates of service on and before February 28, 2018, these must be billed with modifier ET. Effective with dates of service on and after March 1, 2018, modifier ET will be informational only. Hospitals no longer need to bill modifier ET with these codes for facility charges.

Note: Refer to the CPT® codebook for procedure code nomenclature.

- Non-emergent emergency room encounters must be billed using 99281. For one facility charge and one professional charge, only one ER code (99281-99285) is allowed. This is per day per beneficiary regardless of provider. Medical necessity documentation must accompany the claim when more than one ER visit is made on the same day for the same individual.
- **Type B Emergency Departments** – The following codes are covered KMAP services and should be used by Type B Emergency Departments: G0380, G0381, G0382, G0383, or G0384. A Type B emergency department is defined as an emergency department that meets the definition of a “dedicated emergency department” as defined in 42 CFR 489.24 under the EMTALA regulations.
- It must meet at least one of the following requirements:
 - It is licensed by the State in which it is located under applicable state law as an emergency room or emergency department.
 - It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

- During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
- Medical supplies and injections (99070 and J7030-J7130) are considered content of service of the ER visit.

Locum Tenens Physicians

- Locum tenens physicians must not be in place for more than one year.
- It is your responsibility to ensure a locum tenens physician covering for a KanCare care provider is not excluded from participation in governmental programs, including Medicaid.
- Upon review of claims, payments will be recouped if it is determined that KanCare paid for a service that was provided by a locum tenens physician who was excluded from participation in governmental programs including Medicaid on the date of service.

Mid-Level Practitioners

Physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) must be enrolled as Medicaid care providers to bill for services. Indicate the PA's or ARNP's number as the attending care provider on the UB-04 claim form. ARNPs and PAs are reimbursed 75% of the Medicaid allowed amount for services provided.

Observation Room

- For dates of service before April 1, 2015, code 99218ET should be billed for any service which requires monitoring a patient's condition beyond the usual amount of time in an outpatient setting. **This code shall not be used to bill for the recovery room.**
- Currently, code G0378 is billed for outpatient services. This code replaces 99218ET.
- Medical supplies and injections (99070, J7030-J7130) are considered content of service of the observation room services.

Care Provider Clinic Services

- Currently, some care providers make scheduled visits once or twice a week to rural hospitals and see patients in an outpatient hospital room which functions as their office. Care provider clinic services provided in a hospital location are considered content of the care provider service and should not be billed to Medicaid or the beneficiary.
- For dates of service before April 1, 2015, the hospital can bill code 99070ET for use of room and supplies.
- Currently, the hospital can bill G0463 for the use of the room and supplies. G0463 is not considered content of surgery.

Professional Fees

The only physician services billed by the hospital on are hospital-based physicians assigned to the emergency department. The hospital is no longer allowed to bill hospital-based physician professional fees.

Professional/Technical Component Billing

- **Components**
 - **Professional**

Enter the base code for services rendered, including modifier 26 (example: 7207026). Note: Modifier 26 is not covered for a hospital care provider.
 - **Technical**

Enter the base code of the service performed, including modifier TC (example: 72070TC).
Note: Hospitals billing the base code for radiology procedures will be reimbursed at the TC rate.
 - **Professional and Technical**

Enter the base code of the service performed (example: 72070).
- **The same procedures performed on the same day:**
 - Must be billed on the same claim
 - Must clarify the reason for billing more than one procedure (e.g., two X-rays at two different times; Left arm, right arm)
- When the same procedures are not billed on the same claim, the additional claim(s) will be denied as a duplicate. To seek reimbursement for additional services when this occurs, submit an underpayment adjustment using the internal control number (ICN) from the remittance advice (RA) of the paid claim and state on the adjustment request that more than one procedure was performed on the same day. Refer to Section 5600 of the KMAP General Billing Provider Manual.
- **Exception:** Claims that have the same procedures performed on the same date of service but have different places of service should be billed on separate claims. Both claims must include the two-digit place of service code in order to process correctly and not deny as duplicate.

Prosthetic and Orthotic

Hospitals must enroll as prosthetic and orthotic (P&O) providers and bill on the professional claim form (CMS 1500 paper or equivalent electronic claim form) or 837 professional transaction when providing these services. Contact Provider Enrollment at 1-800-933-6593.

- Prosthetic and orthotic items **cannot** be billed as ancillary services on the UB-04 paper or equivalent electronic claim form.
Exception: Prosthesis implanted by a surgical procedure may be billed on the hospital claim form for inpatient services.

Sterilization Procedures

When a sterilization is performed in conjunction with or secondary to an inpatient procedure (such as delivery) and the sterilization is not covered (such as failure to obtain the Sterilization Consent Form), remove all codes and charges related to the sterilization from the claim and bill the primary procedure only. Carefully document in the medical record the reason the sterilization was not billed on the claim.

Supplies

- For dates of service before April 1, 2015, the hospital can bill 99070ET for supplies.
- Currently, the hospital can bill code 99070 without the modifier ET for supplies. Modifier ET is no longer a valid modifier for 99070. Only one supply is allowed per day.

Unit Billing

When billing for outpatient hospital services, round units to the nearest whole number. Do not bill fractions of units.

Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; Surgical or Other Invasive Procedure Performed on the Wrong Patient

- KanCare will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. Medicaid will also not cover hospitalizations and other services related to these non-covered procedures. None of the erroneous surgeries or services is billable to the beneficiary.
- All services provided in the operating room when an error occurs are considered related and therefore are not covered. All care providers in the operating room when the error occurs who could bill individually for their services must submit claims for these services, but are not eligible for reimbursement for these services. All of these providers must submit separate claims for these services using the appropriate methods.

Inpatient Claims

- Hospitals are required to bill two claims when the erroneous surgery(s) is reported.
 - One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a type of bill (TOB) 11X (with the exception of 110)
 - One claim with the non-covered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim)
- The non-covered TOB 110 will be required to be submitted on the UB-04 (hard copy) claim form.
- For dates of service prior to October 1, 2015, you are required to report as an “other diagnosis” one of the applicable External Cause of Injury Codes for wrong surgery performed:
 - E876.5: Performance of wrong operation (procedure) on correct patient
 - E876.6: Performance of operation (procedure) on patient not scheduled for surgery
 - E876.7: Performance of correct operation (procedure) on wrong side/body part

Note: These E codes are not to be submitted in the E code field on the UB-04.
- For dates of service on and after October 1, 2015, you are required to report as an “other diagnosis” one of the applicable external cause of morbidity codes for wrong surgery performed:
 - Y65.51: Performance of wrong procedure (operation) on correct patient
 - Y65.52: Performance of procedure (operation) on patient not scheduled for surgery
 - Y65.53: Performance of correct procedure (operation) on wrong side or body part

Note: These external cause of morbidity codes are not to be submitted in the external cause of morbidity codes field on the UB-04.

Outpatient, Ambulatory Surgical Centers, Other Appropriate Bill Types and Practitioner Claims

You are required to append one of the following applicable modifiers to all lines related to the erroneous surgery(s):

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

8.3 Medical Assessment

Documentation

To verify services provided in the course of a post-payment review, documentation in the patient's medical record must support the service billed. Documentation can be requested at any time to verify that services have been provided within program guidelines.

The information below indicates medical information which may be necessary to document medical necessity of those diagnoses designated as "sometimes payable" on the screen.

Abdominal Plain Films and Ultrasound

Abdominal plain films and ultrasound are medically necessary if the diagnosis indicates abdominal pain, nausea/vomiting, complications associated with ulcers, intestinal obstruction, gall bladder disease, malignant neoplasm of the abdominal organs, injury to the abdomen or nephrolithiasis. It may be necessary to contact the ordering care provider for medical necessity information.

An abdominal plain film may be warranted in a pregnant patient if:

- Fetal position is questionable.
- Obstetrical ultrasound is unavailable and patient is in labor.

Electrocardiograms (EKGs)

Electrocardiograms (up to 12 leads) are considered medically necessary when the diagnosis and/or condition clearly indicates one or more of the following:

- Relevant cardiopulmonary diagnosis
- Significant electrolyte imbalance
- Drug induced EKG changes (identify the drug)
- Progressive renal disease
- Unstable thyroid disease
- Specific central nervous system (CNS) disorders causing EKG changes
- Congenital disorders causing EKG changes

- Symptomatic hypothermia
- Shortness of breath
- Fainting spells
- Monitoring the effects of psychotropic drugs for potential cardiac effects (identify the drug)

Preoperative EKGs are medically necessary for patients over age 40, or those patients under 40 with a history of cardiac problems. It may be necessary to contact the ordering care provider for medical necessity information.

Cardiac Rehabilitation

Phase II Cardiac Rehabilitation is covered using procedure code 93798. This procedure is covered when performed in an outpatient or cardiac rehabilitation unit setting, with the following criteria:

- Beneficiary must have a recent cardiology consultation within three months of starting the cardiac rehabilitation program.
- Beneficiary must have completed Phase I Cardiac Rehabilitation.
- Beneficiary must have one or more of the following diagnoses/conditions:
 - Acute myocardial infarction within the preceding three months, post inpatient discharge § For dates of service prior to October 1, 2015, codes 410.00–410.92, and 414.8
 - For dates of service on or after October 1, 2015, codes I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I25.5, I25.6, I25.89, and I25.9
 - Coronary bypass surgery within the preceding three months, post inpatient discharge § For dates of service prior to October 1, 2015, code V45.81
 - For dates of service on or after October 1, 2015, code Z95.1
 - Stable angina pectoris within three months post diagnosis § For dates of service prior to October 1, 2015, codes 413.9 and 413.0
 - For dates of service on or after October 1, 2015, codes I20.0, I20.1, I20.8, and I20.9

Chest X-Rays

Chest X-rays are determined medically necessary if:

- History or indication of cardiopulmonary disease, malignancy, cardiovascular accident (CVA), or long bone fracture
- Recent thoracic surgery
- Thoracic injury
- Chronic cough of over one month duration
 - Specify as chronic in the diagnosis field. If this designation is not supplied, the condition will be considered acute and the X-ray denied.

Pre-operative and routine admission chest X-rays are non-covered unless documentation of medical necessity (one or more of the following factors) is noted on the claim:

- 60 years of age or older

- Pre-existing or suspected cardiopulmonary disease
- Smoker over age 40
- Acute medical/surgical conditions such as malignancy or trauma Claims denied because other factors are listed, will be reconsidered if appealed

It may be necessary to contact the ordering care provider for medical necessity information.

CT Scans - Abdominal

A CT scan of the abdomen is medically necessary if the diagnosis indicates a malignant neoplasm of the intra-abdominal cavity, lung or genital organs, lymphoma, diseases of the spleen, liver abscess, peritonitis, pancreatitis, abdominal trauma, or abdominal mass.

A CT scan of the abdomen may be medically necessary for abdominal pain, abdominal aneurysm, acute lymphocytic leukemia, or any malignant neoplasm not located in the intra-abdominal cavity, lung or genital organs. Inclusion of the following documentation will assist in the adjudication of your claim.

Abdominal Pain: Indicate the severity and chronicity of the pain, presenting symptoms and suspected conditions or complications.

Abdominal Aneurysms: Indicate the presenting symptoms and suspected complications.

Acute Lymphocytic Leukemia: Indicate the presenting symptoms and a detailed description of area(s) involved.

Malignant Neoplasm Not Located in the Intra-Abdominal Cavity, Lung or Genital Organs: Indicate pertinent symptoms and if performed as part of staging the disease process.

It may be necessary to contact the ordering care provider for medical necessity information.

CT Scans - Head or Brain

A CT scan of the head or brain is medically necessary if the diagnosis indicates intracranial masses/tumors, intracranial congenital anomalies, hydrocephalus, brain infarcts, parencephalic cyst formation, open or closed head injury, progressive headache with or without trauma, intracranial bleeding, aneurysms, or the presence of a neurological deficit.

A CT scan of the head or brain may also be medically necessary with the indication of headache, epilepsy, syncope, dizziness, or acute lymphocytic leukemia. Inclusion of the following documentation will assist in adjudication of your claim:

Headache - Indicate length of chronicity and any accompanying central nervous system (CNS) symptoms.

Epilepsy - Specify if initial or repeat scan, indicate if suspected injury occurred during seizure.

Syncope - Specify if recurrent or single episode.

Dizziness - Specify if recurrent or single episode.

Acute Lymphocytic Leukemia - Indicate any accompanying CNS symptoms.

It may be necessary to contact the ordering care provider for medical necessity information.

Fetal Testing

- Effective with dates of service on and after March 1, 2018, fetal aneuploidy testing codes 81420 and 81507 is covered for at-risk pregnancies when billed with a covered ICD-10 diagnosis code. Fetal aneuploidy testing is limited to coverage of one CPT code per pregnancy (270 days).
- DNA-based noninvasive prenatal tests of fetal aneuploidy are proven and medically necessary as screening tools for trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome) or trisomy 13 (Patau syndrome) in any of these circumstances:
 - Maternal age of 35 years or older at delivery
 - Fetal ultrasound findings indicating an increased risk of aneuploidy
 - History of prior pregnancy with trisomy
 - Positive first or second trimester screening test results for aneuploidy
 - Parental balanced Robertsonian translocation with an increased risk of fetal trisomy 13 and 21
- DNA-based noninvasive prenatal tests of fetal aneuploidy are unproven and NOT medically necessary for all other indications including, but not limited to:
 - Multiple gestation pregnancies
 - Screening for microdeletions
 - Screening for sex chromosome aneuploidies

Hyperbaric Oxygen Therapy

Hyperbaric oxygen therapy is a covered service under KMAP with PA. The following criteria must be met before a PA will be approved.

1. The services must be for one of the following conditions:
 - a. Acute carbon monoxide intoxication
 - b. Decompression illness
 - c. Gas embolism
 - d. Gas gangrene
 - e. Acute traumatic peripheral ischemia
 - f. Compromised skin grafts
 - g. Chronic refractory osteomyelitis
 - h. Osteoradionecrosis
 - i. Soft tissue radionecrosis
 - j. Cyanide poisoning
 - k. Actinomycosis
1. Crush injuries and suturing of severed limbs

- m. Progressive necrotizing infections
- n. Acute peripheral arterial insufficiency
- o. Diabetic wounds of lower extremities

2. It must be documented that other treatments have been attempted with no improvement.

Facilities can bill for this procedure using procedure code 99183 or G0277 (one unit equals 30 minutes with a maximum of four units allowed per treatment session). The facility must choose which procedure code they will bill prior to the approval of the PA.

If there are multiple treatment sessions on the same day, each subsequent session must be billed on a separate detail line with a 76 modifier.

MRI - Head or Brain

MRI scan of the head or brain is medically necessary if the diagnosis indicates intracranial injury, intracranial mass/tumor, CNS malignancies, cerebrovascular disorder, cerebral malformations, disorders of the cerebral hemispheres and higher brain functions, demyelinating diseases, extrapyramidal and cerebellar disorders, brain abscesses, encephalitis, tuberculous meningitis, or the presence of a neurological deficit.

MRI scan of the head or brain may also be medically necessary with the indication of headache, seizure disorders, syncope, dizziness, or non-CNS malignancies. Inclusion of the following information will assist in adjudication of your claim:

Headache - Indicate length of chronicity and any accompanying neurologic symptoms

Seizure - Specify if initial or repeat scan, and if seizures (or convulsions) are of disorders of recent onset, frequency of their occurrence, and any accompanying neurologic symptoms

Syncope - Specify if recurrent or single episode and any accompanying neurologic symptoms

Dizziness - Specify if recurrent or single episode and any accompanying neurologic symptoms

Non-CNS Malignancies - Indicate any accompanying neurologic symptoms

It may be necessary to contact the ordering care provider for medical necessity information.

MRI - Breast

MRI of the breast will be covered with the following indications:

- Staging and therapy planning in patients diagnosed with breast cancer
- Occult primary breast cancer when there are positive axillary nodes and no known primary tumor
- Inconclusive diagnosis after a standard mammography evaluation, for example when scar tissue from previous surgery, dense breast tissue or breast implants render mammographic images inconclusive

MRI used for screening for breast cancer is not justified.

Skull X-Rays

Skull X-rays are medically necessary if diagnosis indicates cranial trauma, primary or metastatic tumors of the skull, or tumors of the pituitary gland.

A skull X-ray may also be medically necessary for indication of chronic sinusitis, trigeminal neuralgia, or anomalies relating to the head. Inclusion of the following documentation will assist in the adjudication of your claim:

Chronic Sinusitis - Indicate any pertinent specific suspected complications resulting from chronicity.

Trigeminal Neuralgia - Specify type of lesion suspected.

Anomalies relating to the head - Specify if done as a scout film for non-cosmetic reconstructive surgery. Indicate type of surgery under consideration.

It may be necessary to contact the ordering care provider for medical necessity information.

Sonograms - Non-Obstetrical Pelvic

Non-obstetrical pelvic sonograms are determined medically necessary if the diagnosis indicates pelvic mass or pain, ovarian cyst, pelvic inflammatory disease, endometriosis, possible retained products of conception, or question/history of metastatic disease.

Non-obstetrical pelvic sonograms may be medically necessary if there is an indication of vaginal bleeding or irregular menstrual cycles. It may be necessary to contact the ordering care provider for medical necessity information.

Obstetrical Pelvic Sonograms

Obstetrical (OB) sonograms are not covered when performed solely to determine the fetal sex or to provide parents a view and/or photograph of the fetus.

Primary or secondary diagnosis must support medical necessity for an OB sonogram. Some examples are: **indication of** vaginal bleeding, multiple birth, diabetes, size/date discrepancy, fetal anomalies, threatened abortion, placental/uterine abnormalities, fetal demise, maternal drug/alcohol/tobacco use, or **history of** previous miscarriage, Cesarean Section, stillbirth, ectopic pregnancy, eclampsia, or intra-uterine growth retardation.

Medical necessity may also be determined based on maternal age, maternal weight, or fetal position. If applicable, this information should be submitted with the claim.

The following OB sonogram procedures must be billed using a primary or secondary diagnosis code from Appendix II of the KMAP Professional Fee-for-Service Provider Manual. OB sonograms billed with any other diagnosis code will be denied.

76801 76802 76805 76810 76811 76812 76813
76814 76815 76816 76817 76818 76819 76820
76821 76825 76826 76827 76828

Upper Gastrointestinal Series

Upper Gastrointestinal (UGI) series are medically necessary if the primary diagnosis indicates persistent dysphagia, melena, symptoms of UGI tract bleeding or signs and symptoms of ulcers affecting the UGI tract after a trial of medicinal therapy has failed to relieve the symptoms. State guidelines allow one UGI series per day, per beneficiary, regardless of care provider.

UGI series may also be medically necessary when diagnoses such as abdominal pain and dyspepsia are used. When these common nonspecific diagnosis codes are used, additional symptoms and/or circumstances that relate to the medical necessity of the procedure must be indicated. Examples of additional information which will assist in adjudication of your claim are as follows:

- Is the symptom persistent? If so, how long has the symptom persisted?
- Is the symptom recurrent? When was the last episode?
- Has the symptom or condition increased in severity?
- Was medicinal therapy initiated prior to any procedure being performed? If so, indicate the date each therapy was initiated, name(s) of medication (list all GI related medications tried) and the length of time each medication was tried. What was the patient's response to each treatment?
- If a chronic condition, has there been a change in symptoms? If so, describe the change(s).
- If cancer diagnosis codes are used, what symptoms are present that indicate UGI involvement?

Claims for UGI X-rays are denied reimbursement when the diagnosis code on the claim is either too nonspecific or is the result, rather than the reason, for the procedure. Whenever possible, use the symptoms that most clearly describe the reason for the test.

It may be necessary to contact the ordering care provider for medical necessity information.

Emergency Room/Department (Outpatient Hospital)

General Information

The State of Kansas defines emergency services as follows:

KAR 30-5-58 (42) "Emergency services are those services provided after the sudden onset of a medical condition manifested by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part."

KAR 30-5-81 (b) (4) "Services provided in the Emergency Department shall be emergency services."

Emergency status is determined based on conditions relating to the emergency visit, not the patient's age and time of admission to the emergency department. Emergency department claims are limited to one visit per beneficiary, per date of service unless accompanying documentation verifies the necessity for more than one emergency room/department visit.

Direct physical attendance by a care provider or mid-level practitioner is required in "emergency" situations. If the care provider or mid-level practitioner has not made entries on the record other than his/her signature and/or diagnosis and documentation does not indicate that he/she had examined the patient, the visit will not be considered emergent. Phone or standing orders do not support emergency treatment.

Axillary temperatures are not considered accurate and will be disregarded when determining emergent status.

Beneficiaries may go to the emergency room without a referral from their care provider based on the definition of an emergency according to a prudent layperson (as defined by the Balanced Budget Act, 1997): What a layperson would consider an emergency in the absence of medical knowledge. Such an emergency could include, but is not limited to: serious impairment to bodily functions; serious dysfunction of any bodily organ or part; severe pain; or an injury/illness that places the health of the individual in serious jeopardy (and in the case of a pregnant woman, her health or that of her unborn child).

Other examples of emergencies are:

- Initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus or other conditions considered “life-threatening.”
- Patients who require transfer to another facility for further treatment or who expire. Non-emergent Situations

Non-emergent Situations:

- Intentional non-compliance with previously ordered medications and treatments resulting in continued symptoms of the same condition.
- Refusal to comply with currently ordered procedures/treatments such as drawing blood for laboratory work.
- Leaving the emergency room against medical advice.
- Having previously been in the same or different emergency room or physician’s office for the same condition and the condition had not worsened.
- Scheduled visits to the emergency room for procedures, examinations or medication administration. Examples include cast changes, suture removal, dressing changes, follow-up examinations and second opinion consultations.
- Visits made to receive a “tetanus” injection in the absence of other emergent conditions.
- Visits made to obtain medication(s) in the absence of other emergent conditions.
- Conditions/symptoms relating to the visit had been experienced longer than 48 hours or are of a chronic nature and emergency medical treatment to stabilize the condition was not required.

The following conditions will not be considered emergent unless the criteria described has been met:

Alcoholism in and of itself is considered non-emergent unless documentation supports an emergent status (i.e., gastric bleeding or coma/stupor).

Ambulance: A patient brought in by ambulance does not necessarily justify an emergency room visit.

Guidelines for Use of Air Ambulance Services:

Time: If time is a critical factor in the patient’s recovery or survival, or duration of ground transport would be excessive and potentially detrimental, air transport may be indicated. In general, if the ground ambulance can arrive at the destination institution within 20 minutes, it is the preferred mode of transport.

Expertise: If the health care institution does not possess the expertise to provide the definitive care required to stabilize the patient (i.e., advanced life support) and the ground ambulance care providers in the near vicinity cannot provide assistance in providing that care, air transport may be indicated.

Coverage: If ground ambulance utilization leaves the service area without adequate ground coverage and patient outcome will be compromised by arranging other ground transport, air transport may be indicated.

Documentation: The above guidelines serve as a guide to documentation which is necessary to determine proper reimbursement and must specify the indication and justification for air transport. If guidelines are not met, or are met but not documented, the billed transportation will be reimbursed at ground ambulance rates or denied altogether.

Depression/Anxiety: Documentation must support the individual to be an immediate danger to self or others.

Disposition: If a patient's disposition is one of the following, the visit would be considered emergency:

- a) requires transfer to another facility for further treatment,
- b) has expired, expires en route to the hospital or in the emergency room,
- c) requires extended observation or admission.

Fevers must be considered with other documented symptoms. Generally, temperatures less than 103 rectally (children) or 102 orally (adults) are not considered emergent. Ear and axillary temperatures will be considered along with additional symptoms. Reported temperatures by patients are not acceptable for determining emergent status.

Insect Bites, Stings, Embedded Ticks: Minor insect bites (tick) with simple local reactions only (i.e., erythema, local edema, itching) are not considered emergent.

Medical Emergency: Initial treatment and/or stabilization for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus or other conditions considered "life-threatening" would be considered emergent. Just because these conditions may be considered "life-threatening" at times, does not automatically indicate a Level of Care III. The Level of Care assignment is dependent upon the severity of the situation and the services provided.

Mental Disorders such as depression or anxiety as an individual diagnosis is considered nonemergency unless the patient is noted to be suicidal or of immediate risk to self or others.

Minor Burns/Sunburns: Minor burns/sunburns are considered non-emergent unless documentation supports the presence of complications such as severe swelling, infection, or the young age of the patient. Eye and chemical burns are considered emergent.

Otitis Media: If tympanic membrane is bulging or ruptured, drainage from the ear(s), fever of 103 or above or is a child of age 3 or under and is crying inconsolably, a visit to the emergency room would be considered emergent for consideration of otitis media. If the physical examination reveals evidence of acute otitis media (after office hours or on the weekend), but does not meet any of the above criteria, the ED visit may be considered emergent because of the time of day/week.

Patient Non-compliance: Intentional non-compliance with previously ordered medications and treatments resulting in continued symptoms of the same condition are considered non-emergent. Refusal to comply with currently ordered procedures/ treatments such as drawing blood for laboratory work will also be considered nonemergent.

Removal of Cutaneous Foreign Bodies: Removal of cutaneous foreign bodies (i.e., simple splinters, cactus needles) are considered non-emergent unless sedation or the use of extensive medical supplies such as cut downs are required.

Seizures: Are considered emergent when:

- a) there is a secondary diagnosis noted (i.e., infection or headache)
- b) the patient is 12 years old or younger
- c) the seizure is still in progress or status epilepticus
- d) this is a febrile seizure
- e) the condition is aggravated by alcohol/drug ingestion
- f) this is a previously undiagnosed condition

Scheduled Visits: Scheduled visits to the emergency department for procedures, examinations or medication administration (i.e., cast changes, suture removal, dressing changes, follow-up examinations and second opinion consultations) are considered non-emergent.

When a patient leaves the emergency department against medical advice (AMA) the service is generally considered non-emergent. However, if the facility provided considerable services before the patient left AMA, the visit will be given consideration as emergent.

Sickle Cell Anemia: If a person has sickle cell anemia and presents with suspicion of an infectious or hypoxic process, or complains of pain, the visit may be considered emergent.

Skin Rash/Hives: Documentation must support presence of systemic complications beyond the local skin discomforts resulting from the rash. If the rash causes eye complications or the beneficiary has a history of anaphylactic (allergic) reactions, the visit is considered emergent.

If the rash causes eye edema or impairment to eye function and the visit is over a weekend when there is no access to a care provider's office, the visit may be considered emergent.

A history of anaphylaxis along with the rash is considered emergent.

Trauma/Injury: Recent trauma or injury is considered emergent. Recent is defined as an injury occurring within 48 hours prior to the emergency room visit. Minor abrasions/lacerations not requiring suture or other injuries not requiring treatment are not emergent.

If the injury is older than 48 hours and symptoms have deteriorated to the point of requiring emergency care, consider as emergent.

An injury that requires only simple first aid treatment that can be done in the home (such as cleansing and/or bandaging an abrasion) is not considered emergent.

A laceration requiring steri-strips indicates a gaping wound and would be considered emergent. X-rays do not define the level of care.

Tetanus Injection: A tetanus injection is not considered emergent and does not change the visit to emergent. However, the patient should not have to make two visits (one to the emergency room and one to an office or public health department) in order to receive the tetanus injection. When needed, a tetanus injection should be given within 48-72 hours of the injury, if possible.

Vital Signs: If the vital signs are outside a reasonable range for the age, consider the visit as emergent (see “fever”).

Emergency Department/Room Guidelines for E&M Codes

History: The age of a patient is a component of every medical record. Documentation of age in relationship to issues such as antisocial behavior or mental status is important; however, age alone is not considered a social history.

Examination: A “comprehensive exam” is considered a “hands-on” specialist examination.

Telephone consultation with a specialist is not the equivalent of comprehensive exam.

Medical Decision Making: Transfers from the emergency department to another facility for additional care should be considered in management options as either the “new problem, additional work-up” or the category of “established problem, worsening”.

A notation that the patient should “follow-up” with his family care provider in the morning or return to the care provider’s office for stitch removal does not justify use of the “additional work-up” statement when considering management options.

In evaluating the “Table of Risk”, infection is the usual risk that pops into mind when talking about minor surgery. To consider infection as a “risk” from minor surgery, there must be documentation to support increased risk due to the quality or condition of the injury or illness.

“Self-limited/minor problems” are defined as those representative of basic emergency department care such as lacerations, stings, insect bites.

“New problems with or without additional work-up” is defined as representing new, long-standing problems that will need attention again at some time.

Observation Room

Observation in the outpatient setting is a service which requires monitoring the patient’s condition beyond the usual amount of time in an outpatient setting. Examples of the appropriate use of the observation room include: monitoring head trauma, drug overdose, cardiac arrhythmias and false labor. A care provider or mid-level practitioner must see the patient within two hours prior to admission to the observation room except for obstetrical labor or scheduled administration of IV medication or blood products. The observation room stay must be medically necessary.

For dates of service before April 1, 2015, there is not a time limit restriction for the observation room. The same reimbursement rate applies regardless of the number of hours required for monitoring. This reimbursement is all inclusive of services and supplies. If there is a discharge and readmission to the observation room from midnight to midnight, only one reimbursement rate will be allowed.

- Currently, the observation stay is limited to 48 hours. A care provider must have personal contact with the patient at least once during the observation stay. A registered nurse or an employee under his or her direct supervision must monitor patients in the observation unit. A patient can begin the observation unit no more than 48 hours. Observation hours in excess of 48 hours are not reimbursable. Ancillary charges (such as lab work or x-rays) may also be billed separately. Medical supplies and injections (99070 and J7030-J7130) are considered content of service of the observation room service.
- Observation services are considered content to any surgical procedure for which global surgery rules apply when performed by the same provider during the global surgery period. Observation services are considered content of service of respiratory services (94010-94700), when performed on the same date of service by the same provider unless the observation is a significantly, separately identifiable service.

Observation room should not be billed for the following:

- Recovery room services following inpatient or outpatient surgery.
- Recovery/observation following scheduled diagnostic tests such as arteriograms, cardiac catheterization, etc.
- ER physician fee

Note: Additional information may be added to the face of your claim if applicable.

If the claim and/or attachments do not support the medical necessity of the service rendered, the service will be denied.

8.4 Medicaid - Inpatient/Outpatient

Advance Directives

Hospital care providers participating in KanCare must comply with federal legislation (OBRA 1990, Sections 4206 and 4751) concerning advance directives. An “advance directive” is otherwise known as a living will or durable power of attorney. Every hospital care provider must maintain written policies, procedures, and materials about advance directives.

Specific Requirements

- Each hospital must provide written information to every adult individual receiving medical care by or through the hospital. This information must contain:
 - The individual’s right to make decisions concerning his or her own medical care
 - The individual’s right to accept or refuse medical or surgical treatment
 - The individual’s right to make advanced directives
 - KDADS “Description of the Law of Kansas Concerning Advance Directives”
- Providers are permitted to contract with other entities to furnish this information, but are still legally responsible for meeting the section requirements. Such information must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the state law.

Note: KDADS does not provide copies of the description to you. It is up to you to reproduce the description. You are free to supplement this description as long as you do not misstate Kansas law.

- Additionally, each hospital must provide written information to every adult individual about the hospital's policy on implementing these rights.
- A hospital must document in every individual's medical record whether the individual has executed an advance directive.
- A hospital may not place any conditions on health care or otherwise discriminate against an individual based upon whether that individual has executed an advance directive.
- A hospital is not required to provide care that conflicts with an advance directive.
- Each hospital must comply with state law about advance directives.
- Each hospital must inform individuals that complaints concerning non-compliance with the advance directive requirements may be filed with the State survey and certification agency.
- Each hospital must provide for educating staff and the community about advance directives. This may be accomplished by brochures, newsletters, articles in the local newspapers, local news reports or commercials.

Incapacitated Individuals

- An individual may be admitted to a facility in a comatose or otherwise incapacitated state, and be unable to receive information or articulate whether he or she has executed an advance directive. If this is the case, families of, surrogates for, other concerned persons of the incapacitated individual must be given the information about advance directives. If the incapacitated individual is restored to capacity, the hospital must provide the information about advance directives directly to him or her even though the family, surrogate or other concerned person received the information initially.
- If an individual is incapacitated, otherwise unable to receive information or articulate whether he or she has executed an advance directive, the hospital must note this in the medical record.

Mandatory Compliance with the Terms of the Advanced Directive

When a patient, relative, surrogate or other concerned/related person presents a copy of the individual's advance directive to the hospital, the facility must comply with the terms of the advance directive to the extent allowed under state law. This includes recognizing powers of attorney.

Description of the Law of Kansas Concerning Advance Directives

There are two types of "advance directives" in Kansas. One is commonly called a "living will" and the second is called a "durable power of attorney for health care decisions."

The Kansas Natural Death Act, K.S.A. 65-28,106, et seq.

This law provides that adult persons have the fundamental right to control decisions relating to their own medical care. This right to control medical care includes the right to withhold life-sustaining treatment in case of a terminal condition.

Any adult may take a declaration which would direct the withholding of life-sustaining treatment in case of a terminal condition. Some people call this declaration a "living will." The declaration must be:

1. In writing;
2. Signed by the adult making the declaration;

3. Dated; and
4. Signed in front of two adult witnesses, or notarized.

There are specific rules set out in the law about the signature in case of an adult who can't write. There are specific rules about the adult witnesses. Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may not serve as witnesses. A woman who is pregnant may not make a declaration.

The declaration may be revoked in three ways:

1. By destroying the declaration;
2. By signing and dating a written revocation; and
3. By speaking an intent to revoke in front of an adult witness. The witness must sign and date a written statement that the declaration was revoked.

Before the declaration becomes effective, two care providers must examine the patient and diagnose the patient has a terminal condition.

The desires of a patient shall at all times supersede the declaration. If a patient is incompetent, the declaration will be presumed to be valid.

The Kansas Natural Death Act imposes duties on care providers and provides penalties for violations of the laws about declarations.

The Kansas Durable Power of Attorney for Health Care Decisions Law, K.S.A. 58-625, et seq.

A “durable power of attorney for health care decisions” is a written document in which an adult gives another adult (called an “agent”) the right to make health care decisions. The power of attorney applies to health care decisions even when the adult is not in a terminal condition. The adult may give the agent the power to:

1. Consent or to refuse consent to medical treatment;
2. Make decisions about donating organs, autopsies, and disposition of the body;
3. Make arrangements for hospital, nursing home, or hospice care;
4. Hire or fire care providers and other health care professionals; or
5. Sign releases and receive any information about the adult.

A “durable power of attorney for health care decisions” may give the agent all those five powers or may choose only some of the powers. The power of attorney may not give the agent the power to revoke the adult’s declaration under the Kansas Natural Death Act (“living will”). The power of attorney only takes effect when the adult is disabled unless the adult specifies that the power of attorney should take effect earlier.

The adult may not make a health care provider treating the adult the agent except in limited circumstances. The power of attorney may be made by two methods:

1. In writing;
2. Signed by the adult making the declaration;
3. Dated;
4. Signed in front of two adult witnesses;

Or:

Written and notarized.

Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may not serve as witnesses.

The adult, at the time the power of attorney is written, should specify how the power of attorney may be revoked.

The Patient Self-Determination Act, Section 1902(w) of the Social Security Act

This federal law, codified at 42 U.S.C. Sec. 1396a(w), was effective December 1, 1991. It applies to all Medicaid and Medicare hospitals, nursing facilities, home health agencies, hospices, and prepaid health care organizations. It requires these organizations to take certain actions about a patient's right to decide about health care and to make advance directives.

This law also required that each state develop a written description of the State law about advance directives. This description was written by the Health Care Policy section of KDADS to comply with that requirement. If you have any questions about your rights to decide about health care and to make advance directives, please consult with your care provider or attorney.

Third Edition: January 14, 2003

Abortions

- Abortions are covered only under the following conditions:
 - In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself
 - If the pregnancy is the result of an act of rape or incest
- You must complete the Abortion Necessity Form to certify the woman's physical health is in danger or that the pregnancy is a result of rape or incest. The form, located online at <https://www.kmap-state-ks.us/Public/forms.asp> and may be photocopied for your use. All blanks must be completed, including the patient's complete address.
- Claims submitted for abortions due to rape or incest must be accompanied by a statement signed by you stating he or she was informed by the patient that the pregnancy was the result of rape or incest. No further documentation is required to process the claim. However, all pertinent information must be retained with the medical record.

Add-On Codes

In accordance with National Correct Coding Initiative guidelines, procedure codes identified as add-on codes must be billed in addition to the primary procedure with which they are associated. An add-on code does not stand alone since it describes work in addition to the primary procedure. For more information on billing add-on codes, refer to Appendix D of the CPT® codebook.

Bariatric Surgery

Open or laparoscopic Roux-en-Y bypass (RYGB), open or laparoscopic biliopancreatic diversion (BPD), with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) will be considered medically necessary when the selection criteria below are met:

- Must meet either one (adults) or two (adolescents):

1. For adults aged 18 years or older, presence of severe obesity that has persisted for at least the last two years (24 months), documented in contemporaneous clinical records, defined as any one of the following:
 - Body mass index (BMI) exceeding 40
 - BMI greater than 35 in conjunction with either of the following severe comorbidities:
 - Clinically significant obstructive sleep apnea
 - Coronary heart disease
 - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite concurrent use of three anti-hypertensive agents of different classes)
 - Type 2 diabetes mellitus

2. For adolescents who have completed bone growth (generally age of 13 in girls and age of 15 in boys), presence of obesity with severe co-morbidities:
 - BMI exceeding 40 with one or more of the following serious co-morbidities:
 - Clinically significant obstructive sleep apnea
 - Type 2 diabetes mellitus
 - Pseudotumor comorbidities
 - BMI exceeding 50 with one or more of the following less serious co-morbidities:
 - Medically refractory hypertension (blood pressure greater than 140mmHg systolic and/or 90 mmHg diastolic despite concurrent use of 3 anti-hypertensive agents of different classes)
 - Dyslipidemias
 - Nonalcoholic steatohepatitis
 - Venous stasis disease
 - Significant impairment in activities of daily living
 - Intertriginous soft-tissue infections
 - Stress urinary incontinence
 - Gastroesophageal reflux disease
 - Weight-related arthropathies that impair physical activity
 - Obesity-related psychosocial distress

Provisional coverage of LASGB for beneficiaries younger than 18 years of age is a covered service. These individuals may receive other bariatric procedures, but LASGB will only be approved on a case-by-case basis. The beneficiary must meet medical necessity criteria. The care provider must submit documentation regarding the risk versus the benefit for individuals younger than 18 years of age. Procedure codes 43770, 43771, 43772, 43773, and 43774 are provisionally covered.

- Beneficiary has attempted weight loss in the past without successful long-term weight reduction

AND

- Beneficiary must meet either the following Criterion 1 (physician-supervised nutrition and exercise program) OR Criterion 2 (multi-disciplinary surgical preparatory regimen):
 1. **Physician-supervised nutrition and exercise program:** Beneficiary has participated in physician-supervised nutrition and exercise program (including dietitian consultation, low-calorie diet, increased physical activity, and behavioral modification), documented in the medical record at each visit. This physician-supervised nutrition and exercise program must meet **ALL** of the following criteria:
 - Beneficiary’s participation in a physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who supervised the beneficiary’s participation. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician. *Note:* A physician’s summary letter is not sufficient documentation.
 - Documentation should include medical records of physician’s contemporaneous assessment of patient’s progress throughout the course of the nutrition and exercise program. For beneficiaries who participate in a physician-administered nutrition and exercise program, program records documenting the beneficiary’s participation and progress may NOT substitute for physician medical records.
 - Nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dietitians and/or nutritionists, with a substantial face-to-face component (must not be entirely remote).
 - Nutrition and exercise program(s) must be for a cumulative total of six months (180 days) or longer in duration and occur within two years prior to surgery, with participation in one program of at least three consecutive months. Precertification may be made prior to completion of nutrition and exercise program as long as a cumulative of six months participation in nutrition and exercise program[s] will be completed prior to the date of surgery.

OR

2. **Multi-disciplinary surgical preparatory regimen:** Proximate to the time of surgery (within six months prior to surgery), beneficiary must participate in organized multidisciplinary surgical preparatory regimen of at least three months (90 days) duration meeting **ALL** of the following criteria, in order to improve surgical outcomes, reduce the potential for surgical complications, and establish the beneficiary’s ability to comply with postoperative medical care and dietary restrictions:
 - Behavior modification program supervised by qualified professional
 - Consultation with a dietitian or nutritionist
 - Documentation in the medical record of the beneficiary’s participation in the multi-disciplinary surgical preparatory regimen at each visit.

Note: A physician’s summary letter, without evidence of contemporaneous oversight, is not sufficient documentation. Documentation should include medical records of the physician’s initial assessment of the beneficiary, and the physician’s assessment of the beneficiary’s progress at the completion of the multidisciplinary surgical preparatory regimen.
 - Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by exercise therapist or other qualified professional
 - A substantial face-to-face component (must not be entirely delivered remotely)
 - Reduced-calorie diet program supervised by dietitian or nutritionist

AND

- For beneficiaries who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression) or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, preoperative psychological clearance is necessary in order to exclude beneficiaries who are unable to provide informed consent or who are unable to comply with the pre- and post-operative regimen.

Note: The presence of depression due to obesity is not normally considered a contraindication to obesity surgery.

Repeat Bariatric Surgery

- Repeat bariatric surgery is considered medically necessary to correct complications from bariatric surgery, such as obstruction, stricture, erosion, or band slippage.
- Repeat bariatric surgery is considered medically necessary for beneficiaries whose initial bariatric surgery was medically necessary (i.e., who met medical necessity criteria for their initial bariatric surgery) and who meet any one of the following medical necessity criteria:
 - Conversion to a RYGB or BPD/DS may be considered medically necessary for beneficiaries who have not had adequate success (defined as loss of more than 50% of excess body weight) two years following the primary bariatric surgery procedure and the beneficiaries have been compliant with a prescribed nutrition and exercise program following the procedure.
 - Revision of a primary bariatric surgery procedure that has failed due to dilation of the gastric pouch or dilation of the gastrojejunostomy anastomosis is considered medically necessary if the primary procedure was successful in inducing weight loss prior to the dilation of the pouch or GJ anastomosis, and the beneficiary has been compliant with a prescribed nutrition and exercise program following the procedure.
 - Replacement of an adjustable band due to complications (e.g., port leakage, slippage) that cannot be corrected with band manipulation or adjustments.

Experimental and Investigational Bariatric Surgical Procedures

Each of the following procedures is considered experimental and investigational because the peer reviewed medical literature shows them to be either unsafe or inadequately researched. These are not covered services.

- Bariatric surgery as a treatment for idiopathic intracranial hypertension
- Gastroplasty, more commonly known as “stomach stapling” (see below for clarification from vertical band gastroplasty)
- Intra-gastric balloon
- Laparoscopic gastric plication
- LASGB, RYGB, and BPD/DS procedures not meeting the preceding medical necessity criteria
- Loop gastric bypass
- Mini gastric bypass
- Roux-en-Y gastric bypass as a treatment for gastroesophageal reflux in non-obese persons
- Silastic ring vertical gastric bypass (Fobi pouch)
- Transoral endoscopic surgery (e.g., the StomaphyX device/procedure)
- Vertical banded gastroplasty (VBG)

Note: Bariatric surgery is not covered as a treatment for infertility.

Cholecystectomy

As a high incidence of gallbladder disease (28%) has been documented after surgery for morbid obesity, routine cholecystectomy is considered medically necessary when performed in concert with elective bariatric procedures.

Covered Services

Sleep studies and polysomnography (PSG) are covered services included in the preoperative process for bariatric surgery candidates. The beneficiary must meet criteria to be considered a candidate for bariatric surgery, which includes a six-month weight loss plan supervised by a physician. Prior authorization is required.

One of the following procedure codes can be billed preoperatively when other criteria are met for bariatric surgery: 95807, 95808, 95810, and 95811.

An open or laparoscopic sleeve gastrectomy (43775) is a covered service and considered medically necessary when the selection criteria documented in the original bariatric policy are met. Kansas Medicaid will follow the lead of CMS by eliminating the certification requirement for facilities that provide bariatric procedures.

Bone Anchored Hearing Aid

- A bone anchored hearing aid (BAHA) is covered by KMAP with the following specifications and limitations. A BAHA is limited to one every four years, with one replacement. PA is required for all BAHA services. You must obtain a PA prior to providing service.

Note: When a bone anchored hearing aid procedure is done in two stages, the charge for the procedure should only be billed once. If it is billed once for each stage, the second charge will be denied. Bone anchored hearing aid procedure codes are as follows: 69710, 69711, 69714, 69715, 69717, 69718, L8690, and L8691.

- A BAHA is covered with PA for a KAN Be Healthy (KBH) beneficiary who meets all of the following criteria:
 - Each of items one, two, three and four
 - Either items five or six
 - **At least one** of items seven, eight or nine
 1. The beneficiary must be five years of age or older.
 2. Standard hearing aids cannot be used due to a medical condition.
 3. The beneficiary has the ability to maintain proper hygiene at the site of the fixture.
 4. Tumors of the external canal and/or tympanic cavity are present.
 5. Congenital or surgically induced malformations (e.g., atresia) of the external ear canal or middle ear are present.
 6. There is unilateral conductive or mixed hearing loss.
 7. There is bilateral conductive hearing loss.
 8. There is unilateral sensorineural hearing loss (single-sided deafness).

Definitions

- **Unilateral conductive or mixed hearing loss:** Unilateral conductive or mixed hearing loss caused by congenital malformations of the external or middle ear. Conventional hearing aids cannot be worn. Beneficiary must have:
 - Average bone conduction threshold better (less) than 45 dB (at 500, 1000, 2000, 3000 Hz) in the indicated ear
 - Speech discrimination score greater than 60% in the indicated ear
- **Bilateral conductive hearing loss:** Conductive and mixed hearing loss involving both ears which is not able to be treated with reconstructive surgery or conventional hearing aids. Beneficiary must meet all of the following:
 - Moderate (40dB) to severe (70dB) conductive hearing loss symmetrically
 - Less than 10 dB difference in average bone conduction (at 500, 1000, 2000, 4000 Hz) or less than 15 dB difference in bone conduction at individual frequencies
 - Mixed hearing loss with an average bone conduction better (less) than 45dB in either ear (at 500, 1000, 2000, 4000 Hz)
- **Unilateral sensorineural hearing loss (single-sided deafness):** Nerve deafness in the indicated ear making conventional hearing aids no longer useful. The implant is designed to stimulate the opposite (good ear) by bone conduction through the bones of the skull. Therefore, the audiometric criteria are for the good ear. Beneficiary must meet all of the following:
 - Severe (70dB) to profound (90dB) hearing loss on one side with poor speech discrimination and the inability to use a conventional hearing aid in that ear
 - Normal hearing in the good ear as defined by an air conduction threshold equal to or better (less) than 20dB (at 500, 1000, 2000, 3000 Hz)
- A child younger than five years of age with unilateral congenital atresia of the ear canal or middle ear in the presence of a maximum conductive hearing loss and adequate cochlear (inner ear) function may be considered on an individual basis. Adequate cochlear function is demonstrated audiologically when stimulation through bone conduction results in significantly improved and functional hearing in the involved ear.
- For a child with congenital malformations, sufficient bone volume, and bone quality must be present for a successful fixture implantation. Alternative treatments, such as a conventional bone conduction hearing aid, should be considered for a child with a disease state that might jeopardize osseointegration.

Replacements

- One replacement BAHA is covered for a KBH beneficiary who meets the initial placement criteria.
- PA is required for all BAHA replacement services. You must obtain a PA prior to providing service.
- A replacement processor cannot be billed at the same time as the original processor or the original surgery.
- Replacements are limited to one every four years if lost, stolen, or broken.
- A replacement is not allowed for the purpose of upgrading. A BAHA can only be replaced if the current processor has an expired warranty, is malfunctioning, and cannot be repaired.

Children and Family Services (CFS) Contractors

Medicaid reimbursable services will not be paid by child welfare contractors. All services for children assigned to contractors, including behavior management and mental health, must be billed directly to KanCare and will be reimbursed at the approved Medicaid rate. Prior authorization (PA) and other restrictions apply.

Immunization/Vaccine

Reimbursement for covered immunizations for children is limited to the administration of the vaccine only. Vaccines are supplied at no cost to you through Vaccines for Children, a federal program.

- Providers must bill the appropriate administration code in addition to the vaccine/toxoid code for each dose administered. Reimbursements of CPT® codes for vaccines covered under the Vaccine for Children (VFC) program will not be allowed for children 18 years of age and younger.
- PACS software requires a charge on each line item being submitted. Providers who bill electronically through the PACS system will need to indicate a charge of \$.01 on the line for the vaccine/toxoid code. MMIS will deny the service even though a charge was submitted.

ADMINISTRATION CODES

| | | | | |
|-------|-------|-------|-------|-------|
| 90460 | 90471 | 90472 | 90473 | 90474 |
|-------|-------|-------|-------|-------|

VFC VACCINE CODES

| | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|
| 90620 | 90648 | 90657 | 90685 | 90703 | 90723 | Q2036 |
| 90621 | 90649 | 90658 | 90686 | 90707 | 90732 | Q2037 |
| 90633 | 90650 | 90660 | 90687 | 90710 | 90733 | Q2038 |
| 90634 | 90651 | 90669 | 90688 | 90713 | 90734 | Q2039 |
| 90644 | 90653 | 90670 | 90696 | 90714 | 90743 | |
| 90645 | 90654 | 90672 | 90698 | 90715 | 90744 | |
| 90646 | 90655 | 90680 | 90700 | 90716 | 90748 | |
| 90647 | 90656 | 90681 | 90702 | 90720 | Q2035 | |

All vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are covered.

Intrathecal Baclofen Pump

- Intrathecal baclofen pumps are covered for Medicaid beneficiaries. This includes the initial and all subsequent implantation(s), revision(s), repairs, catheters, batteries, refills, removals, and maintenance of the intrathecal baclofen pumps when indicated. The following conditions must be met:
 - The beneficiary must have responded favorably to a trial of intrathecal baclofen and documentation of previously used medication.
 - The beneficiary's ICD – diagnosis code must be a covered code and the source of the spasticity must be documented.
 - The beneficiary must be over the age of four years or there must be documentation that there is sufficient space within the child's chest wall for the pump to be implanted.
 - Contraindications include pregnancy and active infection at time of surgery.
- Procedure codes 62350, 62351, 62362, 62311, 62319, 62355, 62365, 62368, 62369, 62370, 95990, and 95991 do not require PA.

Renal Dialysis and Kidney Transplant

- When it has been determined a beneficiary has chronic renal disease (CRD) requiring renal dialysis, the beneficiary or his representative should apply for Medicare CRD eligibility.
- Medicare allows for payment of claims for eligible beneficiaries with chronic renal disease and will reimburse for maintenance dialysis the third month after the maintenance dialysis starts.

Medicare will reimburse for maintenance dialysis in the first three months if the beneficiary has been involved in self-training in a self-care dialysis unit or through a self-care home dialysis support service provided by a qualified care provider. They also reimburse for expenses incurred for a kidney transplant including those for the kidney donor.

- **Medicaid** will reimburse claims for services related to chronic renal dialysis and/or kidney transplants only after proof has been attached to one claim that the beneficiary has applied for Medicare and coverage has been approved or denied. The Medicare CRD eligibility information will be retained in the claims processing system. Therefore, subsequent claims do not need to have proof of Medicare CRD eligibility approval or denial attached.
- Acceptable proof of application and coverage or denial by Medicare are:
 - Medicare EOMB/RA
 - Beneficiary health insurance card
 - Report of Confidential Social Security Benefit Information
 - Letter from Medicare or Social Security explaining that the beneficiary has applied for Medicare and whether beneficiary is eligible

Screening, Brief Intervention, and Referral for Treatment

Screening, Brief Intervention, and Referral for Treatment (SBIRT) is an evidence-based approach identifying patients who use alcohol and other drugs at risky levels, with the goal of reducing and preventing related health consequences, disease, accidents, and injuries.

- The following services will be covered for this program: H0049, H0050, 99408, and 99409.
- SBIRT practitioners include health care and other properly licensed and/or certified professionals.
 - Health care professionals include physicians, physician assistants, nurse practitioners, psychiatrists, nurses, dentists, and certified health educators.
 - Professionals licensed by the Kansas Behavioral Sciences regulatory board include psychologists, social workers, professional counselors, marriage and family therapists, and addiction counselors.
- A properly licensed and/or certified professional who wants to become a SBIRT practitioner must complete the SBIRT training with a KDADS-approved SBIRT trainer and/or through an authorized online training course.
 - The individual must complete the SBIRT coursework with a score of 70% or greater to become a SBIRT practitioner.
 - The SBIRT practitioner then needs to enroll on the [KDADS website](#).

- The SBIRT practitioner must submit the CEU and/or certificate of completion, documentation of a score of 70% or greater, and professional license and/or certificate to all of the following:
 - [KDADS website](#)
 - Each MCO the SBIRT practitioner wants to become affiliated with
- Approved service locations for SBIRT practitioners include primary medical care practices, acute medical care facilities, rural health clinics, critical access hospitals, federally qualified health centers, community mental health centers, state mental hospitals, substance use disorder treatment programs, Indian health services, skilled nursing facilities, hospice, and family planning clinics.
- Approved full screens are AUDIT, DAST, ASSIST, and CRAFFT-Adolescent.
- Providers must maintain documentation in the medical records to include electronic health records. At a minimum, the documentation must include:
 - Full screen results
 - Brief intervention
 - Any appropriate referrals
- SBIRT practitioners who are unable to diagnose should use an appropriate general diagnosis code. Use diagnosis code R68.89.

Sleep Study and Polysomnography Services Criteria

1.0 Description of the Procedure, Product, or Service

Sleep studies and polysomnography refer to attended services for the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six or more hours. Sleep studies and polysomnography are performed with physician review, interpretation and report. Sleep studies and polysomnography are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as nasal continuous positive airway pressure (NCPAP).

1.1 Polysomnography

Polysomnography is the scientific evaluation of sleep that involves a physiologic recording in a specialized facility. Polysomnography is distinguished from sleep studies by the inclusion of sleep staging.

1.2 Sleep Study

A sleep study does not include sleep staging. A sleep study may involve simultaneous recording of ventilation, respiratory effort, electrocardiogram (EKG) or heart rate, and oxygen saturation.

1.2.1 Multiple Sleep Latency Test

- Measures daytime sleepiness.
- The instruction is to try to fall asleep.
- Involves four to five, 20-minute recordings of sleep-wake states spaced at 2-hour intervals throughout the day.

1.2.2 Maintenance of Wakefulness Test

- Measures daytime sleepiness.

- Involves multiple trials throughout a day of low-demand activity when the instructions are to resist sleep.

2.0 Eligible Beneficiaries

2.1 General Provisions

Kansas Medicaid beneficiaries must be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Limitations for Beneficiaries under 21 Years of Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician).

**EPSDT and prior approval requirements

If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval. This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

- That is unsafe, ineffective, or experimental/investigational.
- That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

3.0 When the Procedure, Product, or Service Is Covered

Note: This service is not covered by Kansas Medicaid but consideration is given to EPSDT beneficiaries under 21 years of age for medically necessary services.

3.1 General Criteria

Procedures, products, and services are covered when they are medically necessary and all of the following:

- The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs.
- The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide.

- The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria

A supervised polysomnography or sleep study performed in a sleep laboratory may be considered medically necessary as a diagnostic test in patients who present with one of the following:

3.2.1 Narcolepsy

- Narcolepsy is a syndrome that is characterized by abnormal sleep tendencies (excessive daytime sleepiness, disturbed nocturnal sleep, inappropriate sleep episodes or attacks).
- Polysomnography or sleep studies are covered as a diagnostic test for narcolepsy when the condition is severe enough to interfere with the patient's well-being and health.
- Ordinarily, a diagnosis of narcolepsy can be confirmed by three sleep naps.

3.2.2 Sleep Apnea

- Sleep apnea is a potentially lethal condition where the patient stops breathing during sleep. The three types are central, obstructive, and mixed.
- Apnea is defined as a cessation of airflow for at least ten seconds.
- Hypopnea is defined as an abnormal respiratory event lasting at least ten seconds with at least a 30% reduction in thoracoabdominal movement or airflow with at least 4% oxygen desaturations.

3.2.3 Parasomnia

- Parasomnia is a group of conditions that represent undesirable or unpleasant occurrences during sleep. These conditions may include sleepwalking, sleep terrors, and rapid eye movement (REM) sleep behavior disorders.
- Suspected seizure disorders as possible cause of the parasomnia are appropriately evaluated by standard or prolonged sleep EEG studies.

3.2.4 Periodic Limb Movement Disorder (PLMD)

PLMD is an involuntary, repetitive movement disorder during sleep, primarily in the legs that may lead to arousals, sleep disruption, and corresponding daytime sleepiness.

3.2.5 Chronic Insomnia

At least one of the following conditions must be met.

- Etiology is unknown.
- Diagnosis is uncertain.
- Sleep-related breathing disorder or periodic limb movement disorder is suspected.
- A patient is refractory to treatment.
- Violent behaviors are comorbid.
- Circadian dysrhythmias complicate the clinical picture.

3.2.6 Snoring

At least one of the following conditions must be met.

- Disturbed sleep patterns
- Excessive daytime sleepiness
- Unexplained awake hypercapnia
- Apneic breathing
- Cognitive problems
- Excessive fatigue

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria

Procedures, products, and services are not covered when one of the following apply:

- The beneficiary does not meet the eligibility requirements listed in Section 2.0.
- The beneficiary does not meet the medical necessity criteria listed in Section 3.0.
- The procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service.
- The procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Noncovered Criteria

- Sleep studies and polysomnography are not covered when the service is an unattended home study.
- Sleep studies and polysomnography are not considered medically necessary for the following indications:
 - Impotence.
 - Chronic insomnia, except when an underlying physiology exists, such as those listed under **Subsection 3.2**.
 - Snoring, except when an underlying physiology exists, such as those listed under **Subsection 3.2**.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Prior approval is required.

5.2 Previous Testing

Previous testing performed by the attending physician, to the extent the results are still pertinent, should not be duplicated.

5.3 General Requirements

Sleep studies and polysomnography must include recording, interpretation, and reporting.

5.4 Polysomnography Requirements

For a study to be reported as polysomnography, sleep must be recorded and staged. Sleep staging includes but is not limited to the following:

- 1 to 4-lead electroencephalogram (EEG)
- Electro-oculogram (EOG)
- Submental electromyogram (EMG)

- Electrocardiogram (EKG)
- Airflow, ventilation, and respiratory effort
- Oximetry and/or CO2 measurements
- Extremity muscle activity
- Extended EEG monitoring
- Gastroesophageal reflux
- Continuous blood pressure monitoring
- Snoring
- Body positions

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this criteria, providers must:

- Meet Kansas Medicaid qualifications for participation.
- Be currently enrolled in Medicaid.
- Bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

*Note: Refer to **Subsection 2.2** regarding **EPSDT Exception to Limitations for Medicaid Beneficiaries under 21 Years of Age**.*

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the HIPAA and record retention requirements.

8.0 Billing Information

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8.1 Diagnosis Codes

Providers must bill the diagnosis code(s) to the highest level of specificity that supports medical necessity.

Use the following ICD-10 diagnosis codes:

ICD-10-CM Description

E51.5 Nightmare disorder

E51.8 Other sleep disorders not due to a substance or known physiological condition

E66.01 Morbid (severe) obesity due to excess calories

E67.8 Other specified hyperalimentation

G40.101 Localization-related (focal)(partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, with status epilepticus

G40.109 Localization-related (focal)(partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus

G40.111 Localization-related (focal)(partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus

G40.119 Localization-related (focal)(partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus

G40.501 Epileptic seizures related to external causes, not intractable, with status epilepticus

G40.509 Epileptic seizures related to external causes, not intractable, without status epilepticus

G40.802 Other epilepsy, not intractable, without status epilepticus

G40.803 Other epilepsy, intractable, with status epilepticus

G40.804 Other epilepsy, intractable, without status epilepticus

G40.811 Lennox-Gastaut syndrome, not intractable, with status epilepticus

G40.813 Lennox-Gastaut syndrome, intractable, with status epilepticus

G40.814 Lennox-Gastaut syndrome, intractable, without status epilepticus

G40.89 Other seizures

G40.B01 Juvenile myoclonic epilepsy, not intractable, with status epilepticus

G40.B09 Juvenile myoclonic epilepsy, not intractable, without status epilepticus

G40.B11 Juvenile myoclonic epilepsy, intractable, with status epilepticus

G40.B19 Juvenile myoclonic epilepsy, not intractable, without status epilepticus

G47.10 Hypersomnia, unspecified

G47.20 Circadian rhythm sleep disorder, unspecified type

G47.30 Sleep apnea, unspecified

G47.33 Obstructive sleep apnea (adult) (pediatric)

G47.411 Narcolepsy with cataplexy

G47.419 Narcolepsy without cataplexy

G47.421 Narcolepsy in conditions classified elsewhere with cataplexy

G47.429 Narcolepsy in conditions classified elsewhere without cataplexy

G47.61 Periodic limb movement disorder

G47.8 Other sleep disorders

R06.00 Dyspnea, unspecified

R06.09 Other forms of dyspnea

R06.3 Periodic breathing

R06.83 Snoring

R06.89 Other abnormalities of breathing

R09.01 Asphyxia

R09.02 Hypoxemia

R40.0 Somnolence

R40.1 Stupor

8.2 Billing Codes

Providers are required to select the most specific billing code that accurately describes the service(s) provided. Refer to the *CPT*® codebook for complete descriptions.

95782 95783 95805 95807 95808 95810 95811

8.3 Modifiers

Providers are required to follow applicable modifier guidelines.

8.4 Billing Units

- Polysomnography and sleep studies may be billed as a complete procedure or as professional and technical components.
 - Polysomnography and sleep studies are limited to one procedure per date of service by the same or different provider.
 - The technical or the professional component cannot be billed by the same or different provider on the same date of service as the complete procedure is billed.
 - The complete procedure is viewed as an episode of care that may start on one day and conclude on the next day. When billing for the complete procedure, the date that the procedure began is the date of service that should be billed. The complete procedure should not be billed with two dates of services.
 - If components are billed, the technical and the professional components should be billed with the date the service was rendered as the date of service.
- Separate reimbursement is not allowed for the following procedures on the same date of service by the same or different provider.
 - CPT codes 93224 through 93272 with CPT codes 95805 through 95811
 - CPT codes 94760 and 94761 with CPT codes 95805 through 95811
 - CPT code 94772 with CPT codes 95805 through 95806)
 - CPT code 94660 with CPT code 95811
 - CPT codes 95812 through 95827 with CPT codes 95808 through 95811
 - CPT code 92516 with CPT codes 95808 through 95811

8.5 Place of Service

- Inpatient hospital
- Off campus outpatient hospital
- On campus outpatient hospital
- Physician's office

Surgery - Ambulatory/Outpatient

- Ambulatory surgery centers and outpatient hospitals will be reimbursed for multiple unrelated outpatient surgical procedures performed on the same day as follows: 100% of the current Medicaid rate for the highest value procedure, 50% of the current Medicaid rate for the second procedure, and 25% of the current Medicaid rate for all subsequent procedures.
- IVs, medications, supplies, and injections provided on the same day as an ambulatory/outpatient surgery procedure are considered content of service of the surgery and cannot be billed separately.

- **EXCEPTION:** The following thrombolytic enzymes are not considered content of service when billed in conjunction with outpatient surgery: J2997, J2993, J3364, J2995, and J0350.
- Anesthesia (equipment and supplies), drugs, surgical supplies and other equipment of the operating room and the recovery room are considered content of service of the ambulatory/outpatient surgical procedure.

Surgery - Breast Reconstruction

- Breast reconstruction is covered when the beneficiary had a mastectomy for breast cancer on or after March 1, 2005. Only the following breast reconstruction codes are covered.

| Outpatient Codes | | Physician Codes | | |
|------------------|-------|-----------------|-------|-------|
| 11970 | 11971 | 11970 | 11971 | 19316 |
| 19316 | 19340 | 19340 | 19342 | 19350 |
| 19342 | 19350 | 19357 | 19361 | 19364 |
| 19357 | 19366 | 19366 | 19367 | 19368 |
| | | 19369 | 69990 | |

- This coverage is limited to one breast reconstruction process per breast per lifetime.

Surgery - Cosmetic

All surgeries which are cosmetic in nature (and related complications) are not covered. Any medically necessary procedure which could ever be considered cosmetic in nature must receive PA. The hospital must have a copy of your PA for claim processing purposes.

Surgery - Elective

- The Medicaid program will not reimburse for inpatient/outpatient elective surgery unless the beneficiary is a KBH participant. KBH will only cover if the service is medically necessary. Service does require prior authorization.
- Certain surgical procedures will be reviewed on a post-pay random sample basis. Retain all documentation supporting the non-elective nature of the surgery for review. Supporting documentation includes admission notes/ history and physical, operative report and pathology report. If the documentation does not support the non-elective nature of the surgery, reimbursement for all claims relating to the surgery will be recovered.

Therapy

Therapy treatments are not covered for a psychiatric diagnosis.

Habilitative - Therapy treatments performed in the LEA settings may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness. This therapy is covered only for beneficiaries 0 to under 21 years of age. It must be medically necessary.

The purpose of therapy is to maintain maximum possible functioning for children. LEAs billing for occupational, physical, or speech therapy must have the ordering, referring, or prescribing provider's NPI on the claim.

Note: For additional information regarding developmental therapy services, reference General Therapy Guidelines and Requirements in Section 2710 of the KMAP *General Benefits Fee-for-Service Provider Manual*.

Rehabilitative - All therapies must be physically rehabilitative. Therapies are covered only when rehabilitative in nature and provided following physical debilitation due to an acute physical trauma or physical illness and prescribed by the attending care provider.

- Therapy services are limited to six months for non-KBH participants (except the provision of therapy under HCBS), per injury, to begin at your discretion. There is no limitation for KBH participants.
- Care providers of rehabilitative therapy may submit claims with a combination of the following rehabilitation therapy procedure codes and an appropriate diagnosis code. Use diagnosis code Z51.89 as the primary diagnosis. You are required to submit a secondary diagnosis code to describe the origin of the impairment for which rehabilitative therapy is needed when one of these V-codes or Z51.89 is billed as a primary diagnosis.

| | | | | | |
|-------|-------|-------|-------|-------|-------|
| 97010 | 97024 | 97035 | 97124 | 97164 | 97535 |
| 97012 | 97026 | 97036 | 97140 | 97165 | 97750 |
| 97014 | 97028 | 97110 | 97150 | 97166 | |
| 97016 | 97032 | 97112 | 97161 | 97167 | |
| 97018 | 97033 | 97113 | 97162 | 97168 | |
| 97022 | 97034 | 97116 | 97163 | 97530 | |

Transplants

- Heart, lung, and heart/lung transplants performed in approved in-state or border city hospitals are covered.
- Bone marrow, cornea, kidney, and pancreas transplants performed in approved in-state or border city hospitals are covered and do not require PA.
- Pancreas transplants are only covered when performed simultaneously with or following a kidney transplant.
- Services related to donor complications after transplant surgery will be reimbursed up to and including 60 days following the transplant surgery.
 - o These services must be billed under the recipient’s Medicaid ID number.
 - Services related to donor complications more than 60 days after the surgery are the responsibility of the donor and not billable to Medicaid.

Transplants - Heart, Heart-Lung, and Lung

Heart, heart-lung, and lung transplants for adult beneficiaries will require prior authorization and must be performed by Medicare-approved facilities or facilities that are members of the United Network for Organ Sharing (UNOS).

Heart Transplant

Medicaid considers heart transplantation for adults medically necessary for the following indications when the selection criteria listed below are met and none of the absolute contraindications are present:

- Uncontrollable life-threatening arrhythmias
- Cardiac retransplantation due to graft failure

- Cardiomyopathy due to nutritional, metabolic, hypertrophic, or restrictive etiologies
- Congenital heart disease
- End-stage ventricular failure
- Idiopathic dilated cardiomyopathy
- Inability to be weaned from temporary cardiac-assist devices after myocardial infarction or nontransplant cardiac surgery
- Intractable coronary artery disease
- Myocarditis
- Postpartum cardiomyopathy
- Right ventricular dysplasia/cardiomyopathy
- Valvular heart disease

Selection Criteria for Human Heart Transplantation For beneficiaries off protocol, **ALL** of the following criteria must be met.

- New York Heart Association (NYHA) Class III and Class IV for heart failure * (see table)
Note: This does not apply to pediatric beneficiaries.
- Beneficiary has potential for conditioning and rehabilitation after transplant (e.g. beneficiary is not moribund)
- Life expectancy (in the absence of cardiovascular disease) is greater than two years
- No malignancy (except for nonmelanomatous skin cancers) or malignancy has been completely resected or (upon individual case review) malignancy has been adequately treated with no substantial likelihood of recurrence with acceptable future risks
- Adequate pulmonary, liver, and renal function
- Absence of active infections that are not effectively treated
- Absence of active or recurrent pancreatitis
- Absence of diabetes with severe end-organ damage (neuropathy, nephropathy with declining renal function, and proliferative retinopathy)
- No uncontrolled and/or untreated psychiatric disorders that interfere with compliance to a strict treatment regimen
- No active alcohol or chemical dependency that interferes with compliance to a strict treatment regimen

*NYHA Class III and Class IV for heart failure are defined as follows: Class III Persons with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity (e.g., mild exertion) causes fatigue, palpitation, dyspnea, or anginal pain.

- Class IV Persons with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Contraindications

A heart transplant is not covered for persons with any of the following contraindications:

- Presence of systemic diseases (e.g., autoimmune, collagen vascular disease)
- Presence of irreversible end-organ diseases (e.g., renal, hepatic, pulmonary)
- Presence of severe pulmonary hypertension with irreversibly high pulmonary vascular resistance
- Presence of a recent intra-cranial cerebrovascular event with significant persistent deficit

- Presence of bleeding peptic ulcer
- Presence of hepatitis B antigen
- Presence of diverticulitis
- Presence of life-threatening neuromuscular disorders
- Presence of HIV/AIDS with profound immunosuppression (CD4 count of less than 200 cells/mm³)
- Presence of amyloidosis Note: Although amyloidosis is considered a contraindication to heart transplantation, exceptions may be made in circumstances where curative therapy of amyloidosis has been performed or is planned (e.g., stem cell transplantation in primary amyloidosis, liver transplantation in familial amyloidosis).

The following procedures are considered experimental and investigational because safety and effectiveness has not been established, or the clinical value has not been established.

- Xenotransplantation of the heart
- Left ventricular assist device as destination therapy
- Total artificial heart
- Breath test for heart transplant rejection
- AlloMap[®] molecular-expression blood test

These CPT[®] codes are covered: 33940 and 33945.

Heart-Lung Transplant

Kansas Medicaid considers heart-lung transplantation for adults medically necessary for persons with severe refractory heart failure plus either end-stage lung disease or irreversible pulmonary hypertension, when the following selection criteria are met and no absolute contraindications listed below are present. Examples of qualifying conditions include the following:

- Chronic obstructive pulmonary disease with severe heart failure*
- Congenital heart disease associated with pulmonary hypertension that are not amenable to lung transplantation and repair by standard cardiac surgery
- Cystic fibrosis with severe heart failure*
- Eisenmenger's complex with irreversible pulmonary hypertension and severe heart failure*
- Irreversible primary pulmonary hypertension with severe heart failure*
- Pulmonary fibrosis with uncontrollable pulmonary hypertension or severe heart failure*
- Severe coronary artery disease or cardiomyopathy with irreversible pulmonary hypertension
- Severe pulmonary fibrosis with severe heart failure*

* NYHA Class III and Class IV for heart failure (see table in preceding Heart Transplant portion)

Note: Heart-lung transplantation may be considered medically necessary for other congenital cardiopulmonary anomalies upon individual case review.

Selection Criteria

The beneficiary must meet the transplanting institution's selection criteria. In the absence of an institution's selection criteria,

Kansas Medicaid considers heart-lung transplantation medically necessary when ALL of the criteria below are met:

- Absence of chronic high-dose steroid therapy Note: Due to problems in bronchial healing, persons receiving high-dose steroids are considered inappropriate candidates.
- Absence of acute or chronic active infections that are not effectively treated
- Absence of malignancy (other than nonmelanomatous skin cancers) or malignancy has been completely resected or (upon medical review) it is determined that malignancy has been treated with small likelihood of recurrence and acceptable future risks
- Adequate functional status Note: Active rehabilitation is considered important to the success of transplantation. Under established guidelines, mechanically ventilated or otherwise immobile persons are considered poor candidates for transplantation.
- Adequate liver and kidney function, defined as a bilirubin of less than 2.5 mg/dL and a creatinine clearance of greater than 50 ml/min/kg
- Life expectancy (in the absence of cardiopulmonary disease) of greater than two years
- No active alcohol or chemical dependency that interferes with compliance to a strict treatment regimen
- No uncontrolled and/or untreated psychiatric disorders that interfere with compliance to a strict treatment regimen
- Absence of uncontrolled HIV/AIDS, defined as all of the following:
 - CD4 count greater than 200 cells/mm³ for more than 6 months
 - HIV-1 RNA (viral load) undetectable
 - On stable anti-viral therapy more than three months
 - No other complications from AIDS, such as opportunistic infections (e.g., aspergillus, tuberculosis, Pneumocystis carinii pneumonia, toxoplasmosis encephalitis, cryptococcal meningitis, disseminated coccidioidomycosis, other resistant fungal infections) or neoplasms (e.g., Kaposi's sarcoma, non-Hodgkin's lymphoma)

Contraindications

A heart-lung transplant is considered not medically necessary for persons with any of the following contraindications because the risks of transplantation exceed the benefits:

- Gastro-intestinal disease (e.g., bleeding peptic ulcer, diverticulitis, chronic hepatitis, active or recurrent pancreatitis)
- Multisystem disease Note: Persons with potentially multisystem diseases such as systemic sclerosis (scleroderma) or other collagen vascular diseases such as systemic lupus erythematosus must be carefully evaluated to ensure that their disease is primarily confined to the lung. Persons with diabetes must be carefully evaluated to rule out significant diabetic complications such as nephropathy, neuropathy, or retinopathy.
- Other effective medical treatments or surgical options available
- Progressive neuromuscular disease
- Refractory uncontrolled hypertension
- Severe musculoskeletal disease with debilitating thoracic involvement
- Smoking Note: Persons with a history of smoking must be abstinent for at least 3 months before being considered a candidate for a lung transplant.
- Untreated or unstable cerebrovascular disease

These CPT® codes are covered for heart-lung transplantation: 33930 and 33935.

Lung Transplant

Kansas Medicaid considers lung transplantation for adults medically necessary for any of the qualifying conditions for beneficiaries who meet the transplanting institution's selection criteria. In the absence of an institution's selection criteria, beneficiaries must meet both the general selection criteria and any applicable disease-specific selection criteria (see General Selection Criteria portion) and any applicable disease-specific selection criteria (see the Disease-Specific Selection Criteria accompanying the following list of Qualifying Conditions).

Qualifying Conditions for Lung Transplantation (not an all-inclusive list):

- Alpha1-antitrypsin deficiency. Persons who meet the emphysema/alpha1-antitrypsin deficiency disease-specific selection criteria below.
- Broncho-pulmonary dysplasia.
- Congenital heart disease (Eisenmenger's defect or complex): Persons who meet the disease-specific criteria for Eisenmenger's below.
- Cystic fibrosis: Persons who meet the disease-specific selection criteria for cystic fibrosis.
- Graft-versus-host disease or failed primary lung graft.
- Lymphangiomyomatosis (LAM) with end-stage pulmonary disease.
- Obstructive lung disease (e.g., bronchiectasis, bronchiolitis obliterans, chronic obstructive pulmonary disease [COPD], emphysema): For persons with pulmonary fibrosis, see the disease-specific selection criteria for pulmonary fibrosis below.
- Primary pulmonary hypertension: Persons who meet the disease-specific selection criteria for primary pulmonary hypertension.
- Restrictive lung disease (e.g., allergic alveolitis, asbestosis, collagen vascular disease, desquamative interstitial fibrosis, eosinophilic granuloma, idiopathic pulmonary fibrosis, post-chemotherapy, sarcoidosis, and systemic sclerosis [scleroderma]): For persons with sarcoidosis, see the Disease-Specific Selection Criteria below.

Disease-Specific Selection Criteria

- Lung transplant for cystic fibrosis (CF) is considered medically necessary for persons who meet the general selection criteria for lung transplantation and exhibit at least two of the following signs and symptoms of clinical deterioration:
 - o Cycling intravenous antibiotic therapy
 - Decreasing forced expiratory volume in one second (FEV1)
 - Development of carbon dioxide (CO₂) retention (pCO₂ greater than 50 mm Hg)
 - FEV1 less than 30% predicted
 - Increasing frequency of hospital admission
 - Increasing severe exacerbation of CF, especially an episode requiring hospital admission
 - Initiation of supplemental enteral feeding by percutaneous endoscopic gastrostomy or parenteral nutrition
 - Noninvasive nocturnal mechanical ventilation
 - Recurrent massive hemoptysis

- Worsening arterial-alveolar (A-a) gradient requiring increasing concentrations of inspired oxygen (FiO₂)
- Lung transplant for emphysema (including alpha 1-antitrypsin deficiency) is considered medically necessary for persons who meet the general criteria for lung transplantation and both of the following clinical criteria:
 - Hospitalizations for exacerbation of COPD associated with hypercapnia in the preceding year. Hypercapnia is defined as pCO₂ greater than or equal to 50 mm Hg with hospitalizations and/or the following associated factors:
 - Declining body mass index
 - Increasing oxygen requirements
 - Reduced serum albumin
 - Presence of cor pulmonale (defined as clinical diagnosis by a physician or any two of the following:
 - Enlarged pulmonary arteries on chest X-ray
 - Mean pulmonary artery pressure by right heart catheterization of greater than 25 mm Hg at rest or 30 mm Hg with exercise
 - Pedal edema or jugular venous distention
 - Right ventricular hypertrophy or right atrial enlargement on EKG
 - FEV₁ less than 30% predicted
- Lung transplant for Eisenmenger's complex is considered medically necessary for persons who meet the general criteria for lung transplantation and any of the following disease-specific criteria:
 - Marked deterioration in functional capacity (NYHA Class III)
 - Pulmonary hypertension with mean pulmonary artery pressure by right heart catheterization greater than 25 mm Hg at rest or 30 mm Hg with exercise
 - Signs of right ventricular failure, progressive hepatomegaly, ascites
- Lung transplant for pulmonary fibrosis is considered medically necessary for persons who meet the general criteria for lung transplantation and any of the following disease-specific criteria:
 - Diffusing capacity for carbon monoxide (DLCO) less than 60% predicted
 - Presence of cor pulmonale (indicative of severe pulmonary fibrosis) or pulmonary hypertension
 - Total lung capacity (TLC) less than 70% predicted
- Lung transplant for pulmonary hypertension is considered medically necessary for persons who meet the general criteria for lung transplantation plus any of the following criteria, and valvular disease has been excluded by echocardiography:
 - Persons who are NYHA III, failing conventional vasodilators (calcium channel blockers or endothelin receptor antagonists)
 - Persons who are NYHA III, and have initiated or being considered for initiation of parenteral or subcutaneous vasodilator therapy
 - Pulmonary hypertension with mean pulmonary artery pressure by right heart catheterization of greater than 25 mm Hg at rest or 30 mm Hg with exercise, or pulmonary artery systolic pressure of 50 mm Hg or more defined by echocardiography or pulmonary angiography.

Note: NYHA Class III for heart failure is defined as: Persons with cardiac disease resulting in marked limitation of physical activity.

They are comfortable at rest. Less than ordinary activity (i.e., mild exertion) causes fatigue, palpitation, dyspnea, or anginal pain.

- Lung transplant for sarcoidosis is considered medically necessary for persons who meet the general criteria for lung transplantation plus any of the following disease-specific criteria:
 - DLCO less than 60% predicted
 - Presence of cor pulmonale (indicative of severe pulmonary fibrosis) or pulmonary hypertension
 - Total lung capacity less than 70% predicted

General Selection Criteria

The beneficiary must meet the transplanting institution's selection criteria. In the absence of an institution's selection criteria, ALL of the following selection criteria must be met, and none of the contraindications listed below should be present:

- Absence of acute or chronic active infection (pulmonary or nonpulmonary) that is not adequately treated
- Adequate cardiac status (e.g., no angiographic evidence of significant coronary artery disease, ejection fraction greater than 40%, no myocardial infarction in last 6 months, negative stress test). Persons with any cardiac symptoms may require heart catheterization to rule out significant heart disease
- Adequate functional status Note: Under established guidelines, active rehabilitation is considered important to the success of transplantation. Mechanically-ventilated or otherwise immobile persons are considered poor candidates for transplantation
- Adequate liver and kidney function, defined as a bilirubin of less than 2.5 mg/dL and a creatinine clearance of greater than 50 ml/min/kg
- Life expectancy of less than two years
- No active alcohol or chemical dependency that interferes with compliance to a strict treatment regimen

Note: Persons with a history of drug or alcohol abuse must be abstinent for at least three months before being considered an eligible transplant candidate.

- No uncontrolled and/or untreated psychiatric disorders that interfere with compliance to a strict treatment regimen
- Absence of inadequately controlled HIV/AIDS infection, defined as ALL of the following:
- CD4 count greater than 200 cells/mm³ for greater than six months
 - HIV-1 RNA (viral load) undetectable
 - No other complications from AIDS, such as opportunistic infection (e.g. aspergillus, tuberculosis, coccidioidomycosis, resistant fungal infections) or neoplasms (e.g. Kaposi's sarcoma, non-Hodgkin's lymphoma)
 - On stable antiviral therapy greater than three months

Contraindications

Lung transplantation is considered experimental and investigational for persons with the following contraindications to lung transplant surgery because the safety and effectiveness of lung transplantation in persons with these contraindications has not been established.

- Malignancy involving the lung (primary or metastatic) Note: Persons with a history of nonpulmonary cancer must be in remission before being considered a lung transplant candidate. Because of disappointing results, lung transplantation is considered experimental and investigational as a treatment for bronchioloalveolar carcinoma.
- Multi-system disease Note: Persons with potentially multisystem diseases such as systemic sclerosis (scleroderma), other collagen vascular diseases such as systemic lupus erythematosus, or sarcoidosis must be carefully evaluated to ensure that their disease is primarily confined to the lung. Persons with diabetes must be carefully evaluated to rule out significant diabetic complications such as nephropathy, neuropathy, or retinopathy.

- Other effective medical treatments or surgical options available
- Presence of gastrointestinal disease (e.g. bleeding peptic ulcer, chronic hepatitis, diverticulitis)
- Refractory uncontrolled hypertension
- Single-lung transplantation is contraindicated in persons with chronic pulmonary infections (e.g. bronchiectasis, chronic bronchitis, and cystic fibrosis)
- Smoking **Note:** Persons with a history of smoking must be abstinent for 6 months before being considered eligible for lung transplantation.

Kansas Medicaid considers lobar (from living-related donors or cadaver donors) lung transplantation medically necessary for persons with end-stage pulmonary disease when selection criteria are met (see above).

Kansas Medicaid considers lung xenotransplantation (e.g., porcine xenografts) experimental and investigational for any pulmonary conditions because of insufficient evidence in the peer-reviewed literature.

Kansas Medicaid considers prophylactic anti-reflux surgery to improve lung function and survival in lung transplant recipients without gastroesophageal reflux disease as experimental and investigational because of insufficient evidence in the peer-reviewed literature.

The following CPT® codes will be covered for lung transplantation: 32850, 32851, 32852, 32853, and 32854.

Vagal Nerve Stimulators

- Vagal nerve stimulators (VNS) are covered for beneficiaries with epileptic disorders. With the exception of codes 95970 and 95974, all services must be prior authorized.
- VNS services must meet the following conditions:
 - The beneficiary must have an epileptic disorder. VNS will not be covered for beneficiaries with previous epileptic brain surgery or beneficiaries with progressive disorders.
 - Mental retardation with epilepsy is not a contraindication for VNS but must be considered with other factors.
 - All other courses of treatment must be documented, such as conventional and anticonvulsant drugs.
 - There is no age restriction. The beneficiary’s care providers are expected to determine whether or not VNS surgery is appropriate and to document those findings in the medical record.
 - You are expected to maintain adequate documentation, such as “decreased seizure activity” or “improvement in seizure condition.”

Vacuum Assisted Wound Closure Therapy

Vacuum assisted wound closure therapy is covered for specific benefit plans. PA is required and criteria must be met. Refer to the DME Provider Manual for criteria. For questions about service coverage for a given benefit plan, contact Provider Services at 877-542-9235.

Wheelchair Seating Assessments

Effective July 1, 2017, Physical Medicine and Rehabilitation procedure codes 97542, 97755, and 97760 are covered as medically necessary for management of wheelchair seating assessments for all Medicaid beneficiaries. Regardless of care provider,

reimbursement cannot exceed \$500 per beneficiary per year.

Reimbursement for wheelchair seating assessments is limited to these care providers:

- Cerebral Palsy Research Foundation, Wichita, Kansas
- Children’s Mercy Hospital Seating Clinic, Kansas City, Missouri
- KU Medical Center Seating Clinic, Kansas City, Kansas

8.5 Medicaid – Inpatient Only

General Hospital Reimbursement Policies

- Payment for general inpatient hospital services is based on the following equation: DRG weight times (X) group payment rate plus (+) outlier costs, if appropriate.
- Medicaid does not reimburse for days not medically necessary or deemed “not payable” by federal or state laws, regulations, or state policy.
- All DRGs have the potential for day or cost outliers.
- When a stay is eligible for both day and cost outliers, the greater of the two is paid.
- If a Medicaid beneficiary is transferred from one hospital to another, the reimbursement to the transferring hospital will be the DRG daily rate for each covered day of stay. Total payment to the transferring hospital will be no greater than the standard DRG amount, except where the transferring hospital is eligible for outlier payments. The discharging hospital will be reimbursed the standard DRG amount. If the claim qualifies as an outlier, the discharging hospital will be eligible for an outlier payment based solely on the length of stay at the discharging hospital.
- When a Medicaid beneficiary is discharged prematurely and subsequently readmitted within 15 days, only the DRG payment for the first stay will be made if the discharging and readmitting hospital are the same. If the discharging and readmitting hospitals are not the same, only the readmitting hospital will be reimbursed.
- When the Medicaid beneficiary is not eligible for the entire inpatient stay, the DRG payment is prorated and reimbursement is made only for the days the beneficiary was eligible. Reimbursement shall not exceed the standard DRG payment plus any applicable outlier payment. (Only covered days are used to calculate outliers.) If the Medicaid beneficiary’s inpatient hospital stay spans coverage between an MCO and fee-for-service (FFS), the entire stay will be considered by the entity in which the beneficiary was assigned to at the time of admission.
- Hospitals can issue a continued stay denial to a beneficiary only after the attending care provider has written a discharge order. The hospital must supply the beneficiary with the necessary notification that the beneficiary will assume responsibility for payment since a continued stay is not considered medically necessary and is no longer a covered service.
- Admissions or day outliers found to be unnecessary by the utilization review contractor cannot be billed to the beneficiary.
- The discharge date indicated on each claim will determine the version to be used for DRG assignment and reimbursement.

Dental Admissions

Dental admissions are covered when medically necessary. Documentation supporting the medical or dental condition making hospitalization necessary must be in the medical record. PA is required for adults. Medical review is required for children 21 years of age and younger. Claims for this service are to be billed with procedure code 41899 and must include a detailed description of

the actual service provided.

Long-Term Care Units

Long-term care units must be a distinct or separate unit of a hospital certified to provide skilled and/or intermediate care under KanCare subject to the same federal and state rules and regulations as a free-standing adult care home. This includes compliance with federal regulations for standards of care and related reimbursement.

Non-Covered Services

- Take home drugs
- Non-medical hospital supplies (e.g., hospital kits)

Note: A consultation and a hospital visit are not covered when billed on the same date of service by the same care provider.

8.6 Medicaid - Outpatient Only

Blood

- Blood transfusions, including whole blood, red blood cells, plasma, platelets and cryoprecipitate, and IV infusions are covered services.
- Set-ups including volume controller cassettes are content of service of the procedure billed.

Crisis Resolution Services

- Hospitals may be reimbursed when Medicaid patients are admitted to observation/stabilization beds for crisis resolution services in accordance with the following conditions:
 - There is an affiliation agreement between the admitting hospital and the licensed community mental health center.
 - The patient must be referred by the primary care case manager, agency, or health professional currently providing care (whichever is applicable).
 - The patient shall have demonstrated an acute change in mood or thought that is reflected in behavior, indicating the need for crisis intervention to stabilize and prevent hospitalization.
 - The patient must have a diagnosed psychiatric disorder.
 - The patient must not be in need of acute detoxification or experiencing withdrawal symptoms.
 - The patient must be medically stable.
 - The following documentation must be completed:
 - Nursing assessment (including physical review, mental status, and medication)
 - Strength assessment
 - Personal crisis plan
 - At least one progress note

Crisis resolution services are covered up to two consecutive days and must be billed under code H2013.

Developmental Testing

You are reimbursed one visit per day, up to three visits per beneficiary per year, for code 96111.

Diagnostic Tests

Although not all codes are covered, most codes for laboratory, radiology, EKG, EEG, hearing, and speech testing (if provided following physical debilitation) are covered.

Drugs

- All drugs are content of service of surgery. Oral drugs are content of service of emergency treatment. Take-home drugs are non-covered.
- Injections, IVs, blood infusions, and aerosol inhalant additives are covered if not associated with surgery.
- Injections are not covered when billed on the same day as an office visit by the same care provider.

This applies to the following procedure codes:

- Office visit: 99056, 99058, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99281, 99363, 99364, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99397, and X9003WP
- Injection: 95115 and 95117

Electro-Convulsive Treatments

Electro-convulsive treatments are covered and include all ancillary services needed to provide the treatment, including the charge for use of a bed.

Emergency Room Services

- Emergency room (ER) encounters will not deny based on ICD-10 diagnosis codes. Non-emergent claims will be reduced to the 99281 rate.
- Medical necessity documentation must accompany the claim when more than one ER visit is made on the same day for the same individual.

Laboratory

- Handling fee (drawing/collection) is considered content of service of the outpatient visit/lab procedure and is not covered if billed separately. The beneficiary cannot be billed for the drawing or collection since it is considered content of another service or procedure.
- Laboratory procedures performed on inpatients are content of service of the DRG reimbursement to the hospital and should not be billed by either the independent laboratory or hospital.
- Pathologists not contracted by the hospital may bill modifier 26 for pathology services provided on inpatients.

- Reimbursement will only be made for one complete blood count (CBC) per day.
 - Only the care provider performing the laboratory analysis can bill.
 - When ordered laboratory tests make up a panel or profile, the all-inclusive code should be used to bill.
 - Components should not be billed separately.
 - Three or more multichannel tests are considered a SMA/SMAC profile when performed on the same date of service. Medicaid follows the guidelines outlined in the CPT® codebook to identify automated multichannel tests (SMACs, profiles) performed. When billing for a multichannel test use the appropriate code (80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019).
 - Urinalysis (UA) is considered content of service of care provider reimbursement for antepartum care when the UA is obtained for a diagnosis of pregnancy. The hospital/independent laboratory will not be reimbursed by Medicaid for the UA in this situation.
 - Cytogenetic (chromosome) studies are covered for pregnant women (when medically necessary) and KBH participants only. A medical necessity form must accompany the claim when billing for a cytogenetic study for a pregnant woman older than 21 years of age.
 - HIV testing limitations are as follows:
 - Code 87536 is covered with no limits.
 - The following HIV testing codes are limited to four per calendar year, regardless of care provider: 80018 and 80019.
 - The following HIV testing codes are limited to two per calendar year, regardless of care provider: 87901 and 87906.
 - Medical necessity documentation for 87901 must include information that the patient meets at least one of the following criteria:
 - The patient presents with virologic failure during Highly Active Antiretroviral Therapy (HAART).
 - The patient has suboptimal suppression of viral load after initiation of antiretroviral therapy.
- Note:** Refer to the CPT® codebook for complete descriptions of these procedures.

Life Sustaining Therapy

Chemotherapy, radiation therapy, and renal dialysis are covered.

Non-covered Services

Medical supplies used in conjunction with outpatient surgery and/or the emergency room/observation room are considered content of service and cannot be billed separately. The rental or sale of DME and certain prosthetic and orthotic items are not covered.

Operating Room

Anesthesia (equipment and supplies), drugs, surgical supplies, and other equipment of the operating room, the recovery room and supplies are considered content of service of the operating and/or delivery room charges.

Outpatient Procedures

- Outpatient services provided within three days of an admission from the same hospital for the same or similar diagnosis are considered content of service of the inpatient hospital stay. In this instance, bill the outpatient charges together on the inpatient claim. Critical access hospitals are exempt from this requirement and must bill services prior to the point of admission as outpatient.
- There is one exception to this policy, complications from an outpatient sterilization resulting in an inpatient admission. In this instance, the outpatient charges and the inpatient charges should be billed on two separate claims.

Prosthetic & Orthotic Services

- Outpatient hospitals will be allowed to bill the following prosthetic & orthotic codes:

| | | | | | |
|-------|-------|-------|-------|-------|-------|
| L3700 | L3906 | L3912 | L3918 | L3934 | L3948 |
| L3720 | L3907 | L3914 | L3928 | L3938 | L3954 |
| L3845 | L3908 | L3916 | L3930 | L3942 | L3980 |

- DeFlux, an injectable medical device, is covered with PA. Use code L8606.

8.7 Family Planning/Sterilizations

Family Planning

- Family planning is any medically approved treatment, counseling, drugs, supplies, or devices which are prescribed or furnished by you to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.
- Complete the family planning block on the claim form whenever a procedure or service is performed which relates to family planning.
- The following information is provided to facilitate coding the FL 18-28 of the UB-04 claim form. The two-digit indicator A4 is to be placed in this field.
- The following procedures are family-planning related. The Sterilization Consent Form must be attached to the surgeon's claim at the time of submission. Related claims (anesthesia, assistant surgeon, ambulatory surgery center, hospital, or rural health clinic) do not require an attached Sterilization Consent Form. However, if not attached, processing will be delayed until the consent form with the surgeon's claim is reviewed and determined to be correct.

ICD-10-CM Procedure Code (IP) and Code (USE ON AND AFTER OCTOBER 1, 2015)

| IP | Code | | | | | | |
|-----------|-------------|---------|---------|---------|---------|---------|---------|
| 63.70-.73 | 0V5N0ZZ | 0VBN0ZZ | 0VBQ4ZZ | 0VLN0ZZ | 0VLP3ZZ | 0VLQ4ZZ | 0VBQ3ZZ |
| | 0V5N3ZZ | 0VBN3ZZ | 0VTN0ZZ | 0VLN3CZ | 0VLP4CZ | 0VBN0ZZ | 0VBQ4ZZ |
| | 0V5N4ZZ | 0VBN4ZZ | 0VTN4ZZ | 0VLN3ZZ | 0VLP4ZZ | 0VBN3ZZ | 0VTN0ZZ |
| | 0V5P0ZZ | 0VBP0ZZ | 0VTP0ZZ | 0VLN4CZ | 0VLQ0CZ | 0VBN4ZZ | 0VTN4ZZ |
| | 0V5P3ZZ | 0VBP3ZZ | 0VTP4ZZ | 0VLN4ZZ | 0VLQ0ZZ | 0VBP0ZZ | 0VTP0ZZ |
| | 0V5P4ZZ | 0VBP4ZZ | 0VTQ0ZZ | 0VLP0CZ | 0VLQ3CZ | 0VBP3ZZ | 0VTP4ZZ |
| | 0V5Q0ZZ | 0VBQ0ZZ | 0VTQ4ZZ | 0VLP0ZZ | 0VLQ3ZZ | 0VBP4ZZ | 0VTQ0ZZ |
| | 0V5Q3ZZ | 0VBQ3ZZ | 0VLN0CZ | 0VLP3CZ | 0VLQ4CZ | 0VBQ0ZZ | 0VTQ4ZZ |
| | 0V5Q4ZZ | | | | | | |
| IP | Code | | | | | | |
| 66.20-.21 | 0UL74ZZ | 0UL78ZZ | | | | | |
| IP | Code | | | | | | |
| 66.29 | 0UL70ZZ | 0UL73ZZ | 0UL77ZZ | 0UL70ZZ | 0UL73ZZ | 0UL77ZZ | 0UL70ZZ |
| IP | Code | | | | | | |
| 66.31-.32 | 0UL70ZZ | 0UL73ZZ | 0UL77ZZ | | | | |
| IP | Code | | | | | | |
| 66.39 | 0U570ZZ | 0U577ZZ | 0UL70CZ | 0UL70ZZ | 0UL73CZ | 0UL73ZZ | 0UL77DZ |
| | 0U573ZZ | | 0UL70DZ | | 0UL73DZ | | 0UL77ZZ |
| IP | Code | | | | | | |
| 66.92 | 0U550ZZ | 0U563ZZ | 0UL50DZ | 0UL54CZ | 0UL58DZ | 0UL63CZ | 0UL64ZZ |
| | 0U553ZZ | 0U564ZZ | 0UL50ZZ | 0UL54DZ | 0UL58ZZ | 0UL63DZ | 0UL67DZ |
| | 0U554ZZ | 0U567ZZ | 0UL53CZ | 0UL54ZZ | 0UL60CZ | 0UL63ZZ | 0UL67ZZ |
| | 0U557ZZ | 0U568ZZ | 0UL53DZ | 0UL57DZ | 0UL60DZ | 0UL64CZ | 0UL68DZ |
| | 0U558ZZ | 0UL50CZ | 0UL53ZZ | 0UL57ZZ | 0UL60ZZ | 0UL64DZ | 0UL68ZZ |
| | 0U560ZZ | | | | | | |
| IP | Code | | | | | | |
| V25.2 | Z30.2 | | | | | | |

Sterilizations

Hysterectomy

- Hysterectomies are covered only for medically indicated reasons. Medicaid will reimburse for this service only if at least one of the following three conditions is met and documented.

1. The individual or her representative signs the Hysterectomy Necessity Form (found at kmap-state-ks.us/Public/forms.asp) acknowledging receipt of information that the surgery will make her permanently incapable of reproducing.
 2. You certify in writing the individual was already sterile and state the cause or reason for the sterility. This certification must be retained and made available upon request. In order for the claim to process, a statement must be made on the claim indicating the patient was sterile prior to the surgery.
 3. You certify in writing the surgery was performed under a life-threatening situation and individual certification was not possible, including a description of the nature of the emergency. This certification must be retained and made available upon request. In order for the claim to process, a statement must be made on the claim indicating the situation was “life-threatening.”
- A total hysterectomy and the removal of tubes/ovaries cannot be billed as separate procedures when performed by the same care provider.
 - A copy of the Hysterectomy Necessity Form must be attached to the surgeon’s claim at the time of submission. The form is located at kmap-state-ks.us/Public/forms.asp. It may be photocopied for your use. A copy of the Hysterectomy Necessity Form does not have to be attached to related claims (anesthesia, assistant surgeon, hospital, or rural health clinic) at the time of submission. However, a related claim will not be paid until the Hysterectomy Necessity Form with the surgeon’s claim has been reviewed and determined to be correct, unless the related claim has the correct Hysterectomy Necessity Form attached.

Retroactive Eligibility

- If a hysterectomy is performed during a retroactive eligibility period for a Medicaid beneficiary, the performing care provider can sign and submit a statement indicating the retroactive eligibility. This statement must include the following verbiage:
 - The beneficiary has retroactive eligibility.
 - The beneficiary was informed prior to the surgery that the surgery would make her sterile.
- The document does not need to be signed by the beneficiary.
- This information can be documented on the claim; however, you must sign a statement and it must be kept on file and available on request.

Effective with dates of service on and after December 1, 2016, surgical procedures that render the beneficiary sterile (such as hysterectomies) but that are not performed for the purpose of sterilization do not require a Consent for Sterilization form.

Although hysterectomies no longer require a Consent for Sterilization form, all requirements outlined in Hysterectomy Coverage Guidelines must be met, including the requirements related to the Hysterectomy Necessity form.

All Sterilization Guidelines

- Sterilizations on mentally incompetent individuals or individuals institutionalized for mental illness are not covered.
- The following guidelines must be accurately followed before reimbursement can be made for any sterilization procedure (including, but not limited to, hysterectomy, tubal ligation sterilization, and vasectomy). If each item is not followed completely, it will result in the denial of your claim. KMAP or other authorized agencies may ask for documentation at any time, either during the claims processing period or after payment of a claim, to verify services have been provided within program guidelines.

1. The Sterilization Consent Form, mandated by federal regulation, is located on the public and secure websites: kmap-state-ks.us/Public/forms.asp. Instructions on how to complete the Sterilization Consent Form are attached with the form. You may photocopy this form. All voluntary sterilization claims submitted without this specific Sterilization Consent Form will be denied. All fields must be completed, including the care provider signature.
2. The Sterilization Consent Form must be signed at least 30 days prior to the date the sterilization is performed with the following exceptions:

Premature Delivery

- The date of the beneficiary’s consent must be at least three calendar days prior to the date the sterilization was performed.
- The expected date of delivery must be indicated on the consent form and the date of the beneficiary’s consent must be at least 30 days prior to the expected date of delivery.

Emergency Abdominal Surgery

- The date of the beneficiary’s consent must be at least three calendar days prior to the date the sterilization was performed.
- The circumstances of the emergency abdominal surgery must be described by you sufficiently to substantiate the waiver of the 30-day requirement.

Note: Three calendar days are used in the above exceptions to guarantee compliance with the minimum federal requirement of 72 hours.

3. Sterilization Consent Form is valid for 180 days from the date it is signed by the beneficiary. Sterilization claims for individuals that reflect dates of service beyond 180 days from the date the consent form was signed will be denied.
 4. The individual must be at least 21 years of age or older on the date the consent form is signed, or the sterilization claim will be denied. (This includes those situations in which the individual has misrepresented his or her age on the consent form to you). The birth date information provided by KDADS will be used to determine whether the individual meets the age requirement. This information can be obtained through Customer Service.
 5. Sterilizations on mentally incompetent individuals are not covered. “Mentally incompetent individual” is defined as an individual who has been declared mentally incompetent by a federal, state or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilizations” (42 CFR 441.251).
 6. The sterilization is not covered when consent is obtained from anyone in “labor,” under the influence of alcohol or other drugs, or seeking or obtaining an abortion.
 7. Interpreters must be provided when there are language barriers, and special arrangements must be made for handicapped individuals.
 8. Your statement must be signed and dated no more than two days prior to the surgery, the day of the surgery, or any day after sterilization was performed. If this field is left blank, your claim will be denied.
 9. The care provider statement on the consent form must be signed by the care provider who performed the sterilization. No other signatures will be accepted.
- **For dates of service on or before November 30, 2016, when sterilization results from the treatment of a medical condition, a Consent for Sterilization form is required.**

Transcervical Sterilizations

- Code 58579 is not covered for transcervical sterilization procedures. Use code 58565. The procedure must meet all sterilization requirements. PA is required.
- The Essure Kit is included in code 58565 and should not be billed separately. The invoice is not needed.
- If a beneficiary has had a transcervical hysteroscopy sterilization, a federal Sterilization Consent Form is required. Additionally, three months must have passed before performing code 58340. For dates of service prior to October 1, 2015, ICD-9 CM diagnosis code V25.2 must be used to indicate proof of sterilization. For dates of service on and after October 1, 2015, ICD-10 CM diagnosis code Z30.2 must be used. PA is not required.

Appendix I

Codes

Hospital billers to submit claims using the Health Care Financing Administration Common Procedure Code System (HCPCS). HCPCS is a combination of codes which includes CPT® (Current Procedural Terminology) codes created and controlled by the American Medical Association (AMA); Centers for Medicare & Medicaid Services (CMS) codes created and controlled by CMS; and local codes created and controlled by the regional CMS office. HCPCS codes consist of a five-digit base code with the capability of being up to thirteen digits in length when modifiers are used. A modifier code is a two-digit code that identifies a specific type of service, for example, anesthesia, or a variation of the service identified by the base code. Charts have been developed to assist providers in understanding how KanCare will handle specific modifiers. The Coding Modifiers Table and Ambulance Modifiers Table are available online at kmap-state-ks.us/Provider/PRICING/RefCode.asp

Information on the American Medical Association is available at ama-assn.org.

Not all codes are covered. Please use visit kmap-state-ks.us/Provider/PRICING/RefCode.asp to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the beneficiary ID number or benefit plan.

For further assistance, contact Provider Services at 877-542-9235.

All claims must be coded with the appropriate codes. Claims which only describe the service and do not provide the code will be denied. When a code is not available, the service is non-covered by KanCare. Not otherwise classified (NOC) codes are usually non-covered.

Forms

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