March 2006 **Provider Bulletin Number 631**

Hospital Providers

Revision to Hyperbaric Oxygen Therapy Bulletin Posted December 2005

In December 2005, bulletin number 564 b was published to Hospital providers regarding Hyperbaric Oxygen Therapy. This bulletin is a revision to the original. The corrections are highlighted in gray below.

Effective with dates of service on and after December 15, 2005, hyperbaric oxygen therapy will be a covered service under KMAP with prior authorization (PA). The following criteria must be met before a PA will be approved.

1. The services must be for one of the following conditions:
    a. Acute carbon monoxide intoxication
    b. Decompression illness
    c. Gas embolism
    d. Gas gangrene
    e. Acute traumatic peripheral ischemia
    f. Compromised skin grafts
    g. Chronic refractory osteomyelitis
    h. Osteoradionecrosis
    i. Soft tissue radionecrosis
    j. Cyanide poisoning
    k. Actinomycosis
    l. Crush injuries and suturing of severed limbs
    m. Progressive necrotizing infections
    n. Acute peripheral arterial insufficiency
    o. Diabetic wounds of lower extremities

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

Physicians will bill for this procedure using 99183 (one unit equals one session up to two hours). Facilities will bill for this procedure using either 99183 (one unit equals 30 minutes) or C1300 (four units equals one session, up to two hours). The facility must choose which procedure code they will bill prior to approval of the PA.

If there are multiple sessions on the same day (more than one unit for physicians and more than four units for facilities), each subsequent session must be billed on a separate line detail with a 76 modifier.

Information about the Kansas Medical Assistance Program as well as provider manuals and other publications are on the KMAP Web site at https://www.kmap-state-ks.us. For the changes resulting from this provider bulletin, select the *Hospital Provider Manual*, pages 8-4 through 8-14.

For a hard copy of the revised manual pages, send an email to publications@ksxix.hcg.eds.com or mail a request to:

Publications Coordinator
3600 SW Topeka Blvd, Suite 204
Topeka, KS 66611

Specify the bulletin by number, provider type and date, and include your mailing address with a specified individual or office if possible.

If you have any questions, please contact the KMAP Customer Service Center at 1-800-933-6593 (in state providers) or 785-274-5990 between 7:30 a.m. and 5:30 p.m., Monday through Friday.

8200. Updated 3/06

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

Abdominal Pain: Indicate the severity and chronicity of the pain, presenting symptoms and suspected conditions or complications.
Abdominal Aneurysms: Indicate the presenting symptoms and suspected complications.
Acute Lymphocytic Leukemia: Indicate the presenting symptoms and a detailed description of area(s) involved.
Malignant Neoplasm not located in the Intra-Abdominal Cavity, Lung or Genital Organs: Indicate pertinent symptoms and if performed as part of staging the disease process.

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

CT Scans - Head or Brain:

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

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

Headache - Indicate length of chronicity and any accompanying Central Nervous System (CNS) symptoms.
Epilepsy - Specify if initial or repeat scan, indicate if suspected injury occurred during seizure.
Syncope - Specify if recurrent or single episode.
Dizziness - Specify if recurrent or single episode.
Acute Lymphocytic Leukemia - Indicate any accompanying CNS symptoms.

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

8200. Updated 3/06

Hyperbaric Oxygen Therapy

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

1. the services must be for one of the following conditions:
    a. Acute carbon monoxide intoxication
    b. Decompression illness
    c. Gas embolism
    d. Gas gangrene
    e. Acute traumatic peripheral ischemia
    f. Compromised skin grafts
    g. Chronic refractory osteomyelitis
    h. Osteoradionecrosis
    i. Soft tissue radionecrosis
    j. Cyanide poisoning
    k. Actinomycosis
    l. Crush injuries and suturing of severed limbs
    m. Progressive necrotizing infections
    n. Acute peripheral arterial insufficiency
    o. Diabetic wounds of lower extremities
2. It must be documented that other treatments have been attempted with no improvement.

Facilities bill for this procedure using either 99183 (one unit equals 30 minutes) or C1300 (four units equals one session, up to two hours). The facility must choose which procedure code they will bill prior to the approval of the PA.

If there are multiple sessions on the same day (more than four units for facilities), each subsequent session must be billed on a separate line detail with a 76 modifier.

MRI - Head or Brain:

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

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

Headache - Indicate length of chronicity and any accompanying neurologic symptoms.
Seizure - Specify if initial or repeat scan, and if seizures (or convulsions) are of
Disorders - (or convulsions) are of recent onset, frequency of their occurrence, and any accompanying neurologic symptoms.
Syncope - Specify if recurrent or single episode and any accompanying neurologic symptoms.

8200. Updated 3/06

Dizziness - Specify if recurrent or single episode and any accompanying neurologic symptoms.
Non-CNS Malignancies - Indicate any accompanying neurologic symptoms.

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

MRI - Breast

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

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

MRI used for screening for breast cancer is not justified.

Skull X-Rays:

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

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

Chronic Sinusitis - Indicate any pertinent specific suspected complications resulting from chronicity.
Trigeminal Neuralgia - Specify type of lesion suspected.
Anomalies relating to the head - Specify if done as a scout film for non-cosmetic reconstructive surgery. Indicate type of surgery under consideration.

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

Sonograms - Non-Obstetrical Pelvic:

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

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

8200. Updated 3/06

Obstetrical Pelvic Sonograms:

Routine obstetrical sonograms for a normal pregnancy are not covered.

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

Medical necessity may also be determined based on maternal age, maternal weight or fetal position. If applicable, this information should be submitted with the claim. It may be necessary to contact the ordering physician for medical necessity information.

A biophysical profile will not be reimbursed when a complete OB sonogram has been billed for the same date of service.

Upper Gastrointestinal Series:

Upper Gastrointestinal (UGI) series are medically necessary if the primary diagnosis indicates persistent dysphagia, melena, symptoms of UGI tract bleeding or signs and symptoms of ulcers affecting the UGI tract after a trial of medicinal therapy has failed to relieve the symptoms.

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

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

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

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

8200. Updated 3/06

Emergency Room/Department (Outpatient Hospital):

General Information:
The State of Kansas defines emergency services as follows:

> KAR 30-5-58 (42) "Emergency services are those services provided after the sudden onset of a medical condition manifested by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part."
>
> KAR 30-5-81 (b) (4) "Services provided in the Emergency Department shall be emergency services."

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

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

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

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

Other Examples of Emergencies Are:

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

8200. Updated 3/06

Non-Emergent Situations:

- Intentional non-compliance with previously ordered medications and treatments resulting in continued symptoms of the same condition.
- Refusal to comply with currently ordered procedures/treatments such as drawing blood for laboratory work.
- Leaving the emergency room against medical advice.
- Scheduled visits to the emergency room for procedures, examinations or medication administration. Examples include cast changes, suture removal, dressing changes, follow-up examinations and second opinion consultations.
- Visits made to receive a "tetanus" injection in the absence of other emergent conditions.
- Visits made to obtain medication(s) in the absence of other emergent conditions.

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

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

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

Guidelines for Use of Air Ambulance Services:

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

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

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

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

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

8200. Updated 3/06

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

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

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

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

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

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

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

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

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

8200. Updated 3/06

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

Seizures are considered emergent when:

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

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

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

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

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

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

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

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

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

8200. Updated 3/06

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

A laceration requiring steri-strips indicates a gaping wound and would be considered emergent.

X-rays do not define the level of care.

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

Time of Visit: The **time of the visit** is a consideration in determining emergent vs. nonemergent status. If the condition require immediate attention and it is after office hours, a weekend, or holiday, consider as emergent.

If a patient is brought in by the police at any time, consider as emergent.

If a patient had previously been in the same or different emergency department or physician's office for the same condition and the condition has not worsened, the visit will be considered nonemergent.

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

Emergency Department/Room Guidelines for E&M Codes:

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

Examination: A "comprehensive exam" is considered a "hands on" specialist examination. Telephone consultation with a specialist is not the equivalent of comprehensive exam (per Dr. Aaron Primack, HCFA/AMA consultant).

Medical Decision Making: Transfers from the emergency department to another facility for additional care should be considered in management options as either the "new problem, additional work-up" or the category of "established problem, worsening" (per Dr. Aaron Primack, HCFA/AMA consultant).

A vascular examination is included in the cardiovascular category.

8200. Updated 3/06

A notation that the patient should "follow-up" with his family physician in the morning or return to the physician's office for stitch removal does not justify use of the "additional work-up" statement when considering management options (per Dr. Aaron Primack, HCFA/AMA consultant).

In evaluating the "Table of Risk", infection is the usual risk that pops into mind when talking about minor surgery. To consider infection as a "risk" from minor surgery, there must be documentation to support increased risk due to the quality or condition of the injury or illness (per Dr. Aaron Primack, HCFA/AMA consultant).

"Self-limited/minor problems" are defined as those representative of basic emergency department care such as lacerations, stings, insect bites (per Dr. Aaron Primack, HCFA/AMA consultant).

"New problems with or without additional work-up" is defined as representing new, long-standing problems that will need attention again at some time (per Dr. Aaron Primack, HCFA/AMA consultant).

Observation Room:

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

There is no time limit restriction for the observation room. The same reimbursement rate applies regardless of the number of hours required for monitoring. This reimbursement is all inclusive of services and supplies. If there is a discharge and readmission to the observation room from midnight to midnight, only one reimbursement rate will be allowed.

Observation room is content of service of a minor surgery.

ER physician fee, **non-scheduled** fetal oxytocin stress tests and fetal non-stress tests are content of service of the observation room. Additional reimbursement for these services will not be made.

Observation room should **not** be billed for the following:

- Recovery room services following inpatient or outpatient surgery.
- Recovery/observation following scheduled diagnostic tests such as arteriograms, cardiac catherization, etc.
- **Scheduled** fetal oxytocin stress tests and fetal non-stress tests.

8200. Updated 3/06

NOTE: Additional information may be added to the face of your claim if applicable. Tape billers who have had initial billings denied with EOB 548 (Service denied. This claim and all attachments have been reviewed by the medical staff and the medical necessity of the service rendered is not supported by the documentation provided. Refer to the provider manual section 8200 for further discussion.), may resubmit a paper claim with the applicable documentation noted on the face of the claim.

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