



# Medical Policy Manual

**Version 2.11**

**May 2018**

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## Anesthesia Services

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### Description of Service

Anesthesia is defined as the loss of sensation resulting from pharmacologic depression of nerve function or from neurologic dysfunction. Additionally, anesthesia is a broad term for anesthesiology as a clinical specialty.

Anesthesia services may include, but are not limited to, general anesthesia, regional anesthesia, supplementation of local anesthesia, or other supportive services to give a patient the anesthesia care deemed optimal by the anesthesiologist to reduce or mitigate pain during a procedure.

The services include the usual preoperative and postoperative visits, anesthesia care during the procedure, the administration of fluids and/or blood, and the usual monitoring services. For example, electrocardiogram (ECG), temperature, blood pressure, oximetry, capnography, and mass spectrometry. Other monitoring services such as intra-arterial, central venous, and Swan-Ganz are not included.

### Medical Policy

#### Regional or Selective Nerve Block Medical Direction

IHCP reimbursement is available for medical direction of a procedure involving an anesthetist only when the direction is by an anesthesiologist, and only when the anesthesiologist medically directs two, three, or four concurrent procedures involving qualified anesthetists. An anesthesiologist involved in medically directing more than one and up to four procedures may not be personally performing procedures at the same time.

Criteria for medical direction include the following:

- Ensure that only qualified people administer anesthesia.
- Monitor anesthesia at frequent intervals.
- Participate in the most demanding portions of the procedures, including induction and emergence, if applicable.
- Perform the preoperative evaluation.
- Perform the postoperative evaluation.
- Prescribe an anesthesia plan.
- Remain immediately available and not perform other services.

## Regional Anesthesia (Epidural, Nerve Block, Spinal)

IHCP reimbursement is available for regional anesthesia or nerve blocks involving blocking nerve impulses with a local anesthetic, steroid, narcotic, or other agent. It is administered by a physician and requires special techniques and attention, especially during the initial phase of instituting the block.

## Monitored Anesthesia

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

MAC also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications such as; Atropine, Demerol, or Valium, and the provision of indicated postoperative anesthesia care.

## Postoperative Pain Management Services

IHCP reimbursement is available for postoperative epidural catheter management services.

## Anesthesia for Obstetrical Services

IHCP reimbursement is available for anesthesia during obstetrical services under the following conditions:

- General, regional, or epidural anesthesia administered by the same provider who performs the surgical or obstetrical delivery procedure is not reimbursable, as it is included in the surgical delivery fee.
- Providers billing anesthesia services for vaginal or cesarean deliveries must use the appropriate anesthesia CPT® codes.

## Anesthesia for Dental Services

For information on anesthesia for dental services, please refer to the Dental Services Policy Module.

## Prior Authorization

Prior authorization is not required for anesthesia services. For information on anesthesia for dental services, please refer to the *Dental Services* policy module.

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## Billing and Coding

For further billing information, see the [Anesthesia Services](#) provider reference module. For a list of billing codes, see the *Anesthesia Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

[405 IAC 5](#)

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[IHCP Provider Bulletins](#)

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[IHCP Provider Banners](#)

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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

## Cardiac Rehabilitation

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### Description of Service

Progressive exercise programs have demonstrated benefit in the management and rehabilitation of individuals with cardiac disease, especially following certain cardiac events. Cardiac rehabilitation programs are typically divided into three stages.

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

### Medical Policy Required Components

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

Required components include:

- Medical evaluation
- A program to modify cardiac risk factors (e.g., nutritional counseling, assessing smoking status, history and control of diabetes or hypertension, lipid management, weight management, and any psychosocial interventions such as depression screening)
- Prescribed exercise
- Education
- Counseling
- Under the direct supervision of a physician

### Phase I

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



## Phase II

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

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

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

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

- Stable angina pectoris – International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes I20.1 through I20.9 – with reduced activity tolerance substantially altering lifestyle. Stable angina is defined as exertional chest pains with a constant threshold, predictable symptoms, and the ability to adjust one's activity and medications to avoid symptoms. Members who qualify for a Phase II cardiac rehabilitation program are expected to have a functional classification of Class II or Class III on the Canadian Cardiovascular Society Functional Classification, as follows:
  - Class I: Ordinary physical activity, such as walking and climbing stairs, does not cause angina. Angina may occur with strenuous, rapid, or prolonged exertion at work or during recreation.
  - Class II: Slight limitation of ordinary activity, including walking or climbing stairs; rapidly walking uphill; walking or stair climbing after meals, in cold, in wind, or when under emotional stress, or only during the few hours after awakening; walking more than two blocks on a level surface and climbing more than one flight of ordinary stairs at a normal pace and under normal conditions.
  - Class III: Marked limitation of ordinary physical activity, such as walking one to two blocks on a level surface and climbing more than one flight in normal conditions
  - Class IV: Inability to carry on any physical activity without discomfort; anginal syndrome may be present at rest.
- Documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months
- Coronary artery-bypass surgery
- Heart-valve repair/replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- Heart or heart-lung transplant

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

- Continuous electrocardiogram (ECG) telemetric monitoring during exercise



- ECG rhythm strip with interpretation and physician's revision of exercise prescription
- Physician's evaluation to assess the member's performance, adjust medication, or other treatment changes

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

- New patient comprehensive evaluation, including history, physical, and preparation of initial exercise prescription. One comprehensive evaluation is allowed and separately payable at the beginning of the program, if not already performed by the member's attending physician, or if the evaluation performed by the member's attending physician is not acceptable to the program's director. An assessment performed by a nurse or other personnel does not meet this requirement.
- ECG stress test (treadmill or bicycle ergometer) with physician monitoring and report. One is allowed at the beginning of the program and one after three months (usually at the completion of the program). Pharmacologic stress testing may be indicated in certain circumstances and would be allowed with appropriate documentation of medical necessity in the member's medical records.

Cardiac rehabilitation programs may be provided by the outpatient department of a hospital or in a freestanding cardiac rehabilitation facility. The IHCP requires facilities rendering cardiac rehabilitation services to be:

- Staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life-support techniques and in exercise therapy for coronary disease; and
- The facility must have available for immediate use the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary – for example, oxygen, cardiopulmonary resuscitation equipment and defibrillator.

### **Phase III**

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

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

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

**Note:** HIP Basic members are limited to 60 physical therapy (PT), occupational therapy (OT), speech therapy (ST), and pulmonary rehabilitation combined visits annually. HIP Plus members are limited to 75 PT, OT, ST, and pulmonary rehabilitation combined visits annually. HIP Stat Plan members receive the same coverage as Traditional Medicaid members.

## Prior Authorization

Prior authorization is not required for cardiac rehabilitation services.

## Billing and Coding

Phase II cardiac rehabilitation services are to be billed with the appropriate Current Procedural Terminology (CPT®) procedure code, as noted below, and with an appropriate ICD-10-CM diagnosis code, as described below.

According to the ICD-10-CM coding narratives, cardiac rehabilitation that begins within four weeks of the date of the infarction should be coded as I21.01 – I21.4. Cardiac rehabilitation beginning eight weeks or more from the date of the infarction (but less than 52 weeks) should be coded as I25.2 or I25.6.

### CPT® Procedure Codes for Phase II Cardiac Rehabilitation

CPT® Code	Description
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

### ICD-10-CM Diagnosis Codes for Phase II Cardiac Rehabilitation

ICD-10-CM Code	Description
I20.8	Other forms of angina pectoris
I20.9	Angina pectoris, unspecified
I21.01	ST elevation (STEMI) myocardial infarction involving left main coronary artery
I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
I21.11	ST elevation (STEMI) myocardial infarction involving right coronary artery

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ICD-10-CM Code	Description
I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
I21.21	ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery
I21.29	ST elevation (STEMI) myocardial infarction involving other sites
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site
I21.4	Non-ST elevation (NSTEMI) myocardial infarction
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites
I22.9	Subsequent ST elevation (STEMI) myocardial infarction of unspecified site
I25.2	Old myocardial infarction
I25.6	Silent myocardial ischemia
Z48.21	Encounter for aftercare following heart transplant
Z48.280	Encounter for aftercare following heart-lung transplant
Z94.1	Heart transplant status
Z94.3	Heart and lungs transplant status
Z95.1	Presence of aortocoronary bypass graft
Z95.2	Presence of prosthetic heart valve
Z95.3	Presence of xenogenic heart valve
Z95.4	Presence of other heart-valve replacement
Z95.5	Presence of coronary angioplasty implant and graft
Z95.818	Presence of other cardiac implants and grafts
Z98.61	Coronary angioplasty status
Z98.89	Other specified postprocedural states
*Includes nocturnal angina	

It is the responsibility of the provider to code to the highest level specified in the ICD-10-CM (for example, up to seven characters). The correct use of an ICD-10-CM code listed above does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this policy.

The appropriate revenue code for cardiac rehabilitation services is 943. All charges associated with the elements of a cardiac rehabilitation service, as noted previously in this section, including telemetry and supplies for telemetry, are to be included in this charge.

Separate reimbursements for charges for telemetry, electrodes, and so on, are not provided. One unit equals one cardiac rehabilitation visit. The number of units must be shown on the

Uniform Bill- (UB-) 04 in field 46. A stress test may be billed using revenue code 482. The date of onset or surgery must be indicated on the UB-04 in fields 31-36 with occurrence code 11. The date of the first cardiac rehabilitation session must be indicated in fields 32-35 with occurrence code 46. The total number of cardiac rehabilitation visits from the start of care, including the current claim, must be entered on the UB-04 in fields 39-41 with value code 53.

## Reasons for Denial

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

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

## Documentation Requirements

The diagnosis of stable angina should be substantiated with a physician history and physical (H&P), a hospital-discharge summary, or a physician statement to confirm the diagnosis. The member's medical record must contain documentation that fully supports the medical necessity for cardiac rehabilitation, as it is covered by IHCP.

This documentation includes but is not limited to:

- Medical records confirming the diagnosis and evidence of the elements of a cardiac rehabilitation session (e.g., telemetry-monitoring strips)
- Also, the medical record must indicate the medical necessity for unusual frequency or duration of Phase II cardiac rehabilitation.
- The documentation must be specific in terms of exit criteria and/or setbacks that changed the exercise prescription.

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

## Rules and Citations

### [405 IAC 5](#)

- 405 IAC 5-2-17 "Medically reasonable and necessary service" defined

### [IHCP Provider Bulletins](#)

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### [IHCP Provider Banners](#)

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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

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## Update History

January 1, 2017 – Initial Publication

## Chiropractic Services

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### Description of Service

Chiropractic services are defined in *IC § 25-10-1-1* as the diagnosis and analysis of any interference with normal nerve transmission and expression, the procedure preparatory to and complementary to the correction thereof by an adjustment of the articulations of the vertebral column, its immediate articulation, and includes other incidental means of adjustments of the spinal column and the practice of drugless therapeutics.

Chiropractic services are covered for members when the services are provided by a licensed chiropractor. Services such as office visits, physical medicine treatments, laboratory, x-ray, and muscle testing are available to all IHCP members, pursuant to restrictions outlined in the individual's benefit package, when necessitated by a condition-related diagnosis.

### Medical Policy

#### Office Visits

The IHCP limits reimbursement for chiropractic services to a total of 50 units per member per calendar year, which includes a maximum reimbursement of no more than five office visits per member per calendar year.

**Note:** Hoosier Healthwise Package C members are limited to five visits and 14 procedures per member, per rolling 12-month period. Additional procedures that are medically necessary may be reimbursed subject to prior authorization.

Reimbursement is not available for the following types of extended or comprehensive visits:

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

New patient office visits are reimbursable only once per provider per lifetime of the member.

**Note:** Effective January 1, 2018, the IHCP will add coverage of chiropractic services to the HIP Plus benefit plan. The HIP Plus chiropractic benefit covers services provided by a licensed chiropractor when rendered within the chiropractic scope of practice. Coverage does not require prior authorization or a referral from the member's primary medical provider (PMP). Spinal manipulation visits are limited to six per covered person, per benefit year. Only one service per member per day is allowed.



## X-Rays

Reimbursement for x-rays is limited to one series of full spine x-rays per member per year. Component x-rays of the series are individually reimbursable; however, if components are billed separately, total reimbursement is limited to the allowable amount for the series.

Reimbursement for localized spine series x-rays, and for x-rays of the joints or extremities, is allowable only when the x-rays are necessitated by a condition-related diagnosis.

When requested, chiropractors should read images or a copy of the images of the x-ray films previously taken at no cost to IHCP members. The IHCP does not reimburse for additional x-rays that could be necessitated by the failure of a practitioner to forward x-rays or related documentation to a chiropractic provider when requested. Chiropractors are entitled to receive x-rays from other providers at no charge to the member upon the member's written request to the other providers and upon reasonable notice.

## Laboratory Services

Laboratory services are reimbursable only when such services are necessitated by a condition-related diagnosis.

## Prior Authorization

Prior authorization is not required for the following chiropractic services:

- Office visits
- X-ray services
- Laboratory services

Prior authorization is required for muscle testing services, including manual or electrical.

## Billing and Coding

For further billing information, see the [Chiropractic Services](#) provider reference module. For a list of billing codes, see the *Chiropractic Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

[IC 25-10](#) Chiropractors

[405 IAC 5](#)

- 405 IAC 5-5 Out-of-State Services
- 405 IAC 5-12 Chiropractic Services

[405 IAC 13](#)

- 405 IAC 13-11 Chiropractic Services



## [846 IAC 1](#)

- 846 IAC 1 Board of Chiropractic Examiners

## [IHCP Provider Bulletins](#)

- [BT201776](#) IHCP announces upcoming changes to the HIP program
- [BT200329](#) Limited chiropractic services to 50 visits per rolling 12-month period for members effective July 1, 2003.
- [BT200323](#) New rules modifying the IHCP coverage for chiropractic services for all members.

## [IHCP Provider Banners](#)

## [IHCP Provider Reference Materials](#)

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

January 1, 2018 – IHCP adds chiropractic benefits to HIP Plus

## Clinical Trials

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### Description of Service

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

Medicare has established guidelines to cover the routine costs of approved clinical trials, as well as reasonable and necessary items and services used to diagnose and treat complications arising from beneficiaries' participation in clinical trials. The OMPP has accepted Medicare's established guidelines to reimburse for routine costs and complications of clinical trials.

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

### Medical Policy

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

Items or services already covered by the IHCP will be considered routine costs according to existing coverage rules and regulations, even if the item or service is the investigational item or service. The IHCP policy on clinical trials will not render these investigational items or services noncovered.

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

- The subject or purpose of the trial must be the evaluation of an item or service that would be covered under IAC guidelines. The items or service being investigated must not be a non-covered item or service as listed under *405 IAC 5-10-5*, *405 IAC 5-19-18*, *405 IAC 5-24-3*, *5-29-1*, or *405 IAC 5-30-3*.
- If a clinical trial has one objective, it must have a therapeutic intent. If a clinical trial has multiple objectives, it must have a therapeutic intent as a primary objective. It must have

some ability to improve a subject's condition, such as prolongation of life, shrinkage of a tumor, or improved quality of life, even though cure or dramatic improvement may not necessarily be affected. The trial cannot be designed exclusively to test toxicity or disease pathology.

- Trials of therapeutic intervention must enroll only members with diagnosed diseases, rather than healthy members. Trials including diagnostic interventions may enroll healthy members to have a proper control group.
- The clinical trial must be deemed “automatically qualified” under Medicare guidelines. The following clinical trials are deemed automatically qualified:
  - Trials funded by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), CMS, the Department of Defense (DOD), or Veterans Administration (VA)
  - Trials supported by centers or cooperative groups funded by the NIH, CDC, AHRQ, CMS, DOD, or VA, including but not limited to the FDA, the National Heart, Lung, and Blood Institute (NHLBI), the National Human Genome Research Institute (NHGRI), the National Cancer Institute (NCI), the National Institute of Diabetes and Kidney Diseases (NIDDK), the National Institute of Mental Health (NIMH), and others
  - Trials conducted under an investigational new drug (IND) application reviewed by the FDA
  - Drug trials that are exempt from having an IND under *21 CFR § 312.2 (b)(1)*

Items considered routine costs in clinical trials, and thus reimbursable, include the following:

- Items and services that would otherwise be covered by the program if they were not provided in the context of a clinical trial. Examples include nursing/staffing fees, patient monitoring and evaluation, DME, and IV and catheter line placement.
- Items or services required for the administration and provision of the investigational item or service, up to but not including the actual cost of the investigational item or service. Examples include the administration fee for an investigational chemotherapeutic agent, equipment and ancillary staffing for the implantation of an investigational device, provision of a nebulizer to administer an investigational drug, and room and board as part of a hospital stay required as part of the clinical trial.
- Items required for the clinically appropriate monitoring of the effects of the investigational item or service. Examples include ECGs, electroencephalograms (EEGs), and blood pressure monitoring.
- Items and services required for the prevention of complications – for example, the cost of an anti-nausea drug for an investigational chemotherapeutic agent.
- Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service – in particular, for the diagnosis or treatment of

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

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

- The investigational items or services, unless otherwise covered outside the clinical trial. If the investigational item or service is currently covered only for certain medical conditions and is being tested for use outside the scope of coverage, the item or service will be considered investigational and thus, not reimbursable.
- Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient. Examples include monthly CT scans for a condition usually requiring only a single CT scan, weekly blood draws not needed to monitor side effects, and quarterly Papanicolaou (PAP) smears for a condition usually requiring yearly PAP smears.
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

## Prior Authorization

For specific prior authorization requirements for a particular procedure or treatment, see the appropriate policy module.

## Rules and Citations

[21 CFR Part 312](#) Investigational New Drug Application

[21 CFR Part 812](#) Investigational Device Exemption

[21 CFR §§ 405.201](#) and [21 CFR §§ 405.203](#) Class I to III devices

[Medicare National Coverage Determinations Manual, Section 310](#)

[IC 25-22.5-1-2.1](#) Experimental or nonconventional treatment; protocols for treatment

### [405 IAC 5](#)

- 405 IAC 5-10-5 Noncovered services
- 405 IAC 5-19-18 Noncovered durable medical equipment
- 405 IAC 5-24-3 Coverage of legend drugs
- 405 IAC 5-29-1 Noncovered services
- 405 IAC 5-30-3 Noncovered transportation services

[IHCP Provider Bulletins](#)

[IHCP Provider Banners](#)

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## Update History

January 1, 2017 – Initial Publication

## Dental Services

### Description of Service

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

### Medical Policy Oral Evaluations

The IHCP applies the following limitations for oral evaluation codes:

#### Oral Evaluation Limitations

Dental Code	Unit Limitation
D0120	One every six months, per member, per provider
D0140	N/A
D0145	One per year, per member, per provider
D0150	One per lifetime, per member, per provider*
D0160	One per lifetime, per member, per provider*

\*A two-unit limitation applies to any combination of these two codes billed per year, per member with a lifetime limit of one per lifetime, per member, per provider.

Providers should not use D0140 for periodic oral evaluations or other types of evaluations. The IHCP subjects other periodic oral examinations or other types of evaluations that providers bill using D0140 to recoupment. Documentation in the dental and medical records must support that the provider rendered the oral evaluation in compliance with the procedure definition for the dental code used.

### Prophylaxis

Prophylaxis is a covered IHCP service subject to the following age restrictions:

#### Prophylaxis Age Restrictions

Age	Limitation
Under 12 months	No coverage for prophylaxis service unless medical necessity can be established



12 months up until 21 <sup>st</sup> birthday	One every six months (two units per calendar year)
21 years of age or older	One every twelve months (one unit per calendar year)

Institutionalized members may receive up to one unit of prophylaxis every six months, regardless of age.

## Fluoride

Topical fluoride is a covered IHCP service subject to the following age restrictions:

### Fluoride Age Restrictions

Age	Limitation
From first tooth eruption up until 21 <sup>st</sup> birthday	One application every six months (two units per calendar year)
21 years of age or older	No coverage for fluoride varnish

Brush-in fluoride (topical application of fluoride phosphate) is not a covered service. Topical applications are not covered for members 21 years old or older. Services rendered to members younger than 21 years old may be reimbursed for the topical application of fluoride using the brush-on method versus using a dental tray. Topical fluoride includes varnish, gel, or foam.

## Physician Administered Fluoride Varnish

Effective January 1, 2017, the Indiana Health Coverage Programs (IHCP) will cover physician administered fluoride varnish. Physician administered fluoride varnish is a preventive procedure provided by or under the supervision of a physician and is available to members from the time of first tooth eruption up to the age of 4. Providers are required to complete a certified training course ([Fluoride Varnish Training for Health-Care Professionals or Fluoride Varnish Training for Indiana Practitioners](#)) prior to performing and billing for this service.

IHCP recognizes the following types of providers as eligible to render the service:

- Physicians
- Physician Assistants
- Advanced Practice Nurses

Reimbursement is available for one (1) topical application of fluoride every six (6) months per member.

## Radiographs

Radiographs are IHCP covered services subject to the following restrictions:



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## Radiograph Unit Limitations

Age	Unit Limitation
Full mouth radiographs / panoramic x-rays	One set per member every three years
Bitewing radiographs (four horizontal films / seven to eight vertical films)	One set per member every twelve months
Intraoral / Extraoral radiographs	One first film and seven additional films per member every twelve months

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

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

## Space Maintainers

Space maintenance in children with deciduous molar teeth is a covered IHCP service.

### Prior Authorization for Space Maintainers

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

## Dental Extractions

Dental extractions is a covered IHCP service. Extraction of teeth must be medically necessary, and the diagnosis must support the extraction.

## Restorative

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

## Root Planing and Scaling

Periodontal root planing and scaling is a covered IHCP service subject to the following age restrictions:

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## Periodontal Root Planing and Scaling Restrictions

Age	Limitation
Under three years old	No coverage for root planing and scaling
At least three years old but under 21 years old	Four quadrants every two years*
21 years and older	Four quadrants per lifetime

\*Institutionalized members are subject to the same restriction, regardless of age.

Providers must attach documentation that demonstrates that the member has periodontal disease by showing pocket markings or evidence of attachment loss and that the procedure was necessary for the removal of cementum and dentin that is rough, permeated by calculus, or contaminated with toxins or micro-organisms.

## Full Mouth Debridement

The IHCP limits coverage of full mouth debridement services to once per three years per member and one unit per date of service. The IHCP does not require radiographs to be submitted with the claim, but radiographs must be part of the dental record and maintained in the dentist's office.

## Periodontal Surgery

Periodontal surgery is a covered IHCP service for cases of drug-induced periodontal hyperplasia.

### Prior Authorization for Periodontal Surgery

Prior authorization is required for periodontal surgery. Documentation in the patient's record must substantiate that the service was provided for drug-induced periodontal hyperplasia.

## Maxillofacial Surgery

Maxillofacial surgery is a covered IHCP service.

### Prior Authorization for Periodontal Surgery

Prior authorization is required for maxillofacial surgery. IHCP providers may be required, based on the facts of the case, to obtain a second or third opinion substantiating the medical necessity or approach for maxillofacial surgery related to diseases and conditions of the jaws and contiguous structures. The second opinion is required regardless of the surgical setting in which the surgery is to be performed, such as an ambulatory surgical treatment center, a hospital, or a clinic.

## Periodontal Maintenance

Periodontal maintenance is a covered IHCP service subject to the following restrictions:

### Periodontal Maintenance Age Limitations

Age	Limitation
Under three years old	No coverage for periodontal maintenance
At least three years old but under 21 years old	Once every six months per member*
21 years and older	Once every 12 months per member

\*Institutionalized members are subject to the same restriction, regardless of age.

Additional restrictions for periodontal maintenance apply:

- At least one unit of D4341 or D4342 must have been billed with at least six months between the first date of service for D4341/D4342 and the first date of service for periodontal maintenance.
- Providers cannot bill prophylaxis treatment at the same time as or within six months/12 months of a periodontal maintenance treatment.

## Dentures ~~(Partial or Complete)~~ and Partial

Dentures ~~(partial and complete)~~ and partials are covered by the IHCP. Complete and partial dentures are covered for members of all ages, subject to prior authorization. Immediate dentures are covered only for members 21 years of age and older. The IHCP does not reimburse an additional amount for immediate dentures beyond the current denture allowance.

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

The IHCP covers the removable unilateral partial denture-one piece cast metal (including clasps and teeth) for all members.

Repairs and relines of dentures and partials for members 21 years of age and older are subject to Prior Authorization.

### Prior Authorization for Dentures (Full)

Prior authorization is required for dentures for individuals aged 21 years and older. Eight posterior teeth in occlusion - four maxillary and four mandibular teeth in functional contact with each other - are considered adequate for functional purposes.

The request should include any information about bone or tissue changes due to shrinkage, recent tooth loss, weight loss, bone loss in the upper or lower jaw, recent

sickness or disease, or changes due to physiological aging. If the member's primary source of nutrition is parenteral or enteral nutritional supplements, a plan of care to wean the member from the nutritional supplements must be included with the request. If the prosthesis is six years old or older, dentists should indicate on the PA request whether the useful life of the existing prosthesis can be extended by a repair or a reline. Dentists must also include their office telephone number on the PA request, in case the PA analyst has questions.

The dental provider must submit documentation supporting the need for a new denture or partial, including the following:

- The member is edentulous and unable to properly masticate
- If an individual has been edentulous for three (3) or more years, documentation must be submitted at this time. The documentation must include a favorable prognosis, an analysis of the oral tissue issue (for example, muscle tone, ridge height, and muscle attachments), and justification why the patient has been without a prosthesis. If the request indicates an individual has not worn an existing prosthesis for three (3) or more years and no mitigating circumstances were documented by the provider warranting the authorization of a new prosthesis, the PA request will be denied.
- The individual is physically and psychologically able to wear and maintain the prosthesis
- The existing prosthesis requires replacement due to one of the following reasons:
  - The existing prosthesis is six (6) years old or more, beyond repair, and cannot be relined.
  - The base is ill-fitting, the teeth are worn, and the prosthesis cannot be relined.
  - There is severe loss of vertical dimension and the prosthesis cannot be relined.
  - The prosthesis has been lost, destroyed, or stolen. Providers must submit an explanation of the circumstances; otherwise, the PA request will be denied.

### **Prior Authorization for Dentures (Partial)**

Specific requirements for each type of partial denture are listed below:

#### **Acrylic-Resin partial dentures**

Medical necessity must be established.

#### **Cast-metal partial dentures**

Covered only for members with facial deformity due to congenital, developmental, or acquired defects. The need for cast metal partial must be documented in the member's medical record for all members requiring the partials, and the PA request for members 21 years and older must include specific reasons for the request.-

## **Removable unilateral partial denture – one piece cast metal**

Prior authorization is required for members 21 years of age and older.

## **Flexible-based partial dentures**

Covered only for members with a documented allergic reaction to other denture materials, or for members with facial deformity due to congenital, developmental, or acquired defects (such as cleft palate conditions) that require the use of a flexible-base partial instead of an acrylic or cast-metal partial. The need for a flexible-base partial must be documented in the member's medical record for all members, and the PA request for members 21 years of age and older must include specific reasons for the request.-

## **Services Performed Outside the Dental Office**

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

It is not appropriate for providers to bill the IHCP or the IHCP member (or member's family) an additional charge for covered dental services provided in the hospital or surgery center setting.

## **Orthodontics and Oral Surgery**

Orthodontic procedures are covered IHCP services only for members younger than 21 years old. The IHCP recognizes the following orthodontic treatments:

- **Limited Orthodontic treatment** – This is defined as treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive treatment. The IHCP does not accept limited orthodontic treatment as part of a multiphased treatment plan.
- **Interceptive Orthodontic Treatment** – This is defined as treatment for procedures to lessen the severity or future effects of a malformation and to eliminate its cause. It can be considered an extension of preventive orthodontics that may include localized tooth movement. Such treatment may occur in the primary or transitional dentition. An example might be use of a palatal expander to correct a damaging one-sided crossbite.
- **Comprehensive Orthodontic Treatment** – This is defined as treatment of a dentition as a whole. Treatment usually, but not always, uses fixed orthodontic appliances or braces. Comprehensive treatment includes appliances, retainers, and repair or replacement of retainers; these may not be separately billed if comprehensive treatment is rendered.

## **Prior Authorization for Orthodontics and Oral Surgery**

Prior authorization is required for all orthodontic services. PA requests must be submitted on the IHCP Medical PA Form, not the IHCP PA Dental Request Form. The IHCP accepts PA requests for phased orthodontic treatment. One PA is issued per phase of treatment, and the PA lasts for the length of the treatment specified. The IHCP



will reimburse for a maximum of two phases of orthodontic treatment: one interceptive phase and one comprehensive phase.

When requesting multiple phases of orthodontic treatment, providers should use the following guidance:

- Phase 1: request the most appropriate interceptive orthodontic code
- Phase 2: request the most appropriate comprehensive orthodontic code

Members meet the criteria for medical necessity for orthodontic care when it is part of a case involving treatment of craniofacial anomalies, malocclusion caused as the result of trauma, or a severe malocclusion or craniofacial disharmony that includes, but is not limited to:

- Overjet equal to or greater than 9 mm
- Reverse overjet equal to or greater than 3.5 mm
- Posterior crossbite with no functional occlusal contact
- Lateral or anterior open bite equal to or greater than 4 mm
- Impinging overbite with either palatal trauma or mandibular anterior gingival trauma
- One or more impacted teeth with eruption that is impeded (excluding third molars)
- Defects of cleft lip and palate or other craniofacial anomalies or trauma
- Congenitally missing teeth (extensive hypodontia) of at least one tooth per quadrant (excluding third molars)

The members' diagnosis must include information descriptive of facial and soft tissue, skeletal, dental/occlusal, functional, and applicable medical or other conditions.

Diagnostic records required to establish medical necessity include:

- Panoramic radiograph
- Cephalometric radiograph
- Intraoral and extraoral photos

Members with malocclusions associated with a craniofacial anomaly must be diagnosed by a member of a craniofacial anomalies team recognized and endorsed by the American Cleft Palate-Craniofacial Association (ACPA), presumably an orthodontist, and treated by an orthodontist who may or may not be a member of a recognized craniofacial anomalies team.

Members with malocclusions not associated with a craniofacial anomaly may be diagnosed and treated by any orthodontist, whether a member of a recognized craniofacial anomalies team or not. The treating provider is not required to be associated with a recognized craniofacial anomalies team.

## General Anesthesia

General anesthesia provided in the dentist's office is a covered IHCP service only for members younger than 21 years old.

General anesthesia for members 21 years of age and over is a covered IHCP service only if the procedure is performed in an inpatient or outpatient hospital setting or in an ambulatory surgical center.

Preanesthetic medication is a covered service for all.

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

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

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

### Prior Authorization for Dental Anesthesia

Prior authorization is required for general anesthesia for members 21 years of age or older.

## IV Sedation

Intravenous (IV) sedation in a dental office is a covered IHCP service when provided for oral surgery services only.

### Prior Authorization for IV Sedation

Prior authorization is required for IV sedation for members 21 years of age or older.

## Analgesia - Nitrous Oxide

The IHCP covers nitrous oxide analgesia only for members 20 years old and younger.

## Monitored Sedation for Children

Monitored sedation is the administration of subcutaneous, intramuscular, or oral sedation, in combination with monitoring the patient's vital signs. Monitored sedation for children provided in the dentist's office is a covered IHCP service for members younger than 21 years old. The IHCP does not cover non-IV conscious sedation for members aged 21 years or older.



## **Frenulectomy (Frenectomy or Frenotomy)Frenectomy**

A frenectomy-frenulectomy (frenectomy or frenotomy) in the dental setting is a covered IHCP service. There is a restriction of two units per date of service.

### **Prior Authorization for Frenectomy Frenulectomy**

Prior authorization is required for a frenectomyfrenulectomy. Medical necessity must be established, which may include breast-feeding issues, ankyloglossia (tongue-tie), tissue pull, or diastema.

## **Emergency Services**

Palliative treatment of facial pain, such as abscess, incision, and drainage, is limited to emergency treatment only.

IHCP members eligible for only Package E are entitled to emergency services only. For a complete list of the dental codes that can be billed to members eligible for Package E, please see the *Dental Services Codes* on the [Code Sets/Tables](#) webpage.

## **Behavior Management Services**

Effective July 1, 2015, reimbursement for D9920 – *Behavior management, by report* – is limited to once per member, per date of service. Documentation supporting the medical necessity, type, and appropriateness of dental behavior management services must be retained in the member's chart and is subject to postpayment review.

## **Dental Benefit Period for HIP Members**

Healthy Indiana Plan (HIP) dental benefit limits are calculated within a member's "benefit period." Effective January 1, 2018, a member's benefit' period is a calendar-based benefit year (January through December). Dental benefit limitations renew with each new benefit period. Within any benefit period, eligibility for dental benefits is also contingent on the member's HIP eligibility for a specific date of service.

## **Prior Authorization**

Prior authorization is required for the following services:

**Note:** HIP Plus members are eligible for the following dental benefits: evaluation and cleanings (two per person per benefit year), bitewing x-rays (four per person per benefit year), comprehensive x-rays (one complete set every 5 years), minor restorative services (four per person per benefit year), and major restorative services (one per person per benefit year).

- Periodontal sSurgery
- Space maintenance (for children under three years of age or if permanent teeth are missing)
- Frenulectomy (frenectomy or frenotomy)Frenectomy
- Dentures and partials (for members 21 years of age or older)

- Repairs and relines of dentures and partials (for members 21 years of age or older)
- Orthodontics
- General anesthesia (for members 21 years of age or older)
- IV sedation (for members 21 years of age or older)

## Billing and Coding

For further billing information, see the [Dental Services](#) provider reference module. For a list of billing codes, see the *Dental Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

### [405 IAC 5](#)

#### [IHCP Provider Bulletins](#)

- [BT201778](#) IHCP revises PA criteria for orthodontic services and allows for phased treatment
- [BT201776](#) IHCP announces upcoming changes to the HIP program
- [BT201753](#) IHCP to unbundle moderate (conscious) sedation from CPT codes
- [BT201686](#) IHCP adds coverage for physician-administered topical fluoride varnish
- [BT201678](#) Changes to managed care dental benefit managers coming January 1, 2017
- [BT201533](#) IHCP updates coverage for dental behavior management services

#### [IHCP Provider Banners](#)

- [BR201719](#) IHCP recognizes additional certified training course for physicians administering topical fluoride varnish services
- [BR201612](#) IHCP clarifies the dental benefit period for HIP members
- [BR201551](#) IHCP revises unit restriction on CDT procedure code D7960

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication; added coverage language for D5281; added coverage for physician-administered topical fluoride varnish; updated the age restriction for fluoride varnish'

July 1, 2017 – Updated training course for physicians administering topical fluoride varnish services

November 27, 2017 – Updated coverage and PA criteria for orthodontic services and phased orthodontic treatment

## Diabetes Self-Management Training Services

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### Description of Service

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

### Medical Policy

#### Diabetes Self-Management Training

The IHCP will provide reimbursement for diabetes self-management training services under the following conditions:

- When medically necessary
- Ordered in writing by a physician or podiatrist licensed under applicable Indiana law
- Provided by a health care professional licensed under applicable Indiana law
- The health care professional that provides DSMT must have specialized training in the management of diabetes

The health care professional providing the service must have specialized training in the management of diabetes. Some examples of the training include, but would not be limited to the following:

- Accessing community health care systems and resources
- Behavior changes, strategies and risk factor reduction
- Blood glucose self-monitoring, interpreting, and using results for self-management decision making
- Instruction regarding the diabetic disease state, including an understanding of the prevention, detection, and treatment of acute and chronic complications
- Instruction on incorporating nutritional management and physical activity into lifestyle
- Develop personal strategies to address psychosocial issues and concerns
- Develop personal strategies to promote health and behavior change
- Insulin injection
- Foot, skin, eye, and dental care
- Medication counseling
- Preconception care, pregnancy and gestational diabetes

The IHCP defines self-care management training as services provided in accordance with the terms and provisions of IC 27-8-14.5- 6. The IHCP intends these services to enable the patient

to, or enhance the patient's ability to properly manage a diabetic condition, thereby optimizing the therapeutic regimen.

Coverage of DSMT is limited to the following clinical circumstances:

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

The IAC limits coverage to 16 units per member, per rolling calendar year. Each unit is equal to 15 minutes or a total of four hours. Providers can prior-authorize additional units.

**Note:** HIP covered services are limited to physician authorized visits after receiving a diagnosis of diabetes; after receiving a diagnosis that represents a significant change in symptoms or condition and there is a medically necessary change in self-management; and for re-education or refresher training.

## Prior Authorization

Prior authorization is not required for initial units of diabetes self-management training services that do not exceed the established limits for the service. However, additional units may be authorized through the standard PA request process.

The IHCP reviews the documentation for additional requested units of service for evidence of medical necessity. Documentation must be maintained to provide evidence of medical necessity for additional units requested.

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

## Billing and Coding

For further billing information, see the [Diabetes Self-Management Training Services](#) provider reference module. For a list of billing codes, see the *Diabetes Self-Management Training Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

[IC 27-8-14.5-6](#) Coverage for diabetes self-management training

### [405 IAC 5](#)

- 405 IAC 5-36 Diabetes Self-Management Training

[IHCP Provider Bulletins](#)

[IHCP Provider Banners](#)

# Medical Policy Manual

## Office of Medicaid Policy & Planning



- [BR201348](#) The IHCP announces updated HCPCS codes for reimbursement of diabetes self-management training

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial release

## Durable and Home Medical Equipment and Supplies

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### Description of Service

Medical and surgical supplies are:

- Disposable items that are not reusable and must be replaced on a frequent basis
- Used primarily and customarily to serve a medical purpose
- Generally not useful to a person in the absence of an illness or injury
- Covered only for the treatment of a medical condition

DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to a recipient in the absence of illness or injury.

Items include but are not limited to the following:

- Hospital beds
- Wheelchairs
- Iron lungs
- Respirators
- Oxygen tents
- Commodes
- Traction equipment

### Medical Policy (Overall DME) Capped Rental Items

Certain procedure codes are limited to fifteen (15) months of continuous rental. Continuous rental is defined as rental without interruption for a period of more than sixty (60) days. A change in provider does not cause an interruption in the rental period. Claims submitted for capped rental items are reimbursed in the following manner:

- Claims are paid until the number of rental payments made to date reaches the capped rental number of 15 months.
- Claims submitted for rental in excess of 15 total months will be denied.
- Requests for approval of DME capped rental items are evaluated for documentation of long-term need. In long-term situations, a decision may be made to purchase the item.



The use of a piece of equipment during a rental period may be interrupted; however, if the patient resumes use of the equipment within 60 days of the last payment, the original 15-month period remains active. If the interruption period exceeds the 60-day period, and the interruption reasons are justified, a new PA request must be submitted to begin a new 15-month rental period.

The supplier must document the reason for the greater-than-60-day break in the rental period on the IHCP Prior Authorization Request Form. Justification for a break of more than 60 days in the rental period may include the following:

- Change in medical necessity
- Hospitalization
- Nursing facility stay

Unless a new PA is received requesting a new rental period, the original 15-month period remains active. If a member becomes inactive for a period of more than 60 days, a new PA is required to resume services.

Capped rental items are also subject to replacement or servicing when certain criteria are met. Replacement of capped rental items is not authorized more often than once every five years per member, unless there is a change in the member's medical needs, documented in writing, significant enough to warrant a different type of equipment.

During the 15-month capped rental period, the supplier must supply and service the item at no additional charge to the IHCP or the member. However, subject to prior-approval parameters, reimbursement for repair not covered by warranty is not reimbursed more frequently than six months after the 15th month and every six months thereafter, for as long as the equipment is medically necessary.

### **Prior Authorization for Rental Items**

Capped rental items are subject to prior authorization.

### **Inexpensive or Other Routinely Purchased Items**

Inexpensive or routinely purchased DME is defined as equipment whose purchase price does not exceed \$150, or equipment that is acquired at least 75 percent of the time by purchase. Equipment in this category may be purchased or rented. The decision to rent or purchase DME is based on the least expensive option available for the anticipated period of need. DME items purchased with IHCP funds become the property of the OMPP.

Purchases are reimbursed in lump sums, minus any previous rental payments. If the equipment is rented, the IHCP will allow monthly rental payments until the rental price equals the purchase price.



## Items Requiring Frequent or Substantial Servicing

For items requiring frequent or substantial servicing, the IHCP reimburses providers for rental payments only, as long as the equipment is deemed medically necessary. Claims for the purchase of these items are denied. As noted in *405 IAC 5-19-4*, repair of rental items is the responsibility of the rental provider.

## Customized Items

Custom equipment is defined as equipment uniquely constructed or substantially modified to meet the specific needs of an individual patient, according to the description and orders of the member's treating physician. Due to the unique aspects, these items cannot be grouped with similar items for purposes of payment.

Suppliers must submit documentation of the costs of the item, including the cost of labor and types of materials used in customizing the item. A material and labor itemization and a manufacturer's cost invoice must be attached to the claim when submitted for payment. Each item on the invoice is reviewed when calculating the reimbursement amount for all customized items.

The following are examples of items that are not considered customized items:

- Items that are individually constructed but that have standard costs and charges, and that can be billed using a national HCPCS code
- A wheelchair that is ordered in individual parts from one or multiple manufacturers and assembled by the supplier
- A wheelchair that is ordered from a manufacturer that makes available special features, modifications, or components cannot be considered a customized wheelchair.

### Prior Authorization for Customized Items

Customized items require prior authorization.

## Repair and Replacement of DME

The IHCP reimburses for labor costs associated with the repair and servicing of DME. Repairs of prosthetic and orthotic devices, hearing aids, and augmentative communication devices should be billed using the appropriate repair codes for those devices.

The IHCP will not pay for labor for the repair of DME under the following circumstances:

- IHCP does not pay for repair of equipment still under warranty.
- No payment is authorized for repair necessitated by member misuse or abuse, whether intentional or unintentional.
- Repairs for rental equipment are the responsibility of the rental provider.

- Maintenance charges of properly functioning equipment are not covered.
- Repair costs for DME included in a LTC facility's per diem rate is also included in the per diem rate.

In addition, the IHCP will reimburse for tasks considered to be labor or non-routine servicing of DME. The IHCP will not reimburse for the following types of services:

- Evaluation of a member for a wheelchair or seating system
- Patient education in the use and care of DME
- Measurement of recipient for DME
- Initial assembly of DME

The IHCP will reimburse for the replacement of medically necessary DME under the following circumstances:

**Loss of the item from theft, fire, or natural disaster:**

- If the equipment being replaced does not require PA and does not have a limit restriction, the provider may directly bill for the item. The provider should maintain documentation in his or her records to support the reason for replacement. This documentation would be subject to post-payment review.
- If the item requires PA, the provider must submit a new PA request for the item, including an explanation that the item was lost due to theft or fire. The provider should maintain documentation in his or her records to support the reason for replacement. This documentation is subject to post-payment review.
- If the item has a limit restriction, whether or not the DME item requires PA, the provider should submit a PA request for a replacement item with an explanation that the original item was lost due to natural disaster, fire, or theft. The provider should maintain documentation in his or her records to support the reason for replacement. This documentation would be subject to post-payment review.

**Irreparable damage or wear:**

- Replacement of large DME items is not authorized more than once every five years per member. More frequent replacement is allowed only if there is a change in the member's medical needs.

**Change in the member's condition that requires a change in equipment:**

- These changes must be documented by the member's physician, and a request must be sent to the PA Department demonstrating a significant change warranting new equipment.

## Modifications to DME

The IHCP may make additional payment for modifications to DME. Examples of some modifications to wheelchairs after their assembly are attachments to convert a wheelchair to a one-arm drive, or the addition of brake extensions, wheelchair hand rims, or anti-tipping devices.

## Routine Maintenance

Payment for routine maintenance of properly functioning equipment is not covered by the IHCP. Routine maintenance includes services such as testing, cleaning, regulating, and checking equipment that does not require a technician's skill.

## Medical Policy (Specific Items)

### Artificial Heart

An artificial heart is a biventricular replacement device that requires removal of a substantial part of the native heart, including both ventricles. Removal of this device is not compatible with life, unless the patient has a heart transplant.

Artificial Hearts are most commonly used as a bridge-to-transplant. Bridge-to-transplant for an artificial heart is indicated for candidates with end-stage heart failure (NYHA Class IV) whose hemodynamic status deteriorates despite treatment including the use of a VAD. Artificial hearts for use as destination therapy is a non-covered service.

### Covered Services for Bridge-to-Transplant

Artificial heart for bridge-to-transplant is covered by the IHCP for members who meet the following criteria:

- The member must be at risk of imminent death from nonreversible biventricular heart failure (NYHA Class IV).
- The member does not respond to other treatments
- The member has been prior authorized for a heart transplant (excluding dual eligible members).
- The member is listed as a candidate for heart transplantation by a Medicare/Medicaid approved heart transplant center.
- If the artificial heart is implanted at a different site than the Medicare/Medicaid approved transplant center, the implanting site must receive written permission from the Medicare/Medicaid approved center under which the patient is listed prior to implantation of the artificial heart.

## Non-covered Services

- Use of a non-FDA approved artificial hearts is considered investigational and is a non-covered service.
- Use of a FDA approved artificial heart in a manner that is not approved by the FDA is considered investigational and is a non-covered service.
- The artificial heart is non-covered for bridge-to-destination therapy.
- Artificial heart is non-covered for treatment of postcardiotomy cardiogenic shock.

## Prior Authorization for Artificial Heart

Prior authorization is required for implantation of an artificial heart. To be eligible for implantation of an artificial heart, the member must first have an approved prior authorization request for a heart transplant. Additionally, documentation must be provided showing that the member is currently listed as a heart transplantation candidate or is undergoing evaluation to determine candidacy for heart transplantation and is not expected to survive until a donor heart can be obtained.

If the artificial heart is implanted at a different site than the Medicare/IHCP approved transplant center, the implanting site must receive written permission from the Medicare/IHCP approved center under which the patient is listed prior to implantation of the artificial heart.

## Augmentative Communication Devices

An augmentative communication device is a device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. This term includes only that equipment used for the purpose of communication, including both electronic and non-electronic devices. The IHCP provides reimbursement for an augmentative communication device when the device is ordered in writing by a medical doctor or doctor of osteopathy.

## Prior Authorization for Augmentative Communication Devices

Prior authorization is required for an augmentative communication device. Medical necessity documentation must be provided on, or attached to, the prior authorization request form submitted by the requesting practitioner. A clinical evaluation by a speech pathologist, substantiating the medical necessity for the communication device, must be submitted as part of the prior authorization request.

Authorization for the device may be granted only upon satisfaction of all of the following:

- Documentation must be presented that substantiates that the member has demonstrated sufficient mental and physical capabilities to benefit from the use of the system
- Documentation must be presented that substantiates the member, in the absence of a communication device, cannot effectively make himself or herself understood by others in his or her communication environment
- Documentation must be presented that substantiates the member's medical condition is such that at least two (2) years of use of the device by the member can reasonably be expected.
- Documentation must be presented that:
  - Identifies all communication devices that would meet the member's needs, taking into account the physical and cognitive strengths and weakness of the member and the member's communication environment; and
  - Recommends the least expensive communication device
- Documentation that the device will be used for compensation for loss or impairment of communication function

## Automatic External Defibrillators

The IHCP covers two types of automatic external defibrillators for individual use. The first is a stand-alone model referred to simply as an automatic external defibrillator (AED). The second type of automatic external defibrillator is the wearable cardioverter defibrillator (WCD).

AEDs and WCDs are indicated for members who normally are candidates for an implanted cardioverter defibrillator (ICD), but for whom ICDs are contraindicated or need to be removed. These defibrillators are most often used for members who are awaiting heart transplants, who have recently had heart attacks, or who have had their ICDs removed due to ICD pocket infections. The average time of use is approximately two to three months, although some members awaiting transplant have used the device for more than one year.

If a defibrillator is indicated, the decision to prescribe the AED versus the WCD should be the physician's, in consultation with the member. The option of an AED or a WCD is a clinical decision, influenced by the practical matters discussed above. It should be noted that WCD is a fully automated device i.e. no human intervention is required for it to deliver shock therapy, whereas an AED requires human intervention to recognize a collapsed patient, obtain, apply, and subsequently activate the AED apparatus. This also deserves consideration when deciding which device strategy is most suitable for a given patient.



## Prior Authorization (For the Device)

Prior authorization is required for both AEDs and WCDs using the same PA criteria. Members must meet either **both** criteria A and B **or** criterion C.

### A. The member has one of the following conditions:

- A documented episode of cardiac arrest due to VF, not due to a transient or reversible cause<sup>1</sup>
- A sustained (lasting 30 seconds or longer), ventricular tachyarrhythmia, either spontaneous or induced during an electrophysiologic (EP) study, not associated with acute MI<sup>2</sup>, and not due to a transient or reversible cause
- Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmias, such as long QT syndrome, hypertrophic cardiomyopathy, Brugada syndrome, arrhythmogenic right ventricular cardiomyopathy/dysplasia and familial dilated cardiomyopathy.”
- Coronary artery disease with a documented prior MI, with a measured left ventricular ejection fraction (LVEF)<sup>3</sup> less than or equal to 0.35, and inducible, sustained VT or VF during an EP study. To meet this criterion **both (a) and (b)** below must occur:
  - The MI must have occurred more than four weeks prior to the external defibrillator prescription; and
  - The EP test must have been performed more than four weeks after the qualifying MI.
- Documented prior myocardial infarction (MI) and a measured LVEF less than or equal to 0.30. Patients must not have:
  - New York Heart Association (NYHA) classification IV; or
  - Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm; or
  - Had a coronary artery bypass graft (CABG) or PTCA within the past three months; or
  - Had an enzyme-positive MI within past month; or
  - Clinical symptoms or findings that would make them candidates for coronary revascularization; or
  - Irreversible brain damage from preexisting cerebral disease; or

<sup>1</sup> Transient or reversible causes include conditions such as drug toxicity, severe hypoxia, acidosis, hypocalcemia, hyperkalemia, systemic infections, and myocarditis (not all-inclusive).

<sup>2</sup> MIs must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram. Ejection fractions must be measured by angiography, radionuclide scanning, or electrocardiography.

<sup>3</sup> MIs must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram. Ejection fractions must be measured by angiography, radionuclide scanning, or electrocardiography.



- Any disease, other than cardiac disease (for example, cancer, uremia, liver failure) associated with a likelihood of survival of less than one year.
- Non-ischemic dilated cardiomyopathy with measured LVEF less than or equal to 35% of at least 3-9 months duration with NYHA functional Class II or III while on maximally tolerated guideline-directed medical therapy.

B. Implantation surgery is contraindicated.

C. A previously implanted defibrillator now requires removal.

Claims for defibrillators for other indications will be denied as not medically necessary. The IHCP will not purchase both an AED and WCD for one member, nor rent an AED and a WCD simultaneously for one member.

### **Prior Authorization (For AED and WCD Accessories)**

PA criteria for accessories are based on the estimated average life expectancies of the accessories.

For replacement batteries:

- The member must currently be renting or have purchased an AED or WCD.
- The battery being replaced must be at least 11 months old or completely discharged.

For replacement garment (only for WCD):

- The member must currently rent or have purchased a WCD with integrated ECG analysis, garment type.
- The garment must be damaged or worn beyond repair and have been in use at least five months.

For replacement electrodes:

- The member must currently rent or have purchased an AED or the WCD with integrated ECG analysis, garment type.
- The electrodes being replaced must have been used for at least 22 months, or it must be proven that the equipment is broken or damaged beyond repair.

## **Cardiac Pacemakers**

Cardiac pacemakers are self-contained, battery-operated units that send electrical stimulation to the heart. They are generally implanted to alleviate symptoms of decreased cardiac output related to abnormal heart rate and/or rhythm. Pacemakers are generally used for persistent, symptomatic second- or third-degree atrioventricular (AV) block and symptomatic sinus bradycardia.

IHCP reimbursement is available for implantation of cardiac pacemakers and monitoring when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization and appropriate referrals for recipients enrolled in MCE programs.

## **Single Chamber Cardiac Pacemaker Implantation**

IHCP reimbursement is available for implantation of the single chamber cardiac pacemakers provided the conditions are:

- Chronic or recurrent condition
- Not due to transient causes, such as acute myocardial infarction (MI), drug toxicity, or electrolyte imbalance.

And meet any of the following conditions:

- Acquired complete (also referred to as third degree) AV heart block.
- Congenital complete heart block with severe bradycardia in relation to age or significant physiological deficits or significant symptoms due to the bradycardia.
- Second degree AV heart block of Type II.
- Second degree AV heart block of Type I.
- Sinus bradycardia associated with major symptoms or substantial sinus bradycardia with heart rate less than fifty (50) associated with dizziness or confusion. The correlation between symptoms and bradycardia must be documented, or the symptoms must be clearly attributable to the bradycardia rather than to some other cause.
- Sinus bradycardia of lesser severity (heart rate fifty (50) to fifty-nine (59)) with dizziness or confusion. The correlation between symptoms and bradycardia must be documented, or the symptoms must be clearly attributable to the bradycardia rather than to some other cause.
- Sinus bradycardia, which is the consequence of long term necessary drug treatment for which there is no acceptable alternative, when accompanied by significant symptoms. The correlation between symptoms and bradycardia must be documented, or the symptoms must be clearly attributable to the bradycardia rather than to some other cause.
- Sinus node dysfunction, with or without tachyarrhythmias or AV conduction block, when accompanied by significant symptoms.
- Sinus node dysfunction, with or without symptoms, when there are potentially life-threatening ventricular arrhythmias or tachycardia secondary to the bradycardia.
- Bradycardia associated with supraventricular tachycardia with high degree AV block, which is unresponsive to appropriate pharmacological management and when the bradycardia is associated with significant symptoms.
- Hypersensitive carotid sinus syndrome with syncope due to bradycardia and unresponsive to prophylactic medical measures.

- Bifascicular or trifascicular block accompanied by syncope, which is attributed to transient complete heart block after other plausible causes of syncope have been reasonably excluded.
- Prophylactic pacemaker use following recovery from acute myocardial infarction during which there was temporary complete (third degree) or Mobitz Type II second degree AV block in association with bundle branch block.
- Recurrent and refractory ventricular tachycardia, overdrive pacing (pacing above the basal rate) to prevent ventricular tachycardia.
- Second degree AV heart block of Type I with the QRS complexes prolonged.

Reimbursement is not available for implantation of the single-chamber pacemaker for the following:

- Syncope of undetermined cause.
- Sinus bradycardia without significant symptoms.
- Sinoatrial block or sinus arrest without significant symptoms.
- Prolonged PR intervals (slow ventricular response) with atrial fibrillation without third degree atrial ventricular (AV) block.
- Bradycardia during sleep.
- Right bundle branch block with left axis deviation and other forms of fascicular or bundle branch blocks without significant signs or symptoms.
- Asymptomatic second degree AV block of Mobitz Type I (Wenckebach).

### **Dual Chamber Cardiac Pacemaker Implantation**

IHCP reimbursement is available for implantation of the dual chamber cardiac pacemaker provided the conditions are:

- Chronic or recurrent condition
- Not due to transient causes, such as acute myocardial infarction (MI), drug toxicity, or electrolyte imbalance.

And meet any of the following conditions:

- A definite drop in blood pressure, retrograde conduction, or discomfort during insertion of a single-chamber (ventricular) pacemaker.
- Pacemaker syndrome (atrial ventricular asynchrony) with significant symptoms with a pacemaker that is being replaced.
- A condition in which even a relatively small increase in cardiac efficiency will importantly improve the quality of life.
- A condition in which the pacemaker syndrome can be anticipated.

- Dual-chamber pacemakers will be covered for the conditions listed under the single chamber pacemaker implantation if determined to be medically necessary.
- Prophylactic pacemaker use following recovery from acute myocardial infarction during which there was temporary complete (third degree) or Type II second degree AV block in association with bundle branch block.

Reimbursement is not available for implantation of the dual-chamber pacemaker for the following:

- Ineffective atrial contractions.
- Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of the tachycardia.
- A clinical condition in which pacing takes place only intermittently and briefly and is not associated with a reasonable likelihood that pacing needs will become prolonged.

### Monitoring of Pacemakers

The IHCP provides reimbursement for clinic and telephone monitoring of cardiac pacemakers when the frequency of monitoring does not exceed the following unless medically necessary:

- For clinic monitoring of lithium battery pacemakers with single-chamber pacemakers:
  - Twice in the first six (6) months following implant, then once every twelve (12) months.
- For clinic monitoring of lithium battery pacemakers with dual-chamber pacemakers:
  - Twice in the first six (6) months following implant, then once every six (6) months.
- For clinic monitoring of lithium battery pacemakers with single- or dual-chamber pacemakers within the final twelve months of anticipated pacemaker battery depletion:
  - Up to once every two months for patients with documented pacemaker dependence without access to telephone monitoring.
- For clinic monitoring of lithium battery pacemakers with single- or dual-chamber pacemakers demonstrating documented evidence of pacing system failure or malfunction:
  - Increased follow-up frequency will be covered if determined to be medically necessary.
- For telephone monitoring with single-chamber pacemaker following the first month of the implant:
  - Once every two (2) weeks.
- For telephone monitoring with single-chamber pacemaker following the second month of the implant through the thirty-sixth month:
  - Once every eight (8) weeks.

- For telephone monitoring with single-chamber pacemaker following the thirty-seventh month of the implant through failure:
  - Once every four (4) weeks.
- For telephone monitoring with dual-chamber pacemaker following the first month of the implant:
  - Once every two (2) weeks.
- For telephone monitoring with dual-chamber pacemaker following the second through the sixth month of the implant:
  - Once every four (4) weeks.
- For telephone monitoring with dual-chamber pacemaker following the seventh through the thirty-sixth month of the implant:
  - Once every eight (8) weeks.
- For telephone monitoring with dual-chamber pacemaker following the seventh through the thirty-seventh month through failure of the implant:
  - Once every four (4) weeks.

### **Prior Authorization for Pacemakers**

Prior authorization is not required for the implantation of a pacemaker when performed in an outpatient setting.

## **Continuous Glucose Monitors**

Continuous Glucose Monitors (CGM) are FDA-approved devices used to record ongoing glucose levels in interstitial fluid. CGM monitoring provides information about glucose fluctuations which would otherwise not be obtained with traditional testing methods and alerts the user of impending dangerously low blood sugar. The purpose of continuous glucose monitoring is to provide additional information to the provider and the member in order to aid improved glycemic control and prevent dangerously low blood sugars.

Continuous Glucose Monitors are reimbursable for all ages by the IHCP for both short-term and long-term use when considered medically necessary:

- The member must not have achieved the American Diabetes recommended target hemoglobin A1C despite consistent self-blood glucose monitoring AND/OR, the member has evidence of insulin-induced hypoglycemia occurring multiple times per week
- The member must have shown compliance in their own care
- The member must have one of the three types of diabetes
- The member must show continued suboptimal diabetes control while utilizing multiple daily injections of insulin or an insulin pump to manage glucose levels



- The device used must be approved by the FDA for use in the age range appropriate for the member

### **Short-Term Continuous Glucose Monitoring – Up to 72 hours**

IHCP reimbursement is available for a continuous glucose monitor for up to 72 hours (three days) as an evaluation tool for providers to treat members who have not obtained acceptable glycemic control. The CGM is deemed medically necessary when the following criterion is met. Members must be compliant with their own care and had been instructed by a health care professional regarding diabetic management. The member must also meet **one** of the following:

- Have Type 1 diabetes
- Have Type II insulin dependent diabetes
- Be a pregnant woman with either type 1, type 2, or gestational diabetes.

The member must also have:

- Suboptimal glycemic control despite compliance with multiple daily injections of insulin (minimum of 3 injections per day) and documented frequency of standard self-monitoring of blood glucose (minimum of four times per day)
  - Hemoglobin A1C is >7.0% (ADA recommended goal)
  - Evidence of insulin-induced hypoglycemia (<50 mg/dL) occurring multiple times per week Episodes of diabetic ketoacidosis or hypoglycemia resulting in loss of consciousness, seizure, or need for emergency health services

Starting or reinitiating insulin or an insulin pump The 72 hour continuous glucose monitoring device should be used on appropriate periodic basis (as determined by medical necessity) in order to direct changes in diabetic management.

### **Long-Term Continuous Glucose Monitoring:**

IHCP reimbursement is available for long term continuous glucose monitoring when considered medically necessary and the following criteria has been met:

The member must be compliant and meet **one** of the following:

- Have Type 1 diabetes
- Have Type II insulin dependent diabetes
- Be a pregnant woman with either type 1, type 2, or gestational diabetes

The member must also have **one** of the following:

- Suboptimal glycemic control despite compliance with multiple daily injections of insulin (minimum of 3 injections per day) and documented frequency of standard self-monitoring of blood glucose (minimum of four times per day)Evidence of insulin-induced hypoglycemia (<50 mg/dL) occurring multiple times per week



- History of hypoglycemic unawareness resulting in loss of consciousness, seizure, or need for emergency health services
- An insulin pump used for maintenance of blood sugar control.

### **Prior Authorization for Continuous Glucose Monitors**

Prior authorization must be obtained for use of short-term and long-term continuous glucose monitors based upon the criteria above. The monitoring must be performed for a minimum of 24 hours. If the service is performed less than 24 hours, the service is not considered medically necessary.

## **CPAP and BiPAP Devices**

Non-invasive positive pressure respiratory assist (NPPRA) devices administer positive pressure using a nasal and/or oral mask interface, which creates a seal, avoiding the use of more invasive airway access (e.g., tracheostomy). These devices are sometimes applied to assist insufficient respiratory efforts in the treatment of conditions that may involve sleep-associated hypoventilation. Non-invasive respiratory assist is distinguished from the invasive ventilation administered via a securely intubated airway in a member for whom interruption or failure of ventilatory support would lead to the member's demise. These devices are referred to as respiratory assist devices (RADs). The three types of RADs are as follows:

- CPAP devices
- BiPAP with a backup rate feature
- BiPAP without a backup rate feature

### **CPAP Devices**

The IHCP reimburses for CPAP for members meeting **one** of the following criteria:

- A diagnosis of OSA with an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) equal to or greater than fifteen (15) events per hour, documented in a recorded polysomnography
- A diagnosis of OSA with an AHI or RDI from five (5) to fourteen (14) events per hour documented in a recorded polysomnography with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia or hypertension, ischemic heart disease, or history of stroke
- A diagnosis of moderate or severe OSA in a member for whom surgery is a likely alternative to CPAP

**Note:** "Apnea" is the cessation of airflow for at least ten (10) seconds documented on a polysomnogram "Hypopnea" is an abnormal respiratory rate lasting at least ten (10) seconds associated with at least a thirty percent (30%) reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least four percent (4%) decrease in oxygen saturation. The AHI is the average number

of apneas and hypopneas per hour and, for purposes of this policy, must be based on a minimum of six (6) hours of recorded sleep (for example, a polysomnogram), and may not be extrapolated or projected.

Copies of the member's sleep lab evaluation, including a polysomnogram, must be retained in the physician's record.

**Note:** Polysomnography is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six or more hours with physician review, interpretation, and report. It must include sleep staging, which is defined to include a one- to four-lead EEG, electro-oculogram (EOG), and submental EMG. It must also include at least the following parameters of sleep: air flow, respiratory effort, and oxygen saturation by oximetry. For the purpose of this policy, polysomnographic studies must be performed in a sleep-study laboratory, not in the home or in a mobile facility. Testing must comply with all applicable state regulatory requirements.

## BiPAP Devices

The IHCP provides reimbursement for a BiPAP without backup rate or a BiPAP with backup rate for members meeting the specified criteria:

- Coverage will be considered when the physician's documentation includes a statement stating the member is experiencing symptoms of sleep associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc., and
- Medical necessity must be documented.

BiPAP devices will be covered for the first three months of treatment for members with clinical disorder groups characterized as:

### Restrictive Thoracic Disorders:

- There is documentation in the member's medical record of a progressive neuromuscular disease (for example, amyotrophic lateral sclerosis) or a severe thoracic-cage abnormality (for example, post-thoracoplasty for tuberculosis), and
- An arterial blood gas PaCO<sub>2</sub>, done while the member is awake and breathing the member's usual FIO<sub>2</sub>, is greater than or equal to 45 mm Hg, or
  - Sleep oximetry, done while breathing the member's usual FIO<sub>2</sub>, demonstrates oxygen saturation of less than or equal to 88 percent for at least five continuous minutes, or
  - Member has a progressive neuromuscular disease only, maximal inspiratory pressure is less than 60 cm H<sub>2</sub>O, or forced vital capacity is less than 50 percent predicted, and
- Chronic pulmonary disease does not contribute significantly to the member's pulmonary limitation

If all of the above criteria are met, a BiPAP device with or without backup (based upon the judgment of the treating physician) will be covered for members within this group for the first three months of NPPRA therapy.

### **Severe Chronic Obstructive Pulmonary Disease (COPD) (First Two Months)**

- An arterial blood gas PaCO<sub>2</sub>, done while the member is awake and breathing the member's usual FIO<sub>2</sub>, is greater than or equal to 52 mm Hg, and
- Sleep oximetry demonstrates oxygen saturation less than or equal to 88 percent for at least five continuous minutes done while the member is breathing oxygen at 2 LPM or the member's usual FIO<sub>2</sub> (whichever is higher), and
- Prior to initiating therapy, OSA and treatment with CPAP has been considered and ruled out.

If all the above criteria for members with COPD are met, a BiPAP device without backup will be covered for the first three months of NPPRA therapy.

A BiPAP device with backup will usually not be covered for a member with COPD during the first two months, because therapy with a BiPAP device (without backup) with properly adjusted settings and the member's accommodation to its use will usually result in sufficient improvement without the need of a backup rate.

### **Severe Chronic Obstructive Pulmonary Disease (COPD) (After Two Months)**

- Arterial blood gas PaCO<sub>2</sub>, repeated no sooner than 61 days after initiation of compliant use of a BiPAP device (without a backup) and done while the member is awake and breathing the member's usual FIO<sub>2</sub>, remains greater than or equal to 52 mm Hg, and
- Sleep oximetry, repeated no sooner than 61 days after initiation of compliant use of a BiPAP device (without a backup) and while the member is breathing with the BiPAP device (without a backup), demonstrates oxygen saturation less than or equal to 88 percent for at least five continuous minutes done while breathing oxygen at 2 LPM or the member's usual FIO<sub>2</sub> (whichever is higher), and
- A signed and dated statement from the treating physician, completed no sooner than 61 days after the initiation of the BiPAP device (without a backup), declaring that the member has been compliantly using the BiPAP device (without a backup) an average of four hours per 24-hour period, but that the member is not benefiting from its use. The statement should also say that the physician feels the member meets the listed criteria for a BiPAP device (with a backup).

### **Obstructive Sleep Apnea (OSA)**

- A complete facility-based, attended polysomnogram has established the diagnosis of OSA, and
- A single level device (CPAP) has been tried and proven medically ineffective.

If the above criteria are met, a BiPAP device (without a backup) will be covered for the first three months of NPPRA therapy. A BiPAP device (with a backup) is not medically necessary if the primary diagnosis is OSA.

### **Central Sleep Apnea (CSA)**

Prior to initiating therapy, a complete facility-based, attended polysomnogram must be performed documenting the following:

- The diagnosis of CSA, and
- The ruling out of a single level device (CPAP) as effective therapy if either CSA or OSA is a component of sleep-associated hypoventilation, and
- Significant improvement of the sleep-associated hypoventilation with the use of a BiPAP device (with or without backup) on the settings that will be prescribed for initial use at home, while breathing the member's usual FIO<sub>2</sub>.

If all the above criteria are met, a BiPAP device with or without backup (based upon the judgment of the treating physician) will be covered for members with documented CSA conditions for the first three months of NPPRA therapy.

### **Hypoventilation Syndrome**

A BiPAP device (without a backup) is covered if the following criteria are met:

- An initial arterial blood gas PaCO<sub>2</sub>, done while awake and breathing the beneficiary's prescribed FIO<sub>2</sub>, is greater than or equal to 45 mm Hg, and
- Spirometry shows an FEV<sub>1</sub>/FVC of greater than or equal to 70% and an FEV<sub>1</sub> of greater than or equal to 50% of predicted, and
- An initial arterial blood gas PaCO<sub>2</sub>, done during sleep or immediately upon awakening, and breathing the beneficiary's prescribed FIO<sub>2</sub>, shows the beneficiary's PaCO<sub>2</sub> worsened greater than or equal to 7 mm Hg compared to the original result of the first requirement; or
  - A facility-based PSG demonstrates oxygen saturation of less than or equal to 88% for greater than or equal to five minutes of nocturnal recording time that is not caused by obstructive upper airway events.

A BiPAP device (with backup) is covered for a member with hypoventilation syndrome if the following criteria are met:

- A covered BiPAP device (without a backup) is being used, and
- Spirometry shows an FEV<sub>1</sub>/FVC of greater than or equal to 70% and an FEV<sub>1</sub> of greater than or equal to 50% of predicted, and
- An arterial blood gas PaCO<sub>2</sub>, done while awake, and breathing the beneficiary's prescribed FIO<sub>2</sub>, worsens greater than or equal to 7 mm Hg compared to the result performed to qualify the beneficiary for the E0470 device, or

- A facility-based PSG demonstrates oxygen saturation of less than or equal to 88% for greater than or equal to 5 minutes of nocturnal recording time that is not caused by obstructive upper airway events while using a BiPAP device (without a backup).

For members under the age of 19, appropriate noninvasive testing (such as capillary blood gas and end tidal CO<sub>2</sub> tests) may be substituted in place of an arterial blood gas PaCO<sub>2</sub> test to meet medical criteria for all conditions. All other required criteria listed under each condition must be followed.

### **Continued Coverage of BiPAP Device Beyond First Three Months of Therapy**

Members covered for the first three months of using a BiPAP device (with or without backup) must be re-evaluated to establish the medical necessity of continued coverage by the IHCP. While the member may need to be evaluated at earlier intervals after the initiation of therapy, the re-evaluation upon which IHCP will base a decision to continue coverage beyond this time must occur within 61 to 90 days of initiating therapy.

There must be documentation in the member's medical record about the progress of relevant symptoms and the member's usage of the device up to that time. Failure of the member to consistently use the BiPAP device for an average of four hours per 24-hour period by the time of the 61- to 90-day re-evaluation represents non-compliant utilization for the intended purposes and expected benefits of this therapy. This constitutes reason for the IHCP to deny continued service as not medically necessary.

To continue coverage beyond the first three months of therapy, the above documentation must be in the member's medical record. In addition, the device supplier must obtain documentation signed and dated by the treating physician no sooner than 61 days after initiating use of the device. This documentation must declare that the member is compliantly using the device an average of four hours per 24-hour period, and that the member is benefiting from its use.

### **Humidifiers**

IHCP reimbursement is available for a non-heated and a heated humidifier for use with a non-invasive respiratory assistive device or CPAP, when ordered by a physician, based on medical necessity.

Providers must meet the following criteria for reimbursement:

- A non-heated or heated humidifier for use with a non-invasive RAD or a CPAP will be considered for coverage only when physician documentation supports the medical necessity of the humidifier.
- Documentation must indicate that the member suffers from nosebleeds, extreme dryness of the upper airways, or other conditions that interfere with compliance or use of the RAD or a CPAP, and that the humidifier could improve this condition.

Heated and non-heated humidifiers are considered single patient use devices, categorized as inexpensive and routinely purchased items available for purchase only for Traditional Medicaid members. A rental trial period is no longer required before purchase for these items.



## **Prior Authorization for CPAP and BiPAP devices**

CPAP devices do not require prior authorization.

BiPAP devices and humidifiers require prior authorization using the medical necessity criteria above.

## **Cranial Remolding Orthosis**

The IHCP provides coverage for cranial remolding orthosis for members aged four (4) months to 24 months with benign positional plagiocephaly, plagiocephaly with torticollis, brachycephaly, dolichocephaly, or scaphocephaly due to conditions such as in utero or intra partum molding, premature or multiple births, and supine positioning. A pediatrician, general surgeon with a specialty in pediatrics, pediatric surgeon, craniofacial surgeon, or craniofacial anomalies team member must sign the prescription for the cranial remolding orthosis. The prescribing physician must document the medical necessity and prior authorization criteria in the patient's chart. The prescribing physician must sign the prior authorization form, but the prescribing physician or DME or HME supplies may also submit it.

### **Prior Authorization for Cranial Remolding Orthosis**

A cranial remolding orthosis requires prior authorization. Providers must submit documentation that shows the member received a minimum of a two-month trial of aggressive repositioning and stretching exercises recommended by the American Academy of Pediatrics and has failed to improve.

Exercise should include at least four of the following activities:

- Alternating back and side sleeping
- Supervising "tummy time"
- Rearranging the crib relative to the primary light source
- Limiting time spent in a supine position
- Limiting time in strollers, carriers, and swings
- Rotating activity
- Exercising neck motion

The member must meet one of the following criteria:

- Moderate to severe positional plagiocephaly, with or without torticollis, documented by an anthropometric asymmetry greater than 6 mm in the measurement of the cranial base, cranial vault, or orbitotragial depth
- Brachycephaly documented by a cephalic index two standard deviations above or below the mean (approximately 78%)



- Scaphocephaly or dolichocephaly in premature or breech infants with a cephalic index significantly less than 78%
- Further correction or asymmetry for members after surgical treatment of craniosynostosis, considered on a case-by-case basis
- Moderate to severe residual plagiocephaly after surgical correction of plagiocephaly
  - The pediatric neurosurgeon or craniofacial surgeon who performed the corrective procedure must provide documentation of medical necessity

The IHCP considers treatment for approval on a case-by-case basis for members aged 12 months to 24 months with severe plagiocephaly and who are considered to have a reasonable likelihood of continued skull growth. A pediatric neurosurgeon, craniofacial surgeon, or craniofacial anomalies team member must provide documentation of medical necessity. The member must have a documented trial of repositioning and stretching exercises, as described previously, to be considered for approval.

The following are contraindications to receiving cranial remolding orthosis:

- Members older than 24 months of age
- Unmanaged hydrocephalus
- Craniosynostosis

## Custom Tracheostomy Tubes

A custom tracheostomy tube is a device on which the manufacturer is required to make substantive customization or modification to meet a specific member's medical needs.

### Prior Authorization for Custom Tracheostomy Tubes

Prior authorization is required for a custom tracheostomy tube. Authorization of custom tracheostomy tubes requires clinical documentation supporting the medical appropriateness and a statement from the prescribing practitioner explaining why a standard or off-the-shelf tracheostomy tube will not meet the member's medical needs.

## Enteral Nutrition

The IHCP provides coverage for enteral nutrition.

### Prior Authorization for Enteral Nutrition

Prior authorization is required for enteral nutrition. The IHCP requires a certificate of medical necessity (CMN) for enteral nutrition and allows someone other than the ordering physician to complete the CMN. However, the ordering physician must review

for the accuracy of the information, sign, and date the CMN to indicate agreement. Providers should photocopy CMN forms because the contractor does not supply this form as a routine item. Providers must submit a copy of the CMN with each PA request (including the initial request) for enteral nutrition items.

After the initial PA of enteral nutrition items, the IHCP requires subsequent PA after three, nine, and eighteen months of therapy to document the member's continued need for therapy. After two years, the IHCP determines the need for further PA on a case-by-case basis. If the member does not medically require enteral nutrition services for two consecutive months, the IHCP requires a new PA, and the required extension schedule starts again.

For the initial PA or extension of initial PA, providers must include additional documentation to support medical necessity of the following orders:

- The need for special nutrients
- The need for total caloric intake less than 20 cal/kg/day or greater than 35 cal/kg/day
- The need for a pump

## Food Supplements

The IHCP provides coverage for food supplements, nutritional supplements, and infant formula when no other means of nutrition is feasible or reasonable. Coverage is not available in cases of routine or ordinary nutritional needs. Coverage is also not available in cases in which the item is to be used for other than nutritional purposes.

In a long term care facility, costs for these products, when utilized either for nutritional supplementation or as the sole source of nutrition for the resident, are included in the facility's established per diem rate. When these products are furnished to a long term care facility resident, they are not separately reimbursable by the IHCP and are not to be billed separately to the IHCP by either the long term facility or another provider furnishing the products.

### Prior Authorization for Food Supplements

Prior authorization is required for food supplements, nutritional supplements, and infant formula. The following criteria and considerations apply:

- The feasibility or reasonableness of other means of nutrition, as documented by the requesting practitioner, and as determined by the office's contractor on a case-by-case basis
- Authorization will not be granted when convenience of the member or the member's caretaker is the primary reason for the service

## Gloves

The IHCP provides coverage for sterile and non-sterile gloves for use in the home by the member, family, or other non-paid caregiver.

All gloves must be ordered in writing by a physician. Sterile gloves must be used only when medical conditions necessitate them. Documentation of medical need will be required for all gloves, sterile and non-sterile. The supplier should maintain a signed physician's order in the patient record with a start and stop date, frequency of treatment, and type of treatment for which gloves will be used.

Documentation should indicate the reason the gloves have been ordered by the physician. The physician order must be renewed at least every twelve months to ensure that the need for gloves is ongoing. The order should reflect any changes in the plan of care in the home treatment setting. Providers must maintain records of quantities supplied. If these supplies are delivered or mailed, a record showing proof of delivery must be maintained.

### Non-Sterile

Medical necessity for non-sterile gloves includes, but is not limited to, the following:

- Bowel program requiring manual evacuation
- Ostomy care program
- Wound care program
- Exposure to blood and body fluids

### Sterile

Sterile gloves are covered when ordered by a physician for a medically necessary treatment. Medical necessity for sterile gloves includes, but is not limited to, the following:

- Tracheostomy changes
- Wound care for specified populations, such as those who are immunosuppressed or burn victims

Sterile gloves are not separately reimbursed when included in sterile procedure kits. Such kits include, but are not limited to the following:

- Catheter insertion kits
- Suture removal kits

### Reasons for Non-Coverage

Sterile and non-sterile gloves would be non-covered for the following indications:

- Gloves are used in the home by a paid caregiver.
- Gloves are not used for a medically necessary treatment.

- For members who reside in nursing facilities, gloves are included in the per diem reimbursement.
- For End-Stage Renal Disease (ESRD)/dialysis services, gloves are included in the composite reimbursement.

## High Frequency Chest Wall Oscillation System

A high frequency chest wall oscillation system is a mechanical device that utilizes a vest and a generator to loosen bronchial secretions and clears the airway.

High-frequency chest wall compression devices include but are not limited to the following: The Vest™ Airway Clearance System formally known as ThAIRapy® Vest or ABI vest (Hill-Rom Services, Inc.), The Medpulse™ Respiratory Vest System and The Smartvest® Airway Clearance System (Electromed Inc., Minnetonka, MN), The Incentive™ System (RespirTech, Inc.)

### Prior Authorization for High Frequency Chest Wall Oscillation System

Prior authorization is necessary for a high frequency chest wall oscillation system. The following criteria must be met for a high frequency chest wall oscillation system to be approved and covered by the IHCP:

- A physician order
- The physician's determination that the patient requires airway clearance therapy at least once a day
- A pulmonary function study, done within 90 days of the date of the request, that demonstrates:
  - A Forced Expiratory Volume (FEV1) 80 percent of predicted
  - A forced vital capacity (FVC) 50 percent of predicted
  - A 25 percent decrease on small airway score (Forced Expiratory Flow [FEF] 25-75) over one year
- Documentation supporting that chest physiotherapy or flutter devices used twice a day have been ineffective in managing bronchial secretions
- Documentation supporting that family members and caregivers have been unable to provide effective chest therapy, or that the member is living independently or is away at school
- Risk of continued hospitalization for the member
- The member does not have a cardiac condition

Rental of a high frequency chest wall oscillation system for three months is required before purchase of the equipment is covered or reimbursable. At the end of three months, documentation that the system has been used on a regular basis is required.

Medical records must indicate patient's compliance and tolerance before purchase will be approved.

## Hospital and Specialty Beds

The IHCP will provide coverage for hospital and specialty beds when they are medically necessary in a non-institutional setting, when there is a written physician's order, and when the beds have received prior authorization. The following is a definition of terms used in this section:

### Hospital Beds

- A fixed-height hospital bed is one with manual adjustment elevation for head and leg.
- A variable-height hospital bed is one with manual adjustment elevation for the head, height, and legs.
- A semi-electric hospital bed is one with manual adjustment elevation for height and with electric elevation adjustments for the leg and head.
- A total-electric hospital bed is one with electric elevation adjustments for height, head, and leg.

### Specialty Beds

- An enclosed bed is one that is one piece of equipment, e.g., bed and mesh canopy or a bed with padded walls and a mattress especially designed for patients with TBI.
- A pediatric hospital bed has higher side rails that are close together to prevent injury from falling through the rails. Pediatric hospital beds usually also have a protective covering over the rails.

### Prior Authorization for Hospital and Specialty Beds

Prior authorization is required for all types of hospital beds and specialty beds. All beds require a medical clearance form completed and signed by a physician, documentation of medical necessity in a non-institutional setting, a written physician's order, and appropriate diagnosis demonstrating medical necessity for a bed. The specific requirements for each type of bed are listed below:

#### Hospital Beds

A hospital bed is considered medically necessary if one or more of the following conditions are met:

- Physician ordered positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month; elevation of the head and upper body greater than 30 degrees.
- Physician ordered positioning of the body in ways to alleviate pain that are not possible in an ordinary bed.



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- Physician ordered positioning of the body that requires head elevation greater than 30 degrees most of the time. The need for head elevation must be related to a medical condition, such as congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed.
- Physician ordered traction that requires traction equipment, which can be attached only to a hospital bed.
- A variable height hospital bed is covered if, in addition to meeting one or more of the above criteria for a hospital bed, the physician orders a bed height different from a fixed-height hospital bed to accommodate transfers to a chair, wheelchair, or standing position.
- A semi-electric hospital bed is covered if, in addition to meeting one or more of the above criteria for a hospital bed, the physician orders frequent changes in body positioning or the patient has an immediate need for a change in body position.

### Enclosed or Cubicle Bed

An enclosed bed or cubicle bed is considered medically necessary when all the following criteria are met:

- The patient has an appropriate diagnosis that could include but is not limited to the following:
  - Severe intellectual disabilities
  - Profound intellectual disabilities
  - Leukodystrophy
  - Picks disease
  - Obstructive hydrocephalus
  - Infantile cerebral palsy
  - Generalized convulsive epilepsy
  - Grand mal status epileptic
  - Anoxic brain damage
  - Convulsions
  - Intracranial injury of other and unspecified nature
- Documentation of medical necessity must include at least one of the following:
  - Daily seizure activity
  - Uncontrolled perpetual movement related to diagnosis
  - Self-injurious behavior, such as uncontrolled head banging



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- Documentation of safety factors tried and failed, including but not limited to the following:
  - Chest restraints
  - Side rails
  - A mattress on the floor
  - Protective helmet
- Supporting documentation must include secondary diagnoses and pertinent history:
  - History of injuries or falls
  - High risk for fractures due to osteoporosis
  - At risk for hemorrhage due to thrombocytopenia
  - Frequent upper-respiratory infections or other complications related to aspiration
  - Respiratory complications related to positioning, requiring elevation of the head and upper body greater than 30 degrees
  - Requires frequent positional changes
- A signed physician's order for enclosed bed or cubicle bed
- A medical clearance form completed and signed by the physician
- Verification that the primary caregiver is willing and able to clean and maintain the mesh canopy per the manufacturer recommendations. IHCP will not pay for laundering of the mesh canopy.

### **Pediatric Hospital Bed**

Pediatric hospital beds are considered medically necessary when all the following criteria are met:

- Has a medically necessary diagnosis. Diagnoses could include but are not limited to the following:
  - Tracheostomy
  - Gastrostomy
  - Heart failure
  - Pleural effusion, except tuberculous
  - Acute respiratory failure
  - Pulmonary insufficiency
  - Diseases of the lung
  - Diseases of trachea and bronchus

- Respiratory distress syndrome in newborn
- Other respiratory problems after birth
- Other symptoms involving respiratory system and chest
- Mandatory criteria for PA include all the following requirements:
  - A physician's order for a multi-positional bed because of the need for frequent position changes
  - Elevation of upper body and head greater than 30 degrees
  - Written documentation of why a standard crib is not appropriate and what alternative methods have been tried and failed
  - A medical clearance form completed and signed by the physician
- Recommended criteria (patient must meet at least **one** of the following criteria):
  - Documentation that indicates there is a risk for aspiration pneumonitis or gastric reflux related to disease
  - Documentation of a history of aspiration pneumonitis

### Implantable Cardioverter Defibrillator

The implantable cardioverter defibrillator is an electronic device surgically implanted into members identified at high risk for sudden cardiac death (SCD) due to ventricular tachyarrhythmia (i.e. ventricular tachycardia (VT) and ventricular fibrillation). The implantable cardioverter defibrillator continuously monitors the heart rhythm, automatically senses a tachyarrhythmia, and restores the normal rhythm via electrical impulses or a transcatheter electrical shock. The implantable cardioverter defibrillator consists of an impulse generator, batteries, and electrodes.

The IHCP provides reimbursement for an implantable cardioverter defibrillator when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization. Implantable cardioverter defibrillator therapy is considered medically necessary for the treatment of ventricular tachyarrhythmias and for the prevention of sudden cardiac death (SCD) in individuals who are receiving optimal medical therapy.

Effective July 1, 2016 subcutaneous implantable cardioverter defibrillators (S-ICDs) were made a covered service in addition to the already covered ICDs.

#### Prior Authorization for Implantable Cardioverter Defibrillator

Prior Authorization is required for all implantable cardioverter defibrillators. An implantable cardioverter defibrillator is indicated for members who are receiving ongoing optimal medical therapy, have a reasonable expectation of survival with good functional status for more than one (1) year, and have one of the following conditions:

- Survivors of cardiac arrest due to ventricular fibrillation or hemodynamically unstable sustained VT after evaluation to define the cause of the event and to exclude any completely reversible causes.
  - The following must also be met:
    - Members must be able to give informed consent.
    - Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography.
    - Myocardial Infarctions (MIs) must be documented and defined according the Joint European Society of Cardiology/American College of Cardiology Committee for the Redefinition of Myocardial Infarction as identified below.
- Left ventricular (LV) dysfunction with prior myocardial infarction (Ischemic Cardiomyopathy) and one of the following:
  - With left ventricular ejection fraction (LVEF) less than or equal to 35 percent due to prior myocardial infarction who are at least 40 days post-myocardial infarction and who are in New York Heart Association (NYHA) functional Class II or III. The NYHA functional class levels are identified below.
  - With LV dysfunction due to prior myocardial infarction who are at least 40 days post-myocardial infarction, have an LVEF less than or equal to 30 percent, and are in NYHA functional Class I.
  - With nonsustained VT due to prior myocardial infarction, LVEF less than or equal to 40 percent, and inducible ventricular fibrillation or sustained VT at electrophysiological study.
  - The following must also be met:
    - Members must be able to give informed consent.
    - Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography.
    - MIs must be documented and defined according the Joint European Society of Cardiology/American College of Cardiology Committee for the Redefinition of Myocardial Infarction as identified below.
- Nonischemic dilated cardiomyopathy with a LVEF less than or equal to 35 percent and are in NYHA functional Class II or III.
- Sustained VT, either spontaneous or induced by an electrophysiology (EP) study, not associated with an acute MI and not due to a transient or reversible cause.
- Syncope of undetermined origin with one of the following:
  - Clinically relevant, hemodynamically significant sustained VT.

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- Ventricular fibrillation induced at electrophysiological study.
  - Unexplained syncope, significant LV dysfunction, and nonischemic dilated cardiomyopathy.
- Familial or inherited conditions with a high risk of life-threatening VT (one of the following):
  - Hypertrophic Cardiomyopathy with one or more of the following major risk factors for SCD:
    - Prior cardiac arrest.
    - Spontaneous sustained VT.
    - Spontaneous nonsustained VT.
    - Family History of SCD.
    - Syncope.
    - LV thickness greater than or equal to 30 mm.
    - Abnormal blood pressure response to exercise.
  - For the prevention of SCD in members with arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVD/C) who have one (1) or more risk factor for SCD.
    - Induction of VT during electrophysiological testing.
    - Detection of nonsustained VT on noninvasive testing.
    - Male gender.
    - Severe right ventricular dilation.
    - Extensive right ventricular involvement.
    - Young age at presentation (less than five (5) years).
    - LV involvement.
    - Prior cardiac arrest.
    - Unexplained syncope.
    - Deleterious genetic mutations associated with ARVD/C.
  - To reduce SCD in members with long QT syndrome who are experiencing syncope and/or VT while receiving beta blockers.
- Catecholaminergic polymorphic VT who have syncope and/or documented sustained VT while receiving beta blockers.
- Non-hospitalized members awaiting transplantation.

- Members who have cardiac sarcoidosis, giant cell myocarditis, or Chagas disease.
- Brugada syndrome and one of the following:
  - Previous syncope.
  - Documented VT that has not resulted in cardiac arrest.

### **Pediatric Members and Members with Congenital Heart Disease**

An implantable cardioverter defibrillator is indicated for pediatric members and members with congenital heart disease who have one of the following conditions:

- Survivor of cardiac arrest after evaluation to define the cause of the event and to exclude any reversible causes.
- Members with symptomatic sustained VT in association with congenital heart disease who have undergone hemodynamic and electrophysiological evaluation. Catheter ablation or surgical repair may offer possible alternatives in carefully selected patients.
- Members with congenital heart disease with recurrent syncope of undetermined origin in presence of either ventricular dysfunction or inducible ventricular arrhythmias at electrophysiological study.
- Members with recurrent syncope associated with complex congenital heart disease and advanced systemic ventricular dysfunction when thorough invasive and noninvasive investigations have failed to define a cause.

### **Non-Covered Indications**

Implantable cardioverter defibrillators are not covered when members have any of the following conditions:

- Irreversible brain damage, disease or dysfunction that precludes the ability to give informed consent.
- Significant psychiatric illnesses that may be aggravated by device implantation or that may preclude systematic follow-up.
- Any disease, other than cardiac disease (e.g. cancer, uremia, liver failure, advanced cerebrovascular disease) associated with survival less than one year.
- Ventricular tachyarrhythmias due to a completely reversible disorder in the absence of structural heart disease (e.g., electrolyte imbalance, drugs, or trauma).
- Member has asymptomatic VT or symptomatic VT/VF:
  - Associated with acute MI within two (2) days.
  - Due to a remediable cause.
  - Controlled by appropriate drug therapy.



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- Manageable through the use of other therapies (e.g. ablation procedures, surgery).
- Incessant VT or ventricular fibrillation.
- Syncope of undetermined cause without inducible ventricular tachyarrhythmias and without structural heart disease
- Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm.
- Had a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angiography within the past three (3) months.
- Had an acute MI within the past 40 days.
- Clinical symptoms or findings that would make the member a candidate for coronary revascularization.
- With NYHA Class IV symptoms and drug-refractory congestive heart failure who are not candidates for cardiac transplantation or implantation of a CRT device that incorporates both pacing and defibrillation capabilities.
- When ventricular fibrillation or VT is amenable to surgical or catheter ablation (e.g., atrial arrhythmias associated with Wolff-Parkinson-White syndrome, right ventricular or LV outflow tract VT, idiopathic VT, or fascicular VT in the absence of structural heart disease).
- The planned implantable cardioverter defibrillator has not received full market approval from the FDA.

### Criteria for Acute, Evolving or Recent MI

Criteria for diagnosis for an acute, evolving or recent MI
Either one of the following criteria satisfies the diagnosis for an acute, evolving or recent MI: <ul style="list-style-type: none"><li>• Typical rise and gradual fall (Troponin) or more rapid rise and fall (CK-MB) of biochemical markers of myocardial necrosis with at least one (1) of the following:<ul style="list-style-type: none"><li>○ Ischemic symptoms</li><li>○ Development of pathologic Q waves on the ECG</li><li>○ ECG changes indicative of ischemia (ST segment elevation or depression)</li><li>○ Coronary artery intervention (e.g., coronary angioplasty)</li></ul></li><li>• Pathologic findings of an acute MI</li></ul>
Criteria for Established MI
<ul style="list-style-type: none"><li>• Development of new pathologic Q waves on serial ECGs<ul style="list-style-type: none"><li>○ Member may or may not remember previous symptoms</li></ul></li></ul>



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- Biochemical markers of myocardial necrosis may have normalized, depending on the length of time that has passed since the infarct developed.
- Pathologic findings of a healed or healing MI

### New York Heart Association (NYHA) Functional Classification

NYHA Class	Symptoms
I	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath).
II	Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath).
III	Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
IV	Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

## Implantable Infusion Pumps

Implantable devices for intra-arterial, epidural, and intrathecal infusions are considered medically appropriate, based on the following criteria.

### Chemotherapy for liver cancer

- The implantable infusion pump is covered for intra-arterial infusion of 5-Fluorouridine (FUDR) for the treatment of liver cancer for members with primary hepatocellular carcinoma or Duke's Class D colorectal cancer, in whom the metastases are limited to the liver, and where (1) the disease is unresectable, or (2) the member refuses surgical excision of the tumor.

### Anti-spasmodic drugs

- To intrathecally administer anti-spasmodic drugs (Baclofen, for example) to treat chronic intractable spasticity in members who have proven unresponsive to less invasive medical therapy, as determined by the following criteria:
  - Documented history of at least a six-week trial period on oral anti-spasmodics that has failed to adequately control the spasticity or has produced intolerable side effects.
  - Prior to pump implantation, the member must have responded favorably to a trial epidural or intrathecal dose of an anti-spasmodic drug.

### Opioid drugs

- To intrathecally administer opioid drugs (for example, morphine) to treat severe, chronic, intractable pain of non-malignant or malignant origin in members who have proven unresponsive to less invasive medical therapy, the medical record must reflect the following criteria:
  - An appropriate ICD-10-CM diagnosis
  - The member and the person responsible for the member must be fully aware of the risks and benefits of the surgery, including the providers' mortality and morbidity experience
  - A documented medical history of less invasive medical therapy that was tried and failed

## Other uses

- Coverage for other uses of implanted infusion pumps may be approved if the practitioner has documented in the member's medical record all of the following:
  - The drug is reasonable and necessary for the treatment of the individual member.
  - It is medically necessary that the drug be administered by an implanted infusion pump.
  - FDA-approved labeling for the pump specifies:
    - The drug being administered
    - The purpose for which it is administered is an indicated use for the implantable infusion pump.

**Note:** Reimbursement may also be available for drugs necessary for the effective use of an implantable infusion pump, as long as the drug being used with the pump is itself reasonable and medically necessary for the member's treatment.

## Contraindications for Using Implantable Infusion Pumps

The implantation of an infusion pump is contraindicated in the following situations:

- Known allergy or hypersensitivity to the drug (for example, oral Baclofen, morphine, and so on) being used
- An infection affecting the area of implantation
- Insufficient body size to support the weight and bulk of the device
- Other implanted programmable devices, due to crosstalk between devices may inadvertently change the prescribed settings

## Incontinence Supplies

The IHCP covers incontinence supplies for members three years old and older, based on medical necessity. The following restrictions apply:

- A member may receive a maximum of \$162.50 per month for all incontinence supplies
- A member may receive a maximum of \$1,950 of incontinence supplies per rolling calendar year (in 30-day increments)

Incontinence supplies must be ordered in writing by a physician. The written order should include, at a minimum, the following information, when applicable:

- Patient's name
- Date ordered
- Physician's signature
- Area of body for use (for items that may be appropriate for multiple sites)
- Type and size of the product
- Quantity intended for use
- Frequency of use (for example, change dressing three times per day)
- Anticipated duration of need

The clinical documentation must include a diagnosis of incontinence. The incontinence diagnosis must also be documented on the *CMS-1500* claim form, with information about the specific quantity and description of the supplies provided. The physician's order must be renewed annually at minimum.

Incontinence supplies may be provided to members only in one month increments. The supplier must maintain documentation in the member's medical record of the specific quantity and description (such as brand, type, size, and so forth) of the supplies provided.

In addition to the signed physician's order, the supplier must maintain documentation of proof of delivery. Documentation must include the date of delivery, address of delivery, and signature of the IHCP member, caregiver, or family member who received the supplies.

## Incontinence Supply Vendors

All FFS members are required to obtain incontinence, ostomy, and colostomy supplies, including but not limited to diapers, underpads, ostomy bags, gloves, and other like supplies, through mail order from one of the following contracted providers:

- Binson's Home Health Care Centers
- J & B Medical Supply Company

There are instances when the use of tapes, adhesives, gloves, and other supplies is not related to incontinence, ostomy, or urological conditions. IHCP members will not be restricted to purchasing these only through mail order from one of the two contracted vendors.

## **Prior Authorization for Incontinence Supplies**

Prior authorization is not required for the reimbursement of incontinence supplies unless they are supplied by an out-of-state provider, or if the member is utilizing high-end incontinence products.

Prior authorization, for high-end incontinence products, will be granted based upon medical necessity. At minimum, the following information must be submitted in order to determine medical necessity:

- Member has sampled all applicable products from the three vendors and submitted documentation indicating why the products sampled were not appropriate. (i.e. leakage, skin breakdown, etc.)
- Documentation submitted supporting medical necessity for the high end ostomy supplies. The documentation must include the following:
  - Recurrent infections or skin breakdown
  - Issues the member are having with the current product (allergic reaction, redness, irritation, etc.).
  - Enzymes dissolving the adhesive or causing skin breakdown

The documentation must include the actual quantity needed per month for the member and factors which affect the frequency of the change.

## **Negative Pressure Wound Therapy (NPWT)**

Negative pressure wound therapy (NPWT) is a controlled application of subatmospheric pressure to a wound. NPWT uses an electrical pump to apply, intermittently or continuously, subatmospheric pressure through a connecting tube to a specialized wound dressing. This specialized dressing includes a resilient open cell foam surface dressing, sealed with an occlusive dressing that is meant to contain the subatmospheric pressure at the wound site and promote wound healing.

IHCP will provide coverage for NPWT in a home-care setting or in a long-term care (LTC) setting, based on the following criteria:

- The member must have a physician's order.
- The NPWT must be reasonable and medically necessary.

- The member must have a stage III or IV pressure ulcer, neuropathic ulcer, venous or arterial insufficiency ulcer, chronic (being present for at least 30 days) ulcer of mixed etiology, or a traumatic or surgically created wound.
- A complete wound program described below, depending on the type of wound, must have been tried and failed before applying the NPWT.

### **Ulcers or Wounds:**

For all ulcers or wounds, all the following minimum general measures of a wound-therapy program must be addressed, applied, or considered and ruled out before applying the NPWT:

- Documentation in a patient's medical record of evaluation, care, and wound measurements by a licensed medical professional
- Application of dressings to maintain a moist wound environment
- Debridement of necrotic tissue and treatment of active infection, if present
- Evaluation of and provision for adequate nutritional status
- Ensure adequate wound perfusion

### **Stage III or IV Pressure Ulcers**

In addition to the minimum general measures, stage III or IV pressure ulcers must also be evaluated for all of the following components:

- The patient has been appropriately turned and positioned, and has a current turning and positioning plan in place
- If the wound is on the trunk or the pelvis, the patient has used a group two or three support surface
- The patient's moisture and incontinence has been appropriately managed

### **Neuropathic Ulcers**

In addition to the minimum general measures, neuropathic ulcers must also be evaluated for all of the following components:

- The patient has been on a comprehensive diabetic or other applicable disease management program
- Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities

### **Venous Stasis Ulcers**

In addition to the minimum general measures, venous stasis ulcers must also be evaluated for all the following components:

- Compression bandages or garments have been consistently applied
- Leg elevation and ambulation have been encouraged\



## **Prior Authorization for NPWT**

Prior authorization is required for reimbursement of NPWT. The provider must submit a completed PA form and a completed medical clearance form signed by the physician to the PA contractor for review of medical necessity.

The NPWT is authorized for only four weeks at a time. Each new request requires a statement from the treating physician describing the initial condition of the wound, including measurements, efforts taken to address wound care, and the changes in the wound therapy being applied to affect wound healing.

Each new physician's order for continued use of NPWT requires a new PA period. If a PA is modified and authorized for less time than the physician's order had requested initially, a new PA form and updated physician's orders must be obtained before the current authorization expires.

Authorization for coverage beyond four months in a home care setting will be given individual consideration, based on additional documentation that sets out the reason for continuing use of NPWT.

## **Continued Coverage**

To obtain PA for continued service after the initial PA of NPWT, documentation of the following must be included with the request:

- Indication that a licensed medical professional has directly performed or supervised the performance of the dressing changes
- Progress and changes in the ulcer (If there is no progress in one month, or from month to month, the approval for the NPWT will be discontinued.)
- A completed NPWT medical clearance form, signed and dated by the ordering physician

## **Supplies**

Supplies for the NPWT must be prior authorized. Dressing sets are packaged five or 10 to a case. Each dressing set equals one unit and includes but is not limited to a resilient open cell foam surface dressing, drainage tubing, and an occlusive dressing that creates a seal around the wound site to maintain sub-atmospheric pressure at the wound. No more than 15 units for dressing sets, any size, will be authorized per wound, per month. No more than 10 canisters, any size, per wound, per month, will be authorized unless documentation is submitted with the request to identify proof of an increased amount of supplies.

## **Osteogenic Bone-Growth Stimulator**

Osteogenic bone-growth stimulators are devices that use electrical currents or low-intensity pulsed ultrasound (LIPUS) to promote bone growth and healing. Electrical stimulation produces



calcification and mineralization of the fibrocartilage repair tissue (bone growth) at a fracture site and helps increase vascularity. LIPUS acts through mechanical stimulation at the fracture or nonunion site that leads to a complex cascade of events to improve bone healing. Electrical and LIPUS stimulators are used for non-healing or hard to heal fractures, usually of the long bones, and also for spinal fusions.

The IHCP covers different types of bone-growth stimulators with PA. There are several types of bone-growth stimulators available to deliver therapy by different methods:

- Implantable direct current stimulators – These are used for spinal fusions, nonunions and stress fractures, for use at the time of the surgical procedure, or to be implanted surgically. Invasive electric stimulators can be either fully or partially implantable. A second surgical procedure is necessary at the end of treatment to remove the device. Implantable stimulators allow constant current treatment and increased patient compliance.
- Non-invasive external electrical stimulator – Electrodes or coils are applied to the skin at the fracture site. The electrodes or coils can be placed under a cast when necessary. The device operates on an external battery pack. The unit may be operated up to 24 hours per day depending on manufacturers' recommendations and the prescription by the treating provider.
- Noninvasive external ultrasonic (US) stimulator – This is a non-invasive unit applied directly to the skin. In the event a cast is present, a hole is made in the cast so the device can be applied to the skin. The device operates on an external battery pack. The unit is typically operated intermittently during the day depending on manufacturers' recommendations and the prescription by the treating provider.

The IHCP excludes nonunions of the skull and vertebrae and those that are tumor-related.

The IHCP does not cover treatment for fresh fractures and nonunion associated with osteomyelitis.

## **Prior Authorization for Osteogenic Bone-Growth Stimulator**

Prior authorization is required for osteogenic bone-growth stimulators. The diagnosis of a nonunion fracture must meet the following criteria:

- Serial radiographs must have confirmed that the healing of the fracture has ceased for three or more months prior to starting treatment with an osteogenic stimulator.
- Serial radiographs must include a minimum of two sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days.

Noninvasive Electrical Stimulators – The noninvasive stimulator devices are only covered for the following indications:

- Nonunion of long bone fractures
- Congenital pseudoarthrosis

- As an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site, or for those undergoing multiple level fusions. A multiple level fusion involves three or more vertebrae (e.g. L3-L5, L4-S1, etc.).

Invasive (Implantable) Stimulator – The implantable invasive stimulator is only covered for the following indications:

- Nonunion of long bone fractures
- As an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site; or for those undergoing multiple level fusions. A multiple level fusion involves three or more vertebrae (e.g. L3-L5, L4-S1, etc.).

Non-invasive external Ultrasound Stimulator – The LIPUS stimulator is covered for the following indications:

- Nonunion of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the US stimulator; radiographs must be separated by a minimum of 90 days, and each must include multiple views of the fracture site. Written interpretation by a physician must state that there has been no clinically significant evidence of the fracture healing between the two sets of radiographs.
- The ultrasonic osteogenic stimulator may not be used concurrently with other non-invasive osteogenic devices.

## Oxygen and Oxygen Equipment

The IHCP reimburses liquid and gaseous oxygen systems as rental only items. Reimbursement for oxygen contents is at systems. Oxygen contents are separately reimbursable when a third party has purchased an oxygen system, or the IHCP or third party has rented or purchased a portable oxygen system. Accessories including but not limited to cannulas, masks, and tubing are also included in the allowance for rented systems and are not separately reimbursable unless used with a purchased system.

The IHCP covers home oxygen therapy only for patients with significant hypoxemia in the chronic stable state, provided the following are met:

- The attending physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen.
- The patient's blood gas levels indicate the need for oxygen therapy
- The physician has tried or considered alternative treatment measures and has deemed them clinically ineffective.

The patient needs to meet the criteria in one of the following categories to receive approval of home oxygen therapy:

## Group I Criteria:

- An arterial  $PO_2$  at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken at rest
- The IHCP provides coverage only for nocturnal use of oxygen in the following cases:
  - The patient demonstrates an arterial  $PO_2$  at or below 55 mm Hg or an arterial oxygen saturation at or below 88% during sleep, and the patient demonstrates an arterial  $PO_2$  at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake.
  - The patient demonstrates a greater than normal fall in oxygen level during sleep, a decrease in arterial  $PO_2$  more than 10 mm Hg, or a decrease in arterial oxygen saturation of more than 5%, associated with symptoms or signs reasonably attributable to hypoxemia, such as cor pulmonale, P pulmonale on EKG, documented pulmonary hypertension, and erythrocytosis.
- The IHCP provides coverage only during exercise if the patient demonstrates an arterial  $PO_2$  at or below 55 mm Hg or an arterial oxygen saturation at or below 88% taken during exercise and an arterial  $PO_2$  at or above 56 mm Hg or an arterial oxygen saturation at or above 89% taken during the day while at rest. In this case, the IHCP provides supplemental oxygen during exercise if it is documented that the use of oxygen improves the hypoxemia that was documented during exercise when the patient was breathing room air.

## Group II Criteria:

The patient meets the criteria when the patient demonstrates an arterial  $PO_2$  of 56 to 59 mm Hg or an arterial blood oxygen saturation of 89% and any of the following:

- Dependent edema suggesting congestive heart failure
- Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or P pulmonale on EKG, P wave greater than 3 mm in standard leads II, III, or AVF
- Erythrocythemia with a hematocrit greater than 56%

## Group III Criteria:

The IHCP requires additional documentation to substantiate use of oxygen when the patient demonstrates an arterial  $PO_2$  level at or above 60 mm Hg or an arterial blood oxygen saturation at or above 90%. Providers should ensure that additional documentation appears on the PA form or an attached form, indicating the type, frequency, and severity of incidents or episodes. Episodes include, but are not limited to, the following:

- Apnea conditions
- Bronchopulmonary dysplasia

- Cerebral palsy
- Cyanotic congenital heart disease
- Episodic attacks of acute and severe asthma
- Intermittent cyanosis or dyspnea documented by clinical observation
- Intermittent upper airway obstruction
- Neuromuscular disorders extensive enough to affect pharyngeal and chest muscles, and that clinically interfere with normal breathing
- Severe recurrent attacks of epilepsy
- Significant intellectual disability with repetitive episodes of respiratory difficulties
- Tracheal laryngeal malacia

The IHCP may give PA to patients who fall into Group III for three, six, or twelve months, depending upon the medical necessity demonstrated in the documentation provided. If PA is not waived based on one of the preceding criteria, the IHCP determines whether to require retesting using ABG or transcutaneous oximetry readings when and if authorization is granted. Providers must include such benefits, or the results of the latest ABG or oximetry readings, on the CMN form when submitted with the new PA request.

### **Prior Authorization for Oxygen and Oxygen Equipment**

Oxygen equipment requires prior authorization. Home oxygen therapy prior authorization is based upon the criteria above.

### **Patient-Activated Event Recorder (Implantable Patient-Activated Event Recorder)**

The IHCP covers a patient-activated event recorder (Implantable Patient-Activated Event Recorder) for use after a syncopal event. The device may be implanted at any of three places of service, including inpatient, outpatient, or physician's office. The device may not be implanted in the same member more often than every two years or 24 months. The recorder activator is furnished with the system and is not separately reimbursed.

The following criteria applies for coverage of an Implantable Patient-Activated Event Recorder (ILR):

- The ILR device is covered only if a definitive diagnosis has not been made after meeting all the following conditions:
  - Complete history and physical examination
  - Electrocardiogram (EKG)

- Negative or non-diagnostic 30-day pre-symptom memory loop patient demand recordings (may be either single or multiple event recordings, with or without 24-hour attended monitoring) or symptoms occurring less frequently than every 30 days.
  - Negative or non-diagnostic tilt table testing
  - Negative or non-diagnostic electrophysiological testing
- The patient must be capable of activating the hand-held telemetry unit.
- The ILR device is not covered for the following:
  - Patients with presyncopal episodes
  - Patients failing to fulfill the indications for coverage in this policy
  - Patients for whom compliance or lifestyle make using external monitoring systems inappropriate
- Removal of an ILR on the same day as the insertion of a cardiac pacemaker is considered part of the pacemaker insertion procedure and is not reimbursed separately.
- Only one ILR is covered for a given patient in any two-year time period (24 months).
- ECG analyses obtained during device insertion for signal quality and amplification are considered part of the implant procedure and are not reimbursed separately.
- The ILR is covered for members with cryptogenic stroke who have had a negative initial complete diagnostic evaluation including at least 24 hours of inpatient or outpatient cardiac rhythm monitoring for the purposes of detecting previously undocumented atrial fibrillation.

### **Prior Authorization for ILR device**

Prior authorization is only required if a replacement recorder activated is needed.

## **Phrenic Nerve Stimulator**

A phrenic nerve stimulator is an electrophrenic pacemaker for pacing of the diaphragm. It consists of an external radio frequency transmitter, an antenna, a subcutaneous radio receiver, and a bipolar platinum nerve electrode. Diaphragmatic pacing (intermittent electrical stimulation of the phrenic nerves) offers patients who need long-term ventilation, and have a functionally intact phrenic nerve and chest wall stability, freedom from mechanical ventilation.

The primary objective of implanting the phrenic nerve stimulator is to allow the member to return to a home environment from a skilled nursing facility (SNF) and be more independent. The following criteria are mandatory for prospective candidates requesting this device:

- Functional lungs and diaphragm muscle and both phrenic nerves



- Absence of infection in orofacial, neck, chest, abdomen and any suspicion of systemic infection, including sepsis
- A clear and adequate upper airway (including nasopharynx, pharynx, and larynx)
- Family support that includes an unpaid physical caregiver of adequate quality and the availability of nursing and medical care

### **Prior Authorization for Phrenic Nerve Stimulator**

Prior authorization is required for this device and its implantation. The following criteria for medical necessity applies:

- One or more of the following ICD-10-CM diagnosis codes must be used when submitting requests:
  - G12.20 Motor neuron disease, unspecified
  - G12.21 Amyotrophic lateral sclerosis
  - G12.22 Progressive bulbar palsy
  - G12.29 Other motor neuron disease
  - G47.34 Idiopathic sleep related nonobstructive alveolar hypoventilation
  - G47.35 Congenital central alveolar hypoventilation syndrome
  - G82.50 Quadriplegia, unspecified
  - G82.51 – G82.52 Quadriplegia C1-C4, complete or incomplete
- Members who qualify for this device will demonstrate life-threatening oxygen depletion when respiration is unassisted.
- For stable, non-acute quadriplegics and other spinal-cord or brain-stem injured members [ICD-10-CM G82.50, G82.51 and G82.52 (Quadriplegia C1-C4, unspecified, complete or incomplete)], all of the following criteria must be met:
  - Patient is oriented to name, date, and place.
  - Patient's mobility will be improved. Patient will be able to be out of bed and be mobile per wheelchair, which may include employment or school attendance. Increased mobility will allow the patient to function without the interference of large equipment.
  - Patient's skin integrity will be better maintained because of increased mobility.
  - Patient has capacity to be productive. He or she will more easily perform cognitive tasks within physical limitations.
  - Patient will be better able to eat and swallow.



- For nonobstructive (ICD-10-CM G47.34 Idiopathic sleep related nonobstructive alveolar hypoventilation and G47.35 Congenital central alveolar hypoventilation syndrome diagnosis codes), only when other treatments have failed, the following criteria must be met:
  - The requesting physician will present sleep studies demonstrating clinically significant central sleep apnea and/or hypoventilation requiring respiratory support other than oxygen supplementation for greater than or equal to 16 hours per day currently.
  - The member must have a diagnosis of central sleep apnea (CSA) and have failed to maintain an appropriate PO<sub>2</sub> level (oxygen partial pressure) with continuous positive air pressure (CPAP) and bi-level continuous positive airway pressure (BiPAP) treatments.
  - Documentation by a specialist in otolaryngology or pulmonology of treatment attempts will accompany the PA request.
  - The breathing pacemaker should never be recommended for treatment of obstructive sleep apnea (OSA).
- Documentation indicating medical necessity for the appropriate diagnosis will be submitted prior to surgical implantation of the stimulator wires.

### **Pneumatic Artificial Voicing Systems**

The IHCP provides coverage for a pneumatic artificial voicing system or an artificial larynx, subject to prior authorization.

#### **Prior Authorization for Pneumatic Artificial Voicing Systems**

Prior authorization will be granted upon satisfaction of the following:

- Documentation must be presented that substantiates the member has demonstrated sufficient mental and physical capabilities to benefit from the use of the system
- Documentation must be presented that substantiates the member has demonstrated sufficient articulation and language skills to benefit from the use of the system

### **Spinal Cord Stimulators**

An implanted spinal cord stimulator (SCS) is an electronic device consisting of surgically implanted electrodes connected by leads to a receiver or pulse generator. The power source can be either external or internally implanted. Implantation is often preceded by a trial with a percutaneous electrode system. Electrodes are surgically placed on or near the spinal cord to stimulate large-fiber neurons. In turn, this stimulation blocks small-fiber neuronal signals that are

interpreted as pain, thus relieving pain that has otherwise been intractable to standard treatment.

SCS is used to treat chronic pain syndromes intractable to other treatment modalities. SCS is frequently used to treat failed back surgery, complex regional pain syndromes, peripheral neuropathies, angina, peripheral vascular disease, post-herpetic neuralgia, occipital neuralgia, and chronic pelvic pain. This treatment is considered a last resort for individuals who have failed other treatment options for the management of intractable, chronic pain.

## **Prior Authorization for Spinal Cord Stimulators**

Prior authorization is required for both the trial and permanent phases of this service. The IHCP will only cover SCS services with appropriate medically necessary ICD-10-CM diagnosis codes. Diagnoses of chronic, non-malignant, neuropathic pain will be considered for approval on a case-by-case basis by a pain management consultant if all other PA criteria are met.

### **Trial Stimulation Period**

The first phase of SCS must be evaluated prior to a permanent SCS implantation. Members must meet the following criteria for the three- to seven-day trial stimulation period:

- The implantation of the stimulator is used only as a treatment of last resort for members with chronic intractable, non-malignant pain.
- There is documented pathology, such as an objective basis for the pain complaint.
- There must be documentation of failure of at least six (6) months of conservative treatment, including at least three (3) of the following:
  - Pharmacological therapy
  - Surgical management
  - Physical therapy
  - Psychological therapy
- The member must not be a candidate for further surgical interventions.
- An evaluation must be performed by a physician experienced in treating chronic pain, which includes documentation of a psychological evaluation, as well as a consultation from another pain specialist, that indicates the member would benefit from SCS.
  - The psychological evaluation should reveal no evidence of an inadequately controlled mental health problem (e.g., alcohol or drug dependence, depression, psychosis) that would negatively impact the success of a SCS or contraindicate its placement

- The member must not have any existing, untreated drug addictions.

### **Permanent SCS Implantation**

Following the trial stimulation period, PA will be approved for permanent implantation after the following criteria have been met:

- All six criteria for a three- to seven-day trial implantation period must be met.
- The trial implantation must show a 50 percent reduction in pain for at least two days in order to receive approval for permanent implantation. Providers must submit documentation of successful treatment.
- IHCP providers are directed to use the Multidimensional Affect and Pain Scale, the Brief Pain Inventory, and/or the Faces Pain Scale to measure pain levels. Providers are responsible for deciding which pain measurement scale is appropriate for each member.

### **Intractable Angina**

The IHCP covers SCS for the treatment of intractable angina for members who are not surgical candidates and whose pain is unresponsive to standard therapy. Following the trial stimulation period, PA will be approved for permanent implantation after the following criteria have been met for the treatment of intractable angina:

- Angiography documents significant coronary artery disease, and the patient is not a candidate for percutaneous transluminal coronary angiography (PTCA) or coronary artery bypass grafting (CABG).
- The angina pectoris is New York Heart Association Functional Class III or IV.
- Reversible ischemia is documented by symptom-limited treadmill exercise tests.
- The member has had optimal pharmacotherapy for at least one month. Optimal pharmacotherapy includes the maximum tolerated doses of at least two of the following medications: long-acting nitrates, beta-adrenergic blockers, or calcium channel blockers have failed to adequately improve angina symptoms.
- There is documentation of successful trial spinal cord stimulator implantation showing a 50 percent reduction in pain for at least two days.

### **Standers**

The IHCP will reimburse for standers considered medically necessary in non-institutional settings. Types of covered standers include:

- Prone
- Supine

- Vertical
- Multi-Positional
- Sit-to-Stand

Some standers are categorized as mobile or dynamic standers. These standers allow self-propulsion in the standing position throughout large areas. Mobile standers are identified as having large pneumatic wheels similar or identical to manual wheelchairs. Some mobile standers are electrically powered. The IHCP will not provide reimbursement for mobile standers.

## **Prior Authorization for Standers**

Prior authorization is required for all covered standers. The IHCP has developed a medical clearance form to help providers supply the necessary documentation required for PA staff to evaluate medical information. The medical clearance form must be signed by the physician who orders the stander and must be included with the PA request.

All initial requests for standers require PA and a completed medical clearance form signed by the physician. A copy of a physical therapy and/or occupational therapy evaluation within the last two months, which shows the patient's functional and cognitive baseline and ability to progress with therapy, will be required for the initial PA. The request for initial PA must also include documentation of medical necessity and a plan of care (POC) signed by the ordering physician. Subsequent requests for PA will require ongoing documentation indicating progress towards goals up through the 15th month or the final month, and a completed medical clearance form signed by a physician.

## **Plan of Care (POC)**

The POC must include the following documentation:

- Measurable goals for therapy and training, therapy necessary to obtain a stander may be performed by a physical therapist (PT), occupational therapist (OT), or family member who has been properly trained to perform the necessary exercises.
- Estimated amount of time the member is expected to stand. The member should be able to stand one hour a day or have the potential goal of standing one hour a day. The member is not required to stand for one hour continuously.
- List expected benefits from utilizing the stander as an adjunctive therapy. Examples of the benefits of passive standing include, but are not limited to, the following benefits:
  - Aids in the prevention of atrophy in the trunk and leg muscles
  - Improves circulation to the trunk and lower extremities
  - Prevents formation of decubitus ulcers (pressure sores) with changeable positions

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- Helps maintain bone integrity
- Reduces swelling in the lower extremities
- Improves range of motion
- Improves kidney and bladder function
- Decreases muscle spasms
- Strengthens the cardiovascular system and builds endurance
- Improves strength of the trunk and lower extremities
- Prevents or decreases muscle contractures
- Lessens or prevents progressive scoliosis
- Aids normal skeletal development
- Improves bowel function

### General Diagnosis

The PA request must include an appropriate diagnosis demonstrating the medical necessity for a stander. Diagnoses may include but are not limited to the following.

### Codes Demonstrating Medical Necessity for Stander

Code	Description
F72	Severe intellectual disabilities
F73	Profound intellectual disabilities
G12.21	Amyotrophic lateral sclerosis
G35	Multiple sclerosis
G36, G36.9	Other acute disseminated demyelination
G37, G37.9	Other demyelinating diseases of central nervous system
G71, G71.0-G71.3	Primary disorders of muscles
G80, G80.0, G80.1, G80.9	Cerebral palsy
G81-G81.94	Hemiplegia and hemiparesis
G82-G82.54	Paraplegia (paraparesis) and quadriplegia (quadriparesis)
G93, G93.4-G93.49	Other disorders of brain
G95, G95.20, G95.29, G95.9	Other and unspecified diseases of spinal cord
Q04, Q04.4-Q04.8	Other congenital malformations of brain
Q05, Q05.5-Q05.8	Spina bifida
R62, R62.50, R62.59	Lack of expected normal physiological development in childhood and adults



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S14, S14.1-S14.158S	Injury of nerves and spinal cord at neck level
S24, S24.1-S24.154S	Injury of nerves and spinal cord at thorax level
S34-S34.139S, S34.3-S34.3XXS	Injury of lumbar and sacral spinal cord and nerves at abdomen, lower back and pelvis level
T74.4XXA	Shaken infant syndrome, initial encounter

## **Additional Multiple-Positional Stander PA Criteria**

When a multi-positional stander is requested, the provider must indicate the secondary complications that justify the need for a multi-positional stander. Secondary complications include but are not limited to the following examples:

- The member requires postural drainage.
- The member requires suctioning related to excessive secretions while in the stander.
- The member has a history of postural hypotension.

Additional documentation that must be included in the PA request for a multi-positional stander includes the following:

- Specific muscle groups targeted for stretching and strengthening in the stander and expected outcomes
- Specific orders indicating the proper positioning of the member in the stander

## **Sit-to-Stand Prior Authorization Criteria**

All requests for sit-to-stand standers will be considered on a case-by-case basis. All diagnoses listed previously will be considered for sit-to-stand standers. The member must be able to perform the following:

- Maneuver from a sitting to a standing position without assistance
- Stand vertically or have the medical potential to stand vertically in the near future

Documentation of medical justification for a sit-to-stand stander must be included in the PA request. Some examples of secondary conditions that may justify the need for a sit-to-stand stander are as follows:

- Children who are not ready to stand fully upright, but are actively in transition between sitting and standing
- Highly independent youth and adults who can stand vertically and safely transfer alone



- Members who cannot stand for long periods of time due to contractures or muscle weakness
- Members with orthostatic hypotension

Certain sit-to-stand standers have a mobility option. The mobility option is identified by two medium sized all-terrain tires on the front of the stander and casters in the rear of the stander. Two maneuvering wheels are placed at waist level and attached to a pulley system which allows the member limited mobility in a small area.

The IHCP will cover the mobility option as a reimbursable accessory. The mobility option will be approved only for members with independent capabilities, and the bilateral upper-body strength and coordination to maneuver themselves.

Children are not required to be independent to meet the criteria for sit-to-stand standers. Decisions regarding approval for children will be made on a case by case basis.

The PA will specify the brand name, model number, type of stander, and base price of the stander. Trays are included in the stander's base price. Upgraded trays will not be reimbursed. Certain supports and straps are included in the stander's base price, as noted previously. Upgraded supports and straps are considered on a case-by-case basis. An itemized list of any additional attachments and accessories with individual prices must be included with the PA request.

## Vagus Nerve Stimulator

IHCP reimbursement for implantation, revision, programming and reprogramming, and removal of a vagus nerve stimulator is available for members of all ages with medically intractable partial onset seizures who are not otherwise surgical candidates. Providers are required to perform this procedure on an outpatient basis whenever medically possible.

In situations where complicating factors require this procedure to be performed on an inpatient basis, medical history and records must support the need for the inpatient admission. Prior authorization is not required for the hospital admission or the device (reimbursement for the device is included in the DRG payment). The device cannot be billed separately for inpatients.

Relative contraindications to VNS therapy, which should be evaluated on an individualized basis, include: severe sleep apnea, an absent left vagus nerve, or a medical condition requiring MR imaging incompatible with the VNS.

The IHCP does not cover vagus nerve stimulators for resistant depression or treatment of chronic pain.

## **Prior Authorization for Vagus Nerve Stimulator**

Prior authorization must be obtained by the physician for implantation of a vagus nerve stimulator regardless of setting. Implantation and all equipment requires prior authorization. The following documentation must be maintained in the medical record and submitted with the request for PA:

- Documentation indicating an evaluation has been made by a neurologist
- Documentation of the member's type of epilepsy
- Documentation indicating the member's seizures are medically intractable (member continues with an unacceptable number of seizures with adequate treatment consisting of two or more anti-epileptic drugs (AEDs) for a period of at least 12 months)
- Documentation indicating that the member is not an intracranial surgical candidate or that surgery has been unsuccessful (for example, the member is not a surgical candidate due to multiple epileptic foci)

## **Ventricular Assist Device**

The IHCP only covers ventricular assist devices (VADs) that have been approved by the FDA. VADs, including those designed for use in the left ventricle (LVADs), the right ventricle (RVADs), or both ventricles (BIVADs), are considered medically necessary by the IHCP under the following conditions:

### **Postcardiotomy Cardiogenic Shock**

Treatment of postcardiotomy cardiogenic shock is covered by the IHCP when ventricular dysfunction continues after maximum medical therapy or as a means of myocardial recovery support for individuals who are unable to be weaned off cardiopulmonary bypass with maximal inotropic support and use of an intra-aortic balloon pump (IABP).

### **Bridge-To-Transplant**

Covered by the IHCP for members who meet the following criteria:

- The member must be at risk of imminent death from nonreversible left ventricular failure (New York Heart Association [NYHA] Class III or IV).
- The member has been prior authorized for a heart transplant (excluding dual eligible members).
- The member is listed as a candidate for heart transplantation by a Medicare and Medicaid approved heart transplant center.
- If the VAD is implanted at a different site than the Medicare and Medicaid-approved transplant center, the implanting site must receive written permission from the Medicare

and Medicaid-approved center under which the patient is listed for transport prior to implantation of the VAD.

## **Destination Therapy**

Covered by the IHCP for members who meet the following criteria:

- The member must not be a candidate for heart transplant.
- The member must have chronic end-stage heart failure (NYHA Class IV) for at least 90 days, and have a life expectancy of less than two years.
- The member's Class IV heart failure symptoms must have failed to respond to optimal medical therapy for at least 60 of the last 90 days. Medical therapy must include the treatments as listed.
  - Salt restriction
  - Diuretics
  - Digitalis
  - Beta-blockers
  - Angiotensin receptor blockers (ARBs) or angiotensin-converting enzyme (ACE) inhibitors (if tolerated)
- Left Ventricular Ejection Fraction (LVEF) must be less than 25%.
- The member has demonstrated functional limitation with a peak oxygen consumption of less than 12ml/kg/min or continued need for IV inotropic therapy due to symptomatic hypotension, decreasing renal function, or worsening pulmonary congestion.
- The member has the appropriate body size (greater than or equal to 1.5m<sup>2</sup>) to support the LVAD implantation.
- VAD implantation must occur at a Medicare and Medicaid-approved heart transplant center.

A VAD is a covered service for postcardiotomy cardiogenic shock or bridge-to-transplant only if it has received approval from the FDA for the intended purpose, and only if it is used according to the FDA-approved labeling instructions for that intended purpose.

A VAD is a covered service for destination therapy only if it has received approval from the FDA for destination therapy or as a bridge-to-transplant, or has been implanted as part of an FDA investigational device exemption trial for one of these two indications.

## **Non-covered Services**

- VADs are non-covered for all other conditions not listed above.

- Use of a non-FDA approved VAD is considered investigational and is a non-covered service.
- The artificial heart (i.e. AbioCor, CardioWest) as a replacement heart for a diseased heart is non-covered by the IHCP.

### **Prior Authorization for Ventricular Assist Device**

VADs, including LVADs, RVADs, and BiVADs, and their surgical implantation do not require prior authorization. Members who receive bridge-to-transplant or destination therapy, and who can continue therapy on an outpatient basis, will require accessory equipment for use with the VAD.

### **Stationary Power Base and Display Module**

- The power base is the electrical supply unit for the VAD. It provides tethered functioning of the VAD by powering the VAD and simultaneously recharging the batteries. The display module provides pump functioning information for the physician in order to evaluate patient status.
- The power base is purchased by the hospital or DME provider as a capital expense and loaned to the member. The hospital or DME provider is reimbursed a rental payment while the equipment is being used on an outpatient basis by the member.

### **Patient Supplies and Replacement Equipment**

- Includes system controller, rechargeable batteries, a travel case, a shower kit, and other miscellaneous supplies.
- The hospital or DME provider must supply the patient supplies and replacement equipment.

## **Wheelchairs**

The IHCP will reimburse for a manual wheelchair, motorized/power wheelchair, power operated vehicle (POV), and wheelchair accessories when medically necessary for IHCP members. Certain medical criteria must be met for the approval of each piece of equipment. The different wheelchair accessories included in this section are listed below:

- Programmable electronic parts
- Wheelchair cushions
- Wheelchair positioning accessories
- Mounting hardware
- Universal headrest plates

- Power seating systems
- Leg rests

IHCP will reimburse for one manual wheelchair, motorized/power wheelchair, or power operated vehicle (POV) per five (5) year period, unless there is a change in the recipient's medical needs documented in writing by the requesting provider. The change in medical needs must be significant enough to warrant a different type of equipment. Any wheelchair designated for use as a backup will be denied as not medically necessary.

Reimbursement for manual and motorized/power wheelchairs includes all labor charges involved in the assembly of the wheelchair. Reimbursement of manual wheelchairs, power/motorized wheelchairs, and POVs also includes emergency services, delivery, setup, and items covered under warranty.

**Note:** The IHCP includes standard non-motorized wheelchairs in the *per diem* rate for LTC facilities. Providers can submit requests for custom wheelchairs for LTC members to the appropriate prior authorization entity for approval only if there is a medical necessity for the custom wheelchair.

The care of members in LTC facilities includes safety, propulsion, evaluation of the member for breakdown, and an active plan of care to prevent and treat decubitus ulcers, providers should not request custom wheelchairs for the sole purpose of providing safety, preventing decubitus ulcers, allowing self-propulsion, or providing restraint. However, if a member's diagnosis supports the medical necessity for a custom wheelchair, providers must follow normal PA process using IHCP PA and medical clearance forms.

### Standing Wheelchairs

The IHCP does not cover standing wheelchairs, because there is insufficient clinical data to support the benefits of this equipment.

The manufacturers use criteria for an individual to qualify for a standing wheelchair based upon coordinated efforts with physical therapy, occupational therapy, and physician providers.

### Prior Authorization for Wheelchairs

#### Manual Wheelchairs

The IHCP will reimburse for both standard and nonstandard manual adult wheelchairs, and for manual pediatric wheelchairs. A standard adult wheelchair is defined as a wheelchair with a base that weighs more than 36 pounds, with seat dimensions of 16 to 18 inches wide, 16 inches deep, and between 19 and 21 inches high. A standard wheelchair includes a non-adjustable back height of 16 to 17 inches, fixed or detachable arm rests, fixed or detachable foot rests, and footplate extensions of 16 to 21 inches.



A nonstandard adult wheelchair is a wheelchair base other than a standard wheelchair or custom wheelchair. Nonstandard wheelchair bases include, but are not limited to the following: fully-reclining, hemi, lightweight, ultra-lightweight, high strength lightweight, semi-reclining, amputee, heavy duty, wide heavy duty, extra heavy duty, tilt-in-space, and motorized/power wheelchairs.

The IHCP will reimburse for a manual wheelchair, when medically necessary. Requests for manual wheelchairs require completed medical clearance forms submitted with the PA request, including an IHCP Non-Motorized Wheelchair Medical Clearance form signed by a physician that documents the member's condition, mobility needs, and/or prognosis to support the medical necessity for a manual wheelchair.

### **Power Mobility Devices (PMDs)**

Power Mobility Devices (PMDs) includes POVs and power wheelchairs. Motorized vehicles are covered only when the recipient is enrolled in a school, sheltered workshop, or work setting, or if the recipient is left alone for significant periods of time. It must be documented that the recipient can safely operate the vehicle and that the recipient does not have the upper extremity function necessary to operate a manual wheelchair.

The following defined criteria must be met for a member to qualify for any PMD:

- The member must have significant mobility limitations that restrict his or her ability to complete one or more mobility related activities of daily living (MRADLs), such as toileting, feeding, dressing, or bathing.
- The member's mobility issues are not resolved safely with the use of a cane or walker.
- The member is unable to utilize a properly fitted and functioning manual wheelchair in the home, at work, at school, or in the workshop to complete the MRADL for the following reasons:
  - Lack of upper body strength
  - Lack of coordination
  - Limited range of motion in upper body
  - Presence of pain that limits upper body mobility
  - Upper body physical deformity or amputations

A medical clearance form must be completed for the IHCP to consider requests for power wheelchairs or similar motorized equipment.

### **Motorized/Power Wheelchairs**

A member who requires a motorized/power wheelchair is usually non-ambulatory and has severe weakness of the upper extremities due to a neurologic or muscular disease or condition and would otherwise be confined to a bed or chair without the use of the

power wheelchair. A power wheelchair is covered if the member's condition is such that the requirement for a power wheelchair is long-term (at least six (6) months).

All IHCP members requesting a motorized/power wheelchair must meet the following criteria:

- The CMS defined basic coverage criteria are met.
- The member does not qualify for a POV.
- The member is physically and mentally able to safely operate a power wheelchair or has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available and willing to operate the power wheelchair for the IHCP member.
- The home environment allows appropriate access with a power wheelchair, including maneuvering space and appropriate surfaces.
- The member does not exceed the weight limitations for the power wheelchair provided.
- A power wheelchair will significantly improve the member's ability to independently perform MRADLs.
- The IHCP member is willing to use a power wheelchair.

Providers cannot bill separately for programmable electronic systems that come standard on the specific motorized or power wheelchair model provided. The IHCP allows separate reimbursement only if an electronic system is an upgrade to a system that comes standard on a specific wheelchair model.

Certain patients may need adaptive switch controls such as a sip-and-puff, or patients with degenerative diseases whose prognosis could worsen in the future may need additional drive controls and programming not available on the basic one-drive electronic system. The medical necessity supporting the need for a programmable electronic system upgrade must be included on the IHCP medical clearance form for motorized/power wheelchairs.

The following accessories and options are considered to be included in the basic equipment package for power wheelchairs (any exceptions must be submitted for PA consideration at the time of the wheelchair is purchased or rented):

- Lap belt or safety belt
- Battery charger
- A complete set of tires and casters, any type
- Leg rests
- Leg rest/leg rest platform
- Arm rest

- Weight specific components, such as braces, bars, upholstery, brackets, motors, or gears, mandated by additional patient weight
- Any seat width and depth
- Any back width
- Controller and input devices for non-expandable and standard proportional joystick

The services listed below are allowed outside the basic equipment package for all power wheelchairs in groups 1 through 5 with PA and only if medical necessity criteria are met. Any services billed outside the basic equipment package must be submitted on the same day claim for the same date of service:

- Adjustable height arm rests
- Shoulder harness/straps or chest/straps/vest
- Elevating leg rests
- An expandable controller
- Nonstandard joystick, that is, non-proportional or mini, compact, or short throw proportional

Similarly, the services listed below are allowed outside the basic equipment package for all power wheelchairs in groups 3, 4, and 5 with PA, and only if medical necessity criteria are met. Any services billed outside the basic equipment package must be submitted on the same day claim for the same date of service:

- Angle adjustable foot plates
- Power wheelchairs with a sling/solid seat/back:
  - Standard duty, seat width and/or depth greater than 20 inches
  - Heavy duty, seat width and/or depth greater than 22 inches
  - Very heavy duty, seat width and/or depth greater than 24 inches
- Power wheelchairs with a sling/solid seat/back:
  - Standard duty, back width greater than 20 inches
  - Heavy duty, back width greater than 22 inches
  - Very heavy duty, back width greater than 24 inches

Non-standard seat and back will only be provided if the IHCP member's physical dimensions are provided and require the additional seat width and depth. PA and medical necessity criteria are required.

### **Motorized/Power Wheelchairs – Single Power Option**

For groups 2 and 5, single-power, option-power wheelchairs, **one** of the following additional criteria must apply:

- The IHCP member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as head control, sip and puff, switch control, and so forth)
- The IHCP member meets the requirements for a power tilt or power recline seating system, and the system is being used on the wheelchair.

For groups 3 and 4, single-power, option-power wheelchairs, the following additional criteria apply:

- The IHCP member has mobility limitations due to a neurological condition, myopathy, or congenital skeletal deformity.
- And **one** of the following additional criteria:
  - The IHCP member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as, head control, sip and puff, switch control, and so forth).
  - The IHCP member meets the requirements for a power tilt or power recline seating system, and the system is being used on the wheelchair.

### **Motorized/Power Wheelchairs – Multiple Power Option**

Groups 2 and 5, multiple-power, option-power wheelchairs, require any **two** of the three criteria listed below:

- The IHCP member uses a ventilator that is mounted to the wheelchair.
- The IHCP member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as, head control, sip and puff, switch control, and so forth)
- The IHCP member meets the requirements for a power tilt or power recline seating system and the system is being used on the wheelchair.

For groups 3 and 4, multiple-power, option-power wheelchairs, the following criteria apply:

- The IHCP member has mobility limitations due to a neurological condition, myopathy, or congenital skeletal deformity.
- And any **two** of the three criteria listed below:
  - The IHCP member uses a ventilator that is mounted to the wheelchair.
  - The IHCP member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as, head control, sip and puff, switch control, and so forth)

- The IHCP member meets the requirements for a power tilt or power recline seating system and the system is being used on the wheelchair.

## **Motorized/Power Wheelchairs – No Power Option**

For no-power option groups 3 and 4 power wheelchairs, the IHCP member must have mobility limitations due to a neurological condition, myopathy or congenital skeletal deformity.

## **Power Operated Vehicles (POVs)**

The IHCP will reimburse for a POV, such as scooters, for members who are unable to operate manual wheelchairs and who have adequate trunk stability to safely operate the vehicle. A POV should be considered when the member does not require the full support or features that are provided by power wheelchairs. POVs are not covered by the IHCP when they are needed for use outside the home only, or to allow the member to perform leisure or recreational activities. Therefore, POVs that are designed, by size and features, primarily for outdoor use, will be denied as not medically necessary.

The prior authorization criteria for all POVs are listed below:

- The CMS defined basic coverage criteria are met.
- The member has the ability to safely transfer to and from the POV.
- The member has the ability to operate the tiller-steering system.
- The member has the ability to maintain proper body position and stability while operating the POV.
- The member has the physical and mental capability to safely operate a POV.
- The home environment allows appropriate access with a POV, including maneuvering space and appropriate surfaces.
- The patient does not exceed the weight limitations for the POV provided.
- A POV will significantly improve the IHCP member's ability to independently perform MRADL.
- All accessories and options for a POV are included in the initial reimbursement rate of the POV, including but not limited to the following:
  - Lap or safety belt
  - Battery or batteries required for operation
  - Battery charger, single mode
  - Complete set of tires
  - Weight appropriate upholstery and seating system
  - Tiller steering
  - Non-expandable controller with proportional response to input



- All accessories needed for the safe operation of the POV

A completed IHCP Motorized Wheelchair Purchase Medical Clearance Form must be submitted with the PA request form that documents the member's condition, mobility needs, and/or prognosis to support the medical necessity for a POV. Documentation must indicate the member's condition that renders them unable to operate a manual wheelchair. Documentation must also indicate the member is capable of safely operating a POV, can transfer in and out of a POV, and has adequate trunk stability to safely ride in and operate the POV.

### **Wheelchair Accessories – Universal Headrest Plate**

Reimbursement of the universal plates are subject to the following PA criteria:

- The IHCP covers universal headrest when the initial headrest ordered for a new wheelchair does not meet the member's needs upon the first or subsequent fittings.
- The IHCP covers universal headrest plates for a used wheelchair if the member's condition changes, and if the wheelchair back is not pre-drilled for the headrest. The provider must provide documentation of the medical necessity for the headrest.
- The IHCP covers replacement universal headrest plates with documentation of an explanation for the replacement (for example, the plate is damaged due to high tone or spasticity of the patient).

The IHCP does not cover universal headrest plates for the initial headrest ordered for use on a new wheelchair. The wheelchair back should be predrilled to accommodate the headrest initially ordered with the wheelchair.

On the PA request, the provider must document the brand name and model, of the original headrest, and include an explanation of why the headrest did not meet the member's needs. In addition, the provider must indicate the brand name and model of the subsequent headrest that will be used on the wheelchair.

### **Wheelchair Accessories – Elevating Leg Rests**

IHCP covers elevated leg rests if the member meets the following criteria:

- Documentation of musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee
- Documentation of significant edema of the lower extremities
- Evidence that the IHCP member meets the criteria for and has a reclining back on the wheelchair

The provider must provide documentation that the member meets the above criteria.

### **Wheelchair Accessories – Power Tilt and/or Recline Seating System**

The following criteria must be met to be reimbursed for a power tilt or recline seating system, or the combination of a power tilt and recline seating system:

- The IHCP member must qualify for a power wheelchair that accommodates a power tilt and/or recline seating system.
- The IHCP member had an evaluation that was performed by a licensed/certified medical professional, such as a physical or occupational therapist, or a physician who has specific training and experience in rehabilitation wheelchair evaluations. These professionals must document the medical necessity for the device and its special features in the patient's home, work, school, or workshop. The PT, OT, or physician may have no financial relationship with the supplier, and
- The provider must substantiate and document that the IHCP member meets one of the following in addition to criteria 1 and 2 above:
  - IHCP member is unable to perform a functional weight shift and therefore at high risk of developing pressure ulcers.
  - Patient utilizes intermittent catheterization for bladder management and is unable to transfer independently from the wheelchair to the bed.
  - The seating system will be used to manage increased tone and spasticity.

## Prior Authorization

Prior authorization requests for DME shall be reviewed on a case-by-case basis by the contractor using all of the following criteria:

- The item must be medically reasonable and necessary, as defined in *405 IAC 5-2-17*, for the treatment of an illness or injury or to improve the member's functional level.
- The item must be adequate for the medical need; however, items with *unnecessary* convenience or luxury features will not be authorized.
- The anticipated period of need plus the cost of the item will be considered in determining whether the item shall be rented or purchased. This decision will be made by the contractor based on the least expensive option available to meet the recipient's needs.

For specific prior authorization requirements, see the specific DME section.

## Billing and Coding

For further billing information, see the [Durable and Home Medical Equipment and Supplies](#) and [Surgical Services](#) provider reference modules. For a list of billing codes, see the *Durable and Home Medical Equipment and Supplies Codes* and the *Surgical Services Codes* on the [Code Sets/Tables](#) webpage.

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## Rules and Citations

[405 IAC 5](#)

•

[IHCP Provider Bulletins](#)

•

[IHCP Provider Banners](#)

•

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication; added coverage for custom tracheostomy tubes

## Early and Periodic Screening Services

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### Description of Service

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

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

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#### Initial Screening

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

#### Periodic Screening

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

A periodic screening shall include the following:

- A comprehensive health and developmental history, including assessment of both physical and mental health development.
- A comprehensive unclothed physical exam.
- A nutritional assessment.
- A developmental assessment.
- Appropriate vision and hearing testing.

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- Dental screening.
- Health education, including anticipatory guidance.

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

### HealthWatch Periodicity and Screening Schedule

The initial screening and subsequent, periodic screenings must be performed according to the HealthWatch Periodicity and Screening Schedule (periodicity schedule) shown below. This table can be seen in greater detail at [405 IAC 5-15-8](#).

HealthWatch/EPSDT Periodicity and Screening Schedule

	AGE	INFANCY <sub>1</sub>								EARLY CHILDHOOD <sub>2</sub>					MIDDLE CHILDHOOD <sub>3</sub>					ADOLESCENCE <sub>4</sub>				
		NEWBORN <sub>1</sub>	2-4ds	By 1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	12y	14y	16y	18y	20y	
HISTORY:INITIAL/INTERVAL		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
MEASUREMENTS																								
Height and Weight		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Head Circumference		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Blood Pressure													•	•	•	•	•	•	•	•	•	•	•	
SENSORY SCREENING																								
Vision <sup>5</sup>		S	S	S	S	S	S	S	S	S	S	S	O <sub>6</sub>	O	O	S	S	O	O	S	S	O	S	
Hearing <sup>6</sup>		S/R	S	S	S	S	S	S	←	←	←	←	←	O	O	S	S	O <sub>6</sub>	O <sub>6</sub>	S	S	O <sub>6</sub>	S	
DEVELOPMENTAL																								
BEHAVIOR ASSESSMENT		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
PHYSICAL EXAMINATION		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
PROCEDURES - GENERAL																								
Immunization <sup>7</sup>		•	→	→	•	•	•		←	•	→			←	•	→				•	→			
Lead Screening <sup>8</sup>								•	→			•	R	R	R	R	R	R	R	R	R	R	R	
Hematocrit or Hemoglobin				←	←	←	←	•				•							←	11	←	←	←	
Urinalysis																•			←	12	←	←	←	
PROCEDURES - PATIENTS																								
AT RISK																								
Tuberculin Test <sup>9</sup>									R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	
Slide Cell Test <sup>10</sup>		•																						
Drug/HIV Testing <sup>10</sup>		R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	
STD Screening <sup>10</sup>																			R	R	R	R	R	
Pelvic Exam																			R	R	17	→	R	
ANTICIPATORY GUIDANCE		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Injury Prevention		•			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Dental Referral									←	←	←	←	•	•	•	•	•	•	•	•	•	•	•	
Dental Observation <sup>10</sup>		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Newborn Infant Screen <sup>10</sup>		←	→																					

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

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

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



With regard to dental care, once the member has been referred for dental screening, the dental provider must follow the IHCP EPSDT Dental Periodicity Schedule shown below.

## IHCP EPSDT Dental Periodicity Schedule

Service Provided	Age				
	6-12 months	12-24 months	2-6 years	6-12 years	>12 years
Clinical oral examination <sup>1,2</sup> to include:	•	•	•	•	•
Assess oral growth and development <sup>3</sup>	•	•	•	•	•
Caries-risk assessment <sup>4</sup>	•	•	•	•	•
Anticipatory guidance/ counseling <sup>6</sup>	•	•	•	•	•
Injury prevention counseling <sup>7</sup>	•	•	•	•	•
Counseling for nonnutritive habits <sup>8</sup>	•	•	•	•	•
Counseling for speech/language development	•	•	•		
Substance abuse counseling				•	•
Counseling for intraoral/perioral piercing				•	•
Assessment for pit and fissure sealants <sup>9</sup>			•	•	•
Transition to adult dental care					•
Radiographic assessment <sup>5</sup>	•	•	•	•	•
Prophylaxis and topical fluoride <sup>4,5</sup>	•	•	•	•	•
Assessment and treatment of developing malocclusion			•	•	•
Assessment and/or removal of third molars					•

<sup>1</sup> First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility to disease.

<sup>2</sup> Includes assessment of pathology and injuries

<sup>3</sup> By clinical examination

<sup>4</sup> Must be repeated regularly and frequently to maximize effectiveness

<sup>5</sup> Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

<sup>6</sup> Appropriate discussion and counseling should be an integral part of each visit for care.

<sup>7</sup> Initially play objects, pacifiers, car seats; then, when learning to walk, sports and routine playing, including the importance of mouth guards

<sup>8</sup> At first, discuss the need for additional sucking: digits vs. pacifiers; then, the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

## Treatment

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

## Recipient and Provider Participation

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

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

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

## Screening Referrals

HealthWatch/EPSDT providers are required to make dental, vision, hearing, and lead screening referrals when screening results indicate a problem. Providers may refer members for dental services beginning at 24 months old or as early as 12 months, if indicated in the screening.

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

**Periodicity Schedule – Dental Observation and Screening**

Age of Child	Subjective (S) or Required (R)	Services
Younger than 12 months	S	Direct referral to a dentist for medically appropriate services, if warranted by injury, disease, congenital abnormality, or other cause
12 to 24 months	S	Direct referral to a dentist, if necessary
24 months	R	Direct referral to a dentist for examination, preventive dental care, and anticipatory guidance

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24 months through 20 years	R	Regular dental assessments at intervals defined by the dentist (approximately every six months). The individual member's assessment should include examination, preventive dental care, and anticipatory guidance.
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## Periodicity Schedule – Vision Observation and Screening

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

## Periodicity Schedule – Hearing Observation and Screening

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

4 to 5 years	R	Audiometric screening with an audiometer or audioscope (refer to audiologist, if necessary). Refer child at risk or suspected of a hearing deficit to an appropriate specialist.
6, 8, 14, 16, 20 years	S	Subjective screening, by history and/or other method; refer child with suspected hearing deficit to an appropriate specialist.
10, 12, 18 years	O	Objective hearing screening by a standard testing method (hearing tests are given by the Indiana Department of Education in grades one, four, seven, and 10; several schools also test kindergarten students). Do not duplicate school screenings unless a child is considered at risk and rescreening is warranted.

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

## Blood Lead Screenings

Blood lead screenings must be performed between the ages of 9 and 12 months, and again at 24-month visits. If the member is at high risk for lead exposure, the initial screening should be performed at the six-month visit and repeated at the 12-month and 24-month visits. Children between the ages of 36 months and 72 months of age must receive a blood lead screening if they have not been previously tested for lead poisoning.

A blood lead test result equal to or greater than 5 µg/dl obtained by a capillary specimen (fingerstick) must be confirmed using a venous blood sample. Subsequent screenings are required for children with blood lead levels equal to or greater than 5 µg/dl.

The ISDH, through the Indiana Lead and Healthy Homes Program (ILHHP), monitors lead poisoning. Providers are required to report all results of blood lead screenings to the ISDH no later than one week after completing the examination. The ILHHP provides medical and environmental case management follow-up for children who are identified with elevated levels of lead in their blood.

## Prior Authorization

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

## Billing and Coding

For further billing information, see the [EPSDT Services](#) provider reference module. For a list of billing codes, see the *EPSDT/HealthWatch Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

### [405 IAC 5](#)

- 405 IAC 5-15: Early and Periodic Screening, Diagnosis, and Treatment Services

### [IHCP Provider Bulletins](#)

- [BT201427](#) BMI to be required component of EPSDT screening

### [IHCP Provider Banners](#)

- [BR201640](#) IHCP clarifies lead screening requirements for children

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication



## Emergency Services

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### Description of Service

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

IHCP reimbursement is available for emergency services provided to IHCP members. As defined by 42 U.S.C. § 1395, an emergency may be perceived by the sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, and (3) serious dysfunction of any bodily organ or part.

Providers must indicate in the appropriate field on submitted claim forms that a provided service was an emergency.

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#### Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary Resuscitation (CPR) is a covered service. It is an all-inclusive procedure and includes central venous pressure catheterization, insertion of arterial lines, endotracheal intubation, and cardioversion. Therefore, separate charges for central venous pressure catheterization, insertion of arterial lines, endotracheal intubation, and cardioversion will be denied, as they are included in the charge for CPR.

Additional charges for care of the member on the same day by the same physician (for example, intensive care visits, hospital visits, and emergency room visits) will also be denied, as they are also included in the charge for the cardiopulmonary resuscitation.

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

These guidelines apply when the same physician bills separately for CPR and any of the above components. Physicians other than the primary physician will be paid for services they provide during the cardiopulmonary resuscitation.

#### Emergency Room Services

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

Per 42 U.S.C. § 1395dd(e)(1)(A), an emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a

prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

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

Emergency services are services provided in the emergency department of a hospital. Providers must indicate in the appropriate field on submitted claim forms that a provided service was an emergency.

**Note:** Package E members receive only emergency services, and the services are reimbursed on a fee-for-service basis. Package E services must meet emergency criteria, as noted in the paragraph above. In the case of pregnant women eligible for coverage under Package E, labor and delivery services are also considered emergency medical conditions.

### **Prior Authorization for Emergency Room Services**

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

## **Post-stabilization Care Services**

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

## **Emergency Dental Services**

The IHCP reimburses medically necessary emergency dental services. Package E members are eligible only for services to treat an emergency medical condition. Preventive treatments such as sealants, prophylaxis, and fluoride treatments do not meet the definition of an emergency medical condition.

**Note:** Package E members who seek dental services that are non-emergencies are responsible for payment of such services.

Field 2 on the ADA dental claim form must be used to specify if the services performed were for emergency care. Providers must include the word "emergency" in this field for emergency care rendered to Package E members. All services are subject to post-payment review, and documentation must support medical necessity for the services performed.

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

## **Emergency Services Related to Hospice**

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

If emergency services are related to the terminal illness, and the hospice member has not revoked the hospice benefit, the hospice provider is responsible for hospice and transportation charges associated with all emergency services.

If the emergency services are unrelated to the terminal illness, the IHCP covers transportation and facility services associated with the emergency services, according to the member's program enrollment.

## **Pharmacy Services**

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

In accordance with federal law, the IHCP allows for the provision of at least a 72-hour supply of a prescribed drug in an emergency, without otherwise applicable prior authorization (such as on weekends and holidays). Pharmacy providers should document the circumstances that support providing the emergency supply and are subject to post-payment review.

## **Emergency Department Physicians**

IHCP reimbursement is available to emergency department physicians who render medically necessary emergency service to IHCP members. If the screen determines the member has an emergency condition, the hospital would bill for medically necessary emergency services, using the appropriate revenue and Healthcare Common Procedure Coding System (HCPCS) codes. The screening revenue code may not be billed in conjunction with emergency room treatment services.

## **Non-emergent Services**

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

**Note:** The following copayments will be used for nonemergency services provide in the emergency department:

**Hoosier Care Connect** - \$3.00 for each nonemergent date of service

**Healthy Indiana Plan** - \$8.00 for a member's first nonemergency use of the hospital emergency department, and \$25.00 for each subsequent nonemergency use of a hospital emergency department during the benefit period. Effective February 1, 2018, the graduated copayment amounts for numerous infractions will no longer apply.

## Psychiatric Services

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

## Prior Authorization

PA is not required for emergency services.

## Billing and Coding

For further billing information, see the [Emergency Services](#) provider reference module. For a list of billing codes, see the *Emergency Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

42 CFR 447.15 – Member copayment

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

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

IC § 12-15-12-17 – Coverage for post-stabilization care services

### [405 IAC 5](#)

### [IHCP Provider Bulletins](#)

- [BT201776](#) IHCP announces upcoming changes to the HIP program
- [BT201579](#) IHCP to require copayments for Hoosier Care Connect members

### [IHCP Provider Banners](#)

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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

### Update History

January 1, 2017 – Initial Publication

February 1, 2018 – Removal of graduated ER copayment schedule for HIP members



## Evaluation and Management Services

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### Description of Service

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

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

### Medical Policy

#### Office Visits

The Indiana Health Coverage Programs (IHCP) provides coverage for the following office visits:

- A maximum of thirty (30) office visits per calendar year, per IHCP member, per provider are allowed without prior authorization.
- New patient office visits are limited to one (1) per member, per provider within the last three years.

Providers are advised to select the billing code that most closely describes the services rendered.

#### Prior Authorization for Office Visits

Prior authorization is required for any visits that exceed thirty (30) office visits during the rolling calendar year.

### Consultations

#### Initial Consultation

The IHCP reimbursement for an initial consultation is limited to one (1) per consultant, per member, per inpatient hospital or nursing facility admission. The IHCP will not reimburse for consultation when a member is referred for management of a condition or when the consulting physician assumes management of the member's care. Per 405 IAC 5-8-3(a), a consultation cannot be used for the evaluation of a nonphysician-referred or self-referred recipient.

#### Follow-up Inpatient Consultation

IHCP reimbursement is available for follow-up inpatient consultations, when additional visits are needed to complete the initial consultation, or if subsequent consultative visits are requested by the attending physician. These consultative visits include monitoring progress, recommending

management modifications, or advising on a new plan of care (POC) in response to changes in the patient's status. If the consulting physician has initiated treatment at the initial consultation, and participates thereafter in the patient's management, the codes for subsequent hospital care should be used.

### **Confirmatory Consultation**

A confirmatory consultation must be specifically requested by another physician or the IHCP contractor, and is used for second and third opinions or advice only. A confirmatory consultation to substantiate medical necessity may be required as part of the prior authorization process. The consultation may not be used for the evaluation of a non-physician referred or self-referred member.

### **Pathology Services**

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

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

### **Dental Services**

The ADA has indicated that a consultation is to be used as a second opinion. When billing for a dental consultation, providers are to report one of the oral evaluation codes.

IHCP providers shall be required, based upon the facts of the case, to obtain a second or third opinion substantiating the medical necessity or approach for maxillofacial surgery related to diseases and conditions of the jaws and contiguous structures. The second opinion is required regardless of the surgical setting in which the surgery is to be performed, such as an ambulatory surgical treatment center, a hospital, or a clinic.

### **Podiatry Services**

A second or third opinion substantiating the medical necessity or approach may be required for bunionectomy procedures and all surgical procedures involving the foot. A confirmatory consultation is required regardless of the setting in which the surgery is performed, including ambulatory surgical centers, hospitals, clinics, or in the office.

Consultation services rendered by a podiatrist in a nursing facility are not covered when performed on members on a routine basis for screening purposes, except in those cases where a specific foot ailment is involved. Documentation must be maintained in the member's medical record.

### **Prior Authorization**

Prior authorization is required for any visits that exceed thirty (30) office visits during the rolling calendar year.

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## Billing and Coding

For further billing information, see the [Evaluation and Management Services](#) provider services module.

## Rules and Citations

[405 IAC 5](#)

•

[IHCP Provider Bulletins](#)

•

[IHCP Provider Banners](#)

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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

## Family Planning Services

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### Description of Service

Family planning coverage is for services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Based on Centers for Medicare & Medicaid Services (CMS) policies, the Indiana Health Coverage Programs (IHCP) also considers initial diagnosis and treatment of sexually transmitted disease (STD) and sexually transmitted infection (STI) and screening, testing, counseling, and referral of members at risk for human immunodeficiency virus (HIV), provided during a family planning encounter to be part of family planning services.

Family planning services include the following:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Limited history and physical examination
- Laboratory tests, if medically indicated as part of the decision-making process for choice of contraceptive methods
- Pregnancy testing and counseling
- Provision of contraceptive pills, devices, and supplies, including emergency contraceptives
- Tubal ligation
- Hysteroscopic sterilization with an implant device
- Vasectomy
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Initial diagnosis and treatment of STDs and STIs, if medically indicated, including the provision of FDA-approved anti-infective agents
- Screening, testing, counseling, and referral of members at risk for HIV
- Cytology (Pap tests) and cervical cancer screening, including high-risk human papillomavirus (HPV) testing, within the parameters described in the [Obstetrical and Gynecological Services](#) provider reference module.

Ongoing follow-up and treatment of chronic STDs and STIs are not considered to be part of family planning services.

**Note:** For Hoosier Healthwise (HHW), Hoosier Care Connect (HCC), and Healthy Indiana Plan (HIP) members, family planning services are self-referred.

## Medical Policy

### Contraceptives

IHCP reimbursement is available for most Food and Drug Administration (FDA)-approved oral contraceptives and contraceptive supplies and devices. Covered drugs, supplies, and devices are as follows:

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

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

Norplant contraceptive systems are no longer available in the United States; however, the IHCP does reimburse for removal of the Norplant systems.

Members must be given information and education about all methods of contraception available, including reversible methods (for example, oral, emergency, injectable, implant, IUD, diaphragm, cervical cap, contraceptive patch, vaginal ring, foam, condom, and rhythm) and irreversible methods (for example, tubal ligation, and vasectomy). Education regarding all contraceptive methods must include relative effectiveness, common side effects, risks,



appropriate use, and difficulty in usage. Basic information concerning STDs and STIs must also be discussed.

Prescriptions for a contraceptive method must reflect the member's choice, except where such choice is in conflict with sound medical practice. Generic medications must be dispensed when available; however, if generic drugs are not available, brand name drugs may be dispensed. Generic and preferred drugs must be used when available, unless the physician indicates a medical reason for using a different drug. In exception, brand name drugs may be dispensed, even if generic drugs are available, if Indiana Medicaid determines that the brand name drugs are less costly to the Indiana Medicaid program.

Contraceptive drugs and supplies may be administered, dispensed, prescribed, or ordered. Prescriptions for family planning drugs and supplies may be refilled as prescribed by the practitioner for up to one year. Emergency contraception may be dispensed or prescribed.

Members are encouraged to follow up with their family planning provider when a specific problem related to a contraceptive method occurs, or additional services and supplies are needed. All members, regardless of the contraceptive method chosen, must be encouraged to return for a physical examination, laboratory services, and health history at least once per year.

### **Sterilization**

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

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

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

A sterilization consent form is not necessary when a provider renders a patient sterile as a result of an illness or injury. The physician must attach a certification to the claim indicating that the sterilization occurred due to an illness or injury when prior acknowledgement was not possible. The provider must also include a description of the nature of the emergency.

### **Informed Consent for Sterilization**

Providers must allow at least 30 days, but not more than 180 days, to pass between the date when the member gives the informed consent and the date when the provider performs the sterilization procedure.

For sterilizations planned concurrent with a delivery, the patient must give the informed consent at least 30 days before the expected date of delivery or confinement. The following exceptions

apply to premature delivery (defined by the IHCP as labor before 37 weeks' gestation) or emergency abdominal surgery:

- The member must sign the *Consent for Sterilization* form 72 hours before the sterilization, when done at the time of a premature delivery.
- The physician must indicate the reason for the surgery being performed early and the individual's expected date of delivery. The reason for the surgery must be only premature delivery or emergency abdominal surgery.

The person who obtains informed consent must verbally communicate all information about a sterilization procedure to the member to be sterilized, including a member who is blind, deaf, or otherwise handicapped. Providers must furnish an interpreter if a language barrier exists. For a full description of the informed-consent process, *42 CFR 441.257* provides additional information.

Providers cannot obtain informed consent while the member to be sterilized is in one of the following situations:

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol or other substances that affect the member's state of awareness

### **Vasectomy**

The IHCP may reimburse for a vasectomy for sterilization that is performed on a male by an IHCP-enrolled provider. Vasectomies are considered permanent, once-per-lifetime procedures. If a vasectomy has previously been reimbursed for the member, providers may appeal with documentation that supports the medical necessity for the repeat sterilization.

### **Tubal Ligation**

The IHCP may reimburse for a tubal ligation for sterilization that is performed on a female by an IHCP-enrolled provider. Tubal ligations are considered permanent, once-per-lifetime procedures. If a vasectomy has previously been reimbursed for the member, providers may appeal with documentation that supports the medical necessity for the repeat sterilization.

### **Hysteroscopic Sterilization with an Implant Device**

Hysteroscopic sterilizations with an implant device provide a nonincision permanent sterilization option. The IHCP covers the Essure implant device as a nonincision permanent sterilization option. The implant can be performed by a medical doctor (MD) or a doctor of osteopathy (DO) trained in the procedure, and can be performed in the office, at an outpatient hospital facility, or in an ASC.

### **Prior Authorization**

Prior authorization is not required for family planning services.

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## Billing and Coding

For further billing information, see the [Family Planning Services](#) provider reference modules. For a list of billing codes, see the *Family Planning Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

[IC 12-15-5](#) Services Provided

- 

[405 IAC 5](#)

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[IHCP Provider Bulletins](#)

- 

[IHCP Provider Banners](#)

- [BR201730](#) IHCP adds diagnosis codes for services covered under the Family Planning Eligibility Program

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

## Federally Qualified Health Centers and Rural Health Clinics

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### Description of Service

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

### Medical Policy

Reimbursement is available for IHCP members seeking medical care in FQHCs and RHCs. A valid encounter visit is described as a face-to-face encounter between a clinic patient and a provider. The following providers may receive reimbursement for services provided in FQHCs and RHCs:

- Clinical psychologist
- Clinical social worker
- Dental Hygienist
- Dentist
- Nurse practitioner
- Optometrist
- Physician
- Physician assistant
- Podiatrist
- Chiropractor

### Covered Services

IHCP reimbursement is available for services and supplies incidental to such services, which would otherwise be covered if furnished by a physician or as an incident to a physician's services. Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, filling and dispensing prescriptions, or providing optician services do not constitute encounters.

Services to a homebound individual are available only in the case of FQHCs located in areas with shortages of home health agencies, as determined by Indiana Medicaid. Any ambulatory service included in the Indiana Medicaid State Plan is considered a covered FQHC service if the FQHC offers such a service. FQHC services are defined the same as services provided by RHCs.

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

These services can be included in the encounter reimbursement when performed in conjunction with the office visit to a valid provider. These services are not reimbursable through claim submission if performed without a face-to-face visit to a valid provider.

FQHCs and RHCs can provide preventive services and encounters, care coordination, and HealthWatch services.

### **Enrollment Status**

FQHCs receive funds through the Public Health Services and receive FQHC status from the Centers for Medicare and Medicaid Services (CMS). To enroll as an FQHC with the IHCP, the CMS letter granting the FQHC status must be forwarded to HPE Provider Enrollment with a completed application. RHCs receive their Medicare designations through CMS and must contact the Indiana State Department of Health (ISDH) to receive RHC status as IHCP providers.

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

### **Multiple Providers on One Day**

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

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

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



## Prior Authorization

FQHCs and RHCs are subject to the same prior authorization requirements that apply to fee-for-service (FFS) and risk-based managed care (RBMC).

## Billing and Coding

For further billing information, see the [Federally Qualified Health Centers and Rural Health Clinics](#) provider reference module.

## Rules and Citations

### [405 IAC 5](#)

- 405 IAC 5-16-5 Rural health clinics and federally qualified health clinics; reimbursement
- 405 IAC 5-16-6 Free-standing clinics and surgical centers; limitations

### [IHCP Provider Bulletins](#)

### [IHCP Provider Banners](#)

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

## Genetic Testing Services

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### Description of Service

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

### Medical Policy Genetic Testing Overview

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

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

Genetic testing is not covered in the following circumstances:

- For the sole convenience of information for the patient without impacting treatment
- All screening tests, except those listed under the newborn screening
- The test is performed for the medical management of other family members unless otherwise specified
- History, physical examination, pedigree analysis, genetic counseling, or completion of conventional diagnostic studies has given a definitive diagnosis

- If a genetic test has previously been performed in order to provide a conclusive diagnosis of the same genetic disorder
- The establishment of paternity

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

## Molecular Pathology

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

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

- Meet all test specific American College of Medical Genetics guidelines
- Receive appropriate PA if required

## Chromosomal Microarray Analysis (CMA)

The IHCP covers CMA testing when it is determined to be medically necessary for diagnosing a genetic abnormality in children with apparent nonsyndromic cognitive DD/ID or ASD, according to the latest accepted Diagnostic and Statistical Manual Disorders (DSM) guidelines.

CMA testing is not considered medically necessary and will not be covered under the following circumstances:

- To confirm the diagnosis of a disorder or syndrome that is routinely diagnosed based on clinical evaluation alone
- For prenatal genetic testing
- For the screening, diagnosis, and management of hematologic or oncologic malignancies
- As a means to predict or evaluate pregnancy loss
- In cases of family history of chromosome rearrangement in a phenotypically normal individual
- All other cases of suspected genetic abnormality in children with DD/ID or ASD

## Definitions Applicable for Chromosomal Microarray Analysis

The following definitions are from the American College of Medical Genetics Guidelines, Evaluation of the Newborn with Single or Multiple Congenital Abnormalities:

- A malformation refers to abnormal structural development.
- A major malformation is a structural defect that has a significant effect on function or social acceptability, e.g. ventricular septal defect or cleft lip.
- A minor malformation is a structural abnormality that has a minimal effect on function or social acceptance, e.g. preauricular ear pit or partial syndactyly (fusion) of the second or third toes.
- A syndrome is a recognizable pattern of multiple malformations. Syndrome diagnoses are often relatively straightforward and common enough to be clinically recognized without specialized testing. Examples include Down Syndrome, neural tube defects, and achondroplasia. However, in the very young, or in the case of symptoms with variable presentation, confident identification may be difficult without additional testing.

### **Prior Authorization for Chromosomal Microarray Analysis**

Prior authorization (PA) is required for CMA testing. To obtain PA for CMA testing, all the following conditions must be met:

- Any indicated biochemical tests for metabolic disease have been performed, and results are nondiagnostic
- FMR1 gene analysis (for Fragile X), when clinically indicated, is negative
- In addition to a diagnosis of nonsyndromic DD/ID or ASD, the child has one or more of the following (see definitions above):
  - Two or more major malformations
  - A single major malformation or multiple minor malformations in an infant or child who is also small-for-dates
  - A single major malformation and multiple minor malformations
- The results for the genetic testing have the potential to impact the clinical management of the patient.
- Testing is requested after the parent(s) have been engaged in face-to-face genetic counseling with a healthcare professional who is licensed under Indiana Code Article 25-17.3.

## **Cytogenetics**

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

Most cytogenetic tests are covered by the IHCP. In order to be reimbursed for these services, all tests must meet the general criteria, **and**

- Meet all test specific American College of Medical Genetics guidelines
- Receive appropriate PA if required

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

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

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

## **Genetic Tests for Cancer Susceptibility and Treatment**

Several genetic tests exist for a determination or risk score associated with inheritable cancer susceptibility, such as BRCA or HNPCC testing. Providers should check the [IHCP fee schedule](#) for coverage of specific tests. Cancer susceptibility genetic testing is covered when the general criteria AND the following conditions are met:

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

## **Breast Cancer Susceptibility Gene 1 (BRCA1) and Breast Cancer Susceptibility Gene 2 (BRCA2) for Breast and Ovarian Cancer**

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

IHCP members referred to an oncologist or geneticist for BRCA1 and BRCA2 testing must have a completed personal and family cancer history that should include three generations on both



maternal and paternal sides of the family in the member's medical record to include the following:

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

### Definitions

Please note for the purpose of this policy:

- Close blood relatives are first, second, and third degree relatives as defined below:
  - First degree relatives include parents, siblings and offspring
  - Second degree relatives include half-brothers/sisters, aunts/uncles, grandparents, grandchildren, and nieces/nephews affected on the same side of the family
  - Third degree relatives include first cousins, great-aunt/uncles, great-grandchildren and great grandparents affected on the same side of the family
- A breast cancer diagnosis includes either invasive or non-invasive (ductal carcinoma in situ) types.
- Ovarian cancer also includes fallopian tube cancers and primary peritoneal carcinoma.
- Persons are not considered to have a limited family history unless they have fewer than two first-degree or second-degree female relatives or female relatives surviving beyond 45 years of age on either side of the family.
- Two breast primary cancers include cancers appearing at the same time (synchronous) and one is not a metastasis of the other, or primary cancers developing at intervals (metachronous). The tumors may be in one or two breasts.
- Hereditary Breast Ovarian Cancer Syndrome (HBOC)-associated malignancies include prostate cancer, pancreatic cancer, or melanoma. The presence of these malignancies does not necessarily justify BRCA testing. For example, a female with breast cancer over age 50 whose sister had melanoma at 40 and whose father has prostate cancer would meet criteria. In another example a female with breast cancer over age 50 whose maternal aunt had pancreatic cancer and whose paternal uncle had prostate cancer would not meet criteria because the aunt and uncle are on different sides of the family.
- Triple-negative breast cancer refers to any breast cancer that does not express the genes for estrogen receptor (ER), progesterone receptor (PR) or HER2/neu. This subtype of breast cancer is clinically characterized as more aggressive and less responsive to standard treatment and is associated with poorer overall patient prognosis. It is diagnosed more frequently in younger women, women with BRCA1 mutations and those belonging to African-American and Hispanic ethnic groups.

## Prior Authorization for BRCA1 or BRCA2

The IHCP requires PA for BRCA1 or BRCA 2 testing when medically necessary as described below.

### Existing qualifying criteria regarding personal history

Individuals with a personal history of at least one of the following:

- Breast cancer diagnosis at age 45 or younger with or without family history

OR

Breast cancer diagnosis at age 50 or younger with one or more of the following:

- Two breast primary cancers, with the first breast cancer diagnosis occurring at age 50 or younger
- At least one close blood relative with breast cancer at age 50 or younger
- At least one close blood relative with epithelial ovarian/fallopian tube/primary peritoneal cancer diagnosed at any age
- A limited family history or adopted
- Diagnosed at age 60 or younger with triple-negative (ER-, PR-, HER2-) breast cancer
- Breast cancer diagnosed at any age with one or more of the following:
  - Two breast primary cancers in a single individual with at least one close blood relative with breast cancer diagnosed at age 50 or younger
  - Two breast primary cancers in a single individual with at least one close blood relative with epithelial ovarian/fallopian tube/primary peritoneal cancer diagnosed at any age
  - Two or more close blood relatives with breast and/or epithelial ovarian/fallopian tube/primary peritoneal cancer diagnosed at any age
  - Two or more close blood relatives with pancreatic cancer diagnosed at any age
  - Two or more close blood relatives with prostate cancer (Gleason score of 7 or greater) diagnosed at any age
  - Close male blood relative with breast cancer (first-degree or second-degree blood relative allowable)
  - A close relative with a known BRCA1 or BRCA2 gene mutation

- At least two close blood relatives on the same side of the family with other hereditary breast and ovarian cancer (HBOC) syndrome-associated malignancies (prostate, pancreatic, melanoma)
  - Ethnicity associated with deleterious mutations, including Ashkenazi Jewish, Icelandic, Hungarian, Swedish, and Dutch
- Pancreatic, prostate (Gleason score of 7 or greater), epithelial ovarian/fallopian tube/primary peritoneal cancer with two or more close blood relatives with at least one of the following:
  - Breast cancer diagnosed at any age
  - Ovarian cancer diagnosed at any age
  - Pancreatic cancer diagnosed at any age
  - Prostate cancer (Gleason score of 7 or greater) diagnosed at any age
- Male breast cancer diagnosis

## **New qualifying criteria regarding family history**

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

- Relative with known BRCA1 or BRCA2 mutation
- Male relative with breast cancer
- Woman of Ashkenazi Jewish, Icelandic, Hungarian, Swedish, or Dutch ancestry with one or more of the following:
  - One or more first-degree relative with breast cancer or epithelial ovarian cancer
  - Two or more second-degree relative on same side of family with breast cancer
  - Two or more second-degree relative on same side of family with epithelial ovarian cancer
- Woman not of Ashkenazi Jewish, Icelandic, Hungarian, Swedish, or Dutch ancestry with one or more of the following:
  - First-degree or second-degree relative with breast cancer and one or more of the following:
    - Diagnosed at age 45 or younger
    - Diagnosed at age 50 or younger with unknown or limited family history

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- Diagnosed at age 50 or younger with one or more close blood relatives with breast cancer diagnosed at any age
- Diagnosed at age 60 or younger with triple-negative breast cancer
- First-degree or second-degree relative with two breast primary cancers with the first primary diagnosed at age 50 or younger
- First-degree or second-degree relative with breast cancer diagnosed at any age, who in turn has one or more of the following:
  - One or more close blood relatives with breast cancer diagnosed at age 50 or younger
  - One or more close male blood relatives with breast cancer diagnosed at any age
  - One or more close blood relatives with epithelial ovarian cancer diagnosed at any age
  - Two or more close blood relatives with breast cancer diagnosed at any age
  - Two or more close blood relative with pancreatic cancer diagnosed at any age
  - Two or more close blood relative with prostate cancer (Gleason score of 7 or greater) diagnosed at any age
- First-degree or second-degree relative with breast cancer diagnosed at any age who is of male gender
- First-degree or second-degree relative with breast cancer who is of ethnicity associated with deleterious mutations, including Ashkenazi Jewish, Icelandic, Hungarian, Swedish, or Dutch
- First degree or second-degree relative with epithelial ovarian cancer diagnosed at any age
- First-degree or second-degree relative with pancreatic cancer diagnosed at any age who in turn has two or more close blood relative with one or more of the following:
  - Breast cancer diagnosed at any age
  - Ovarian cancer diagnosed at any age
  - Pancreatic cancer diagnosed at any age
  - Prostate cancer (Gleason score of 7 or greater) diagnosed at any age

- First-degree or second-degree relative with prostate cancer (Gleason score of 7 or greater) diagnosed at any age, who in turn has two or more close blood relatives with one or more of the following:
  - Breast cancer diagnosed at any age
  - Ovarian cancer diagnosed at any age
  - Pancreatic cancer diagnosed at any age
  - Prostate cancer (Gleason score of 7 or greater) diagnosed at any age
- Third-degree relative with breast or epithelial ovarian cancer, who in turn has one or more of the following:
  - One close blood relative with epithelial ovarian cancer and another close blood relative with breast cancer diagnosed at age 50 or younger
  - Two or more close blood relatives with breast cancer with at least one diagnosed at age 50 or younger
  - Two or more close blood relatives with epithelial ovarian cancer diagnosed at any age

Providers must submit documentation with the PA request and must maintain the documentation in the member's medical record:

## **Oncotype DX® Breast Recurrence Score Testing**

The IHCP provides reimbursement for Oncotype DX® Breast Recurrence Score services when the service is provided in compliance with all IHCP guidelines, including obtaining PA. The IHCP covers Oncotype DX® Breast Recurrence Score when it is considered medically necessary for managing the treatment of breast cancer. The 21-gene RT-PCR assay should only be ordered after surgery and subsequent pathological examination of the tumor have been completed. The test should be ordered in the context of a provider-patient discussion regarding risk preferences when the test result will aid in making decisions regarding chemotherapy.

Gene expression profiling as a technique of managing the treatment of breast cancer is considered investigational and not medically necessary when a gene profiling test other than the Oncotype DX® Breast Recurrence Score is being used, including but not limited to:

- Breast Cancer Gene Expression Ratio (also known as Theros H/ISM)
- Breast Cancer IndexSM
- Insight® DX Breast Cancer Profile
- MammaPrint® (also referred to as the "Amsterdam signature" or "70-gene signature")
- Mammostrat



- Oncotype DX® DCIS
- PAM50 Breast Cancer Intrinsic Classifier™
- The 41-gene signature assay
- The 76-gene "Rotterdam signature" assay
- THEROS Breast Cancer Index<sup>SM</sup>

Gene expression profiling as a technique of managing the treatment of ductal carcinoma in situ (DCIS) is considered investigational and not medically necessary under all circumstances.

Repeat gene expression profiling with the Oncotype DX® Breast Recurrence Score for the same tumor, such as a metastatic focus, or from more than one site when the primary tumor is multifocal is considered investigational and not medically necessary.

### **Prior Authorization for Oncotype DX ® Breast Recurrence Score**

The IHCP requires PA for the Oncotype DX® Breast Recurrence Score. To obtain PA for this test, all the following criteria must be met:

- Individual has had surgery and full pathological evaluation of the specimen has been completed
- Histology is ductal, lobular, mixed, or metaplastic
- Histology is not tubular or colloid
- Estrogen receptor is positive (ER+), or progesterone receptor is positive (PR+), or both
- HER2 receptor is negative
- pN0 (node negative) or pN1mi with axillary lymph node micrometastasis is less than or equal to 2mm
- Individual has one of the following:
  - Tumor size 0.6-1.0 cm moderate/poorly differentiated
  - Tumor size 0.6-1.0 cm well-differentiated with any of the following unfavorable features: angiolymphatic invasion, or high nuclear grade, or high histologic grade
  - Tumor size greater than 1.0 cm and less than or equal to 4.0 cm
- Individual does not have a pT4 lesion.
- Chemotherapy is a therapeutic option being considered and will be supervised by the practitioner ordering the gene expression profile.

Gene expression profiling with the Oncotype DX® Breast Recurrence Score as a technique of managing the treatment of breast cancer is considered not medically necessary when the criteria listed have not been met.

## Genetic Testing Panels

Genetic testing panels are non-covered by IHCP unless otherwise stated.

## Prior Authorization

Prior authorization for genetic testing is always required, unless noted within the IHCP fee schedule or by a test-specific coverage policy.

Prior authorization is test specific and providers must follow all American College of Medical Genetics guidelines if available. If no guidelines are available, then providers should follow commonly accepted medical guidelines (eg, Amsterdam II or revised Bethesda guidelines for hereditary non-polyposis colorectal cancer [HNPCC]) and all other requirements must still be met. The following documentation must be submitted for prior authorization review:

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

## Billing and Coding

For further billing information, see the [Genetic Testing](#) provider reference module. For a list of billing codes, see the *Genetic Testing Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

### [405 IAC 5](#)

- 405 IAC 5-18 Laboratory Services

### [IHCP Provider Bulletins](#)

- [BT201459](#) General Coverage Policy for Genetic Testing Services
- [BT201642](#) Updated PA Criteria for BRCA Testing
- [BT201408](#) Chromosomal Microarray Analysis Coverage
- [BT201406](#) Oncotype DX® Breast Recurrence Score Coverage

### [IHCP Provider Banners](#)

- N/A

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial publication; revised PA criteria for BRCA1 and BRCA2 genetic testing for breast and ovarian cancer

## Hearing Services

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### Description of Service

Audiology services are provided for IHCP members with speech, hearing, and/or language disorders. These services include diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist. IHCP reimbursement is available for the purchase, repair, or replacement of hearing aids

### Medical Policy

#### Audiology/Hearing Tests

Audiology services are allowed, with these restrictions:

- The physician must certify in writing the need for an audiological assessment or evaluation.
- The audiology service must be rendered by a licensed audiologist or a person registered for his clinical fellowship year that is supervised by a licensed audiologist. A registered audiology aide can provide services under the direct on-site supervision of a licensed audiologist under 880 IAC 1-1
- When a member is to be fitted with a hearing amplification device, by either the audiologist or a registered hearing aid specialist, a [Medical Clearance and Audiometric Test \(MCAT\) form](#) must be completed in accordance with instructions and submitted with the request for prior authorization (PA). This form must be complete and must include the proper signatures where indicated before the PA request will be reviewed.
- Initial audiological assessments are limited to one assessment every three years per member. If more frequent audiological assessments are necessary, a PA is required. The MCAT form must be complete and must include the proper signatures where indicated before the PA request will be reviewed.

Provisions of audiology services are subject to the following criteria:

- The member's history must be completed by any involved professional.
- The referring physician must complete Part 2 of the [MCAT form](#) no earlier than six months prior to the provision of the hearing aid. Children 14 years of age and under must be examined by an otolaryngologist; members 14 years of age and older may be examined by a licensed physician if an otolaryngologist is not available.
- All testing must be conducted in a sound-free enclosure. If a member is institutionalized and his or her physical or medical condition precludes testing in a sound-free enclosure, the ordering physician must verify medical confinement in the initial order for audiological testing. The audiological assessment must be conducted by a licensed audiologist, clinical fellowship year audiologist, or otolaryngologist. Testing conducted by other professionals and cosigned by an audiologist or otolaryngologist will not be reimbursed by the IHCP. If the audiological evaluation reveals one or more of the following conditions, the member must be referred to an otolaryngologist for further evaluation.

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- Speech discrimination testing indicates a score of less than 60% in either ear.
  - Pure tone testing indicates an air bone gap of fifteen (15) decibels or more for two adjacent frequencies in the same ear.
- The hearing aid evaluation may be completed by a licensed audiologist or registered hearing aid specialist. The results must be documented on the prior authorization request and indicate that significant benefit can be derived from amplification before prior authorization is granted for the amplification device.
- The hearing aid contract portion of the audiometric test form must be signed by a registered hearing aid specialist.
- Audiological assessments rendered more frequently than every three years will be assessed on a case-by-case basis, based upon documented otological disease.

Audiologic procedures cannot be fragmented and billed separately. Hearing tests, such as whispered voice and tuning fork, are considered part of the general otolaryngology services and cannot be reported separately as follows:

- Basic comprehensive audiometry includes pure tone, air and bone threshold, and discrimination; testing provided for both ears.
- All other audiometric testing procedures will be reimbursed on an individual basis, based on the medical necessity for such test procedures.

### **Prior Authorization for Audiology/Hearing Tests**

Audiological assessments are limited to one assessment every three years per member. PA is required if more frequent audiological assessments are necessary. All PA audiology/hearing tests requests are reviewed on a case-by-case basis.

The following audiological services do not require PA:

- A screening test indicating the need for additional medical examination (screenings are not reimbursed separately under the IHCP)
- Initial assessment of hearing
- Determination of suitability of amplification and the recommendation regarding a hearing aid
- The determination of functional benefit to be gained by the use of a hearing aid
- Audiology services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate

### **Air Conduction Hearing Aids**

The air conduction hearing aid, or conventional hearing aid, amplifies and sends sound through the ear mold, into the ear canal, through the middle ear and to the inner ear. This type of hearing aid is not appropriate for a child with Atresia, as the ear canal is blocked and the sound cannot get through.

## **Prior Authorization for Air Conduction Hearing Aids**

Prior authorization is required for the purchase of hearing aids.

## **Bone-Anchored Hearing Aids (BAHA)**

A bone conduction hearing aid is different from a conventional air conduction hearing aid. Unlike other hearing aids, BAHA hearing aids transmit sound through the bone of the skull rather than to the ear canal. This process is called direct bone conduction.

### **Prior Authorization for BAHA**

Prior authorization is required for the purchase of hearing aids. Medical necessity indications for BAHA's include the following:

- Chronic ear infection
- Congenital hearing loss
- Single-sided deafness (SSD)
- History of middle ear damage

## **Contralateral Routing of Signals (CROS)/Bilateral-Contralateral Routing of Signals (BiCROS) Hearing Aids**

A CROS hearing aid is fit to a person who has normal hearing in one ear and one ear that is unaidable. The unaidable ear may be unaidable due to the severity of the loss, a physical malformation of the ear, a chronic medical condition that causes occlusion of the ear canal or any combination of the three.

A CROS hearing aid consists of a microphone at the level of the unaidable ear which transmits via a wire or frequency modulation (FM) to a receiver in (or at) the normal hearing ear. BiCROS refers to a hearing aid system which incorporates two microphones, one in (or at) each ear and a single amplifier and receiver. In this case, the BiCROS device is fit to an individual who has a hearing loss in both ears, but one ear is unaidable, allowing the individual to receive sounds from both sides of their head in their "good" ear.

### **Prior Authorization for CROS or BiCROS Hearing Aids**

Prior authorization is required for the purchase of hearing aids. Binaural aids or CROS-type aids will be authorized only when significant, objective benefit to the member can be documented.

## **Programmable Hearing Aids**

Programmable hearing aids are pre-programmed based on the member's hearing loss. Most programmable aids can accommodate from one to seven pre-programmed settings at a time. The device easily adjusts to different types of noise when a member enters different sound environments. The device can also be re-programmed to make adjustments to the sound quality. In addition, because they are custom programmed specifically to a member's hearing loss, programmable hearing aids offer advantages over conventional devices, such as better sound quality, flexibility, and better clarity of speech.



Programmable hearing aids may be authorized for monaural amplification (one ear) or for binaural amplification (two ears). Hearing aids come in a variety of models and styles; therefore, prices vary depending on not only the hearing aid model and style, but also on the degree of hearing loss, and the special options chosen to personalize the instrument.

IHCP classifies programmable hearing aids as a customized item, which is defined as equipment uniquely constructed or substantially modified to meet the specific needs of an individual member.

### **Prior Authorization for Programmable Hearing Aids**

Programmable hearing aids are usually considered a comfort/convenience and not medically reasonable or necessary. Programmable hearing aids require PA. Coverage may be considered for the following indications:

- Fluctuating hearing loss (Meniere's disease, autoimmune sensorineural hearing loss, otogenic syphilis, large vestibular aqueduct syndrome, and other entities resulting in fluctuant hearing loss)
- Progressive hearing loss (Meniere's disease, Alport's syndrome, and other entities resulting in progressive hearing loss, retrocochlear hearing loss must be excluded, particularly when the loss is asymmetrical)
- Severe recruitment or very narrow dynamic range
- Very young children who are hard to test or hard to fit
- Hearing loss with unusual audiometric configurations

The PA request must be accompanied by the following documentation:

- A completed [Medical Clearance and Audiometric Test \(MCAT\) form](#). Medical necessity for programmable hearing aids must be clearly documented in the sections entitled "Recommendation Information" or "Special Conditions".
- A record of the audiogram obtained not more than three months from the date of the request.
- An otological examination report, signed by the physician, which includes the medical etiology and diagnosis for the hearing loss.
- A diagnosis supporting the medical necessity must be included on the PA request and on the claim form.
- A documented case history should include at least the following information regarding the member's needs and lifestyle:
  - The past history of hearing aid use.
  - The reason programmable hearing aids, rather than conventional hearing aids, would be medically necessary.
  - A description of the hearing environments in which the member has trouble hearing and to which the member is subjected. The frequency and duration of exposure to these environments should also be included.

- Documentation of any other factors, such as lack of normal dexterity, should be included.
- Documentation must be provided that supports the medical necessity of the programmable hearing aids outside vocational needs.

Documentation should support the number of pre-programmed settings requested. Only the least costly alternative to meet the member's medically necessary hearing aid needs will be approved.

## Cochlear Implants

A cochlear implant device is an electronic instrument. Part of the device is implanted surgically to stimulate auditory nerve fibers, and the other part is worn or carried by the individual to capture, analyze, and code sound. Cochlear implant devices are available in single-channel and multi-channel models. The purpose of the implanted device is to provide awareness and ID of sounds to facilitate communication for persons who are moderately to profoundly hearing impaired.

Cochlear Implants will be covered only if they are medically necessary and objective evidence of significant benefit to the member is documented. Indications for cochlear implants include the following:

- Cochlear implantation will be covered for treatment of bilateral pre-or-post-linguistic, sensorineural, moderate-to-profound hearing loss in individuals who demonstrate limited benefit from amplification.
- Post-linguistically deafened adults must demonstrate test scores of less than or equal to 40% on sentence recognition scores from tape recorded tests in the patient's best listening condition.
- Cochlear implants are covered for children between ages 1-17 if there is a demonstrated ability to improve on age-appropriate, closed-set word ID tasks with amplification.
- Coverage is provided only for those patients who meet all of the following selection guidelines:
  - Diagnosis of bilateral moderate-to-profound sensorineural hearing impairment (HI) with limited benefit from appropriate hearing (or vibrotactile) aids
  - Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation
  - Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system
  - No contraindications to surgery
  - The device must be used in accordance with FDA-approved labeling

Individuals must have hearing test scores of greater than 40% and less than or equal to 60% only when the provider is participating in, and patients are enrolled in, either an FDA-approved category B investigational device exemption clinical trial as defined at 42 CFR 405.201, a trial under the CMS Clinical Trial Policy as defined at section 310.1 of the National Coverage

Determinations Manual (NCDM), or a prospective, controlled comparative trial approved by CMS as consistent with the evidentiary requirements for National Coverage Analyses and meeting specific quality standards. See the Medical Policy Fact Sheet for Clinical Trials for further information.

### **Prior Authorization for Cochlear Implants**

Prior authorization is required for the cochlear implantation procedure. All required prerequisite testing and documentation of medical necessity also require PA as indicated herein.

### **Maintenance and Repair for Hearing Aids and Cochlear Implants**

The IHCP may reimburse for the maintenance or repair of a hearing aid or cochlear implant under the following conditions:

#### **Hearing aids**

- Repairs for hearing aids and ear molds are reimbursed once every 12 months.
- Batteries, sound hooks, tubing, and cords are covered without PA.

#### **Cochlear implants**

- Repairs for cochlear implants are eligible for reimbursement once every 12 months, after initial 12 months of use.
- Batteries, headset/headpiece, microphone, and transmitting coil/cable.
- The device is in continuous use and still meets the medical necessity needs of the beneficiary.
- All charges for cochlear implant parts and repairs are to reflect no more than the usual and customary (U&C) charge to the public.

### **Prior Authorization for Hearing Aid and Cochlear Implants Maintenance and Repair**

The following services do require PA:

- Repairs for hearing aids and cochlear implants may be prior authorized more frequently for members under 21 years of age if circumstances justifying need are documented.

### **Replacement for Hearing Aid and Cochlear Implant**

IHCP reimbursement is available for the replacement of hearing aids under the following conditions:

- Replacement of hearing aids is subject to 405 IAC 5-19-14.
- Requests for replacement of hearing aids must:
  - Document a change in the member's hearing status; **and**

- State the purchase date and condition of the current hearing aid.

The IHCP provides reimbursement for the replacement of cochlear implants under the following conditions:

- Replacement of a cochlear implant is subject to repair and maintenance criteria.
- Requests for replacement of cochlear implants must
  - Document a change in the member's status; **and**
  - State the purchase date and condition of the current cochlear implant.
- For replacement of a cochlear implant with an upgraded model:
  - Documentation substantiates that the newer generation technology provides additional capacity.
  - The current implant has been worn for at least four years.

### **Prior Authorization for Hearing Aid and Cochlear Implant Replacement**

Hearing aid and cochlear implant replacements may be prior authorized more frequently for members under 21 years of age, if circumstances justifying medical necessity are documented.

### **Non-Covered Hearing Aids or Supplies**

IHCP reimbursement is not available for the following hearing aids or supplies:

- Hearing aids for members with a unilateral pure tone average loss (500, 1,000, 2,000, or 3,000 hertz) equal to or less than thirty decibels
- Canal hearing aids
- Repair for a hearing aid or cochlear implant device that is still under warranty
- Routine servicing of functioning hearing aid or cochlear implant
- Repair or replacement of hearing aids or cochlear implants necessitated by member misuse or abuse whether intentional or unintentional
- Replacement of hearing aids or cochlear implants prior to five years from the purchase date

**Note:** For Healthy Indiana Plan (HIP) Basic and Plus members, hearing aids are covered once per member every five (5) years.

### **Prior Authorization**

IHCP reimbursement is available for the purchase, repair, or replacement of hearing aids, including, air conduction or conventional hearing aids, bone anchored or bone conduction hearing aids (BAHA), and programmable hearing aids, under the following conditions.

- PA is required for the purchase of hearing aids.
- A [Medical Clearance and Audiometric Test \(MCAT\) form](#) must be completed and submitted with the [IHCP PA Request form](#).

- Hearing aids will be authorized only if they are medically necessary and significant, and objective benefit to the member is documented
- Any involved professional must complete a member history. The referring physician must complete Part 2 of the [Medical Clearance and Audiometric Test \(MCAT\) form](#) no earlier than six months prior to the provision of the hearing aid.
- Hearing aid fitting may be provided by either the audiologist or a registered hearing aid specialist. Services must be performed in accordance with the appropriate provisions of 405 IAC 5-22.
- Hearing aids purchased by the IHCP become the property of the IHCP. All hearing aids purchased by the IHCP, which are no longer needed by a member, must be returned to the county Department of Family Resources (DFC).

PA is not required for the following:

- Batteries

## Billing and Coding

For further billing information, see the [Hearing Services](#) provider reference module. For a list of billing codes, see the *Hearing Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

### [405 IAC 5](#)

- 405 IAC 5-3 Prior Authorization
- 405 IAC 5-4 Provider Enrollment
- 405 IAC 5-15 Early and Periodic Screening, Diagnostic, and Treatment Services
- 405 IAC 5-19-13 Hearing Aids; Purchase
- 405 IAC 5-22-7 Audiology Services
- 405 IAC 5-25 Physician Services

### [880 IAC 1](#)

- 880 IAC 1 Speech-Language Pathology and Audiology Board

### [IHCP Provider Bulletins](#)

- [BT201117](#) Hearing aid reimbursement
- [BT201213](#) Cost invoices no longer required for manually priced DME, supplies, and hearing aids
- [BT201327](#) Update regarding reduction in reimbursement for speech/hearing therapists and audiologists
- [BT201627](#) IHCP revises coverage policies for therapy services

### [IHCP Provider Banners](#)

- [BR201713](#) Adds prior authorization for cochlear device implantation



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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

### Update History

January 1, 2017 – Initial Publication

April 28, 2017 – Added prior authorization for cochlear device implantation

## Home Health Services

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### Description of Service

Home Health Services are services that are provided on a part-time and intermittent basis to Medicaid consumers of any age. Home health services include home health nursing, home health aide, and skilled therapies (physical therapy, occupational therapy, respiratory therapy, and speech-language pathology).

The medical necessity for home health services must be certified by the consumer's qualifying treating physician. A face-to-face encounter with the consumer and the physician, advanced practice nurse in collaboration with the physician, or a physician assistant under the supervision of the physician is required for certification of medical necessity. A face-to-face encounter must be conducted within the 90 days prior to the home health care start-of-care date, or within 30 days following the start-of-care date, inclusive of the start-of-care date. Home and community based services (HCBS) programs and benefits are outside the scope of this regulation and are not subject to the face-to-face encounter requirements.

The following definitions apply:

**Multiple member care situation** – A home care situation in which more than one member of a single household is receiving home health services. When this situation occurs, care must be coordinated in the most efficient manner. Multiple care member situations must be reported on each member's individual PA request. When one member of a home health agency provides care to multiple members during an encounter, only one overhead may be billed.

**Home health care provider** – registered nurse (RN), licensed practical nurse (LPN), physical therapist (PT), occupational therapist (OT), speech therapist (ST), speech-language pathologist (SLP), respiratory therapist (RT), or home health aide (HHA).

## Medical Policy

### Home Health Care Hourly Determination Guidelines

The following are guidelines for determining the appropriate number of hours reimbursable for general categories of home health care services. These are guidelines only and do not override medical decisions based on individual case review.

Factors for consideration when determining the hours of service to be approved include:

- Severity of illness and symptoms
- Stability of the condition and symptoms
- Change in medical condition that affects the type or units of service that can be authorized

- Treatment plan, including identified goals
- Intensity of care required to meet needs
- Complexity of needs
- Amount of time required to complete treatment tasks
- Whether the services required in the current care plan are consistent with prior care plans
- Need for instructing the member on self-care techniques in the home or need for instructing the caregiver on caring for the member in the home, or both
- Other home care services currently being utilized including, but not limited to; Medicare, Medicaid Waiver Programs, CHOICE, vocational rehabilitation, and private insurance (The number of hours per day and the number of days per week should be listed for each service)
- Whether the member works or attends school outside the home, including what assistance is required
- Caregivers available to provide care for the member, including the following considerations:
  - Number of caregivers available
  - Whether the caregiver works outside the home
  - Whether the caregiver attends school outside of the home
  - Reasonably predictable or long term physical limitations of available caregiver(s) that limit the ability of the caregiver(s) to provide care to the member
  - Whether the caregiver has additional child care responsibilities
  - Number of hours requested, compared to availability of caregiver(s) available time (A copy of the caregiver's work schedule from the employer or the class schedule from the school must be submitted with the PA request. The provider is responsible for coordinating home care services with the caregiver's work or school schedule to meet the member's needs, and should clearly document caregiver information on the PA request form.

Special situations may occur where additional home health hours may be authorized on a short term or temporary basis. These situations are evaluated individually, on a case-by-case basis. Examples of these situations are as follows:

- Significant deterioration in the member's condition, particularly if additional hours will prevent an inpatient or extended inpatient hospital admission
- Major illness or injury of the caregiver with expectation of recovery, including, but not limited to:
  - Illness or injury that requires an inpatient acute-care stay

- Chemotherapy or radiation treatments
  - A broken limb, which would impair the caregiver's ability to lift the member
- Temporary, but significant, change in the home situation, including but not limited to:
  - A caregiver's call to military duty
  - Temporary unavailability due to employment responsibilities

(These must be substantiated in writing by the commanding officer, other military representative, or by the employer.)
- Significant permanent change in the home situation, including, but not limited to, death or divorce with loss of a caregiver. Additional units of service may be authorized for a short period of time to assist in providing a transition.

## **12 to 16 Hours a Day of Home Health Care Services**

Members requiring 24-hour monitoring may be authorized for up to 12 hours a day of skilled nursing or home health aide services to prevent deterioration in life sustaining systems. Examples of these conditions include, but are not limited to:

- Severe respiratory conditions resulting from pulmonary disorders, such as bronchopulmonary dysplasia, severe respiratory complications of cystic fibrosis, bronchitis, asthma; central nervous system disorders; cardiovascular disorders, such as cardiac anomalies; and neuromuscular disorders, such as muscular dystrophy and Guillain-Barré syndrome
- Dependency on mechanical ventilator assistance
- Tracheostomy

Special situations may occur where home health hours may be approved for up to 16 hours per day of skilled care on an ongoing basis, although each individual situation must be evaluated with a PA request. These special situations include but are not limited to:

- A single caregiver is available who also works full-time (or a significant number of part-time hours) outside the home. This also applies to situations where there may be two adults present, but one is unable to provide any, or a very limited amount, of care due to physical disability or severe physical limitations. The disabled caregiver's physician must substantiate this in writing.
- Significant additional child care responsibilities. Significant is defined as:
  - Three or more children under the age of six, or four or more children under the age of 10
  - One or more children in the home with special medical care needs requiring extensive medical and physical care above and beyond the needs of the average well child. If the IHCP is not providing services to this child at home also, the child's physician must provide a statement of the child's medical needs. The

same caregivers must be caring for these children, as well as for the member for whom the PA request has been submitted.

## **8 Hours a Day Home Health Care Services**

Members who require extensive care and daily monitoring of their medical/physical conditions, but who do not possess the same degree of potential to deteriorate quickly into life threatening situations as do members requiring 24-hour monitoring, may receive up to eight hours of care daily. An additional hour or two may be allowed for transportation to and from work in situations where the caregivers work full time outside the home. Examples of these situations/conditions include, but are not limited to:

- Chronic, debilitating conditions, such as severe forms of cerebral palsy, muscular dystrophy, spina bifida, and other congenital anomalies; and quadriplegia.
- Conditions that require equipment or treatment needs with potential for serious complications – for example, central lines or Hickman catheters
- Frequent treatments, such as RT required (in the form of updrafts, chest PT, etc.)
- Nutrition provided by hyperalimentation or by gastrostomy tube feedings, in addition to one of the above
- Skilled nursing assistance required to attend school
- The member receives multiple medications that require monitoring for severe side effects or responses

## **3 to 7 Hours a Day of Home Health Care Services**

Members without the severity of conditions noted above who require primarily heavy physical care, with some skilled nursing monitoring to avoid deterioration, may receive three to seven hours of care per day. These members are generally chronic but stable and may have conditions such as congenital anomalies, neuromuscular disorders, central nervous system disorders, or other disorders that severely disrupt the capacity to care for self.

Consideration may be given to paraplegics, quadriplegics, or other disabled members unable to provide self-care, such as bathing or dressing, who are able to drive mechanically altered vehicles to maintain meaningful employment and a relationship with the community. Such adults may be considered for assistance from a HHA for up to three to four hours per day. The agency may split the hours between morning and evening to attend to the bedtime needs of the member. This service is subject to medical necessity, and documentation must demonstrate the need.

## **Indicators for Home Health Services**

One of the following indicators from each category must be present for a member to be eligible for home health services:



## **Category I: Member**

- The member is at risk of respiratory failure, severe deterioration, or hospitalization without constant monitoring.
- The member requires total care – monitoring 24 hours per day.
- The member desires to stay in the home, rather than in a LTC facility.
- The medical condition of the member has deteriorated, creating the need for more intense short-term care (physician's statement required).
- The member does not have a primary caregiver or access to other care.

## **Category II: Caregiver**

- Primary caregiver is employed and absent from the home, or is unable to provide the necessary care.
- Primary caregiver has additional child care responsibilities, disallowing the time needed to care for the member (three or more children under six years of age, or four or more children under the age of 10).
- Primary caregiver also has additional children with special needs to care for (one or more children with special healthcare needs requiring extensive medical and physical care).
- Major illness or injury of caregivers, with expectation of recovery (physician's statement required)
- Temporary but significant change in the availability of caregiver – for example, military service (commanding officer, other military representative, or employer's statement required).
- Significant permanent change in caregiver's status – for example, death or divorce with loss of one caregiver (physician's statement required)

## **Indicators for Central Nervous System (CNS) Disorders**

One of the following indicators must be present for a member to receive home health care for CNS disorders:

- Altered level of consciousness
- Respiratory distress
- Potential for increased intracranial pressure
- Body temperature fluctuations (hypothalamus involvement)
- Posturing (decerebrate/decorticate)
- Seizure activity (current)
- Spasticity (severe)

- Pain
- Impaired motor/sensory function to include:
  - Paresis
  - Paralysis
  - Vision impairment
  - Hearing impairment
  - Impaired gag reflex
  - Decreased tactile sensation
- Potential for injury to self
- Need for constant supervision

One of the following services must also be necessary to receive either skilled or non-skilled nursing care for CNS disorders:

Services Requiring Skilled Care	Services Requiring Non-skilled Care
<ul style="list-style-type: none"> <li>• Vital signs</li> <li>• Ventilator operation/maintenance</li> <li>• Central line maintenance/dressings</li> <li>• Complex treatment modalities (sterile dressings, soaks, packing, etc.)</li> <li>• Parenteral/enteral nutrition</li> <li>• Oxygen therapy</li> <li>• Respiratory treatments</li> <li>• Tracheostomy maintenance/change</li> <li>• Suctioning (frequency/secretion type)</li> <li>• Stimulation (verbal/tactile)</li> <li>• Tube feedings/maintenance of tube</li> <li>• IV medication administration</li> <li>• Urinary catheter maintenance/change</li> <li>• Exercise (active/passive)</li> </ul>	<ul style="list-style-type: none"> <li>• Bathing/linen change/dressing</li> <li>• Catheter care</li> <li>• Skin care</li> <li>• Minor treatment modalities</li> <li>• Oral care</li> <li>• Stimulation</li> <li>• Continue plan of OT/PT</li> <li>• Assist with transfers/ambulation</li> <li>• Positioning</li> <li>• I&amp;O records</li> <li>• Assist with oral feedings</li> <li>• Splint or brace application</li> <li>• Exercise (active/passive)</li> <li>• Ensure safety measures (seizure precautions)</li> <li>• Vital signs</li> </ul>

**Note:** On the above table and subsequent Skilled vs. Non-skilled Care tables, those services appearing on both sections may be either, as justified by the required Plan of Treatment during PA review.

## Indicators for Gastrointestinal Disorders

One of the following indicators must be present for a member to receive home health care for GI disorders:

- Nutritional impairment
  - Malabsorption
  - Mechanical cause
- Stomatitis, pharyngitis, esophagitis
- Swallowing disorders
- Gastric reflux
- Vomiting
- Anorexia
- Pain
- Orthostatic blood pressure (B/P)
- Significant rapid weight loss
- Morbid obesity >200% optimal weight
- Periorbital/perirectal lesions
- Unhealed wound(s)
  - Surgical
  - Fistula, abscess, fissures
- Bacterial/parasitic infections
- Diarrhea
- Constipation
- Subtotal/total gastrectomy
- Ostomies
- Anemia
- Weakness and fatigue

One of the following services must also be necessary to receive either skilled or non-skilled nursing care for GI disorders:

Services Requiring Skilled Care	Services Requiring Non-skilled Care
<ul style="list-style-type: none"><li>• Vital signs</li></ul>	<ul style="list-style-type: none"><li>• Bathing/linens/dressing</li></ul>

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<ul style="list-style-type: none"><li>• IV medication administration</li><li>• Parenteral/enteral nutrition</li><li>• Administration/maintenance</li><li>• Central line maintenance</li><li>• Oral medication administration</li><li>• Gastric tube medication administration</li><li>• Placement of nasogastric tubes</li><li>• Complex treatment/wound care, sterile dressings/wound packing/medicated soaks, etc.</li><li>• Ostomy care/irrigation</li><li>• Oxygen therapy</li><li>• Bowel training</li><li>• Weight</li><li>• I&amp;O</li></ul>	<ul style="list-style-type: none"><li>• Oral care</li><li>• Skin care</li><li>• Feedings (oral)</li><li>• Force fluid</li><li>• Assist with ambulation</li><li>• Exercise active/passive</li><li>• Reinforce teaching of OT/PT/ST</li><li>• I&amp;O</li><li>• Weight</li></ul>
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## Indicators for Musculoskeletal Disorders

One of the following indicators must be present for a member to receive home health care for musculoskeletal disorders:

- Pain
- Loss of locomotor ability
- Decreased muscle strength
- Stiffness
- Joint pain, swelling, redness, tenderness
- Muscle wasting
- Paralysis
- Postamputation
- Multiple fractures
- Muscle spasms
- Potential for injury to self

One of the following services must also be necessary to receive either skilled or non-skilled nursing care for musculoskeletal disorders:

Services Requiring Skilled Care	Services Requiring Non-Skilled Care
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<ul style="list-style-type: none"><li>• Assistance with prostheses, braces, splints</li><li>• Treatments requiring sterile procedures</li><li>• Assistance with transfers/ambulation</li><li>• Assistance with prostheses, braces, splints</li><li>• Exercise – active or passive</li><li>• Position changes</li><li>• Non-invasive treatments, comfort measures</li></ul>	<ul style="list-style-type: none"><li>• Bathing/linen/dressing</li><li>• Assistance with activities of daily living (ADLs)</li></ul>
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## Indicators for Respiratory Disorders

One of the following indicators must be present for a member to receive home health care for respiratory disorders:

- Dyspnea
- Quality of respiration (shallow, air hunger, etc.)
  - Rate of respiration
  - Dyspnea at rest
  - Dyspnea with exertion
  - Cyanosis
  - Use of accessory muscles
  - Apnea/bradycardia
- Abnormal breath sounds
- Splinting respirations
- Strenuous coughing
- Excessive, tenacious secretions
- Ineffective airway clearance
- Abnormal arterial blood gases (ABGs)
- Decreased ability to be mobile due to dyspnea
- Irritability/depression
- Fatigue/weakness
- Anxiety

One of the following services must also be necessary to receive either skilled or non-skilled nursing care for respiratory disorders.



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Services Requiring Skilled Care	Services Requiring Non-Skilled Care
<ul style="list-style-type: none"><li>• Oral medication administration</li><li>• IV medication administration</li><li>• Parenteral/enteral nutrition</li><li>• Vital signs</li><li>• Ventilator operation/maintenance</li><li>• Tracheostomy maintenance/change</li><li>• Suctioning</li><li>• Complex treatment modalities (sterile dressing, wound care)</li><li>• Respiratory treatments</li></ul>	<ul style="list-style-type: none"><li>• Assist with bathing, dressing, ADLs (total care may be required)</li><li>• Skin care</li><li>• Oral care</li><li>• Force fluids as instructed</li><li>• Assist with ambulation</li><li>• Exercise active/passive</li><li>• Assist with meals (oral feeding)</li><li>• Vital signs</li></ul>

## Indicators for Urinary/Renal Disorders

One of the following indicators must be present for a member to receive home health care for urinary/renal disorders:

- Anemia
- Dyspnea
- Increased blood urea nitrogen (BUN)/creatinine
- Decreased mental acuity
- Increased B/P
- Abnormal electrolytes
- Oliguria
- Weakness/fatigue
- Decreased mobility
- Neuropathies
- New diagnosis of renal failure
- Vascular access
- Newly initiated hemodialysis
- Recent admission for renal failure
- Recent admission for UT surgery
- Peritoneal dialysis
- Pain

- Edema
- Potential for self-injury

One of the following services must also be necessary to receive either skilled or non-skilled nursing care for urinary/renal disorders.

Services Requiring Skilled Care	Services Requiring Non-Skilled Care
<ul style="list-style-type: none"> <li>• Complex treatment modalities <ul style="list-style-type: none"> <li>○ Sterile dressings</li> <li>○ Special catheter care (ureteral catheters, irrigation, etc.)</li> </ul> </li> <li>• Urinary, suprapubic catheter care</li> <li>• Input and Output (I&amp;O)</li> <li>• Weight</li> <li>• Vital Signs</li> </ul>	<ul style="list-style-type: none"> <li>• Assist bathing/linens/dressing</li> <li>• Skin care</li> <li>• Oral care</li> <li>• Assist with exercise and ambulation</li> <li>• Reinforce nutritional teaching</li> <li>• Weight</li> <li>• I&amp;O</li> <li>• Vital signs</li> <li>• Safety measures</li> </ul>

## Non-Covered Services

The following services are non-covered home health services, except as specified under the applicable IHCP waiver service programs:

- Transportation to and from grocery stores, drug stores, banks, etc.
- Homemaker services, including shopping, laundry, cleaning, meal preparation, etc.
- Companion or sitter services, including escort services, activity planning, etc.
- Chores, including picking up prescriptions, household supplies and/or groceries, etc.
- Respite care

**Note:** Healthy Indiana Plan (HIP) members are limited to 100 home health visits per year. These services include skilled medical services; nursing care given or supervised by an RN; nutritional counseling furnished or supervised by registered dietician (RD); home hospice services; home health aides; laboratory services, drugs, and medicines prescribed by a physician in connection with home health care; and medical social services. Home hospice services are considered a separate service. HIP State Plan are eligible for the same home health benefits available on Traditional Medicaid.

## Prior Authorization Home Health Services

All home health services require PA (exceptions are listed below).

The following information must be submitted with the PA request form for home health services:

- A copy of the current plan of treatment, developed by the attending physician, therapists, and agency personnel, and signed by the attending physician, must be included with the PA request for home health services. The plan of treatment should include the following:
  - the date of onset of the medical problems
  - progress notes regarding the necessity, effectiveness, and goals of therapy services
  - mental status
  - the types of services and equipment required
  - the frequency of visits
  - prognosis
  - rehabilitation potential
  - functional limitation
  - activity permitted
  - nutritional requirements
  - medications and treatments
  - safety measures to protect against injury
  - instructions for timely discharge or referral
  - other relevant information
- An estimate of the costs for the services ordered by the physician and set out in the written plan of treatment. The cost estimate must be provided with the plan of treatment and signed by the attending physician. The estimate must reflect the cost of each service requested, plus the overhead rate for the time periods requested, as reflected on the plan of treatment.
- Documentation of a face-to-face encounter in accordance with 42 CFR 440.70(f). The face-to-face encounter requirements do not apply to recertification of home health services.

Other factors taken into consideration for the hourly determination of home health services are included under the "Home Health Care Hourly Determinations Guidelines" listed above.

Electronic signatures are acceptable on supporting documents submitted with prior authorization requests for home health services. Electronic signatures are accepted as long as the provider's electronic health record system provides the appropriate protection and assurances that the rendering provider signed the document and the signature can be authenticated. If the appropriate controls are in place, electronic signatures are acceptable. Providers using electronic systems need to recognize the potential for misuse or abuse with alternate signature methods. Providers bear the responsibility for the authenticity of the

documentation and the signatures. Physicians are encouraged to check with their attorneys and malpractice insurers regarding electronic signatures. Any provider using an electronic signature is required to follow the requirements of *Indiana Code (IC) 26-2-8-116*.

## Home Health PA Exceptions

The following circumstances do not require PA for home health services:

- Services provided by an RN, LPN, or home health aide that have been ordered in writing by a physician prior to the member's discharge from a hospital and that do not exceed 120 hours within 30 days of discharge do not require PA. These services may not continue beyond 30 calendar days, unless PA is obtained.
- Any combination of therapy services ordered in writing by a physician prior to the member's hospital discharge that does not exceed 30 units in 30 calendar days does not require PA. These services may not continue beyond 30 days following discharge, unless PA is obtained.

## Home Health Nursing Services

Reimbursement is available for intermittent or part-time nursing provided in the home by home health nurse services. PA is required for all nursing services rendered by registered nurses (RNs), licensed practical nurses (LPNs), and home health aides from agencies that are IHCP providers.

In addition to the home health services PA requirements above, services provided by an RN, LPN, or HHA must be as follows:

- Prescribed or ordered in writing by a physician
- Provided in accordance with a written plan of treatment developed by the attending physician
- Intermittent or part-time, except for ventilator-dependent patients who have a developed plan of home health care
- Medically necessary
- Less expensive than any alternative modes of care
- Must follow all other requirements for nursing services as laid out in 405 IAC 5-22-2

## Home Health Occupational Therapy, Physical Therapy, Respiratory Therapy, or Speech Pathology

In addition to the home health services PA requirements above, OT, PT, RT, or speech pathology must be as follows

- Provided by an appropriately licensed, certified, or registered therapist employed or contract by the agency
- Ordered or prescribed in writing by a physician
- Provided in accordance with a written plan of treatment developed cooperatively between the therapist and the attending physician
- Medically necessary

## Billing and Coding

For further billing information, see the [Home Health Services](#) provider reference module. For a list of billing codes, see the *Home Health Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

### [405 IAC 5](#)

- 405 IAC 5-3-13 Prior authorization – services requiring prior authorization
- 405 IAC 5-16 Home health agency and clinic services
- 405 IAC 5-16-2 Home health agency services
- 405 IAC 5-16-3 Home health agency services; limitations
- 405 IAC 5-19-6 Durable medical equipment subject to prior authorization
- 405 IAC 5-19-12 Home hemodialysis equipment
- 405 IAC 5-22 Nursing and therapy services
- 405 IAC 5-34 Hospice services

### [IHCP Provider Bulletins](#)

- [BT201749](#) Clarification of face-to-face encounter requirements for coverage of home health services
- [BT201625](#) Home Health Rates for State Fiscal Year 2017 are effective July 1, 2016
- [BT201723](#) IHCP Revises Coverage Policies for Home Health Services

### [IHCP Provider Banners](#)

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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication



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May 1, 2017 – Added face-to-face encounter requirement for home health services

July 25, 2017 – Clarified requirement of face-to-face encounter for home health services

## Hospice Services

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### Description of Service

Hospice Care is a specialized form of interdisciplinary health care designed to alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phase of a terminal illness or disease. Hospice care also provides for the psychological, social, spiritual, and other needs of the hospice program patient's family before and after the patient's death.

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Hospice core services are covered services in the Medicare and IHCP hospice *per diem* that must be provided directly to members by hospice employees. Hospice core services include nursing services, medical social work services, and counseling services (including bereavement, dietary, spiritual, and other services). The following is a list of hospice services included in the Medicare and Medicaid hospice *per diem*:

- Nursing care provided by or under the supervision of a registered nurse
- Medical social work services provided by a social worker with at least a bachelor's degree, working under the supervision of a physician
- Physician services provided by the medical director or a physician who is part of the IDT participating in services as follows:
  - General supervising services, participating in the establishment and supervision of the plan of care, conducting periodic reviews, establishing governing policies, and providing direct care to members
- Counseling services provided to the member, member's family, and other people caring for the member
- Short-term inpatient care provided on a hospice inpatient unit, participating hospital, and nursing home setting
- Medical equipment and supplies, including palliative drugs, related to the palliation and management of the member's terminal illness
- Home health services furnished by qualified aides
- Homemaker services that assist in providing a safe and healthy environment
- Physical and occupational therapy, and speech-language pathology services provided for the purpose of symptom control
- Inpatient hospice care, such as inpatient hospice respite or general inpatient care
- Room and board (dually eligible hospice members) residing in long term care facilities
- Room and board for IHCP-only hospice members who reside in long term care facilities
- Any other item or service specified in the member's POC, if the item or service is a covered service under the Medicare program and required to treat the terminal illness or related conditions

In order for an individual to receive Medicaid-covered hospice services, a physician must certify in writing the individual is terminally ill and expected to die from that illness within six (6) months,

if the terminal illness runs its normal course. Services provided in hospice care must be reasonable and medically necessary for the palliation or management of the terminal illness.

IHCP members in need of hospice care must be eligible for program services, a physician must certify in writing the individual is terminally ill and expected to die from that illness within six (6) months, if the terminal illness runs its normal course, and the member must elect hospice services.

Hospice eligibility is available to qualifying IHCP-eligible members in three consecutive benefit periods:

- Period I- 90 days
- Period II- 90 days (expected maximum length of illness to run its course)
- Period III- Unlimited 60 day period

Different IHCP programs may have different prior authorization and plan of care requirements for coverage

### **Healthy Indiana Plan**

The Indiana Health Coverage Programs (IHCP) covers in-home and institutional hospice services under the Healthy Indiana Plan (HIP) program. HIP members receiving hospice services will remain enrolled in managed care with their health plan.

#### **Prior Authorization for Healthy Indiana Plan**

Contact the member's managed care entity (MCE) or plan administrator for more specific guidelines regarding their policies and prior authorization procedures for hospice services

### **Hoosier Care Connect**

All covered hospice benefits for members enrolled in Hoosier Care Connect will be the responsibility of the enrolling health plan. Members will remain enrolled with their managed care entity (MCE) for the duration of the hospice period. A member enrolled in Hoosier Care Connect is eligible to receive all hospice levels of care available under the hospice benefit: routine home care, continuous home care, inpatient respite care, and general inpatient (GIP) care. A Hoosier Care Connect member receiving in-home hospice benefits is eligible to receive inpatient care, as needed.

#### **Prior Authorization for Hoosier Care Connect**

For inpatient stays related to the terminal illness, at the general inpatient (GIP) hospice level of care (GIP) or the inpatient respite hospice level of care, the hospice provider is responsible for obtaining prior authorization (PA) and for reimbursing the facility. As the professional manager of the member's hospice care, the hospice provider is responsible for obtaining contracts with all IHCP providers for arranged services. The hospice provider will pay the facility according to the contract between the hospice provider and the facility where the member receives care. The contract between the hospice provider

and the facility covers all costs related to the terminal illness. The hospice provider will submit claims directly to the MCE for reimbursement. The hospice provider will be paid at the rate appropriate to the level of care provided to the hospice member; general inpatient (GIP) hospice level of care will be reimbursed at the GIP rate and inpatient respite hospice level of care will be reimbursed at the respite rate.

For members receiving inpatient care unrelated to the terminal illness, the facility is responsible for obtaining PA, as required, from the MCE and submitting claims directly to the MCE for reimbursement. The facility will be responsible for all the member's care and treatment while the member remains at the facility.

The hospice provider is responsible for obtaining PA for inpatient stays related to the terminal illness for both GIP level of care and respite level of care. For any inpatient stay unrelated to the terminal illness, the hospice provider and the inpatient facility are expected to work together in obtaining the necessary PA. Contact the member's managed care entity (MCE) or plan administrator for more specific guidelines regarding their policies and prior authorization procedures for hospice services

### **Hoosier Healthwise**

Members enrolled in Hoosier Healthwise must disenroll from managed care prior to receiving in-home or institutional hospice benefits. Hospice services will be available through traditional Medicaid. Disenrollment is necessary for hospice authorization to be completed. Members become eligible for hospice services the business day following disenrollment from the MCE.

#### **Prior Authorization for Hoosier Healthwise**

Prior Authorization is required for in-home or institutional hospice benefits.

### **Traditional Medicaid**

The Indiana Health Coverage Programs (IHCP) covers in-home and institutional hospice services.

#### **Prior Authorization for Traditional Medicaid**

Prior authorization is required for in-home and institutional hospice services.

### **Concurrent Hospice and Curative Care Services for Children**

Section 2302 of the Affordable Care Act (ACA), titled "Concurrent Care for Children," requires hospice services to be provided to children without forgoing any other service to which the child is entitled under Medicaid for treatment of a terminal condition. This provision was effective with the enactment of the ACA. Before the ACA's enactment, curative treatment for terminal illnesses ceased when Medicaid members elected hospice benefits.

In compliance with the ACA, the IHCP covers hospice care for children, 20 years of age and under, concurrently with all medically necessary curative treatment for the terminal illness, for dates of service on or after March 23, 2010.

## **Prior Authorization for the Concurrent Hospice and Curative Care Services for Children**

Prior authorization is required.

## **Dually Eligible and Medicaid-Only Hospice Members in Nursing Facilities**

The IHCP hospice benefits must comply with the *OBRA of 1989*. *OBRA of 1989* requires dually eligible Medicare/IHCP members to elect, revoke, or change providers under both the Medicare and the IHCP programs simultaneously. Hospice providers are required to notify both programs of any changes in the member's hospice care status.

Additionally, hospice providers are required to coordinate regularly with NF providers. To ensure that the IHCP member's enrollment in the IHCP hospice benefit is clear to both hospice and NF staffs, the hospice provider must furnish the NF staff with the member's Medicaid hospice forms. The hospice must develop coordination procedures with the NF billing department to inform the NF of hospice care status.

## **Prior Authorization for Dually Eligible and Medicaid-Only Hospice Members in Nursing Facilities**

Prior Authorization is required.

## **Treatment of Non-terminal Conditions**

The IHCP covers medical care for conditions unrelated to the terminal illness. The IHCP expects the hospice provider to actively interface and coordinate these services with other IHCP providers. Medical care for non-terminal conditions may be met by one of the following methods:

- Outpatient physician services
- Inpatient and outpatient hospital admissions
- Emergency admissions to a NF from a private home

If the IHCP hospice member requires an inpatient or outpatient hospital admission for conditions unrelated to the terminal illness, the hospital must bill the IHCP directly for these services. The hospice provider coordinates the inpatient or outpatient hospital services. Hospice providers' responsibility for the treatment of non-terminal conditions is case specific. The following guidelines provide clarification for hospice providers regarding this issue:

- If the hospice member currently does not receive treatment for a non-terminal condition, the hospice provider is required to locate appropriate IHCP services for the treatment of a non-terminal condition.
- To ensure that the hospice member is not billed for these services, the hospice provider must ensure the non-hospice provider is enrolled as an IHCP provider.
- The hospice provider must communicate and coordinate with the non-hospice provider's personnel to ensure the source does not compromise the member's hospice care.



- If the IHCP hospice member is admitted to the hospital from a private home, the hospice provider must submit a Change in Status of Medicaid Hospice Patient form to the PA Department of CMCS. This form reflects the hospice member's change of care. The same form must be completed once the hospice member is discharged from the hospital to either another institutional care setting or to a private home.

Any Medicaid member who is terminally ill and meets medical necessity criteria may receive services from an IHCP hospice provider. Hospice providers are required to comply with federal hospice regulations at 42 CFR, Part 418, and the Balanced Budget Act of 1997, which requires hospice providers to list all hospice covered services in frequency and scope on the hospice plan of care (POC) necessary to treat the terminal illness and related conditions.

Furthermore, hospice providers must provide care based on the medical acuity of the member at one of four distinct hospice levels of care: routine home care, continuous home care, general inpatient hospice care, and inpatient hospice respite care.

### **Prior Authorization for the Treatment of Non-terminal Conditions**

The IHCP provider billing for the treatment of the non-terminal illness must obtain PA for the treatment of the non-terminal illness services. The following services do not require PA for the treatment of non-terminal conditions:

- Pharmacy services not related to the member's terminal condition
- Dental services
- Vision care services

### **Non-terminal Medical Conditions**

The diagnostic information in this section was researched from the following organizations: American Academy of Neurology, American College of Cardiology, American Heart Association, American Lung Association, American Psychiatric Association, National Institute of Neurological Disorders and Stroke, Renal Physicians Association and American Society of Nephrology, and the U.S. National Library of Medicine and NIH.

### **Amyotrophic Lateral Sclerosis (ALS)**

The following information is for general diagnosis and consideration of medical necessity for ALS:

- ALS tends to progress in a linear fashion over time; therefore, the overall rate of decline in each patient is fairly constant and predictable, unlike many other non-cancer diseases.
- No single variable deteriorates at a uniform rate in all patients; therefore, multiple clinical parameters are required to judge the progression of ALS.
- Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time patients become end-stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist.

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- Progression of disease differs markedly from patient to patient. Some patients decline rapidly and die quickly; others progress more slowly. For this reason, the history of the rate of progression in individual patients is important to predict prognosis.
- In end-stage ALS, two factors are critical in determining prognosis. These factors are the ability to breathe and the ability to swallow. The ability to breathe can be managed by artificial ventilation, and the ability to swallow by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. While not necessarily a contraindication to hospice care, the decision to institute either artificial ventilation or artificial feeding will significantly alter a six-month prognosis.
- Examination by a neurologist within three months of assessment for hospice is advised, both to confirm the diagnosis and to assist with prognosis.
- Member must demonstrate a rapid progression of ALS within the 12 months preceding initial hospice certification. All the following clinical findings document this progression:
  - Progression from independent ambulation to wheelchair, or to bed-bound status
  - Progression from normal to barely intelligible or unintelligible speech
  - Progression from normal to pureed diet
  - Progression from independence in most or all ADLs to needing maximum assistance by caretaker in all ADLs

Member must demonstrate critically impaired breathing capacity by the following characteristics occurring within 12 months preceding initial hospice certification. Presence of any of the following will support a terminal illness status:

- Vital capacity is less than 30 percent of normal
- Significant dyspnea at rest
- Requiring supplemental oxygen at rest
- Patient declines artificial ventilation

Member must demonstrate critical nutritional impairment by all the following characteristics occurring within 12 months preceding initial hospice certification:

- Oral intake of nutrients and fluids insufficient to sustain life
- Continuing weight loss
- Dehydration or hypovolemia
- Absence of artificial feeding methods

Member must demonstrate life-threatening complications by one of the following characteristics occurring within 12 months preceding initial hospice certification:

- Recurrent aspiration pneumonia (with or without tube feedings)
- Upper UT infection, e.g., pyelonephritis
- Sepsis
- Fever recurrent after antibiotic therapy

## Alzheimer's disease and Related Disorders

Alzheimer's disease and related disorders must support a prognosis of six months or fewer to meet the medical necessity for hospice services. The identification of specific structural impairments, functional impairments, and relevant activity limitations serves as the basis for palliative interventions and care planning.

The structural and functional impairments associated with a primary diagnosis of Alzheimer's disease may be complicated by co-morbid or secondary conditions. Documentation of structural impairments, functional impairments, and activity limitations facilitates the selection of intervention strategies and provides objective criteria for determining the effects of such interventions.

### Co-morbid conditions

- The significance of a given co-morbid condition is defined by the structural and functional impairments, together with any limitation in activity related to the co-morbid condition.
- Ultimately, the combined effect of Alzheimer's disease (stage 7) and any co-morbid condition should be such that most members with Alzheimer's disease and similar impairments would have a prognosis of six months or fewer.

### Secondary conditions

- Secondary conditions, such as delirium and pressure ulcers, are directly related to a primary condition.
- Secondary conditions may be described by defining the structural or functional impairments, together with any limitation in activity or related to the secondary condition.
- The occurrence of secondary conditions in members with Alzheimer's disease may be facilitated by the presence of impairments in body functions, such as mental functioning and movement functions.
- Such functional impairments may contribute to the increased incidence of secondary conditions, such as delirium and pressure ulcers.
- Secondary conditions themselves may be associated with a new set of structural or functional impairments that may respond to treatment.
- The combined effects of the Alzheimer's disease and any secondary condition may indicate a prognosis of six months or fewer.

The Reisberg Functional Assessment Staging (FAST) Scale may be used to assess the functional level of members with Alzheimer's disease and establish a prognosis of six months or fewer. Members who have a FAST score of 7 and specific co-morbid or secondary conditions may meet medical necessity.

## Cardiopulmonary Disease

Cardiopulmonary conditions are associated with impairments, activity limitations, and disability. Their impact on any given individual depends on the individual's overall health status. Cardiopulmonary conditions may support a prognosis of six months or less under many clinical scenarios.

The health status changes associated with cardiopulmonary conditions can be characterized using categories contained in the ICF. The ICF contains domains (for example, structures of cardiovascular and respiratory systems, functions of the cardiovascular and respiratory system, communication, mobility, and self-care) that allow for a comprehensive description of an individual's health status and service needs. Information addressing relevant ICF categories, defined within each of these domains, should form the core of the clinical record and be incorporated into the care plan, as appropriate.

Additionally, the care plan may be impacted by relevant secondary and/or comorbid conditions. Secondary conditions are directly related to a primary condition. In the case of cardiopulmonary conditions, examples of secondary conditions could include delirium, pneumonia, stasis ulcers, and pressure ulcers. Comorbid conditions affecting beneficiaries with cardiopulmonary conditions are, by definition, distinct from the primary condition itself. An example of a comorbid condition would be end-stage renal disease (ESRD).

The important roles of secondary and comorbid conditions are described in the following sections to facilitate their recognition and assist providers in documenting their impact. The identification and documentation of relevant secondary and comorbid conditions, together with the identification and description of associated structural/functional impairments, activity limitations, and environmental factors would help establish hospice eligibility and maintain a beneficiary-centered plan of care.

### **Secondary Conditions**

Cardiopulmonary conditions may be complicated by secondary conditions. The significance of a given secondary condition is best described by defining the structural/functional impairments – together with any limitation in activity and restriction in participation – related to the secondary condition. The occurrence of secondary conditions in beneficiaries with cardiopulmonary conditions results from the presence of impairments in such body functions as heart/respiratory rate and rhythm, contraction force of ventricular muscles, blood supply to the heart, sleep functions, and depth of respiration. These impairments contribute to the increased incidence of secondary conditions such as delirium, pneumonia, stasis ulcers, and pressure ulcers observed in Medicaid beneficiaries with cardiopulmonary conditions. Secondary conditions themselves may be associated with a new set of structural/functional impairments that may or may not respond/be amenable to treatment.

Ultimately, to support a hospice plan of care, the combined effects of the primary cardiopulmonary condition and any identified secondary conditions should be such that most beneficiaries with the identified impairments would have a prognosis of six months or less.

### **Comorbid Conditions**

The significance of a given comorbid condition is best described by defining the structural/functional impairments – together with any limitation in activity and restriction in participation – related to the comorbid condition. For example, a beneficiary with a primary cardiopulmonary condition and ESRD could have specific ESRD-related impairments of water, mineral, and electrolyte balance functions coexisting with the cardiopulmonary impairments.

associated with the primary cardiopulmonary condition, such as aortic stenosis, chronic obstructive pulmonary disease, or heart failure)

Ultimately, to support a hospice plan of care, the combined effects of the primary cardiopulmonary condition and any identified comorbid conditions should be such that most beneficiaries with the identified impairments would have a prognosis of six months or less.

The documentation of structural/functional impairments and activity limitations facilitate the selection of the most appropriate intervention strategies (palliative/hospice vs. long-term disease management) and provide objective criteria for determining the effects of such interventions. The documentation of these variables is thus essential in the determination of reasonable and necessary IHCP Hospice Services

## Heart Disease

Member must have current findings from numbers 1 and 2 below. Findings from numbers 3 and 4 are primarily supportive documentation for medical necessity.

1. Member has been treated with diuretics and vasodilators, which may include ACE inhibitors or the combination of hydralazine and nitrates. If side effects, such as hypotension or hyperkalemia, prohibit the use of ACE inhibitors or the combination of hydralazine and nitrates, the documentation submitted must reflect this reasoning. If a member has angina pectoris at rest that is resistant to standard nitrate therapy; and if the member is not a candidate for or declines invasive procedures, these factors must be documented in the medical records.
2. Member has significant findings of recurrent congestive heart failure at rest and is classified as NYHA Class III or IV. Class III or IV patients with heart disease cannot carry on any physical activity without discomfort. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort increases. Class III heart failure (moderate) is defined as the marked limitation of physical activity. These patients are comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea. Class IV heart failure (severe) is defined as the inability to carry out any physical activity without discomfort, along with symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort increases.
3. Congestive heart failure may be documented by an ejection fraction of < 40 percent. Documentation of an ejection fraction is not required if it is not already available.
4. Documentation of the following findings will support eligibility for hospice care:
  - a. Treatment resistant symptomatic supraventricular or ventricular arrhythmias
  - b. History of cardiac arrest or resuscitation
  - c. History of unexplained syncope
  - d. Brain embolism of cardiac origin
  - e. Concomitant HIV disease
  - f. Documentation of ejection fraction – 40 percent or less



## Pulmonary Disease

Member must have current findings from numbers 1 through 5. Findings from numbers 6 through 9 primarily support documentation for medical necessity.

1. Severe chronic lung disease, as documented by both sections a and b:
  - a. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, which results in decreased functional capacity; e.g., bed to chair existence, fatigue, and cough.
  - b. Prior visits to the emergency department or hospitalizations, which have increased over time, for pulmonary infections or respiratory failure indicating end-stage pulmonary disease.
2. Progression of end-stage pulmonary disease, as evidenced by the following:
  - a. Prior increasing visits to the emergency department
  - b. Prior hospitalizations for pulmonary infections
  - c. Respiratory failure (documentation of FEV1 – forced expiratory volume after one second) < 30 percent is objective evidence for disease progression that may not be necessary to obtain
3. Swelling in the lower extremities which may indicate cor pulmonale or right-sided heart failure, secondary to pulmonary disease, e.g., not secondary to left heart disease or valvulopathy
4. Hypoxemia
5. Long-term oxygen therapy
6. Unintentional progressive weight loss of greater than 10 percent of body weight over the preceding six months
7. Resting tachycardia >100/min
8. Previous use of ventilator during hospital admissions
9. Pulmonary hypertension

## HIV/AIDS

Member must have current findings from numbers 1 and 2 below. Findings from number 3 primarily support documentation for medical necessity.

1. CD4+ count less than or equal to 200 cells/mm<sup>3</sup> or persistent viral load >100,000 copies/ml, plus one of the following findings:
  - a. CNS lymphoma
  - b. Wasting (loss of 33 percent of lean body mass), untreated or not responsive to treatment

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- c. Mycobacterium avium complex bacteremia, untreated, unresponsive to treatment, or treatment refused
  - d. Progressive multifocal leukoencephalopathy
  - e. Systemic lymphoma with advanced HIV disease and partial response to chemotherapy
  - f. Visceral Kaposi's sarcoma, unresponsive to therapy
  - g. Renal failure in the absence of dialysis
  - h. Cryptosporidium infection
  - i. Toxoplasmosis, unresponsive to therapy
2. Decreased performance status, as measured by the Karnofsky Performance Status Scale, of < 50 percent
3. Documentation of the following findings will support eligibility for hospice care:
  - a. Chronic persistent diarrhea for one year
  - b. Persistent serum albumin <2.5 gm/dl
  - c. Age > 50 years old.
  - d. Absence of antiretroviral, chemotherapeutic, and prophylactic drug therapy related specifically to HIV disease
  - e. Toxoplasmosis
  - f. Congestive heart failure, symptomatic at rest
  - g. Advanced AIDS dementia complex
  - h. Concomitant, active substance abuse

## Liver Disease

Members must have current findings from numbers 1 and 2 below. Findings from number 3 primarily support documentation for medical necessity.

1. The member must present with findings from both a and b:
  - a. Prothrombin time prolonged more than five seconds over control, or International Normalized Ratio (INR) >1.5
  - b. Serum albumin <2.5 gm/dl
2. End-stage liver disease is present, and the patient shows at least one of the following:
  - a. Ascites, refractory to treatment or patient non-compliant
  - b. Spontaneous bacterial peritonitis
  - c. Hepatorenal syndrome (elevated creatinine and BUN with oliguria (<400 ml/day) and urine sodium concentration <10 meq/l)
  - d. Hepatic encephalopathy, refractory to treatment, or patient non-compliant
  - e. Recurrent variceal bleeding, despite intensive therapy
3. Documentation of the following findings will support eligibility for hospice care:
  - a. Progressive malnutrition
  - b. Muscle wasting with reduced strength and endurance
  - c. Continued active alcoholism (>80 gm ethanol/day)
  - d. Hepatocellular carcinoma

- e. Hepatitis B surface antigen (HBsAg) positive
- f. Hepatitis C refractory to interferon treatment

Members awaiting a liver transplant who otherwise fit the hospice criteria may receive hospice benefits. However, if a donor organ is procured, the member must be discharged from hospice services.

## Renal Disease

Members with acute renal failure must have current findings from numbers 1 and 2 below. Findings from number 3 primarily support documentation for medical necessity.

1. Creatinine clearance < 10 cc/min (<15 cc/min for diabetics)
2. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)
3. Co-morbid conditions
  - a. Mechanical ventilation
  - b. Malignancy (other organ system)
  - c. Intractable hyperkalemia (>7.0), not responsive to treatment
  - d. Uremic pericarditis
  - e. Hepatorenal syndrome
  - f. Intractable fluid overload, not responsive to treatment
  - g. Immunosuppression/AIDS
  - h. Albumin <3.5 gm/dl
  - i. Cachexia
  - j. Platelet count <25,000
  - k. Disseminated intravascular coagulation
  - l. Gastrointestinal bleeding
  - m. Chronic lung disease
  - n. Advanced cardiac disease
  - o. Advanced liver disease
  - p. Sepsis

Member with chronic renal failure must have current findings from numbers 1 and 2 below. Findings from number 3 primarily support documentation for medical necessity.

1. Creatinine clearance <10cc/min (<15 cc/min for diabetics)
2. Serum creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics)
3. Signs and symptoms of renal failure
  - a. Uremia
  - b. Oliguria (<400 cc/day)
  - c. Intractable hyperkalemia (>7.0) not responsive to treatment
  - d. Uremic pericarditis
  - e. Hepatorenal syndrome

- f. Intractable fluid overload, not responsive to treatment

## Stroke

The medical criteria listed below support a terminal prognosis for members with a diagnosis of stroke. Medical criteria are indicators of functional and nutritional status that support medical necessity for hospice services.

- Palliative Performance Scale (PPS) of 40.
  - Degree of ambulation (i.e., bedridden)
  - Activity and extent of disease (i.e., unable to work and extensive disease)
  - Inability for self-care (i.e., assistance needed) or the incapability of regaining the ability for self-care
  - Food and fluid intake (i.e., greatly reduced or reduced to the point of inability to maintain homeostasis)
  - State of consciousness (i.e., fully conscious, drowsy, or confused)
- Inability to maintain hydration and caloric intake with one of the following:
  - Weight loss > 10 percent during previous six months
  - Weight loss > 7.5 percent in previous three months
  - Serum albumin > 2.5 gm/dl
  - Current history of pulmonary aspiration without effective response to intervention by a speech/language therapist
  - Calorie counts documenting inadequate caloric and fluid intake
  - Determination of the inability to improve by a neurologist, neurosurgeon, internal medicine specialist, or family practitioner, along with a review by a PT or OT.

If a member does not meet the medical criteria, documentation must describe a relevant co-morbidity and rapid decline of functional abilities. For example, a stroke patient with a co-morbidity (i.e., Alzheimer's, Parkinson's disease, adult failure to thrive syndrome, or ALS) may not be able to regain functionality.

## Coma

Medical criteria listed below may support a terminal prognosis for members with a diagnosis of coma when any three of the following conditions are met on day three of a coma:

- Abnormal brain stem response
- Absent verbal response
- Absent withdrawal response to pain
- Serum creatinine > 1.5 mg/dl

Medical criteria is based on a neurological evaluation, which may include an electroencephalography (EEG), magnetic resonance imaging (MRI), or computed axial tomography (CT scan).

## Adult Failure to Thrive Syndrome

The following information is for general diagnosis and consideration of medical necessity for adult failure to thrive syndrome:

- The adult failure to thrive syndrome is characterized by unexplained weight loss, malnutrition, and disability.
- This syndrome has been associated with multiple primary conditions (e.g., infections and malignancies), but always includes two defining conditions, those being malnutrition and disability.
- The syndrome may be an irreversible progression in the member's malnutrition or worsening of disability despite therapy (i.e., failure of treatment intended to affect the primary condition responsible for the patient's clinical presentation).
- Co-morbid conditions may increase the progression of this syndrome and should be identified and addressed.

The following medical criteria would support a terminal prognosis of adult failure to thrive syndrome.

- Nutritional impairment should be significant enough to have an impact on the member's weight.
  - Member's BMI is below 22kg/m<sup>2</sup>.
  - Member is either refusing enteral/parenteral nutritional support or has not responded to such nutritional support, despite an adequate caloric intake.
- Disability associated with adult failure to thrive should be such that the member is significantly disabled, which would be demonstrated by a Karnofsky or Palliative Performance scale value less than or equal to 40 percent.

Both the BMI and the level of disability of the member should be determined using measurements and observations made within six months (180 days) of the most recent certification/recertification date. If enteral nutritional support has been instituted before considering hospice and will be continued, the BMI and levels of disability should be determined using measurements and observations at the time of the initial certification and at each subsequent recertification for hospice.

At the time of recertification, recumbent measurements, such as mid-arm muscle area in cm<sup>2</sup>, may be used instead of BMI measurement, so long as there is documentation proving the necessity of such replacement in the member's file.

Also, in the event a member with nutritional impairment does not meet the criteria of refusing enteral/parenteral nutritional support or has not responded to nutritional support (as listed above) but is still considered eligible for hospice care, he or she may have an alternative diagnosis that adequately describes the clinical circumstances of the member (e.g., R63.4 – abnormal loss of weight and R64 – Cachexia).



Following are the documentation requirements needed for hospice admission of members with adult failure to thrive syndrome:

- Documentation supporting the medical necessity should be legible, maintained in the member's medical records, and be available for review on request.
- Documentation certifying terminal status must contain sufficient information to confirm that the status is based on the criteria of medical necessity.
- Both measurement of BMI and functional status of the member using the Karnofsky scale must be documented every 180 days for recertification of hospice benefits.

### **Medicaid Home and Community Based Services Waiver Members**

Members who receive home and community-based services through one of the IHCP waiver programs and meet the hospice criteria are eligible for IHCP hospice services. IHCP waiver members who choose the IHCP hospice benefit do not have to disenroll from the waiver program. The member may continue to receive waiver services that are not related to the terminal condition and are not duplicative of hospice services.

- IHCP members currently receiving HCBS may also elect the Medicare or Medicaid hospice benefit as deemed eligible. The HCBS case manager may request additional home and community-based services, as long as those home and community-based services are not related to the terminal condition and do not duplicate hospice services.
- IHCP members currently receiving the Medicare or Medicaid hospice benefit may supplement services by applying for HCBS through the appropriate division, as long as those HCBS are not related to the terminal condition, do not duplicate hospice services, and are available through the applicable source.

The IHCP hospice provider must provide all required services to meet the needs of the member in relation to the terminal diagnosis.

The number of hours related to the member's non-terminal condition is determined on a case specific basis. The member should not be provided with additional waiver services other than those the IHCP waiver program would have provided if the waiver member had not elected hospice care.

The IHCP expects the hospice provider to coordinate with other non-hospice providers to ensure the member's overall care is met and non-hospice providers do not compromise the hospice POC. The hospice provider and the waiver case manager must collaborate and communicate regularly to ensure that the best possible care is provided.

### **Prior Authorization for Medicaid Home and Community Based Services Waiver Members**

Prior authorization for IHCP hospice services is required.

## Discharge by a Hospice Provider

Once a hospice provider chooses to admit a member, the provider may not automatically or routinely discharge the member at its discretion, even if the care is costly or inconvenient. The election of the hospice benefit is the member's choice, rather than the hospice's choice; therefore, the hospice may not revoke the member's election. Additionally, hospice providers may not request or demand hospice revocation.

Reasons a hospice provider may discharge a member from care include the following situations:

- Member dies
- Member's prognosis is determined to be greater than six months
- Member moves out of the hospice service area
  - The hospice provider notifies the fiscal intermediary of the discharge, so hospice services and billings are terminated as of the discharge date. In this situation, the member loses the remaining days in the benefit period; however, there is no increased cost to the member.
- Member's safety or hospice staff's safety is compromised
  - The hospice must make every effort to resolve these problems satisfactorily before discharge is considered an option. All efforts by the hospice to resolve the problem must be documented in detail in the member's record. The hospice must notify the fiscal intermediary and the State Survey Agency of the circumstances surrounding the impending discharge. Hospice providers must submit specific forms to facilitate the discharge
- Member is admitted to a NF that does not have a contract with a hospice

Hospice providers may fax the Medicaid Hospice Discharge form to the PA Department of CMCS, if all the hospice benefit periods preceding the hospice discharge date have been previously authorized. The documented discharge date cannot precede the actual discharge.

For members residing in nursing facilities, hospice providers are encouraged to provide a copy of the discharge form to the appropriate staff in the NF to ensure that the form is included in the clinical record the NF maintains for the hospice member. This coordination ensures that staff is aware of the exact date the hospice provider discharged the member.

- Hospice providers must bill the IHCP for the hospice per diem for NF room and board for the hospice discharge date.
- Nursing facilities may resume billing the IHCP directly for NF care for the DOS following the hospice discharge date.

## Prior Authorization

All hospice services require prior authorization.

The IHCP hospice provider must submit documentation to the CMCS PA Department within 10 business days of the member's election effective date, and for each benefit period, for approval of the hospice benefit. CMCS preferred method for providers to submit PA requests is by fax.

### Plan of Care

The IHCP hospice benefit program mirrors the Medicare hospice program. IHCP hospice providers are required to comply with federal hospice regulations located at *42 CFR, Part 418 et seq.* The Medicare Conditions of Participation (CoPs) were updated January 23, 2006 to affect change in the *Balanced Budget Act of 1997*.

These regulations require hospice providers to list all hospice covered services in frequency and scope on the hospice POC necessary to treat the terminal illness and related conditions. Hospice providers must provide care based on the medical acuity of the member at one of four distinct hospice levels of care:

- routine home care
- continuous home care
- general inpatient hospice care
- inpatient hospice respite care

IHCP hospice providers must be Medicare-certified and licensed as hospice providers by ISDH as a condition of provider enrollment.

### Documentation Requirements

The individual must have a terminal prognosis as well as the physician certification that meets the Medicare guidelines of participation (providers should refer to *42 CFR 418.56* for the pertinent regulations for the hospice plan of care).

- The clinical evidence must support the terminal diagnosis at the time of the initial certification and at the time of each subsequent certification and must describe the patient's condition.
- Documentation must illustrate why the patient is considered to be terminal and not chronic. History is helpful when it provides clarification as to why the current documentation only reflects a chronic condition.
- Each patient's documentation must be specific to the individual and include any additional documentation, which distinguishes this patient from other patients with the same disease who may be chronic but who are not terminal.
- For each hospice benefit period, the interdisciplinary team must assess the patient's condition and hospice appropriateness and the documentation must distinguish between exacerbation and stabilization as well as exacerbation and deterioration.
- The documentation must include the most specific and most terminal ICD-10 CM code appropriate to the patient.
- The documentation must specify why any medication, treatments, or services could be considered aggressive are considered necessary for the patient's palliative treatment.
- The patient's decline must be documented in detail.

- Providers must show how the systems of the body are in a terminal condition.

For PA, IHCP consults hospice criteria published by the fiscal intermediary for Indiana Medicare hospice providers, Palmetto Government Benefits Administrators, LLC. Palmetto has established these guidelines as a matter of protocol for medical criteria. Providers are to use current professional guidelines, including the LCD, to determine when hospice services meet medical necessity.

Hospice providers are reminded that the IHCP recognizes that the local coverage determination policies (LCD) are only guidelines to determine when members may qualify for hospice or palliative services. The LCD is not meant to replace the overall clinical evaluation by the hospice provider, IHCP, or its contractor, when evaluating the unique clinical condition of each hospice member.

The IHCP will use existing medical documentation submitted by the hospice provider to determine medical necessity for hospice. Existing labs and other forms of medical tests may be helpful to determine appropriateness for hospice care and may be requested of the provider if such documentation exists; however, the IHCP would not expect the patient to undergo invasive tests at the end of life unless they were absolutely necessary to validate a prognosis. The existence of documented co-morbidities, as well as the documentation of decline in the member's health status, will be used in the evaluation. Existence of a patient advance directive should also be taken into consideration.

The IHCP and its contractors are not prevented from requesting medical documentation about any hospice member at any point during that member's enrollment in the IHCP. This practice is consistent with the IHCP provider agreement.

Hospice inpatient care must be provided in an inpatient unit or contracted inpatient facility that meets the parameters at 42 *CFR Part 418.100 et seq.*

## Billing and Coding

For further billing information, see the [Hospice Services](#) provider reference module. For a list of billing codes, see the *Hospice Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

### [405 IAC 1](#)

- 405 IAC 1-16 Reimbursement for Hospice Services

### [405 IAC 5](#)

- 405 IAC 5-2-10.2 Hospice Program Defined
- 405 IAC 5-5-1 Out-of-State Services; General
- 405 IAC 5-34 Hospice Services

### [IHCP Provider Bulletins](#)

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- [BT201809](#) Enrolling health plans to be responsible for hospice services for Hoosier Care Connect members
- [BT201626](#) IHCP clarifies coverage of hospice and home health services in HIP
- [BT201526](#) IHCP amends electronic signature policy for home health and hospice PA documentation.
- [BT201433](#) Patient liability established for qualifying individuals with end-stage renal disease
- [BT201205](#) Concurrent Hospice and Curative Care Services for Children

## [IHCP Provider Banners](#)

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

March 13, 2018 – Clarified Health Plans Responsible for Hospice Services for Hoosier Care Connect Members



## Hospital Inpatient Services

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### Description of Service

"Inpatient" is defined as a patient required to be admitted to the hospital to treat a condition requiring close monitoring or skilled professional management. Inpatient hospital services may be covered when determined to be medically reasonable and necessary for the services to be performed only in an inpatient hospital setting.

### Medical Policy

#### Inpatient Acute Care Hospital Admissions

Inpatient hospital services are covered by IHCP when such services are provided or prescribed and documented by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition, subject to the following limitations:

- Reimbursement for inpatient hospital services is available only when it is determined to be medically reasonable and necessary for the services to be performed only in an inpatient hospital setting.
  - Reimbursement will be denied for any days of the hospital stay during which the inpatient hospitalization is found not to have been medically necessary.
- If an inpatient procedure requires prior authorization, and prior authorization is either not obtained or denied, reimbursement for the inpatient procedure and any associated services, including inpatient days, shall be denied.
- The recipient's medical condition, as described and documented in the medical record by the primary or attending physician, must justify the intensity of service provided.
- Reimbursement shall not be made for any hospital services not covered by the IHCP.
- Reimbursement is not available for reserving a bed during a therapeutic leave of absence from an acute care hospital.

#### Prior Authorization for Inpatient Acute Care Hospital Admissions

Prior authorization is required for all non-emergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. 405 IAC 5-33 provides criteria for acute care hospital admissions for both adult and pediatric recipients. Below are the criteria for acute care hospital admissions for day of admission.

#### Acute Care Hospital Admission Criteria for Adults

##### Severity of Illness Criteria

- Sudden onset of unconsciousness or disorientation (coma or unresponsiveness);
- Pulse rate:
  - less than fifty (50) per minute; or
  - greater than one hundred forty (140) per minute;
- Blood pressure:
  - systolic less than ninety (90) or greater than two hundred (200) millimeters mercury; or

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- diastolic less than sixty (60) or greater than one hundred twenty (120) millimeters mercury;
- Acute loss of sight or hearing;
- Acute loss of ability to move body part;
- Persistent fever equal to or greater than one hundred (100) (p.o.) or greater than one hundred one (101) (R) for more than five (5) days;
- Active bleeding;
- Severe electrolyte/blood gas abnormality, including any of the following:
  - Na < 123 mEq/L
  - Na > 156 mEq/L
  - K < 2.5 mEq/L
  - K > 6.0 mEq/L
  - CO<sub>2</sub> combining power (unless chronically abnormal) < 20 mEq/L
  - CO<sub>2</sub> combining power (unless chronically abnormal) > 36 mEq/L
  - Blood pH < 7.30
  - Blood pH > 7.45;
- Acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, or breathe); must also meet intensity of service criterion simultaneously in order to certify; do not use for back pain;
- EKG evidence of acute ischemia; must be suspicion of a new MI; or
- Wound dehiscence or evisceration.

### Intensity of Service

- Intravenous medications and/or fluid replacement (does not include tube feedings);
- Surgery or procedure scheduled within twenty-four (24) hours requiring:
  - general or regional anesthesia; or
  - use of equipment, facilities, or procedure available only in a hospital;
- Vital sign monitoring every two (2) hours or more often (may include telemetry or bedside cardiac monitor);
- Chemotherapeutic agents that require continuous observation for life-threatening toxic reaction;
- Treatment in an intensive care unit;
- Intramuscular antibiotics at least every eight (8) hours; and
- Intermittent or continuous respirator use at least every eight (8) hours

### Criteria of appropriateness of day of care

- Medical services:
  - procedure in operating room that day;
  - scheduled for procedure in operating room the next day, requiring preoperative consultation or evaluation;
  - cardiac catheterization that day;
  - angiography that day;
  - biopsy of internal organ that day;

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- thoracentesis or paracentesis that day;
  - invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day;
  - any test requiring strict dietary control for the duration of the diet;
  - new or experimental treatment requiring frequent dose adjustments under direct medical supervision;
  - close medical monitoring by a doctor at least three (3) times daily (observations must be documented in record); or
- Postoperative day for any procedure covered listed below:
  - procedure in operating room that day;
  - cardiac catheterization that day;
  - angiography that day;
  - biopsy of internal organ that day;
  - thoracentesis or paracentesis that day;
  - invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day
- Nursing/life support services:
  - respiratory care—intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB) at least three (3) times daily;
  - parenteral therapy—intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein, or medications);
  - continuous vital sign monitoring, at least every thirty (30) minutes, for at least four (4) hours;
  - IM and/or SC injections at least twice daily;
  - intake and output measurement;
  - major surgical wound and drainage care (chest tubes, T-tubes, hemovacs, Penrose drains); or
  - close medical monitoring by nurse at least three (3) times daily, under doctor's orders.
- Patient condition:
  - within twenty-four (24) hours before day of review inability to void or move bowels (past twenty-four (24) hours) not attributable to neurologic disorder;
  - within forty-eight (48) hours before day of review:
    - transfusion due to blood loss;
    - ventricular fibrillation or ECG evidence of acute ischemia, as stated in progress note or in ECG report;
    - fever at least one hundred one (101) degrees rectally (at least one hundred (100) degrees orally), if patient was admitted for reasons other than fever;
    - coma—unresponsiveness for at least one (1) hour;
    - acute confusional state, not due to alcohol withdrawal;
    - acute hematologic disorders, significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis yielding signs or symptoms; or
    - progressive acute neurologic difficulties; and

- within fourteen (14) days before day of review, occurrence of a documented, new acute myocardial infarction or cerebrovascular accident (stroke).

### **Acute Care Hospital Admission Criteria for Pediatrics**

#### **Severity of Illness**

- Sudden onset of unconsciousness (coma or unresponsiveness) or disorientation;
- Acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, breathe, or urinate);
- Acute loss of sight or hearing;
- Acute loss of ability to move body part;
- Persistent fever (> one hundred (100) degrees orally or > one hundred one (101) degrees rectally) for more than ten (10) days;
- Active bleeding;
- Wound dehiscence or evisceration;
- Severe electrolyte/acid-base abnormality, including any of the following:
  - Na < 123 mEq/L
  - Na > 156 mEq/L
  - K < 2.5 mEq/L
  - K > 6.0 mEq/L
  - CO<sub>2</sub> combining power (unless chronically abnormal) <20 mEq/L
  - CO<sub>2</sub> combining power (unless chronically abnormal) > 36 mEq/L
  - Arterial pH < 7.30
  - Arterial pH > 7.45;
  - Hematocrit < thirty percent (30%);
- Pulse rate outside following ranges (optimally a sleeping pulse for < twelve (12) years old):
  - 2–6 years old 70–200/minute
  - 7–11 years old 60–180/minute
  - 12 years old 50–140/minute
- Blood pressure outside following ranges:
  - Systolic/Diastolic
  - 2–6 years old 75–125 mm Hg/ 40–90 mm Hg
  - 7–11 years old 80–130 mm Hg/ 45–90 mm Hg
  - < 12 years old 90–200 mm Hg/ 60–120 mm Hg
- Need for lumbar puncture, where this procedure is not done routinely on an outpatient basis;
- Any conditions not responding to outpatient, including emergency room:
  - seizures;
  - cardiac arrhythmia;
  - bronchial asthma or croup;
  - dehydration;
  - encopresis (for clean-out); or
  - other physiologic problem (specify);
- Special pediatric problems:

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- child abuse;
- noncompliance with necessary therapeutic regimen; or
- need for special observation or close monitoring of behavior, including calorie intake in cases of failure to thrive.

### **Intensity of Service**

- Surgery or procedure scheduled within twenty-four (24) hours requiring:
  - general or regional anesthesia; or
  - use of equipment, facilities, or procedure available only in a hospital;
- Treatment in an intensive care unit;
- Vital sign monitoring every two (2) hours or more often (may include telemetry or bedside cardiac monitor);
- Intravenous medications and/or fluid replacement (does not include tube feedings);
- Chemotherapeutic agents that require continuous observation for life-threatening toxic reaction;
- Intramuscular antibiotics at least every eight (8) hours; and
- Intermittent or continuous respirator use at least eight (8) hours.

### **Criteria of appropriateness of day of care**

- For medical services, the following documented criteria will be used for continued stay reviews; at least one (1) of the criteria must be met for the continued stay to be recertified:
  - Procedure in operating room that day.
  - Procedure scheduled in operating room the next day, requiring preoperative consultation or evaluation.
  - If day being reviewed is the day of admission, any procedure listed below (cardiac catheterization through gastrointestinal endoscopy) scheduled for the day after admission unless that procedure is usually done at that facility on a same-day basis.
  - Cardiac catheterization that day.
  - Angiography that day.
  - Biopsy of internal organ that day.
  - Thoracentesis or paracentesis that day.
  - Invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day.
  - Gastrointestinal endoscopy that day.
  - Any test requiring strict dietary control for the duration of the diet.
  - New or experimental treatment requiring frequent dose adjustments under direct medical supervision.
  - Close medical monitoring by a doctor at least three (3) times daily (observations must be documented in record).
  - Postoperative day for any procedure covered below:
    - Procedure in operating room that day
    - Cardiac catheterization that day
    - Angiography that day



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- Biopsy of internal organ that day
  - Thoracentesis or paracentesis that day
  - Invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day
  - Gastrointestinal endoscopy that day
- Nursing/life support services shall be as follows:
  - Respiratory care—intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB), at least three (3) times daily, Bronkosol with oxygen, oxyhoods, or oxygen tents.
  - Parenteral therapy—intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein, or medications).
  - Continuous vital sign monitoring, at least every thirty (30) minutes for at least four (4) hours.
  - IM and/or SC injections at least twice daily.
  - Intake and/or output measurement.
  - Major surgical wound and drainage care, for example, chest tubes, T-tubes, hemovacs, or Penrose drains.
  - Traction for fractures, dislocations, or congenital deformities.
  - Close medical monitoring by nurse at least three (3) times daily, under doctor's orders.
- Patient condition:
  - within twenty-four (24) hours on or before day of review, inability to void or move bowels, not attributable to neurologic disorder—usually a post-op;
  - within forty-eight (48) hours on or before day of review:
    - transfusion due to blood loss;
    - ventricular fibrillation or ECG evidence of acute ischemia as stated in progress note or in ECG report;
    - fever at least one hundred one (101) degrees rectally (at least one hundred (100) degrees orally) if patient was admitted for reason other than fever;
    - coma—unresponsiveness for at least one (1) hour;
    - acute confusional state, including withdrawal from drugs and alcohol;
    - acute hematologic disorders—significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis—yielding signs of symptoms; or
    - progressive acute neurologic difficulties; and
  - within fourteen (14) days before day of review, occurrence of a documented, new acute myocardial infarction or cerebrovascular accident (stroke).

## Inpatient Psychiatric Admissions

The IHCP reimburses for inpatient psychiatric services provided to eligible individuals between 22 and 65 years old only in certified psychiatric hospitals with 16 beds or less. Reimbursement is available for inpatient care provided on the psychiatric unit of an acute care hospital only

when the need for admission has been certified. For more information, please see the *Mental Health and Addiction Services* policy module.

## **Inpatient Rehabilitation Admission**

Per CMS, inpatient rehabilitation is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

The IHCP provides reimbursement for inpatient rehabilitation services when such services are prior authorized and determined to be medically necessary.

### **Prior Authorization for Inpatient Rehabilitation Admission**

Prior authorization is required for all inpatient rehabilitation admissions. Prior to admission to a physical rehabilitation unit, an assessment of the patient's total rehabilitative potential must be completed and documented in the medical record. Also, a written plan of care, cooperatively developed by the therapist or psychologist and the attending physician, is required for all rehabilitation services.

Prior to admission to a physical rehabilitation unit, the member's total rehabilitation potential must be evaluated. Documentation in the medical record must include the member's condition, IHCP criteria, and level of care necessary in the rehabilitation unit.

The following conditions must be met for reimbursement for physical rehabilitation admission:

- The patient is medically stable.
- The patient is responsive to verbal or visual stimuli.
- The patient has sufficient mental alertness to participate in the program.
- The patient's premorbid condition indicates a potential for rehabilitation.
- The expectation for improvement is reasonable.
- The criteria listed in *405 IAC 5-32* are met.

Per *405 IAC 5-32*, the following criteria shall demonstrate the inability to function independently with demonstrated impairment. The following criteria contains the evaluation necessary to determine the member's ability or inability to function independently.

### **Severity of Illness Criteria**

- Cognitive function (attention span, memory, or intelligence).
- Communication (aphasia with major receptive or expressive dysfunction).
- Continence (bladder or bowel).
- Mobility (transfer, walk, climb stairs, or wheelchair).
- Pain management (pain behavior limits functional performance).

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- Perceptual motor function (spatial orientation or depth or distance perception).
- Self-care activities (drink or feed, dress, maintain personal hygiene, brace or prosthesis).

## **Intensity of Service Criteria**

- Multidisciplinary team evaluation at least every two (2) weeks.
- Physical therapy and at least one (1) of the following therapies (totaling a minimum of three (3) hours daily):
  - Occupational therapy.
  - Speech therapy.
- Participation in a rehabilitation program under the direction of a qualified physician.
- Skilled rehabilitative nursing care or supervision required at least daily.

## **Discharge Criteria**

- Evidence in record that patient has achieved stated goals.
- Medical complications preclude intensive rehabilitative effort.
- Multidisciplinary therapy no longer needed.
- No additional functional improvement is anticipated.
- Patient's functional status has remained unchanged for fourteen (14) days.

## **Inpatient Surgical Admission**

### **Admission Indicators for Surgical Procedures**

- Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient, must be prior authorized. The length of stay for the inpatient admission is determined by the appropriate DRG but is subject to retrospective review for medical necessity.
- Criteria for determining the medical necessity for inpatient admission includes the following information:
  - Technical or medical difficulty during the outpatient procedure as documented in the medical record
  - Presence of physical or mental conditions, which make prolonged preoperative or postoperative observations by a nurse or other skilled medical personnel a necessity
  - Performance of another procedure simultaneously, which itself requires hospitalization
  - Likelihood of another procedure, which would require hospitalization following the initial procedure

### **Prior Authorization for Inpatient Surgical Admission**

Prior authorization is required for all surgical procedures typically performed on an outpatient basis, when performed on an inpatient basis, require PA.

## Dental Admissions

Any one of the following is an inpatient dental admission indicator:

- Mental incapacitation such that the recipient's ability to cooperate with procedures is impaired, including intellectual disability, organic brain disease, and behavioral problems associated with uncooperative, but otherwise healthy children
- Severe physical disorders affecting the tongue or jaw movements
- Seizure disorders
- Significant psychiatric disorders resulting in impairment of the recipient's ability to cooperate with procedures
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication
- The need for oral surgery, listed in 405 IAC 5-19-17; or in extreme cases of facial trauma, pathology, or deformity
- Periodontal surgery only in cases of drug-induced periodontal hyperplasia
- Elective oral surgery when recipient is unable to cooperate with or tolerate the procedure

### Prior Authorization for Dental Admissions

Prior authorization is required for all dental admissions.

## Inpatient Burn Admissions

The following criteria list below for hospitalization for adults and children with burns are to be used for reference in determining IHCP appropriate inpatient burn admissions.

### Hospitalization for Adults with Burns (Age 10 and Over)

#### First Degree

- Superficial
- Damage is limited to the epidermis
- Erythema appears
- Between 10 and 20 percent of total body surface (TBS) area – Minor Burn

#### Second Degree

- Deep partial thickness burns of eyes, ears, face, hands, feet, or perineum; or
- Burns complicated by fractures or respiratory damage;
- Electrical burns; and
- All burns in poor-risk patients
- Involvement of less than 15 percent TBS area – Minor Burn
- Involvement of 15 to 25 percent TBS area – Moderate Burn
- Involvement of more than 25 percent TBS area – Major Burn

#### Third Degree

- Minor Burn: Full thickness burns covering less than 3 percent of the body
  - Excluding the eyes, ears, face, hands, feet or perineum –

**Or**

- Moderate Burn: Full thickness burns covering greater than 3 percent and less than 10 percent TBS area
  - Including the eyes, ears, face, hands, feet, or perineum
- Or**
- Major Burn: Full thickness burns of more than 10 percent of the TBS

## Admission Indicators

The admission may be approved without referral for physician review if **one** of the following is present (recent onset):

- Loss or damage of skin  $\geq 15$  percent of TBS area
- High-voltage burn with devitalized skin, fat, or muscle
- Second- or third-degree burns of one of the following: face, hands, perineal region, encircling neck or extremities, anterior or posterior neck or limbs
- $T \geq 104.0^{\circ} \text{ F}$
- $T \geq 102.0^{\circ} \text{ F}$  and one of the following:
  - White blood cells (WBC)  $\geq 18,000/\text{cu.mm}$
  - WBC  $\geq 15,000/\text{cu.mm}$  with  $\geq 7$  percent bands
- $T \geq 100.5^{\circ} \text{ F}$  and **one** of the following:
  - Absolute neutrophil count  $\leq 500/\text{cu.mm}$
  - WBC  $\leq 1,500/\text{cu.mm}$
- Admission for an invasive procedure which necessitates an inpatient setting **and** is scheduled for the same day as admission

**And one** of the following treatments is being provided (at least daily):

- Post surgery or procedure care  $\leq$  three days and at least **two** of the following:
  - IV fluids  $\geq 100 \text{ mL/h}$
  - IV or IM analgesics
  - IV or IM anti-emetics
  - Graft or wound care
- Burn therapy with at least **three** of the following:
  - IV electrolyte (K, Ca, Mg, P)
  - IV fluids  $\geq 100 \text{ mL/h}$
  - IV plasma expanders
  - $\text{O}_2 \geq 28$  percent (4L) or hyperbaric
  - Total parenteral nutrition (TPN)

**Or** at least **three** of the following treatments are being provided:

- Blood or blood products
- Complex burn, graft, or wound care
- IV fluids  $\geq 100 \text{ mL/h}$
- Restorative PT or OT at least 2x/24h
- TPN



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- IV or IM corticosteroids at least 3x/24h
- IV or IM diuretics at least 2x/24h
- IV or IM analgesics at least 4x/24h
- IV or IM anti-emetics at least 4x/24h
- IV or IM anti-infectives at least 3x/24h

### Hospitalization for Children with Burns (Age 10 and Under)

#### First Degree

- Superficial
- Damage is limited to the epidermis
- Erythema appears
- Minor Burn: Between 10 and 20 percent area

#### Second Degree

- Deep partial thickness burns of eyes, ears, face, hands, feet, or perineum; or
- Burns complicated by fractures or respiratory damage;
- Electrical burns; and
- All burns in poor-risk patients
- Minor Burn: Involvement of less than 10 percent TBS area
- Moderate Burn: Involvement of 10 to 20 percent TBS area
- Major Burn: Involvement of more than 20 percent TBS area

#### Third Degree

- Major Burn: Full thickness burns covering 2 percent of the body
  - Excluding the eyes, ears, face, hands, feet or perineum
- Or**
- Major Burn: Full thickness burns covering greater than 1 percent and less than 10 percent TBS area
  - Including the eyes, ears, face, hands, feet, or perineum

#### Admission Indicators

The admission may be approved without referral for physician review if **one** of the following is present (recent onset):

- Electrical burns with devitalized skin, fat, or muscle
- First-degree burns covering 40 percent of TBS
- Second-degree burns covering 15 percent of TBS
- Second-degree burns covering face, genitalia, hands, or feet
- Third-degree burns covering 5 percent or more of TBS

And at least **one** of the following treatments is being provided at least daily

- Post surgery or procedure care ≤ two days
- IV electrolytes
- Burn therapy with at least two of the following:
  - IV fluids ≥ 30 mL/kg/24h

- IV plasma expanders
- O2 > 28 percent (4L)

Or at least **three** of the following treatments are being provided:

- Blood or blood products
- Complex burn, graft, or wound care
- PT
- IV fluids  $\geq 30$  mL/kg/24h
- IV plasma expanders
- TPN or enteral feeding
- IV or IM corticosteroids at least 3x/24h
- IV diuretics at least 2x/24h
- IV or IM analgesics at least 4x/24h
- IV or IM anti-emetics at least 4x/24h
- IV or IM anti-infectives at least 3x/24h
- Inpatient Dental Admission

### **Prior Authorization for Inpatient Burn Admissions**

Prior authorization is required for inpatient hospitalizations for the immediate treatment of burns, except those with an admit of type 1 (emergency) or type 5 (trauma).

### **Hospital Inpatient Readmissions**

Readmission is the term used when patients are admitted into the hospital, acute care or other, following a previous admission and discharge for the same or a related diagnosis.

Readmissions are subject to medical review to determine if the previous discharge was premature. Reviews are conducted based on statistical data sets for readmissions. If the discharge was premature and payment made, the readmission or discharge may be subject to recoupment. For payment purposes, readmissions within three days after discharge will be treated as the same admissions, while readmissions after three days will be treated as separate stays but are subject to medical review.

### **Out-Of-State Services**

All out-of-state services require Prior Authorization (see *405 IAC 5-5-1*). The following services are exceptions:

- Emergency services
- Recipients of the adoption assistance program placed outside of Indiana
- Services that are provided by designated cities listed in *405 IAC 5-5-2(a) (3)-(4)*.

### **Long Term Acute Care (LTAC) Hospitals**

LTAC hospitals are designed to provide specialized acute care for patients that require especially long recovery periods. These patients are usually in acute-care facilities. Their medical conditions have stabilized, but they continue to require an acute level-of-care (LOC). A lesser LOC, such as a SNF or sub-acute care facility, is not appropriate.

Federal regulations for LTAC hospitals require average inpatient stays greater than 25 days. Medicare program criteria are used to qualify a facility as a LTAC hospital. Patients are generally discharged to home with or without home care services, to acute inpatient rehabilitation hospitals, sub-acute rehabilitation programs, or to SNFs. LTAC hospitals are licensed by state acute care licensing standards and are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

### **Admission Criteria**

Before admission to a LTAC hospital, assessment of the patient's current medical status and discharge goals must be provided to the appropriate PA vendor for PA purposes. This information should also be documented in the medical record. Each PA request is reviewed for medical necessity on an individual, case-by-case basis.

The proposed admission needs to be to a facility that meets the definition of a LTAC hospital in 405 IAC 1-10.5-2(s), which states, "LTC hospital means a freestanding general acute care hospital licensed under Indiana Code IC 16-21 that:

- Is designated by the Medicare program as a long-term hospital; or
- Has an average inpatient length of stay greater than twenty-five (25) days as determined using the same criteria used by the Medicare program to determine whether a hospital's average length of stay is greater than twenty-five (25) days."

The Indiana Code goes on to state: "Freestanding does not mean a wing or specialized unit within a general acute care hospital." However, LTC hospitals may be licensed hospitals that operate as separate entities within a host hospital.

The patient must be admitted directly from an acute care facility or be readmitted from a NF or rehabilitation facility. No PA will be approved for requests for initial admission directly from a NF, from a physician's office, or from home.

The following documentation must be included with requests for admission to a LTAC hospital and must be available for review by the PA Department or SUR Department, as applicable:

- A signed statement from the referring physician indicating medical necessity for transfer to a LTAC hospital.
- The following information must accompany a request for approval and an evaluation by the requesting facility:
  - Diagnosis and premorbid conditions. If the patient is currently in an acute care hospital, the diagnosis at discharge should be included if it has changed from the time of admission.
  - Information about where the patient is being admitted from, if not hospitalized
  - Neurological assessment
  - Complete listing of long- and short-term goals
  - Discharge plan with two options, depending on the member's condition
  - Potential date of admission
  - Projected date of discharge
  - History of any previous rehabilitation therapies

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- Prognosis and documentation that there is a reasonable expectation the member's functional and medical status will improve
- History, physical, and discharge or case summary, if the member is currently hospitalized
- Completed IHCP Prior Authorization Request Form, located at [www.indianamedicaid.com](http://www.indianamedicaid.com). Click on forms. Scroll down to PA.

All the following situations apply to the patient's status and current requirements before admission to the LTAC hospital:

- The patient is medically stable.
- The initial diagnostic workup is completed.
- There are no major surgical procedures planned.
- The patient has a prognosis requiring a prolonged stay in an acute setting, and there is a reasonable expectation for improvement in the status of his or her medical condition.
- The patient requires interactive physician direction with daily on-site assessment.
- The patient requires significant ancillary services dictated by complex, acute medical needs. Examples include but are not limited to full service and STAT laboratory, radiology, and respiratory care services.
- There is a patient-centered, outcome-focused, interdisciplinary approach requiring a physician directed professional team that includes intensive case management to move the patient efficiently through the continuum of care.
- Education for the patient and family must be provided to manage the patient's present and future healthcare needs.

During the PA process, the medical director may help determine whether the admission is medically necessary. Admissions requested for categories not specified in the following sections will be reviewed for medical necessity and intensity of service on a case-by-case basis.

### **Respiratory**

The patient must meet two or more of the following requirements for admission and continued stay:

- Requires ventilator assistance and has failed attempts to be extubated or maintain adequate ventilation, oxygenation, or functional level after extubation
- Requires one or more of the following IV medications daily:
  - Bronchodilators
  - Corticosteroids
  - Diuretics
  - Antiviral agents
  - Anti-tuberculosis agents
  - Antiprotozoal agents
  - Chemotherapy
  - Antibiotics
  - Antifungal agents
  - Anticoagulation medications

- Requires frequent monitoring of tissue oxygenation (for example, pulse oximetry), frequent RT treatments, or suctioning or inhalation medications

### **Impaired Skin Integrity**

Impaired skin integrity means the patient has stage three or stage four decubitus wounds, infected necrotic skin conditions, surgical wounds, or burns. The patient must meet each of the following requirements for admission or continued stay:

- The patient has non-healing wounds that have failed to improve while receiving home care, SNF, or acute hospital care.
- The patient requires complex dressing changes using daily whirlpool, debridement, frequent intramuscular or IV analgesics or antifungals, frequent positioning, or hyperbaric treatments.
- The patient requires more than one of the following IV medications at least daily:
  - Antiviral agent
  - Antibiotics
  - Antifungal agent
  - IV plasma expanders
  - IV electrolytes
  - Total parenteral nutrition (TPN)

### **Cardiac**

Cardiac care is required if the member is unable to maintain adequate circulation related to mechanical or electrical dysfunction of the cardiovascular system. The patient must meet each of the following requirements for admission or continued stay:

- The patient requires frequent monitoring of tissue oxygenation (for example, pulse oximetry) and continuous telemetry.
- The patient requires management of hemodynamic instability, cardioversion or valsalva maneuver, temporary pacemaker, or monitoring of a functional permanent pacemaker, monitoring for drug toxicity, defibrillation, pulmonary artery catheterization and arterial monitoring, and monitoring of electrolyte imbalance.
- The patient requires two or more of the following medications intravenously to maintain cardiovascular integrity:
  - Anticoagulants
  - Anti-anginal agents
  - Anti-arrhythmics
  - Antibiotics
  - Alpha/beta-adrenoreceptor blocking agents
  - Antihypertensives
  - Beta blockers
  - Calcium channel blockers
  - Cardiac glycosides
  - Corticosteroids
  - Diuretics
  - Inotropic agents
  - Mucarinic receptor antagonists
  - Sodium channel blockers



- Thrombolytic enzymes
- Tissue plasminogen activators
- Vasodilators
- Vasopressors

### **Continued Stay Criteria**

All of the following are required to be documented for review of a continued stay in the LTAC hospital:

- Multidisciplinary team evaluation at least weekly
- Evidence of participation in a rehabilitation-therapy program
- Continued daily on-site direction of a qualified physician
- Continued skilled nursing care or supervision required
- Continued need for acute LOC, as evidenced by continuing to meet the admission criteria category requirements

### **Documentation Requirements for Continued Stay**

Concurrent review for approval of additional days must be received by the PA department at least 48 hours before the last approved day, including:

- Completed IHCP Prior Authorization Request Form
- A summary of the current discharge plans
- Documentation of family or friend participation in the discharge planning process
- A neurological assessment update, if appropriate
- Documentation of the member's cooperation, participation, or progress

### **Discharge Criteria**

Continued length of stay will not be authorized without the medical director's review when any of the following conditions occur:

- There is evidence in the patient record that the patient has achieved stated goals.
- Medical complications require readmission to an inpatient acute facility.
- Multidisciplinary services are no longer needed.
- No additional improvement is anticipated.
- Patient's progress towards goals has remained unchanged for seven days.

### **Prior Authorization for LTAC**

Prior authorization is required for LTAC hospital admissions according to the criteria listed above.

## **Prior Authorization**

In addition to prior authorization information set forth at *405 IAC 5-3*, general prior authorization requirements for hospital services can be found in *405 IAC 5-17-2*. These requirements include:

- Prior authorization is required for all nonemergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. This applies to medical and surgical inpatient admissions. Emergency admissions, routine vaginal deliveries, C-

section deliveries, newborns stays, and inpatient hospital admissions covered by Medicare do not require PA.

- Prior authorization is required for all Medicaid covered rehabilitation, burn, and psychiatric inpatient stays that are reimbursed under the level of care methodology described in *405 IAC 1-10.5* as well as substance abuse stays that are reimbursed under the DRG methodology also described at *405 IAC 1-10.5*.
- Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient procedure, must be prior authorized. The length of stay for the inpatient admission is determined by the appropriate DRG, but will be subject to retrospective review for medical necessity.

Criteria for determining the medical necessity for inpatient admission shall include the following:

- Technical or medical difficulties during the outpatient procedure as documented in the medical record.
- Presence of physical or mental conditions that make prolonged preoperative or postoperative observations by a nurse or skilled medical personnel a necessity.
- Performance of another procedure simultaneously, which itself requires hospitalization.
- Likelihood of another procedure following the initial procedure, which would require hospitalization.

Days that are not prior authorized under the level of care methodology as required by *405 IAC 5-17* will not be covered by Medicaid.

PA must be obtained for all admissions within 48 hours, excluding Saturdays, Sundays, and legal holidays. Concurrent review is necessary beyond the approved days.

## Billing and Coding

For further billing information, see the [Inpatient Hospital Services](#) provider reference module. For a list of billing codes, please see the *Inpatient Hospital Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

### [405 IAC 1](#)

- 405 IAC 1-10.5-2 – Definitions
- 405 IAC 1-10.5-3 – Reimbursement for Inpatient Hospital Services
- 405 IAC 1-10.5 – Reimbursement for Inpatient Hospital Services

### [405 IAC 5](#)

- 405 IAC 5-3-13 – Services requiring prior authorization
- 405 IAC 5-17 – Hospital Services
- 405 IAC 5-32 – Rehabilitation Unit
- 405 IAC 5-33 – Acute Care Hospital Admission

### [IHCP Provider Bulletins](#)

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## [IHCP Provider Banners](#)

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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## **Update History**

January 1, 2017 – Initial Publication

## Hospital Outpatient Services

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### Description of Service

The IHCP defines hospital outpatient as a member whom the hospital has not admitted as an inpatient but who is registered in hospital records as an outpatient and receives services directly from the hospital. If personnel not employed by the hospital take a tissue sample, blood sample, or specimen and send it to the hospital for tests, the IHCP classifies the tests as non-patient (rather than outpatient) hospital services, because the patient did not directly receive services from the hospital.

### Medical Policy

Outpatient services are covered for members who are not registered as inpatients in acute care or psychiatric hospitals. The member's medical condition, as described and documented in the medical record by the primary or attending physician, must justify the intensity of service provided.

### Liver Elastography

The IHCP covers ultrasound transient elastography to assess liver fibrosis.

#### Prior Authorization for Liver Elastography

Prior authorization is required for ultrasound transient elastography to assess liver fibrosis when the following criteria are met:

- Diagnosis is either of the following:
  - Chronic liver disease as evidenced by sustained elevation of liver function tests (LFTs) of greater than six months
  - Hepatitis C virus (HCV), as evidenced by either quantitative (such as HCV RNA viral load) and/or qualitative (such as HCV antibody positive serum serology)
- Liver biopsy has not been performed within previous six months
- Ultrasound transient elastography has not been performed more frequently than once every six months

### Prior Authorization

Surgical procedures that are usually provided on an outpatient basis but are performed as inpatient services (that is, medical difficulties during the outpatient procedure, prolonged pre- or post-operative observation, and simultaneous procedures requiring hospitalization) require prior authorization (PA).

The following services require PA:

- All out-of-state services
- Separately reimbursable, implantable durable medical equipment (DME) items

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## Billing and Coding

For further billing information, see the [Outpatient Hospital and Ambulatory Surgical Center Services](#) provider reference module.

## Rules and Citations

[42 CFR 440.20](#) Outpatient Hospital Services

[405 IAC 5](#)

- 405 IAC 5-17-2 Hospital Services

[IHCP Provider Bulletins](#)

- [BT201770](#) IHCP adds coverage for CPT code 91200 to assess liver fibrosis

[IHCP Provider Banners](#)

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

November 25, 2017 – Coverage of liver elastography



## Injections, Vaccines, and Other Physician-Administered Drugs

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### Description of Service

According to the World Health Organization (WHO), immunizations are preparations that improve resistance to a particular disease. They typically contain an agent that resembles the disease causing organism, which could be the killed or weakened infectious organism, its toxins, or one of its surface proteins. Immunizations are typically injected, although they may also be taken by mouth or by inhaling through the nose.

It is recommended that all children receive vaccinations to prevent them and others from serious childhood illness, unless the child has medical risk factors that prevent them from doing so. Adults who meet age requirements for vaccinations but lack documentation of vaccination or have no evidence of previous infection should receive certain vaccinations as recommended by their physician. Also, adults who have risk factors on the basis of medical, occupational, lifestyle, or other indications, may require additional vaccinations.

Physician administered drugs, commonly referred to as J-codes, include drugs that ordinarily cannot be self-administered, chemotherapy drugs, immunosuppressives, inhalation solutions, and other miscellaneous drugs and solutions.

### Medical Policy

#### Vaccines for Children (VFC) Program

The Vaccines for Children (VFC) program is a federally funded program intended to help raise childhood immunization levels in the United States by supplying health care providers with free vaccines to administer to children 18 years old and younger. Recipients must meet one or more of the following criteria:

- Be enrolled in the IHCP
- Have no health insurance
- Be identified by a parent or guardian as an American Indian or Alaskan native
- Be underinsured – for example, children with health insurance that does not cover immunizations (administered in FQHCs or RHCs only)

The VFC program makes vaccines available at no cost to providers for members 18 years old and younger (including those enrolled in Hoosier Healthwise Package C).

- All vaccine ordering, distribution, and accountability processes are administered through the Indiana State Department of Health's (ISDH) Indiana Immunization Program. The federal VFC program includes private and public practitioners across Indiana. Providers are not required to physically separate vaccine stock for children in the VFC program

from the vaccine stock for Hoosier Healthwise Package C children. No additional storage rules apply. Providers should contact ISDH to enroll in the VFC program.

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

- [Chickenpox](#)
- [Diphtheria](#)
- [Flu \(Influenza\)](#)
- [Hepatitis A](#)
- [Hepatitis B](#)
- [Hib](#)
- [HPV \(Human Papillomavirus\) - related Cancers](#)
- [Measles](#)
- [Meningococcal Disease](#)
- [Mumps](#)
- [Polio](#)
- [Pneumococcal](#)
- [Rotavirus](#)
- [Rubella](#)
- [Tetanus](#)
- [Whooping Cough \(Pertussis\)](#)

For vaccines supplied through the VFC program, reimbursement for the vaccine itself is not available since the vaccine is supplied at no cost to the provider. However, providers may be reimbursed either the lower of their submitted charge or \$8 for the administration of each vaccine.

## Vaccines Outside the VFC Program

Vaccines purchased by providers outside the VFC program are known as private stock vaccines. The IHCP will reimburse providers for private stock vaccines. For private stock vaccines, the IHCP will cover both the vaccine and the administration of the vaccine.

## Vaccine Administration by Pharmacy Providers

The IHCP will reimburse IHCP-enrolled pharmacy providers for pharmacist-administered vaccines to eligible IHCP members. IHCP-enrolled pharmacy providers will be reimbursed for the administration of a covered vaccine by a pharmacist employed by the pharmacy provider. Pharmacies are not VFC providers in Indiana.

The administration of vaccines is reimbursable with a protocol approved by an IHCP-enrolled physician who meets the requirements of IC 25-26-13-31.2(c) for the following vaccines only:

- Influenza
- Herpes zoster (shingles) for members 60 years of age and older

- Tetanus, diphtheria, and a cellular pertussis (Tdap)
- Human papilloma virus (HPV); for males and females
- Pneumococcal for members 65 years of age and older
- Meningococcal

## Physician Administered Drugs (General)

The IHCP generally provides coverage for all physician administered drugs for medically necessary conditions. However, reimbursement is not available to a physician for injecting medications that can be self-administered unless justified by the patient's condition. Possible noncompliance by a recipient to oral medications is insufficient justification to administer injections.

It is the provider's responsibility to ensure the treatment is appropriate based on FDA approved indications, peer reviewed journals, and standards of practice. IHCP reserves the right to place diagnosis restrictions on physician administered drugs when deemed appropriate.

The IHCP limits joint injections to four injections per joint site, per provider, per month. Claims submitted for more than three injections per joint site in a one-month period must have supporting documentation attached to indicate the medical necessity of the fourth injection per joint site. Additionally, providers billing for more than four joint injections per provider in a one month period must have supporting documentation to indicate that the injections involve different joint sites and that no more than four injections were administered to a single joint

The IHCP limits Vitamin B12 injections to one per 30 days per member.

## Botulinum Toxin Injections

Treatment with botulinum toxin injections provides temporary relief of symptoms and is indicated for use when conventional treatment has failed or in conjunction with physical therapy or other therapeutic techniques. IHCP provides reimbursement for chemodenervation using botulinum toxins for treating certain neuromuscular conditions, including cervical dystonia, cerebral palsy, multiple sclerosis, and other muscular and neurological conditions that cause excessive muscle contractions.

Reimbursement is available only when administered in a physician's office, consistent with IHCP policy concerning reimbursement for injectable pharmaceutical products. Reimbursement is limited to one injection, per member, every three months. The IHCP does not provide reimbursement for botulinum toxins for cosmetic purposes.

## Histrelin Implant (Supprelin LA)

Supprelin LA implant is approved by the FDA for the treatment of central precocious puberty (CPP). Children with CPP have an early onset of secondary sexual characteristics before age eight (8) in females and age nine (9) in males. They also show significantly advanced bone age that can result in diminished adult height attainment

Supprelin LA is considered medically necessary when **ALL** of the following criteria are met:

- The diagnosis of Central Precocious Puberty is made before the age of 8 years in girls and 9 years in males
- The diagnosis of Central Precocious Puberty is documented in clinical records (history, physical findings and laboratory analysis)
- A pediatric endocrinologist has been consulted and is in agreement with the diagnosis and treatment plan
- Documented inability to tolerate leuprolide acetate (Lupron Depot Ped) intramuscularly (not due to pain) once every 4 weeks due to recurrent sterile fluid collections at the sites of injections
- Documentation that subcutaneous injections of aqueous leuprolide, given once or twice daily (total dose 60 mg/kg/24hr), or intranasal administration of the GnRH agonist nafarelin (Synarel) 800 mg bid would not be tolerated or complied with.

## Histrelin Implant (Vantas)

Vantas is a drug-delivery system that contains the medicine histrelin and is placed under the skin. After it is placed under the skin, Vantas delivers histrelin continuously for 12 months. Vantas is a sterile, non-biodegradable, diffusion-controlled Hydron polymer reservoir containing histrelin acetate, a synthetic nonapeptide analog of the naturally occurring gonadotropin releasing hormone (GnRH), also known as luteinizing hormone releasing hormone (LH-RH), possessing a greater potency than the natural sequence hormone. Vantas is used to help relieve the symptoms of advanced prostate cancer; it is not a cure.

Vantas is considered medically necessary for the palliative treatment of advanced prostate cancer when **ALL** of the following criteria are met:

- A medical need for the implant (e.g. mobility or compliance issues, inability to receive daily injects) is determined
- A documented diagnosis of cancer of the prostate is made
- A demonstrated response to luteinizing hormone-releasing hormone (LHRH) agonists is confirmed by periodic measurement of testosterone and prostate-specific antigen (PSA) levels
- The member has a life expectancy of more than one year
- The member has not had a bilateral orchiectomy.

The IHCP does not reimburse for J9225 if a member is hypersensitive to gonadotropin releasing hormone (GnRH), GnRH analogs, or any of the components of Vantas.

## **Pegloticase (Krystexxa)**

Pegloticase (Krystexxa) is an intravenous medication that breaks down uric acid. It is used for the treatment of chronic gout. IHCP Reimbursement is available only when administered in a physician's office, consistent with IHCP policy concerning reimbursement for injectable pharmaceutical products.

### **Prior Authorization for Pegloticase**

Prior authorization is required for pegloticase. Pegloticase may be considered medically necessary in patients with gout when criteria A, B, and C are met:

#### **Criteria A – Symptomatic gout with one or more of the following:**

- Three (3) gouty flares or more in previous 18 months
- Presence of one or more tophi
- Chronic gouty arthritis

#### **Criteria B – Serum Uric Acid Level**

- Serum uric acid level greater than eight (8) mg/dL

#### **Criteria C – Treatment with oral xanthine oxidase inhibitors with one of the following**

- A 90-day course each of two xanthine oxidase inhibitors alternatives (example allopurinol and febuxostat) is ineffective in normalizing serum uric acid levels to less than six (6) mg/DL
- Intolerance to two xanthine oxidase inhibitors alternatives (example allopurinol and febuxostat)
- Use of two xanthine oxidase inhibitors alternatives (example allopurinol and febuxostat) is contraindicated

Pegloticase is considered investigational when used for all other conditions, including but not limited to hyperuricemia not associated with gout and asymptomatic hyperuricemia.

When prior authorization is approved, pegloticase may be authorized in quantities of one eight (8) mg infusion every two (2) weeks, not to exceed 26 infusions in one year.



## Plasmapheresis

Plasmapheresis is covered when performed in a hospital setting (either inpatient or outpatient); or in a non-hospital setting (e.g. a physician directed clinic), when the following conditions are met:

- A physician is available to perform medical services and to respond to medical emergencies at all times during patient care hours.
- The member is under the care of a physician.
- All non-physician services are furnished under the direct responsibility of a physician.

Plasmapheresis is considered medically necessary for the following indications:

- Plasma exchange for acquired myasthenia gravis
- Plasmapheresis in the treatment of primary macroglobulinemia (Waldenstrom)
- Plasmapheresis and plasma exchange for the treatment of hyperglobulinemias, including (but not limited to) multiple myelomas, cryoglobulinemia, and hyperviscosity syndromes
- Plasmapheresis or plasma exchange as a last resort treatment of thrombotic thrombocytopenic purpura (TTP)
- Plasmapheresis or plasma exchange as the last resort treatment of life threatening rheumatoid vasculitis
- Plasma exchange in the treatment of Goodpasture's Syndrome
- Plasma exchange in the treatment of glomerulonephritis, associated with antiglomerular basement membrane antibodies and advancing renal failure, or pulmonary hemorrhage
- Plasmapheresis, with plasma exchange, for treatment of chronic relapsing polyneuropathy for members with severe or life-threatening symptoms who have failed to respond to conventional therapy
- Plasmapheresis, with plasma exchange, for treatment of life-threatening scleroderma and polymyositis that is unresponsive to conventional therapy
- Plasmapheresis for treatment of Guillain-Barre Syndrome
- Plasmapheresis, as a last resort, for life threatening systemic lupus erythematosus (SLE), when conventional therapy has failed to prevent clinical deterioration

## Makena

Makena (hydroxyprogesterone caproate) is considered medically necessary for women who have a history of spontaneous preterm birth.

## Prior Authorization for Makena

Prior authorization is required for the use of Makena. The following criteria must be met:

- Member must be pregnant
- Member must have a history of preterm delivery
- The intended use of the drug is for the prevention of preterm delivery

## Spinraza

Spinraza (nusinersen) is considered medically necessary for the treatment of spinal muscular atrophy (SMA).

### Prior Authorization for Spinraza

Prior authorization is required for the use of Spinraza. The following criteria must be met:

Documentation of confirmatory diagnosis by one of the following:

- SMA diagnostic test results confirming zero copies of SMN1
- Molecular genetic testing of 5q SMA for any of the following:
  - Homozygous gene deletion
  - Homozygous conversion mutation
  - Compound heterozygote

Documentation of one of the following:

- Genetic testing confirming no more than two copies of SMN2
- SMA-associated symptoms before six months of age

Note: if the member has more than two copies of SMN2, but has point mutations on SMN 2 exon 7, treatment would be considered medically necessary.

Continuation of treatment with Spinraza beyond six months after the initiation of therapy, and every six months thereafter, is medically necessary for the treatment of spinal muscular atrophy when individuals meet both of the following criteria:

- When initial therapy was determined to meet the above criteria
- When there is documentation of clinically significant improvement in spinal muscular atrophy-associated symptoms (for example, progression, stabilization, or decreased decline in moto function) compared to the predicted natural history trajectory of the disease.

## Exondys 51

Exondys 51 (eteplisen) is an antisense oligonucleotide indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 51 skipping.

### Prior Authorization for Exondys 51

Prior authorization is required for injections of Exondys 51. The following medical necessity criteria must be met:

- Diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 51 skipping
- Dose is 30 mg/kg once weekly (patient weight must be provided to confirm dose)
- Prescriber must provide documentation of current clinical status to compare upon re-evaluations of therapy (for example, Brooke Score, 6-minute walk test, and others)

### Prior Authorization

Prior authorization is required for Exondys 51, Pegloticase, Makena, and Spinraza.

### Billing and Coding

For further billing information, see the [Injections, Vaccines, and Other Physician-Administered Drugs](#) provider reference module. For a list of billing codes, see the *Injections, Vaccines, and Other Physician-Administered Drugs Codes* on the [Code Sets/Tables](#) webpage.

### Rules and Citations

#### [405 IAC 5](#)

- 405 IAC 5-24-4: Injections Administered by Physicians
- 405 IAC 5-24 Pharmacy Services
- 405 IAC 5-3-13 Services Requiring Prior Authorization

#### [IHCP Provider Bulletins](#)

- [BT201802](#) IHCP revises coverage policy for the administration of epoetin
- [BT201742](#) IHCP to add coverage for HCPCS code Q9986
- [BT201727](#) IHCP revises reimbursement policy for vaccines purchased outside the VFC program
- [BT201363](#) The IHCP provides coverage and billing guidelines for HCPCS code J9225

#### [IHCP Provider Banners](#)

- [BR201748](#) Prior authorization is now required for HCPCS code C9484
- [BR201737](#) IHCP to cover HCPCS code C9489

# Medical Policy Manual

## Office of Medicaid Policy & Planning



**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

### Update History

January 1, 2017 – Initial Publication

June 1, 2017 – Updated language on private stock vaccines

June 27, 2017 – Added coverage for Makena (hydroxyporgestronone caproate)

October 12, 2017 – Added coverage for Spinraza (nusinersen)

December 28, 2017 – Added prior authorization for Exondys 51 (eteplirsen)

## Laboratory Services

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### Description of Service

A clinical laboratory is a place where materials derived from the human body are tested, measured, or examined to provide information on diagnosis, monitoring, prevention, or treatment of disease or for information about impairment or assessment of health.

IHCP reimbursement is available for most clinical diagnostic laboratory procedures performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients. Laboratory procedures are subject to the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA).

In order to be eligible for reimbursement, a laboratory service must be ordered in writing by a physician or other practitioner authorized to do so under state law.

### Medical Policy Specimen Collection

A minimal fee will be allowed for separate charges made by physicians, independent laboratories, or hospital laboratories for drawing or collecting specimens. These services are covered only in circumstances when a blood sample is drawn through venipuncture or where a urine sample is collected by catheterization. Specimen collection fees must be itemized when billed. Only one charge per day for each member will be allowed for venipuncture. A charge for catheterization will be allowed for each patient encounter – that is, there is no per day or per claim limitation.

### Handling/Conveyance

IHCP reimburses for handling and conveyance of a specimen to a laboratory if services are billed by a physician, chiropractor, or podiatrist. Providers will be reimbursed for no more than two conveyance fees per patient per provider on the same date of service. Providers can charge this only if the physician has an expense involved in the conveyance.

### CLIA

Providers rendering laboratory services must obtain a Clinical Laboratory Improvement Amendment (CLIA) number. Information regarding CLIA can be obtained at [www.cms.hhs.gov](http://www.cms.hhs.gov).

The CLIA program is intended to ensure that providers who perform laboratory procedures do so in accordance with federal regulations. Laboratory procedures are defined as *any procedure for the examination of materials derived from the human body*.

CLIA certification types are as follows:



- Certificate of Waiver – this certificate is issued to a laboratory to perform only waived tests.
- Certificate for Provider-Performed Microscopy (PPM) Procedures – this certificate is issued to a laboratory in which a physician, midlevel practitioner, or dentist performs no test other than the PPM procedures. This certificate permits the laboratory to also perform waived tests.
- Certificate of Registration – this certificate is issued to a laboratory that enables the entity to conduct moderate or highly complex laboratory testing (or both) until the entity is determined by survey to be in compliance with the CLIA regulations.
- Certificate of Compliance – this certificate is issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.
- Certificate of Accreditation – this is a certificate that is issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by HCFA.

To receive reimbursement from the IHCP for laboratory services falling under CLIA regulations, the provider must have a valid copy of the CLIA certificate on file with the provider enrollment contractor and must bill only lab codes allowed by the certificate. For additional information about CLIA, the provider can contact the Indiana State Department of Health (ISDH).

## Consultative Laboratory Services

Consultative laboratory services are covered for clinical laboratory tests if the following conditions are met:

- Service was requested by the member's attending physician
- Service relates to a test result that lies outside the clinically significant normal or expected range in view of the condition of the member
- Service results in a written narrative report included in the member's medical record
- Service requires the exercise of medical judgment by the consulting physician

Hospice providers should note that they must not include costs for services, such as laboratory and X-rays, with the attending physician's billed charges. The daily hospice care rates that the IHCP pays include these costs, and they are expressly the responsibility of the hospice provider.

## Group A Beta Hemolytic Streptococcal Pharyngitis Tests

IHCP reimbursement is available for approved laboratory tests used for the detection of Group A Beta Streptococcus.

Group A beta-hemolytic Streptococcus is a bacterium that can live in a person's nose and throat, causing inflammation and soreness, or what is commonly referred to as "strep throat."

Standard laboratory tests used to aid in the diagnosis of Group A Streptococcal pharyngitis are the rapid antigen detection test (RADT) and/or a bacterial throat culture.

## **Human Epidermal Growth Factor Receptor 2 (HER-2/neu) Gene Detection Test and HER-2 Protein Expression Test**

The human HER-2/neu gene (also known as c-erbB-2, ERBB2 or neu) encodes a protein called HER-2 protein or p185<sup>HER-2</sup>. This protein receptor plays a role in controlling cell growth and division. In 25-30% of patients with breast cancer, the HER-2 protein is overexpressed as part of the malignant transformation and tumor progression. Overexpression of HER-2 protein has been shown to contribute to the progression of the cancer and is associated with poor clinical outcome.

Targeted antibody therapy to HER-2 has played a significant role in the treatment of metastatic breast cancer. Clinical trial results show that the HER-2 protein on breast cancer cells is an important target for cancer therapies and that trastuzumab (HERCEPTIN<sup>®</sup>) can be an effective treatment, whether used by itself or in combination with other chemotherapy drugs.

Several types of HER-2 overexpression tests are available. One type is a semiquantitative immunohistochemical assay that measures the overexpression of HER-2 protein (for example, the HercepTest<sup>®</sup>). Another type is a gene-probe assay, which detects the qualitative presence of the gene amplification in human breast tissue (for example, Oncor's INFORM<sup>®</sup> phosphorylated HER-2/neu (pHER-2/neu) Gene Detection Test). This test is a deoxyribonucleic acid (DNA) probe assay known as fluorescent in situ hybridization (FISH).

Laboratory testing for HER-2 protein and gene detection tests is covered by the IHCP when medically necessary for recipients who have been diagnosed with a malignant neoplasm of the breast. The ICD-10-CM diagnosis codes that support the medical necessity of HER-2 protein overexpression and gene detection tests are as follows:

- C50.019 through C50.922 Malignant neoplasms of male and female breast
- C79.81 - Secondary malignant neoplasm of breast D05.00 through D05.82 Lobular, intraductal, and other specified carcinoma of breast
- D05.90 through D05.92 Unspecified type of carcinoma in situ of breast
- D48.60 through D48.62, and D49.3 Neoplasm of uncertain behavior and unspecified behavior, breast

The ordering physician must have documentation in the member's medical records to support the medical necessity of the tests ordered. Laboratories performing the test must have documentation indicating laboratory personnel education has been completed in the proper performance of the test and reporting of the test results. Reimbursement will be provided to CLIA-certified laboratories only.

## Prior Authorization for HER-2 Testing

Prior Authorization is not required for HER-2 testing. However, as described above, documentation of medical necessity is required.

## Human Immunodeficiency Virus (HIV) Testing

HIV is the human immunodeficiency virus which is the virus that can lead to acquired immunodeficiency syndrome, or AIDS. HIV progressively damages and kills CD4+ blood cells of the body's immune system, destroying the body's ability to fight infections and certain cancers. HIV can be transmitted when blood, semen, vaginal fluid, or breast milk is internally passed from an infected person to an uninfected person. HIV is most commonly transmitted in three ways: (1) through unprotected sexual activity with an infected partner; (2) through contact with infected blood; or (3) from mother to child during pregnancy, birth, or breast feeding. According to the Centers for Disease Control, a diagnosis of AIDS is appropriate when an individual with HIV has a T4 lymphocyte (CD4) cell count below 200. The presence of various opportunistic infections can also indicate the onset of AIDS.

Early HIV infection often causes no symptoms and requires a blood test to detect the presence of HIV antibodies. HIV antibodies are often not detectable in the blood for one to three months following infection, and can take up to six months following infection to be detected in standard blood tests. In babies born to mothers with HIV, a definitive diagnosis of HIV infection cannot be made using standard antibody tests until after 18 months of age. Because no diagnostic test or algorithm can be completely accurate in all cases of HIV infection, inconsistent or conflicting test results obtained during the clinical evaluation may warrant additional testing of follow-up specimens.

Routine laboratory testing for HIV is covered by the IHCP when it is done to establish a HIV diagnosis. HIV testing is covered only in circumstances when a blood sample is drawn through venipuncture or when a urine sample is collected by catheterization. Oral HIV testing methods are not covered by the IHCP.

The United States Preventive Services Task Force (USPSTF) has found evidence that identification and treatment of HIV infection is associated with a markedly reduced risk for progression to acquired immune deficiency syndrome (AIDS), AIDS-related events, and death in individuals with immunologically advanced disease. Providers are encouraged to follow these USPSTF guidelines:

- Clinicians should screen for HIV infection in adolescents and adults aged 15 to 65. Younger adolescents and older adults who are at increased risk should also be screened.
- Screen all adolescents and adults once to identify persons who are already HIV-positive, with repeated screenings for:
  - Those who are known to be at risk for HIV infection
  - Those who are actively engaged in risky behaviors

- Those who live or receive medical care in a high-prevalence setting (defined as a geographic location or community with an HIV seroprevalence of at least 1%)
- Persons at very high risk, defined by the USPSTF, should be screened at least annually.
- Persons at increased risk should be screened at least every three to five years.
- Routine rescreening may not be necessary for individuals not at increased risk since they were found to be HIV-negative.

### **HIV Testing of Pregnant Women and Newborns**

The IC § 16-41-6-8 requires, as a routine component of prenatal care, physicians, advanced practice nurses, or the physicians or advance practice nurses designee explain the purpose, risks, and benefits of HIV testing and order HIV tests for pregnant women. The results of this test are confidential. Pregnant women have the right to refuse this test. A signed statement acknowledging the pregnant woman was counseled and provided the information necessary to make an informed decision regarding whether or not to be tested must be maintained in the medical records.

If the woman consents to an HIV test, and the test is positive for HIV infection, the provider must inform the pregnant woman of the test results and provide treatment and referral options available to her for HIV prevention, healthcare, and psychosocial services. The physician must also discuss risk reduction activities, including methods to reduce the risk of perinatal HIV transmission and HIV transmission through breast milk.

A physician overseeing the care of a newborn infant may offer the parent the option of a confidential HIV test for the newborn within the first 48 hours after birth under the following circumstances, as required in IC § 16-41-6-4:

- The mother of the newborn has not been previously tested for HIV.
- The mother of the newborn has refused an HIV test for the newborn.
- The physician believes that testing the newborn is medically necessary for reasons other than those listed above.

If the parent objects, in writing, to testing the newborn for religious reasons, the newborn is exempt from the testing requirement.

The results of the HIV test must be released to the newborn's mother. If the test results are positive, the individual who provides the test results must provide the mother with treatment or referral options available to the newborn.

Testing for HIV is also covered in conjunction with family planning services and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

### **Sweat Chloride Test**

The sweat chloride test (sweat test) is used to diagnose cystic fibrosis (CF). According to the Merck Manual and the Cystic Fibrosis Foundation, the iontophoresis sweat test is the standard

of care for confirming the diagnosis of CF. CF is a generalized, autosomal recessive disorder of infants, children, and young adults in which there is widespread dysfunction of the exocrine glands.

The disease causes excess mucus production in the respiratory tract, signs of chronic pulmonary disease, pancreatic enzyme deficiency resulting in steatorrhea and azotorrhea, abnormally high levels of electrolytes in the sweat, and occasionally, biliary cirrhosis.

The sweat test is ordered when an individual, usually an infant, displays symptoms of CF, such as noticeably salty sweat, or has a close relative who has been diagnosed with CF. It is also used to help confirm or rule out a diagnosis of CF in individuals who have tested positive or indeterminate with other tests, such as a newborn screen. The sweat test measures the amount of salt in the sweat. A high level of salt indicates CF.

For children who have a positive screen for CF on a newborn screen, sweat chloride testing is recommended to be performed when an infant is at least two weeks of age and weighs >2kg. It is typically necessary to have two positive sweat chloride tests to confirm the diagnosis of CF.

The IHCP reimburses sweat chloride testing when used to confirm a diagnosis of CF. Usage of the sweat test as a predictor of efficacy of sympathectomy in peripheral vascular disease is unproven and, therefore, is not covered.

## Prior Authorization

For prior authorization requirements, please see specific test policies. If a test requires PA and no independent section is available, then the prior authorization will be reviewed by clinical staff for standard medical necessity.

## Billing and Coding

For further billing information, see the [Laboratory Services](#) provider module. For a list of billing codes, see the *Laboratory Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

[IC 16-41-6](#) Communicable Disease: Mandatory Testing of Individuals With Communicable or Dangerous Diseases

[42 CFR 441.17 Laboratory Services](#)

[42 CFR 440.30 Other Laboratory and X-ray Services](#)

[405 IAC 5](#)

- 405 IAC 5-12-4 Chiropractic Services- Laboratory Services
- 405 IAC 5-18 Laboratory Services
- 405 IAC 5-26-4 Podiatric Services- Laboratory or X-ray Services

[IHCP Provider Bulletins](#)

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## [IHCP Provider Banners](#)

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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## **Update History**

January 1, 2017 – Initial Publication

## Lead Services

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### Description of Service

Screening for blood lead toxicity is a federal requirement for all children enrolled in Medicaid.

### Medical Policy

#### Verbal Risk Assessment

The following questions should be asked at each well child visit:

1. Is your child living in or regularly visiting, or has your child lived in or regularly visited, a house or child care center built before 1978?
2. Does your child have a sibling or playmate who has or who has had lead poisoning?
3. Does your child frequently come in contact with an adult who works in an industry or has a hobby using lead (battery factory, steel smelter, stained glass)?
4. Is your child a recent immigrant or a member of a minority group?
5. Does anyone in your family use ethnic or folk remedies or cosmetics?

If the answer to any question is positive, a child is considered at high risk for high doses of lead exposure, and a blood lead level test must be obtained immediately regardless of the child's age.

Subsequent verbal risk assessments can change a child's risk category. If, as a result of a verbal risk assessment a previously low risk child is re-categorized as high risk, that child must be given a blood lead level test.

#### Prior Authorization for Verbal Risk Assessment

Prior authorization is not required for screening services. Individual treatment services may require prior authorization.

### Blood Lead Screenings

Blood lead screenings must be performed between the ages of 9 and 12 months, and again at 24-month visits. If the member is at high risk for lead exposure, the initial screening should be performed at the six-month visit and repeated at the 12-month and 24-month visits. Children between the ages of 36 months and 72 months of age must receive a blood lead screening if they have not been previously tested for lead poisoning.

A blood lead test result equal to or greater than 5 µg/dl obtained by a capillary specimen (fingerstick) must be confirmed using a venous blood sample. Subsequent screenings are required for children with blood lead levels equal to or greater than 5 µg/dl.

The ISDH, through the Indiana Lead and Healthy Homes Program (ILHHP), monitors lead poisoning. Providers are required to report all results of blood lead screenings to the ISDH no later than one week after completing the examination. The ILHHP provides medical and

environmental case management follow-up for children who are identified with elevated levels of lead in their blood.

### **Prior Authorization for Blood Lead Screenings**

Prior authorization is not required for screening services. Individual treatment services may require prior authorization.

### **Comprehensive Environmental lead testing**

The Indiana Health Coverage Programs (IHCP) will cover initial and follow-up comprehensive environmental lead investigation services for IHCP members with a confirmed elevated blood lead level (EBLL). EBLL is defined by the Centers for Disease Control (CDC) as a blood level of 5 mcg/dL or higher.

Services are limited to one unit, per member, per 12 month rolling calendar year.

### **Prior Authorization for Comprehensive Environmental Lead Testing**

Prior authorization is not required for initial and follow up comprehensive environmental lead testing.

### **Prior Authorization**

Prior authorization is not required for screening services. Individual treatment services may require prior authorization.

### **Billing and Coding**

For further billing information, see the [EPSDT Services](#) provider reference module. For a list of billing codes, see the *EPSDT/HealthWatch Codes* on the [Code Sets/Tables](#) webpage.

### **Rules and Citations**

#### [405 IAC 5](#)

- 405 IAC 5-15; Early and Periodic Screening, Diagnosis, and Treatment Services

#### [IHCP Provider Bulletins](#)

- [BT201709](#) IHCP to Cover HCPCs Code T1029- Comprehensive Environmental Lead Investigation

#### [IHCP Provider Banners](#)

- [BR201641](#) IHCP Encourages Providers to Review Reporting Processes for Submitting Lead Screening Information
- [BR201640](#) IHCP Clarifies Lead Screening Requirements for Children
- [BR201636](#) IHCP Reminds Providers Lead Screening is Required for Children

# Medical Policy Manual

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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

April 1, 2017- Initial Publication

## Mental Health and Addiction Services

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### Description of Service

The Indiana Health Coverage Programs (IHCP) offers coverage for inpatient and outpatient mental health services, including tobacco cessation and substance abuse services.

### Medical Policy

#### Psychiatric and Substance Abuse Inpatient Services

Acute psychiatric and substance abuse inpatient services are mental health interventions used to stabilize and manage people with severe symptoms and behaviors that have harmed or may result in harm to themselves or others. The following information describes presenting factors that may meet medical necessity for inpatient services:

- Current or recent serious suicide ideation, with plan and potential means with lethal intent
- Current or recent serious, violent, impulsive, and unpredictably dangerous homicidal ideation, with plan and potential means with lethal intent
- Current or recent harm to self or others, with plan and potential means with lethal intent
- Unable to care for self, due to a psychiatric condition, so that imminent life-threatening deterioration has occurred
- Acute psychotic symptoms, severely bizarre thinking, and psychomotor agitation or retardation that cannot be safely treated in a less restrictive level of care (LOC)

Depending on the patients' needs, acute psychiatric and substance abuse inpatient services often include, but are not limited to, 24-hour psychiatric and medical services, continuous monitoring, medication management, treatment planning, individual therapy, family therapy, and group therapy.

Effective February 1, 2018, the IHCP expanded coverage for inpatient stays for opioid use disorder (OUD) and other substance use disorder (SUD) treatment to members 21 through 64 years of age in facilities that qualify as institutions for mental disease (IMD). Providers enrolled as psychiatric hospitals (provider type 01 and provider specialty 011) that have 17 or more beds are currently the only providers recognized as qualified IMDs. Inpatient stays are allowed to be authorized for up to 15 days in a calendar month.



**Note:** Healthy Indiana Plan (HIP) mental health inpatient coverage does not include hypnotherapy, behavioral modification, or milieu therapy, when used to treat conditions that are not recognized as mental disorders, personal comfort items, and room and board when temporary leave available. HIP substance abuse inpatient coverage does not include services and supplies for the treatment of co-dependency or caffeine addiction, personal comfort items, and room and board when temporary leave permitted.

## Admission Criteria

Members must meet medical necessity to be eligible for acute inpatient psychiatric and substance abuse inpatient services. Members must present with the following criteria at the time of admission:

- Admissions for inpatient detoxification stays may be approved using one of the following evidenced-based, peer-reviewed sources of clinical criteria:
  - Milliman Care Guidelines (MCG)
  - InterQual Criteria
  - American Society of Addiction Medicine (ASAM) Patient Placement Criteria
  - Anthem Clinical Utilization Management (UM) Guidelines
- Acute psychiatric inpatient admissions are available for members with a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:
  - Danger to the individual
  - Danger to others
  - Death of the individual
- Substance abuse inpatient admissions must be to a psychiatric facility or unit. Admissions to a general hospital floor are only appropriate when medical services are required for life support and cannot be rendered in a substance abuse treatment facility or unit. These inpatient detoxification, rehabilitation, and aftercare admissions are available for members when the following criteria have been determined:
  - Evaluation, treatment, and detoxification are based on the stated medical condition and/or primary diagnosis for inpatient admission
  - Need for safe withdrawal from alcohol and/or other drugs is indicated
  - Reasonable evidence that detoxification and aftercare cannot be accomplished in an outpatient setting

- There is a history of recent convulsions or poorly controlled convulsive disorder

### **Plan of Care (POC)**

Each Medicaid-eligible patient admitted to an acute psychiatric facility or unit must have an individually developed plan of care (POC). For members between 22 and 65 years old in a psychiatric hospital of 16 beds or fewer, or a person 65 years old or older, a POC must be developed by the attending or staff physician. For members under 21 years old, POCs must be developed by a physician and Interdisciplinary team.

All POCs must be developed within 14 days of the admission date, regardless of the member's age. For a patient who becomes eligible for Medicaid after admission to a facility, the POC must be prepared to cover all periods for which Medicaid coverage is claimed.

The following components must be documented in each member's POC:

- Treatment objectives and goals, including an integrated program of appropriate therapies, activities, and experiences designed to meet the objectives
- At the appropriate time, a post-discharge plan and a plan for coordination of inpatient services with partial discharge plans, including appropriate services in the member's community to ensure continuity of care when the patient returns to his or her family and community upon discharge

The POC is developed as a result of a diagnostic evaluation that includes an examination of the medical, psychological, social, and behavioral aspects of the member's presenting problem and previous treatment interventions. The POC must be reviewed and updated at least every 90 days for members between 22 and 65 years old in psychiatric hospitals with 16 beds or fewer and for members 65 years old or older.

The POC will be reviewed by the attending or staff physician to ensure that appropriate services are being provided and that they continue to be medically necessary. The attending or staff physician will also recommend necessary adjustments in the plan, as indicated by the member's overall adjustment as an inpatient. The quarterly POC must be in writing and must be part of the member's record.

The requirements for the development of a POC for all members 21 years old or younger are the same as for members who are older than age 22, as stated above, with the following exceptions:

- An Interdisciplinary Team (IDT), which will include the child and parents, legal guardians, or others to whose care or custody the individual will be released following discharge, is required to develop and direct the POC.
- This team is responsible for developing and updating POCs at least every 30 days.
- The team will be responsible for determining that the services provided were and are required on an inpatient basis and for determining adjustments that may be needed in the POC.

Recertification is required at least every 60 days. Initial evaluative examinations are exempt from prior review and authorization.

One of the following professionals or combination of professionals must be active in the development of the POC planning process:

- A board certified or eligible psychiatrist
- A psychologist endorsed as a health service provider in psychology (HSPP) and a physician licensed to practice medicine or osteopathy
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases; and a psychologist endorsed as a HSPP or licensed psychologist

A professional who is qualified to make determinations regarding mental health conditions and treatments must be part of the IDT, as well. At least one of the following professionals must be active in planning and implementing the POC:

- A licensed clinical social worker (LCSW), licensed marital and family therapist (LMFT), licensed mental health counselor (LMHC), or a person holding a master's degree in social work, marital and family therapy, or mental health counseling
- An advanced practice nurse or RN who has specialized training or one year's experience in treating people with mental illnesses
- An occupational therapist (OT), registered with the National Association of OTs who has specialized training or one year of experience treating people with mental illnesses
- A psychologist endorsed as a HSPP or a licensed psychologist

### **Readmission**

A readmission is defined as a hospital admission within three days following a previous hospital admission and discharge for the same or a related condition. Same or related condition refers to the primary diagnosis code.

- If the initial admission was paid on a per diem basis, the readmission should be considered a new admission and billed accordingly. The readmission is treated as a separate stay for payment purposes, but is subject to medical review.
- If the initial admission was paid using the DRG methodology, providers should bill one inpatient claim when a member is readmitted to their facility within three days of a previous inpatient discharge (the stays should be consolidated on one claim) for the same or a related diagnosis.

If it is determined that a discharge is premature, payment made as a result of the discharge or readmission may be subject to recoupment. Additionally, post payment review of readmissions will be conducted to ensure that providers are appropriately following the readmission policies and guidelines.

### **Observation Stays**

Psychiatric and substance abuse observation stays in acute care hospitals and freestanding psychiatric hospitals are reimbursable. The observation period must last no more than three days (72 hours). If the member meets the criteria for inpatient admission prior to the end of the observation period, the member's status may be changed to inpatient at that time. IHCP members may qualify for observation status meeting both of the following criteria:

- The criteria for inpatient admission have not been met.
- The treating physician or mental health provider has determined that allowing the member to leave the facility would likely put the member at serious risk.

Observation stays are reimbursed according to outpatient mental health services.

### **Less than 24-Hour Stays**

Providers should bill any inpatient stay that is less than 24 hours as an outpatient service. Inpatient stays less than 24 hours that are billed as inpatient services will be denied or will be subject to retrospective review.

### **Outpatient Service within Three Days of an Inpatient Stay**

Outpatient services that occur within three days preceding an inpatient admission to the same facility for the same or a related diagnosis are considered part of the corresponding inpatient admission. Providers are required to submit an inpatient claim only when both of the services, outpatient and inpatient, occur at the same facility.

If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim will be denied with an explanation of benefits (EOB) code indicating that the provider should bill services on the inpatient claim. The provider should adjust the outpatient claim (complete adjustment) and resubmit one inpatient claim.

### **Reserving Beds**

Reimbursement is available for reserving beds in psychiatric hospitals; it is not available in general acute care hospitals. Hospitalization must be ordered by a physician for the treatment of an acute condition that cannot be treated in a psychiatric facility. Physician orders must be maintained in the member's file at the facility. The total length of time reimbursable per inpatient stay is 15 days. If a member requires more than 15 consecutive days, the member must be discharged from the psychiatric facility. Facilities are reimbursed for the reserved bed at one-half the regular *per diem* rate.

### **Therapeutic Leave of Absence (LOA)**

Reimbursement is available for a therapeutic LOA from psychiatric hospitals; it is not available from general acute hospitals. A LOA must be for therapeutic reasons and ordered by a physician, as indicated in the member's POC. Physician orders must be maintained in the member's file at the facility.

The total length of time available for therapeutic leaves of absence is 60 days per calendar year per member. If a member is absent from a psychiatric hospital for more than 60 days per year,

no further reimbursement will be available for reserving a bed for that member in that year. Facilities are reimbursed at one-half the regular *per diem* rate.

## **Prior Authorization for Inpatient Psychiatric and Substance Abuse Stays**

PA is required for all inpatient psychiatric admissions, rehabilitation, and substance abuse inpatient stays. PA for inpatient detoxification, rehabilitation, and aftercare for chemical dependency must include consideration of the following information:

- Review on a case-by-case basis by the appropriate PA department based on the program assignment of the member
- Treatment, evaluation, and detoxification based on the stated medical condition
- Need for safe withdrawal from alcohol or other drugs
- History of recent convulsions or poorly controlled convulsive disorder
- Reasonable evidence that detoxification and aftercare cannot be accomplished in an outpatient setting

IHCP members must meet the following criteria for inpatient detoxification:

- Evidence of symptoms of withdrawal that require close medical monitoring or continuous observation. Three or more of the following conditions:
  - Delirium tremens
  - Hypertension of recent onset
  - Impaired or absence of gag reflex
  - Tachycardia
  - Elevated temperature
  - Diaphoresis
  - Piloerection (goose bumps)
- Or one of the following conditions:
  - Seizures
  - Hallucinations of recent onset
  - Disorientation or confusion
- History of severe withdrawal reaction, such as seizures, delirium tremens, or psychotic episode
- Intoxicated with a history of recent, severe idiosyncratic intoxication, such as violence or blackouts while under the influence



- In addition to alcohol/drug condition, member has a co-existing medical and/or psychiatric condition which requires medical and psychiatric services
- Recent history of alcohol or other drug abuse and is currently unable to control abuse outside of a restrictive 24-hour care environment that is demonstrated by documented recent failed attempts.
- Dependency or abuse must be contributing to severe social and/or emotional dysfunction in one or more life spheres, e.g., vocational, familial, or social

The facility is responsible for initiating the PA review process. Providers should contact the appropriate PA entity for the initial PA and concurrent review.

Reimbursement is available for inpatient care provided on the psychiatric unit of an acute care hospital only when the need for admission has been certified. The Division of Family and Children State Form 44697, [OMPP 1261A – Certification Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility](#) - fulfills the written certification of need requirements. The certification of need must be completed in writing at least every 60 days after admission, or as requested, to recertify that the member continues to require inpatient psychiatric hospital services.

All requests for PA will be reviewed on a case-by-case basis. The PA entity reviews each OMPP 1261A form and determines whether the requested acute inpatient services meet medical necessity. Reimbursement is denied for any days the facility cannot justify a need for inpatient care. If the provider fails to complete a telephone PA pre-certification, reimbursement will be denied from the admission to the actual date of notification.

### **Emergency Admissions**

- A telephone precertification must be completed within 48 hours of the admission date, not including Saturdays, Sundays, and legal holidays
- A completed OMPP 1261A form must be received via U.S. mail within 14 working days of the admission date, not including Saturdays, Sundays, and legal holidays

### **Non-Emergency Admissions**

- A telephone PA must be completed prior to admission
- A completed OMPP 1261A form must be received via U.S. mail within 10 working days of the admission date, not including Saturdays, Sundays, and legal holidays

When an individual applies to become an IHCP member after admission to a facility, providers must notify the PA entity in writing within 10 days of receiving a notification of IHCP eligibility. At that time, providers may request coverage for the entire period of service for which reimbursement is sought.

### **Continuation of Services after Discharge from an Inpatient Hospital**

When a member's physician determines that an inpatient hospital setting is no longer necessary, but that IHCP-covered services should continue after the recipient is discharged from inpatient hospital care, services may continue for a period not to exceed 120 hours within 30 calendar days of discharge without prior review and authorization, if the physician has specifically ordered such services in writing upon the member's discharge from the hospital. Services provided are subject to all appropriate limitations. This exemption does not apply to durable medical equipment, neuropsychological and psychological testing, or out-of-state medical services.

Prior review and authorization by the office must be obtained for reimbursement beyond the 120 hours within 30 calendar days of the discharge period. Physical, speech, respiratory, and occupational therapies may continue for a period not to exceed 30 hours, sessions, or visits in 30 calendar days without prior approval, if the physician has specifically ordered such services in writing upon the member's discharge or transfer from the hospital. Prior review and authorization must be obtained for reimbursement beyond the 30 hours, sessions, or visits in the 30 calendar day period for physical, speech, respiratory, and occupational therapies.

### **Residential Substance Use Treatment**

The IHCP provides coverage for short-term low-intensity and high-intensity residential treatment for OUD and other SUD treatment in settings of all sizes, including facilities that qualify as IMDs. Residential stays are allowed to be authorized with a statewide average length of 30 calendar days, based on medical necessity.

Services built into the daily per diem residential payment include:

- Individual therapy
- Group therapy
- Medication training and support
- Case management
- Drug testing
- Peer recovery supports

Specific billing instructions for residential SUD treatment are currently found in [BT201801](#).

### **Prior Authorization for Residential Substance Use Treatment**

PA is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria Level 3.1 (Clinically Managed Low-Intensity Residential Services) and Level 3.5 (Clinically Managed High-Intensity Residential Services). Providers are required to include all appropriate documentation demonstrating medical necessity for residential treatment with PA requests.

## Outpatient Mental Health and Substance Abuse Services

Outpatient mental health services are interventions intended to reduce or alleviate symptoms, improve level of functioning, and prevent further or recurrent deterioration. After clients are assessed, a determination is made as to what forms of therapy will most likely be beneficial. Common interventions of outpatient treatment include individual, family, couple, and group counseling.

Therapy is a collaborative process; therefore, the client is expected to be active and cooperative when establishing the treatment plan. Treatment plans include specific goals, methods to accomplish goals, and methods to measure the progress of treatment goals. Measurable goals are also necessary to determine when improvement or deterioration of a client's functioning has occurred. Treatment plans must be reviewed and updated on a regular basis to reflect continued needs and identify the client's new goals.

**Note:** Healthy Indiana Plan (HIP) mental health outpatient treatment does not include self-help training or other related forms of non-medical self-care, marriage counseling, hypnotherapy, behavioral modification, or milieu therapy, when used to treat conditions that are not recognized as mental disorders. HIP substance abuse outpatient treatment does not include services or supplies unrelated to mental health for the treatment of co-dependency or caffeine addiction.

### Outpatient Mental Health Services

The IHCP covers outpatient mental health services provided by a licensed medical doctor, doctor of osteopathy, psychologist endorsed as a health service provider in psychology (HSPP), psychiatric hospitals, psychiatric wings of acute care hospitals, and outpatient mental health facilities. Reimbursement is also available for services provided by mid-level practitioners when services are supervised by a physician or a HSPP.

Mid-level practitioners who are eligible to provide outpatient mental health services must have obtained one of the following credentials:

- Advanced practice nurse who is a licensed RN with a master's degree in nursing, with a major in psychiatric or mental health nursing from an accredited school of nursing
- Independent practice school psychologist
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)
- Licensed psychologist
- Master's degree in social work, marital and family therapy, or mental health counseling
- Licensed clinical addiction counselors (LCAC)

These mid-level practitioners cannot be separately enrolled as individual providers to receive direct reimbursement. Mid-level practitioners can be employed by an outpatient mental health facility, clinic, physician, or a HSPP enrolled in the IHCP.

The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and supervising the treatment plan. The physician, psychiatrist, or HSPP must be available for emergencies. They are responsible for seeing the member during the intake process or reviewing the medical information obtained by the mid-level practitioner within seven days of the intake process. Also, the physician, psychiatrist, or HSPP must see the member or review the medical information and certify medical necessity on the basis of medical information provided by the mid-level practitioner at intervals not to exceed 90 days. Both reviews must be documented in writing; co-signatures alone are not sufficient.

The IHCP requires written evidence of physician or HSPP involvement and personal evaluation to document the member's acute medical needs. If practicing independently, a physician or a HSPP must order therapy in writing.

### **Prior Authorization for Outpatient Visits**

Prior authorization is required for mental health services provided in an outpatient or office setting that exceed twenty (20) units per recipient, per provider, per rolling twelve (12) month period of time.

**Note:** For Hoosier Healthwise Package C members, the IHCP covers thirty (30) office visits per member, per rolling calendar year. The IHCP may cover an additional twenty (20) visits with PA for a maximum of 50 visits per year.

### **Partial Hospitalization**

The IHCP reimburses for partial hospitalization services under the following conditions:

- Partial hospitalization programs must be highly intensive, time-limited medical services that either provide a transition from inpatient psychiatric hospitalization to community-based care, or serve as a substitute for an inpatient admission. Partial hospitalization programs are highly individualized with treatment goals that are measureable and medically necessary. Treatment goals must include specific time frames for achievement of goals, and treatment goals must be directly related to the reason for admission.
- Partial hospitalization programs must have the ability to reliably contract for safety. Consumers with clear intent to seriously harm the self or others are not candidates for partial hospitalization services.
- Services may be provided for consumers of all ages who are not at imminent risk to harm to self or others. Consumers who currently reside in a group home or other residential care setting are not eligible for partial hospitalization services. Consumers

must have a diagnosed or suspected behavioral health condition and one (1) of the following:

- A short-term deficit in daily functioning.
  - An assessment of the consumer indicating a high probability of serious deterioration of the consumer's general medical or behavioral health.
- Partial hospitalization services must be ordered and authorized by a psychiatrist.
- A face-to-face evaluation and an assignment of a behavioral health diagnosis must take place within twenty four (24) hours following admission to the program.
- A psychiatrist must actively participate in the case review and monitoring of care.
- Documentation of active oversight and monitoring of progress by a physician, a psychiatrist, or a HSPP must appear in the consumer's clinical record.
- At least one (1) individual psychotherapy service or group psychotherapy service must be delivered daily.
- For consumers under eighteen (18) years of age, documentation of active psychotherapy must appear in the consumer's clinical record, including a minimum of one (1) family encounter per five (5) business days of episode of care.
- Programs must include four (4) to six (6) hours of active treatment per day and be provided at least four (4) days per week.
- Programs must not mix consumers receiving partial hospitalization services with consumers receiving outpatient behavioral health services.

The following exclusions apply for partial hospitalization services:

- Consumers at imminent risk of harm to self or others are not eligible for services.
- Consumers who concurrently reside in a group home or other residential care setting are not eligible for services.
- Consumers who cannot actively engage in psychotherapy are not eligible for services.
- Consumers with withdrawal risk or symptoms of a substance-related disorder whose needs cannot be managed at this level of care or who need detoxification services.
- Consumers who by virtue of age or medical condition cannot actively participate in group therapies are not eligible for services

### **Prior Authorization for Partial Hospitalization**

Prior authorization is required for partial hospitalization services subject to medical necessity.



## Testing Services (Neuropsychological and Psychological)

The IHCP covers neuropsychology and psychology testing. A physician or HSPP must oversee all testing services, as well as interpretation and reporting. The following practitioners may only administer neuropsychological and psychological testing under the direction supervision of a physician or HSPP:

- A licensed psychologist
- A licensed independent practice school psychologist
- A person holding a master's degree in a mental health field and one (1) of the following
  - A certified specialist in psychometry (CSP)
  - Two-thousand (2,000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed

A cosignature by the physician or HSPP is required for services rendered by one of the practitioners listed above.

### Prior Authorization for Testing Services

Prior authorization is required for all neuropsychology and psychology testing, subject to medical necessity.

## Screening and Brief Intervention Services

The IHCP provides coverage for screening and brief intervention (SBI) services. SBI identifies and intervenes with individuals who are at risk for substance abuse related problems or injuries. SBI services use established systems, such as trauma centers, emergency rooms, community clinics, and school clinics, to screen patients who are at risk for substance abuse and, if necessary, provide the patients with brief interventions or referrals to appropriate treatment.

## Bridge Appointments

The IHCP provides coverage for bridge appointments, which are follow-up appointments after inpatient hospitalization for behavioral health issues, when no outpatient appointment is available within seven days of discharge. The goal of the bridge appointment is to provide proper discharge planning while establishing a connection between the member and the outpatient treatment provider.

During the bridge appointment, the provider should ensure at minimum that:

- The member understands the medication treatment regimen as prescribed.
- The member has ongoing outpatient care.
- The family understands the discharge instructions for the member.
- Barriers to continuing care are addressed.
- Any additional questions from the member or family are answered.

The following conditions must be met for bridge appointments to be reimbursed:

- Appointments must be conducted face-to-face in an outpatient setting on the day of discharge from an inpatient setting.
- Appointments must be a minimum of 15 minutes long.
- The member must have one or more identified barriers to continuing care, such as:
  - Special needs
  - Divorce or custody issues
  - Work conflicts
  - Childcare problems
  - Inability to schedule within seven days
  - History of noncompliance
  - Complex discharge plans
- The member must have one of the ICD diagnosis codes listed on the Diagnosis Codes for Bridge Appointments tables in *Mental Health and Addiction Services Codes* on the [Code Set](#) pages at indianamedicaid.com. Bridge appointments may be appropriate for members with psychiatric diagnoses not listed; however, documentation must be maintained in the member's chart, indicating the reason the bridge appointment service was necessary.

The appointment must be conducted by a qualified mental health provider, defined as:

- A licensed psychologist
- A licensed independent practice school psychologist
- A licensed clinical social worker (LCSW)
- A licensed marital and family therapist (LMFT)
- A licensed mental health counselor (LMHC)
- A person holding a master's degree in social work, marital and family therapy, or mental health counseling
- An advanced practice nurse (APN) who is a licensed, registered nurse holding a master's degree in nursing, with a major in psychiatric or mental health nursing from an accredited school of nursing

## Medicaid Rehabilitation Option (MRO)

For all coverage and billing information around Medicaid Rehabilitation Option (MRO) services, please see the [Medicaid Rehabilitation Option Services](#) provider reference module.

## Annual Depression Screening

The IHCP covers annual depression screening. Providers are expected to use validated standardized tests for the screening. These tests include, but are not limited to, the Patient Health Questionnaire (PHQ), Beck Depression Inventory, Geriatric Depression Scale, and Edinburgh Postnatal Depression Scale (EPDS)

## Smoking Cessation

Smoking cessation refers to a course of treatment designed to assist individuals in decreasing or stopping the use of tobacco products.

### Smoking Cessation Products

Reimbursement is available to pharmacy providers for smoking cessation products under the following conditions:

- When prescribed by a licensed practitioner within the scope of his or her license under Indiana law.
- Over-the-counter smoking cessation products must be prescribed by licensed practitioners.
  - A licensed practitioner must prescribe all smoking cessation products for use, along with counseling.
- Tobacco dependence pharmacotherapy will be available for up to 180 days per member per calendar year.
- Pharmacies should bill for reimbursement according to the normal procedures.

Only patients who agree to participate in smoking cessation counseling will receive prescriptions for smoking cessation products. The prescribing practitioner may request the patient sign a commitment to establish a “quit date” and to participate in counseling as the first step in smoking cessation treatment. A prescription for smoking cessation products will serve as documentation the prescribing practitioner has prescribed or obtained assurance from the patient counseling will concomitantly occur with the receipt of smoking cessation products.

Products covered by Indiana Medicaid include, but are not limited to, the following:

- Sustained release bupropion products
- Varenicline tartrate tablets (Chantix)
- Nicotine replacement drug products (patch, gum, inhaler)

### Smoking Cessation Counseling

Counseling services must be prescribed by a licensed practitioner within the scope of his or her license under Indiana law. Reimbursement is available for smoking cessation counseling services rendered by the following licensed practitioners participating in the Indiana Medicaid program:

- A physician
- A physician's assistant
- A nurse practitioner
- A registered nurse
- A psychologist
- A pharmacist
- A dentist
- An optometrist
- A clinical social worker
- Marital and family counselors
- Mental health counselors
- Licensed clinical addiction counselors

Counseling must be provided as follows: A minimum of 30 minutes (two units) and a maximum of 150 minutes (10 units) per member per calendar year. Providers must bill counseling in 15-minute increments.

**Note:** For Hoosier Healthwise (HHW), providers of smoking cessation treatment services must obtain the PMP certification.

## Opioid Treatment Program (OTP) Services

The IHCP provides coverage for services provided within an Opioid Treatment Program (OTP). The following services are considered part of a bundled daily payment within an OTP:

- Oral medication administration, direct observation, daily
- Methadone, daily
- Drug testing, monthly
- Specimen collection and handling, monthly
- Pharmacologic management, daily
- One hour of case management, per week
- Group or individual psychotherapy, as required by DMHA
- Hepatitis A, B, and C testing, as needed
- Pregnancy testing, as needed
- One office visit every 90 days

- Tuberculous testing, as needed
- Syphilis testing, as needed
- Complete blood count, as needed

**Note:** The daily bundled rate for OTP services is only billable for individuals who are receiving daily methadone maintenance treatment. If a member is using an alternative medication for treatment, such as Suboxone or Vivitrol, the medication, along with any related services rendered, should be billed separately.

A psychiatric diagnostic evaluation with medical services, as well as psychotherapy services over and above the therapy covered under the bundled rate, may be rendered and billed separately from the daily bundled rate.

These services are available to members enrolled in all IHCP progress, except for those with the following benefit plans:

- Individuals eligible for Family Planning Eligibility Program only
- Individuals eligible for Package E – Emergency Services only
- Individuals eligible for Medicare Savings Programs only – Qualified Medicare Beneficiary (QMB)-only, Specified Low Income Medicare Beneficiary (SLMB)-only, or Qualified Individual (QI)

Individuals who are aged 18 and older seeking OTP services must meet the following medical necessity criteria:

- Must be addicted to an opioid drug
- Must have been addicted for at least one year before admission to the OTP
- Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria

Individuals under the age of 18 seeking OTP services must meet the following medical necessity criteria:

- Must be addicted to an opioid drug
- Must have two documented unsuccessful attempts at short-term withdrawal management or drug-free addiction treatment within a 12-month period preceding admission
- Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria

The following individuals are exempt from the one-year addiction requirement:



- Members released from a penal institution – if the individual seeks OTP services within six months of release
- Pregnant women
- Previously treated individuals – if the individual seeks OTP services within two years after treatment discharge

The IHCP recognizes the following credentials, under the direction of a physician or health services provider in psychology (HSPP), for individuals rendering individual, group, or family counseling services in an OTP setting:

- A licensed psychologist
- A licensed clinical social worker (LCSW)
- A licensed marriage and family therapist (LMFT)
- A licensed mental health counselor (LMHC)
- A licensed clinical addiction counselor (LCAC)
- A physician assistant
- A nurse practitioner
- A clinical nurse specialist
- An individual credentialed in addiction counseling by a nationally recognized credentialing body approved by the Division of Mental Health and Addiction (DMHA)\*

\*The Medication Assisted Treatment Specialist (MATs) credential is not currently recognized by DMHA and will not be allowed by the IHCP.

### **Prior Authorization for OTP Services**

Prior authorization (PA) is not required for OTP services. However, providers must maintain documentation demonstrating medical necessity, that the coverage criteria are met, as well as the individual's length of treatment, in the member's records.

### **Prior Authorization**

Prior authorization is not required for the following services:

- Screening and brief intervention services
- Smoking cessation
- Opioid Treatment Program (OTP) services

Prior authorization is required for the following services:

- Inpatient psychiatric and substance abuse stays

- Outpatient mental health services that exceed twenty (20) units per recipient, per provider, per rolling twelve (12) month period of time
- Partial hospitalization services
- Neuropsychology and psychology testing

## Billing and Coding

For further billing information, see the [Mental Health and Addiction Services](#) provider reference module. For a list of billing codes, see the *Mental Health and Addiction Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

### [405 IAC 5](#)

- 405 IAC 1-8-2 – Hospital and ambulatory surgical center reimbursement for outpatient services
- 405 IAC 1-10.5-3 – Perspective reimbursement methodology
- 405 IAC 5-2-19 – “Outpatient services” defined
- 405 IAC 5-3 – Prior authorization
- 405 IAC 5-2-17 – “Medically reasonable and necessary service” defined
- 405 IAC 5-20-1 – Reimbursement limitations
- 405 IAC 5-20-4 – Individually developed plan of care
- 405 IAC 5-20-6 – Emergency admissions
- 405 IAC 5-20-8 – Outpatient mental health services
- 405 IAC 5-21 – Community mental health rehabilitation services
- 405 IAC 5-25 – Physician services
- 405 IAC 5-29 – Services not covered by Medicaid
- 405 IAC 5-37 – Smoking cessation treatment policy
- 440 IAC 5.2-2-3 – Assertive community treatment services
- 405 IAC 5-2-19 – Outpatient Services Defined
- 405 IAC 5-3 – Prior Authorization
- 405 IAC 5-20-8 – Outpatient Mental Health Services
- 405 IAC 5-21.5 – Medicaid Rehabilitation Option Services

### [IHCP Provider Bulletins](#)

- [BT201801](#) IHCP enhances coverage for substance use treatment
- [BT201755](#) IHCP issues revised reimbursement policy and billing guidance for OTP-specific services
- [BT201744](#) IHCP to enroll OTPs under a designated provider type and cover OTP-specific services
- [BT201149](#) The IHCP to cover bridge appointments
- [BT201023](#) Medicaid Rehabilitation Option program updated code set and modifier information

## [IHCP Provider Banners](#)

- [BR201730](#) IHCP to reimburse for certain procedures rendered by LCACs
- [BR200923](#) Screening and brief intervention services

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## **Update History**

January 1, 2017 – Initial Publication; revised tobacco dependence treatment; revised criteria for inpatient detoxification admissions; added coverage of annual depression screening

August 17, 2017 – Added coverage for OTP services

August 25, 2017 - Added LCAC to list of mid-level practitioners for outpatient mental health services

February 1, 2018 – Expanded coverage for inpatient stays in IMDs

March 1, 2018 – Added coverage for residential substance use treatment

## Obstetrical and Gynecological Services

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### Description of Service

Obstetric care includes the care of and services provided to a member during pregnancy, childbirth, and the postpartum care.

Gynecology services are provided to women, particularly for the diagnosis and treatment of disorders affecting the female reproductive organs. Treatment begins with thorough diagnosis to evaluate the condition and its causes. Gynecologists provide care for women of all ages and have the knowledge to address a full span of health conditions related to the female reproductive system.

### Medical Policy

#### Obstetric Care

##### Antepartum Services

The IHCP utilizes guidelines from the American College of Obstetricians and Gynecologists (ACOG).

The IHCP covers 14 visits for normal antepartum care. Below are the number of visits in a normal pregnancy:

- Three visits in trimester one
- Three visits in trimester two
- Eight visits in trimester three

Additional antepartum care visits are allowed for members considered to have a high-risk pregnancy.

In addition to the antepartum visits, the IHCP covers antepartum tests and screenings delivered according to standards established by the ACOG and the American Academy of Pediatrics (AAP). The IHCP covers for prenatal care delivered according to national standards as outlined by ACOG, AAP, and the Agency for Health Care Research and Quality, Guidelines for prenatal care.

##### Antepartum and Postpartum Immunizations

Please refer to [ACOG](#), [AAP](#), and [The Centers for Disease Control and Prevention \(CDC\)](#) guidelines for the recommended immunizations for pregnant women.

##### Other Outpatient Office Visits

Providers may bill for outpatient office visits rendered to pregnant members, if the service is related to a concurrent medical condition requiring medical care or consultative referral.

## Normal Pregnancies

A normal pregnancy is one in which the physician determines the pregnant member is not at risk of a preterm birth or poor pregnancy outcome due to medical or psychosocial reasons.

## High-Risk Pregnancies

A pregnant woman may be considered high-risk if at least one medical or psychosocial reason is identified in her current pregnancy or obstetrical history which places her at risk for preterm birth or a poor pregnancy outcome. The provider should utilize the IHCP Prenatal Risk Assessment Form as a tool for identifying pregnant members at risk of preterm births or poor pregnancy outcomes. Providers may refer members identified as having high-risk pregnancies only to appropriate physicians. Referrals to non-physicians for high-risk pregnancy-related services are not covered.

High-risk pregnancy is defined as pregnant members who have medical or psychological complications which, if not adequately addressed, may adversely affect the pregnancy's outcome. These complications, usually identified during the prenatal assessment, may place the member and the fetus in a high-risk pregnancy category that requires additional primary care management. Members identified as being high-risk pregnancies may receive additional antepartum care visits beyond the maximum of 14 allowed for a normal pregnancy. The IHCP recognizes the care of pregnant women in the high-risk category requires greater physician management.

The IHCP does not determine conditions which may or may not complicate a pregnancy. Therefore, if a physician determines an illness or injury could complicate a pregnancy or have an adverse effect on the pregnancy's outcome, the IHCP allows billing for covered services provided to treat the illness or injury.

## Ultrasound/Sonography/Echography

Ultrasound/Sonography Echography services performed during pregnancy are covered by the IHCP when indicated by one or more of the following conditions:

- Early diagnosis of ectopic or molar pregnancy
- Placental localization associated with abnormal bleeding
- Fetal postmaturity syndrome
- Suspected multiple births
- Suspected congenital anomaly
- Polyhydramnios or oligohydramnios
- Guide for amniocentesis
- Fetal age determination if necessitated by:
  - Discrepancy in size versus fetal age
  - Lack of fetal growth or suspected fetal death

In addition, reimbursement is available for US guidance to perform a procedure that improves fetal status.



IHCP covers ultrasounds for fetal age determination prior to therapeutic, non-elective abortions when the age of a fetus cannot be determined by the patient's H&P examination in the case of fetal demise, or for a missed abortion (miscarriage). The information may also be essential for the selection of an abortion method when a procedure is being considered and the conditions meet the requirements of *IC § 16-10-3-3* for an elective abortion.

### **First Trimester Fetal Nuchal Translucency Ultrasound**

The first-trimester fetal nuchal translucency ultrasound does not require prior authorization. However, the first-trimester fetal nuchal translucency ultrasound must be performed in conjunction with maternal serum-free beta human chorionic gonadotropin (hCG) and pregnancy-associated plasma protein A for the detection of chromosomal defects. The IHCP does not cover first-trimester fetal nuchal translucency testing when performed alone for the detection of chromosomal defects, as it is considered investigational. For optimal test results, the first-trimester fetal nuchal translucency ultrasound should be performed between 11 and 13 weeks of pregnancy. First-trimester fetal nuchal translucency ultrasounds are subject to the requirements found in *405 IAC 5-27-6*.

The IHCP does not provide reimbursement for routine ultrasounds or ultrasounds performed for gender determination. The diagnosis of a normal pregnancy does not substantiate the medical necessity for an ultrasound to be performed. Documentation must be maintained in the patient's medical record to support the medical need for an ultrasound.

### **Early Elective Deliveries**

The IHCP does not cover early elective deliveries (EEDs). Deliveries that are not medically indicated prior to 39 weeks and 0 days, known as EEDs, are noncovered. Deliveries that meet one of the approved medical indications for a medically necessary delivery prior to 39 weeks listed below are covered. The medical indications listed below are compiled from lists released by the Indiana Perinatal Quality Improvement Collaborative (IPQIC), ACOG, and The Joint Commission as indications for a medically necessary delivery prior to 39 weeks. The comprehensive list of medical indications is intended to ensure all medically indicated deliveries prior to 39 weeks remain covered. The IHCP will continue to evaluate the list of approved medical indications to ensure that all medically necessary indications are covered.

Approved medical indications for a medically necessary delivery prior to 39 weeks and 0 days include the following:

#### **Maternal Indications**

- Antiphospholipid Syndrome
- Chronic Hypertension
- Cardiovascular Diseases
- Chronic Pulmonary Disease
- Coagulopathy Defect
- Coagulopathy Disorders
- Congenital Heart Defect/
- Heart Disease
- Current Cancer

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- Diabetes Mellitus
- Epilepsy/Seizure Disorder
- Gastroenteric Diseases/ Disorders
- Hematological Disorder
- HIV; Asymptomatic HIV Infection Status
- Hypertension Non-Specified
- Liver Disease
- Maternal/Fetal Hemorrhage
- Previous Stillborn
- Prior Classical Cesarean Delivery
- Prior Myomectomy Entering Endometrial Cavity
- Renal Disease

## **Fetal Indications**

- ABO Isoimmunization
- Abnormal Fetal Heart Rate
- Chorioamnionitis
- Congenital Heart Defect/Heart Disease
- Fetal Abnormality
- Fetal Chromosomal Anomaly
- Fetal CNS Anomaly
- Fetal Damage due to Disease
- Fetal Damage due to Drugs
- Fetal Damage due to Radiation
- Fetal Damage due to Virus
- Fetal Demise-Singleton
- Fetal Distress
- Fetal/Maternal Hemorrhage
- Intrauterine Growth Restriction
- Non-Reassuring Fetal Antepartum Testing
- RH Isoimmunization

## **Obstetric Indications**

- Members presenting in labor
- Abruptio Placenta
- Abruptio
- Antepartum Hemorrhage/Bleeding
- Chronic Hypertension with Super Imposed Preeclampsia
- Chorioamnionitis
- Gestational Diabetes
- Gestational Hypertension
- Hypertensive Disorder
- Increta
- Maternal/Fetal Hemorrhage

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- Mild Preeclampsia
- Severe Preeclampsia/HELLP/Eclampsia
- Multiple Gestation/ Multiple Gestation with Loss
- Oligohydramnios
- Percreta
- Placenta Accreta
- Placenta Previa
- Placental Previa Hemorrhage
- Polyhydramnios
- Premature Rupture of Membranes
- Prolonged Rupture of Membranes
- Ruptured Membranes
- Unstable Lie; Multiple Gestation with Malpresentation
- Vasa Previa

## **Anesthesia for Vaginal or Cesarean Delivery**

The IHCP covers anesthesia services for a vaginal or cesarean delivery. For additional information, please see the Anesthesia Services policy module.

## **Postpartum**

The IHCP allows postpartum visits within 60 days post-delivery. The IHCP covers inpatient or outpatient postpartum visits when billing for postpartum care only.

## **Pharmacy Services**

The IHCP does not require a copayment for drugs dispensed to a pregnant member. Family planning services and supplies furnished to individuals of a childbearing age do not require copayments.

## **Transportation Services**

No copayment is required for transportation provided to pregnant members; however, transportation exceeding the 50-mile one-way trip limitation is subject to PA. Refer to the Transportation Services policy module for additional information.

## **Pediatric and Neonatal Critical Care During Interfacility Transportation**

Effective January 1, 2015, the IHCP will provide coverage for critical care during a pediatric or neonatal interfacility transport. The following restrictions apply:

- Patient must be 24 months of age or younger
- Patient must be in critical condition, as determined by a physician using the following guidelines:
  - Patient has a critical illness or injury that acutely impairs one or more vital organ systems; and
  - Imminent or life-threatening deterioration of the patient's condition is highly probable during transport
- This service must be rendered by a physician or a neonatal nurse practitioner (NNP).

## Gynecology Services

### Cervical Cancer Screenings

The IHCP covers cervical cancer screening services including cytology (Pap smear) and human papillomavirus (HPV) testing, as well as medically necessary services, such as the collection of samples, a screening by a cytotechnologist, and a physician's interpretation of the test results. The IHCP follows the recommendations for cervical cancer screening set by the U.S. Preventive Services Task Force (USPSTF) and the American Society for Colposcopy and Cervical Pathology (ASCCP).

For repeat testing, cytologic thresholds for further diagnostic testing (colposcopy) and treatments, and extended surveillance, the IHCP will follow the recommendations of the ASCCP.

The USPSTF recommends the following guidelines for cervical cancer screenings:

- **Women younger than 21 years of age:** No screening for cervical cancer
- **Women 21 through 64 years of age:** Screening for cervical cancer with cytology (Pap smear) every three years
- **Women younger than 30 years of age:** No screening for cervical cancer with HPV testing, alone or in combination with cytology
- **Women 30 through 64 years of age:** Screening for cervical cancer with a combination of cytology and HPV testing every five years for women in this age range who want to lengthen the screening interval
- **Women with human immunodeficiency virus (HIV):** Screening for cervical cancer within one year of sexual activity or initial HIV diagnosis using conventional or liquid-based cytology, with testing repeated six months later
- **Women who have had a hysterectomy:** No screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer

### Pelvic Examination

IHCP provides coverage for pelvic examinations (including breast examination) for female recipients, subject to certain frequency and other limitations. A pelvic examination screening should include at least seven of the following eleven elements:

- External genitalia (for example, general appearance, hair distribution, or lesions)
- Urethral meatus (for example, size, location, lesions, or prolapse)
- Urethra (for example, masses, tenderness, or scarring)
- Bladder (for example, fullness, masses, or tenderness)
- Vagina (for example, general appearance, estrogen effect, discharge lesions, pelvic support, cystocele, or rectocele)
- Cervix (for example, general appearance, lesions, or discharge)
- Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support)
- Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity)
- Anus and perineum

A pelvic exam performed under anesthesia may be done as part of another gynecological surgical procedure or as a single procedure. The IHCP covers when the member requires anesthesia/conscious sedation to enable the practitioner to complete the exam. Based on accompanying documentation, medically necessary care provided prior to surgery will be reimbursed.

## **Hysterectomy**

The IHCP covers hysterectomy only when medically necessary, and only when the member has given informed consent. The provider must have informed the member orally and in writing that the procedure will render the member permanently incapable of reproducing, and the member must have signed a written acknowledgement of receipt of that information.

The member or member's representative must sign an informed consent or acknowledgement except when the patient is already sterile or a life-threatening emergency exists for which the physician determines prior acknowledgement is not possible. However, the physician who performs the hysterectomy under these circumstances must complete the following requirements:

- Certify in writing that the individual was already sterile at the time the hysterectomy was performed.
- State the cause of the sterility at the time of the hysterectomy.
- Certify in writing that the hysterectomy was performed under a life-threatening emergency in which the physician determined that prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

The IHCP denies improperly completed acknowledgment statements. Providers cannot use the sterilization consent form for hysterectomy procedures under any circumstances.

## **Prior Authorization for Total or Partial Hysterectomy**

Prior authorization for total or partial hysterectomies will be granted for members with documentation supporting one of the following:

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



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- excision procedure (LEEP), large loop excision of transformation zone (LLETZ), or loop surgical excision
- Fibroids in premenopausal woman with both of the following:
  - Uterus greater than 12 weeks' size or documentation of need for abdominal, rather than vaginal, approach; and one of the following:
    - Abnormal bleeding
    - Uterus size doubled within one year
    - Ureteral compression by US or intravenous pyelogram (IVP)
    - Other symptoms, such as pelvic or abdominal pain or discomfort without other explanation, urinary frequency or urgency, or dyspareunia
  - Fibroids in postmenopausal woman with all of the following:
    - Uterus greater than 12 weeks' size, or documentation of need for abdominal rather than vaginal approach; and one of the following:
    - Uterus size doubled within any time period
    - Ureteral compression by US or IVP
    - Other symptoms, such as pelvic or abdominal pain or discomfort without other explanation, urinary frequency or urgency, or dyspareunia
    - Papanicolaou (pap) smear within six months
  - Dysfunctional uterine bleeding with all of the following:
    - Premenopausal woman
    - Abnormal bleeding uncontrolled by conservative therapy, such as hormonal therapy
    - No evidence of cancer demonstrated by hysteroscopy, endometrial biopsy, dilation and curettage (D&C), or transvaginal US
    - Pap smear within six months
  - Postmenopausal bleeding with all of the following:
    - Abnormal bleeding continued after change in or discontinuation of hormone replacement therapy
    - No evidence of cancer demonstrated by hysteroscopy, endometrial biopsy, D&C, or transvaginal US
    - Pap smear within six months
  - Pelvic inflammatory disease (PID) with one of the following:
    - Suspected rupture or leakage of pelvic abscess
    - Unsuccessful management with antibiotics for 10 to 14 days
    - Surgery for residual, inactive but symptomatic disease, if conservative therapy is not possible.
  - Chronic PID with both of the following:
    - Chronic pelvic pain
    - Adhesions, scarring, or hydrosalpinx
  - Recurrent abnormal uterine bleeding (lasting longer than eight days for more than two cycles, requiring additional protection, defined as large clots and gushes, with limitations of normal activity) and benign endometrial biopsy after failed medication therapy – excluding members on birth control pills or those with intrauterine devices (IUDs).
  - Chronic incapacitating pelvic pain, unresponsive to conservative therapy, such as analgesics, and evidence of normal GI/genitourinary (GU) evaluations.

- A four- to six-month failed trial of oral contraceptives, diuretics, anti-inflammatories, or induced amenorrhea
  - Negative examinations of UT, GI tract, and musculoskeletal
  - Psychological and psychosexual counseling reveals no etiology of pain
- Postmenopausal bleeding more than one year after LMP, with D&C or endometrial biopsy within past six months. Positive cytology of cervix requires abdominal procedure (cervical intra-epithelial neoplasia including carcinoma in situ).
- Premalignant adenomatous hyperplasia or adenocarcinoma of the endometrium, confirmed by pathology report
- Postmenopausal (more than one year) with benign or malignant ovarian tumor and/or cyst
- Abdominal procedure when associated with abdominal procedure for correction of urinary stress incontinence or vaginal repair of cystocele, rectocele, enterocele, or uterine prolapse
- Uncontrolled postpartum bleeding within six hours of delivery, uncontrolled by drug therapy (e.g., Pitocin, Methergine, or Prostaglandin therapy) or D&C
- Endometriosis uncontrolled by hormonal therapy (for example, depot medroxyprogesterone, oral contraceptives, Gonadotropin-releasing hormone [GnRH] agonist, or danazol), surgical ablation, or excision
- Tubo-ovarian abscess
- Urinary incontinence due to fistula into vagina, uterus, or perineum, and fistula demonstrated by cystoscopy, radiological examination, visual inspection, or probing
- Uterine prolapse, second or third degree, and one of the following:
  - Pain
  - Pelvic pressure
  - Stress incontinence
  - Ulceration of vaginal mucosa or cervix with bleeding or spotting
  - Vaginal splinting

## Freestanding Birthing Centers

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

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

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

eligible to render services in a freestanding birthing center include physicians and licensed certified nurse midwives (CNMs). Other staff services such as registered nurses (RNs), licensed nurse practitioners (LPNs), and other birth attendants are included in the delivery rate

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

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

## **Placental Alpha Microglobulin-1 (PAMG-1) Test for Detection of Rupture of Membranes (ROM)**

Premature rupture of the membranes (PROM) is defined by the American College of Obstetricians and Gynecologists (ACOG) as rupture of the amniotic sac and leakage of amniotic fluid prior to the onset of labor at any gestational age. Preterm premature rupture of membranes (PPROM) is defined as rupture of fetal membranes that occurs prior to thirty-seven (37) weeks of gestation.

PROM is a complication in approximately one third of preterm birth and is typically associated with brief latency between membrane rupture and delivery, increased potential for perinatal infection, and in utero umbilical cord compression. Because of this, both PROM at and before term can lead to significant perinatal morbidity and mortality.

The PAMG-1 test detects the presence of the PAMG-1 protein marker found in the amniotic fluid in vaginal secretions, and is intended to aid in detecting PROM in pregnant women with signs, symptoms or complaints suggestive of PROM.

The IHCP covers PAMG-1 test when considered medically necessary to confirm the diagnosis of PROM.

### **Prior Authorization for PAMG-1 Test for Detection of ROM**

Prior authorization is not required for PAMG-1. However, use of the PAMG-1 test is closely monitored for appropriateness of use.

## Spontaneous Abortion or Missed Abortion

IHCP covers spontaneous abortion or missed abortion therapeutic and other related services. Spontaneous abortion or missed abortion occurs for no apparent reason during early pregnancy and requires treatment to ensure the health of the mother

## Elective Abortion

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

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

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

- A physician has found, and certified in writing to the Medicaid agency, on the basis of his professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient.  
OR
- If the pregnancy is the result of an act of rape or incest, and signed documentation has been received from a law enforcement agency or public health service stating:
  - That the person upon whom the medical procedure was performed was reported to have been the victim of an incident of rape or incest
  - The date on which the incident occurred
  - The date on which the report was made, which must have been within 60 days of the date on which the incident occurred; the name and address of the victim; and the name and address of the person making the report (if different from the victim)
  - That the report included the signature of the person who reported the incident

The IHCP reimburses for abortions to terminate pregnancies resulting from rape or incest, in addition to abortions necessary to save the life of the pregnant mother. No other abortions, regardless of funding, can be provided as a benefit under the IHCP. Elective abortions performed for any other reason are non-covered services per *405 IAC 5-28-7*.

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

## Required Documentation

The IHCP requires the physician to specify in writing the following:

- A physician has found, and certified in writing to the Medicaid agency, on the basis of his professional judgment, the life of the mother would be endangered if the fetus were carried to term. The physical condition of the patient leading to the professional

judgment the abortion was necessary to preserve the life of the pregnant woman. The certification must contain the name and address of the patient.

OR

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

### Non-surgical Abortions

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

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

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

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

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

#### Day 1:

- Member reviews and signs the Patient Agreement
- Provider orally administers three 200 mg tablets of mifepristone.
- Provider bills HCPCS code S0190–Mifepristone, oral, 200 mg, three units.
- Provider bills the appropriate evaluation and management (E/M) code for the office visit.

#### Day 3:

- Provider checks pregnancy status with clinical examination or ultrasound (US) exam.



- If an US is performed, provider bills the appropriate code for the service provided.
- Provider orally administers two 200 mcg tablets of misoprostol
- Provider bills HCPCS code S0191–Misoprostol, oral, 200 mcg, two units.
- Provider bills appropriate E/M code for the office visit.

#### Day 14:

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

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

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

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

These agreements are available from Danco Laboratories, which is responsible for manufacturing, marketing, distributing, and monitoring FDA compliance in the use of mifepristone in the United States. Danco also requires use of these forms.

## Billing and Coding

For further billing information, see the *Obstetrical and Gynecological Services* provider reference module. For a list of billing codes, see the *Obstetrical and Gynecological Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

[42 CFR Part 50 Subpart C](#) Abortions and Related Medical Services in Federally Assisted Programs

[42 CFR Part 441 Subpart E](#) Abortions

[IC 16-18-2-36.5](#) Birthing center

[IC 16-34-1-2](#) Public funds; payment restricted

[Humphrey's v. Clinic for Women, Inc., 796 N.E.2d 247 \(Ind. 2003\)](#)

[405 IAC 5](#)

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- 405 IAC 5-16.5 Freestanding Birthing Centers
- 405 IAC 5-17 Hospital Services
- 405 IAC 5-18 Laboratory Services
- 405 IAC 5-22-3 Nursing and Therapy Services – Certified Nurse Midwife Services
- 405 IAC 5-24-7 Obstetric Services – Copayment for Legend and Nonlegend Drugs
- 405 IAC 5-27-2 Radiology Services – Utilization Criteria
- 405 IAC 5-27-6 Sonography
- 405 IAC 5-28-7 Abortion
- 405 IAC 5-28-9 Hysterectomy

## [410 IAC 27](#)

- 410 IAC-27 Birthing Centers

## [IHCP Provider Bulletins](#)

- [BT201421](#) IHCP implements early elective delivery policy
- [BT201206](#) The IHCP to Allow Birthing Centers to Enroll as Medicaid Providers
- [BT201158](#) The IHCP to Allow Birthing Centers, CORFs, and IDTFs to Enroll as Medicaid Providers

## [IHCP Provider Banners](#)

- [BR201421](#) Clarification and billing information for the IHCP's early elective delivery policy

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

## Oncology Services

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### Description of Service

Oncology is the study and treatment of cancer. A tumor is a morbid enlargement or a new growth of tissue in which the multiplication of cells is uncontrolled and progressive; also called neoplasm.

### Medical Policy Oncology Services

Oncology services are covered if the services are medically necessary and reasonable, and are provided by a doctor of medicine or doctor of osteopathy for diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided within the scope of the practice of medicine, as set forth in 405 IAC 5-25-1. Per 405 IAC 5-28-10, outpatient administration of chemotherapy and costs related to this therapy, including catheterization, physician's visits, cost of drugs and solutions, pump regulators, and servicing, will be covered and do not require PA.

#### Prior Authorization for Oncology Services

Prior authorization is required for the following:

- Bone marrow transplants
- Stem cell transplants
- Chemotherapy services provided by a home health agency

Prior authorization is not required for parenteral infusion pumps when used in conjunction with parenteral hyperalimentation, including central venous catheters.

### Radioimmunotherapy

Radioimmunotherapy utilizes a tumor-killing dose of radioactive substance that is linked to a monoclonal antibody, which targets and binds selectively to a malignant tumor. The ability of the antibody to bind to a tumor-associated antigen ensures that the tumor receives a high dose of radiation, killing the targeted cancer cells, while normal tissue receives only a minimal dose. Radioimmunotherapy may result in significant tumor shrinkage while avoiding larger full body doses of radiation.

Currently, the IHCP reimburses for radioimmunotherapy for the treatment of refractory low-grade B-cell non-Hodgkin's lymphoma utilizing Zevalin®. Zevalin® is a monoclonal antibodies that target lymphocytes, including malignant B-cells involved in the disease. Additional radioimmunotherapy regimens will be evaluated by the IHCP as they are approved by the FDA.

The radioimmunotherapy regimen is administered in two separate steps – the diagnostic step and the therapeutic step. The purpose of the diagnostic step is to determine the radiopharmaceutical biodistribution of radiolabeled antibodies. The published criteria for

determining appropriate biodistribution involve making a qualitative comparison of isotope uptake in several organ systems between at least two nuclear medicine scans.

Therefore, these scans cannot be read in isolation and should be reported once, regardless of the number of scans performed during the treatment regimen. The therapeutic step is characterized by the administration of targeted radiolabeled antibodies. Rituximab and its infusion prior to the administration of Zevalin® is separately reimbursable. Likewise, the radiopharmaceutical is separately reimbursable from the nuclear scanning procedure.

Currently, radioimmunotherapy is not a procedure typically performed more than once. Therefore, codes specific to the radioimmunotherapy procedure are limited to one unit per lifetime. The IHCP will re-examine the policy if future research determines that multiple dosing of the radioimmunotherapy regime is appropriate.

## Prior Authorization

Prior authorization is required for the following:

- Bone marrow transplants
- Stem cell transplants
- Chemotherapy services provided by a home health agency

## Billing and Coding

All outpatient hospital chemotherapy and radiation treatment services are billed on the UB-04 claim form. When chemotherapy and radiation treatment services are rendered on the same day, all applicable components should be billed.

## Chemotherapy

Chemotherapy services consist of four components: treatment room services, administration of chemotherapy agent, chemotherapy agent, and IV solution and equipment. Each of these four components is separately reimbursable when chemotherapy is administered. To bill for chemotherapy services, providers should adhere to the following guidelines:

- Treatment room services – Bill using revenue codes 45X, 483, 51X, 52X, or 76X. Treatment room reimbursement is limited to one unit per day, per member, per provider.
- Administration of chemotherapy agent – Bill using revenue codes 331, 332 or 335. The appropriate CPT® chemotherapy administration codes (96401 – 96549) should be listed along with revenue codes. Preparation of chemotherapy agents is included in the service for administration of the agent. [American Medical Association (AMA) CPT® 2002]
- Chemotherapy agent – Bill using revenue code 636 (Drugs requiring detailed coding) along with the appropriate covered HCPCS J code(s) (J9000 – J9390).
- IV solution and IV equipment – Bill using revenue code 258 for the IV solution and revenue code 261 for IV equipment. No reimbursement will be made for other revenue codes associated with supplies.

## Radiation

Radiation treatment consists of two components: treatment room services and administration of radiation treatment. To bill for radiation treatment services, providers should adhere to the following guidelines:

- Treatment room services – Bill using revenue codes 45X, 483, 51X, 52X, or 76X.  
Treatment room reimbursement is limited to one unit per day, per member, per provider.

Administration of radiation treatment – Bill using revenue codes 330, 333, or 339 along with the appropriate CPT® radiation treatment codes (77261-77799).

## Radioimmunotherapy

The radiopharmaceutical (Zevalin®) is separately reimbursable from the nuclear medicine scanning procedure. Providers should bill the diagnostic and therapeutic supply of Zevalin® (A9542 and A9543, respectively), and the infusion and supply of Rituximab (J9310) in the Zevalin® regime.

## Outpatient Facility Setting or Physician's Office

The outpatient facility or physician's office should bill the TC of the procedure using CPT® code 78804 (diagnostic component) and 79403 (therapeutic component); the radiopharmaceutical using the appropriate HCPCS code (A9542 or A9543), and the appropriate revenue code on the UB-92 claim form or 837I transaction.

Rituximab (J9310) and its infusion (Q0084, 96413, 96416, 96422, or 96425)) prior to the administration of Zevalin® is separately reimbursable to the facility. The physician should bill the professional component with the code-modifier combination 78804-26 or 79403-26 on a CMS-1500 claim form or 837P transaction. Billing codes for outpatient facilities and physicians' offices are summarized in Table 1.



## Zevalin® Therapy Provided in an Outpatient Facility or Physician's Office

Code	Revenue Code	Description
78804* (outpatient facility)	341	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging (Diagnostic)
79403* (outpatient facility)	340, 342	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by IV infusion (Therapeutic)
78804-26* (physician)	N/A	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging (Diagnostic)
79403-26* (physician)	N/A	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by IV infusion (Therapeutic)
A9542* (Zevalin®)	343	IN-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries
A9543* (Zevalin®)	344	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries
J9310 (Zevalin® regime)	636	Injection, rituximab, 100 mg
Also use one of the following administration codes, as appropriate		
Q0084	335	Chemotherapy administration by infusion technique only, per visit
96413	335	Chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug
96416	335	Chemotherapy administration, intravenous infusion technique, initiation of prolonged chemotherapy infusion (more than 8 hours), requiring the use of a portable or implantable pump
96422	335	Chemotherapy administration, intra-arterial; infusion technique, up to one hour
96425	335	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump

\*Limited to one unit per lifetime

## Rules and Citations

[405 IAC 5](#)

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[IHCP Provider Bulletins](#)

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[IHCP Provider Banners](#)

# Medical Policy Manual

Office of Medicaid Policy & Planning



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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

## Out-of-State Services

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### Description of Service

Members of the IHCP may require health care services when they are outside the state of Indiana under specifically defined circumstances. If an IHCP member requires health care services, he or she should inquire, if possible before receiving services, whether the organization is enrolled as an IHCP provider. Out-of-state health care providers must enroll in the IHCP.

### Medical Policy Reimbursement of Out-of-State Services

IHCP reimbursement is available for following specified services provided outside the state of Indiana:

- Acute general hospital care
- Chiropractic services
- Dental services
- Diagnostic services, including genetic testing
- Durable medical equipment and supplies
- Hospice services, subject to the conditions in *405 IAC 5-34-3*
- Pharmacy services
- Physician services
- Podiatry services
- Therapy services
- Transportation services

The above services may be rendered to the member while outside the state of Indiana or under the following specifically defined circumstances:

- The service is not available in Indiana. Care provided by out-of-state Veterans Affairs (VA) and Shriners Hospitals for Children is an exception to this requirement.
- The member has received services from the provider previously.
- Transportation to an appropriate Indiana facility would cause undue exposure or hardship to the member, to the member's family, or to the Medicaid program.
- The out-of-state provider is a regional treatment center or distributor.

- The out-of-state provider is significantly less expensive than the Indiana providers – for example, large laboratories versus an individual pathologist.

## Designed Out-of-State Areas

Members may receive services in the following designated out-of-state areas, subject to the prior authorization requirements as in-state service providers.

### Designated Areas for In-State PA Requirements

State	City
Illinois	Chicago
	Danville
	Watseka
Kentucky	Louisville
	Owensboro
Michigan	Sturgis
Ohio	Cincinnati
	Hamilton
	Harrison
	Oxford

Members may receive services in Chicago, Illinois, subject to all of the following conditions:

- The member's physician determines the service is medically necessary.
- Transportation to an appropriate Indiana facility would cause undue hardship to the member or the member's family.
- The service is not available in the immediate area.
- The member's physician complies with all the criteria set forth in this article, in accordance with the state plan and 42 CFR 456.3.

## Out-of-State Suppliers of Medical Equipment

To be treated as an in-state provider, any out-of-state supplier of medical equipment must comply with the following:

- Maintain an Indiana business office, staffed during regular business hours, with telephone service.
- Provide service, maintenance, and replacements for Indiana Medicaid members whose equipment has malfunctioned.

- Qualify with the Indiana Secretary of State as a foreign corporation.

## Prior Authorization

Prior authorization (PA) is required for out-of-state services when they are provided to IHCP members with the following exceptions:

- Emergency services provided out-of-state are exempt from PA; however, continuation of inpatient treatment and hospitalization is subject to the PA requirements of Indiana and must be requested within 48 hours of admission.
- Recipients of the adoption assistance program placed outside of Indiana will receive approval for all routine medical and dental care provided out-of-state.

PA may be granted for any time period from one day to one year for out-of-state medical services listed above as long as the service meets the criteria for medical necessity, and any one of the above criteria is also met.

PA will not be approved for the following services outside Indiana and are not covered when provided by any out-of-state provider or designated out-of-state providers:

- Nursing facilities, Intermediate Care Facilities for the Intellectually Disabled (ICFs/ID), or home health agency services
- Any other long term care (LTC) facility, including facilities directly associated with or part of an acute general hospital
- Any provider type that is not eligible for enrollment in the IHCP

## Billing and Coding

For further billing information, see the [Out-of-State Providers](#) provider reference module.

## Rules and Citations

[405 IAC 5](#)

•

[IHCP Provider Bulletins](#)

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[IHCP Provider Banners](#)

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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

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## Podiatry Services

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### Description of Service

Podiatry is a specialized practice focusing on the study and care of the foot and related structures, including its anatomy, pathology, and medical and surgical treatment.

### Medical Policy

#### Office Visits

The IHCP covers podiatric office visits, subject to the following restrictions:

- Reimbursement is limited to one (1) office visit, per 12 months.
- Reimbursement for a new patient office visit is limited to one (1) office visit, per member, per provider, within the last three (3) years.

Reimbursement is not available for the following types of extended or comprehensive office visits:

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

A new patient is “one who has not received professional services from the provider or another provider of the same specialty who belongs to the same practice within the last three years.”

#### Routine Foot Care Restrictions

The IHCP covers routine foot care only if a medical doctor or doctor of osteopathy has seen the patient for treatment or evaluation of a systemic disease during the six-month period prior to rendering routine foot care services.

The IHCP may provide reimbursement for a maximum of six (6) routine foot care services per year only when the member:

- Has a systemic disease of sufficient severity that unskilled performance of the procedure would be hazardous; and
- The systemic condition has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet.

Routine foot care includes the following:

- Cutting or removal of corns, calluses, or warts (including plantar warts)
- Trimming of nails, including mycotic nails
- Treatment of fungal (mycotic) infection of the toenail is routine foot care only when:
  - Clinical evidence of infection of the toenail is present; and
  - Compelling medical evidence exists documenting that the member has either marked limitation of ambulation requiring active treatment of the foot or, in the

case of non-ambulatory members, has a condition that is likely to result in significant medical complications in the absence of such treatment.

### **Prior Authorization for Routine Foot Care**

PA for routine foot care is not required. However, no more than six visits per year are covered. The patient must have been seen by an MD or doctor of osteopathy for treatment or evaluation of the systemic disease during the six-month period prior to the rendering of routine foot care services.

### **Doppler Evaluations**

The IHCP may provide reimbursement for ultrasonic measurement of blood flow (Doppler evaluation) providing prior authorization has been obtained for the proposed medical procedure and is subject to the following limitations:

- There is a preoperative diagnosis of diabetes mellitus, peripheral vascular disease, or peripheral neuropathy.
- The measurement is for preoperative podiatric evaluation.
- The measurement cannot be used for routine screening.
- The measurement cannot be used as an evaluation of routine foot care procedures, including such services as removal or trimming of corns, calluses, and nails.
- The preoperative Doppler evaluation is limited to one per year.

### **Surgical Procedures**

The IHCP may reimburse for the following podiatric surgical procedures without PA:

- Drainage of skin abscesses of the foot
- Drainage or injections of a joint or bursa of the foot
- Surgical cleansing of the skin
- Trimming of skin lesions of the foot, other than those identified as included in routine foot care services
- The IHCP allows surgical procedures other than those mentioned above, performed within the scope of the podiatrist's license, subject to PA, as specified in *405 IAC 5-26*. For covered, paid claims, the IHCP pays 100 percent of the IHCP allowance for the major procedure and 50 percent of the IHCP allowance for subsequent procedures.

### **Second Opinions**

Podiatrists may be required to obtain a confirmatory consultation, in accordance with the guidelines for consultations and second opinions at *405 IAC 5-8-4*, to establish medical necessity for the following podiatric surgical procedures:

- Bunionectomy procedures
- All surgical procedures involving the foot

A confirmatory consultation is required regardless of the surgical setting in which the surgery is performed, including ambulatory surgical centers, hospitals, clinics, or offices.

### **Laboratory or X-Ray Services**

The IHCP may reimburse for laboratory or X-ray services provided by a podiatrist only if the services are rendered by or under the personal supervision of the podiatrist. Services ordered by a podiatrist, but performed by a laboratory or X-ray facility, will be billed directly to the IHCP by the laboratory or X-ray facility. The podiatrist may be reimbursed for handling or conveyance of a specimen sent to an outside laboratory in accordance with *405 IAC 5-18*. Reimbursement is not available for comparative foot x-rays, unless prior authorized. The IHCP may reimburse for the following lab and X-ray services billed by a podiatrist:

- Cultures for foot infections and mycotic (fungal) nails for diagnostic purposes
- Sensitivity studies for treatment of infection processes
- Medically necessary pre-surgical testing

All services provided by the podiatrist must be performed within the scope of practice for podiatric medicine. Reimbursement for other surgical procedures performed within the scope of the podiatrist's license may be available, subject to the PA requirements of *405 IAC 5-3*.

### **Orthopedic or Therapeutic Footwear**

The IHCP may reimburse when a podiatrist renders orthotic services covered by Medicare for all eligible members receiving Medicare and Traditional Medicaid. With a physician's written order, the IHCP may provide reimbursement for the following for members of all ages:

- Corrective features built into shoes such as heels, lifts, wedges, arch supports, and inserts
- Orthopedic footwear, such as, shoes, boots, and sandals
- Orthopedic shoe additions

If a member currently has a brace, the IHCP covers the shoes and supportive devices if providers document continued medical necessity. The IHCP also provides coverage for therapeutic shoes for members with severe diabetic foot disease.

### **Prior Authorization**

PA is required for the following services:

- Hospital stays, as outlined in *405 IAC 5-17*
- When a podiatrist prescribes or supplies corrective features built into shoes, such as heels, lifts, and wedges, for a recipient under 21 years old
- When a podiatrist fits or supplies orthopedic shoes for a recipient with severe diabetic foot disease, subject to the restrictions and limitations outlined in *405 IAC 5-19*
- Comparative foot X-rays

## Billing and Coding

For further billing information, see the [Podiatry Services](#) provider reference module. For a list of billing codes, see the *Podiatry Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

### [405 IAC 5](#)

### [IHCP Provider Bulletins](#)

- [BT201320](#) Update regarding reduction in reimbursement for podiatry services

### [IHCP Provider Banners](#)

- [BR201728](#) IHCP establishes a Podiatry Services Code Set

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

July 11, 2017 – Created a podiatry services code set

## Radiology Services

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### Description of Service

Radiology is the branch of medicine that uses radioactive substances, electromagnetic radiation, and sound waves to create images of the body, its organs, and structures for diagnosis and treatment. Radiology can be classified broadly into diagnostic radiology and therapeutic radiology. Diagnostic radiology is the interpretation of images of the human body to aid in the diagnosis or prognosis of disease. Therapeutic radiology utilizes radiation to treat cancer and other diseases.

### Medical Policy Radiology Services

Medicaid reimbursement is available to radiology inpatient and outpatient facilities, freestanding clinics, and surgical centers for services provided to IHCP members. Radiological services must be ordered in writing by a physician or other practitioner authorized to do so under state law.

Criteria for the use of radiological services include consideration of the following:

- Evidence that this radiological procedure is necessary for the appropriate treatment of illness or injury.
- X-rays of the spinal column are limited to cases of acute documented injury or a medical condition in which interpretation of X-rays would make a direct impact on the medical or surgical treatments.
- Reimbursement is available for X-rays of the extremities and spine for the study of neuromusculoskeletal conditions.

Reimbursement is not available for radiology examinations of any body part taken as a routine study not necessary for the diagnosis or treatment of a medical condition. Situations generally not needing radiology services include, but are not limited to the following:

- Fluoroscopy without films
- Pregnancy
- Premarital examinations
- Research studies
- Routine physical examinations or check-ups
- Screening, pre-operative chest X-ray

Providers must document all services related to radiological examinations in the patient's record.

Radiology providers are required to submit copies of their Registration Certificates, ISDH Notices of Compliance, and operator certificates for all employee operators except PET CT scanner operators. Please note that PET and MRI services do not require certification or Notices of Compliance.



Out-of-state mobile radiology providers performing services in Indiana must be certified in Indiana and possess Notices of Compliance in Indiana. All operators must be certified in the state of Indiana.

### **CT Scans**

Reimbursement may be available for diagnostic examination of the head and of other parts of the body, head scans, and body scans, performed by CT scanners, subject to the following restrictions:

- The scan should be reasonable and necessary for the individual patient.
- The use of a CT scan must be found to be medically appropriate, considering the patient's symptoms and preliminary diagnosis.
- Reimbursement is made only for CT scans performed with equipment certified by the Food and Drug Administration (FDA).
- Whole abdomen or whole pelvis scans on more than 20 cuts is not reimbursed, except in staging cancer for treatment evaluation.

### **Radionuclide Bone Scans**

Reimbursement is available for radionuclide bone scans when performed for the detection and evaluation of suspected or documented bone disease.

### **Gastrointestinal Studies**

Reimbursement is available for upper gastrointestinal (GI) studies when performed for detection and evaluation of diseases of the esophagus, stomach, and duodenum. An upper GI study is not a covered service for a patient with a history of duodenal or gastric ulcer disease unless recently symptomatic. An upper GI study is not a covered service in the pre-operative cholecystectomy patient unless symptoms indicate an upper GI abnormality in addition to cholelithiasis, or if the etiology of the abdominal pain is uncertain.

### **Stereotactic Radiosurgery (SRS)**

IHCP covers three types of non-robotic cranial and total body SRS: particle beam (proton), cobalt-60 (gamma, photon), and linear accelerator (linac).

### **Prior Authorization for Radiology Services**

Prior authorization is required for any radiological services that exceed the use parameters set out in this document.

### **Positron Emission Tomography (PET) Scans**

PET is a non-invasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting, radioactive tracer substances (radiopharmaceuticals) that are administered intravenously to the patient.

The IHCP reimburses radiology inpatient and outpatient facilities and freestanding clinics for services provided to members. The following criteria apply:

- There must be sufficient evidence that the radiological procedure is necessary for the appropriate treatment of illness or injury.
- For a radiological service, a physician or other practitioner authorized to do so under state law must order the service in writing.
- The IHCP does not reimburse for radiology examinations of any body part as a routine study not necessary for the diagnosis or treatment of a medical condition.
- Providers must document all services related to radiological examinations in the patient's records.

The following diagnosis codes support medical necessity for PET scans:

### ICD-10-CM Codes Supporting Medical Necessity

Pet Scan Imaging	CPT® Code	ICD-10-CM Code
Breast Cancer	78811, 78812, 78814, 78815	C50.011 - C50.929
Myocardial perfusion imaging	78459, 78491, 78492	I20.0 – I20.9, I24.0, I24.8, I24.9, I25.2, , I25.5, I25.89, I25.9, I25.10, I25.810 – I25.812
Refractory seizures	78608, 78609	G40.A11, G40.A19, G40.311, G40.411, G40.A01, G40.A09, G40.301, G40.211, G40.219, G40.111, G40.119, G40.823, G40.824, , G40.804, G40.911, G40.919
Regional or whole body, for single pulmonary nodule	78811, 78812, 78813, 78814, 78815, 78816	C80.0, D38.1, D49.1, R91.1, R91.8
Thyroid cancer	78811, 78812, 78814, 78815	C73
Whole body, for colorectal cancer	78813, 78815, 78816	C18.0 – C18.9, , C19, C20, C21.1, C78.5, C80.0, Z85.038, Z85.048
Whole body, for esophageal cancer	78813, 78815, 78816	C15.3 – C15.9, C80.0, Z85.01
Whole body, for melanoma	78813, 78816	C43.0 – C43.9, C80.0, Z85.820
Whole body, for non-small cell lung carcinoma	78811, 78812, 78813, 78815, 78816	C34.00 – C34.92, C77.1, C80.0, J98.4, Z85.118
Whole body, for lymphoma	78813, 78816	C80.0, C81 – C86.6, C91 – C96.2, R59.0, R59.1, R59.9, Z85 – Z85.9
Whole body, or regional, for head and neck cancer	78811, 78812, 78813, 78815, 78816	C00.0-C14.8, C30-C33, C41.0, C41.1, C44.00-C45, C47.0, C49.0, C69-C70, C75.0-C76.0, Z85.20-Z85.22, Z85.810-Z85.89
Other	78815	C25.9, C53.9, C90.00

## Billing and Coding

For further billing information, see the [Radiology Services](#) provider reference module.

## Rules and Citations

### [405 IAC 5](#)

- 405 IAC 5-27 Radiology Services

### [IHCP Provider Bulletins](#)

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### [IHCP Provider Banners](#)

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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial publication

## Surgical Services

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### Description of Service

Surgical services are services for a member requiring or seeking medically necessary peri-operative care. These include, but are not limited to, pre-operative preparation, the operating room, recovery room, outpatient admitting and discharge. Prior to the performance of a surgical procedure, either inpatient or outpatient, the member consults with the surgeon who will be performing the procedure. The visit may occur in the physician's office, in the emergency room, in the outpatient surgery area, or an Ambulatory Surgical Center (ASC).

Surgical procedures are based on the global concept that includes three parts: preoperative management, intraoperative (surgical) care, and postoperative management.

Plastic or reconstructive surgery is intended to restore the normal appearance or function of tissues or body structures that are missing, defective, damaged, misshapen, or have been significantly altered due to disease, trauma, surgery, or congenital anomalies. When a significant functional impairment is present, reconstructive services may be considered medically necessary.

The IHCP covers reconstructive or plastic surgery for congenital defects, developmental anomalies, trauma, infection, tumors, or disease. The primary goal of reconstructive surgery is to improve function, but may also be performed to reshape abnormal structures of the body, and/or to allow a person to have a more normal appearance.

### Medical Policy

#### Preoperative Office Visits and Post-operative Care

A surgical procedure generally includes the preoperative visits performed on the same day or the day prior to the surgery for major surgical procedures, and the day of the surgical procedure for minor surgical procedures.

The postoperative care days for a surgical procedure include 90 days following a major surgical procedure and 10 days following a minor surgical procedure.

#### Removal of Implants

The IHCP provides reimbursement for removal of medical implants (i.e., pins, screws, rods, plates, etc.) when a fracture has healed or the symptoms that required implantation of the device abate. Implant removals requiring an operating room are usually considered minor procedures and the rules governing minor procedures in 405 IAC 5-28-1 apply. Some implants may be removed in the physician's office.

#### Perioperative Encounters

The following perioperative encounters require additional/specific documentation:

- Surgery Payable at Reduced Amount When Related Post-Operative Care Paid
- Post-Operative Care Within 0-90 days of Surgery
- Pre-Operative Care on Day of Surgery
- Surgery Payable at Reduced Amount When Pre-Operative Care Paid Same DOS

To explain the above situations, the IHCP requires that the provider submit the following documentation:

- Medical reason and unusual circumstances for the separate E/M visit
- The medical necessity of visit occurring due to a complication, such as cardiovascular complications, comatose conditions, elevated temperature for two or more consecutive days, medical complications due to anesthesia other than nausea and vomiting, post-operative wound infection requiring specialized treatment, or renal failure

## Surgeon and Assistant Surgeon

A member may require two procedures coincidentally by two different surgical specialists. Each surgeon may serve as the assistant surgeon during the other surgeon's procedure. Each surgeon may bill as primary surgeon for that portion of surgery for which he/she was responsible.

Physician as an assistant surgeon is available with the following restrictions:

- If extenuating circumstances require an assistant surgeon when customarily one is not required:
  - The circumstances must be well documented in the hospital record; and
  - Documentation must be attached to the claim form.
- Reimbursement is not available for a surgical assistant who assists in diagnostic surgical procedures or for minor surgical procedures.
- Reimbursement is limited to the procedures that generally require the skills and services of an assistant surgeon as set out in HCPCS.

## Wound Closure

There are times that it is not advisable to close an operative incision at the time of the initial surgical procedure based on the wound classification (i.e. clean, clean-contaminated, contaminated, dirty). The patient may remain in the hospital for observation and return to the operating room for secondary wound closure. Secondary closure after the initial surgical procedure may be considered part of the initial surgery and part of the global fee schedule.

However, when a dehiscence occurs in the immediate post-operative period, the patient may return to the operating room for suturing as an emergency procedure. Dehiscence of a wound is considered a complication of the primary procedure. As an emergency procedure, the rules pertaining to emergency procedures will apply.



## Split Care

Split care occurs when a component of the global surgery is rendered by a physician other than the physician performing the surgical service. Although there are three surgical procedure components, the Indiana Health Coverage Programs (IHCP) only recognizes split billing for two of the components: intraoperative and postoperative care. It is expected that the physician performing the intraoperative portion will perform the preoperative service.

## Bariatric Surgery and Revisions

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

Morbid obesity is defined as a body mass index (BMI)<sup>1</sup> of at least 35 kilograms per meter squared, with comorbidity or co-existing medical conditions, such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or a BMI of at least 40 kilograms per meter squared without comorbidity.

### Restrictive Operations

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

- Adjustable gastric banding – A band creating a gastric pouch with a capacity of approximately 15 to 30 cc’s encircles the uppermost portion of the stomach. The band is an inflatable doughnut-shaped balloon, the diameter which can be adjusted in the clinic by adding or removing saline via a port that is positioned beneath the skin. The bands are adjustable, allowing the size of the gastric outlet to be modified as needed, depending on the rate of a patient’s weight loss. ABG procedures are laparoscopic only.
- Vertical banded gastroplasty (VBG) – VBG involves stapling of the upper part of the stomach, creating a narrow gastric inlet or pouch that remains connected with the remainder of the stomach. Also, a non-adjustable band is placed around this new inlet in an attempt to prevent future enlargement of the stoma (opening). As a result, the patient experiences a sense of fullness after eating small meals.
- Sleeve gastrectomy – Sleeve gastrectomy is a 70%-80% greater curvature gastrectomy (sleeve resection of the stomach) with continuity of the gastric lesser curve being maintained while simultaneously reducing stomach volume. Sleeve gastrectomy procedures can be open or laparoscopic.

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<sup>1</sup> Body mass index is equal to weight in kilograms divided by height in meters squared

## Malabsorptive Operations

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

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

## Coverage for Bariatric Surgeries

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

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

**or**

  - Member has successfully achieved weight loss after participating in a physician-supervised nonsurgical medical treatment, but has been unsuccessful at maintaining weight loss for two years ( > 3-kilogram [6.6-pound] weight gain).

Successful weight-loss therapy is defined as the ability to reduce body weight by approximately 10% from baseline in a period of eight months. Unsuccessful weight-loss maintenance is defined as a weight regain of > 3 kilograms (6.6 pounds) in two years and the inability to maintain a sustained reduction in waist circumference of at least 4 centimeters.

Members younger than 21 years of age must have documentation in the medical record by two physicians who have determined bariatric surgery is necessary to save the life of the member or restore the member's ability to maintain a major life activity defined as self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency. In addition, the member has reached sexual maturity and has reached a Tanner Scale stage IV or V plus 95 percent of predicted adult stature based on bone age.

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

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- A psychological or psychiatric evaluation by a health service provider in psychology (HSPP) or a psychiatrist is required before surgery. Members with one or more of the following contraindications will not be candidates for bariatric surgery:
  - Active abuse of alcohol, illicit or social drugs and other chemicals, or tobacco use during the six months before the request
  - Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for bulimia or binge-eating disorder (BED)
  - Other eating patterns that are deemed likely to interfere with postsurgical safety and success
  - Active psychosis
  - Uncontrolled depression
  - Borderline personality disorder
  - Other complex psychiatric problems that might interfere with a successful weight-loss outcome
- Member is able to understand, tolerate, and comply with all phases of care and is committed to long-term follow-up requirements.
- Member is abstinent from alcohol use, illicit drug use, and tobacco use; member has a negative urine drug screen.
- Member's treatment plan includes preoperative and postoperative dietary evaluations.
- Member has received a thorough explanation of the risks, benefits, and possible complications of the procedure.
- Member's postoperative expectations have been addressed before the bariatric surgery.
- Member has agreed in writing to participate in all preoperative and postoperative evaluations and sessions considered essential to his or her having a successful outcome to the bariatric surgery.

### **Additional Criteria for Children under the age of 18**

Individuals under 18 years of age must meet the following criteria:

- The member has reached sexual maturity and has reached a Tanner Scale stage IV or V plus 95 percent of predicted adult stature based on bone age
  - BMI > 35 with at least one severe comorbidity listed below that has significant short-term effects on health that is uncontrolled with lifestyle or pharmacotherapy management:
    - Type II diabetes mellitus,
    - Moderate to severe sleep apnea [apnea-hypopnea index"15],
    - Severe Non-alcoholic steatohepatitis, and
    - Pseudotumor cerebri
- or**
- The member has reached sexual maturity and has reached a Tanner Scale stage IV or V plus 95 percent of predicted adult stature based on bone age
  - BMI  $\geq$  40 with at least one comorbidity listed below that is uncontrolled with lifestyle or pharmacotherapy management:
    - hypertension,
    - insulin resistance,
    - glucose intolerance,

- substantially impaired, quality of life or activities of daily living,
- dyslipidemia, and
- sleep apnea with apnea-hypopnea index "5

## **Non-covered Services for Bariatric Surgeries**

The IHCP does not reimburse for the following:

- Procedures that are considered investigational or not meeting safety or efficacy standards will not be covered. The following procedures are not covered by the IHCP (this list may not be all-inclusive):
  - Fobi-Pouch (limiting proximal gastric pouch)
  - Gastroplasty (stomach stapling)
  - Intestinal bypass (jejunoileal bypass)
  - Intragastric balloon
  - Loop gastric bypass
  - Mini-gastric bypass.
  - Natural orifice transluminal endoscopy surgery (NOTES), e.g., StomphyX is not covered
  - Panniculectomy following gastric bypass procedures performed for cosmetic reasons, even if performed incidentally to a ventral herniorrhaphy, is a non-covered service.
  - Laparoscopic Adjustable Gastric banding (LAGB), for children under the age of 18. LAGB is considered investigational for children under the age of 18

## **Prior Authorization for Bariatric Surgeries**

Prior authorization is required for all bariatric surgeries as described per *405 IAC 5-3-13*.

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

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

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

**Note:** HIP Plus members are eligible for bariatric surgery when they meet the following criteria:

- Member must have morbid obesity that has persisted for at least five years duration, and physician-supervised non-surgical medical treatment has been unsuccessful for at least six consecutive months; **OR**
- Member has successfully achieved weight loss after participating in physician-supervised non-surgical medical treatment but has been unsuccessful at maintaining weight loss for two years ( > 3 kg/6.6 lbs. weight gain).

## Surgical Revisions for Bariatric Surgery

Members may require subsequent surgery because of a complication during the perioperative period. They may also require a revision to correct a postoperative technical failure. Re-operation to repair a complication or to correct a technical failure requires PA. Examples of perioperative complications of surgery include but are not limited to the following:

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

Postoperative technical failures of the primary operation include but are not limited to the following:

- Staple-line disruption – documented by x-ray or endoscopy
- Gastrogastic fistula with weight gain
- Expanded outlet – documented by gastroscopy
- Enlarged anastomosis – documented by gastroscopy
- Intolerance to solid food after a band procedure
- Intractable reflux after a band procedure
- Weight loss as a result of anastomotic stenosis
- Stomal ulceration



## **Prior Authorization Requirements for Surgical Revisions for Bariatric Surgery**

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

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

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

## **Maxillofacial Surgery**

Maxillofacial surgery includes the diagnosis and surgical treatment of congenital or acquired diseases, dysfunction, defects, or injuries of the mouth, jaws, face, neck, and associated regions. Maxillofacial surgical services are provided by individuals licensed to practice dentistry and who have completed an approved residency in oral surgery. They must be eligible for certification by the Board of Oral and Maxillofacial Surgery, or they must be physicians who have completed residency training in plastic surgery who are eligible for certification by the American Board of Plastic Surgery

IHCP providers are required, based upon the facts of the case, to obtain a second or third opinion substantiating the medical necessity or approach for maxillofacial surgery related to diseases or conditions of the jaws and contiguous structures. The second opinion is required regardless of the surgical setting in which the surgery is to be performed.

The IHCP provides coverage for maxillofacial surgery services. Providers may be required, based on the facts of the case, to obtain a second or third opinion substantiating the medical necessity or approach for maxillofacial surgery related to disease, and conditions of the jaw and contiguous structures, regardless of the setting in which the procedure is performed.

The following maxillofacial services are covered by the IHCP:

- Orthognathic (jaw realignment) surgery with or without osteotomy
- Treatment of TMJ syndrome
- Removal of non-cancerous cysts, tumors, and growths of the oral and facial region
- Surgical removal of impacted teeth
- Treatment of facial fractures
- Treatment of soft tissue trauma
- Osseointegrated (bone anchored) implants, including dental and craniofacial implants
- Adjunctive treatment of sleep apnea, including mandibular advancement splints and jaw advancement surgery
- Reconstructive surgery for disease or trauma
- Salivary gland surgery
- Radiology services for evaluation of maxillofacial anomalies
- Anesthesia services for maxillofacial surgery

## **Transcatheter placement of intravascular stents**

The IHCP covers transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed.

### **Prior Authorization for Transcatheter placement of intravascular stents**

Prior authorization is required and is limited to members with stenosis at or above 70% for whom all other additional medical treatments have failed.

## **Sinus Surgery**

The IHCP covers sinus surgery.

### **Functional endoscopic sinus surgery (FESS)**

FESS is considered medically necessary for the treatment of sinusitis, polyposis, or sinus tumor when any one of the following:

- Suspected tumor seen on imaging, physical examination, or endoscopy
- Suppurative (pus forming) complications, including but are not limited to
  - Subperiosteal abscess
  - Brain abscess
- Chronic polyposis with symptoms unresponsive to medical therapy
- Allergic fungal sinusitis, with all of the following:
  - Nasal polyposis
  - Positive CT findings
  - Eosinophilic mucus
- Mucocele causing chronic sinusitis
- Recurrent sinusitis with significant associated comorbid conditions
- Uncomplicated sinusitis (such as confined to paranasal sinuses without adjacent involvement of neurologic, soft tissue or bony structures) and all of the following:
  - Either of the following:
    - Four or more documented episodes of acute rhinosinusitis (for example, less than 4 weeks duration) in one year

- Chronic sinusitis (for example, greater than 12 weeks duration) that interferes with lifestyle
- Maximal medical therapy has been attempted, with all of the following:
  - Antibiotic therapy for at least 4 consecutive weeks
  - Trial of inhaled steroids
  - Nasal lavage
  - Allergy testing (if symptoms are consistent with allergic rhinitis and have not responded to appropriate environmental controls and pharmacotherapy)
- Abnormal findings from diagnostic work-up, with any one of the following
- CT findings suggestive of obstruction or infection
- Nasal endoscopy findings suggestive of significant disease
- Physical exam findings suggestive of chronic/recurrent disease
- Fungal mycetoma
- Previously failed sinus surgery
- Cerebrospinal fluid rhinorrhea
- Nasal encephalocele
- Posterior epistaxis (relative indication)
- Persistent facial pain after other causes ruled out (relative indication)
- Cavernous sinus thrombosis caused by chronic sinusitis

### **Balloon sinus ostial dilation**

Balloon sinus ostial dilation is medically necessary for treating chronic rhinosinusitis when all of the following are met:

- Rhinosinusitis lasting longer than 12 weeks
- Chronic rhinosinusitis of the sinus to be dilated is confirmed on computed tomography (CT) scan. CT scan findings of chronic rhinosinusitis include one or more of the following
  - Mucosal thickening,
  - Bony remodeling,
  - Bony thickening or
  - Obstruction of the ostiomeatal complex
- Balloon sinus ostial dilation is limited to the frontal, maxillary or sphenoid sinuses
- Balloon sinus ostial dilation is performed either as a stand-alone procedure or as part of functional endoscopic sinus surgery (FESS)
- Balloon sinus ostial dilation is performed in persons older than 12 years of age whose symptoms persist despite medical therapy with one or more of the following:
  - Nasal lavage
  - Antibiotic therapy, if bacterial infection is suspected
  - Intranasal corticosteroids

### **Orthognathic Surgery (Jaw Realignment)**

Orthognathic surgery is the revision of the upper jaw (maxilla) and/or the lower jaw (mandible) by ostectomy, osteotomy, or osteoplasty, and is intended to alter the relationship of the jaws and teeth. These surgical procedures are intended to correct jaw and cranio-facial deformities

that are associated with significant functional impairment, or to reposition the jaws when conventional orthodontic therapy is unable to correct dental malocclusion.

The IHCP reimburses orthognathic surgery to correct jaw and craniofacial deformities causing significant functional impairment for members with congenital abnormality present at birth, or to treat a significant accidental injury, infection, or tumor when one or more of the following clinical indications are met:

### **Anteroposterior discrepancies**

- Maxillary/mandibular incisor relationship: overjet of 5 mm or more, or a value less than or equal to zero (norm 2 mm)
- Maxillary/mandibular anteroposterior molar relationship discrepancy of 4 mm or more (norm 0 to 1 mm)
- These values represent two or more Standard Deviations (SD) from published norms.

### **Vertical discrepancies**

- Presence of a vertical facial skeletal deformity which is two or more SDs from published norms for accepted skeletal landmarks
- Open bite
  - No vertical overlap of anterior teeth
  - Unilateral or bilateral posterior open bite greater than 2 mm
- Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch
- Supraeruption of a dentoalveolar segment due to lack of occlusion

### **Transverse discrepancies**

- A transverse skeletal discrepancy which is two or more SDs from published norms
- Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth

### **Asymmetries**

- Presence of anteroposterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry. One of the following symptoms must be present due to the malocclusion:
  - Difficulty swallowing and/or choking, or ability to chew only soft or liquid food; symptoms must be documented in the medical record, must be significant, and must persist for at least four months.
  - Other causes of swallowing and/or choking problems must have been ruled out by history, physical exam, and/or appropriate diagnostic study including, but not limited to, allergies, neurologic or metabolic diseases, and hypothyroidism
  - Speech abnormalities have been determined by a speech pathologist or therapist to be due to the malocclusions and have not been improved by ST or orthodontia

- Malnutrition must be related to the inability to masticate; significant weight loss must be documented over four months, and a low serum albumin exists that is related to malnutrition
- Intra-oral trauma while chewing related to malocclusion or recurrent damage to the soft tissues of the mouth during mastication
- Documentation of significant OSA that is not responsive or treatable by conservative means
- An oral surgeon or a plastic surgeon may provide orthognathic surgical services as the maxillofacial specialist performing the procedure. Other specialists, such as an orthodontist or otolaryngologist, may be required to assist with the procedure. The procedure may be performed in an inpatient hospital, outpatient hospital, or ASC.
- Anesthesia for orthognathic surgery may be performed by an anesthesiologist or certified nurse anesthetist, as medically appropriate.

## Facial Plastic and Reconstructive Surgeries

Facial plastic surgery is a general term for any surgery that proposes to alter the appearance of the face and includes the restoration of appearance after accidental injury or correction of a physical functional impairment caused by an accidental injury, a congenital anomaly, disease, or previous therapeutic process. Reconstructive surgery may require completion in staged procedures.

IHCP reimburses for facial plastic or reconstructive surgery related to disease or trauma, specifically for surgery that alters the appearance of the lower face including the upper jaw, lower jaw, and chin. Surgery for these portions of the face may be considered cosmetic or may be indicated when severe abnormalities result in functional impairment affecting the ability to eat, swallow, or breathe. Procedures may be indicated to correct or restore appearance following traumatic injuries, or following medical or surgical treatments resulting in anatomical changes.

### Prior Authorization for Facial Plastic and Reconstructive Surgeries

PA is obtained for medically necessary surgical procedures to remove excess skin from the face and tighten the muscles of the face to correct a facial abnormality caused by functional impairments, disease, or injury-related facial changes – for example, following burn injury or facial palsy from neurologic disease.

## Craniofacial Deformities

Major mid-face craniofacial deformities of the facial bones or skull may require corrective reconstructive surgeries due to abnormal development in position, size, or shape. There are multiple diagnoses, such as Crouzon, Apert, Pfeiffer, Saethre-Chotzen, Carpenter, and Antley-Bixler that cause restricted growth of the mid-face. Members with these craniofacial mid-face diseases often require long-term monitoring of the ears, nose, and throat for occurrence of the following conditions frequently related to mid-face anomalies:

- Vision, hearing, speech, and language disabilities
- Learning disabilities



- Orthodontic problems due to abnormal shape and position of the jaw
- Abnormalities in the facial skeleton about the orbits, maxilla, and mandible
- Skull deformities, including a narrow width and an elongation from front to back
- Triangularly shaped skull, often with ridging in the midline of the forehead
- Flattening of the forehead on one side with bulging on the opposite side
- Proptosis (bulging eyes)
- Strabismus (wandering eye)
- Dry eyes
- Corneal ulcers
- Blindness (if corneal damage is untreated)
- Upper airway obstruction with sleep apnea (partial or complete cessation of respiration during sleep)

### **Rhinoplasty and Septoplasty**

Nasal deformities may be congenital or acquired. Rhinoplasty that changes the shape or size of the nose is considered medically necessary when performed as a result of disease, structural abnormality, previous therapeutic process, or reconstruction due to trauma.

#### **Prior Authorization for Rhinoplasty and Septoplasty**

Rhinoplasty may be required to treat a cleft lip or cleft palate. PA is not required for members receiving rhinoplasty surgery related to a documented, primary diagnosis of cleft lip and/or cleft palate. Please refer to information in this section regarding cleft lip and cleft palate services for additional information.

Septoplasty is the surgical procedure to correct defects or deformities of the nasal septum, often by alteration or partial removal of skeletal structures. Septoplasty is considered medically necessary when a functional impairment does not respond to medical management treatment.

All of the following criteria must be documented in the member's medical record to confirm the medical necessity for these services:

- Documentation of the extent of the deformity and associated symptoms
- Documentation of the plan for surgical correction
- Photographs to verify a plan that includes multiple surgeries
- H&P, including any problems/congenital deformities that could potentially affect the outcome of the requested procedure
- Documented evidence of family/caregiver education about the POC and special health care needs of the member, pre and post op
- Statement that the requested surgery is expected to correct a specified portion of the deformity
- Statement that the requested surgery is expected to improve the member's functional status

Congenital birth defects have a variety of presentations, including cleft nasal deformity, which may be associated with cleft lip and/or cleft palate. Cleft nasal deformity is characterized by distorted, abnormally developed nasal structures. Deviations in the septum can alter normal airflow, which may result in mucosal changes. This interference in airflow may cause middle or inferior turbinate abnormalities. Additionally, sinus drainage may be compromised by deviation of the septum and can result in recurrent or chronic sinusitis. Surgical correction of congenital birth defects may involve staged procedures, flaps, or grafts.

Rhinoplasty is medically necessary when performed for correction or repair of the following conditions:

- Nasal deformity secondary to a cleft lip/palate or other congenital craniofacial deformity causing functional impairment
- Chronic, non-septal, nasal obstruction due to vestibular stenosis (collapsed internal valves) secondary to trauma, disease, or congenital defect, when both of the following criteria are met:
  - Documentation of the member's condition
  - Nasal airway obstruction unresponsive to a recent trial of conservative medical management that either has not resolved or would not be expected to resolve with septoplasty/turbinelectomy alone

Septoplasty is medically necessary when performed for the following conditions:

- Recurrent epistaxis related to septal deformity
- Asymptomatic septal deformity that prevents access to other transnasal areas when such access is required to perform medically necessary procedures (e.g., ethmoidectomy)
- In association with cleft lip or cleft palate repair
- Obstructed nasal breathing due to septal deformity or deviation that is unresponsive to medical management and is interfering with the effective use of medically necessary CPAP for treatment of obstructive sleep disorder

## External Ear Disorders

Microtia is a condition defined by an external ear that is not fully formed. Often, there is an associated malformation of the external auditory canal and the middle ear bones that transmit vibration of the eardrum to the cochlea. These anomalies occur as a part of many developmental anomalies of the head and neck. Conductive hearing loss may be associated with an abnormality of the external ear canal or middle ear. If hearing loss occurs in both ears, hearing aid devices may be considered to regain functional hearing ability.

## Facial Nerve Disorders

Facial nerve disorders often result from inflammation, infection, injury, or tumors in the nerve tissue. Common symptoms of facial nerve disorders include, but are not limited to, the conditions listed below:

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- Numbness of the face
- Dryness of the eye secondary to reduced tear production
- Dryness of the mouth secondary to reduced saliva production
- Eyelid retraction and poor blinking mechanism
- Malpositioned eyelid and eyebrow
- Abnormal facial movement
- Facial twitching and/or spasms
- Disturbance of taste
- Restricted breathing
- Weakness of the arm, fingers, and hand on the same side as the facial weakness

Many types of nerve anomalies necessitate multiple operative procedures occurring at different stages of skeletal development. When facial nerve injury occurs, treatment may include repair or grafting of nerve tissue. The treatment of neurologic disorders may require surgery that includes the following procedures:

- Facial nerve decompression
- Nerve repair and grafting
- Re-innervation techniques
- Regional muscle transfers
- Free muscle transfers

Physical Therapy (PT) will improve functional outcomes allowing surgical repair of facial nerves, especially for patients requiring tissue transfer. PT utilizes facial neuromuscular retraining to optimize the motor control of facial muscles.

## **Blepharoplasty**

Blepharoplasty is a surgical procedure that removes excess skin and fatty tissue around the eyes. The IHCP provides reimbursement for blepharoplasties to improve abnormal function resulting in significant loss of visual field or to reconstruct deformity due to trauma or disease. Reimbursement is not provided for blepharoplasties to enhance the appearance of the eyes.

### **Prior Authorization for Blepharoplasty**

PA is required for all blepharoplasties, and documentation must support the medical necessity to improve abnormal function, which has resulted in significant visual field loss or to reconstruct deformity due to trauma or disease. PA will be granted for blepharoplasty under the following indications:

- Upper eyelid blepharoplasty to relieve obstruction of central vision when all of the following criteria are met:
  - Visual field test without the eyelid or brow taped shows points of visual loss inside the 25° circle of the superior field, and

- Visual field test with the eyelid or brow taped shows improvement in the superior field with no visual loss inside the 40° circle of the superior field, and
  - A photograph of the patient looking straight ahead shows the eyelid at or below the upper edge of the pupil.
- Upper eyelid blepharoplasty for upper eyelid position that is contributing to prosthesis difficulties in an anophthalmic (complete absence of the eye) socket
- Lower eyelid blepharoplasty to relieve excessive lower lid bulk secondary to systemic corticosteroid therapy, myxedema, Graves' disease, nephritic syndrome, or other metabolic or inflammatory disorders that preclude proper positioning of eyeglasses
- Upper or lower eyelid blepharoplasty to treat chronic corneal exposure and/or recurrent corneal abrasions caused by conditions such as ectropion (eyelid turning outward) or entropion (eyelid turning inward)

### **Temporomandibular Joint Syndrome (TMJ)**

TMJ syndrome or TMJ disorder is a condition resulting from macro-trauma or micro-trauma to the temporomandibular jaw joint and the surrounding muscles and tissues. Macro-trauma is usually a result of direct trauma to the TMJ. Micro-trauma is usually a chronic, indirect process that can be associated with conditions such as stress, anxiety, sleep disorders, dysfunctional occlusions, and myofascial disorders. Causes of TMJ include acute injury, clenching or grinding of the teeth, muscle spasms, dental occlusions, and degenerative joint disease. Common symptoms of TMJ include the following:

- Clicking, popping, grating, or grinding sounds when moving the jaw
- TMJ pain or stiffness while chewing, talking, or yawning
- Facial pain, especially in the ear region
- Jaw locking open or closed
- Difficulty in opening the jaw wide
- Uncomfortable bite
- Headache or earache

The IHCP will cover both non-surgical and surgical treatments for TMJ. There are several approaches to treat TMJ based on the cause and severity of the disease; however, most members can be treated without surgery. IHCP members must receive a trial of conservative therapy before surgical treatment for TMJ will be prior authorized.

### **Nonsurgical Treatment of TMJ**

Before being evaluated for surgical treatment of TMJ, documentation in the member's medical records must indicate that at least two of the following forms of non-surgical interventions have been performed without adequate relief for a total of three to six months:

- Medical Management
- Physical Therapy
- Psychiatric/psychological therapy

- Mechanical therapy is provided through removable intra-oral appliances. Intra-oral appliances are used to treat members with dysfunctional occlusions. Treatment generally lasts for up to six months.

## Medical Management

Medical management may include nonopiate analgesics and nonsteroidal anti-inflammatory drugs (NSAIDs) for mild-to-moderate inflammatory conditions and pain. Low-dosage tricyclic antidepressants may be prescribed for chronic pain, sleep disturbances, and nocturnal bruxism. Adjuvant pharmacologic therapies may include anticonvulsants, membrane stabilizers, and sympatholytic agents for unremitting pain, and opiate analgesics, corticosteroids, anxiolytics, and muscle relaxants for refractory pain. Osteopathic manipulative therapy may be included as part of the medical management. Medical management may be prescribed by a dentist, an orthodontist, an ear, nose, and throat (ENT) specialist, a psychiatrist, or an oral surgeon.

## Physical Therapy for TMJ

Physical therapy (PT) for TMJ may include active and passive jaw exercises, thermal modalities, manipulation modalities, electrogalvanic stimulation, and TENS. Cranial manipulation, continuous passive motion, diathermy, infrared, and US treatment, hydrotherapy, myofunctional therapy, iontophoresis, and neuromuscular re-education are not considered medically necessary PT treatments for TMJ.

Per 405 IAC 5-22-8 physical therapy services must be performed by a licensed physical therapist or certified therapist assistant under the direct, on-site supervision of a licensed physical therapist.

## Psychiatric/Psychological Therapy for TMJ

Psychiatric/psychological therapy may be initiated when TMJ is caused by a psychosomatic condition due to stress or anxiety. For example, bruxism, or teeth grinding, considered a psychophysiological disorder, is a common tension habit that can lead to TMJ. IHCP members without other obvious causative factors for TMJ symptoms (such as major trauma, arthritis, or jaw misalignment) should be evaluated for psychosomatic causes and treated appropriately.

The IHCP provides reimbursement for the psychiatric codes listed below relation to treatment of TMJ when services are provided by a:

- Licensed Physicians
- Licensed Psychiatric
- Psychologists endorsed as a health service provider in psychology (HSPP).

CPT® Code Range	Description
90791-90792	Psychiatric diagnostic evaluation
90832-90838	Psychotherapy
90846-90853	Family and group psychotherapy



## Surgical Treatment of TMJ

Treatment of TMJ by maxillofacial surgery will be covered if the following conditions are met:

- A physical exam, diagnostic X-rays, arthrography, or orthopantomogram and diagnostic imaging (CT, MRI, or arthroscopy) indicate an intra-articular cause of TMJ.
- At least two non-surgical methods of treatment, as described previously, have been tried and have failed to adequately relieve the member's symptoms. Documentation in the medical record must establish that non-surgical treatment has been attempted for a period of three to six months prior to a request for PA for surgery.

### Prior Authorization for the Surgical Treatment of TMJ

PA is required for a diagnostic arthroscopy and an arthrotomy of the TMJ joint.

PA will be granted for surgical treatment of TMJ under the following circumstances: Documentation must be maintained in the member's medical record and submitted for PA of these procedures:

- Arthrocentesis is covered when the following conditions are met:
  - Persistent pain for more than three to six months that cannot be controlled by non-surgical treatment
  - Clinical examination and/or diagnostic imaging that indicates the presence of hypomobility of the TMJ joint
  - Medically necessary instillation of therapeutic drugs into the joint
  - Arthroscopy is covered when the following conditions are met:
    - Persistent pain for more than three to six months that cannot be controlled by non-surgical treatment
    - Clinical examination and/or diagnostic imaging indicates joint pathology, such as internal derangement, hypomobility, or hypermobility that requires internal structural modification
- Arthrotomy, disc plication, discectomy, and arthroplasty with or without autograft and allograft are covered when the following conditions are met:
  - Persistent pain for more than three to six months that cannot be controlled by non-surgical treatment
  - Severe, unremitting pain
  - Clinical examination and/or diagnostic imaging indicates joint pathology, such as internal derangement, hypomobility, or hypermobility that requires internal structural modification where minimally invasive surgery, such as arthrocentesis or arthroscopy, is not appropriate or has failed
- Arthroplasty with total prosthetic joint replacement is covered when the following conditions are met:
  - Inflammatory arthritis involving the TMJ which is not responsive to other modalities of treatment
  - Recurrent fibrosis and/or bony ankylosis that is not responsive to other modes of treatment
  - Failed tissue graft

- Failed previous joint reconstruction
- Loss of vertical mandibular condylar height due to bone reabsorption, trauma, developmental abnormality, or pathologic lesion

## **Mechanical Therapy for Treatment of TMJ**

Mechanical therapy is provided through removable intra-oral appliances. Intra-oral appliances are used to treat members with dysfunctional occlusions. Treatment generally lasts for up to six months. Intra-oral appliances may be provided by a dentist, ENT specialist, orthodontist, or oral surgeon.

## **Anesthesia for the Surgical Treatment of TMJ**

Local anesthesia is usually adequate for arthrocentesis and arthroscopic TMJ procedures. The local anesthesia is included in the reimbursement for the procedure. General anesthesia may be necessary for other TMJ procedures. General anesthesia may be performed by an anesthesiologist or certified nurse anesthetist, as medically appropriate.

## **Cleft Lip and Cleft Palate**

Cleft lip and cleft palate are congenital defects that occur during in-utero stages of development. Cleft lip is a separation of the two sides of the lip. This separation may include the bones of the upper jaw and/or upper tissue of the gum. Cleft palate is an opening in the roof of the mouth in which the two sides of the palate do not fuse or join together. Either defect may occur unilaterally or bilaterally.

Cleft palate and cleft lip may cause problems related to eating, speaking, and facial structure. The following findings are common problems resulting from these developmental defects:

- Swallowing difficulties
- Middle ear dysfunction
- Speech difficulties
- Poor facial muscle control
- Abnormal dentition

The IHCP stipulates the treatment of cleft lip and cleft palate must be provided by a craniofacial IDT of healthcare professionals. According to the American Cleft Palate-Craniofacial Association, the following health disciplines may be included in the overall treatment process:

- Anesthesiology
- Audiology
- Dentistry
- Genetic counseling
- Neurology
- Ophthalmology
- Oral and maxillofacial surgery
- Orthodontics

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- Plastic surgery
- Prosthodontics
- Radiology
- Speech-language pathology
- Social services

The craniofacial team monitors the member's condition throughout treatment and provides any required interventions. Consultation with other professionals may be necessary depending on the member's needs. Specific aspects that are monitored may include, but are not limited to, the following:

- Height and weight
- Nutritional intake and feeding disorder symptoms
- Growth, motor, cognitive, and social development
- Speech and language development
- Hearing status
- Dentition
- Genetic diagnoses

Otolaryngologists, plastic surgeons, and oral surgeons usually recommend surgery to correct cleft lip and cleft palate deformities. Depending on the member's condition, secondary surgical procedures may be required involving the lip, nose, palate, and jaw. These procedures usually are staged over a period of several years.

### **Prior Authorization for Cleft Lip and Cleft Palate Services**

PA is not required for cleft lip and cleft palate services, except orthodontic services related to cleft palate

### **Panniculectomy**

Panniculectomy is the surgical removal of a redundant, large and/or long overhanging apron of skin and subcutaneous fat located in the lower abdominal area. The condition may accompany significant overstretching of the lax anterior abdominal wall and, therefore, often occurs in morbidly obese individuals or following substantial weight loss.

The panniculectomy is similar to an abdominoplasty; however, the abdominoplasty may include muscle placentation, neoumbilicoplasty or flap evaluation and is typically performed for cosmetic purposes.

The IHCP covers panniculectomy when the service is provided in compliance with all IHCP guidelines.

Obesity is a predisposing factor for this condition. Massive weight loss, defined as loss of 50 percent of excess weight, often results in laxity and redundancy of the abdominal skin termed a

panniculus. Patients with a massive overhanging apron of fat and skin may cause chronic and persistent local skin conditions in the abdominal folds.

These conditions may include intertrigo, intertriginous dermatitis, cellulitis, ulcerations or tissue necrosis, or they may lead to painful inflammation of the subcutaneous adipose tissue (i.e., panniculitis).

When panniculitis is severe, it may interfere with activities of daily living, such as personal hygiene and ambulation. In addition to excellent personal hygiene practices, treatment of these skin conditions generally involves topical or systemic corticosteroids, topical antifungals, and topical or systemic antibiotics.

The American Society of Plastic Surgeons grades the severity of abdominal deformities as follows:

- Grade 1: panniculus covers hairline and mons pubis but not the genitals
- Grade 2: panniculus covers genitals and upper thigh crease
- Grade 3: panniculus covers upper thigh
- Grade 4: panniculus covers mid-thigh
- Grade 5: panniculus covers knees and below

Panniculectomy for medical necessity should be considered when all the following criteria are met:

- Pannus hangs at or below the level of the symphysis pubis, as demonstrated on pre-operative photographs.
- Pannus causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis, or skin ulcerations) that is refractory to at least six months of medical treatment, in addition to good hygiene practices. Treatment should include topical antifungals; topical and/or systemic corticosteroids; and/or local or systemic antibiotics.
- Pannus interferes with activities of daily living

### **Non-Covered Services**

Panniculectomy following gastric bypass procedures performed for cosmetic reasons, even if performed incidentally to a ventral herniorrhaphy, is a non-covered service.

### **Prior Authorization for Panniculectomy**

PA is required for a panniculectomy. Providers must submit a PA request with the appropriate clinical summary and physician's documentation supporting medical necessity.

The following information must be included with the PA request:

- Member's diagnosis
- The member's current weight and height
- Preoperative photographs, front and lateral views

- H&P, including all previous surgeries and the member's weight loss history
- Medical documentation of medical conditions and complications of infections outlining all treatments, including duration and responses
- Documentation of limitations on mobility and daily activities due to the pannus or resulting complications

There are numerous surgeries which require PA. Per *405 IAC 5-3*, PA for multiple surgeries performed on the same day does not override the restrictions of *405 IAC 5-28*.

## Breast Plastic and Reconstructive Surgery

Breast reconstruction is defined as those surgical procedures designed to restore the normal appearance of the breast (male and female) after surgery, accidental injury, or trauma. The most common indication for reconstructive breast surgery is a prior mastectomy.

Reduction mammoplasty is defined as the surgical removal of a substantial portion of the breast(s), including the skin and underlying glandular tissue, in order to obtain a clinically normal size breast(s). Bilateral surgery is usually performed; however, when there is significant hypertrophy of one breast, resulting in an abnormal difference in appearance between the member's breasts, a unilateral breast reduction may be performed. Such a procedure may also be needed to achieve symmetry of the contralateral side when the opposite breast has been reconstructed after mastectomy.

IHCP reimbursement is not available for breast reconstruction in order to:

- Reshape the normal structure to improve appearance or self-esteem, or
- For conditions not related to congenital defects, developmental anomalies, trauma, infection, tumors, or disease.
- IHCP reimbursement is not available for:
- Cosmetic symptoms including ptosis, poorly fitting clothing, unacceptable appearance, or nipple-areolar distortion.
- The use of liposuction to perform breast reduction is considered investigational.

## Prior Authorization for Breast Plastic and Reconstructive Surgery

PA is required for plastic or reconstructive surgery per *405 IAC 5-3-13*. In addition, plastic or reconstructive surgery is non-covered unless related to disease or trauma deformity per *405 IAC 5-29-1*.

## Breast Reduction in Females

The following PA criteria is required for reimbursement for breast reduction surgery in females. Documentation must be maintained in the member's medical record:

- History of the member's symptoms for at least six months related to the large, pendulous breasts must include the following:
  - Neck and shoulder pain
  - Low back pain



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- Strap mark indentation
  - Restriction of physical activities
  - Poor posture
  - Skin irritation (submammary intertigo)
- Asymmetry of the breasts will not be authorized unless it is performed to achieve symmetry of the contralateral side when the opposite breast has been reconstructed after mastectomy for cancer.
- Specific weight guidelines vary with the height and weight of the member. The below table displays the height and weight categories indicating the minimum amount of breast tissue expected to be removed. Variances may occur which may not be accommodated by this table; these variances will be reviewed on an individual basis.

**Expected Minimum Amount of Breast Tissue to Be Removed**

Height	Weight	Expected Amount of Breast Tissue to Be Removed
Under 5'	Less than 140 lbs	300 gm per breast
5' – 5'4"	Up to 180 lbs	350 gm per breast
5'4" – 5'7"	Up to 220 lbs	400 gm per breast
5'7" and up	211 lbs and greater	500 gm per breast

### **Breast Reduction in Males**

The following PA criteria is required for reimbursement for breast reduction surgery in males older than 18 or 18 months after the end of puberty, for gynecomastia, when medically necessary.

- The tissue to be removed is glandular breast tissue and not the result of obesity, adolescence, or reversible effects of a drug treatment which can be discontinued. Documentation must be maintained in the medical record.
- Documentation in the medical record indicates the conditions which may be associated with gynecomastia and includes, but is not limited, to the following:
  - Documented androgen deficiency
  - Chronic liver disease that causes decreased androgen availability
  - Klinefelter's syndrome (Chromosome 47XYY Syndrome)
  - Adrenal tumors that cause androgen deficiency or increased secretion of estrogen
  - Brain tumors that cause androgen deficiency
  - Testicular tumors causing androgen deficiency or tumor secretion of estrogen
  - Endocrine disorders, such as hyperthyroidism

### **Genitourinary System Plastic and Reconstructive Surgery**

Reconstructive surgery is considered medically necessary for missing, defective, damaged, or misshapen structures of the genitourinary system. Additionally, the IHCP will provide reimbursement if a member has had significant alterations due to disease, trauma, surgery, or congenital anomalies.

The IHCP does not provide reimbursement for the following:

- Scar removal or tattoo removal by excision or abrasion
- Penile implants
- Perineoplasty for sexual dysfunction
- Tubal reanastomosis for the purpose of infertility

The IHCP defines intersex surgery as surgical intervention for members having congenital anomalies, resulting in both male and female characteristics. The IHCP considers intersex surgery medically necessary for congenital anomalies resulting in a member having ambiguous genitalia. Documentation in the member's medical record is required to support medical necessity. All other intersex surgery is not covered..

### **Prior Authorization Genitourinary System Plastic and Reconstructive Surgery**

PA is required for plastic or reconstructive surgery per *405 IAC 5-3-13*. In addition, plastic or reconstructive surgery is non-covered unless related to disease or trauma deformity per *405 IAC 5-29-1*.

#### **Genitourinary Surgery**

IHCP reimburses for female reconstructive surgery with PA for one of the following conditions. Documentation supporting medical necessity must be maintained in the medical record:

- Agenesis of the vagina
- Post-trauma
- Post-cancer therapy

IHCP reimburses for male reconstructive surgery with PA in the following circumstances. Documentation supporting medical necessity must be maintained in the medical record:

- Absence of testicle as a result of illness, injury, or congenital anomaly.
- No evidence of active infection, malignancy, or current treatment for malignancy.

#### **Intersex Surgery**

The IHCP provides reimbursement for intersex surgery with PA for congenital anomalies, resulting in a member having ambiguous genitalia. Documentation supporting medical necessity must be maintained in the medical record.

### **Collagen Implants for Stress Urinary Incontinence (SUI)**

A collagen implant is a prosthetic device used in the treatment of SUI resulting from intrinsic sphincter deficiency (ISD). The prosthetic device is injected into the submucosal tissues of the urethra and/or the bladder neck and into tissues adjacent to the urethra. SUI can be caused by incompetence of the urethral sphincter mechanism at the bladder neck.

This type of SUI may be caused by scarring from previous surgery (for example, prostatectomy), urethral, myelomeningocele, epispadias, trauma, radiation, or sacral cord lesions; or by any process that limits the ability of the proximal sphincter to form an effective watertight seal. ISD is a cause of SUI in which the urethral sphincter is unable to contract and generate sufficient resistance in the bladder.

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

- Male or female patients with congenital sphincter weakness secondary to conditions such as myelomeningocele or epispadias
- Male or female patients with acquired sphincter weakness secondary to spinal-cord lesions
- Male patients following trauma, including prostatectomy and/or radiation
- Female patients without urethral hypermobility and with abdominal leak point pressures (ALPPs) of 100 cm H<sub>2</sub>O or less

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

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

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

In female patients, the evaluation must include a complete H&P examination (including a pelvic exam) and a simple cystometrogram to rule out abnormalities of bladder compliance and abnormalities of urethral support. Following that determination, an abdominal leak-point pressure (ALPP) test is performed. Leak-point pressure, stated in cm H<sub>2</sub>O, is defined as the intra-abdominal pressure at which leakage occurs from the bladder (around a catheter) when the bladder has been filled with a minimum of 150 cc fluid. If the patient has an ALPP of less than 100 cm H<sub>2</sub>O, the diagnosis of ISD is established.

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

## Non-covered Services

The IHCP does not provide reimbursement for the following services:

- Blepharoplasties when not related to significant obstructive vision problems
- Dermabrasion surgery for acne pitting or marsupialization
- Ear piercing
- Ear lobe reconstruction
- Otoplasty for protruding ears unless one of the following applies:
  - Multifaceted craniofacial abnormalities due to congenital malformation or maldevelopment, such as Pierre Robin Syndrome
  - Member's pending or actual employment where protruding ears would interfere with the wearing of required protective devices
- Removal of keloids caused from pierced ears unless one of the following is present:
  - Keloids are larger than three centimeters
  - Obstruction of the ear canal is 50 percent or more
  - Rhinoplasty or bridge repair of the nose in the absence of a significant obstructive breathing problem
- Rhytidectomy
- Scar removals or tattoo removals by excision or abrasion

## Prior Authorization

Per 405 IAC 5-17-2, PA is required for all nonemergent inpatient hospital admissions, including all elective or planned inpatient hospital admissions. This applies to medical and surgical inpatient admissions. Emergency admissions, routine vaginal deliveries, C-section deliveries, and newborn stays do not require PA.

The IHCP follows Milliman guidelines for all nonemergent and urgent care inpatient admissions. If IHCP criteria already exist, that criteria are used first when determining if admissions are appropriate. If criteria are not available within Milliman or IHCP policy, the IHCP relies on medical necessity determination of current evidence-based practice. To ensure a 48-hour turnaround, the PA request should be made by a clinical staff person. For nonemergent and urgent care admissions that occur outside normal business hours, including weekends and holidays, providers have 48 hours from the time of admission to request PA.

PA is required for the following surgical procedures:

- Hysterectomy
- Reduction mammoplasty
- Rhinoplasty or bridge repair of the nose when related to a significant obstructive breathing problem
- Intersex surgery
- Blepharoplasties for a significant obstructive vision problem
- Sliding mandibular osteotomies for prognathism or micrognathism
- Reconstructive or plastic surgery
- Bone marrow or stem cell transplant

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- Organ transplants
- Maxillofacial surgeries related to diseases and conditions of the jaws and contiguous structures
- Temporomandibular joint (TMJ) surgery
- Submucous resection of nasal septum and septoplasty when associated with significant obstruction
- Weight reduction surgery, including gastroplasty and related gastrointestinal surgery
- Orthodontic procedures for members under 21 years of age for cases of craniofacial deformity or cleft palate
- All dental procedures requiring hospital admission
- Out-of-state procedures

For surgeries normally schedule as outpatient and are scheduled as inpatient, the following criteria are used for determining the medical necessity for an inpatient admission:

- Technical or medical difficulty during the outpatient procedure as documented in the medical record.
- Presence of physical or mental conditions which make prolonged preoperative or postoperative observations by a nurse or other skilled medical personnel medically necessary.
- Performance of another procedure simultaneously, which itself requires hospitalization.
- Anticipation of an additional procedure, which would require hospitalization following the initial procedure.
- Documentation must be maintained in the medical record and clearly document any complications and services provided.

### **Prior Authorization Criteria for Facial Disorders**

The IHCP will provide reimbursement for members with mid-face disorders, nasal deformities, external ear disorders, and facial disorders. Providers are advised to report the most appropriate code for the procedure performed. The following information must be maintained in the member's medical record:

- History of the presenting problem
- Symptoms related to the facial disorder
- Previously attempted, less-invasive medical management treatment that has failed
- Any other medical documentation that supports the member's need of this service
- Absence of any additional medical condition jeopardizing the end result of the surgery, which could include, for example:
  - A suppressed immune system
  - A current infection unresponsive to medical management
  - Medical instability following illness or injury



## Billing and Coding

For further billing information, see the [Surgical Services](#) provider reference module. For a list of billing codes, see the *Surgical Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

IC § 12-8-6-3 Administration of state program

IC § 12-8-6-5 Rules

IC § 12-15-1-10 Administrative actions and directions

IC § 12-15-21-2 Acceptance by provider of Medicaid claim payment

### [405 IAC 5](#)

- 405 IAC 5-3-13 – Services Requiring Prior Authorization
- 405 IAC 5-1-5 – Global Fee Billing
- 405 IAC 5-10 – Anesthesia Services
- 405 IAC 5-14-3 – Diagnostic Services
- 405 IAC 5-14-21 – Maxillofacial Surgery
- 405 IAC 5-17-2 – Prior Authorization; Generally
- 405 IAC 5-25 – Physician Services
- 405 IAC 5-26-9 – Surgical Procedures; Reimbursement
- 405 IAC 5-28-1 – Reimbursement limitations
- 405 IAC 5-28 – Medical and Surgical Services
- 405 IAC 5-28-9 – Hysterectomy
- 405 IAC 5-29-1 – Services Not Covered by Medicaid

Senate Enrollment Act 360

### [IHCP Provider Bulletins](#)

- [BT201583](#) IHCP expands age eligibility for coverage of bariatric surgery
- [BT201420](#) IHCP to cover sleeve gastrectomy surgery
- [BT201759](#) IHCP issues correction regarding coverage policy for sinus surgery

### [IHCP Provider Banners](#)

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial publication

March 14, 2017 – Added prior authorization criteria for sinus surgery

September 19, 2017 – Corrected coverage around sinus surgery

## Telehealth and Telemedicine Services

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### Description of Service

#### Telehealth

Telehealth services are defined as the scheduled remote monitoring of clinical data through technologic equipment in the member's home. Data is transmitted from the member's home to the home health agency to be read and interpreted by a registered nurse (RN). The technologic equipment allows the home health agency to detect minute changes in the member's clinical status that allow home health agencies to intercede before the member's condition advances and requires emergency intervention or inpatient hospitalization.

#### Telemedicine

Telemedicine services refer to a specific method of delivery of certain services, including medical exams and consultations, which are already reimbursed by Medicaid. Telemedicine uses videoconferencing equipment to allow a medical provider to deliver an exam or other services to a patient at a distant location.

In any telemedicine service, there will be a distant site, a originating site, an attendant to connect the patient to the specialist at the distant site, a computer or television so that the patient has real-time, interactive, and face-to-face communication with the distant site specialist/consultant via the interactive television technology. These services may be offered in an inpatient, outpatient, or office setting.

Telemedicine is not the use of the following:

- Telephone transmitter for transtelephonic monitoring; or
- Telephone or any other means of communication for consultation from one provider to another.

#### Definitions

- **Distant site** – Location of the physician or provider rendering consultation services.
- **Originating site** – Location where the patient is physically located when services are provided.
- **Interactive Television (IATV)** – Videoconferencing equipment at the distant and originating sites that allows real-time, interactive, and face-to-face consultation.
- **Store and Forward** – Electronic transmission of medical information for subsequent review by another health care provider

### Medical Policy

#### Telehealth

The IHCP provides reimbursement for telehealth services when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization (PA). Telehealth services are considered medically necessary for individuals with uncontrolled chronic

conditions, as evidenced by emergency room visits and inpatient hospital stays directly related to the chronic condition.

In any telehealth services encounter, a licensed RN must read the transmitted health information provided from the member, in accordance with the written order of the physician. The nurse must review all data on the day the ordered data is received or, in cases when the data is received after business hours, on the first business day following receipt of the data. Transmitted data must meet Health Insurance Portability and Accountability Act (HIPAA) compliance standards

The home health agency will follow the monitoring criteria and interventions for the treatment of the member's qualifying condition, as outlined in the plan of treatment. Any potential medical concerns should be communicated to the ordering physician. Members who are unable or unwilling to use the telehealth equipment appropriately will be dis-enrolled from telehealth services.

The initial visit is limited to a one-time visit to educate the member or caregiver about how to properly operate the telehealth equipment. A remote skilled nursing visit cannot be billed on the same DOS that a member received a skilled nursing visit in the home. The telehealth reading should be included in the skilled nursing home visit when the reading and the home visit are performed on the same day.

### **Prior Authorization for Telehealth**

Prior authorization is required for all for telehealth services, per Indiana Administrative Code 405 IAC 1-4.2-3 and 405 IAC 5-16-3. Telehealth services are indicated for members who require scheduled remote monitoring of data related to the member's qualifying chronic diagnoses that are not controlled with medications or other medical interventions.

Per 405 IAC 5-16-3.1, to initially qualify for telehealth services, the member must have had two or more of the following events within the previous 12 months:

- Emergency room visits
- Inpatient hospital stays

An emergency room visit that results in an inpatient hospital admission does not constitute two separate events. The two qualifying events must be for the treatment of one of the following diagnoses:

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Diabetes

Additionally, to qualify for telehealth services, the member must be receiving or approved for other IHCP home health services. The PA request for telehealth services must be submitted separately from other home health service PA requests. Once initially

qualified, to continue receiving telehealth services, the member must have a current diagnosis of one of the previous qualifying diagnoses and continue to receive other home health services. Services may be authorized for members for up to 60 days per PA request.

The telehealth PA request form must include a physician's written order that is signed and dated by the physician. The PA request must also include an attestation from the home health agency that the telehealth equipment to be placed in the member's home is capable of monitoring any data parameters included in the plan of treatment, and that the transmission process meets HIPAA compliance standards.

A plan of treatment must be signed and dated by the physician and submitted with the PA request. Monitoring criteria and interventions for the treatment of the member's qualifying conditions must be developed collaboratively between the member's physician and the home health agency and included in the member's plan of treatment. The plan of treatment must clearly outline the patient's health data and information to be monitored and measured, and the circumstances under which the ordering physician should be contacted to address any potential health concerns. The monitoring criteria and interventions should be directly related to the member's qualifying diagnoses. Other monitoring criteria and interventions may be developed for other conditions the member may have, but the primary criteria and interventions must be for treatment of the qualifying diagnoses. The plan of treatment must also indicate how often an RN must perform a reading of transmitted health information.

## Telemedicine

The IHCP will provide reimbursement for the telemedicine when the services are medically necessary and provided in compliance with all applicable IHCP guidelines and per 405 IAC 5-38.

Telemedicine shall be limited to the following conditions:

- Telemedicine is reimbursable for the following services or provider types:
  - Consultations,
  - Office visits,
  - Psychotherapy
  - Psychiatric diagnostic interview
  - End-stage renal disease (ESRD) services
  - Pharmacologic management
- The member must be:
  - Physically present at the originating site; and
  - Must participate in the visit.
- The physician or practitioner who will be examining the patient from the distant site must determine if it is medically necessary for a medical professional to be at the originating site.
- Separate reimbursement for a provider at the originating site is payable only if that provider's presence is medically necessary. Documentation must be maintained in the

patient's medical record to support the need for the provider's presence at the originating site during the visit.

Store-and-forward technology to facilitate other reimbursable services is allowed; however, separate reimbursement of the originating-site payment is not provided for this technology.

## **Federally Qualified Health Centers and Rural Health Clinics**

Subject to the following criteria, reimbursement is available to FQHCs and RHCs when they are serving as either the distant site or the originating site for telemedicine services:

- When serving as the distant site (the location of the physician or provider rendering services), the service provided at the FQHC or RHC must meet both the requirements of a valid encounter and an approved telemedicine service as defined in the IHCP's telemedicine policy.
- When serving as the originating site (the location where the patient is physically located), an FQHC or RHC may be reimbursed if it is medically necessary for a medical professional to be with the member, and the service provided includes all components of a valid encounter code.

Pursuant to the Code of Federal Regulations (42 CFR 405.2463), an encounter is defined by the Centers for Medicare & Medicaid Services (CMS) as a face-to-face meeting between an eligible provider and a Medicaid member during which a medically necessary service is performed.

## **Special Considerations**

- When ongoing services are provided, the member should be seen by a physician for a traditional clinical evaluation at least once a year, unless otherwise stated in policy. In addition, the distant site physician should coordinate with the patient's primary care physician.
- The existing service limitations for office visits are applicable. All telemedicine consultations billed using the codes listed in the Distant site Services and Billing Requirements section are counted against the office visit limit. Third-party liability (TPL), spend-down, managed care, and all other considerations apply.
- Reimbursement for ESRD-related services is permitted in the telemedicine setting. The IHCP requires at least one monthly visit for ESRD-related services to be a traditional clinical encounter to examine the vascular access site.

Telemedicine is not reimbursable for the following services or provider types:

- Ambulatory surgical centers.
- Outpatient surgical services.
- Home health agencies or services.
- Radiological services.
- Laboratory services.



- Long term care facilities, including nursing facilities, intermediate care facilities, or community residential facilities for the developmentally disabled.
- Anesthesia services or nurse anesthetist services.
- Audiological services.
- Chiropractic services.
- Care coordination services.
- DME, medical supplies, hearing aids, or oxygen.
- Optical or optometric services.
- Podiatric services.
- Services billed by school corporations.
- Physical or speech therapy services.
- Transportation services.
- Services provided under a Medicaid waiver.

## Documentation Standards

- Documentation must be maintained at the distant and originating locations to substantiate the services provided. Documentation must indicate the services were rendered via telemedicine.
- Documentation must clearly indicate the location of the distant and originating sites.
- All other IHCP documentation guidelines for services rendered via telemedicine apply, for example chart notes and start and stop times.
- Documentation is subject to post-payment review.

Providers must have written protocols for circumstances when the member must have a hands-on visit with the consulting provider. The member should always be given the choice between a traditional clinical encounter versus a telemedicine visit. Appropriate consent from the member must be obtained by the originating site and maintained at the distant and originating sites

## Prior Authorization for Telemedicine

Please refer to the appropriate section of the Indiana Medicaid Medical Policy Manual for each service covered under telemedicine. Telemedicine is the method by which a service is delivered; all services which are available for reimbursement under telemedicine are still subject to the same limitations and restrictions as services not delivered by telemedicine.

## Billing and Coding

For further billing information, see the [Telemedicine and Telehealth Services](#) provider reference module.

## Rules and Citations

[42 CFR 410.78](#) - Telehealth services.

### [405 IAC 1](#)

- 405 IAC 1-4.2-2 Definitions

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- 405 IAC 1-4.2-3 Home health care services; general information
- 405 IAC 1-4.2-6 Telehealth services

## 405 IAC 5

- 405 IAC 5-2-27 "Telehealth services" defined
- 405 IAC 5-2-28 "Telemedicine services" defined
- 405 IAC 5-16-2 Home health agency services
- 405 IAC 5-16-3.1 Home health agency services; limitations
- 405 IAC 5-38 - Telemedicine Services

## IHCP Provider Bulletins

- [BT201807](#) IHCP revises policy for telemedicine services
- [BT201454](#) IHCP to cover group and family crisis psychotherapy telemedicine services
- [BT201452](#) Elimination of 20-mile requirement for telemedicine services for certain provider types
- [BT200802](#) Telemedicine

## IHCP Provider Banners

- [BR201625](#) IHCP telemedicine coverage policy remains unchanged
- [BR201409](#) Coverage of telemedicine services clarified for FQHCs and RHCs

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

March 2, 2018 – Revised Policy for Telemedicine Services

## Therapy Services

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### Description of Service

The IHCP covers therapy services for its members. Therapy services, as described in this policy, encompass physical, speech, and occupational therapy, among others.

### Medical Policy Habilitative Therapy

Habilitative therapy refers to therapy addressing chronic medical conditions where further progress is not expected. Habilitative therapy services include physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology services provided to members for the purpose of maintaining their level of functionality but not the improvement of functionality. Although the development of a habilitation therapy plan is considered part of rehabilitative services, the services furnished under a habilitation therapy plan are not skilled therapy.

IHCP policy regarding the coverage of habilitative therapy services makes the following distinction based on the member's age:

- Habilitative therapy services are not covered for members 21 years of age and older.
- Habilitative therapy services are covered for members under 21 years of age on a case-by-case basis.

Educational services, including but not limited to the remediation of learning disabilities, are not considered habilitative therapy services and remain noncovered by the IHCP.

#### **Prior Authorization for Habilitative Therapy**

Habilitative therapy services are subject to prior authorization.

### Rehabilitative Therapy

Rehabilitative therapy refers to the federal definition outlined in *Code of Federal Regulations 42 CFR 440.130(d)* and includes physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology services provided to members.

IHCP policy regarding the coverage of rehabilitative therapy services makes the following distinction based on the member's age:

- For members 21 years of age and older, rehabilitative therapy services are covered for no longer than two years from the initiation of the therapy unless there is a significant change in the member's medical condition requiring longer therapy.

- For members under 21 years of age, rehabilitative therapy services are covered when it is determined to be medically necessary.

## Physical Therapy

Physical Therapy (PT) is the evaluation of, administration of, or instruction in physical rehabilitative and habilitative techniques and procedures to evaluate, prevent, correct, treat, alleviate, and limit physical disability, pathokinesiological function, bodily malfunction, pain from injury, disease, and any other physical disability or mental disorder.

Physical therapy must be performed by a licensed physical therapist or certified physical therapist's assistant under the direction supervision of a licensed physical therapist or physician for reimbursement (the consultation can be either face to face or by telephone).

Payment for the following services is included in the Medicaid allowance for the modality provided by the licensed therapist and may not be billed separately to Indiana Medicaid:

- Assisting members in preparation for and, as necessary, during and at the conclusion of treatment
- Assembling and disassembling equipment
- Assisting the physical therapist in the performance of appropriate activities related to the treatment of the individual patient
- Following established procedures pertaining to the care of equipment and supplies
- Preparing, maintaining, and cleaning treatment areas and maintaining supportive areas
- Transporting:
  - Patients
  - Records
  - Equipment
  - Supplies
- Performing established clerical procedures'

Evaluations and reevaluations are limited to three (3) hours of service per member evaluation.

Effective February 1, 2017, the following provider types may order physical therapy services:

- Physician
- Chiropractor
- Dentist
- Nurse practitioner
- Physician assistant
- Podiatrist
- Psychologist

## **Prior Authorization for Physical Therapy**

For all prior authorization information for physical therapy, occupational therapy, respiratory therapy, and speech pathology, see general prior authorization guidelines below.

## **Occupational Therapy**

The practice of occupational therapy (OT) means the therapeutic use of everyday life occupations and occupational therapy services to:

- Aid individuals or groups to participate in meaningful roles and situations in the home, school, the workplace, the community, or other settings
- Promote health and wellness through research and practice
- Serve individuals or groups who are well but have been or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction.

Occupational therapy must be performed by a licensed occupational therapist or a licensed occupational therapy assistant under the supervision of a licensed occupational therapist. An evaluation must be performed by a licensed occupational therapist in order for reimbursement to be made.

Evaluations and reevaluations are limited three (3) hours of service per evaluation.

Effective February 1, 2017, the following provider types may order occupational therapy services:

- Physician
- Chiropractor
- Nurse practitioner
- Optometrist
- Physician assistant
- Podiatrist
- Psychologist

The following occupational therapy services are not covered by the IHCP:

- General strengthening exercise programs
- Passive range of motion services (as the only or primary modality of therapy)
- Occupational therapy psychiatric services

## **Prior Authorization for Occupational Therapy**

For all prior authorization information for physical therapy, occupational therapy, respiratory therapy, and speech pathology, see general prior authorization guidelines below.



## Speech Pathology

Speech pathology services are provided for IHCP members with speech, hearing, and/or language disorders. These services include diagnostic, screening, preventive, or corrective services.

The speech pathology service must be rendered by a licensed speech-language pathologist or a person registered for a clinical fellowship year who is supervised by a licensed speech-language pathologist. A registered speech-language pathology aide may provide services.

Evaluations and reevaluations are limited three (3) hours of service per evaluation.

Group therapy is covered in conjunction with, not in addition to, regular individual treatment. Indiana Medicaid will not pay for group therapy as the only or primary means of treatment.

Speech pathology must be ordered in writing by a physician (doctor of medicine or doctor of osteopathy).

### Prior Authorization for Speech Therapy/Pathology

For all prior authorization information for physical therapy, occupational therapy, respiratory therapy, and speech pathology, see general prior authorization guidelines below.

## Respiratory Therapy

Respiratory therapy services will be reimbursed only when performed by a licensed respiratory therapist or a certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency, or clinic. The equipment necessary for rendering respiratory therapy will be considered part of the provider's capital equipment.

Respiratory therapy must be ordered in writing by a physician (doctor of medicine or doctor of osteopathy).

### Prior Authorization for Respiratory Therapy

Respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis, and upper respiratory infection may be provided without prior authorization for a period not to exceed fourteen (14) hours on fourteen (14) calendar days.

For all other prior authorization information for physical therapy, occupational therapy, respiratory therapy, and speech pathology, see general prior authorization guidelines below.

## Hippotherapy

The IHCP covers hippotherapy for physical therapy. To be covered, services must be provided by a licensed physical therapist and should be billed using the appropriate CPT® codes. Services must be ordered by a physician and included in the patient's plan of care.

### Prior Authorization for Hippotherapy

Prior authorization requirements for physical therapy apply to hippotherapy.

**Note:** HIP Basic members are limited to 60 physical therapy, occupational therapy, speech pathology services, and pulmonary rehabilitation combined visits annually. HIP Plus members are limited to 75 physical therapy, occupational therapy, speech pathology services, and pulmonary rehabilitation combined visits annually.

## Applied Behavior Analysis (ABA) Therapy

Applied Behavior Analysis (ABA) therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior.

An initial course of ABA therapy is subject to prior authorization and is covered when all of the following criteria are met:

- A diagnosis of ASD has been made by a qualified healthcare provider as described in the 'Provider Requirements' outlined below;
- The individual has completed a comprehensive diagnostic evaluation by a qualified healthcare provider. The evaluation must utilize a standardized assessment tool and include a referral for ABA services.
- The individual is no older than twenty (20) years of age;
- The goals of the intervention are appropriate for the individual's age and impairment; and,
- Documentation is provided which describes the individual-specific treatment plan that is developed by a licensed or certified behavior analyst and includes all of the following:
  - Addresses the identified behavioral, psychological, family and medical concerns; and,
  - Measurable short-term, intermediate, and long-term goals based on standardized assessments relative to age-expected norms and that address the behaviors and impairments for which the intervention is to be applied (Note: this should include baseline measurements, progress to date and anticipated timeline for achievement based on both the initial assessment and subsequent interim assessments over the duration of the intervention);
  - Identifies plans for parent/guardian training and school transition; and

- Documents that ABA services will be delivered by an appropriate provider who is licensed or certified as a Behavior Analyst (see “Provider Requirements’ below).

Continuation of ABA therapy is subject to prior authorization and may be covered when all of the following criteria are met:

- The individual has met criteria for an initial course of ABA
- The individual-specific treatment plan will be updated and submitted as outlined below
- For each goal in the individual-specific treatment plan, the following is documented:
  - Developmental testing is done no later than 2 months after the initial course of ABA treatment has begun in order to establish a baseline in the areas of social skills, communication skills, language skills, and adaptive functioning; and
  - Progress to date; and
  - Anticipated timeline for achievement of the goals based on both the initial assessment and subsequent interim assessments over the duration of the intervention; and
- The individual-specific treatment plan includes age and impairment appropriate goals and measures of progress:
  - The treatment plan should include measures of the progress made with social skills, communication skills, language skills and adaptive functioning. Clinically significant progress in social skills, communication skills, language skills, and adaptive functioning must be documented.
- The treatment plan must also identify and describe plans for parent/guardian training and school transition.

Reimbursement is not available when the following services do not meet medical necessity criteria, nor qualify as ABA therapy services:

- ABA components that focus on recreational or educational outcomes are not covered.
- Therapy services rendered when measurable functional improvement is not expected or documented;
- Services that are duplicative, such as services rendered under an individualized educational program (IEP);
- Services performed by an RBT in the home or school setting.

### **Prior Authorization for ABA Therapy**

Prior authorization is required for the initial course of ABA therapy and may be approved for up to six (6) months. ABA therapy services shall not exceed a total duration of three (3) years.

Documentation supporting the PA request is required, and must include the following:

#### **Initial Course of ABA**

- An individual specific treatment plan, including:

- Identification of the individuals behavioral, psychological, family and medical concerns; and,
  - Measurable goals based on standardized assessments that address the behaviors and impairments for which the intervention is to be applied (Note: this should include, for each goal, baseline measurements and anticipated timeline for achievement based on the initial assessment); and,
  - The number of hours per week being requested, including justification for the specific number of hours based on the individual's needs.
  - Plans for parent/guardian training and school transition.
- Documentation that ABA services will delivered by an appropriate provider who is licensed or certified as a Behavior Analyst (see 'Provider Requirements' below).

### **Continuation of ABA**

- Documentation that the member has been approved for the initial course of ABA based on the criteria above;
- An individual specific treatment plan must be updated and submitted up to 6 months. The treatment plan must include:
  - Age and impairment appropriate goals, including baseline measures for each goal;
  - Measureable progress to date;
  - Anticipated timeline for achievement of each goal;
  - Plans for parent/guardian training and school transition.
- Documentation that ABA services will delivered by an appropriate provider who is licensed or certified as a Behavior Analyst (see 'Provider Requirements' below).

Treatment plans must include measures and progress specific to language skills, communication skills, social skills and adaptive functioning. The individual treatment plan must include justification and supporting documentation for the number of hours being requested. The number of hours must give consideration to the child's age, school attendance requirements, and other daily activities. The treatment plan must include a clear schedule of services planned, and that all identified interventions are consistent with ABA techniques.

In addition, for members 13 through 20 years of age, the treatment plan must include measures of the specific behaviors or deficits targeted and also include assessments of social, communication, and language skills, as well as adaptive functioning and developmental status.

### **Provider Requirements**

For purposes of the initial diagnosis and comprehensive diagnostic evaluation, a qualified provider includes any of the following:

- Licensed physician;
- Licensed Health Service Provider in Psychology (HSPP);
- Licensed pediatrician;
- Licensed psychiatrist; or
- Other behavioral health specialist with training and experience in the diagnosis and treatment of autism spectrum disorder.

ABA therapy services must be delivered by an appropriate provider that is licensed or board certified as a Behavior Analyst, including Bachelor-level (BCaBA), Master's (BCBA) and doctoral level (BCBA-D) behavior analysts. ABA therapy services may also be provided by a credentialed Registered Behavior Technician (RBT). Services performed by a BCaBA or RBT must be under the direct supervision of a BCBA, BCBA-D, or HSPP).

Services performed by RBTs under the supervision of a BCBA, BCBA-D, or HSPP will be reimbursed at 75% of the rate on file. Providers must bill the appropriate modifier (U1, U2, or U3) to indicate who is providing the services rendered.

Services rendered by a non-approved provider will not be reimbursed.

An [IHCP ABA Prior Authorization Checklist](#) is available for providers. Voluntary use of this tool should help providers prepare comprehensive requests for ABA therapy and reduce suspensions for requests for additional information.

## Hyperbaric Oxygen Therapy

Hyperbaric oxygen therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure, increasing vascular flow and improving oxygenation of body tissue. Originally developed for the treatment of decompression sickness, hyperbaric oxygen is adjunctive treatment for the management of select non-healing wounds, treatment of carbon monoxide poisoning, and other conditions.

The following table provides reimbursable conditions for hyperbaric oxygen therapy:

**Diagnosis Codes for Hyperbaric Oxygen Therapy**

Diagnosis	ICD-10-CM Codes	Limitations
Inflammatory conditions of jaw	M27.49	
Irradiation cystitis	N30.40, N30.41	



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Diabetic wounds of the lower extremities	E08.620- E08.628, E09.620-E09.628, E10.51-E10.59, E10.610, E10.618, E10.620-E10.628, E10.630, E10.638, E10.51- E10.59, E10.69, E11.618-E11.638 , E13.620-E13.628,	CMS criteria described in Transmittal AB-02-183
Acute carbon monoxide intoxication	T58.01XA-T58.94XS,	
Decompression illness	T70.3XXA -T70.3XXS	
Gas embolism	T79.0XXA-T79.0XXS	
Gas gangrene	A48.0	
Acute traumatic peripheral ischemia	S35.511A-S35.513S, S45.001A-S45.099S, S55.001A- S55.999S, S65.001A-S65.999S, S75.001A S75.999S, S85.001A-S85.999S, S95.001A -S95.999S,	Adjunctive treatment to be used in combination with accepted standards and therapeutic measures
Complications of reattached extremity or body part	T87.0X1-T87.2	
Crush injuries and suturing of severed limbs	S07.0XXA- S07.9XXS, S17.0XXA-S17.0XXS, S28.0XXA-S28.229S, S38.001A-S38.1XXS, S57.00XA-S57.82XS, S67.00XA-S67.92XS, S77.00XA -S77.22XS, S97.00XA-S97.82XS,	An adjunctive treatment when loss of function, limb or life is threatened
(Meleney Ulcers) Progressive necrotizing infections	M72.6	Other types of cutaneous ulcers are not covered
Acute peripheral arterial insufficiency	I74.2-I74.5	
Compromised skin grafts	T86.820-T86.829	Preparation and preservation
Chronic Refractory Osteomyelitis	M86.30-M86.9	Use when unresponsive to conventional medical and surgical management
Osteoradionecrosis	M27.8	Adjunct to conventional treatment
Soft tissue radionecrosis	T66.XXXA-T66.XXXS	Adjunct to conventional treatment
Cyanide poisoning	T65.0X1A-T65.0X4S, T57.3X1A-T57.3X4S	

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Actinomycosis	A42.0-A42.9	Only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment
Acute cerebral edema	G93.6	

Reimbursement is not available for hyperbaric oxygen therapy for the following conditions:

- Topical application of oxygen
- Cutaneous, decubitus, and stasis ulcers
- Chronic peripheral-vascular insufficiency
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility
- Myocardial infarction
- Cardiogenic shock
- Sickle-cell crisis
- Acute thermal and chemical pulmonary damage, including smoke inhalation with pulmonary insufficiency
- Acute or chronic cerebral-vascular insufficiency
- Hepatic necrosis
- Aerobic septicemia
- Nonvascular causes of chronic brain syndrome, including Picks, Alzheimer's, and Korsakoff's disease
- Tetanus
- Systemic-aerobic infection
- Organ transplantation
- Organ storage
- Pulmonary emphysema
- Exceptional blood loss anemia
- Multiple sclerosis
- Arthritic diseases

Treatment may include multiple sessions, which may be administered over a duration ranging from less than one week to two months, the average being two to four weeks. Claims submitted for treatment sessions lasting more than a two-month period will be suspended for submission of documentation to support medical necessity of continued therapy.

Hyperbaric therapy shall be clinically practical and shall not be a replacement for other standard successful therapeutic measures.

## Prior Authorization

### **For physical therapy, occupational therapy, respiratory therapy, and speech pathology**

Prior authorization is required for all therapy services. The following criteria must be met for PA of physical therapy, occupational therapy, respiratory therapy, and speech pathology when it is provided outside the exceptions stated below:

- Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. Therapy must be ordered by a qualifying provider (see individual policy sections for qualifying providers).
- A current plan of treatment, developed 60 to 90 days from the date of the PA submission, must include clearly stated and measurable goals and progress.
- Therapies must be provided by a qualified therapist or a qualified assistant under direct supervision of a therapist, as appropriate.
- Therapy must be of such a level of complexity and sophistication and the condition of the member must be such that the judgment, knowledge, and skills of a qualified therapist are required.
- Therapy must be medically necessary.
- Therapy for diversional, recreational, vocational purposes, or avocational purposes, for the remediation of learning disabilities, or for developmental activities which can be conducted by nonmedical personnel is non-covered.
- One hour of therapy must include a minimum of 45 minutes of direct care with the member. Only one hour per day, per type of therapy may be approved.
- Therapies which duplicate other services provided to a patient will not be authorized (e.g., nursing services).

For the following situations, PA is not required:

- Initial evaluations
- Emergency respiratory therapy
- Any combination of therapy, ordered in writing prior to a recipient's discharge from inpatient hospital care, may continue for a period not to exceed 30 hours/sessions/visits in 30 calendar days

- Deductible and copayment for services covered by Medicare Part B
- Oxygen equipment and supplies necessary for the delivery of oxygen with the exception of concentrators
- Therapy services provided by a nursing facility or large private or small intermediate care facility for individuals with intellectual disabilities (ICF/IID), which are included in the facility's per diem rate

### **For physical therapy, occupational therapy, respiratory therapy, and speech pathology in the home health setting**

The following criteria must be met for PA of physical therapy, occupational therapy, respiratory therapy, and speech pathology when it is provided by a home health agency:

- Therapy must be provided by an appropriately licensed, certified, or registered therapist employed or contracted by the agency
- Ordered or prescribed in writing by a physician
- Provided in accordance with a written plan of treatment developed cooperatively between the therapist and the attending physician
- Medically necessary
- Provided in accordance with all other PA requirements for physical therapy, occupational therapy, respiratory therapy, and speech pathology

## **Billing and Coding**

For further billing information, see the [Therapy Services](#) provider reference module. For a list of billing codes, see the *Therapy Services Codes* on the [Code Sets/Tables](#) webpage.

## **Rules and Citations**

### [405 IAC 5](#)

- 405 IAC 5-22-6 Prior Authorization; exceptions
- 405 IAC 5-16 Home Health Agency and Clinic Services
- 405 IAC 5-16-4 Rehabilitation center services; limitations
- 405 IAC 5-17-4 Physical rehabilitation services
- 405 IAC 5-22 Nursing and Therapy Services
- 405 IAC 5-22-8 Certified Physical Therapist 's Assistants
- 405 IAC 5-32-1 Rehabilitation Unit

### [IHCP Provider Bulletins](#)

- [BT201627](#) IHCP Revises Coverage Policies for Therapy Services

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- [BT201126](#) Removal of Physical, Speech, and Occupational Therapy Services Limitations
- [BT201690](#) IHCP Expands Provider Types Allowed to Order Physical and Occupational Therapy Services
- [BT201736](#) IHCP Revises Policy Regarding Robotic Therapy

## [IHCP Provider Banners](#)

- [BR201737](#) IHCP makes Applied Behavioral Analysis PA Checklist available
- [BR201338](#) Prior authorization no longer required when billing for initial evaluations for speech therapy

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

February 1, 2017 – Expanded list of provider types allowed to order physical and occupational therapy

June 13, 2017 – Removed separate policy language around robotic therapy

September 12, 2017 – Added reference to IHCP ABA PA Checklist



## Transplant Services

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### Description of Service

Stedman's Medical Dictionary defines a transplant as *a transfer from one part to another, such as tissue or an organ, in grafting and transplantation*. Autologous transplants involve tissue or organ transferred into a new position in the body of the same individual. Allogenic transplant pertains to transfer of human tissue or an organ from one person to another; allogenic indicates it is genetically different but still within the same species.

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#### Donor Hospital and Surgical Expenses

IHCP covers the transplant donor's hospital and surgical expenses for the removal of the donor tissue or organ during the inpatient admission will be provided when:

- The recipient of the transplant is an IHCP member,
- The member meets criteria for the transplant, and
- The transplant is considered medically necessary.

#### Removal of Transplanted Organ

Certain organs may require removal following transplantation due to organ rejection.

##### Prior Authorization for Removal of Transplanted Organ

Removal of a transplanted organ does not require PA. Transplantation of another organ does require a new PA request.

#### Out-of-State Transplants

The IHCP will provide for transplant surgeries in out-of-state facilities when the hospital specializes in the particular transplantation procedure, or if the hospital is one of a limited number of hospitals that can perform the procedure.

##### Prior Authorization for Out-of-State Transplants

All out-of-state services must be prior authorized. The requests for these procedures are reviewed on an individual basis. For more information on out-of-state services, please see the *Out-of-State Providers* policy module.

Out-of-state providers who receive approval from OMPP for transplantation will receive a written notification regarding how the claim will be reimbursed (either by the IHCP statewide rate or a percentage of the provider's usual and customary), and the coverage period (such as 365 days from transplant). The provider will be assigned a point of contact at EDS to assist with tracking expenditures, and processing of payment for services. Outpatient lab services are paid at the IHCP rate on file, with no additional payment unless specific approval is given by OMPP.

## Corneal Tissue Transplant

Corneal tissue transplant, also known as keratoplasty, replaces the patient's damaged cornea utilizing the cornea from the eye of a human cadaver. Corneal transplant is used when vision is lost in an eye due to damage to the cornea by disease or traumatic injury. Eye banks acquire and store eyes from donor individuals largely to supply the need for transplant corneas.

### Indications for Corneal Tissue Transplantation

IHCP provides reimbursement for corneal transplantation for full thickness corneal disease for the following medical conditions:

- Bullous keratopathy
- Corneal opacity
- Corneal thinning with potential for corneal perforation
- Keratoconus with  $\geq 2$  episodes of corneal hydrops
- Keratoconus (conical protrusion of cornea caused by thinning of the stroma)
- Potential for corneal perforation

The IHCP provides reimbursement for corneal transplantation for partial thickness corneal disease for one of the following medical conditions:

- Superficial stromal opacification
- Marginal corneal thinning or infiltration
- Localized corneal thinning or descemetocoele formation

The IHCP provides reimbursement for transplantation of new tissue to the cornea for the treatment of severe corneal surface disease, reported with ocular surface reconstruction for the following medical conditions:

- Corneal pannus or superficial corneal scarring
- Persistent corneal epithelial defects
- Corneal perforation
- Neurotrophic keratitis
- Persistent corneal epithelial defects
- Bullous keratopathy
- Corneal thinning
- Corneal ulcer
- Chemical burns of the ocular surface
- Erythema multiforme, including Stevens-Johnson syndrome

## Bone Marrow or Stem Cell Transplant

The IHCP covers autologous or allogenic bone marrow or stem cell transplants.

### Prior Authorization for Bone Marrow and Stem Cell Transplant

Prior authorization criteria for bone marrow or stem cell transplantation for indications are as follows:

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- Adult or childhood acute myeloid leukemia (includes nonlymphocytic or nonlymphoblastic)
- Adult or high risk childhood lymphocytic (lymphoblastic) leukemia in remission
- Myelodysplastic syndromes
- Acute lymphocytic or non-lymphocytic leukemia in remission
- Non-Hodgkin's lymphoma of intermediate and high grade (stage 3 or 4) in remission or with evidence of chemotherapy responsive disease
- Hodgkin's Disease (lymphoma) in second remission or refractory to primary therapy
- Neuroblastoma: High risk disease by the International Neuroblastoma Staging System criteria with no evidence of disease progression at the time of transplant
- Congenital Marrow Failure Syndromes unresponsive to medical therapy
- Severe Aplastic Anemia
- Severe Combined Immunodeficiency Disease
- Multiple Myeloma (tandem stem cell transplants for treatment of Multiple Myeloma must receive PA as two separate procedures). Tandem stem cell transplants are considered medically necessary in patients who fail to achieve a complete remission or a good partial remission (at least 50% reduction in tumor cells) after the first transplant.
- Germ-cell Cancer: recurrent or refractory to primary therapy (tandem stem cell transplants should be considered for relapsed patients and must receive PA as two separate procedures)
- Ovarian cancer
- Hurler's Syndrome (other inherited metabolic diseases will be considered based on published literature)
- Ewing's Sarcoma limited to pulmonary relapse only
- Sickle cell anemia
- Thalassemia major or transfusion dependent thalassemia intermedia

**AND when a member meets ALL of the following criteria;**

- The life expectancy following the transplant can reasonably be expected to be one year or more, measured by current standards.
- The member, or his or her guardian, demonstrates a reasonable ability to comply with physician-directed post-operative treatment meant to reduce the chance of organ rejection.
- The adult member is competent and understands the risks and benefits of the transplant.
- The member has normal or treatable cardiovascular, pulmonary, hepatic, and renal function.

**Contraindications to Bone Marrow or Stem Cell Transplantations**

PA will not be given for bone marrow transplants in the following circumstances:

- The member is a juvenile and has no identifiable caretaker or no adequate family support structure
- The member is septic or has an active infection

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- The member has a frank relapse or progression of leukemia or disease
- The member has a condition preventing rehabilitation
- BMI > 40 kg/m<sup>2</sup>
- The member has an abnormal CNS condition, e.g., CVA, Organic Brain Syndrome, or dementia. (CNS metastasis as a consequence of the primary diagnosis for which the transplant is being requested would be excluded from this restriction.)
- The member has another active malignancy or history of active malignancy within two years, excluding skin cancers cured by simple excision. Documentation will be required at the time of PA request.
- Transplant is contraindicated for AIDS as defined by a CD4 count of less than 200 cells/mm<sup>3</sup> unless the following are noted.
  - CD4 count greater than 200 cells/mm<sup>3</sup>
  - HIV-1 ribonucleic acid (RNA) undetectable
  - Stable anti-retroviral therapy for more than 90 days
  - No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, or antimicrobial resistant fungal infections, or Kaposi's sarcoma or other neoplasms)
- The member is moribund
- The member has an active illegal drug or alcohol dependence within the six months prior to the submission of the request
- The member has two or more significant abnormal lab or x-ray results, non-disease related
- Congestive heart failure (systolic ejection fraction < 40%)
- Liver disease
- Abnormal pulmonary function (DLCO < 60%)
- Renal failure (creatinine clearance < 40mg/dl)

## Lung Transplant

Lung transplantation involves removal of one or both diseased lungs from a patient and the replacement of the lungs with healthy organs from a donor. Lung transplantation may refer to single, or double.

The IHCP provides reimbursement for three components of lung transplantation, when medical necessary and with prior authorization:

- Harvesting of the lung includes cold preservation
- Backbench work consists of preparation of cadaver donor single lung or both lungs prior to transplantation. This includes dissection of the lung from tissue around it and preparation of the pulmonary venous/atrial cuff, pulmonary artery and bronchus bilaterally
- Recipient transplantation includes transplanting a single lung or both lungs into the patient

### Prior Authorization for Lung Transplant

The IHCP considers lung transplants medically necessary with PA for **one** of the following indications.

- Primary pulmonary hypertension
- Alpha-1 antitrypsin deficiency
- Interstitial Lung Disease
  - Pulmonary fibrosis (primary or secondary)
  - Usual interstitial pneumonitis
  - Fibrosing non-specific interstitial pneumonitis
- Pulmonary fibrosis (primary or secondary)
- Cystic fibrosis
- Surfactant deficiency
- Bronchopulmonary dysplasia
- Pulmonary berylliosis (with chronic interstitial granulomatous fibrosis)
- Atrioventricular canal
- COPD (Chronic Bronchitis, Emphysema , Bronchiolitis Obliterans)
- Bronchiectasis
- Pulmonary vascular disease
- COPD
- Cystic fibrosis

### Contraindications for Lung Transplantation

IHCP reimbursement for lung transplantation will not be provided when any of the following clinical situations are present.

- Active illegal drug, tobacco, or alcohol dependence within the last six months
- Active malignancy or other organ disease
- AIDS as defined by a CD4 count of less than 200 cells/mm<sup>3</sup> unless the following are noted
  - CD4 count greater than 200 cells/mm<sup>3</sup>
  - HIV-1 RNA undetectable
  - Stable anti-retroviral therapy for more than 90 days
  - No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, or Kaposi's sarcoma or other neoplasms)

### Documentation for Lung Transplantation

- No use of tobacco products for a period of six months prior to request or transplant
- Life expectancy without transplant is expected to be 18 months or less
- Life expectancy with transplant is expected to be 24 months or greater
- Ventilator dependency
- Current Prednisone use of less than 20 mg/day. Chronic high dose steroids for extrapulmonary disease are a contraindication. Prednisone dosage >5mg/day for a child with cystic fibrosis may be considered a contraindication.
- Karnofsky performance status > 70
- Chest X-ray, posteroanterior view



- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- Computerized tomography (CT) scan of lungs (other CT scans as applicable)
- Thallium stress test results, or suitable alternative per a cardiologist, for members with history of significant cardiac risk factors
- Results of ABGs and carboxyhemoglobin, and pulmonary function, including a FEV of 25% normal and decreasing FVC of 40% normal or less.
- HIV, HBV, HCV, syphilis, and CMV serologies
- Lab values within normal limits
  - Complete blood count, urine, CEA, CMP
  - Plasma ammonia
  - CK
  - Serum magnesium
  - Lactic Acid Dehydrogenase
  - Serum phosphate
  - Platelet count
- Dental evaluation with treatment of any significant dental disease

## Heart Transplant

Cardiac transplantation is a therapeutic modality for individuals with end-stage heart disease, characterized by cardiac failure that does not respond to standard, optimal medical or surgical treatments.

The IHCP reimburses for the following three components of heart transplantation (with or without lung transplant) when considered medically necessary with prior authorization.

- Cadaver donor cardiectomy consists of harvesting and cold preservation of the graft prior to transport
- Backbench work consists of dissection of the donor heart from surrounding soft tissue prior to transplantation and preparation of aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for transplantation
- Recipient transplantation includes transplanting the heart/lungs into the patient

### Prior Authorization for Heart Transplant

The IHCP considers heart transplants medically necessary with PA for ONE of the following indications.

- Eisenmenger's syndrome (ventricular septal defect - cardiac failure with significant right-to-left shunt producing cyanosis)
- Other complex congenital defects
- Myocardial failure unresponsive to medical management
- End-stage cardiomyopathy
- Inability to be weaned from temporary ventricular-assist devices after MI or non-transplant cardiac surgery
- Valvular heart disease
- Intractable, life threatening arrhythmias unresponsive to medical treatment, surgery, ablation, or an implantable cardioverter-defibrillator.

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**And** meets **all** of the following criteria:

- Life expectancy with current medical management is expected to be 12 months or less
- Life expectancy after transplant expected to be two years
- The present degree of disability severely limits the member's activity. (NYHA Classification III or IV)
- Member or guardian demonstrates a reasonable ability to comply with postoperative treatments meant to reduce the possibility of organ rejection, including medication administration and cardiac biopsies
- Adult member understands the risk and benefits of the transplant
- Member is one week of age or older

### **Contraindications to Heart Transplantation**

IHCP reimbursement for heart transplantation will not be provided when any of the following clinical situations are present.

- The member is moribund
- Fixed pulmonary hypertension or severe pulmonary disease (unless receiving combined heart/lung transplantation)
- Uncontrolled diabetes or uncontrolled hypertension
- Hepatic fibrosis or cirrhosis
- Hepatitis C with histological evidence of hepatic disease
- Uncorrected abdominal aneurysm greater than 4 centimeters
- BMI > 40 kg/m<sup>2</sup>
- Abnormal Central Nervous System condition (e.g., cerebral vascular accident)
- Active malignancy or infection
- Active systemic disease that would not be alleviated by the requested transplant or that severely limits life expectancy or precludes adequate post-transplant rehabilitation such as autoimmune or collagen vascular disease
- Active Gastrointestinal disease, such as bleeding peptic ulcer or diverticulitis
- Active illegal drug, tobacco, or alcohol dependence within the last six months
- AIDS as defined by a CD4 count of less than 200 cells/mm<sup>3</sup> unless the following are noted
  - CD4 count greater than 200 cells/mm<sup>3</sup>
  - HIV-1 RNA undetectable
  - Stable anti-retroviral therapy for more than 90 days
  - No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, or Kaposi's sarcoma or other neoplasms)
- Uncontrolled or untreated psychiatric disorders that interfere with compliance to a strict treatment regimen

### **Relative Contraindications**

Members meeting any **one** of the following general or disease specific relative contraindications must be evaluated carefully.

- older than 70 years of age
- Heart Failure Survival Score if the member falls into the high risk category

## **Documentation for Heart Transplantation**

- Complete blood count (CBC), UA, and CMP
- Chest X-ray, posteroanterior view
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- Appropriate screening for colon cancer, if member is greater than 40 years of age
- HIV, HBV, HCV, syphilis, and CMV serologies
- Results of EKG, multiple gate acquisition (MUGA) scan, heart catheterization(s), or EP studies
- Results of ABGs and pulmonary function tests if member was (is) a smoker or has a history of lung disease. FEV less than 60% of normal and FVC less than 50% of normal may be a contraindication to transplant.
- Dental evaluation with treatment of any significant dental disease

## **Heart/Lung Transplant**

Cardiopulmonary transplantation (heart and lung transplantation) is the simultaneous surgical replacement of the heart and lungs in patients with end-stage cardiac and pulmonary disease. The IHCP provides reimbursement for the following three components of heart/lung transplantation, with Prior Authorization.

- Cadaver donor cardiectomy with pneumonectomy consists of harvesting and cold preservation of the graft prior to transport
- Backbench work includes dissection of the tissue around the heart and lungs and preparation of aorta, superior vena cava, inferior vena cava, and trachea for transplantation
- Recipient transplantation includes transplanting the heart/lungs into the patient

## **Prior Authorization for Heart/Lung Transplant**

The IHCP considers heart/lung transplants medically necessary with PA if criteria for both heart and lung transplantation are met

## **Contraindications for Heart/Lung Transplantation**

IHCP reimbursement for heart/lung transplantation will not be provided when any of the contraindications for either a heart or lung transplantation, indicated previously in this document, are present.

## **Documentation for Heart/Lung Transplantation**

The IHCP requires documentation for heart lung transplantation meet the same criteria required for both heart and lung transplantation.

## **Hepatic (Liver) Transplant**

A liver transplant is a surgical procedure to remove a diseased liver and replace it with a healthy liver from a donor. Liver transplantation is performed for individuals with end-stage liver disease.

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The IHCP provides reimbursement for the following three components of Hepatic (Liver) Transplantation, with Prior Authorization.

- Cadaver or living donor hepatectomy consists of harvesting and cold preservation of the graft prior to transplantation and care of the donor, in the case of living donor hepatectomy
- Backbench work consists of preparation of donor liver prior to transplantation. . This includes preparation of whole liver graft, including dissection and removal of surrounding tissue and soft tissue, preparation of the vena cava, portal vein, hepatic artery, and common bile duct. Also included is preparation of the whole liver with splitting of the liver for partial grafts. Additional reconstruction of the liver graft including venous and arterial anastomosis(es) may also be performed
- Recipient transplantation includes transplanting the liver into the patient and care of the recipient

### **Prior Authorization for Hepatic (Liver) Transplant**

The IHCP considers Hepatic (liver) transplants medically necessary with PA for the **one** of the following indications:

- Acute liver failure due to viral hepatitis, drug reactions or toxins
- Chronic liver failure due to **one** of the following:
  - Primary biliary cirrhosis
  - Chronic active hepatitis
  - Autoimmune hepatitis
  - Sclerosing cholangitis
  - Biliary atresia
  - Budd-Chiari syndrome
  - Alcoholic cirrhosis
  - Cryptogenic cirrhosis
  - Toxin induced cirrhosis
- Non-resectable, primary tumors of the liver, such as primary hepatomas and cholangiocarcinomas
- The development of life-threatening complications may include but are not limited to, such as variceal hemorrhage, encephalopathy, spontaneous bacterial peritonitis, hepatorenal syndrome, or intractable ascites
- Inborn errors of metabolism, such as Alpha-1 antitrypsin deficiency, Wilson's disease, primary hyperoxaluria, primary hypercholesterolemia, or tyrosinosis
- Traumatic or inflammatory, non-infectious conditions, other than metastatic cancer, which has resulted in the destruction of the liver or in the inability of the liver to function

**And** meets **all** of the following criteria:

- Member, or guardian, demonstrates a reasonable ability to comply with post-operative treatments meant to reduce the possibility of organ rejection
- Life expectancy following transplant is expected to be two years
- Adult member is competent and understands the risks and benefits of the procedure

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- Juveniles, or guardians, understand the likelihood of growth retardation as a result of the liver condition
- Member has normal or reversible cardiac, pulmonary, and renal function

### **Contraindications to Liver Transplantation**

IHCP reimbursement will not be provided for liver transplantation when any of the following clinical situations are present:

- Sepsis
- Age greater than 70 years of age and/or less than 90 days of age
- Any condition that would prevent rehabilitation
- Any severe, uncorrectable, pulmonary, cardiovascular, or renal dysfunction
- BMI > 40 kg/m<sup>2</sup>
- Active extrahepatic infection (including metastatic hepatocellular carcinoma)
- An abnormal central nervous system disorder (e.g., cerebral vascular accident)
- An active extrahepatic malignancy
- AIDS as defined by a CD4 count of less than 200 cells/mm<sup>3</sup> unless the following are noted
  - CD4 count greater than 200 cells/mm<sup>3</sup>
  - HIV-1 RNA undetectable
  - Stable anti-retroviral therapy for more than 90 days
  - No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, or Kaposi's sarcoma or other neoplasms)
- Active systemic disease, other than diabetes, that would not be alleviated by the requested transplant or would limit life expectancy or compromise recovery, e.g., systemic vasculitis
- Active gastrointestinal disease, such as bleeding peptic ulcer or diverticulitis
- The member is moribund
- Active illegal drug or alcohol dependence within the previous six months
- Two or more significant, non-liver associated, abnormal lab or x-ray results
- Relative contraindications include, but are not limited to, previous extensive upper abdominal surgery, and thrombosis involving portal, superior mesenteric or splenic veins
- MELD score < 15
- Severe cardiac or pulmonary disease
- AIDS
- Ongoing alcohol or illicit substance abuse
- Hepatocellular carcinoma with metastatic spread
- Uncontrolled sepsis
- Anatomic abnormality that precludes liver transplantation
- Intrahepatic cholangiocarcinoma
- Extrahepatic malignancy
- Fulminant hepatic failure with sustained ICP > 50 mm Hg or CPP < 40 mm Hg
- Hemangiosarcoma
- Persistent noncompliance



- Lack of adequate social support system

## **Documentation for Liver Transplantation**

- Complete blood count, UA, CMP, and EKG
- Chest X-ray, posteroanterior view
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- Appropriate screening for colon cancer if the member is over 50 years of age
- Thallium stress test results or suitable alternative per a cardiologist, if the member has a history of significant cardiac risk factors
- HIV, HBV, HCV, syphilis, and CMV serologies
- Results of ABGs and pulmonary function tests if member was (is) a smoker or has a history of lung disease. FEV less than 60% of normal and FVC less than 50% of normal may be a contraindication to transplant.
- Dental evaluation with treatment of any significant dental disease

## **Renal (Kidney) Transplant**

Renal (Kidney) transplantation is a surgical procedure to remove a healthy, functioning kidney from a living or brain-dead donor and implant it into a patient with non-functioning kidneys. Kidney transplantation is performed on patients with chronic kidney failure, or end-stage renal disease (ESRD). ESRD occurs when a disease or disorder damages the kidneys so that they are no longer capable of adequately removing fluids and wastes from the body or of maintaining the proper level of certain kidney-regulated chemicals in the bloodstream. Without long-term dialysis or a kidney transplant, ESRD is fatal

The IHCP provides reimbursement for the following three different components of renal transplantation:

- Cadaver or living donor nephrectomy consists of harvesting and cold preservation of the graft prior to transplantation and care of the donor
- Backbench work consists of preparation of the donor kidney prior to transplantation. This includes removal of perinephretic fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland; and preparation of ureter(s), renal vein(s), renal artery(s), and ligating branches as necessary. Other reconstruction procedures may involve venous, arterial, or ureteral anastomosis(es) necessary for the transplant
- Recipient transplantation includes transplanting the kidney into the patient

## **Prior Authorization for Renal (Kidney) Transplant**

Procedure is Indicated by ALL of the following

- End-stage renal disease (ESRD)
- Glomerular Filtration rate (eGFR) is <30 mL/min/1.73 m<sup>2</sup>
- No contraindications present as indicated by All of the following, including but not limited to:
  - Active infection
  - Active malignancy

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- Active neoplastic disease
- Active substance abuse
- Advanced cardiac disease
- Advanced pulmonary disease
- Chronic illness with shortened life expectancy
- BMI > 40 kg/m<sup>2</sup>
- Reversible renal failure
- Uncontrolled psychiatric disease
- Urologic or vascular problems

### Documentation for Renal Transplantation

- Complete blood count (CBC), UA, CMP, and EKG
- Chest X-ray, posteroanterior view
- CT scans or nuclear scan results when appropriate for the work-up
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- Appropriate screening for colon cancer, for members over 50 years of age
- Thallium stress test results, or suitable alternative per a cardiologist, for members with history of significant cardiac risk factors
- HIV, HBV, HCV, syphilis, and CMV serologies
- Dental evaluation with treatment of any significant dental disease

Results of ABGs and pulmonary function tests if member was (is) a smoker or has a history of lung disease. FEV less than 60% of normal and FVC less than 50% of normal may be a contraindication to transplant.

## Pancreatic Transplant

A pancreas transplant is a surgical procedure to place a healthy pancreas from a donor into a person whose pancreas no longer functions properly.

The IHCP provides reimbursement for three different components of pancreatic transplants with Prior Authorization. Pancreatic transplantation which is performed at the same time as kidney transplantation is to be reported with the appropriate CPT® code for each organ transplanted..

- Cadaver pancreatectomy consists of harvesting and cold preservation of the graft prior to transplantation
- Backbench work consists of preparation of the donor pancreas prior to transplantation. This includes preparation of the pancreas by dissecting the soft tissues surrounding the pancreas, splenectomy, duodenotomy, ligation of the bile duct, ligation of the mesenteric vessels, and Y-graft arterial anastomosis from the iliac artery to the superior mesenteric artery and to the splenic artery. Venous anastomosis(es) may also be included in reconstruction of the donor pancreas.
- Recipient transplantation includes transplanting the pancreas into the patient

### Prior Authorization for Pancreatic Transplant

The IHCP considers pancreatic transplantation medically necessary with PA when **ONE** of the following criteria is met:

- Type I diabetes mellitus

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- Diabetic nephropathy with deteriorating or poor status
- Diabetic neuropathy
- Diabetic enteropathy
- Diabetic retinopathy, such as proliferative retinitis
- Diabetics who fail aggressive medical management of blood sugar
- Diabetics who demonstrate multiple episodes of ketoacidosis or hypoglycemia despite rigorous control and compliance
- Traumatic or inflammatory conditions, other than cancer, which has resulted in the destruction of the functional ability of the pancreas

And meets **all** of the following criteria:

- Life expectancy following the transplant can reasonably be expected to be one year, measured by current standards and the transplant results of the institution doing the procedure
- Member or guardian demonstrates a reasonable ability to comply with the postoperative treatments meant to reduce the chance of organ rejection
- Adult member is competent and understands the risks and benefits of the transplant

## **Contraindications to Pancreas Transplantation**

The IHCP will not provide reimbursement for pancreatic transplantation for the following clinical situations:

- Type II diabetes
- The member is moribund
- Any condition preventing rehabilitation
- Severe, uncorrectable pulmonary, cardiac, renal, or hepatic dysfunction
- BMI > 40 kg/m<sup>2</sup>
- Abnormal central nervous system condition (e.g., cerebral vascular accident)
- Active malignancy currently, or within past two years
- Active infection
- Active systemic disease other than diabetes, e.g., systemic vasculitis
- Active Gastrointestinal disease, such as bleeding peptic ulcer or diverticulitis
- Active illegal drug, tobacco, or alcohol dependence within the last six months
- Two or more abnormal lab or x-ray reports, non-disease related
- AIDS as defined by a CD4 count of less than 200 cells/mm<sup>3</sup> unless the following are noted
  - CD4 count greater than 200 cells/mm<sup>3</sup>
  - HIV-1 RNA undetectable
  - Stable anti-retroviral therapy for more than 90 days
  - No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, or Kaposi's sarcoma or other neoplasm)

## **Documentation for Pancreas Transplantation**

- Complete blood count (CBC), UA, CMP, and EKG
- HIV, HBV, HCV, syphilis, and CMV serologies
- Chest X-ray, posteroanterior and lateral views

- CT scans or nuclear scan results when appropriate for the work-up
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- Appropriate screening for colon cancer, results for members greater than 50 years of age
- Thallium stress test results, or suitable alternative per a cardiologist, for members with history of significant cardiac risk factors
- Results of ABGs and pulmonary function tests if member was (is) a smoker or has a history of lung disease. FEV less than 60% of normal and FVC less than 50% of normal may be a contraindication to transplant.
- Dental evaluation with treatment of existing caries

### Islet Cell Transplant

Islet cell transplantation is a procedure, which is performed to prevent diabetes or reduce the severity of diabetes after removal of the pancreas (pancreatic resection). When the pancreas is removed, the body loses its ability to produce insulin causing diabetes. Typically, the form of diabetes that occurs after pancreas resection is very severe and difficult to control.

The IHCP provides reimbursement for islet cell transplantation when considered medically necessary and with Prior Authorization.

#### Prior Authorization for Islet Cell Transplant

The IHCP considers Islet Cell Transplantation medically necessary as an adjunct to a total or near total pancreatectomy in patients with chronic pancreatitis.

#### Contraindications for Islet Cell Transplantation

The IHCP will not provide reimbursement for pancreatic islet cell transplantation for the following clinical situations.

- Allogenic islet cell transplantation
- Treatment of type I diabetes
- Other applications for allogenic transplantation
- Active illegal drug, tobacco, or alcohol dependence within the last six months

#### Documentation for Islet Cell Transplantation

- HIV, HBV, HCV, syphilis, and CMV serologies
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- 

### Intestinal (or Small Bowel) Transplant

The IHCP provides reimbursement for three different components of intestinal (or small bowel) transplantation with Prior Authorization:

- Cadaver or living donor enterectomy consists of harvesting and cold preservation of the graft prior to transplantation and care of the donor
- Backbench work consists of preparation of donor intestine prior to transplantation. This includes mobilizing and developing the superior mesenteric artery and vein. Also included is any additional reconstruction of graft including venous and arterial anastomosis (es) prior to transplantation.

- Recipient transplantation includes transplanting the intestine into the patient

## Prior Authorization for Intestinal (or Small Bowel) Transplant

The IHCP considers intestinal transplant medically necessary with Prior Authorization for members with irreversible intestinal failure who can no longer be maintained on TPN. PA may be given for small bowel or intestinal transplantation for the indications listed below. Clinical indications of TPN failure are also listed below.

Members must meet both of the following criteria:

- The member must be capable of following a complex medical regimen post-transplantation.
- The member must be emotionally stable with a realistic attitude demonstrated during past and current illness.

### Indications for Intestinal Transplantation

Pediatric	Adult
Aganglionosis (Hirschsprung's disease)	Crohn's disease
Congenital epithelial mucosal disease (microvillus inclusion disease, tufting enteropathy)	Desmoid tumors
Gastroschisis	Gardner's syndrome/familial polyposis
Intestinal atresia	Ischemia
Necrotizing enterocolitis	Trauma
Pseudo-obstruction	Volvulus
Volvulus	Surgical adhesions
Radiation enteritis	Hollow visceral myopathy
Short gut syndrome	Inflammatory bowel disease
	Short Gut Syndrome

### Clinical Indications of TPN Failure

Clinical Indications
<p>Impending or overt liver failure due to TPN. Symptoms include:</p> <ul style="list-style-type: none"> <li>• Elevated bilirubin and/or liver enzymes</li> <li>• Gastroesophageal varices</li> <li>• Coagulopathy</li> <li>• Splenomegaly</li> <li>• Thrombocytopenia</li> <li>• Stomal bleeding</li> <li>• Hepatic fibrosis/cirrhosis</li> </ul>
<p>Central line access failure as evidenced by:</p> <ul style="list-style-type: none"> <li>• Thrombosis of two or more of the major central channels (jugular, subclavian, and femoral veins)</li> <li>• Pulmonary embolism</li> <li>• Superior vena cava syndrome</li> <li>• Chronic venous insufficiency</li> </ul>



### Clinical Indications

Two or more episodes of systemic sepsis due to line infection per year that requires hospitalization or a single episode of line-related fungemia, septic shock or acute respiratory distress syndrome

Frequent episodes of severe dehydration despite IV fluid supplementation

### Contraindications for Intestinal Transplantation

The IHCP will not provide reimbursement for intestinal transplantation for the following clinical situations.

#### Absolute Contraindications

Members with the following absolute contraindications will not be approved for intestinal transplantation.

- Active malignancy, with the exception of squamous or basal cell carcinoma
- Active or untreatable infections
- Serious cardiac insufficiencies that create an inability to tolerate transplantation
- Active systemic illness
- Active illegal drug, tobacco, or alcohol dependence within the last six months
- Demonstrated patient noncompliance with medical recommendations
- AIDS as defined by a CD4 count of less than 200 cells/mm<sup>3</sup> unless all of the following are noted
  - CD4 count greater than 200 cells/mm<sup>3</sup> for greater than 5 months
  - HIV-1 RNA undetectable
  - Stable anti-retroviral therapy for more than 90 days
  - No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, Kaposi's sarcoma or other neoplasm)

#### Relative Contraindications

Members meeting any **one** of the following general or disease specific relative contraindications must be evaluated carefully.

- Potential complications from immunosuppressive medications
- Cerebrovascular disease or accident, or progressive neuropathy or myopathy that is not amenable to rehabilitation
- Malnutrition defined by a BMI of less than 17 or greater than 33
- Uncontrolled co-morbid conditions such as diabetes mellitus, hypertension, autoimmune disease, or cytopenia
- Uncorrected abdominal aortic aneurysm greater than four centimeters
- Diabetes with end-organ damage such as neuropathy, nephropathy, and retinopathy
- The member is greater than 70 years of age
- Peripheral vascular disease not amenable to surgical or percutaneous therapy

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## Documentation for Intestinal Transplantation

- Chemistries, including complete blood count (CBC), CMP, UA and creatinine clearance (if creatinine is greater than 2.0)
- Lipid and hepatic function panels
- HIV, HBV, HCV, syphilis, and CMV serologies
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion.
- Recent EKG and chest X-ray, posteroanterior view
- Psychosocial evaluation, performed at the transplant center
- Dental evaluation with treatment of any significant dental disease

## Multi-Visceral Transplant

A visceral organ is defined as any organ within the chest or abdomen. A multi-visceral transplantation includes transplantation of the intestine, pancreas, and liver. Additional organs could include the stomach and colon.

The IHCP provides reimbursement for the three components (removal of donor organ, backbench work, and recipient transplantation) for each organ included in the multi-visceral transplant when medically necessary and with Prior Authorization:

- Cadaver or living donor enterectomy consists of harvesting and cold preservation of the organs prior to transplantation and care of the donor.
- Backbench work consists of preparation of donor organs prior to transplantation.
- Recipient transplantation includes transplanting the organs into the patient

## Prior Authorization for Multi-Visceral Transplant

### Indications for Multi-Visceral Transplantation

The IHCP considers multi-visceral transplant medically necessary with PA when **one** of the following criteria are met:

- Irreversible intestinal and multi-visceral organ failure that can no longer be maintained with TPN
- Total occlusion of the splanchnic circulation
- Extensive GI polyposis
- Myopathy or neuropathy of the hollow viscera
- Abdominal malignancy

**Note:** Members must meet the PA criteria listed in this fact sheet for intestinal, liver and/or pancreatic transplantation in order to qualify for multi-visceral transplantation of these organs. Providers should refer to the intestinal transplantation criteria for indication of intestinal failure and TPN failure.

And **both** of the following criteria:

- The patient must be capable of following a complex medical regimen post-transplantation.
- Emotionally stable with realistic attitude demonstrated during past and current illness.

## Contraindications to Multi-Visceral Transplantation

The IHCP will not provide reimbursement for multi-visceral transplantation for the following clinical situations:

### **Absolute Contraindications**

Members with the absolute contraindications as listed below will not be approved for multi-visceral transplantation:

- Active malignancy, with the exception of squamous or basal cell carcinoma
- Ongoing, recurring, or unsuccessfully treated infections
- Serious cardiac insufficiencies that create an inability to tolerate transplantation
- Active systemic illness
- Active illegal drug, tobacco, or alcohol dependence within the last six months
- Demonstrated patient noncompliance with medical recommendations
- AIDS as defined by a CD4 count of less than 200 cells/mm<sup>3</sup> unless all of the following are noted
  - CD4 count greater than 200 cells/mm<sup>3</sup>
  - HIV-1 RNA undetectable
  - Stable anti-retroviral therapy for more than 90 days
  - No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis, antimicrobial resistant fungal infections, Kaposi's sarcoma or other neoplasm)

### **Documentation for Multi-Visceral Transplantation**

- Chemistries, including CBC, CMP, UA, and creatinine clearance (if creatinine is greater than 2.0)
- Lipid and hepatic function panel
- HIV, HBV, HCV, syphilis, and CMV serologies
- Urine drug screen within 90 days prior to submission of the request for members > 18 years of age or based on physician discretion
- Recent EKG and chest X-ray, posteroanterior view
- Psychosocial evaluation, performed at the transplant center
- Dental evaluation with treatment of any significant dental disease

## **Prior Authorization**

PA is required for transplant surgeries per 405 IAC 5-3-13. The IHCP does not reimburse providers for any services requiring prior authorization unless prior authorization is obtained first. Please refer to the prior authorization requirements indicated within each transplant type.

### **Documentation**

This is for general documentation requirements, for transplant specific documentation requirements; please see the specific transplant section above under Medical Policy. Documentation in the member's medical record must indicate the following information was obtained within a medically reasonable timeframe prior to the request for PA:

- H&P examination signed by a physician that includes the member's height, weight, and gender. Additionally, the H&P should include psychiatric or psychological evaluation in

cases having a history of depression, suicide attempts, or drug dependence signed by a psychiatrist or HSPP.

- Clear documentation of the disease status of the member including copies of all recent results of imaging studies, bone marrow testing (when indicated), cytogenetics, molecular studies, etc.
- All current medication and treatment plans

## Billing and Coding

For further billing information, see the [Surgical Services](#) provider reference module. For a list of billing codes, see the *Surgical Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

### [405 IAC 5](#)

- 405 IAC 5-3-13 Services Requiring Prior Authorization
- 405 IAC 5-29-1 Services not Covered by Medicaid; Non-covered Services

### [IHCP Provider Bulletins](#)

### [IHCP Provider Banners](#)

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

## Transportation Services

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### Description of Service

The IHCP reimburses transportation services to and from IHCP-covered services. The IHCP defines a trip as transporting a member from the initial point of pick-up to the drop-off point at the final destination. The member being transported must be present in the vehicle in order for IHCP reimbursement to be available. The transportation provided must be the least expensive type of transportation that meets the medical needs of the member.

Additionally, providers are expected to transport members along the shortest, most efficient route to and from a designation. IHCP reimbursement is available for emergency and non-emergency transportation services, subject to program restrictions.

### Medical Policy Advanced Life Support

The IHCP provides coverage for medically necessary emergency and nonemergency advanced life support (ALS) ambulance services when the level of services rendered meets the Indiana Emergency Medical Services Commission's (EMSC) definition for advanced life support. The EMSC defines ALS as follows:

"Care given at the scene of an accident, act of terrorism, or illness, care given during transport, or care given at the hospital by a paramedic, emergency medical technician-intermediate, and care that is more advanced than the care usually provided by an emergency medical technician or an emergency medical technician-basic advanced."

Thus, advanced life support may include any of the following acts of care:

- Defibrillation
- Endotracheal intubation
- Parenteral injection of appropriate medications
- Electrocardiogram (ECG) interpretation
- Emergency management of trauma and illness

ALS services are covered only when the level of service is medically necessary, and basic life support (BLS) services are not appropriate due to the medical conditions of the member being transported. Base rate, mileage, and wait time are reimbursed. The codes for the base rate include reimbursement for supplies and oxygen and, thus are not separately reimbursed.

Vehicles and staff that provide emergency services must be certified by the EMSC to be eligible for reimbursement for transports involving either ALS or BLS services.



## Basic Life Support

The IHCP provides coverage for medically necessary emergency and nonemergency basic life support (BLS) ambulance services when the level of services rendered meets the EMSC definition of basic life support. The EMSC defines BLS as the following:

- Assessment of emergency patients
- Administration of oxygen
- Use of mechanical breathing devices
- Application of anti-shock trousers
- Performance of cardiopulmonary resuscitation (CPR)
- Application of dressings and bandage materials
- Application of splinting and immobilization devices
- Use of lifting and moving devices to ensure safe transport
- Use of an automatic or semiautomatic defibrillator
- Administration of epinephrine through an auto-injector
- An emergency medical technician-basic advanced may perform the following:
  - ECG interpretation
  - Manual external defibrillation
  - IV fluid therapy

Thus, basic life support services do not include invasive medical care techniques or advanced life support. The IHCP provides reimbursement for medically necessary emergency and non-emergency BLS ambulance services when the level of service rendered meets the EMSC definition of BLS. Base rate, mileage, wait time, and oxygen are separately reimbursable.

## Commercial or Common Ambulatory Service

The IHCP provides reimbursement for transportation of ambulatory (walking) members to or from an IHCP-covered service. Common Ambulatory Service (CAS) transportation may be provided in any type of vehicle; however, providers must bill all transportation services according to the level of service rendered. Thus, if transportation of an ambulatory member is provided by an ambulance, but no ALS or BLS services are medically necessary for the transport of the member, the ambulance provider must bill the CAS charges.

## Non-Ambulatory Services (NAS) (Wheelchair Van)

Non-Ambulatory Services (NAS) or wheelchair services are reimbursable when a member must travel in a wheelchair to or from an IHCP-covered service. Providers must bill all transportation services according to the level of services rendered. Thus, claims for ambulatory members transported in a vehicle equipped to transport non-ambulatory members must be billed according to the CAS level of service and rate, and not billed according to the vehicle type.

## Taxi Transportation

The IHCP provides reimbursement for transportation of a member to or from an IHCP-covered service via taxi. Taxi providers may operate under authority from a local governing body (city

taxi or delivery license). Taxi providers whose rates are regulated by local ordinance must bill the metered or zoned rate, as established by local ordinance, and are reimbursed up to the maximum allowable fee. Taxi providers whose rates are not regulated by local ordinance are reimbursed the lower of their submitted charge or the maximum allowable fee based on trip length. Mileage is not reimbursable.

## **Family Member Transportation**

Family members enrolled as transportation providers under 405 IAC 5-4-3 are eligible for reimbursement for mileage only. Reimbursement is determined by the actual loaded mileage multiplied by the rate per mile established by the Indiana legislature for state employees. The local county office of the Division of Family Resources (DFR) in which the member resides must authorize all family member transportation.

## **Rotary Air Wing Transportation**

Rotary air ambulance is furnished when the member's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.

Generally, transport by rotary wing air ambulance may be necessary because the member's condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery by ground transport to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the member is inaccessible by a ground or water vehicle.

Transportation by air ambulance is only covered for transport to a hospital. Air ambulance services are not covered for transport to a facility that is not an acute care hospital. Transport to a nursing facility, a physician's office, or a beneficiary's home by rotary air ambulance is not reimbursable.

## **Medical Necessity**

Rotary air ambulance transport is a covered service when the member has a potentially life-threatening condition that does not permit the use of another form of transportation. IHCP reimburses rotary air transportation services to a hospital facility under medical appropriate circumstances. Medical necessity is only established when the member's condition is such that the time needed to transport a member by ground, or the instability of transportation by ground, poses a threat to the member's survival or seriously endangers the member's health. The list below includes examples of medical conditions in which rapid transport may be necessary. This list does not guarantee reimbursement nor is it intended to be all inclusive. Diagnosis only does not serve as justification for reimbursement.

- Intracranial bleeding requiring neurosurgical intervention
- Cardiogenic shock
- Burns requiring treatment in a burn center
- Conditions requiring treatment in a Hyperbaric Oxygen Unit
- Multiple severe injuries
- Life-threatening trauma

Air transport must be to the nearest suitable hospital. If the air transport was medically necessary but the member could have been treated at a nearer hospital than one to which they were transported, the air transportation mileage reimbursement is limited to the rate for the distance from the point of pickup to the nearer hospital.

### **Severe Weather**

If the flight is aborted due to bad weather, or other circumstance beyond the pilot's control, any time before the beneficiary is loaded onboard, i.e. prior to or after take-off to point of pick up, IHCP will not reimburse for the flight. If the flight is aborted after the beneficiary is loaded, the appropriate air base mileage and rural adjustment is available.

### **Member Death**

If the member dies before being transported, then no IHCP payment may be made. Thus, in a situation where the member dies, whether any payment is made depends on the time at which the member is pronounced dead by an individual authorized by the State to make such pronouncements. If the time of death pronouncement is prior to take-off to point of pick-up with notice to dispatcher and time to abort the flight, no payment is made. This included scenarios in which the air ambulance has taxied to the runway, and/or has been cleared for takeoff, but has not actually taken off. If member is pronounced after takeoff to point of pickup, but before the member is loaded, the appropriate air base rate with no mileage is reimbursed. When the member is pronounced after the member is loaded onboard, but prior to or upon arrival at the receiving facility, reimbursement is such as if the member had not died.

### **Multiple Patients**

Additional reimbursement is not available for multiple passengers in a rotary air ambulance.

### **Hospital to Hospital Transfer**

Air ambulance transport is covered for transfer of a patient from one hospital to another if the medical appropriateness criteria is met, i.e. transportation by ground ambulance would endanger the member's health, and the transferring hospital does not have adequate facilities to provide the medical services needed by the patient. Example of such specialized medical services that are generally not available at all types of facilities may include, but are not limited to, burn care, cardiac care, trauma care, and critical care. A patient transported from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Reimbursement is not available for transport from a hospital capable of treating the patient because the patient and/or family prefer a specific hospital or physician.

### **Accompanying Parent/ Attendant**

Separate reimbursement is not available for an accompanying parent/ attendant in a rotary air ambulance.

### **Prior Authorization for Rotary Air Wing Transportation**

Prior authorization (PA) is required for airline or air ambulance services. A PA request must include a brief description of the care and description of the clinical circumstances necessitating the need for the transportation. In addition, any transportation services

provided by a provider located in an out-of-state, non-designated area require PA. Emergency ambulance transportation is exempt from the 20 one-way trip limitation

### Other Transportation Services

IHCP reimbursement is available for other transportation services, including but not limited to intrastate bus or train transportation. IHCP payment for other transportation services will be the fee usually and customarily charged the general public, subject to federal, state, or local law, rule, or ordinance. Intrastate bus or train services (including services provided in designated areas) require authorization by the county office, and interstate bus or train services require authorization from the contractor. Authorization may be given for use of monthly bus passes in situations where a recipient has an ongoing medical need, so that purchase of the bus pass is cost effective when compared to the cost of other modes of transportation. Such authorization shall be given only if the recipient has agreed to use this mode of transportation. To be reimbursed, the bus or train company providing services must be enrolled as an IHCP provider.

### Non-covered Transportation Services

Reimbursement is not available for the following transportation services:

- One-way trips exceeding 20 per member, per rolling 12-month period, except when medical necessity for additional trips is documented through the PA process
- Trips of 50 miles or more one way, unless PA is obtained
- First 30 minutes of waiting time for any type of conveyance, including ambulance
- Non-emergency transportation provided by any of the following:
  - A volunteer with no vested or personal interest in the member
  - An interested individual or neighbor of the member
  - A caseworker or social worker
- Ancillary, non-emergency transportation charges including, but not limited to, the following:
  - Parking fees
  - Tolls
  - Member meals or lodging
  - Escort meals or lodging
- Disposable medical supplies, other than oxygen, provided by a transportation provider
- Transfer of durable medical equipment, either from the member's residence to a place of storage or from a place of storage to the member's residence
- Use of red lights and siren for an emergency ambulance call
- All inter-hospital transportation services, except when the member has been discharged from one hospital for admission to another hospital
- Delivery services for prescribed drugs, including transporting a member to or from a pharmacy to pick up a prescribed drug

**Note:** Nonemergency transportation is a noncovered service for HIP Basic or HIP Plus. Members should check with their MCE for nonemergency transportation covered as an enhanced benefit.

## Copayments for Transportation Services

The IHCP requires a copayment for transportation services. The copayment shall be made by the member and collected by the provider at the time the service is rendered. The provider shall collect from the member a copayment amount equal to the following:

- Fifty cents (\$0.50) for services for which the IHCP pays ten dollars (\$10) or less
- One dollar (\$1.00) for services for which the IHCP pays ten dollars and one cent (\$10.01) to fifty dollars (\$50.00)
- Two dollars (\$2.00) for services for which the IHCP pays fifty dollars and one cent (\$50.01) or more
- No copayment will be required for an accompanying adult traveling with a minor recipient or for an attendant

The following transportation services are exempt from the copayment requirement:

- Emergency ambulance services
- Services furnished to individuals less than eighteen (18) years of age
- Services furnished to pregnant women
- Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, or other medical institutions
- Services furnished to members of the Indiana Breast and Cervical Cancer Program

**Note:** The following copayment rules apply the risk-based managed care:

**Hoosier Care Connect (HCC)** - \$1.00 for each one-way trip

**Hoosier Healthwise (HHW) Package C** - \$10.00 for ambulance transport

## Prior Authorization

Prior authorization is required for the following transportation services:

- Trips exceeding 20 one-way trips per member, per rolling 12-month period, with certain exceptions.
- Trips of 50 miles or more one way, including all codes associated with the trip (wait time, parent or attendant, additional attendant, and mileage).
- Interstate transportation or transportation services rendered by a provider located out-of-state in a non-designated area.
- Train or bus services
- Airline or air ambulance services

PA requests must include a brief description of the anticipated care and description of the clinical circumstances necessitating the need for the transportation. PA requests are reviewed, and a PA decision letter is sent to the member and the requesting provider.



Transportation is limited to 20 one-way trips per member, per rolling calendar year. Providers must request PA for members who exceed 20 one-way trips if frequent medical intervention is required. Examples of situations that require frequent medical intervention include, but are not limited to, prenatal care, chemotherapy, and other therapy services. PA may be granted up to one year following the date of service. However, some services, listed below, are exempt from the 20 one-way trip limitations:

- Emergency transportation services
- Hospital admission or discharge (this includes interhospital transfers when a member has been discharged from one hospital for the purpose of admission to another hospital)
- Members on renal dialysis
- Members residing in nursing home
- Accompanying parent or attendant, except when the trip exceeds 50 miles
- Additional attendant, except when the trip exceeds 50 miles

## Billing and Coding

For further billing information, see the [Transportation Services](#) provider reference module. For a list of billing codes, see the *Transportation Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

### [405 IAC 5](#)

- 405 IAC 5-3-9(4) Prior authorization after services have begun
- 405 IAC 5-4-2 Provider agreement requirements for transportation services
- 405 IAC 5-4-3 Enrollment of a family member as a transportation provider
- 405 IAC 5-5-1 Out-of-state services; general
- 405 IAC 5-5-2 Prior authorization requirements for out-of-state services
- 405 IAC 5-30 Transportation Services

### [IHCP Provider Bulletins](#)

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### [IHCP Provider Banners](#)

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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

## Traumatic Brain Injury Program

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### Description of Service

Traumatic brain injury (TBI) is an injury sustained after birth from physical trauma, an anoxia or hypoxic episode, allergic conditions, toxic substances, or other acute medical clinical incidents resulting in psychological, neurological or anatomical changes in brain functions. Traumatic brain injury does not include:

- Strokes that can be treated in nursing facilities providing routine rehabilitation services;
- Spinal cord injuries for which there are no known or obvious injuries to the intracranial central nervous system;
- Progressive dementias and other mentally impairing conditions;
- Depression and psychiatric disorders in which there is no known or obvious central nervous system damage;
- Intellectual disability and birth defect related disorders of long standing nature; or
- Neurological degenerative, metabolic, and other medical conditions of a chronic, degenerative nature.

Each brain injury is unique. A brain injury may be mild, with a brief change in mental status, moderate, with a loss of consciousness, or severe, causing a prolonged coma. Mild, moderate and severe brain injuries can lead to long-term symptoms and the potential for permanent disability. The outcome following a brain injury depends on several factors including:

- Nature and severity of the brain injury
- Type and degree of any resulting impairments and disabilities
- Overall health of the patient
- Family support
- Quality of the rehabilitation care

TBI services are provided based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive and behavioral function.

## Medical Policy

### Reimbursement of TBI Services

The IHCP provides reimbursement for TBI services when the services are provided in compliance with all IHCP guidelines, including obtaining prior authorization, for members who have been determined to meet eligibility.

Reimbursement for TBI services is determined based upon the member's level of need in each of the ten (10) domains listed below and the total score of the 10 domains. Based upon the domain total the member will fall within one (1) of four (4) levels of service reimbursement categories which are described in the *Level of Service* section of this policy.

#### Domains

Domains:	Level of Need
Residential	<ul style="list-style-type: none"> <li>Low: basic residential services</li> <li>Medium: moderate assist with residential living</li> <li>High: significant assistance with residential needs</li> </ul>
Case Management	<ul style="list-style-type: none"> <li>Low: minimal logistical assistance</li> <li>Medium: moderate coordination of care and family engagement</li> <li>High: significant management of complex medical and social issues</li> </ul>
Medical Management	<ul style="list-style-type: none"> <li>Low: routine medical care</li> <li>Medium: moderate basic medical services and care delivery</li> <li>High: significant and complex medical services</li> </ul>
Speech/Language Therapy	<ul style="list-style-type: none"> <li>Low: maintenance services for speech and language skills</li> <li>Medium: moderate frequency of speech therapy with progress to goals</li> <li>High: intensive speech therapy for language, speech, and receptive skills</li> </ul>
Productive Activity/Physical Therapy	<ul style="list-style-type: none"> <li>Low: basic activity that does not require skilled staff</li> <li>Medium: moderate individualized therapy with progress to goals</li> <li>High: intensive and frequent services requiring skilled professional staff</li> </ul>
Occupational Therapy	<ul style="list-style-type: none"> <li>Low: basic activity that does not require skilled staff</li> <li>Medium: moderate individualized therapy with progress to goals</li> <li>High: intensive and frequent services requiring skilled professional staff</li> </ul>

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Rehabilitation Therapy	<ul style="list-style-type: none"><li>• Low: basic activity that does not require skilled staff</li><li>• Medium: moderate individualized therapy with progress to goals</li><li>• High: intensive and frequent services requiring skilled professional staff</li></ul>
Vocational Therapy	<ul style="list-style-type: none"><li>• Low: basic activity that does not require skilled staff</li><li>• Medium: moderate individualized therapy with progress to goals</li><li>• High: intensive and frequent services requiring skilled professional staff</li></ul>
Neuro-cognitive Therapy	<ul style="list-style-type: none"><li>• Low: basic activity that does not require skilled staff</li><li>• Medium: moderate individualized therapy with progress to goals</li><li>• High: intensive and frequent services requiring skilled professional staff</li></ul>
Behavioral Health/Psychiatric Therapy	<ul style="list-style-type: none"><li>• Low: basic activity that does not require skilled staff</li><li>• Medium: moderate individualized therapy with progress to goals</li><li>• High: intensive and frequent services requiring skilled professional staff</li></ul>

## Scoring of Domains

Scoring of the Domains
<p>An assessment is utilized to review each case based upon ten domains of service and the intensity of service within each discipline as well as services provided to that member during the review process. Services will be rated on a 1 to 3 scale, e.g.</p> <p>1-----2-----3 Low Medium High</p>

## Level of Services Reimbursement Categories

The goal of TBI rehabilitation is re-integration into the community. The member's ability to live at home and/or in the community is related to the severity of the illness (SI) and intensity of services (IS). The member's needs must be balanced with the resources available in the recovery environment. These resources include:

- Physical health care needs
- Behavioral health care needs
- Cognitive Impairments
- Safety needs, and
- Other support needs

The IHCP has developed four (4) levels of service reimbursement categories utilizing the ten domains of service, identifying the severity of the illness and the intensity of services required by each member. The four levels of service are described below.

## **Level I – Intense NeuroRehabilitation/NeuroBehavioral Programming**

Level I is assigned to members who require immediate admission into an TBI program in order to receive intensive therapy and may be appropriate for up to the first four (4) months of intervention. Members requiring additional days after the first four (4) months for level 1 services will be reviewed on a case-by-case basis.

Members must demonstrate needs in the following areas:

### **Cognitive/Behavioral Needs**

- Cognition – memory, impulsivity, poor judgment, lack of initiation, poor problem solving, poor social skills which significantly impact safety and well being
- Unwanted behaviors – including demonstration of, frequency and intensity of high risk behaviors secondary to the brain injury
- Non-compliance with traditional therapies due to cognitive/behavioral barriers.
- Crisis intervention and ultra-high risk support

### **Safety Needs**

- Supervision – may require additional one on one supervision for behaviors
- Environment – may require durable, secure, highly supervised living environment to decrease risk to self or others.

### **Physical Health Care Needs**

- Medical needs requiring daily nursing availability to ensure safety/wellbeing
- Medication management
- Coordination of physician specialists and/or any orthotic/prosthetic devices
- Pharmacological intervention through psychiatrist consults and medically necessary therapeutic interventions in all of the areas listed below.
- Residential

### **Other Needs**

- Transportation/Escort
- Interagency communication/coordination
- Family/Caregiver Training



- Available continuum of treatment/environmental options to practice skill acquisition and simulate discharge environment.
- Begin discharge planning as part of the program to match home community based services in Indiana

Requires therapeutic interventions in the following areas

- Residential
- Case Management
- Medical Management
- Speech Language Therapy
- Productive Activity/Physical Therapy
- Occupational Therapy
- Rehabilitation Therapy
- Vocational Therapy
- Neuro-cognitive Therapy
- Mental/Behavioral Health

Level I may be appropriate for up to the first 4 months of intervention.

#### Level I Per Diem Rates

Billing Level	Total Score of Domains	Corresponding per diem
Level I	30	\$ 567
Level I	28 – 29	\$ 541
Level I	26 – 27	\$ 509

Members at level 1 will have a total domain score between 26 and 30.

#### Level II – Active NeuroRehabilitation/NeuroBehavioral Step-Down Program

Level II offers individualized support needed at any time, specifically during times of crisis, and a member may require or be provided additional residential and programmatic support. The team may change the intensity of assistance from time to time, while taking advantage of certain “therapeutic windows”. Regardless of the setting or type of program, rehabilitation interventions are intended to help members practice strategies to remain free from harm and attain personal goals that are durable over time . Discharge planning efforts continue to be geared toward exploring and securing living environments, therapeutic services, and productive activities that match the needs and desires of the member with a focus on returning to the home community.

Level II members’ have made progress in active rehabilitation and exhibit the following needs:

- Training in self-management of behavioral, cognitive, and/or medical/physical challenges
- Continues to require specialized therapeutic intervention in the following areas although at a reduced frequency and duration
  - Residential
  - Case Management
  - Medical Management
  - Speech Language Therapy
  - Productive Activity/Physical Therapy
  - Occupational Therapy
  - Rehabilitation Therapy
  - Vocational Therapy
  - Neuro-cognitive Therapy
  - Mental/Behavioral Health
- Still unable to access their home environment, independent living options, or transitional supported living due to the continual unwanted behaviors or the significant cognitive/physical challenges.
- Ready to engage in therapeutic interventions geared toward maintaining the durability of goals achieved as well as continued work on upgraded objectives

#### Level II Per Diem Rates

Billing Level	Total Score of Domains	Corresponding per diem
Level II	25	\$ 477
Level II	23 – 24	\$ 445
Level II	21 – 22	\$ 413

Members at level II will have a total domain score between 21 and 25.

#### Level III: NeuroRehabilitation/NeuroBehavioral Step Down Program

Level III members' have made progress in more intensive, active rehabilitation and require reduced formal clinical service delivery. Members who are appropriate for this level of program will transition into a residential and programmatic continuum designed to replicate the type of support the person will experience once they return to their home community. Members will continue to practice strategies to increase independence, safety, and behavioral self-management while pursuing discharge placement in the discharge community. During times of crisis, a member may require or be provided additional residential and programmatic support. If

the crisis maintains, the member may need to move to Level I or II with the corresponding rate until stabilized.

Level III places strong emphasis on discharge planning as the member continues to practice skills attained and prepares for transfer to an alternative environment or to reside in the most independent environment possible.

Level III members' exhibit the following needs:

- Additional experience and feedback with a variety of daily living situations to ensure self-management skills are effective and risk is minimized
- Supported living skill training and supervision with feedback
- Productive activity and community involvement with therapeutic intervention and feedback provided
- Supported practice with individualized cognitive, behavioral, or medical strategies to minimize health and safety risk.
- Continues to require specialized therapeutic intervention in the following areas although at a reduced frequency and duration:
  - Residential
  - Case Management
  - Medical Management
  - Speech Language Therapy
  - Productive Activity/Physical Therapy
  - Occupational Therapy
  - Rehabilitation Therapy
  - Vocational Therapy
  - Neuro-cognitive Therapy
  - Mental/Behavioral Health

## Level III Per Diem Rates

Billing Level	Total Score of Domains	Corresponding per diem
Level III	20	\$ 381
Level III	16 – 19	\$ 349

Members at level III will have a total domain score between 16 and 20.

## Level IV: NeuroRehabilitation/Neurobehavioral Step-Down Support Services

Level IV members' have made progress in more intensive, active rehabilitation and are appropriate for step down services to maintain goals achieved through supportive services. Members who are appropriate for this level of step down support services will attempt to replicate the type of interventions the individual will experience once they return to their home community. Members will continue to practice learned strategies to increase independence, safety, and behavioral self-management while pursuing discharge placement in the appropriate community. During times of crisis, members may require or be provided additional residential and programmatic support. If the crisis maintains, the member will be recommended to a move to Level I, II, or III with the corresponding rate until stabilized.

Level IV places a strong emphasis on discharge planning as the member continues to practice skills attained and maintain those skills designed to meet future placement needs in the home community.

Level IV members' exhibit the following needs:

- Additional experience and feedback with a variety of daily living situations to ensure self-management skills are effective and risk is minimized
- Supported living skill training and supervision with feedback
- Productive activity and community involvement with therapeutic intervention and feedback provided
- Supported practice with individualized cognitive, behavioral, or medical strategies to maintain current health and overall functioning level.
- Continues to require specialized therapeutic intervention at a moderate level in the following areas although at a reduced frequency and duration:
  - Residential
  - Case Management
  - Medical Management
  - Speech Language Therapy
  - Productive Activity/Physical Therapy
  - Occupational Therapy

- Rehabilitation Therapy
- Vocational Therapy
- Neuro-cognitive Therapy
- Mental/Behavioral Health

## Level IV Per Diem Rates

Billing Level	Total Score of Domains	Corresponding per diem
Level IV	15	\$ 317
Level IV	10 – 14	\$ 285

Members at this level will have a total domain score between 10 and 15.

## Per Diem Rates

The total score of the domains determines the billing level and reimbursement rate. Rates are adjusted according to the level of intensity, on a scale of 1-3, as evidenced by medical necessity based upon the member's individual needs. All reimbursement rates are directly communicated to the facility via the Notice of Action (Admission or Extension) letter. Each member's reimbursement rate is reviewed at the time of the clinical reassessment and the extension request. Table 7 – *TBI Per Diem Rates* is utilized to determine the rate for reimbursement for the prospective period. Level assignment and rate determinations will be based upon the information supplied by the TBI facility from documentations submitted for review and dialogue from collaborative case rounds with the Prior Authorization Vendor.

The per diem rates include the following services:

- Room and board
- Staffed residence
- Therapeutic interventions

## TBI Per Diem Rates

Billing Level	Total Score of Domains	Corresponding per diem
Level I	30	\$ 567
Level I	28 – 29	\$ 541
Level I	26 – 27	\$ 509
Level II	25	\$ 477
Level II	23 – 24	\$ 445
Level II	21 – 22	\$ 413
Level III	20	\$ 381



Level III	16 – 19	\$ 349
Level IV	15	\$ 317
Level IV	10 – 14	\$ 285

## Prior Authorization

Prior Authorization is required for TBI services per 405 IAC 5-5. The IHCP does not reimburse providers for any services requiring prior authorization unless prior authorization is obtained first.

### Admission Requests

Placement within a TBI facility is available to members who have been determined to meet eligibility. Qualifications for enrollment in the TBI -program include (but are not limited to) the following:

- Diagnosis of Traumatic Brain Injury
  - The injury resulted from an acute anoxic event or brain injury caused by external trauma
- Medical need for long term neuro-cognitive rehabilitation
- Therapeutic benefit from rehabilitation services proposed is reasonable
- Acute services for brain injury and other services within Indiana must have been considered and utilized when available
- Formal clinical assessment for need of long term rehabilitation has been conducted by brain injury specialists within Indiana
- Member must be 18 years of age or older.
  - Requests for admission for members under age 18 will be reviewed on a case-by-case basis

Consideration of admission includes submission of documentation to support the following criteria:

- Diagnosis of Traumatic Brain Injury
- Rancho Los Amigos Levels of Cognitive Functioning level of V or greater and/or
- Mayo-Portland Adaptability Inventory (MPAI-4)
- The member's current residence/living situation
- Summary of the member's complete medical history, including
  - past hospitalizations
  - rehabilitation services

- initial date of any head injury
  - history of previous head injury or cerebral harm
  - history of pre-injury behavior and social condition (including history of drug abuse, abuse, or police arrests)
- Evidence of behavioral problems including
  - aggressiveness
  - sexual inappropriateness
  - danger to self or others
- Neuropsychiatric evaluation (if completed)
- Psychiatric history (including depression, suicide, etc)
- Ability to participate in a minimum of 3 hours of therapy per day
- Free of mental illness or illicit drug use
- Medically stable
- A reasonable expectation for improvement with therapy
- A reasonable expectation that the member would be eligible to return to his/her community for ongoing services upon completion of program
- Head injury that is no more than 4 years old; exceptions include
  - Member has had no previous treatment for their TBI
- Cannot be placed and adequately cared for in any in-state facility
- The member must meet one of the four (4) levels of need

All TBI admission requests are reviewed by the Prior Authorization (PA) Vendor on a case-by-case basis. The PA vendor determines the medical necessity for placement and if appropriate services are available to address the member's needs within Indiana. When members qualify for placement, the level of services provided is reviewed as submitted by the requesting facility.

### **Extension Requests**

Providers must submit a re-assessment of the member's functional status along with the extension request. The re-assessment is utilized to review each case based upon the ten domains of service, the intensity of service within each discipline, as well as services provided to the member during the review process, and initial or ongoing discharge planning efforts.

Each domain will be evaluated by the Prior Authorization Vendor as documented in the extension request and a determination will be made based upon the member's level of need in each of the ten (10) domains.

### **Hearing & Appeals Procedures**

Requests for the Administrative Review, Appeals, & Hearing process are consistent with the procedures as outlined in the [Prior Authorization](#) provider reference module.

## Billing and Coding

Once a member's stay has been authorized for admission or an extension, the authorization will be approved with one of the 10 HCPCS procedure codes listed below. Providers must bill on the UB-04 claim form utilizing the authorized HCPCS procedure code along with the usual and customary charges. Billing, payment, and enrollment is contingent upon member's Medicaid eligibility.

**TBI HCPCS Codes and Rates**

HCPC Code	Rate	Billing Level
H2013 UB	\$567	Level I
H2013 UA	\$541	Level I
H2013 U9	\$509	Level I
H2013 U8	\$477	Level II
H2013 U6	\$445	Level II
H2013 U5	\$413	Level II
H2013 U4	\$381	Level III
H2013 U3	\$349	Level III
H2013 U2	\$317	Level IV
H2013 U1	\$285	Level IV

The following services are included in the per diem rate:

- Room and board
- Staffed residence
- Therapeutic interventions

### Member Leave Days

The IHCP no longer covers "bed hold" days in a TBI facility as a member benefit. This change impacts all IHCP members receiving long term neuro-cognitive rehabilitation in the TBI facilities. Facilities must make members aware of their policies and that members cannot be charged for services that they do not request or that are not provided.

## Rules and Citations

### [405 IAC 5](#)

- 405 IAC 5-5-1 Services; General

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- 405 IAC 5-3 Prior Authorization  
[IHCP Provider Bulletins](#)
- [BT201127](#) The IHCP eliminates reimbursement for targeted case management  
[IHCP Provider Banners](#)

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**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication

## Vision Services

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### Description of Service

Medicaid reimbursement is available for vision services as defined in IC 25-24-1-4 rendered by a licensed provider within the scope of his or her license.

- Ophthalmologists are licensed medical physicians or osteopathic physicians who have the ability and credentials to perform surgical procedures on the eye and related structures.
- Optometrists are licensed professionals trained to examine eyes and vision, prescribe and fit lenses, and diagnose and treat visual problems and impairment.

Other vision related services such as pharmaceutical, surgeries, and diabetes self-management training (DSMT) are covered services when determined to be medically necessary.

### Medical Policy Eye Examinations

An initial examination is the initial vision care service performed for the determination of the need for additional vision care services. Medical necessity will determine which type of initial exam will be given.

IHCP coverage for an initial and routine eye examination will be limited to:

- One (1) examination per 12-month period for a member under 21 years of age
- One (1) examination every two (2) years for a member 21 years of age or older

If more frequent examination of care is medically necessary, documentation supporting such medical necessity determinations must be maintained in the provider's office and is subject to post-payment review and audit.

Eye examinations may include the following services, and providers should not bill them separately:

- Eye examination, including history
- Visual acuity determination
- External eye examination
- Biocular measure
- Routine ophthalmoscopy
- Tonometry and gross visual field testing, including color vision, depth perception, or stereopsis



## Diagnostic Services

The IHCP provides coverage for diagnostic services, if medically necessary, in addition to an eye examination. These services include the following:

- Supplemental evaluation
- Multiple pattern fields, including Roberts, Harrington, or Flods
- Central field study
- Peripheral field study
- Tangent screen study
- Color field study
- Binocular ophthalmoscope
- Other supplemental testing
- Visual skills study
- Clinical photography
- Bifocal determination
- Trifocal determination
- Definitive fundus evaluation
- Electrophysiology
- Gonioscopy
- Neutralization of lens or lenses
- Neutralization of contact lenses
- Extended ophthalmoscopy
- Serial tonometry
- Refractions
- Out-of-office visit
- Office visit
- Consultation
- Visual skills testing

Screening services (excluding Early and Periodic Screening, Diagnosis, and Treatment – EPSDT) for recipients are not covered by the IHCP, and payment will not be made for such care. All services provided to recipients in long-term care (LTC) facilities must be documented in the recipient medical record maintained by the facility.

## Eyeglasses

The IHCP provides coverage for eyeglasses with the following limitations:

- One (1) pair of eyeglasses per 12-month period for a member under 21 years of age
- One (1) pair of eyeglasses every five (5) years for a member 21 years of age or older

The following medical necessity criteria must be met for an initial or subsequent pair of eyeglasses:

- In at least one (1) eye, a minimum initial prescription or, for a subsequent pair of eyeglasses, a change of 0.75 diopters for members aged 6 to 42 years old
- In at least one (1) eye, a minimum initial prescription or, for a subsequent pair of eyeglasses, a change of 0.50 diopters for members over the age of 42 years old
- An axis change of at least 15 degrees

The IHCP will provide reimbursement for repairs or replacements of eyeglasses only after receiving documentation that the repair or replacement is necessary due to extenuating circumstances beyond the member's control, such as fire, theft, or automobile accident. This documentation must include a signed statement by the member detailing how the eyeglasses were lost, stolen, or damaged beyond repair. The documentation of the extenuating circumstances must be maintained in the provider's office and shall be subject to postpayment review and audit.

### Lenses

The prescription of lenses, when required, is included in the CPT® code 92015 – *Determination of refractive state*. It includes specification of lens type, monofocal, bifocal, lens power, axis, prism, absorptive factor, impact resistance, and other factors.

Safety lenses are covered only for corneal lacerations and other severe, intractable ocular or ocular adnexal diseases. The IHCP may reimburse for only tints 1 and 2, including the following:

- Rose A
- Pink 1
- Soft lite
- Cruxite
- Velvet lite

If a member chooses to upgrade to progressive lenses, transitional lenses, anti-reflective coating, or tint numbers other than 1 or 2, the basic lens V code can be billed to the IHCP. The upgrade portion can be billed to the member only if the member was given an appropriate advance notification of the non-covered service, and if a separate procedure code for the service exists.

The IHCP does not provide coverage for all lenses. Noncovered lenses include:

- Lenses with decorative designs
- Fashion tints, gradient tints, sunglasses, or photochromatic lenses
- Except when medical necessity is documented, lenses larger than size 61 millimeters

## Polycarbonate Lenses

The IHCP has developed specific criteria for polycarbonate lenses to ensure that they are used only for medically necessary conditions that require additional ocular protection for members.

Polycarbonate lenses may be billed when a corrective lens is medically necessary, and if one or more of the following criteria is met:

- Member has carcinoma in one eye, and the healthy eye requires a corrective lens.
- Member has only one eye, which requires a corrective lens.
- Member has had eye surgery and still requires the use of a corrective lens.
- Member has retinal detachment or is post-surgery for retinal detachment and requires a lens to correct a refractive error of one or both eyes.
- Member has a cataract in one eye or is post-cataract surgery and requires a lens to correct a refractive error of one or both eyes.
- Member has low vision or legal blindness in one eye with normal or near normal vision in the other eye.
- Other conditions deemed medically necessary by the optometrist or ophthalmologist. These conditions must be such that one eye is affected by an intractable ocular condition, and the polycarbonate lens is being used to protect the remaining vision of the healthy eye.

## Frames

IHCP reimbursement is available for frames, including but not limited to, plastic or metal subject to the following limitation:

- The maximum amount reimbursed for frames is \$20 per pair, except when medical necessity requires a more expensive frame.

Situations where medical necessity for a more expensive frame may be indicated include but are not limited to the following:

- Frames to accommodate facial deformity or anomaly
- Allergy to standard frame materials
- Specific lens prescription requirements
- Frames with special modifications, such as a ptosis crutch
- Infant or child where special size frames must be prescribed that are unavailable for \$20 or less

All Medicaid claim forms submitted for more expensive frames must be accompanied by documentation supporting medical necessity. Providers who receive payment from the IHCP for frames may not bill the member for any additional cost that is more than the IHCP reimbursement.

The IHCP does not cover any portion of a deluxe or fancy frame purchase, except when medically necessary. If a member chooses to upgrade to a deluxe frame without medical

necessity, the entire frame is considered non-covered and may be billed to the member, if proper advance notice of non-coverage was provided and signed by the member. In these situations, only the claim for the lenses should be submitted to the IHCP for reimbursement.

### **Contact Lenses**

Contact lenses are covered when medically necessary. Documentation is not required with the claim, but must be maintained in the member's medical record for post-payment review. Medical necessity for contact lenses includes but is not limited to:

- Members with severe facial deformities who are physically unable to wear eyeglasses
- Members who have severe allergies to all frame materials

The prescription of contact lenses includes the specification and physical characteristics such as power, size, curvature, flexibility, and gas permeability. Fitting contact lenses includes instruction, training, and incidental revision of the lenses during the training period. Follow-up and documentation of successful fitting of extended-wear lenses is necessary, as well.

### **Ophthalmologic Surgeries**

Documentation must be maintained in the member's medical records to support medical necessity for all ophthalmologic surgeries, including Argon and Krypton laser-beam therapy, yttrium aluminum garnet (YAG) laser, intraocular stents, intraocular lenses (IOLs), new technology intraocular lenses (NTIOLs), and vitrectomy.

### **Argon and Krypton Light Amplification by Stimulated Emission of Radiation (LASER) Beam Therapy**

Argon and Krypton LASER Beam therapy uses a variety of gases to produce light beams to provide therapy for multiple conditions. Argon and Krypton LASER Beam treatment may be used to weld the retina to the back of the eye in the case of small retinal detachment, or it may be used to incise tissue to provide a new avenue for the aqueous humor to drain as part of glaucoma treatment.

### **Intraocular Stents**

The IHCP covers intraocular stents inserted in conjunction with cataract surgery.

### **Retisert**

The IHCP provides coverage for Retisert® for the treatment of chronic posterior uveitis. Retisert should not be billed for diabetic macular edema. Billing for Retisert is limited to one unit per date of service and must be billed with the appropriate National Drug Code (NDC). Coverage applies to all IHCP programs, subject to prior authorization and to limitations established for certain benefit packages.

## IOLs and NTIOLs

IOLs and NTIOLs are intraocular lenses that are implanted to replace the natural lenses following procedures such as cataract surgery. Other diagnoses supporting medical necessity of NTIOLs include, but are not limited, to the following:

- Glaucoma
- Iris melanoma
- Ciliary body melanoma
- Choroids melanoma

## Vitrectomy

A vitrectomy is the removal of the vitreous humor when it is diseased or damaged. Diagnoses that may support medical necessity of vitrectomy as a sight-saving procedure include but are not limited to the following:

- Vitreal hemorrhage
- Retinal detachment
- Scarring or fibrosis of vitreous
- Proliferative retinopathy

Documentation must be maintained in the member's medical record. The operative report should be reviewed and the claim paid as follows:

- If the vitrectomy is performed through the pars plana, the vitrectomy and the appropriate cataract extraction code will be paid according to the multiple surgical procedure payment guidelines.
- If the claim states "restorations of anterior chamber," the cataract extraction will be paid, and the vitrectomy is included in the procedure and will not be reimbursed separately.
- If an open sky vitrectomy is performed with the cataract extraction, the vitrectomy and the cataract extraction will be paid according to the multiple surgical procedure payment guidelines.

Vitrectomy services billed with corneal transplant on the same eye should be denied if the service is to restore the anterior chamber. Vitrectomy through the pars plana or the open sky technique with the corneal transplant should be paid according to the guidelines for vitrectomy with cataract surgery. A pars plana vitrectomy and photocoagulation billed separately should be combined and coded appropriately.

## YAG LASER

The YAG LASER treatment is the laser separation of the posterior capsule. The treatment is used when there is a blockage between the lens and the vitreous humor of the eye. This treatment allows the passage of light through the media to the retina, which was initially retracted and obstructed. The YAG LASER may be used for the surgical removal of pathological tissue, that is, brain tumors, hemorrhoids, and chondylmata. When used in conjunction with a



surgery not specific to ophthalmological treatments, it should be included in the global fee billing schedule when filing a claim.

## Orthoptic or Pleoptic Training, Vision Training, and Therapies

All vision training therapies are covered under 92065 – *Orthoptic and/ or pleoptic training, with continuing medical direction and evaluation*. The medical record must be maintained to support medical necessity and must include the following coverage criteria for these services:

- 92065 is limited to one unit or visit per day.
- Vision therapy services must be ordered by a physician or an optometrist.
- The physician or optometrist must document a diagnosis, treatment plan, and the need for continued treatment in the medical record.
- Vision therapy services can be performed by an optometrist, a physician, or supervised staff. Staff must be trained or certified to provide these vision services.
- Staff trained or certified in vision training may perform orthoptic and pleoptic training only under the direct supervision of an optometrist or physician. Direct supervision requires that the supervising physician or optometrist be physically available at the time and location the vision therapy services are rendered.
- All documentation of directly supervised vision therapy services rendered by staff must be cosigned in the medical record by the supervising optometrist or physician.

**Note:** HIP Plus members are eligible for the following vision benefits: routine eye exam (once every two years); eyeglasses, including frames and lenses (one pair every five years if there is not a sufficient change in prescription (vision), loss, irreparable damage, or theft; replacement eyeglasses (covered when medical necessity guidelines are met or due to loss, theft, or damage beyond repair); contact lenses (covered for medical necessity, such as facial deformity or allergy to frame prevents wearing eyeglasses); vision surgeries (covered for medical necessity); and vision training therapies (covered for medical necessity). Not all frames and lenses are covered, unless medically necessary. Members may choose to upgrade frames and lenses and pay the difference.

## Prior Authorization

Most vision care services do not require prior authorization; however, PA is required for the following services:

- Blepharoplasty for a significant obstructive vision problem
- Prosthetic device, except eyeglasses
- Reconstructive or plastic surgery
- Retisert

PA is required for all vision services provided to 590 members when an amount greater than \$500.00 per procedure is billed, regardless of whether the services require PA in the traditional Medicaid program.

## Billing and Coding

For further billing information, see the [Vision Services](#) provider reference module. For a list of billing codes, see the *Vision Services Codes* on the [Code Sets/Tables](#) webpage.

## Rules and Citations

[42 CFR 440.120 Subpart A](#) Prescribed drugs, dentures, prosthetic devices, and eyeglasses.

[42 CFR 441.30, Subpart A](#) Optometric services

### [405 IAC 5](#)

- 405 IAC 5-9-1 – E/M services
- 405 IAC 5-3-1 – Prior Authorization
- 405 IAC 5-16 – Home Health Agency and Clinic Services
- 405 IAC 5-19-11 – Prosthetic Devices
- 405 IAC 5-23 – Vision Care Services
- 405 IAC 5-28-1 – Reimbursement Limitations
- 405 IAC 5-36 – Diabetes Self Management Treatment

### [IHCP Provider Bulletins](#)

- [BT201324](#) Update regarding reduction in reimbursement for eye care and eyewear
- [BT201557](#) IHCP to add diagnosis codes for coverage of visual evoked potential
- [BT201546](#) IHCP adds coverage for intraocular stents
- [BT201542](#) IHCP announces coverage of Retisert for the treatment of chronic posterior uveitis
- [BT201049](#) Change in coverage for vision services

### [IHCP Provider Banners](#)

**Note:** For the most updated information regarding the Provider Reference Materials, Bulletins, and Banners, please visit <http://provider.indianamedicaid.com/>.

## Update History

January 1, 2017 – Initial Publication