Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

Professional

Updated 07.2024

PART II
PROFESSIONAL FEE-FOR-SERVICE PROVIDER MANUAL

INTRODUCTION

FORMS: All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

PART II
PROFESSIONAL

Updated 01/18

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

Billing Instructions contains instructions on completion and submission of the CMS 1500 paper or equivalent electronic claim form.

Benefits and Limitations defines specific aspects of the scope of services covered within the Kansas Medical Assistance Program (KMAP).

Appendix I contains information concerning codes.

Forms are on the public and secure websites. These forms can be duplicated for your use, except the sample claim forms.

Access to Records
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

Confidentiality & HIPAA Compliance
Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164.

KMAP Audit Protocols
The KMAP Audit Protocols are available on the Provider page of the KMAP website under the ***Provider Documents*** heading.

BILLING INSTRUCTIONS

7000. Updated 08/17

Introduction to CMS 1500 Claim Form
Providers of professional services must use the CMS 1500 paper or equivalent electronic claim form when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website, through Provider Electronic Solutions (PES), or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it is returned to the provider.

An example of the paper CMS 1500 Claim Form and instructions are available on the KMAP public and secure websites on the Forms page under the Claims (**Sample Forms and Instructions**) heading.

Any of the following billing errors may cause a paper CMS 1500 Claim Form to deny or be sent back to the provider:

- Sending a CMS 1500 Claim Form carbon copy.
- Sending a KanCare paper claim to KMAP.
- Using a PO Box in the Service Facility Location Information field.

The fiscal agent does not furnish the paper CMS 1500 Claim Form to providers. Refer to **Section 1100** of the *General Introduction Fee-for-Service Provider Manual*.

BILLING INSTRUCTIONS

7010. SPECIFIC BILLING INFORMATION Updated 05/24

Allergy

- When billing for an allergy evaluation, follow the instructions in the *CPT*® codebook and utilize Evaluation and Management (E&M) office visit codes.
- Procedure code 95165 is limited to 156 doses per year. Providers can request a prior authorization for services excess of 156 doses. Medical necessity documentation must be submitted with the prior authorization request.

  Allergy Immunotherapy Injection, Antigen, and Supervision of Preparation codes are only allowed to be billed by Professional Providers. These codes are not allowed to be billed by hospitals.

  Allergy Immunotherapy Injection codes:

95115	95117

  Antigen codes:

95144	95145	95146
95147	95148	95149

  Supervision of Preparation codes:

95165	95170

Anesthesia

- Medicaid claims for anesthesia must be billed using the American Society of Anesthesiologists (ASA) codes. Medical direction or supervision of anesthesia services by an anesthesiologist cannot be billed in addition to certified registered nurse anesthetist (CRNA) anesthesia services. Only bill for direct face-to-face patient time, not wait time.
- In Field 24G, indicate the number of **minutes** anesthesia was administered. Give only whole numbers. Round all decimals upward to the nearest whole number. Example: 13.4 minutes of anesthesia administered should be indicated as 14 in Field 24G.
- Anesthesia modifiers are required for procedure codes 00100-01999 except for codes 01990 and 01996. One of the following modifiers must be reported with anesthesia services in the first modifier field to indicate who performed the anesthesia service. Anesthesia services billed without one of these modifiers will be denied.
  - AA – Anesthesia services performed personally by anesthesiologist.
  - AD – Medical supervision by a physician: more than four concurrent anesthesia procedures. **Modifier AD is not covered by KMAP.**
  - QK – Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals. Effective with dates of service prior to December 1, 2023, modifier QK is not covered by KMAP. Effective with dates of service on and after December 1, 2023, claims utilizing this modifier will be reimbursed at 50%.

7010. Updated 05/24

Anesthesia continued

- QX – CRNA/AA service; with medical direction by a physician. Effective with dates of service on and after December 1, 2023, claims utilizing this modifier will be reimbursed at 50%.
- QY – Medical direction of one CRNA by an anesthesiologist. Modifier QY is not covered by KMAP. Claims utilizing this modifier will be reimbursed at 50%.
- QZ – CRNA/AA service; without medical direction by a physician.

- The following modifiers can be reported in the second position under appropriate circumstances in addition to one of the previous anesthesia modifiers.
  - GC – Service(s) performed in part by a resident under the direction of a teach physician (TP). Effective with dates of service on and after December 1, 2023, when teaching anesthesiology claims are billed, the AA modifier is entered as the first modifier followed by the GC modifier denoting this service has been performed in part by a resident under the direction of a teaching physician. The reimbursement rate will be the same as if the AA modifier was the sole modifier used.
  - G8 – Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
  - G9 – Monitored anesthesia care for member who has history of severe cardiopulmonary condition
  - QS – Monitored anesthesia care service
  - 23 – Unusual anesthesia

  An AA is a specially trained professional who participates in the care of a surgical patient during general, regional, or conscious sedation anesthesia through the medical direction and under the supervision of an Anesthesiologist. The AA and the supervising anesthesiologist must be employed by the same anesthesia group. The supervising anesthesiologist will bill on behalf of the AA. Currently, an AA practicing in Kansas must work under delegated authority.

- HCPCS code 00170 can be billed when providing anesthesia in conjunction with dental procedures. Providers are to bill the anesthesia code appropriate for their provider type and provider specialty. For the most current information and verification of coverage, access the KMAP Reference Codes page under ***Interactive Tools*** on the Provider tab of the KMAP public website or under Pricing and Limitations from the KMAP secure website.
  Note: This does not change current coverage for codes 00100-01999.

Chemotherapy

- The following chemotherapy injection codes must be used for chemotherapy **administration**.

  96401 96402 96405 96406 96409 96411 96413 96415 96416 96417 96420
  96422 96423 96425 96440 96446 96450

- Chemotherapy **drugs** should be billed with the appropriate **injection** code. For the most current information and verification of coverage, access Reference Codes under the Provider tab on the public website or from the secure website under Pricing and Limitations.

Children Immunization Administration – Please see **Immunization Administration** in this section.

7010. Updated 04/24

E Diagnosis Codes

External causes of injury and poisoning diagnosis (E) codes are accepted as a secondary diagnosis when billed in conjunction with a covered primary diagnosis code.

End Stage Renal Disease

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

Enteral and Parenteral Product Billing Guidance

Enteral Products:

An Enteral Product Supplemental Billing Form is required and should be submitted along with the product invoice. The Enteral Product Supplemental Billing Form can be found here.

Effective with dates of service retroactive to October 1, 2024, enteral supplies that do not have an assigned code may be covered under B9998 (not otherwise classified enteral supplies). Procedure code B9998 requires PA for all ages. Enteral supplies that have an assigned HCPCS code must be requested under the appropriate code.

Code B9998 will be manually priced. The manual pricing methodology for enteral nutrition products and supplies is provider cost plus 35% based off the invoice price.

Parenteral Products: Physician Administered Drugs (PADs)

The requirement by Centers for Medicare and Medicaid Services (CMS) to collect drug rebates means drug specific information must be included on physician administered drug (PAD) claims.

Providers billing for PADs in an office or outpatient setting using a PAD procedure code must include the following:

- NDC - Each PAD detail must include a valid NDC that reflects the content of the PAD billed. If a compounded procedure code, use the same Compound/Linkage number for each detail. Each NDC must be an 11-digit code unique to the manufacturer in a 5-4-2 format (99999-9999-99). Refer to the NDC 11-Digit Format Information section for a detailed explanation regarding converting NDCs to the correct 11-digit format.
- National drug unit count (quantity) for each submitted NDC (up to three digits to the right of the decimal point are available).
- Unit of measurement for each submitted NDC.
  Note: **The State strongly recommends providers use the bolded values to lessen the chance of a drug rebate dispute.** Valid codes include:
  - **UN (unit)**
  - **GR (gram)**
  - **ML (milliliter)**
  - F2 (international unit)
  - ME (milligram)

Enteral and Parenteral Product Billing Guidance continued

- Drug unit price greater than zero for each submitted NDC (price per unit, not total dollar amount for the NDC). Submit a value of $0.00 if not known.

- Compound/Linkage Number is required for a compounded procedure code. Use the same compound/linkage number when the procedure code is made up of more than one unique NDC-11, or when different procedure codes are compounded with multiple different NDC-11s.

The fields listed above are available for users of the:

- Batch 837 health care claim and encounter transactions (professional and institutional)
- Provider Electronic Solutions (PES) application
- KMAP Portal
- Paper claims via billing guidance or use of a KMAP form titled "NDC Detail Attachment" can be filled out and attached to the paper claim available in the Forms section of the KMAP website.
  Note: **If submitting a compounded procedure code, use the 837, PES, or KMAP portal to submit these claims until further notice.**

NDC 11-digit Format Information

Most NDCs are printed on prescription packaging in a 10-digit format. Proper NDC billing requires an 11-digit format. Converting NDCs from a 10 to an 11-digit format requires the placement of an extra zero, dependent upon the 10-digit format.

The following table shows common 10-digit NDC formats and the associated conversion to an 11-digit format with the proper placement of a zero.

10-Digit Format	10-Digit Format Example	11-Digit Format	11-Digit Format Example	Actual 10-Digit NDC Example	11-Digit Converted NDC Example
4-4-2	9999-9999-99	5-4-2	**0**9999-9999-99	0002-7635-11 Zyprexa Relprevv™ 210mg vial	**0**0002-7635-11
5-3-2	99999-999-99	5-4-2	99999-**0**999-99	65757-402-03 Aristada® 662 mg syringe	65757-**0**402-03
5-4-1	99999-9999-9	5-4-2	99999-9999-**0**9	39822-3050-1 Pentamidine 300mg vial	39822-3050-**0**1

Drug Rebate Impact

On a quarterly basis, drug manufacturers are invoiced for covered outpatient drug (COD) NDC utilization. Drug manufacturers can pay or dispute any of the utilization, including previously paid utilization data back to 1991. There are several reasons why a dispute may be initiated. The following are the most common reasons for a dispute:

- Wrong unit of measure
- Units/quantity appear inconsistent
- Generic substitution
- Invalid/terminated NDC

Enteral and Parenteral Product Billing Guidance continued

Once a manufacturer has disputed a drug, the plan payer is required to gather all the documents that verify the actual NDC and the units dispensed. If this occurs, providers may receive a letter or phone call requesting a copy of office records to include documentation pertaining to the billed procedure code. Requested records may include NDC invoices showing purchase of drugs and documentation showing what drug (NDC-11, name, strength, and amount) was administered and on what date, to the member in question. Providers should have processes in place to record and maintain the NDC administered to the member and the amount given.

PAD Claim Edits to Support Rebate-Eligible Data

Claims editing is in place to support rebate-eligible PAD NDC-11 use. Claim details may be rejected for some of the following drug rebate-related reasons:

If an NDC is submitted with a CMS Termination Date in effect for the service dates, the HCPCS detail will be denied. A CMS Termination Date indicates the product has been discontinued. This occurs if the product is being replaced, discontinued (the shelf-life expiration of the last batch sold), or pulled from the market because of health or safety reasons.

- If an NDC is submitted with a Drug Efficacy Study Implementation (DESI) value indicating it is less than effective for all indications or is less than effective and has been withdrawn from the market, the HCPCS detail will be denied.
- If an NDC is submitted, whose manufacturer or labeler does not have a rebate agreement with CMS in effect for the service dates, or the NDC is not rebate-eligible, the HCPCS detail will be denied.
- If an NDC is submitted that does not match the HCPCS being billed, the HCPCS detail will be denied. For example, HCPCS J2175 (injection, meperidine hydrochloride, per 100 mg) is billed, but an NDC for morphine is submitted.

Parenteral Billing Examples

The following examples are provided to assist providers with proper billing of physician administered drugs (PADs) including the NDC-related fields and single NDC or multiple NDC (compounded) PADs.

Note: Rebate-eligible NDCs must be used when billing PADs. All examples include active NDCs in the Medicaid Drug Rebate Program (MDRP) that meet the definition of a covered outpatient drug at the time of this update (August 2023).

Synagis® Examples:
F/TDOS: Same for all details in single example
HCPCS: 90378>Respiratory Syncytial Virus, monoclonal antibody, recombinant, for IM use, 50 mg each
NDC: 66658023101> Synagis® 100 mg/ml vial
NDC: 66658023001> Synagis® 50 mg/0.5 ml vial

Enteral and Parenteral Product Billing Guidance continued

Example: Same NDC-11 makes up the HCPCS dose.
Dose Ordered: 100 MG IM
NDC(s) Administered: 66658023101 x 1

Detail #	HCPCS	HCPCS Units	NDC	NDC UOM	NDC Units	NDC Price	Compound/Linkage Number
1	90378	2	66658023101	ML	1.000	3500.00	11111

Dose Ordered: 100 MG IM
NDC(s) Administered: 66658023001 x 2

Detail #	HCPCS	HCPCS Units	NDC	NDC UOM	NDC Units	NDC Price	Compound/Linkage Number
1	90378	2	66658023001	ML	1.000	3500.00	11112

Dose Ordered: 150 MG IM
NDC(s) Administered: 66658023001 x 3

Detail #	HCPCS	HCPCS Units	NDC	NDC UOM	NDC Units	NDC Price	Compound/Linkage Number
1	90378	3	66658023001	ML	1.500	6000.00	11113

Example: Different NDC-11s make up the HCPCS dose.
Dose Ordered: 150 MG IM
NDC(s) Administered: 66658023101 x 1 and 66658023001 x 1

Detail #	HCPCS	HCPCS Units		NDC	NDC UOM	NDC Units	NDC Price	Compound/Linkage Number
1	90378	2		66658023101	ML	1.000	3500.00	11114
2	90378	1		66658023001	ML	0.5	2000.00	11114

Use the same Compound/Linkage number for two or more details that make up a HCPCS dose to avoid duplicate errors.

Total Parenteral Nutrition Examples
B4193 - Parenteral Nutrition Solution; Compounded Amino Acid and Carbohydrates with Electrolytes, Trace Elements, and Vitamins, Including Preparation, Any Strength, 52 to 73 grams of protein – premix

NDC	NDC Description	Ingredient	Amount/Day (1 HCPCS)	ML/Day (1 HCPCS)	ML/Week (7 HCPCS)
00990717217	Aminosyn II (AA 10%)	AA (10%)	60 gm	600	4200.00
00338071906	D70W	Dextrose 70%	200 gm	285.71	1999.97
00409488750	Water for Injection	Water for Injection	317.85 ml	321.29	2249.03
63323064250	MgSo4 IV 4 MEQ/ML Vial	MgSO4	20 mEq	5	35.00
00409329451	K Acetate IV 2 MEQ/ML Vial	K Acetate	40 mEq	20	140.00
00409665305	KCl IV 2 MEQ/ML Vial	KCl	15 mEq	7.5	52.50
00409114112	NaCl IV 4 MEQ/ML Vial	NaCl	92mEq	23	161.00
00409739172	NaPO4 IV 3 Mmol/ML Vial	NaPO4	15 mM	5	35.00
63323036059	CaGl IV 100MG/ML Vial	Ca Gluconate	10 mEq	21.5	150.50
00517930201	Multrys	MTE	1 ml	1	7.00
54643564901	Infuvite Adult	MTV	10 ml	10	70.00
			Totals	**1300**	**9100.00**

7010. Updated 08/23

Enteral and Parenteral Product Billing Guidance continued

B4189 - Parenteral Nutrition Solution; Compounded Amino Acid and carbohydrates with electrolyts, trace elements, and vitamins, including preparation, any strengh, 10-51 grams of protein - premix

NDC	NDC Description	Ingredient	Amount/Day (1 HCPCS)	ML/Day (1 HCPCS)	ML/Week (7 HCPCS)
00990717217	Aminsyn II (AA 10%)	AA (10%)	50 gm	500	3500.00
00338071906	D70W	Dextrose 70%	200 gm	285.71	1999.97
00409488750	Water for Injection	Water for Injection	317.85 ml	421.29	2949.03
63323064250	MgSo4 IV 4 MEQ/ML Vial	MgSO4	20 mEq	5	35.00
00409329451	K Acetate IV 2 MEQ/ML Vial	K Acetate	40 mEq	20	140.00
00409665305	KCl IV 2 MEQ/ML Vial	KCl	15 mEq	7.5	52.50
00409114112	NaCl IV 4 MEQ/ML Vial	NaCl	92 mEq	23	161.00
00409739172	NaPO4 IV 3Mmol/ML Vial	NaPO4	15 mM	5	35.00
63323036059	CaGl IV 100MG/ML Vial	Ca Gluconate	10 mEq	21.5	150.50
00517930201	Multrys	MTE	1 ml	1	7.00
54643564901	Infuvite Adult	MTV	10 ml	10	70.00
			Totals	**1300**	**9100.00**

B4185 - Parenteral Nutriton Solution, Not Otherwise Specified, 10 Grams Lipids

NDC	NDC Description	Ingredient	Amount/Day (1 HCPCS)	ML/Day (1 HCPCS)	ML/Week (7 HCPCS)
00338051913	Intralipid 20%	Lipids 20%	40 gm	200	1400.00

Procedure Code HCPCS Detail Unit Splitting Examples Using First TPN Example

Detail #	HCPCS	HCPCS Units	NDC	NDC UOM	NDC Units	NDC Price	Compound or Linkage Number
1	B4193	X	00990717217	ML	4200.000	2400.00	12345
2	B4193	X	00338071906	ML	1999.970	300.00	12345
3	B4193	X	00409488750	ML	2249.030	100.00	12345
4	B4193	X	63323064250	ML	35.000	12.50	12345
5	B4193	X	00409329451	ML	140.00	4.50	12345
6	B4193	X	00409665305	ML	52.500	0.45	12345
7	B4193	X	00409114112	ML	161.000	1.20	12345
8	B4193	X	00409739172	ML	35.000	2.25	12345
9	B4193	X	63323036059	ML	150.500	3.24	12345
10	B4193	X	00517930201	ML	7.000	60.00	12345
11	B4193	X	54643564901	ML	70.000	120.00	12345
Totals		**7.000**			**9100.00**	**3003.14**	

X - Provider determines detail HCPCS units based on one of the following:

- **Ratio of total NDC units**
- **Ratio of total cost**
- **Ratio of ingredient count**
- **Ratio of amino acids (AA)/Dextrose (DEX)/Other as a 40%-20%-20%-20%**

7010. Updated 08/23

Enteral and Parenteral Product Billing Guidance continued

Ratio of Total NDC Units

HCPCS Units	NDC Units
3.231	4200.000
1.538	1999.970
1.730	2249.030
0.027	35.000
0.108	140.000
0.040	52.500
0.124	161.000
0.027	35.00
0.116	150.500
0.005	7.000
0.054	70.000
7.000	

Ratio of Total Cost

HCPCS Units	NDC Price
5.594	2400.00
0.699	300.00
0.233	100.00
0.029	12.50
0.010	4.50
0.001	0.45
0.000	0.20
0.005	2.25
0.008	3.24
0.140	60.00
0.280	120.00
7.000	

Ratio of Ingredient Count

HCPCS Units	Detail
0.636	1
0.636	2
0.636	3
0.636	4
0.636	5
0.636	6
0.636	7
0.636	8
0.636	9
0.636	10
0.636	11
7.000	

Ratio AA/Dex/W/Other (40/20/20/20)

HCPCS	NDC	Ratio
2.800	Amino Acid	40%
1.400	Dextrose	20%
1.400	Water	20%
0.175	Other	20% for 8 other ingredients
0.175	Other	
0.175	Other	
0.175	Other	
0.175	Other	
0.175	Other	
0.175	Other	
0.175	Other	
7.000		

Tools to Assist Providers

Interactive Reference Tools:
There is an interactive Reference Codes (Search by Procedure) page on the KMAP website. Providers can input a procedure code. If coverage information is displayed, the provider can input a valid NDC-11 in the 'Related NDCs' section and press 'Search'. If the NDC-11 is a valid rebate eligible NDC for the procedure code, a positive message will be given. If the NDC-11 is not valid for the procedure code, an explanatory message will be given.

Response examples:
- NDC XXXXXXXXXXX is valid for procedure XXXXX.
- NDC XXXXXXXXXXX is valid for procedure XXXXX, but the manufacturer is not participating in the drug rebate program on the date of service.
- NDC XXXXXXXXXXX is not valid for procedure XXXXX, and the manufacturer is not participating in the drug rebate program on the date of service.
- Other messages may be returned depending on the procedure code and NDC combination entered.

NDC to NOC/NOS procedure code crosswalk:
To further assist providers with the proper NDC billing for not otherwise classified/not otherwise specified (NOC/NOS) procedure codes, a crosswalk is available on the Kansas Department of Health and Environment (KDHE) website here under 'Billing Information.' This crosswalk mostly has newly approved Food and Drug Administration (FDA) drugs that require the use of an NOC/NOS code due to lack of a pure procedure code. The crosswalk will be updated quarterly.

Additional resources for billing assistance:
Electronic Data Interchange (EDI) on the KMAP website:
- PES

7010. Updated 08/23

Enteral and Parenteral Product Billing Guidance continued

- Health Insurance Portability and Accountability Act (HIPAA) Companion Guides for KMAP, including the 837 Institutional and 837 Professional

KDHE-DHCF Kansas Medicaid Pharmaceutical Program on the KDHE website:

- Billing Information
- Clinical Program Information
- Prior Authorization Information

CMS Medicaid Drug Rebate Program on the Medicaid website:

- New, reinstated, and terminated labeler information

National Uniform Claim Committee (NUCC) website:

- NUCC Structure
- 1500 Claim Form
- Code Sets

Additional PAD Information Resources:

Provider page of the KMAP website:

- Secured web claim submissions
- Forms, such as the *NDC Detail Attachment*, sample claim forms and instructions, or the *Request for Review – NDC-HCPCS or CPT Crosswalk* (for pure and NOC/NOS crosswalk inquiries)
- Reference code look-up tools – Search by Procedure (Search by NDC is specific for retail pharmacy claims and not professional/outpatient claims)
- Manuals and bulletins

Emergency Room Services

- The **primary** diagnosis code must reflect the **emergent condition** (presenting symptoms). Refer to the *CPT* codebook for levels of care definitions when selecting the appropriate procedure to bill.
- The ER visit is considered content to any surgical procedure for which global surgery rules apply when performed by the same provider during the global surgery period. ER services are considered content of service of respiratory services (94010-94700) unless the ER visit is a significantly, separately identifiable service.

Exempt License Physicians

License-exempt physicians (retired), performing services in a clinic setting, can enroll as a Medicaid provider. The clinic is reimbursed for expenses incurred for providing such services. The billing provider should be the clinic, and the performing provider should be the exempt licensed physician. Exempt licensed physicians will be reimbursed at 75% of the Medicaid allowed amount for services provided.

Immunization Administration

- Providers must bill the appropriate administration code in addition to the vaccine/toxoid code for each dose administered. Reimbursements of Current Procedural Terminology (CPT) codes for

7010. Updated 08/23

Immunization Administration continued

vaccines covered under the Vaccine for Children (VFC) program will not be allowed for children 18 years of age and younger.

- PACS software requires a charge on each line item being submitted. Providers who bill electronically through the PACS system will need to indicate a charge of $.01 on the line for the vaccine/toxoid code. MMIS will deny the service even though a charge was submitted.
- All vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are covered.

Injections

- In Field 24D, enter the code, strength, and dosage. For the most current information and verification of coverage, access Reference Codes under the Provider tab on the public website or under Pricing and Limitations on the secure website. A predetermination request may be submitted if it is felt a specific injection should be covered. Refer to **Section 4200** of the *General Special Requirements Fee-for-Service Provider Manual*.
- Code 96372 is to be billed when the member furnishes his or her own medication and reimbursement is only for the administration of the injection. It is not to be billed in conjunction with an injection code.
- Injections are not covered when billed on the same day as an office visit by the same provider. This applies to the following procedure codes:

Office visit

99056	99058	99202	99203	99204	99205	99211
99212	99213	99214	99215	99281	99381	99382
99383	99384	99385	99386	99387	99391	99397
X9003WP						

Injection

95115	95117

Laboratory Panels/Profiles

- When ordered laboratory tests make up a panel or profile, the all-inclusive code should be used to bill. Do not bill each component separately.

Locum Tenens Physicians

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

7010. Updated 08/23

Missed Appointments

Providers should not bill members for missed appointments. Missed appointments are not a distinct reimbursable service but are a part of the providers' overall cost of doing business.

Newborn Services (When the birth mother is NOT assigned to an MCO)

- Only procedure codes which specifically state "newborn" in the code description according to the *CPT* codebook are considered newborn services. These services can be paid under the mother's member ID number for the first 45 days after the baby's date of birth. These services must be billed with a newborn diagnosis code to receive payment.
- When billing newborn services for a newborn who does not have a member ID number, use "Newborn", "Baby Girl", or "Baby Boy" in the first name field and enter the last name. Use the newborn's date of birth and the mother's member ID number.
- This process is to be used when billing the following CPT codes:

31520	36450	36456	36510	36660	43831	54000	54150	54160	88029
94652	94780	94781	99238	99239	99297	99460	99461	99462	99463
99464	99465	99468	99469	99471	99472	99475	99476	99477	99478
99479	99480	99502	S3620						

Claims for newborn services billed under the mother's member ID may be suspended for 30 days pending receipt of the newborn's member ID number from the eligibility system. If a newborn ID is received, the claim will be denied notifying the provider they must submit the claim using the newborn's ID number.

If no newborn ID is received and the date of service is within 45 days of the newborn's date of birth, the claim may be paid using the mother's ID number. If the date of service is not within 45 days of the newborn's date of birth, the claim will be denied. All other criteria as stated in policy E2015-115 will remain the same.

Notify the birth mother's assigned MCO of the birth, at which time the MCO will provide billing instructions. The mother's MCO will notify the eligibility system and the fiscal agent of the birth.

Obstetrical and Gynecological

- If you have not provided total obstetrical care and delivery but did provide predelivery or postdelivery visits, refer to **Section 8400** for appropriate codes.
- Bill prenatal laboratory services using the corresponding code for each test performed or use the OB panel code. **(Routine urinalysis is content of service of prenatal care).**
- Use the following table when billing multiple birth claims. Only one code for the first birth can be used in conjunction with another code for the consecutive birth(s). Codes must be billed on the same claim with one unit of service each regardless of the number delivered. Only one code from each column can be billed regardless of the number delivered. With some of these coding combinations, the claims may be subject to the National Correct Coding Initiative (NCCI) editing. For coding combinations that require NCCI editing, it is recommended to add modifier 59. It will be necessary to include an attachment when using modifier 59 for the purpose of billing multiple births.

7010. Updated 12/20

Obstetrical and Gynecological continued

Type of Delivery	Code for First Birth	Code for Consecutive Births
All Vaginal	59400 59409 59410 59610 59612 59614	59409 59612
All Cesarean	59510 59514 59515 59618 59620 59622	59514 59620
Mixed Delivery	59400 59409 59410 59610 59612 59614	59514 59620

Physician Services in Hospital Outpatient Setting

- Only one ER code (99281-99285) can be billed per day per member regardless of provider.
- Medical necessity documentation must accompany the claim when more than one ER visit is made on the same day for the same individual.
- Physicians providing outpatient services must bill using the CMS 1500 Claim Form paper version or electronic equivalent. Hospitals can no longer bill claims on their behalf. The physicians must be enrolled Medicaid providers.
- Physicians providing ER or observation services must bill the following procedure codes as appropriate:

99221	99222	99223	99231	99232	99233
99234	99235	99236	99238	99239	99281
99282	99283	99284	99285	99291	99292

Professional/Technical Component Billing

- **Professional**
  In Field 24D, enter the Healthcare Common Procedure Coding System (HCPCS) base code for services rendered, including **modifier 26**. (Example: **7207026**)
- **Technical**
  In Field 24D, enter the HCPCS base code of the service performed, including **modifier TC**. (Example: **72070TC**)
- **Professional and Technical**
  In Field 24D, enter the HCPCS base code of the service performed. (Example: **72070**)

The same procedures performed on the same day:

- Must be billed on the same claim
- Must clarify in Field 24D the reason for billing more than one procedure (such as two X-rays at two different times; left arm, right arm)

When the same procedures are not billed on the same claim, the additional claim(s) will be denied as a duplicate. To seek reimbursement for additional services when this occurs, submit an underpayment adjustment using the ICN from the remittance advice (RA) of the paid claim, **and** state on the adjustment request that more than one procedure was performed on the same day. Refer to **Section 5600** of the *General Billing Fee-for-Service Provider Manual* for details.

Exception: Claims that have the same procedures performed on the same date of service but have different places of service should be billed on separate claims. Both claims must include the two-digit place of service code to process correctly and not deny as duplicate

7010. Updated 04/23

Stand-Alone Vaccine Counseling

Stand-alone vaccine counseling for **non-COVID-19** vaccines will be a covered Early Periodic Screening, Diagnostic, and Treatment (EPSDT) service for ages 0-21. This service can be billed using procedure codes G0312 and G0313.

Stand-alone counseling for **COVID-19** vaccines will be a covered EPSDT service for ages 0-21. This service can be billed using procedure codes G0314 and G0315.

Stand-alone vaccine counseling will be covered only when the vaccine counseling and the administration of the vaccine occur on two separate visits. Vaccine counseling is content of service when the vaccine counseling and administration of the vaccine occur at the same visit. Stand-alone vaccine counseling may also be covered when provided via telehealth.

Supplies and Accessories

For splints and accessories supplied by the provider over and above those usually included with the office visit or other services rendered, use the code that best fits the item. If a specific code cannot be found, use code 99070 and list the drugs, trays, supplies, or materials provided.

Surgery

- **Always** break down charges for each procedure.
- When billing multiple surgical procedures on the same date of service, bill the comprehensive procedure as the primary procedure as detail 1 on the claim. Bill all surgical procedures on the same claim.
- When billing for multiple surgical procedures on the same day, bill your usual and customary charge for all procedures. Medicaid will reduce subsequent procedures for you.

Assistant Surgeon

In Field 24D, enter the base code for the surgery performed, including modifiers 80, 81, 82, or AS, as appropriate. (Example: **3369280**)

Bilateral Procedures

- Procedures performed bilaterally during a single operative session must be identified with the appropriate code. When a procedure is identified in the *CPT* codebook as one that should have modifier 50 added to the base code when performed bilaterally, bill the procedure as a single line item with modifier 50. Procedures billed with modifier 50 must be billed only once on the claim as one unit. For example, a bilateral tympanostomy must be billed indicating code 6943650 as one unit.
- When a code states "unilateral or bilateral" in the description, do not add modifier 50. In this instance, the base code is billed only once on the claim and the number of units is one. For example, code 58900 equals one unit.

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

- KMAP will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure

Surgery continued

altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. Medicaid will also not cover hospitalizations and other services related to these noncovered procedures. None of the erroneous surgeries or services is billable to the member.

- All services provided in the operating room when an error occurs are considered related and therefore are not covered. All providers in the operating room when the error occurs who could bill individually for their services must submit claims for these services but are not eligible for reimbursement for these services. All these providers must submit separate claims for these services using the appropriate methods.

Inpatient Claims

Hospitals are required to bill two claims when the erroneous surgery(s) is reported.

- One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a type of bill (TOB) 11X (with exception of 110)
- One claim with the noncovered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim)
    - The noncovered TOB 110 will be required to be submitted on the UB-04 (hard copy) claim form.
- Providers are required to report as an "other diagnosis" one of the applicable external causes of morbidity codes for wrong surgery performed:

    Y6551 Y6552 Y6553

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

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

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

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

BENEFITS & LIMITATIONS

8100. COPAYMENT Updated 12/23

Effective with dates of service on and after January 1, 2024, copayments will no longer apply to Kansas Medicaid Fee-for-Service (FFS) members. The mandatory managed care authority for KanCare is transitioning from the 1115 Waiver to the Medicaid State Plan and a 1915b Waiver. Copayments are being removed from the Medicaid State Plan and will not apply to FFS members.

Managed Care members will continue to be exempt from copayments.

BENEFITS & LIMITATIONS

8300. BENEFIT PLANS Updated 12/22

KMAP members are assigned to one or more benefit plans. These benefit plans entitle the member to certain services. If there are questions about service coverage for a given benefit plan, refer to **Section 2000** of the *General Benefits Fee-for-Service Provider Manual* for information on eligibility verification.

For more information about benefit plans, refer to the *General Benefits Fee-for-Service Provider Manual*. For example, coverage for the MediKan benefit plan is the same as for Medicaid members (refer to **Section 8400**) with the following exceptions:

- Procedure codes for drugs and biologics deemed a Physician Administered Drug (PAD) will not be covered.
- Inpatient general hospital services are covered for MediKan members for the following conditions only:
  - Acute psychotic episodes
  - Alcohol and drug detoxification
  - Burns
  - Severe acute traumatic injuries
  - Tuberculosis (TB)

Physicians should be aware that hospital admissions coverage determination for MediKan members are based on the nature of the injury indicated by the diagnosis on the claim and by the medical documentation submitted.

Note: If medical documentation is not submitted, the claim will be denied.

BENEFITS & LIMITATIONS

8400. MEDICAID PROGRAM OVERVIEW Updated 08/17

The following benefits and limitations provide an overview of covered KMAP services that can be used in the member's total treatment. The following information is intended to be general in nature and not inclusive of every benefit and limitation. If more information is desired, contact Customer Service. (Refer to **Section 1000** of the *General Introduction Fee-for-Service Provider Manual.*)

ABORTION

- Abortions are covered only under the following conditions:
  - In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself.
  - Use modifier G7 when billing for abortion services if the pregnancy is the result of an act of rape or incest.
- The physician must complete the Abortion Necessity Form to certify that the woman's physical health is in danger or that this pregnancy is a result of rape or incest. The Abortion Necessity Form is located on Forms page of the public and secure websites. The form may be photocopied for your use. All fields **must** be completed, including the member's complete address. All pertinent information must be retained with the medical record.

ADD-ON CODES

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

ADULT CARE HOME SERVICES

The Adult Care Home (ACH) program provides room and board, plus all routine services and supplies required by members. To place a Kansas Medicaid member in a long-term care facility, it must first be determined placement is appropriate. The Client Assessment Referral Evaluation (CARE) screening program is designed to identify the community-based service needs of the individual and determine whether a Level II Preadmission Screening and Annual Resident Review (PASARR) is required. Providers should contact the local area agencies on aging for non-Medicaid applicants. For Medicaid-eligible applicants, contact the local Kansas Department for Aging and Disability Services (KDADS) area office.

Requirements for Supervision of ACH Patients

Federal regulations set minimum standards with which the State must comply if it is to continue payment to the provider and the ACH.

Admission Evaluations

- **Nursing Facilities**: A medical evaluation must be forwarded to the facility which includes diagnoses, a summary of current medical findings, medical history, mental and physical functional capacity, and prognosis.

ADULT CARE HOME SERVICES continued

- **NF/MH**: Requirements are the same as for nursing facilities. In addition, appropriate professional personnel must make a psychiatric evaluation which shall be forwarded to the facility upon approval.
- **ICF-IID**: Requirements are the same as for nursing facilities. In addition, appropriate professional personnel must make a psychiatric evaluation and summary of developmental findings which shall be forwarded to the facility upon approval. Recertification, medication check and/or plan of care review is considered content of service of the ACH visit and is not covered if billed separately. No other ACH visits are covered on the same day as an ACH history and physical.

Annual Medical Evaluation

By State Health Department regulations, an annual medical evaluation must be completed on each ACH resident to include a history and physical with updated diagnosis and prognosis. Tests or observations of the resident indicated by his or her medication regimen must be made when appropriate and properly documented.

ACH Visits

- One routine visit per month is covered. If more than one ACH visit is required per resident, per month, medical necessity must be attached to the claim. (Refer to **Section 4000** of the *General Special Requirements Fee-for-Service Provider Manual*.)
- Recertification, medication check and/or plan of care review is considered content of service of the ACH visit and is not covered if billed separately.
- One ACH history and physical is covered every 330 days per member, regardless of provider. No other ACH visits are covered on the same day as an ACH history and physical.

AMBULANCE

Emergency Transportation

The use of an ambulance must be medically necessary. (Refer to **Section 4100** of the *General Special Requirements Fee-for-Service Provider Manual* for medical necessity documentation criteria.) The member's condition must be such that the use of any other method of transportation is not possible without placing the member's health in serious jeopardy, seriously impairing bodily functions, or results in serious dysfunction of any bodily organ or part. Some examples of "medical necessity" are:

- Transporting in an emergency (accident, injury, acute illness)
- Member needs to be restrained
- Unconscious or in shock
- Requires oxygen or another emergency treatment
- Immobilizing fracture or possible fracture
- Acute stroke or myocardial infarction
- Hemorrhaging
- Bedridden
- Requires a stretcher or gurney

AMBULANCE continued

Nonemergent Ambulance Transportation and Medical Necessity
All nonemergent transportation requires medical necessity. A medical necessity (MN) form must be attached to the claim at the time of submission. See the examples below:

- Routine transportation for non-ambulatory members
- Transportation from the member's home to the hospital (or from the hospital to the member's home)
- Transfers between hospitals

Guidelines for Use of Air Ambulance Services

- **Time:** If time is a critical factor in the member'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 member (i.e. advanced life support) and the ground ambulance providers in the near vicinity cannot assist in providing that care, air transport may be indicated.
- **Coverage:** If ground ambulance utilization leaves the service area without adequate ground coverage and member 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.

APNEA MONITORS

- Determination of the medical necessity for a home apnea monitor is based on factors placing the infant at risk for sudden death as well as on the infant's age. The monitoring device must be ordered by a physician. Home monitoring is medically necessary in infants at risk for sudden death for up to six months of (corrected) age, and up to one year of (corrected) age in infants with bronchopulmonary dysplasia requiring home oxygen. Corrected age is defined as the age of the child had he or she been born at full term (i.e., a child born four weeks premature would not become one year of corrected age until one year and four weeks after the delivery date). The prescribing physician must indicate the length of time he or she feels the apnea monitor will be necessary.
- An infant with the following factor(s) is considered at risk:
  - One or more apparent life-threatening event(s) requiring adult intervention, such as mouth-to-mouth resuscitation or "shaken baby syndrome"
  - Sibling of one or more sudden infant death syndrome victim(s)
  - A newborn who continues to have apnea when he or she would otherwise be ready for care at home
    Note: Gestational age at discharge and frequency and dates of apneic episodes while hospitalized will assist in determining this condition.

APNEA MONITORS continued

- Bronchopulmonary dysplasia
  Note: Indicate if oxygen is required following hospital discharge.
- Tracheostomy
- Certain diseases/conditions associated with apnea or impaired ventilation, such as central hypoventilation

- A risk factor must be demonstrated on each member through the accurate completion of the Home Monitor Informational Form or similar medical necessity form providing the same information. The form(s) and valid prescription (dated on or prior to service dates) must be retained in the files of the provider supplying the monitoring device and are to be provided upon request.
- If the member has used an apnea monitor longer than six months, the Home Monitor Informational Form and a copy of a valid prescription are required to be attached to the claim when billing for the seventh month. Claims billed for apnea monitor rental for the seventh month and beyond are reviewed for medical necessity, regardless of provider. Documentation supporting continued need for the apnea monitor must accompany the claim. This documentation should include information from the past six months regarding any apneic episodes or conditions that put the child at risk and indicating continued need of the monitor.

AUDIOLOGY

- The following audiology services are covered under KMAP:
  - Audiological testing, ear examinations, and evaluations
  - Dispensing and repair of hearing aids
  - Trial rental of hearing aids
  - Batteries
- Limitations on covered services are outlined below and on the following pages.

Batteries

Batteries are limited to six per month for monaural hearing aids and 12 per month for binaural hearing aids. **PA will not override these limitations**. Batteries for use with cochlear devices are limited to lithium ion (three per 30 days) and zinc air (six per 30 days). Batteries for cochlear devices are covered for KBH-EPSDT-eligible members only. Only one type of battery is allowed every 30 days.

Bone Anchored Hearing Aid

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

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

69710	69711	69714	69715	69717	69718
69728	69729	69730	L8690	L8691	

A BAHA is covered with PA for a KBH-EPSDT member who meets all the following criteria:

- **Each of items one, two, three, and four**

AUDIOLOGY continued

1. The member must be five years of age or older.
2. Standard hearing aids cannot be used due to a medical condition.
3. The member must have good manual dexterity or have assistance to snap the device onto the abutment.
4. The member has ability to maintain proper hygiene at the site of the fixture.

- **Either items five or six**
  5. Tumors of the external canal and/or tympanic cavity are present.
  6. Congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear are present.
- **At least one of items seven, eight, or nine**
  7. There is **unilateral conductive or mixed hearing loss**.
     - Unilateral conductive or mixed hearing loss caused by congenital malformations of the external or middle ear. Conventional hearing aids cannot be worn. Member must have:
       - Average bone conduction threshold better (less) than 45 dB (at 500, 1000, 2000, 3000 Hz) in the indicated ear
       - Speech discrimination score greater than 60% in the indicated ear
  8. There is **bilateral conductive hearing loss**.
     - Conductive and mixed hearing loss involving both ears which is not able to be treated with reconstructive surgery or conventional hearing aids. Member must meet all the following:
       - Moderate (40dB) to severe (70dB) conductive hearing loss symmetrically
       - Less than 10dB difference in average bone conduction (at 500, 1000, 2000, 4000 Hz) or less than 15 dB difference in bone conduction at individual frequencies.
       - Mixed hearing loss with an average bone conduction better (less) than 45dB in either ear (at 500, 1000, 2000, 4000 Hz)
  9. There is **unilateral sensorineural hearing loss (single-sided deafness)**.
     - Nerve deafness in the indicated ear making conventional hearing aids no longer useful. The implant is designed to stimulate the opposite (good ear) by bone conduction through the bones of the skill. Therefore, the audiometric criteria are for the good ear. Member must meet all of the following:
       - Severe (70 dB) to profound (90dB) hearing loss on one side with poor speech discrimination and the inability to use a conventional hearing aid in that ear
       - Normal hearing in the good ear as defined by an air conduction threshold equal to or better (less) than 20 dB (at 500, 1000, 2000, 3000 Hz)

Definitions

- **Unilateral conductive or mixed hearing loss:** Unilateral conductive or mixed hearing loss caused by congenital malformations of the external or middle ear. Conventional hearing aids cannot be worn. Member must have:
  - Average bone conduction threshold better (less) than 45 dB (at 500, 1000, 2000, 3000 Hz) in the indicated ear

8400. Updated 06/16

AUDIOLOGY continued

- Speech discrimination score greater than 60 percent in the indicated ear

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

Replacements

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

Dispensing of Hearing Aids

- Only one dispensing fee is allowed for monaural or binaural services. The appropriate dispensing fee must be used. **DO NOT BILL TWO DISPENSING FEES.** If services are monaural, the left or right modifier must be submitted on the claim. If the services are binaural, the left and right modifiers are not allowed. **For binaural aids, providers are required to use the binaural dispensing fee code.** Hearing aid dispensing services include

AUDIOLOGY continued

adjusting the aid to meet the member's medical need. If the aid cannot be adjusted to meet the member's need within the one-month trial period, the aid is to be replaced or returned to the dispenser.

- If the aid is returned, Medicaid will cover one month's rental, not to exceed $65 plus the cost of the ear mold.
- Fitting of binaural hearing aids are covered, with documentation on the hearing evaluation form, for the following:
    - Children under 21 years of age, KBH-EPSDT not required
    - A legally blind adult with significant bilateral hearing loss
    - A previous binaural hearing aid user
    - An occupational requirement for binaural listening

Modifiers

Billing for audiology services now requires the use of left (LT) and right (RT) modifiers on all monaural services. If the services are binaural the use of left and right modifiers is not allowed.

Explanation of Necessity for Hearing Aids Form

Providers must submit the Explanation of Necessity for Hearing Aids form with the prior authorization request before approval for a replacement hearing aid will be considered. An example of this form is located on the Forms page of the public or secure website.

Repairs

- Repairs under $15 are **not** covered.
- Repairs exceeding $75 must be **prior authorized** (refer to **Section 4300** of the *General Special Requirements Fee-for-Service Provider Manual*). Approval will be given if, in the opinion of the consultant, the repairs are not so extensive that good judgment indicates the fitting and dispensing of a new hearing aid.
- Repairs must provide a warranty of six months.

Replacements

- Hearing aids may be replaced every four years when a medical examination confirms the necessity.
- Lost, broken, or destroyed hearing aids will be replaced **once** with PA during a four-year period. The dispenser and member must sign a statement documenting the loss, breakage, or destruction of the hearing aid and submit it along with the PA request.
- All hearing aid replacements require the use of modifier RA. Modifier RA must be present on all claims for replacement hearing aids. Replacement hearing aids continue to require PA.
- Replacement cords for hearing instruments and cochlear implants are covered with medical necessity documentation.

Testing and Examination

- Members are required to have a medical examination by a physician for pathology or disease. This exam must be provided no more than six months prior to the fitting of a hearing aid and documented on the Explanation of Necessity for Hearing Aids form.

AUDIOLOGY continued

- Enrolled physicians and licensed or certified audiologists will be reimbursed for hearing tests. Certified program for otolaryngology personnel (CPOP) technicians are not allowed to enroll. All services performed by a CPOP technician must be billed through an otolaryngologist.
- Basic hearing services can be performed by CPOP technicians under the following guidelines:
    - The CPOP technician must be certified by the American Academy of Otolaryngology which includes sponsorship by an otolaryngologist. Certification documentation must be on file in the ear, nose, and throat (ENT) facility.
    - Services may only be performed in the office of an enrolled ENT specialist.
    - The CPOP technician must be directly supervised by an otolaryngologist.
    - All CPOP services must be signed off by an otolaryngologist. The otolaryngologist assumes all responsibility for CPOP technicians and services provided.
- The audiology hearing tests listed below can be performed by hearing instrument specialists, also known as hearing aid dealers (PT/PS 22/220), as long as they are licensed as a hearing instrument fitter and dispenser within the State of Kansas. The hearing instrument specialist must be enrolled as a Medicaid provider to perform and bill the following codes:

92552	92553	92555	92556	92557*

* 92553 and 92556 combined

Note: For KBH-EPSDT screening guidelines, see the *KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment Provider Manual*.

BARIATRIC SURGERY

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

1. Must meet either a (adults) or b (adolescents):
    a. For adults aged 18 years or older, presence of severe obesity that has persisted for at least the last 2 years (24 months), documented in contemporaneous clinical records, defined as any one of the following:
        i. Body mass index (BMI) exceeding 40
        ii. BMI greater than 35 in conjunction with either of the following severe comorbidities:
            1. Clinically significant obstructive sleep apnea
            2. Coronary heart disease
            3. Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite concurrent use of 3 anti-hypertensive agents of different classes)
            4. Type 2 diabetes mellitus
    b. For adolescents who have completed bone growth (generally age of 13 in girls and age of 15 in boys), presence of obesity with severe co-morbidities:
        i. BMI exceeding 40 with one or more of the following serious co-morbidities:
            1. Clinically significant obstructive sleep apnea
            2. Type 2 diabetes mellitus
            3. Pseudotumor comorbidities
        ii. BMI exceeding 50 with one or more of the following less serious co-morbidities:

BARIATRIC SURGERY continued

1. Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite concurrent use of 3 anti-hypertensive agents of different classes)
2. Dyslipidemias
3. Nonalcoholic steatohepatitis
4. Venous stasis disease
5. Significant impairment in activities of daily living
6. Intertriginous soft-tissue infections
7. Stress urinary incontinence
8. Gastroesophageal reflux disease
9. Weight-related arthropathies that impair physical activity
10. Obesity-related psychosocial distress

Note: Provisional coverage of LASGB for members younger than 18 years of age is a covered service. These individuals may receive other bariatric procedures, but LASGB will only be approved on a case-by-case basis. The member must meet medical necessity criteria. The provider must submit documentation regarding the risk versus the benefit for individuals younger than 18 years of age. Procedure codes 43290, 43291, 43770, 43771, 43772, 43773, and 43774 are provisionally covered.

2. Member has attempted weight loss in the past without successful long-term weight reduction.
3. Member must meet either the following Criterion a (physician-supervised nutrition and exercise program) **OR** Criterion b (multi-disciplinary surgical preparatory regimen):
    a. **Physician-supervised nutrition and exercise program:** Member has participated in physician-supervised nutrition and exercise program (including dietician consultation, low-calorie diet, increased physical activity, and behavioral modification), documented in the medical record at each visit. This physician-supervised nutrition and exercise program must meet **ALL** the following criteria:
        i. Member's participation in a physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who supervised the member's participation. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician.
        Note: A physician's summary letter is not sufficient documentation.
        ii. Documentation should include medical records of physician's contemporaneous assessment of member's progress throughout the course of the nutrition and exercise program. For members who participate in a physician-administered nutrition and exercise program, program records documenting the member's participation and progress may NOT substitute for physician medical records.
        iii. Nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists, with a substantial face-to-face component (must not be entirely remote).
        iv. Nutrition and exercise program(s) must be for a cumulative total of 6 months (180 days) or longer in duration and occur within 2 years prior to surgery, with participation in one program of at least 3consecutive months. (Precertification may be made prior to completion of nutrition and exercise program as long as a

cumulative of 6 months participation in nutrition and exercise program[s] will be completed prior to the date of surgery).

b. **Multi-disciplinary surgical preparatory regimen:** Proximate to the time of surgery (within 6 months prior to surgery), member must participate in organized multidisciplinary surgical preparatory regimen of at least 3 months (90 days) duration meeting **ALL** the following criteria, to improve surgical outcomes, reduce the potential for surgical complications, and establish the member's ability to comply with postoperative medical care and dietary restrictions:
   i. Behavior modification program supervised by qualified professional
   ii. Consultation with a dietician or nutritionist
   iii. Documentation in the medical record of the member's participation in the multi-disciplinary surgical preparatory regimen at each visit.
   Note: A physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the member, and the physician's assessment of the member's progress at the completion of the multidisciplinary surgical preparatory regimen.
   iv. Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by exercise therapist or another qualified professional
   v. A substantial face-to-face component (must not be entirely delivered remotely)
   vi. Reduced-calorie diet program supervised by dietician or nutritionist

4. For members who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression) or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, preoperative psychological clearance is necessary to exclude members who are unable to provide informed consent or who are unable to comply with the pre- and post-operative regimen.
   Note: The presence of depression due to obesity is not normally considered a contraindication to obesity surgery.

Repeat Bariatric Surgery

- Repeat bariatric surgery is considered medically necessary to correct complications from bariatric surgery, such as obstruction, stricture, erosion, or band slippage.
- Repeat bariatric surgery is considered medically necessary for members whose initial bariatric surgery was medically necessary (i.e., who met medical necessity criteria for their initial bariatric surgery), and who meet any one of the following medical necessity criteria:
  - Conversion to a RYGB or BPD/DS may be considered medically necessary for members who have not had adequate success (defined as loss of more than 50% of excess body weight) 2 years following the primary bariatric surgery procedure and the member has been compliant with a prescribed nutrition and exercise program following the procedure.
  - Revision of a primary bariatric surgery procedure that has failed due to dilation of the gastric pouch or dilation of the gastrojejunostomy anastomosis is considered medically necessary if the primary procedure was successful in inducing weight loss prior to the dilation of the pouch or GJ anastomosis, and the member has been compliant with a prescribed nutrition and exercise program following the procedure.

BARIATRIC SURGERY continued

- Replacement of an adjustable band due to complications (e.g., port leakage, slippage) that cannot be corrected with band manipulation or adjustments.

Experimental and Investigational Bariatric Surgical Procedures

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

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

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

Cholecystectomy

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

Covered Services

- Sleep studies and polysomnography (PSG) are covered services included in the preoperative process for bariatric surgery candidates. The member must meet criteria to be considered a candidate for bariatric surgery, which includes a six-month weight loss plan supervised by a physician. Prior authorization is required.
- One of the following procedure codes can be billed preoperatively when other criteria are met for bariatric surgery: 95807, 95808, 95810, and 95811.
- An open or laparoscopic sleeve gastrectomy (43775) is a covered service and considered medically necessary when the selection criteria documented in the original bariatric policy are met.
- Kansas Medicaid will follow the lead of CMS by eliminating the certification requirement for facilities that provide bariatric procedures.

Two Behavior Interventions services are available for KBH-EPSDT members:

Consultative Clinical and Therapeutic Services

Procedure codes 97151, 97152, 97153, 97154, 97155,-97156, and 97158 can be billed by provider type 11 and specialty 403. One unit is equal to 15 minutes.

8400. Updated 06/24

BEHAVIORAL INTERVENTIONS

- CMHC providers may provide these services and should consult the Mental Health Fee-for-Service Provider Manual for additional information.

Note: Coverage of this service requires that a recommendation be made by a physician or other licensed practitioner and is subject to a prior authorization process.

Note: See *Mental Health Fee-for-Service Manual* **Section 8400** Behavioral Interventions for Provider Requirements of CCTS.

Intensive Individual Supports

Procedure code 97153 and 97154 can be billed by provider type 11 and specialty 404. One unit is equal to 15 minutes.

- CMHC providers may provide these services and should consult the *Mental Health Fee-for-Service Provider Manual* for additional information.

Note: Coverage of this service requires that a recommendation be made by a physician or other licensed practitioner and is subject to a prior authorization process.

Note: See *Mental Health Fee-for-Service Manual* **section 8400** Behavioral Interventions for Provider Requirements of IIS.

CARDIAC REHABILITATION

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

- Member must have a recent cardiology consultation within three months of starting the cardiac rehabilitation program. Member must have completed Phase I Cardiac Rehabilitation.
- Member must have one or more of the following diagnoses/conditions:
    - Acute myocardial infarction within the preceding three months, post inpatient discharge
        - I2101, I2102, I2109, I2111, I2119, I2121, I2129, I213, I214, I220, I221, I222, I228, I229, I255, 1256, I2589, and I259
    - Coronary bypass surgery within the preceding three months, post inpatient discharge
        - Z951
    - Stable angina pectoris within three months post diagnosis
        - I200, 1201, I208, and I209

CHILD WELFARE

Medicaid-reimbursable services for foster care children will not be paid by the Kansas Department for Children and Families (DCF/PPS). All services for foster care children, including behavior management and mental health, must be billed directly to the assigned MCO or KMAP and will be reimbursed at the approved Medicaid rate. PA and other restrictions apply.

8400. Updated 07/23

CHIROPRACTIC SERVICES

Chiropractic services are not covered under the State Plan; however, the MCOs have the option to cover these services under EPSDT if deemed medically necessary.

COLORECTAL SCREENINGS

KanCare will cover the colorectal cancer screening procedures recommended by the American Cancer Society. One of the following screening tests based upon clinical presentation:

- Fecal occult blood testing (iFOBT)
- Fecal immunoassay testing (FIT)
- Multi-targeted stool DNA (mt-sDNA)
- Sigmoidoscopy or colonoscopy for adults 45 to 75 years of age

Intervals for recommended screening strategies:

Visual (structural) exams of the colon and rectum:

- Colonoscopy every 10 years
  - G0105, G0120 or G0121
- Flexible sigmoidoscopy (FSIG) every 5 years
  - G0104 or G0106

Stool-based test:

- Highly sensitive fecal immunochemical test (FIT) 82274
- Highly sensitive guaiac-based fecal occult blood test (gFOBT) 82270
- Multi-targeted stool DNA (mt-sDNA) every 3 years 81528

COMMUNITY HEALTH WORKER SERVICES

Kansas Medicaid will provide reimbursement for services provided by a Community Health Worker (CHW) for the following codes:

98960	98961	98962

A CHW is an individual certified in the State of Kansas to provide services within the scope of the certification program. Supervision of the certified CHW is included in the scope of practice for each supervising licensed practitioner. Each supervising licensed practitioner shall assume professional responsibility for the services provided by the certified CHW and attest to the CHW's certification. Each supervising licensed practitioner shall bill for the services of the certified CHW.

Coverage Parameters and Limitations:

Kansas Medicaid will apply the following parameters and limitations to covered CHW services:

- Services must be provided face-to-face with the member, individually or in a group, in an outpatient, home, clinic, or other community setting.
- Services are limited to 4 units (or 2 hours) per day, per member.
- Services are limited to 24 units (or 12 hours) per month, per member.

COMMUNITY HEALTH WORKER SERVICES continued

Billing Instructions:
The services must be billed using the individual or individual group member National Provider Identification (NPI). These services are not reimbursable to a Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), or Indian Health Center (IHC). If the RHC/FQHC/IHC shares an NPI with the physician group, reimbursement should be to the physician group only.

When billing these services, providers must append modifier U7 to codes 98960, 98961, and 98962 to indicate the CHW has met the required training requirements and has received a certificate of completion. The billing provider must maintain documentation of CHW certification and background checks for the individual providing the CHW services.

Community Health Worker Qualification:
To provide CHW services to members under Kansas Medicaid, a CHW must be certified through a CHW certification recognized by the KDHE. Applicants may apply for certification through one of two pathways listed below and must complete KDHE approved CHW training or work experience requirements. Please choose only one pathway option:
Education Pathway*:* Applicant must complete the KDHE approved CHW training program through the Kansas CHW Coalition or certified Kansas CHW education provider.
Work Experience Pathway: Applicant must complete 800 hours over three years plus three letters of recommendation to document work and/or volunteer experience.

The CHW services shall include:

- Screening and assessment to identify health-related social needs and barriers to accessing health care.
- Health promotion and coaching to assist members to set goals and action plans to address health-related social needs and barriers to accessing health care; and provide information, coaching, and support to assist members to engage and re-engage in their own health care including adherence to treatment plans, follow up with necessary health care, and self-management of chronic conditions.
- Health system navigation and resource coordination and groups of members, consistent with established or recognized health care standards, on methods and measures to prevent disease, disability, and other health conditions or their progression.
- Care planning with a member's care team to support a person-centered holistic approach to care delivery to promote physical and mental health and efficiency, and to address health-related social needs and barriers to accessing health care.

These services may be provided in the community, in a clinic setting, individually or in a group.

COMMUNITY MENTAL HEALTH CENTER

When a physician desires to send a member to a community mental health center (CMHC), he or she should call the center before making this referral. Each center has its own referral requirements and initial appointment procedures and varies in services provided. CMHC services are covered for outpatient treatment.

8400. Updated 09/23

CPAP for KBH-EPSDT MEMBERS

Continuous positive airway pressure (CPAP) is a covered service for **KBH-EPSDT members**. PA for MN is required. For MN, one of the following criteria must be met:

1. Infant Respiratory Distress Syndrome in newborns (e.g., Hyaline Membrane Disease)
2. Morbid obesity with documented sleep apnea
    - 30% over average weight for height, sex, and age
    - Sleep study with documented arterial oxygen (O_2) saturation of 80% or less
      Note: A printout of the documented arterial O_2 saturation must be supplied by the provider upon request from the fiscal agent and/or KDHE-DHCF.
    - Documented participation in a weight reduction program
      Note: This documentation must be supplied by the provider upon request from the fiscal agent and/or KDHE-DHCF.

DENTAL

HCBS Adult Oral Health Services

Oral health services are no longer available to adults 21 years of age and older who are enrolled in the Home and Community Based Services (HCBS) Intellectual/Developmentally Disabled (I/DD), Brain Injury (BI), and Physical Disability (PD) waiver programs. For information about covered dental benefits, reference the *Dental Provider Manual,* or contact Customer Service at 1-800-933-6593.

- **Fluoride Application**
  Physicians (general practitioners, pediatricians, and family practice physicians), nurse practitioners, and physician assistants can provide a topical application of fluoride for TXIX- and TXXI-eligible children. Fluoride treatment for children will be covered in local health departments with services limited to three applications per member, per calendar year. CPT code 99188 should be used on CMS 1500 Claim Form to indicate the application of topical fluoride.
- **Orthodontia**
  For information about covered orthodontia benefits, reference the *Dental Provider Manual,* or contact Customer Service at 1-800-933-6593.

DEVELOPMENTAL TESTING

Providers are reimbursed one visit per day up to three visits per member per year for codes 96112 and 96113. 96112 and 96113 are only covered for KBH-EPSDT.

DIABETES SELF-MANAGEMENT TRAINING

KMAP covers Diabetes Self-Management Training (DSMT), which is a preventive outpatient service for persons diagnosed with diabetes. An accredited outpatient DSMT program includes education on self-monitoring of blood glucose, diet and exercise, and an insulin treatment plan developed specifically for the patient who is insulin dependent and motivates patients to use the skills for successful self-management of diabetes. DSMT services minimizes the occurrence of disease disability through instruction and maintaining the health and well-being of the patient.

DSMT Covered Services

A physician or approved designee must order all diabetic DSMT services.

8400. Updated 09/23

DIABETES SELF-MANAGEMENT TRAINING continued

DSMT services include:

- Diabetic overview/pathophysiology of diabetes
- Nutrition
- Exercise and activity
- Diabetes medication (including skills related to the self-administration of injectable drugs)
- Self-monitoring and use of the results
- Prevention, detection, and treatment of acute complications
- Prevention, detection, and treatment of chronic complications
- Foot, skin, and dental care
- Behavior change strategies, goal setting, risk factor reduction, and problem-solving
- Preconception care, pregnancy, and gestational diabetes
- Relationships among nutrition, exercise, medication, and blood glucose levels
- Stress and psychosocial adjustment
- Family involvement and social support
- Benefits, risks, and management options for improving glucose control
- Use of health care systems and community resources

An approved entity must collect and record in an organized, systematic manner the following patient assessment information and medical information that includes the following:

- Duration of the diabetic condition
- Use of insulin or oral agents
- Height and weight
- Results and date of last HbA1C
- Information on self-monitoring (frequency and results)
- Blood pressure with the corresponding dates
- Date of last eye exam
- Educational goals
- Assessment of educational needs
- Training goals
- Plan for follow-up assessment of achievement of training goals between 6 months and 1 year after the member completes the training

Billing

The following codes will be allowed for DSMT and will be reimbursed at 75% of the Medicare rate:

- G0108 – $40.26 per unit, 1 unit equals 30 minutes of training
- G0109 – $11.11 per unit, 1 unit equals 30 minutes of training
- The claim must contain a diagnosis code from the following range of diagnosis codes:
  - E08.00 - E13.9 – Diabetes Mellitus

DIABETES SELF-MANAGEMENT TRAINING continued

Limitations
Allow a maximum of 6 hours of training in ½ hour units within a continuous 12-month period. This may be a combination of individual sessions or group sessions, not to exceed a combined total of 12 units per year. Services must be reasonable and necessary and are covered for both newly diagnosed individuals and those who need additional support/training for self-management of their diabetes. A diagnosis of diabetes must appear on the claim.

DIETITIAN SERVICES

- Dietitian services are covered for **KBH-EPSDT members** when provided by a registered dietitian licensed through KDHE.
- Dietitian services may only be rendered as the result of a medical or dental screening referral. Other insurance and Medicare are primary and must be billed first.
- Individual-focused services are limited to two units (30 minutes) of initial evaluation and 11 follow-up visits per member, per year. Additional visits may be covered with PA.
- For the most current information and verification of coverage, access **Reference Codes** under the **Interactive Tools** heading on the Provider page of the public website or Pricing and Limitations on the secure website.

DOCUMENTATION

To verify services provided in the course of a post payment review, documentation in the member's medical record must support the service (level of service) billed. Documentation can be requested at any time to verify that services have been provided within program guidelines. Refer to **Section 5000** of the *General Billing Fee-for-Service Provider Manual*.

DOULA SERVICES

Effective with enrollment dates on and after June 1, 2024, Kansas Medicaid will recognize Doulas as non-physician providers and cover doula services from the date of confirmed conception through the postpartum period (1 year after delivery). The coverage will be effective with dates of service on and after July 1, 2024. Coverage will include different types of doula services:

- Community-based doulas
- Prenatal doulas
- Labor and birth doulas
- Postpartum doulas

Doula services may only be provided during pregnancy, labor and delivery, miscarriage, and within one year of the end of a member’s pregnancy.

Documentation and Service Recommendation Requirements:
A physician or other licensed healthcare provider must recommend doula services. The licensed healthcare providers qualified to recommend doula services are those licensed in the state of Kansas as registered nurses, clinical social workers, nurse practitioners, physician assistants, certified nurse midwives, or physicians.

8400. Updated 05/24

DOULA SERVICES continued

The initial recommendation can be provided through the following methods:

- Written recommendation in member's record,
- Standing order for doula services by plan, physician group, or another group by a licensed provider, or
- Use a standard Doula Services Referral Form from the Kansas Medical Assistance Program (KMAP) website that a member can provide to the licensed provider, or a doula can provide to a member to obtain the licensed provider's signature.

Doula must obtain the signed form before the service and maintain documentation of the recommendation.

Enrollment Requirements for Doulas:

- Online enrollment application in one of the ways listed below:
  1. Practice and bill independently, OR
  2. Practice and bill as part of a doula group.
- Each Doula must enroll with their own National Provider Identifier (NPI) (type 1) to provide the covered services with taxonomy code **374J00000X**.
- Doula will be enrolled with a new provider type/provider specialty (PT/PS) 32/212 (Non-physician/Doula).
- Doula must be certified with a doula training organization (training pathway 1) OR complete a minimum of 30 hours of training (training pathway 2).
- The required documents should be attached to the application. The enrolling Doula will complete the Primary Doula Attestation Form to attest that they have provided support at a minimum of three births.

  Download the Doula Attestation Form packet here for full instructions.

Covered Doula Services:

The following services are covered for Doulas:

Visit Type	Code	Primary Diagnosis Code	Limit per Pregnancy
Prenatal Visits	T1032	Z33.1	28 – 15-minute units
Attendance at Labor and Delivery	T1033	Z33.1	1 Visit
Postpartum Visits	T1032 TS	Z39.2	25 – 15-minute units

Doulas are allowed to bill T1033 once per 280 days. If billed more frequently, documentation must accompany the claim to indicate that these charges represent another pregnancy. If no documentation is attached, the claim will be denied, and any prenatal or postpartum visits related to that time frame will be recouped.

8400. Updated 01/18

DURABLE MEDICAL EQUIPMENT

- Durable medical equipment (DME) items require a written prescription from the physician. In addition, many DME items and medical supplies require PA before they can be dispensed and payment made. Be sure to give the DME provider adequate information and adequate time to secure PA.
- Although an item is classified as DME, it may **not** be covered in every instance. Coverage is based on what is reasonable and necessary for treatment of an illness or injury or will improve the physical functioning of the member. Medical equipment is primarily used for medical purposes and is not generally useful in the absence of illness or injury.

  Note: Reference the **Home Health** portion in this section of the manual for additional information on coverage of DME in accordance with 42 Code of Federal Regulation 440.70.

ELECTROCARDIOGRAMS

- Electrocardiograms (EKGs), up to 12 leads, are covered if medical necessity is met.
- Preoperative EKGs are medically necessary for members over 40 years of age or those members under 40 with a history of cardiac problems.

EMERGENCY MEDICAL SERVICES FOR ALIENS

In addition to inpatient hospital and emergency room hospital, emergency services performed in outpatient facilities and related physician, lab, and X-ray services will be allowed for the following places of service: office, outpatient hospital, federally qualified health clinics, state or local public health clinics, rural health clinics, ambulance, and lab for SOBRA claims. Inpatient hospital reimbursement will not be limited to 48 hours. Follow-up care will not be allowed once the emergent condition has been stabilized. Refer to **Section 2040** of the *General Benefits Fee-for-Service Provider Manual* for specific information.

FAMILY PLANNING

- Family planning is any medically approved treatment, counseling, drug, supply, or device prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.
- Only one unit of specific family planning contraceptives is covered for each member on the same day, regardless of provider. This includes:

  J7300 J7301 J7306 J7307
- Planned Parenthood clinics must bill family planning services using E&M CPT procedure codes.

HOME HEALTH

The following federal regulatory changes for Medicaid home health services as documented in CMS 2348 Final Rule are implemented in accordance with revisions to 42 Code of Federal Regulation 440.70.

1. Coverage of home health services cannot be contingent upon the member needing nursing or therapy services.
2. Home health services may be provided in any setting in which normal life activities take place, other than a hospital, nursing facility (NF), intermediate care facility for individuals with intellectual disabilities (ICF-IID), or any setting in which payment is or could be made under

8400. Updated 07/13

HOME HEALTH continued

Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to members who are homebound.

3. Medical supplies, equipment, and appliances are suitable for use in any setting in which normal life activities take place.
4. Supplies are defined as health care-related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury.
5. Equipment and appliances are defined as items that are primarily and customarily are used to serve a medical purpose; generally, they are not useful to an individual in the absence of a disability, illness, or injury; can withstand repeated use; and can be reusable or removable. State Medicaid coverage of equipment and appliances is not restricted to the items covered as DME in the Medicare program.
6. Additional services or service hours may, at the State's option, be authorized to account for medical needs that arise in the settings where home health services are provided.
7. Payment may not be made for the services listed below unless the physician or allowed nonphysician practitioner, with exception of a certified nurse midwife, documents that there was a face-to-face encounter with the member that meets the requirements of 42 CFR 440.70.
    - Nursing services
    - Home health aide services
    - Medical supplies, equipment, and appliances
    - Physical therapy, occupational therapy, or speech pathology and audiology services
8. For the initiation of home health services, the face-to-face encounter must be related to the primary reason the member requires home health services and must occur within the 90 days before or within the 30 days after the start of the services.
9. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the member requires medical equipment and must occur no more than six months prior to the start of services.
10. The face-to-face encounter may be conducted by one of the following practitioners:
    - Physician
    - Nurse practitioner or clinical nurse specialist (working in collaboration with the physician and in accordance with state law)
    - Certified nurse midwife
    - Physician assistant (under the supervision of the physician)
    - Attending acute or postacute physician (for members admitted to home health immediately after an acute or postacute stay)
11. The allowed nonphysician practitioner performing the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician. Those clinical
12. findings must be incorporated into a written or electronic document included in the member's medical record.
13. To ensure clinical correlation between the face-to-face encounter and the associated home health services, the physician responsible for ordering the services must:
    - Document that the face-to-face encounter which is related to the primary reason the member requires home health services occurred within the required timeframes prior to the start of home health services.
    - Indicate the practitioner who conducted the encounter and the date of the encounter.

HOME HEALTH continued

The documentation requirement of the face-to-face encounter will be monitored through the home health program prior authorization (PA) process. All home health services require PA. The home health provider must submit documentation of the face-to-face encounter in addition to the PA request form, Outcome and Assessment Information Set (OASIS), and CMS-485 (home health plan of care) which includes the physician's or nonphysician practitioner's orders and certification for care. A specific form for the face-to-face encounter is not required, but the documentation must contain all key information.

Note: Copies of the PA and face-to-face encounter documentation must be retained on file in the member's medical record at the home health agency.

14. The face-to-face encounter may occur through telehealth, as implemented by the State.
15. Payment may not be made for medical equipment, supplies, appliances, or DME if the face-to-face encounter is performed by a certified nurse midwife.
16. The face-to-face encounter for medical equipment, supplies, or appliances may be performed by any of the practitioners described above, with exception of the certified nurse midwife.
17. A member's need for medical supplies, equipment, and appliances must be reviewed by a physician annually.

This policy will expand coverage of specified incontinence supplies for members 21 years of age and older. Reference the **Incontinence Supplies** portion in **Section 8400** of the *Home Health Agency Fee-for-Service Provider Manual* for a list of covered incontinence supplies and a list of acceptable incontinence diagnosis codes. The coverage criteria for incontinence supplies for KBH-EPSDT members (ages 5 to 20) remains the same.

Note: All home health initial start of care dates on and after July 1, 2017, will require a face-to-face visit performed by a physician or an allowed nonphysician practitioner. Supporting documentation must be included as specified above. Existing home health prior authorizations and plans of care will not require a face-to-face encounter.

HOSPICE

In situations where the attending physician is not operating under contractual arrangement with the hospice, the attending physician will be reimbursed at the regular Medicaid rate for all professional services, including those related to the treatment of the terminal illness without PA. These services include procedure codes which contain a professional component identified with modifier 26, such as lab and X-ray.

Hospice Care for Children in Medicaid

Members receiving services reimbursed by Medicaid and Children's Health Insurance Program (CHIP) can continue medically necessary curative services, even after the election of the hospice benefit by or on behalf of children receiving services.

Section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children," allows curative treatment upon the election of the hospice benefit by or on behalf of children enrolled in Medicaid or CHIP. The Affordable Care Act does not change the criteria for receiving hospice services. However, prior to enactment of the new law, curative treatment of the terminal illness ended upon election of the hospice benefit.

8400. Updated 08/17

HOSPICE continued

This new provision requires states to make hospice services available to children eligible for Medicaid and Medicaid-expansion CHIP programs without terminating any other service which the child is entitled to under Medicaid for treatment of the terminal condition.

Limitations

An individual can elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period
- A subsequent 90-day period
- Unlimited subsequent 60-day periods with appropriate physician recertification for continued hospice care

Medical Services and Concurrent Care for Children Receiving Hospice Services

Children receiving hospice services can continue to receive other reasonable and necessary medical services, including curative treatment for the terminal hospice condition.

- PA is required.
- Hospice providers will be responsible for coordinating all services related to the hospice diagnosis and assisting nonhospice providers to obtain authorization for services not related to the hospice diagnosis in accordance with 42 Code of Federal Regulations 418.56.
- Hospice providers will be responsible for all DME, supplies, and services related to the hospice diagnosis.
- Nonhospice providers must first communicate and coordinate with hospice providers regarding needed services or procedures prior to rendering concurrent care for children.
- Nonhospice providers must bill hospice first to receive a payment or denial for the service provided.
- If payment is denied by hospice, nonhospice providers must submit a paper claim, documentation of medical necessity and the hospice denial form to the PA department for review.
- If PA cannot be obtained prior to rendering services to children, providers may be allowed a backdated approval for services upon submission of a paper claim for the service with documentation attached to support medical necessity and hospice denial of the service.
- Hospice members (0 through 20 years of age) can receive the services identified below so long as the services are not duplicative of services provided by the hospice facility.
- Case management services when provided and billed by an APRN enrolled in KMAP
- Technology Assisted (TA) waiver program attendant care services

Note: Hospice providers will continue to be responsible for all DME and supplies.

HOSPITAL

Inpatient

- All inpatient stays are subject to utilization review (UR) except stays involving members who have Medicare Part A (primary payer). URs are performed on a post payment basis for general inpatient hospital stays.

HOSPITAL continued

- When an inpatient hospital admission is determined not to be medically necessary by the inpatient utilization review contractor and results in recoupment of payment, the inpatient physician E&M service claim(s) will be recouped, and the provider(s) can resubmit the claim(s) as an outpatient service.
- Take-home drugs are limited to the amount a member needs to allow time to get to a pharmacy.

Hospital Visits

- One inpatient hospital visit, per provider, per member, per day is covered.
- The **same** provider cannot bill a consultation and a hospital visit on the same date of service for the same member.
- The **same** provider cannot bill an inpatient hospital visit and emergency room visit on the same date of service for the same member.
- A hospital visit and chemotherapy administration to the same member by the same provider on the same date of service is not covered.
- The **same** provider cannot bill a hospital visit and psychotherapy on the same day for the same member.
- Only one inpatient follow-up visit is covered within a 10-day period per member, by the same provider.

Substance Use Disorder

- **Acute detoxification** is covered in any general hospital.
  Substance use disorder intensive outpatient treatment is only covered when provided in a residential substance abuse treatment facility or a nonresidential substance abuse treatment facility and only by those provider specialties of residential alcohol/drug abuse treatment facility or alcohol and drug rehabilitation.
- Billing for substance use disorder specific codes can only be considered for reimbursement for the following provider specialties: residential alcohol/drug abuse treatment facility or alcohol and drug rehabilitation.

Outpatient

- Outpatient services are reimbursed on a fee-for-service basis.
- The following are examples of covered outpatient services:
  - Emergency room services
  - Laboratory services
  - Diagnostic or therapeutic radiology services
  - Nuclear medicine services
  - Outpatient surgery
  - Rehabilitative occupational therapy
  - Rehabilitative physical therapy
- These services should be used for minor surgical or medical procedures which would not require an inpatient stay.
- The hospital will not be paid for the use of the emergency room when a member repeatedly abuses emergency room services. Any member who continually abuses these

HOSPITAL continued

privileges despite reprimand should be reported to KDHE-DHCF. (Refer to **Section 2400** of the *General Benefits Fee-for-Service Provider Manual*).

- When emergency room services have been determined to be nonemergent, the physician's fee will be reduced to the nonemergency level.

Emergency Room

- The member's age and time of admission to an emergency room does not determine emergent status. Conditions relating to the emergency room visit, such as stabilization of an injury or condition, may support the emergent need.
- Direct physical attendance by the provider (physician, APRN, or PA) must be documented in the medical record for the visit to 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.
- Members 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."
- Members who require transfer to another facility for further emergency treatment or who expire.

Nonemergent Situations

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

HOSPITAL continued

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

- **Alcoholism**: An acute medical/surgical condition exists (e.g., gastric bleeding, dehydration).
- **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 member to be an **immediate** danger to self or others.
- **Disposition:** If a member's **disposition** is one of the following, the visit would be considered emergent:
  - Requires transfer to another facility for further treatment
  - Has expired, expires en route to the hospital or in the emergency room
  - Requires extended observation or admission
- **Fever:** Documented fever is present in the emergency room of 103° Fahrenheit (39.5° Celsius) or above rectally in children and of 102° Fahrenheit (38.9° Celsius) or above orally in adults.
- **Insect bites, stings, embedded ticks:** Documentation must support the presence of complications resulting from the bite/sting beyond the expected local reactions such as redness, itching or swelling.
- **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

HOSPITAL continued

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 member is noted to be suicidal or of immediate risk to self or others.
- **Minor burns/sunburns**: Documentation must support presence of complications such as severe swelling, infection, or the young age of the member. Eye and chemical burns are considered emergent.
- **Otitis media -** not emergent unless:
    - The tympanic membrane is bulging or ruptured.
    - There is drainage from the ear(s).
    - Documented fever is present in the emergency room of 103° Fahrenheit (39.5° Celsius) or above rectally in children and of 102° Fahrenheit (38.9° Celsius) or above orally in adults.
    - The member is age three or under and is crying inconsolably.
    - The physician's examination documents the presence of acute otitis media and there is no access to a physician's office due to holiday or weekend or is after office hours.
- **Patient noncompliance:** Intentional **noncompliance** 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.
- **Removal of cutaneous foreign bodies**: Sedation or the use of extensive medical supplies were required for the removal of the foreign body (e.g. splinters, cactus needles).
- **Seizures** - not emergent unless:
    - The condition was previously undiagnosed, and the visit was following or during a seizure.
    - A secondary disorder/diagnosis exists (e.g. hypoglycemia, infection, etc.)
    - The member is 12 years of age or younger.
    - The member was brought in by the police and the condition was unknown.
    - The member was in status epilepticus.
    - The member is in an epileptic state aggravated by alcohol/drug ingestion.
- **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 member leaves the emergency department against medical advice (AMA) the service is generally considered nonemergent. However, if the facility provided considerable services before the member 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.

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- **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 member 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.
    - 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 member should not have to make two visits (one to the emergency room and one to an office or public health department) in order to receive the tetanus injection. When needed, a tetanus injection should be given within 48-72 hours of the injury, if possible.
- **Vital signs:** If the **vital signs** are outside a reasonable range for the age, consider the visit as emergent (see **Fever**).
- **Observation Room**: Observation is a service which requires monitoring a member's condition. Examples of the appropriate use of the observation room may include:
    - Monitoring head trauma
    - Drug overdose
    - Cardiac arrhythmias
    - False labor
- The observation room stay must be medically necessary.
- The observation stay is limited to 48 hours. A physician must have personal contact with the member at least once during the observation stay. A registered nurse or an employee under his or her direct supervision must monitor members in the observation unit. A member can be in the observation unit no longer than 48 hours. Observation hours in excess of 48 hours are not reimbursable. Ancillary charges (such as lab work or x-rays) can also be billed separately. Medical supplies and injections (99070 and J7030-J7121) are considered content of service of the observation room service.
- Observation services are considered content to any surgical procedure for which global surgery rules apply when performed by the same provider during the global surgery period. Observation services are considered content of service of respiratory services (94010-94700), when performed on the same date of service by the same provider unless the observation is a significantly, separately identifiable service.

HOSPITAL continued

- The following examples are considered content of service of the observation room and will not be reimbursed separately:
    - Recovery room services following inpatient or outpatient surgery
    - Recovery/observation following scheduled diagnostic tests such as arteriograms, cardiac catherization
    - ER physician fee
- If the claim and/or attachments do not support the medical necessity of the service rendered, the service will be denied.

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

Urgent Psychiatric

An observation bed may be used to provide security and "observation" for individuals in imminent danger and to assist in the determination of the need for psychiatric hospitalization.

Group/Individual Psychotherapy

Daily individual or group psychotherapy is required for inpatient hospital stays for psychiatric illness; however, **group** psychotherapy is not covered when provided by psychologists, physicians, or CMHCs in a hospital setting. **Inpatient group psychotherapy is content of service of the DRG reimbursement to the hospital**.

- Psychotherapy is not covered on days electroshock is given.
- A maximum of 12 inpatient electroshock treatments per month are covered.

Psychiatric Observation Beds

- Outpatient psychiatric observation beds are covered for up to three consecutive days. During the observation period, the member must receive:
    - A physical examination
    - History of psychiatric assessment containing recommendations for ongoing treatment
    - An initial nursing assessment
    - Nursing progress notes written each shift
    - A discharge summary
- A physician must admit the member to an observation bed. If, at the end of the observation period, the member is not admitted to the hospital or discharged, no additional payment will be made at the end of the observation stay. When an admission follows an observation stay, the physical examination report and the psychiatric assessment must be included in the member's medical record. The observation bed stay becomes part of the DRG payment to the hospital. Refer to **Section 7010** for billing instructions.

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- Procedure code S9485 is used for psychiatric observation. Code H2013 will no longer be covered. The appropriate revenue code to be utilized would be outpatient observation. The submitted claim for reimbursement of code S9485 should have a psychiatric diagnosis noted as either a primary or secondary designation.

HYPERBARIC OXYGEN THERAPY

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

1. The services must be for one of the following conditions:
    a. Acute carbon monoxide intoxication
    b. Decompression illness
    c. Gas embolism
    d. Gas gangrene
    e. Acute traumatic peripheral ischemia
    f. Compromised skin grafts
    g. Chronis 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 bill for this procedure using 99183 (one unit equals one treatment session). If there are multiple sessions on the same day (more than one unit for physicians), each subsequent session must be billed on a separate detail line with modifier 76.

Immunizations/Vaccines – Please see **Immunization Administration** in **Section 7010** of this manual.

INJECTIONS OF B12

Vitamin B12 injections are covered only when one or more of the following diagnoses are present:

- Anemia
    - Fish, tapeworm
    - Iron deficiency
    - Addison's, Biermer's, macrocytic, megaloblastic, pernicious
- Chronic enteritis/colitis
- Crohn's disease (ileitis), chronic or regional
- Dumping syndrome, jejunal syndrome
- Friedreich's ataxia; postlateral sclerosis
- Hepatic diseases or dysfunctions
    - Malignant and benign neoplasms

INJECTIONS OF B12 continued

- Neuropathies of malnutrition and alcoholism
- Renal disease

- Sprue, short gut syndrome, short bowel syndrome
- Strictures of intestines: Whipples disease

INSTITUTION OF MENTAL DISEASE

Federal regulations classify a free-standing psychiatric hospital as an institution for mental disease (IMD). The appropriate place of service is 51(Inpatient Psychiatric Facility) which should be used when billing for members in an IMD. Medicaid reimbursement for professional services is prohibited for members 22 to 64 years of age.

INTRATHECAL BACLOFEN PUMP

- Intrathecal baclofen pumps are covered for Medicaid members. This includes the initial and all subsequent implantation(s), revision(s), repairs, catheters, batteries, refills, removals, and maintenance of the intrathecal baclofen pumps when indicated. Three services require PA:
  62350 62351 62362
- The following conditions must be met:
  - The member must have responded favorably to a trial of intrathecal baclofen and include documentation of previously used medication.
  - The member's ICD diagnosis code must be a covered code and the source of the spasticity must be documented.
  - The member must be over the age of four years, or there must be documentation that there is sufficient space within the child's chest wall for the pump to be implanted.
- Contraindications include pregnancy and active infection at time of surgery.

The following procedure codes do not require PA:

62322	62323	62326	62327	62355	62365
62368	62369	62370	95900	95991	

LABORATORY

- When a general health panel is performed, the provider must bill the components of this panel. To bill the components of this panel, bill the following procedure codes separately: 80053 and 84443. Procedure code 80050 is not covered.
- When all other ordered laboratory tests make up a panel or profile the all-inclusive procedure code should be used to bill; do not bill each component separately.
- A drawing or collection fee is considered content of service of an office visit or other procedure and is not covered if billed separately. The member cannot be billed for the drawing or collection since it is considered content of another service or procedure.
- Laboratory procedures performed on inpatients are content of service of the DRG reimbursement to the hospital and should not be billed by an independent laboratory.
- Pathologists not contracted by a hospital may bill the professional component (modifier 26) on pathology services provided on inpatients.
- Reimbursement will only be made for one complete blood count (CBC) per day.
  KMAP considers three or more multichannel tests to be a SMA/SMAC, or profile, when performed on the same date of service. Medicaid follows the guidelines outlined in the *CPT*

LABORATORY continued

Codebook to identify automated multichannel tests (SMACs, profiles). When billing for a multichannel test use the appropriate CPT procedure code (organ or disease-oriented panels).

- Cytogenetic (chromosome) studies are covered for pregnant women (when medically necessary) and KBH-EPSDT members only. A medical necessity form must accompany the claim when billing for a cytogenetic study for a pregnant woman over 21 years of age.
- HIV testing code 87536 is covered with no limits.
- The following HIV testing codes are limited to four per calendar year, regardless of provider:
  86689 86701 86702 86703 87390 87391 87534
  87535 87537 87538 87539 87900 87903 87904
- The following HIV testing codes are limited to two per calendar year, regardless of provider:
  87901 87906
- Medical necessity documentation for 87901 must include information that the member meets at least one of the following criteria:
  1. The member presents with virologic failure during Highly Active Antiretroviral Therapy (HAART).
  2. The member has suboptimal suppression of viral load after initiation of antiretroviral therapy.

Note: Refer to the *CPT* codebook for complete descriptions of these procedures.

CLIA Certification

Providers billing for lab services that require the Clinical Laboratory Improvement Amendments (CLIA) certification and approved type must ensure current CLIA information is on file with

KMAP. The CLIA certificate presented during KMAP provider enrollment or revalidation must match the associated service location of the laboratory.

KMAP will only consider claims for payment when the CLIA certification and type support the procedure and date of service being billed.

Hospitals, physicians, and independent laboratories must confirm the CLIA status of the performing laboratory prior to billing KMAP for those services. Referring providers are required to confirm the CLIA status for the performing lab prior to billing KMAP for those services.

This is to be noted on the claim with the use of Modifier 90 - Reference (outside) Laboratory. When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

Gene Analysis

- Genetic testing is covered only when:
  - There are signs and/or symptoms of an inherited disease in the affected individual.
  - There has been a physical examination, pretest counseling, and other diagnostic studies.
  - The determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.

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- Documentation to support medical necessity must be submitted with the claim.
- Kansas Medicaid uses Medicare's updated Tier 1 pricing for the coverage of select molecular pathology/gene analysis codes in the range of 81200-81383. The coverage criteria established with the original policy to cover molecular pathology codes will remain in effect.
- Medicare issued updated Tier 1 rates for select gene analysis codes.

Gene Expression Profiling

KMAP will consider the following for coverage:

The use of the 21-gene reverse transcriptase-polymerase chain reaction (RT-PCR) assay that is not considered experimental or investigational (such as Oncotype DX®, EndoPredict®, Breast Cancer IndexSM, and Prosigna®) to determine recurrence risk for deciding whether to undergo adjuvant chemotherapy may be considered **medically necessary** in individuals with primary, invasive breast cancer meeting ALL the following characteristics:

- Unilateral tumor
- Hormone receptor-positive (that is, estrogen-receptor [ER]-positive or progesterone receptor [PR]-positive)
- Human epidermal growth factor receptor 2 (HER2) –negative
- Tumor size 0.6 to 1 cm with moderate/poor differentiation or unfavorable features OR tumor size larger than 1 cm
- Node negative (lymph nodes with micrometastases [less than 2 mm in size] are considered node negative for this policy statement)
- Will be treated with adjuvant endocrine therapy, e.g. tamoxifen or aromatase inhibitors
- When the test result will aid the patient in making the decision regarding chemotherapy (e.g. when chemotherapy is a therapeutic option)
- When ordered within six months following diagnosis, since the value of the test for making decisions regarding delayed chemotherapy is unknown

- The 21-gene RT-PCR assay Oncotype DX should only be ordered on a tissue specimen obtained during surgical removal of the tumor and after subsequent pathology examination of the tumor has been completed and determined to meet the above criteria (e.g. the test should not be ordered on a preliminary core biopsy). The test should be ordered in the context of a physician-patient discussion regarding risk preferences when the test result will aid in making decisions regarding chemotherapy.
- For patients who otherwise meet the above characteristics but who have multiple ipsilateral primary tumors, a specimen from the tumor with the most aggressive histological characteristics should be submitted for testing. It is not necessary to conduct testing on each tumor; treatment is based on the most aggressive lesion.
- All other indications for the 21-gene RT-PCR assay (e.g. Oncotype DX), including determination of recurrence risk in invasive breast cancer patients with positive lymph nodes or patients with bilateral disease, are considered experimental/investigational.
- All other indications for the 21-gene RT-PCR assay (e.g. Oncotype DX, EndoPredict, Breast Cancer Index, and Prosigna) including determination of recurrence risk in invasive breast cancer patients with positive lymph nodes, patients with bilateral disease, or to consider length of treatment with tamoxifen, are considered experimental/ investigational.
- Use of a subset of genes from the 21-gene RT-PCR assay for predicting recurrence risk in patients with noninvasive ductal carcinoma in situ (e.g. Oncotype DX, Breast DCIS Score) to

LABORATORY continued

inform treatment planning following excisional surgery is considered experimental/ investigational.

- Use of 70-gene signature (MammaPrint®) for any indication is no longer considered experimental/investigational but medically necessary when criteria is met.
- The use of BluePrint® in conjunction with MammaPrint or alone is considered experimental/ investigational.
- Repeat gene expression profiling for the same tumor (for example a metastatic focus) or from more than one site when the primary tumor is multifocal is considered investigational and not medically necessary.

The following codes are covered:
CPT procedure codes: 81519, 81520, 81521

Breast cancer diagnosis codes

C50011	C50012	C50021	C50022	C50111	C50112	C50211	C50121	C50122
C50211	C50212	C50221	C50222	C50311	C50312	C50321	C50322	C50411
C50412	C50421	C50422	C50511	C50512	C50521	C50522	C50611	C50612
C50621	C50622	C50811	C50812	C50821	C50822	Z170		

Guidance for Coverage of Cytogenic Microarray and Fragile X Testing for Global Developmental Delay (GDD) and Fragile X Syndrome.

A suspected diagnosis of Global Developmental Delay (GDD) or Fragile X is appropriate to bill with these codes. These tests are considered the standard of care when genetic conditions are suspected and supported by clinical examination.

- Primary care physicians, developmental pediatricians, neurologists, psychiatrists and other non-geneticist providers may order genetic testing.
- Genetic consultation is not required.
- Providers may bill code 81229 or 81243 with a diagnosis from the list of codes, but is not limited to:

Table 1: Acceptable ICD-10 diagnosis codes for testing may include but is not limited to the following codes:

Diagnosis Code	Description
F84.0	Autistic disorder
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorder
F84.9	Other pervasive developmental disorder, unspecified
F88.0	Other disorder of psychological development (e.g. Global developmental delay)
Q99.2	Fragile X chromosome (fragile X syndrome)

Note: Genetic testing is covered only when there are signs and/or symptoms of an inherited disease in the affected individual; there has been a physical examination, pretest counseling, and other diagnostic studies and the determination of the diagnosis in the absence of such testing

LABORATORY continued

remains uncertain and would impact the care and management of the individual on whom the testing is performed.

- Gene expression profiling as a technique of managing the treatment of breast cancer will be limited to one test per breast cancer diagnosis.
  Note: Information to determine coverage and pricing information is available on the KMAP public and secure websites. For accuracy, use your provider type and specialty as well as the member ID number or benefit plan. For further assistance, contact Customer Service at 1-800-933-6593.

LACTATION COUNSELING

Lactation counseling services will be covered under code S9443 for nonphysician lactation consultants. A physician who provides lactation counseling services can bill under the appropriate office visit E&M code. The service includes a face-to-face visit of no less than 30 minutes that involves the following:

- A comprehensive feeding assessment related to lactation
- Interventions including positional techniques, proper latching, and counseling
- Community support information
- Evaluation of interventional outcomes
  This service is only covered if it is a one-on-one session. Group sessions are not covered.

Lactation counseling services are primarily intended for mothers with children from birth to 90 days old (postpartum or corrected for gestational age). However, it may be available for mothers with children up to 21 months old when medically necessary. There is a limit of five counseling sessions per child, and each session can last up to 90 minutes. This service limit may be exceeded based on medical necessity.

Medical lactation services provided in hospital outpatient clinics, physician or medical diagnostic clinics, and physician offices shall be performed by either:

- Physicians, certified nurse midwives (CNMs), nurse practitioners (NPs), physician assistants (PAs), and Local Health Departments (LHDs) who have training and experience providing medical lactation services
- International board-certified Lactation Consultants (IBCLCs) who are employed by the physician or physician group

Peri-partum Optimization – Postpartum Visit Tag From OB Global Code

Submission of procedure code 0503F, with the following diagnosis codes, will be used to track postpartum visits up through 12 weeks postpartum:

Z39.1	Z39.2

LOCAL EDUCATION AGENCY SERVICES

Providers of local education agency (LEA) services shall have appropriate credentials from the Kansas State Department of Education. Refer to the *Local Education Agency Fee-for-Service Provider Manual* for a complete list of covered services.

8400. Updated 12/23

MANAGEMENT OF SELF-MONITORING BLOOD PRESSURE TREATMENT PLANS

Effective with dates of service on and after January 1, 2024, professional services to validate blood pressure equipment, training and interpretation of blood pressure readings, will be covered using the following codes:

99473 - Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration.

- This code is allowed annually and reimbursed at $7.50.

99474 - Separate self-measurements of two reading one minute apart, twice daily over a 30-day period (a minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communications of a treatment plan to the patient.

- This code is allowed up to four times per year and reimbursed at $9.27. This limitation may be exceeded with prior authorization.

An acceptable diagnosis code from the following ranges must be included on the claim:

- I12.0-I12.9 - Hypertensive chronic kidney disease
- I13.0-I13.2 - Hypertensive heart and chronic kidney disease
- I50.1-I50.9 - Heart failure
- N18.5-N18.6 - Chronic-kidney disease, stage 5, and ESRD

Covered PT/PS are 31/000, 31/349, 09/093, and 10/100.

Note: Finger and wrist monitors are not covered for heart failure and ESRD diagnoses.

MATERNAL DEPRESSION SCREENINGS

Maternal Depression screenings are reimbursable for Early Child Intervention services using the Current Procedural Technology (CPT) and Health Care Common Procedure Coding System (HCPCS) 96161, G8431 and G8510 when using one or more of the following validated screening tools:

- Edinburgh Postnatal Depression Scale (EPDS)
- Postpartum Depression Screening Scale (PDSS)
- Patient Health Questionnaire 9 (PHQ-9)
- Beck Depression Inventory II (BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Zung Self-Rating Depression Scale (SDS)

Approved Provider Type / Provider Specialty Codes:

08-080	08-081	08-083	08-183	09-093	09-095	10-100
11-111	11-112	11-115	11-116	11-122	11-176	13-131
13-181	31-316	31-318	31-323	31-328	31-335	31-339
31-345	31-348	31-349	31-350			

8400. Updated 08/22

MATERNAL DEPRESSION SCREENINGS continued

Approved Place of Service Codes:

11	12	17	19	20	22	23
25	49	50	53	57	62	71
72						

A screening that occurs after the child is born is considered an Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit per Centers for Medicare and Medicaid Services (CMS) guidance, and should be billed under the infant's Medicaid ID number, using CPT code 96161. If the child does not have an assigned Medicaid ID number, CPT code 96161 can be billed under the mother's Medicaid ID number for up to 45 days postpartum. The screening CPT code 96161 is reimbursable postpartum, up until the child is 12 months of age.

The Maternal Depression Screenings can be administered by non-licensed staff. This includes home visitors, medical assistants, and community health workers since they are supervised by licensed professionals performing the primary service. These screenings should be reviewed by licensed professionals to ensure accuracy of the scoring and any necessary follow-up.

Referral and Follow-up Process on Positive Screenings Recommended by the American Academy of Pediatrics (AAP):

Immediate action is necessary if:

- Possible suicidality indicated in screening tool
- Mother expresses concern about her or her infant's safety
- Provider suspects that the mother is suicidal, homicidal, severely depressed, manic, or psychotic
- When a depression screen is positive, management varies according to the degree of concern and need.

Management of Postpartum Depression includes:

- Demystification (reducing guilt and shame by emphasizing how common these feelings are);
- Support resources (family and community); and
- Referrals for the mother (to a mental health professional or the mother's PCP or obstetrician), for the mother-infant dyad, for the child (for targeted promotion of social-emotional development and early intervention, and for the mother who is breastfeeding (for lactation support from an experienced provider).

Training Opportunities:

Optional training will be offered to screeners, including medical providers and their clinical staff, to increase timely detection of maternal depression.

The Mental Health Integration Toolkit on the KDHE website, will be updated by Public Health and will provide guidance on screening practices and patient and provider resources. There is also a national program, Mental Health First Aid, that teaches the skills to respond to the signs of mental illness and substance use.

MATERNAL DEPRESSION SCREENINGS continued

Clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both. Evidence suggests that collaborative care models implemented in obstetrics and gynecology offices improve long-term patient outcomes.

Follow-up with these patients and clinical support and training offered to staff results in greater reduction in depression prevalence. Initiation of treatment or referral to mental health care providers offers maximum benefit.

Miscarriage, Stillbirth and Neonatal Loss; Bereavement Follow-up Recommendations:
Loss of a pregnancy or death of a newborn affects every aspect of a family's life. Every effort should be made to determine the cause of the loss, to understand the family's grief responses, and to facilitate healthy coping and adjustment. The consequences of intense grief due to perinatal loss may include significant couple relationship issues, depression, anxiety, social phobia, obsessive compulsive disorder and post-traumatic stress disorder (PTSD) that may extend into the subsequent healthy pregnancies.

When the Perinatal Grief Intensity Scale (PGIS) is given shortly after the loss, it can also predict women who will continue to have intense grief 3-5 months in the future, and have higher risk for developing clinical level anxiety, depression, PTSD and couple relationship issues.

It is recommended that healthcare providers routinely screen for symptoms of depression and anxiety among women after a perinatal loss, as well as subsequent pregnancies.

Studies have shown that women who had experienced a stillbirth are twice as likely to have a high depression score compared to women who had a live birth and that women with a history of depression are especially vulnerable to persistent depression after a stillbirth, even after the subsequent birth of a healthy child. One study was the first to show that women who have no history of depression may face a risk for depression many months after a stillbirth.

Depression after a miscarriage is usually most severe immediately after a pregnancy is lost and that the depression rates dropped over the course of the year.

One of the key recommendations is that every woman who has experienced a miscarriage, stillbirth or neonatal death should receive follow-up care.

MATERNITY CENTER SERVICES

Labor and delivery in a maternity center setting are covered for Medicaid and MediKan members. The appropriate procedure code to be billed is 59409. For reimbursement, maternity centers must be licensed by the State of Kansas (or equivalent if located in another state) and enrolled as a provider in KMAP. The physician is responsible for billing his or her charges for care provided. Maternity Center fees should be billed on a UB04, using type of bill 84X and revenue code 0724. All other billing instructions will remain the same.

The list below is inclusive and applicable to the service you provide.

- Reimbursement is on a fee-for-service basis.

MATERNITY CENTER SERVICES continued

- Maternity center services are exempt from member copayment.
- Maternity center services are exempt from primary care case manager (PCCM) referral.
- Supplies are content of service of labor and delivery charges.

Medically Recalled Items and Services
KMAP allows reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. KMAP will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Payment will be reduced by the amount of the device credit.

Medically Recalled Items and Services
KMAP allows reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. KMAP will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Payment will be reduced by the amount of the device credit.

Providers should code services with the appropriate modifier (FB or FC) or condition code (49 or 50) to indicate services have been medically recalled.

- Modifier FB (item provided without cost to provider, supplier, or practitioner or credit received for replaced device) is used when items are provided without cost to the provider, supplier, or practitioner.
- Modifier FC (partial credit or replaced device) is used when partial credit is received by the provider, supplier, or practitioner for the replacement device.
- Condition code 49 signifies products replaced within the product lifecycle due to the product not functioning properly.
- Condition code 50 is used for product replacement for a known recall of a product.
  In circumstances where KMAP has reimbursed the provider for repair or replacement of items or procedures related to items due to a medical recall, KMAP is entitled to recoup or recover fees from the manufacturer and/or distributor as applicable. In circumstances where KMAP has reimbursed the provider the full or partial cost of a replaced device and the provider received a full or partial credit for the device, KMAP is entitled to recoup or recover fees from the provider.

MEDICATION ASSISTED TREATMENT – OPIOID TREATMENT PROGRAMS

Effective October 1, 2020, through September 30, 2025, all Medication Assisted Treatment (MAT) drugs and biological products used for Opioid Use Disorder (OUD) will be covered. All MAT drugs and biologicals billed through the medical benefit require a diagnosis code to be considered for payment.

Medications Covered:
MAT drugs used for OUD are considered Part B drugs, per Medicare guidelines. The following drugs are covered MAT drugs for Opioid Treatment Program (OTP):

- Buprenorphine brand products and their associated generics:
  - Buprenorphine sublingual tablets (Subutex)
  - Buprenorphine/naloxone sublingual films (Suboxone)
  - Buprenorphine/naloxone) sublingual tablets (Zubsolv)

  - Buprenorphine/naloxone buccal film (Bunavail)
  - Buprenorphine implants (Probuphine)
  - Buprenorphine extended-release injection (Sublocade)
- Methadone
- Naltrexone brand products and their associated generics:
  - Naltrexone tablets (Depade, Revia)
  - Naltrexone injection (Vivitrol)

Provider Information:
Collaboration and documentation between the OTP and other providers assisting with related OTP services is required to coordinate services included in codes that are a bundled service.

Opioid treatment providers are required to be enrolled in Medicare as an OTP provider. Verification of Medicare enrollment is required. Providers who are enrolled as a Medicare provider for OTP and enroll as a Medicaid provider will be exempt from the Medicaid enrollment fee. Medicaid dual eligible information can be found here.

All licensures must be in accordance with Medicare standards.

Approved Providers:
Allowed Practitioners will be those individuals employed in a licensed Substance Use Disorder (SUD) program as allowed by State Licensing regulations and/or standards.

Coding for MAT and Add on Codes:
The threshold for billing the codes describing weekly episodes, HCPCS codes G2067-G2075, is the delivery of at least one service in the weekly bundle (either the drug or non-drug component). If no drug was provided to the patient during the episode, the OTP must bill the G-code describing a weekly bundle does not include the drug (G2074) and the threshold to bill would be at least one service in the non-drug component. If a drug was provided with or without additional non-drug component services, the appropriate G-code describing the weekly bundle that includes the drug furnished may be billed.

CMS established HCPCS G-codes describing treatment with:
- Methadone (G2067)
- Buprenorphine oral (G2068)
- Buprenorphine injectable (G2069)
- Buprenorphine implants (insertion, removal, and insertion/removal) (G2070, G2071, and G2072)
- Extended-release, injectable naltrexone (G2073)
- Non-drug bundle (G2074) bill for services furnished during an episode of care when a medication is not administered. For example, in the case of a patient receiving injectable buprenorphine, OTPs would bill HCPCS code G2069 for the week during which the injection was administered and would bill HCPCS code G2074, which describes a bundle not including the drug, during any subsequent weeks when at least one non-drug service is furnished until another injection is administered, at which time, OTPs would bill HCPCS code G2069 again for that week.
- Medication not otherwise specified (G2075) - Use when MAT services are given with a new

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MEDICATION ASSISTED TREATMENT – OPIOID TREATMENT PROGRAMS continued

opioid agonist or antagonist treatment medication approved by the Food and Drug Administration (FDA) under Section 505 of the United States Federal Food, Drug, and Cosmetic Act (FFDCA) for the treatment of OUD.

- Intake activities (G2076)
- Periodic assessments (G2077)
- Take-home supplies of methadone (G2078) and take-home supplies of oral buprenorphine (G2079)
- Additional counseling furnished (G2080)

Frequency of use and other billing guidelines:

- G2067 – G2075 may not be billed more than once per 7 days.
- G2069 and G2073 may not be billed more than once every 4 weeks.
- G2070 and G2072 may not be billed more than once every 6 months.
- G2076 (describing intake activities) should only be billed for new patients. (No specific direction for this code currently).
- G2078 or G2079 may not be billed with more than 3 units (one month take home supply). Substance Abuse and Mental Health Services Administration (SAMHSA) allows a maximum take-home supply of one month of medication; therefore, the add-on codes describing take-home doses of methadone and oral buprenorphine should not be billed any more than 3 times in one month (in addition to the weekly bundled payment).
- G2078 (take-home supply of methadone) may only be billed with G2067 (methadone weekly episode of care).
- G2079 (take-home supply of buprenorphine) may only be billed with G2068 (buprenorphine weekly episode of care).
- G2080 may be billed when counseling or therapy services are furnished that exceed the amount specified in the patient's individualized treatment plan. OTPs are required to document the medical necessity for these services in the patient's medical record.
- Codes G2067 through G2075 may not be billed within the same 7-day period. When a patient is switching from one drug to another, the OTP should only bill for one code describing a weekly bundled payment for that week and should determine which code to bill based on which drug was furnished for the majority of the week.
- G2067 or 80358 cannot be billed within the same 14 days.
- G2067 or G2078 AND 83840 or H0020 or S0109 cannot be billed in the same week.
- G2080 AND H0004 or H0005 cannot be billed within the same week.
- H0004 AND G2067 or G2068 or G2069 or G2070 or G2071 or G2072 or G2073 or G2074 cannot be billed within the same week.
- H0005 or H0005 U5 AND G2067 or G2068 or G2069 or G2070 or G2071 or G2072 or G2073 or G2074 cannot be billed within the same week.
- H0006 or H0006 U5 AND G2067 or G2068 or G2069 or G2070 or G2071 or G2072 or G2073 or G2074 cannot be billed within the same week.
- H0015 or H0015 U5 AND G2067 or G2068 or G2069 or G2070 or G2071 or G2072 or G2073 or G2074 cannot be billed within the same week.
- G2068 or 80348 cannot be billed within the same 14 days.
- G2068 or G2079 AND J0571 or J0572 or J0573 or J0574 or J0575 cannot be billed within the

same week.

- G2073 and J2315 cannot be billed within the same 4 weeks.
- G2069 AND Q9991 or Q9992 cannot be billed within the same 4 weeks.
- G2080 and H0004 should not be billed within the same week.
- G2070, G2071, G2072 and J0570 cannot be billed more than 2 times within 12 months and no more than 2 billings per patient, per current FDA approval of this drug.
- G2070 or G2072 and J0570 cannot be billed within the same 6 months.
- G2071 and G2072 cannot be billed within the same 6 months.
- G2070 and G2071 can only be billed once within the same 12 months as G2072
- H0001 should not be billed by an OTP.
- G2075 requires manual review.

Date of Service:

For the codes that describe a weekly bundle (G2067-G2075), one week is defined as 7 contiguous days. OTPs may choose to apply a standard billing cycle by setting a particular day of the week to begin all episodes of care. In this case, the date of service would be the first day of the OTP's billing cycle. If a member starts treatment at the OTP on a day that is in the middle of the OTP's standard weekly billing cycle, the OTP may still bill the applicable code for that episode of care provided that the threshold to bill for the code has been met.

Alternatively, OTPs may choose to adopt weekly billing cycles that vary across patients. Under this approach, the initial date of service will depend upon the day of the week when the patient was first admitted to the program or when Medicare billing began. Under this approach of adopting weekly billing cycles that vary across patients, when a patient is beginning treatment or re-starting treatment after a break in treatment, the date of service would reflect the first day the patient was seen and the date of service for subsequent consecutive episodes of care would be the first day after the previous 7-day period ends.

For the codes describing add-on services (G2076-G2080), the date of service should reflect the date that service was furnished; however, if the OTP has chosen to apply a standard weekly billing cycle, the date of service for codes describing add-on services may be the same as the first day in the weekly billing cycle.

Covered Place of Service Codes:

- 58 - Non-Residential Opioid Treatment Facility - A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of MAT.
- 15 - Mobile Unit - OTPs which have a Drug Enforcement Administration (DEA) approved mobile unit, will be reimbursed for delivery of Methadone to patients. A current agreement for approval to provide mobile unit service with the Drug Enforcement Agency is required. All requirements of the agreement and licensure thereof must be adhered to and are auditable.

  Telehealth and transportation codes are covered codes for OTP services. Please refer to the Kansas Medicaid Telehealth and Non-Emergency Medical Transportation (NEMT) policies.

  Current rules for other health insurance apply. Providers of this type of service are required to bill

MEDICATION ASSISTED TREATMENT – OPIOID TREATMENT PROGRAMS continued

claims to primary insurance, if applicable.

MEDICATION ASSISTED TREATMENT - OFFICE BASED OPIOID TREATMENT (OBOT) PROGRAMS

MAT drugs, excluding Methadone, will be covered for Office-based Opioid Treatment (OBOT), according to the inclusions and exceptions listed below. Methadone used for MAT is only covered in an OTP setting. MAT drugs used for OUD are considered Part B drugs, per Medicare guidelines.

Covered drugs and biological products approved for OBOT are listed below and providers should follow the laws and guidelines for providing OBOT. More information can be found here.

Buprenorphine products indicated for MAT are the following:

- Buprenorphine brand products and their associated generics:
  - Buprenorphine sublingual tablets (Subutex)
  - Buprenorphine/naloxone sublingual films (Suboxone)
  - Buprenorphine/naloxone) sublingual tablets (Zubsolv)
  - Buprenorphine/naloxone buccal film (Bunavail)
  - Buprenorphine implants (Probuphine)
  - Buprenorphine extended-release injection (Sublocade)
- Naltrexone brand products and their associated generics:
  - Naltrexone tablets (Depade, Revia)
  - Naltrexone injection (Vivitrol)

Buprenorphine products that are indicated for pain, such as Belbuca, Butrans, and Buprenex, should not be prescribed for MAT.

Kansas Medicaid will no longer require the DATA Waiver (X-Waiver) to be obtained and submitted for verification, by the provider, before prescribing medications for the treatment of OUD.

Physicians, nurse practitioners, physician assistants, and qualified mid-level practitioners approved by Substance Abuse and Mental Health Services Administration (SAMHSA), may dispense or prescribe any Controlled Substances Act (CSA) scheduled III, IV, V medication approved by the Food and Drug Administration (FDA) for the treatment of Opioid Use Disorder (OUD). More information can be found here.

From October 1, 2018, and ending on October 1, 2023, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives are included in the provider types approved for MAT services, per the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018. More information can be found here.

Services covered:

The SUPPORT Act requires counseling and behavioral therapy to be part of a MAT program. Coordination of these services is necessary to ensure services are rendered and proper billing occurs. Compliance with the K.S.A. 39-708c, 65-4016, and 65-4607. “Standards for Licensure/Certification

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MEDICATION ASSISTED TREATMENT - OFFICE BASED OPIOID TREATMENT (OBOT) PROGRAMS continued

of Alcohol and/or Other Drug Abuse Treatment Programs" R03—711, Section K, regarding counseling requirements is required:

80348	H0001	H0004	H0005	H0005 U5	H0006	H0006 U5
H0007	H0015	H0015 U5	J0570	J0571	J0572	J0573
J0574	J0575	J2315	Q9991	Q9991	G2086	G2087
G2088						

*J0592 refers to buprenorphine injections for pain only, not OUD.

For presumptive and definitive urine drug screens, no more than 24 tests cumulative per patient per rolling year will be allowed from the same MAT provider (80348 and 80358). Medication use counseling for OUD medications that is provided by pharmacists are not included as part of OBOT services.

Current rules for other health insurance apply. Providers of this type of service are required to bill claims to primary insurance, if applicable.
All licensures must be in accordance with Medicare standards.

MID-LEVEL PRACTITIONERS

- Physician assistants (PAs) and advanced practice registered nurses (APRNs) must be enrolled as Medicaid providers to bill for services. Indicate the clinic's number as the billing provider and the PA's or APRN's number as the performing provider on the CMS 1500 paper or equivalent electronic claim form. APRNs and PAs are reimbursed at 75% of the Medicaid allowed amount for services provided.
- All services performed by PAs or APRNs within the scope of their license are covered with the same limitations that apply to physician services.
- PAs and APRNs in multispecialty clinics may append modifier U8 when seeking reimbursement for new patient E&M visits (procedure codes 99202, 99203, 99204, and 99205). In the multispecialty clinic setting, a new E&M visit is billable when the patient has not received a professional service from a physician or mid-level practitioner representing that individual specialty within the previous three years. Per existing policy, the code will be reimbursed at the 75% rate that applies to mid-level practitioners.

NURSING FACILITY

- Bill appropriate code 99307, 99308, 99309, or 99310 when providing a routine annual history and physical examination.
- If the nursing facility (NF) resident is seen for medical reasons other than what can be billed under 99307, 99308, 99309, or 99310, the appropriate code(s) should be used. If the resident is Medicare eligible, bill Medicare first.

OBSTETRICAL AND GYNECOLOGICAL (OB/GYN)

- The following procedures are content of service of total obstetrical (OB) care:
    - Office visits (nine months before and six weeks after delivery)
    - Urinalysis

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OBSTETRICAL AND GYNECOLOGICAL (OB/GYN) continued

- Internal fetal monitor

- Total OB care generally consists of 13 office visits, delivery (vaginal or cesarean), and postpartum care. The provider of total OB care should bill codes 59400 or 59510 whichever applies. If an APRN or PA provides part of the prenatal care but does not deliver the baby, the physician may bill the global fee without indicating the PA or APRN as the performing provider.
- If the APRN or PA provides part of the prenatal care and delivers the baby, the services must be broken out and the PA or APRN indicated as the performing provider. Providers should **not** bill for OB services until care is completed (for example, the member delivers, or the member is no longer a patient).
- When a provider does not complete total OB care, and only partial antepartum care has been provided, the following guidelines apply when billing services:
  - **One to three prenatal visits only** - Bill using E&M office visit codes.
  - **Four to six prenatal visits only** - Bill using code 59425. This code must NOT be billed by the same provider in conjunction with one to three office visits, or in conjunction with code 59426.
  - **Complete antepartum care without delivery** - Bill using code 59426. Complete antepartum care is limited to one member pregnancy per provider.
  - **Delivery only** (no antepartum care provided) - Bill using code 59409 or 59514.
  - **Delivery and postpartum care only** - Bill using code 59410 or 59515.
- **Codes 59425 and 59426** may be billed only once per provider, per member pregnancy. These codes must not be billed together by the same provider for the same member, during the same pregnancy.
- Pregnancy-related (E&M) office visits must not be billed in conjunction with code 59425 or 59426 by the same provider for the same member, during the same pregnancy.
- Code 59426 is limited to one per pregnancy, per provider.
- Only one IUD insertion every seven days per member is covered.
- Smoking cessation codes G0436, G0437, and S9453 are covered for pregnant women.
- Smoking cessation codes S9453, 99406, and 99407 are covered for pregnant women. These codes are only payable when billed with either:
  - O99330, O99331, O99332, or O99333
  - A combination of Z3310, Z3400-Z3493, O0900-O0943, or Z392 **AND** F17200 or Z87891
- Tobacco cessation counseling codes S9453, 99406, and 99407 are covered for pregnant women. The appropriate ICD-10 diagnosis codes are F17200-F17299, O99330-O99335, and Z720.
- Fetal aneuploidy testing codes 81420 and 81507 are covered for at-risk pregnancies when billed with a covered ICD-10 diagnosis code. Fetal aneuploidy testing is limited to coverage of one CPT code per pregnancy (270 days).
- DNA-based noninvasive prenatal tests of fetal aneuploidy are proven and medically necessary as screening tools for trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome) or trisomy 13 (Patau syndrome) in any one of the following circumstances:

  Fetal Testing
  - Maternal age of 35 years or older at delivery
  - Fetal ultrasound findings indicating an increased risk of aneuploidy
  - History of prior pregnancy with trisomy

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OBSTETRICAL AND GYNECOLOGICAL (OB/GYN) continued

- Positive first or second trimester screening test results for aneuploidy
- Parental balanced Robertsonian translocation with an increased risk of fetal trisomy 13 and 21

- DNA-based noninvasive prenatal tests of fetal aneuploidy are unproven and NOT medically necessary for all other indications including, but not limited to, the following:
  - Multiple gestation pregnancies
  - Screening for microdeletions
  - Screening for sex chromosome aneuploidies

Obstetrical Pelvic Sonograms

- OB sonograms are not covered when performed solely to determine the fetal sex or to provide parents a view and/or photograph of the fetus. Only one routine OB sonogram per pregnancy is allowed. Medical necessity for more than one OB sonogram per pregnancy needs to be demonstrated with medical documentation available for review to support this necessity.
- A primary or secondary diagnosis must support medical necessity for an OB sonogram. ***Note:*** If applicable, this information should be submitted with the claim.
- The following OB sonogram procedures must be billed using a primary or secondary diagnosis code indicating this was an OB procedure.

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

OFFICE VISITS

- One comprehensive office visit per calendar year per member is covered.
- E&M office visit procedure codes 99202, 99203, 99204, and 99205 may be used for any new patient meeting program requirements.
- A new patient visit is not covered when it is within three years of any professional face-to-face service (such as E&M) or surgery service when performed by the same provider or a member of the same group with the same specialty. Refer to the **Mid-Level Providers** portion in this section for additional billing instruction.
- School or employment physicals can be billed if completed within the course of an office visit that meets the criteria for an E&M encounter.
- An office visit billed on the same day as chemotherapy administration, cast application, or an IUD removal by the same provider for the same patient is not covered.

OXYGEN THERAPY

- All oxygen equipment (stationary and portable), supplies, and accessories must be supplied by the same provider. Only one provider can bill for these services at a time.
- All claims for monthly rental items must be billed using appropriate date ranges.
  - Claims must range from the first day of service through the last day of service for the month being billed. (One unit equals one month/30 days.)
  - Claims billed using the same date for the beginning and the ending dates will be denied.
  - If member changes provider, the dates billed by the previous provider and the new provider cannot overlap.

OXYGEN THERAPY continued

- Once a member no longer requires oxygen services, it is the responsibility of the DME provider to obtain a discharge order from the physician or have the member sign a medical release of liability form and immediately pick up all equipment. All rented oxygen systems must be billed using modifier RR. DME suppliers cannot bill KMAP or the member for equipment left in the home unused.
- If a member wants to switch providers, it is the DME supplier's responsibility to obtain a physician's order or a medical records release signed by the member. It is the responsibility of both DME suppliers to coordinate delivery and pick-up of the equipment with each other. The new provider cannot bill KMAP until he or she has a pick-up ticket from the old company to prove he or she is the new supplier.

Coverage Criteria

Home oxygen is covered if the member meets all of criteria 1-5 and at least one of criteria 6-9.

1. The treating physician has diagnosed the member with a severe lung disease or hypoxia-related symptoms that are expected to improve with oxygen.
2. The member meets the laboratory values listed under the following section, Qualifying Laboratory Value Requirements.
3. The qualifying laboratory values were performed by a physician or qualified provider of laboratory services.
4. The qualifying laboratory values were obtained under either of the following conditions:
   - If the qualifying laboratory value is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than two days prior to, the hospital discharge date.
   - If the qualifying laboratory value is not performed during an inpatient hospital stay, the reported test must be performed while the member is in a chronic stable state not during a period of acute illness or an exacerbation of their underlying disease.
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.
6. Member has an arterial PO2 at or below 55 mm Hg or arterial oxygen saturation at or below 88% taken at rest (awake).
7. Member has an arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88% for at least five minutes during sleep with an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 88% while awake.
8. Member has a decrease in arterial PO2 more than 10 mm Hg or a decrease in arterial oxygen saturation more than 5% for at least five minutes during sleep and associated symptoms or signs reasonably attributable to hypoxemia (such as cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis).
9. Member has an arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88% during exercise with an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% during the day while at rest lasting at least five minutes. In this case, oxygen is provided during exercise if it is documented that the use of oxygen improves the hypoxemia demonstrated during exercise when the member was breathing room air.

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OXYGEN THERAPY continued

Oxygen therapy is not covered in the following conditions:

- Angina pectoris in the absence of hypoxemia
  Note: This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
- Dyspnea without cor pulmonale or evidence of hypoxemia
- Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia
  Note: There is no evidence that increased PO2 will improve the oxygenation of tissues with impaired circulation.
- Terminal illnesses that do not affect the respiratory system
- Treatment of sleep apnea (when medical necessity indicates a CPAP machine is needed but oxygen is being used instead)
- Back-up oxygen
  Note: Back-up is considered extra equipment in case one fails; extra refillable tanks stored for use when one runs out is not considered back-up.
- Oxygen furnished by an airline
- Any place of service other than home (such as skilled nursing facility [SNF], NF, psychiatric residential treatment facility [PRTF], ICF-IID, or hospital)
- Stand-by or emergency (oxygen in place just in case something happens) oxygen for members who do not have severe lung disease
  Note: Acute infections/episodes are not considered severe lung disease.

Qualifying Laboratory Value Requirements:

The term "qualifying laboratory value" refers to either an arterial blood gas (ABG) test or an oximetry test. An ABG is the direct measurement of the partial pressure of oxygen (PO2) on a sample of arterial blood. The PO2 is reported as mm Hg. An oximetry test is the indirect measurement of arterial oxygen saturation using a sensor on the ear or finger. The saturation is reported as a percentage. All members must meet new laboratory value requirements.

The qualifying laboratory value must be performed by a provider who is qualified to bill Medicaid for the test (Part A provider, laboratory, independent diagnostic testing facility [IDTF]) or a physician. A DME supplier is not considered a qualified provider or a qualified laboratory. Laboratory value studies performed by a supplier are not acceptable. In addition, the qualifying laboratory value cannot be paid for by any DME supplier.

When oxygen is covered based on an oxygen study obtained during exercise, there must be documentation of three oxygen studies in the member's medical record (testing at rest without oxygen, testing during exercise without oxygen, and testing during exercise with oxygen applied demonstrating the improvement of the hypoxemia). All results must be maintained in the member's file with the DME provider.

Qualifying laboratory value studies must be performed annually (every three months for acute conditions) for all members, and they must continue to meet all criteria. The DME provider must

OXYGEN THERAPY continued

maintain all results in the member's file. When a physician orders to extend oxygen coverage, a repeat qualifying blood gas study must be performed within 30 days prior to the date of extension, and the member must continue to meet criteria.

For a member with acute, short-term conditions (for example, bronchitis or pneumonia) a new qualifying laboratory value and a new physician's order must be obtained prior to initiation of oxygen and every three months following. The member must continue to meet oxygen criteria. Once the member no longer meets oxygen criteria, providers are to cease billing KMAP. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. The physician's order or prescription must include diagnosis, flow rate, frequency, and estimated duration. A generic prescription only stating: "Oxygen PRN" is not acceptable.

Stationary Oxygen Systems

A stationary oxygen system is covered if the member meets oxygen criteria. All stationary oxygen systems will be reimbursed on a monthly rental basis (one unit equals a one-month rental). All supplies, repairs, maintenance, and contents are considered content of the rental and are not reimbursed separately. A system is considered member-owned if the ownership of the entire system has been previously transferred to the member. For those member-owned systems, the supplies, repairs, maintenance, and oxygen contents will be allowed separate reimbursement.

Portable Oxygen

A portable oxygen system is covered if the member meets oxygen criteria, is mobile within the home, and the qualifying blood gas study was performed while at rest (awake) or during exercise.

If the only qualifying blood gas study was performed during sleep, portable oxygen is noncovered. If a portable oxygen system is covered, the supplier must provide whatever quantity of oxygen the member uses.

All portable oxygen systems will be reimbursed on a monthly rental basis (one unit equals a one-month rental). All supplies, repairs, maintenance, and contents are considered contents of the rental and are not reimbursed separately. A system is considered member-owned if the ownership of the entire system has been previously transferred to the member. For those member-owned systems, the supplies, repairs, maintenance, and oxygen contents will be allowed separate reimbursement.

Oxygen Contents

Stationary and portable oxygen contents are payable separately only when the coverage criteria for home oxygen have been met, and they are used with a member-owned stationary gaseous or liquid system respectively. One unit equals a one-month supply.

Accessories

All oxygen accessories, parts, and supplies are included in the allowance for rented oxygen systems. The supplier must provide any accessory ordered by the physician. Accessories are separately payable only when used with a member-owned oxygen system. Kansas Medicaid limitations will apply.

OXYGEN THERAPY continued

Delivery, Maintenance, and Repairs

All delivery charges are content of service and cannot be billed separately. The DME supplier can deliver no more than a three-month supply at a time. The DME supplier is responsible for all delivery and pick up of oxygen and supplies for all oxygen systems and services. The DME supplier is responsible for maintenance and repairs. All maintenance and repairs of rented systems are considered content of service and cannot be billed separately. Maintenance and repair of member-owned systems require prior authorization. Routine maintenance on member-owned systems will be allowed no more than once every six months with PA.

PATIENT DEMAND CARDIAC MONITORING

Patient Demand Cardiac Monitoring is covered in the following situations:

- Patient demand single or multiple event recording with pre-symptom memory loop, 24-hour attended monitoring, per 30-day period; includes transmission, physician review and interpretation
- Patient demand single or multiple event recording with pre-symptom memory loop, per 30-day period; recording includes hook-up, recording, and disconnection
- Patient demand single or multiple event recording with pre-symptom memory loop, per 30-day period; monitoring, receipt of transmissions and analysis
- Patient demand single or multiple event recording with pre-symptom per 30-day period; physician review and interpretation only

PHARMACY

Pharmacist as Provider – Approved Billable Services

Kansas Medicaid will recognize pharmacists as providers and reimburse pharmacies or medical practice groups on behalf of pharmacist's services that are not directly related to dispensing medications.

Enrollment Requirements for Pharmacists:

- Online enrollment application with the pharmacist as "Individual within a Group (IG)" is required.
- An active Kansas pharmacist licensure in good standing with the Kansas Board of Pharmacy is required.
- A Clinical Laboratory Improvement Amendment (CLIA) Waiver is an optional requirement for pharmacists.
- Each pharmacist must enroll with their own National Provider Identifier (NPI) (type 1) to provide the covered services with taxonomy code 1835P0018X.
- Pharmacists must be affiliated with a pharmacy or medical practice for the services to be billed to Medicaid. Medical practice groups include Physician (provider type 31) or Advanced Practice Registered Nurse (APRN) (provider type 09) groups.
- With IG enrollment, pharmacists are required to follow current state policy enrollment requirements, related to 42 CFR 455.101.
- Pharmacists will be enrolled with new provider type/provider specialty (PT/PS) 32/276 (Non-physician/Pharmacist).

8400. Updated 08/23

PHARMACY continued

Enrollment Requirements for Pharmacies:

- Pharmacies must be enrolled as a Group provider to allow pharmacists to be associated as an IG.
- Pharmacies must follow the existing enrollment requirements to enroll as a Group provider.
- Pharmacies will be enrolled with new PT/PS 32/240 and function as a billing provider for pharmacists. Pharmacies will use the existing taxonomy code 333600000X.

Billing Guidelines:

- The billing provider reported on the claim must be the pharmacy's (type 2) NPI, or the medical facility's NPI, and be actively enrolled in Kansas Medicaid to be paid.
- The rendering provider reported on the claim (Line 24J of the Professional Services Form) must be the pharmacist's (type 1) NPI and they must be actively enrolled in Kansas Medicaid.
- Pharmacies or medical facility groups must bill pharmacist services through the Kansas Modular Medicaid System (KMMS) Provider Web Portal, on a CMS-1500 Professional Claim Form, or ASC X12N 837P transaction, using appropriate HCPCS codes.
- The two-digit national Place of Service (POS) code of 01 (Pharmacy) or 11 (Office) is required on the claim.

Covered Services:

The following services are covered for pharmacist PT/PS 32/276.

Point of Care Testing:

A pharmacist may initiate therapy using the Point of Care Testing codes listed below. A CLIA Testing Waiver is required at the time the service is provided. The State Board of Pharmacy protocols for these services must be followed. The pharmacist's NPI should be the prescriber on the prescription billed by the pharmacy. Pharmacists will be considered prescribers for prescriptions resulting from performing these protocols. Pharmacists billing these claims as the prescriber must practice strictly in accordance with the State Pharmacy Practice Act.

These claims are subject to audit for all requirements needed to provide these services.

Point of Care Testing	E&M Services
81002	99202
81003 QW	99203
87400 QW	99211
87502 QW	99212
87651 QW	99213
87804 QW	99214
87880 QW	

CLIA Waived Testing:

Pharmacies are to have protocols in place for any CLIA Waived Tests that the Laboratory Improvement Program Office of the KDHE laboratories have approved them to do.

CLIA Waived Testing	
80061 QW	86780 QW
82465 QW	86803 QW
82947 QW	87389 QW
83036 QW	87635 QW
83037 QW	87811 QW
86618 QW	87889 QW
86701 QW	82962

Reimbursement:
The covered services will be reimbursed same as other mid-level practitioners, at 75% of Medicaid rate.

Audits/Edits/Limitations:
All codes listed will have the same audits/edits/limitations that these codes currently have or change to in the future. The provider is to follow all current provider documentation requirements.

DAW Documentation Required
For KMAP to increase member safety, decrease unnecessary expenditures, and assist in monitoring drug products, if a prescriber specifies dispense as written (DAW) on a drug which has a bioequivalent generic substitute available, the prescriber will be required to fill out the FDA MedWatch form 3500. This MedWatch form must be submitted to the dispensing pharmacy AND to the FDA. The dispensing pharmacy will then submit this to the KMAP Prior Authorization department for evaluation and receive approval if medical necessity is met.

Submitting MedWatch documentation for review:
The FDA MedWatch forms can be obtained on the FDA website.

- Prescribers must mail or fax the completed FDA MedWatch forms to the FDA AND to the dispensing pharmacy.

  Address: MedWatch
  5600 Fishers Lane
  Rockville, MD 20852-9787

  Fax 1-800-FDA-0178

- Pharmacists fax the completed FDA MedWatch and PA forms to the KMAP Prior Authorization department for consideration at 1-800-913-2229.
- The Prior Authorization department will contact the pharmacy to inform them of the status of the DAW request.

CRITERIA TO MEET MEDICAL NECESSITY FOR A BRAND NAME DRUG WHEN BIOEQUIVALENT GENERIC SUBSTITUTE IS AVAILABLE

A. Adverse reaction(s) to the generic:
Documentation by prescriber that the adverse reaction caused by the generic meets one of the following criteria:

1. Life threatening
2. Hospitalization
3. Disability
4. Required intervention to prevent impairment or damage

OR

B. Allergic reaction(s) to the generic:
Prescriber must document the member's experience of an allergic reaction to the generic product of one or more manufacturers. The dates and clinical details with the name of specific companies and the generic versions involved must be included.

OR

C. Therapeutic failure(s) of the generic:
Prescriber must document the clinical failure due to member's suboptimal drug plasma concentration while taking the generic drug when compared to published full pharmacokinetic profiles for the brand name drug.
The term "generic drug" means a drug that is "bioequivalent." Kansas law refers to the Federal Food and Drug Administration's definition, which says drugs are bioequivalent if:

1. They use the same active ingredient as the original version of the drug.
2. The active ingredient is absorbed and available where it is needed in the body at the same rate.

Single source reimbursement may be considered for multisource brand name drugs if specific medical necessity criteria is met.

Kansas Prescription Drug Monitoring Program (PDMP) Attestation Requirement
Medicaid providers that are required to check the Kansas Prescription Drug Monitoring Program (PDMP), also known as K-TRACS, prior to writing a controlled substance medication for a Medicaid member will be required to submit an annual attestation form. The annual attestation form will acknowledge the awareness of and compliance with Medicaid PDMP related policies.

The PDMP policies are located on the Kansas PDMP website here.

Complete and submit your attestation form here.

The first submission is due by June 1, 2023, and should reflect provider compliance for the 2022 Federal Fiscal Year (FFY), date range October 1, 2021, through September 30, 2022. After June 1, 2023, the annual attestation submission is due by January 1st of every year, beginning January 1, 2024. Each annual attestation will reflect PDMP activities performed for the previous FFY. For example:

Attestation Due Date	Attestation FFY Period	FFY Start	FFY End
January 1, 2024	FFY 2023	October 1, 2022	September 30, 2023
January 1, 2025	FFY 2024	October 1, 2023	September 30, 2024
January 1, 2026	FFY 2025	October 1, 2024	September 30, 2025

PHARMACY continued

The state will follow up with any provider that did not submit an attestation form or submitted a form showing non-compliance, to address any barriers to provider compliance.

Accessing K-TRACS through an Electronic Medical Record (EMR) is to be compliant with checking the K-TRACS portal for Kansas Medicaid providers.

Frequency:
The frequency requirement for Medicaid providers to review K-TRACS is as follows:

For a NEW patient to an individual provider:
When an individual provider has a new patient visit (as defined by current policy), the provider must check K-TRACS prior to writing/e-scribing a controlled substance prescription for that patient.

For a CURRENT* patient to an individual provider:
When an individual provider has a current patient, in which that provider has ordered a controlled substance previously, the frequency of future K-TRACS reviews for continued re-ordering of that same controlled substance, must be done every 180 days.

When an individual provider has a current patient, and that provider is intending to order a different or an additional controlled substance, a review of K-TRACS is required.

**For this requirement, a "current" patient is defined as a patient having had at least one previous appointment with the same individual provider.*

Exceptions:
Prescribers will not be required to check K-TRACS for members with the following designations:

- Patients with a diagnosis of cancer or sickle cell disease.
- Patients receiving hospice or palliative care.
- Patients residing in an assisted or custodial care environment*
- Patients below the age of 13 years.

**Members residing in an assisted or custodial care environment means the member resides in a "facility" where a health care worker oversees and/or administers the medication to the patient.*

If the KDHE Secretary waives the K-TRACS requirement for natural disasters and emergency services, the requirement will be temporarily waived for Medicaid providers.

Additionally, the following exceptions are allowed regarding the Medicaid provider's ability to check the K-TRACS website before prescribing a controlled substance for a Medicaid member:

- If the provider is not able to check the K-TRACS website because the K-TRACS website is inaccessible, the provider will document in the member's record, the date and time the attempt was made and not successful, prior to writing or prescribing an e-scription for a controlled substance.

PHARMACY continued

- If the provider's personal or facility electronic device capability is not able to check the K-TRACS website, the date and time of the attempt will be noted intermittently prior to writing a prescription for a controlled substance. When electronic access to records/internet is restored, then official documentation in the member's chart is required.

  This documentation will be used and considered acceptable for auditing purposes.

Prior Authorization
Some medications require PA before they can be dispensed, and payment made to the pharmacy provider. A staff member may contact you for a patient diagnosis or laboratory data to justify the authorization. Approved PAs will have a specified duration, not to exceed one year.

The KMAP PA and PA criteria forms can be viewed and downloaded from the KDHE website.

Emergency Situation
Refer to **Section 8400** of the *Pharmacy Fee-for-Service Provider Manual* for instructions regarding emergency PA.

Preferred Drug List
Refer to the **Preferred Drug Listing** portion of **Section 8400** in the *Pharmacy Fee-for-Service Provider Manual* for information regarding the PDL.

Day's Supply
Refer to the **Maximum Allowable Day's Supply** portion of **Section 8400** in the *Pharmacy Fee-for-Service Provider Manual* for information.

Drug Efficacy Study Implementation
All drugs classified as Drug Efficacy Study Implementation (DESI), less-than-effective drugs and their Identical, Related, and Similar (IRS) drugs are noncovered by KMAP.

Legend/Over-the-Counter (OTC) Drugs
Most legend drugs are covered for Medicaid members. Some OTC products are covered with a prescription. Legend prenatal vitamins are covered for pregnant females only and up to three months postpartum for lactating women.

Drug Restrictions
To view KMAP drug restrictions, access the *Pharmacy Fee-for-Service Provider Manual* from the public or secure websites. Drug limitations are listed under Benefits and Limitations.

Coverage of Therapeutic Phlebotomy
CPT code 99195 may be reimbursed when billed with one of the following polycythemia diagnosis codes:

- D45.0
- D75.0
- D75.1
- P61.1

PHARMACY continued

Procedure code 99195 will be paid when billed for polycythemia and other previously allowed diagnoses (porphyria, hemochromatosis) related to disorders with iron metabolism.

POSITIVE BEHAVIOR SUPPORTS

Three Positive Behavior Supports (PBS) services were created for KBH-EPSDT members. These services are:

PBS Environmental Assessment: An assessment of environmental events, antecedents, and consequences that are associated with or maintain the behaviors of interest, including physiological responses. This service should be billed as H2027. A unit is equal to 15 minutes and up to 30 hours are covered per year.

PBS Treatment: Procedures that include environmental manipulation of one or more of the following: antecedent events, setting events, consequent events, and teaching new skills. This service should be billed as H2027 (U3). A unit is equal to 15 minutes and up to 60 hours are covered per year.

PBS Person-Centered Planning: The use of person-centered planning approaches that integrate a person's desired quality of life including barriers to achievement. This service should be billed as 90882 (U3). 15 minutes is equal to one unit, and up to 40 hours are covered per year.

The following conditions apply with respect to these services:

- Provider type-specialty 11-239 (Mental Health-Positive Behavior Support) is the only provider type allowed for reimbursement of these services.
- The place of service cannot be a school (03).
- PBS services cannot be billed simultaneously with another service.
- The PBS facilitator cannot be providing any other Medicaid-reimbursable service for his or her assigned PBS member.
- Individuals providing PBS services must have, at a minimum, a bachelor's degree and have completed the Kansas Institute for Positive Behavior Supports (KIPBS) training program.
- PBS providers are required to have a signed referral form from a physician or licensed practitioner on file prior to submitting a plan of care for approval. A referral form is available for this purpose. This should accompany the plan of care request.
  Note: Typically, the delivery of services will be limited to one billing cycle per member (the allowable hours of assessment, treatment, and person-centered planning that can be used during a one-year billing cycle).
- There may be occasions when a case is determined to be so severe that a subsequent year of service is required. If this occurs, an exception may be considered. All exceptions for fee-for-service (FFS) members must be prior authorized using the process developed and implemented by KDADS.
  Note: If the limitation of allowable hours of assessment, treatment, and person-centered planning has not been used during the first year of service, the remaining allotment of billable hours cannot be carried over into the second year as part of any new prior authorized service for an exception.

8400. Updated 03/17

POSITIVE BEHAVIOR SUPPORTS continued

- All services approved by the prior authorization system as part of an exception will constitute a new service arrangement for a member with specific limitations and conditions.

All FFS PBS services must be authorized through KDADS. The following conditions apply:

- Only persons who have successfully completed the KIPBS training system and are currently recognized by that system as approved for reimbursement can make application to KDADS for an approved prior authorization.
- PBS providers are required to have a signed referral from a physician or licensed practitioner on file prior to submitting a plan of care for approval. A referral form is available for this purpose. This should accompany the plan of care request.
- If the KDADS State Program Manager approves an application, it is faxed to the appropriate fiscal agent contact person for action. KDADS will also send notification to the PBS facilitator to forward a copy of their Notice of Action on Prior Authorization document to the appropriate parties.
- All approved applications constitute an agreement on the part of the service provider to deliver all PBS services in a comprehensive and integrated fashion. For example, person-centered planning, assessment, and intervention should not be separated whenever possible to specialized personnel.
- Service providers maintain internal documentation systems that comply with all necessary regulations and laws pertaining to confidentiality and privacy protection. For all PBS services, documentation for billing should be in quarter of an hour time increments.
- The PBS service provider must maintain a record of the individuals to whom he or she provides services that shows:
  - Name of the individual receiving the service
  - Date the service was provided
  - Name of the provider agency
  - Name of the individual providing the service
  - Location at which the service was provided
  - Type of PBS treatment provided
  - Amount of time it was provided to the nearest quarter hour

PROSTHETIC and ORTHOTIC DEVICES

- The prosthetic or orthotic device **must** be necessary and appropriate for the treatment of the member's illness or injury or replace or improve the functioning of a body part.
  Prosthetic devices are covered when:
  - The device is ordered by a physician and supplied by a prosthetic and orthotic provider enrolled in KMAP.
  - The device will replace all or part of the external body members.
- Repairs or replacements are covered.
- Orthotic devices are covered when:
  - Ordered by a doctor
  - Serve in the treatment of the member's illness
  - Improve the functioning of a body part

8400. Updated 12/22

PSYCHIATRIC

Outpatient psychotherapy (individual, group, family) will not be covered for KMAP members when provided by the same provider within the same quarter as partial hospitalization activity **and** targeted case management services, except for brief therapy for crisis or continuing evaluation purposes. If more than six hours of individual, group, or family therapy are billed in the same quarter a Certificate of Medical Necessity form must be completed and attached to the claim.

- Medical necessity (MN) is defined as the individual exhibiting behavior that is dangerous to himself or herself or others, and without additional therapy inpatient hospitalization would be required.
- KBH-EPSDT members continue to be eligible for outpatient psychotherapy (individual, group, family), targeted case management, and partial hospitalization services concurrently.
- Six electroshock treatments per month are covered. Psychotherapy is not covered on days that electroshock treatment is given.
- Mental health services to members residing in a nursing facility for mental health will be noncovered. Exception will be made for up to eight hours of therapy for individuals in acute trauma and for targeted case management and community psychiatric supportive treatment during the 120 days just prior to discharge. These exceptions must be approved by the local quality enhancement coordinator. Other exceptions are code 90791 and psychiatric preadmission assessments which require no special approval.

Psychological Testing

Psychological evaluation and psychological testing can be ordered by a physician but are not covered when performed by an M.D. (These services must be performed and billed by a psychologist who is an enrolled provider.)

PULMONARY REHABILITATION

Pulmonary rehabilitation means a physician-supervised program for chronic obstructive pulmonary disease (COPD) and certain other chronic pulmonary disease such as but not limited to; asthma, cystic fibrosis, bronchiectasis, interstitial lung disease, perioperative conditions (thoracic or abdominal surgery, lung transplantation, lung volume reduction surgery), and conditions that affect pulmonary function (lung cancer, Guillain-Barre syndrome, sarcoidosis) designed to optimize physical and social performance and autonomy.

Pulmonary rehabilitation includes all the following components:

- Physician-prescribed exercise (some aerobic exercise must be included in each pulmonary rehabilitation session).
- Education or training closely and clearly related to the individual's care and treatment which is tailored to the individual's needs, including information on respiratory problem management and, if appropriate, brief smoking cessation counseling.
- Psychosocial assessment, include written evaluation of an individual's mental and emotional functioning as it relates to the member's rehabilitation or respiratory condition.
- Outcome's assessment, including beginning and end evaluations, objective clinical measures of effectiveness, and self-reported measures of shortness of breath and behavior.

PULMONARY REHABILITATION continued

- An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician who is involved in the patient's care and has knowledge related to his or her condition, every 30 days.

The outpatient Pulmonary Rehabilitation services are 94625 and 94626**.**

RADIOLOGY

The primary diagnosis code on the claim must reflect the medical need for the procedure.

Abdominal Plain Films and Ultrasound

- Abdominal plain films and ultrasound are considered medically necessary when the primary diagnosis clearly indicates one of the following:
    - Abdominal pain, nausea/vomiting
    - Complications associated with ulcers
    - Intestinal obstruction
    - Gallbladder disease
    - Injury to the abdomen or kidneys
    - Malignant neoplasm of the abdominal organs
    - An abdominal plain film may be warranted in a pregnant member when the member is in labor, fetal position is questionable, and OB ultrasound is unavailable. Supporting documentation must be attached to the claim. It may be necessary to contact the ordering physician for medical necessity information.

Chest X-Rays

- Chest X-rays are covered if medical necessity is met.
- Preoperative and routine admission chest X-rays are not covered unless documentation of medical necessity (one or more of the following factors) is noted on the claim:
    - Sixty years of age or older
    - Pre-existing or suspected cardiopulmonary disease
    - Smokers over age forty
    - Acute medical/surgical conditions such as malignancy or trauma
- It may be necessary to contact the ordering physician for medical necessity information.

CT Scans - Abdominal

- A CT scan of the abdomen is considered medically necessary when the primary diagnosis clearly indicates a malignant neoplasm of the intra-abdominal cavity, lung, genital organs, lymphoma,

diseases of the spleen, liver abscess, peritonitis, pancreatitis, abdominal trauma, or abdominal mass.
- A CT scan of the abdomen **may** be considered medically necessary for:
    - **Abdominal Pain** - Indicate the severity and length of time the pain, presenting symptoms, suspected conditions, or complications have been present.
    - **Abdominal Aneurysms** - Indicate the presenting symptoms and suspected complications.

RADIOLOGY continued

- **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 presenting symptoms and if the CT scan was performed as part of staging the disease process.

- Medical necessity documentation **must** be attached to the claim. It may be necessary to contact the ordering physician for medical necessity information.

CT Scans - Head or Brain

- A CT scan of the head or brain is considered medically necessary when the primary diagnosis clearly 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** be considered medically necessary for:
  - Headache - Indicate length of time and any accompanying central nervous system (CNS) symptoms.
  - Epilepsy - Specify if initial or repeat scan. Indicate if suspected injury occurred during seizure.
  - Syncope (fainting) - Specify if recurrent or single episode.
  - Dizziness - Specify if recurrent or single episode.
  - Acute Lymphocytic Leukemia - Indicate any accompanying CNS symptoms.
- Medical necessity documentation **must** be attached to the claim. It may be necessary to contact the ordering physician for medical necessity information.

Low Dose CT

Counseling visit to discuss need for lung cancer screening using low dose CT (LDCT) scan and Low dose CT scan for lung cancer screening is covered by Kansas Medicaid with Prior Authorization (PA) for the Fee-for-Service (FFS) population. Individuals must meet all criteria requirements, to have these services covered every 12 months.

The written orders for lung cancer LDCT screenings must be documented in the member's medical record before the first lung cancer LDCT screening occurs. The member must receive a written order for LDCT lung cancer screening during a Lung Cancer Screening Counseling and Shared Decision-Making visit that includes the following elements and is documented in the member's medical records. The service must be furnished by a physician (as defined in section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) as defined in section1861(aa)(5) of the Act); and must include all the following elements:

- Determination of member eligibility
  - Age (50-77)
  - Asymptomatic (absence of signs or symptoms of lung cancer)
  - A specific calculation of cigarette smoking pack-years (tobacco smoking history of at least 20 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes)

- If a former smoker, the number of years since quitting

- Shared decision-making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure.

Mammography – Diagnostic and Screening Mammograms

- The following codes shall be covered for 3D Digital Breast Tomosynthesis (DBT):
  - 0633T
  - 0634T
  - 0635T
  - 0636T
  - 0637T
  - 0638T
  - 77061 (List separately in addition to 77065)
  - 77062 (List separately in addition to 77066)
  - 77063 (List separately in addition to primary procedure code)
- A radiological mammogram is a covered diagnostic test under the following conditions:
  - A patient has distinct signs and symptoms for which a mammogram is indicated;
  - A patient has a history of breast cancer; or
  - A patient is asymptomatic, based on the patient's history and other factors the physician considers significant, the physician's judgement is that a mammogram is appropriate.
- These codes are currently covered and shall remain covered for mammography screening:
  - 77065
  - 77066
  - 77067
- An MRI scan of the head or brain is considered medically necessary when the primary diagnosis clearly 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.
- An MRI scan of the head or brain **may** be considered medically necessary for:
  - **Headache** - Indicate length of time and accompanying neurologic symptoms.

MRI - Head or Brain

  - **Seizure Disorders** - Specify if initial or repeat scan and if seizures (or convulsions) are of recent onset, frequency of their occurrence, and any accompanying neurologic symptoms.
  - **Syncope (fainting)** - Specify if recurrent or single episode and any accompanying neurologic symptoms.
  - **Dizziness** - Specify if recurrent or single episode and any accompanying neurologic symptoms.
  - **Non-CNS Malignancies** - Indicate any accompanying neurologic symptoms.
- Medical necessity documentation **must** be attached to the claim. It may be necessary to contact the ordering physician for medical necessity information.

RADIOLOGY continued

MRI - Breast

- MRI of the breast will be covered with the following indications:
    - Staging and therapy planning members with diagnosed breast cancer
    - Occult primary breast cancer when there are no 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 considered medically necessary when the primary diagnosis clearly indicates head trauma, primary or metastatic tumors of the skull, or tumors of the pituitary gland.
- A skull X-ray **may** be considered medically necessary when indicated for:
    - **Chronic Sinusitis** - Indicate any pertinent specific suspected complications resulting from chronicity.
    - **Trigeminal Neuralgia** - Specify type of lesion suspected.
    - **Abnormalities relating to the head** - Specify if done as an evaluation film for non-cosmetic reconstructive surgery. Indicate type of surgery being considered.
- Medical necessity documentation **must** be attached to the claim. It may be necessary to contact the ordering physician for medical necessity information.
- Non-obstetrical pelvic sonograms are considered medically necessary when the primary diagnosis clearly indicates pelvic mass or pain, ovarian cyst, pelvic inflammatory disease, endometriosis, possible retained fetal tissue, or question/history of metastatic disease.

Sonograms – Non-Obstetrical Pelvic

- Non-obstetrical pelvic sonograms **may** be considered medically necessary for either:
    - Abnormal vaginal bleeding
    - Irregular menstrual cycles
- It may be necessary to contact the ordering physician for medical necessity information.

Upper Gastrointestinal (UGI) Series

- UGI series is considered medically necessary when the primary diagnosis clearly indicates persistent dysphagia, melena, symptoms of UGI tract bleeding, or signs and symptoms of ulcers affecting the UGI tract after medication has failed to relieve the symptoms. State guidelines allow one UGI series per day, per member, regardless of provider.
- UGI series **may** be considered medically necessary when nonspecific diagnoses such as abdominal pain or dyspepsia are used. When these common nonspecific diagnosis codes are used, **additional symptoms** and/or circumstances that relate to the medical necessity of the procedure **must be indicated**. For example:
    - Is the symptom persistent? If so, how long has the symptom persisted?
    - Is the symptom recurrent? When was the last episode?

RADIOLOGY continued

- 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 member's response to each treatment?
- If a chronic condition, has there been a change in symptoms? If so, describe the change(s).
- If cancer diagnosis codes are used, what symptoms are present that indicate UGI involvement?

- Claims for UGI X-rays are denied reimbursement when the diagnosis code on the claim is either too nonspecific or is the result, rather than the reason, for the procedure. Whenever possible, use the symptoms that most clearly describe the reason for the test.
- It may be necessary to contact the ordering physician for medical necessity information.

Oncologic Positron Emission Tomography (PET) Scanning

Positron Emission Tomography (PET) scans, and the radiopharmaceuticals associated with the scans, will be covered for all Medicaid members for oncological indications. Radiopharmaceuticals associated with scans are considered content of service and may not be billed separately. Codes will be covered at 85% of the Medicare rate. Oncological indications are limited to diagnosing, staging, restaging, and monitoring.

Diagnosis: PET meets the definition of medical necessity only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.

Staging: PET meets the definition of medical necessity for staging in clinical situations in which the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (CT, MRI, or ultrasound), or the PET could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient, and clinical management of the patient would differ depending on the stage of the cancer identified.

Restaging: PET meets the definition of medical necessity for restaging after completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence or metastasis, to determine the extent of a known recurrence, or if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient. Restaging applies to testing after a course of treatment is completed.

Monitoring: Refers to the use of PET to monitor tumor response to treatment during the planned course of therapy (e.g., when a change in therapy is anticipated).

Below PET Scans are eligible for Medicaid Coverage in the following oncological conditions:

PET for Cancers/Tumor Type	Diagnosing & Staging	Restaging & Monitoring
Brain	Cover	Cover
Breast (male and female)	Cover	Cover
Cervix	Cover	Cover
Colorectal	Cover	Cover
Esophagus	Cover	Cover
Head and Neck (not thyroid, CNS)	Cover	Cover
Lymphoma	Cover	Cover
Melanoma	Cover	Cover
Myeloma	Cover	Cover
Non-Small Cell Lung	Cover	Cover
Ovary	Cover	Cover
Pancreas	Cover	Cover
Prostate	Cover	Cover
Small Cell Lung	Cover	Cover
Soft Tissue Sarcoma	Cover	Cover
Testes	Cover	Cover
Thyroid	Cover	Cover
All other cancers not listed	Cover	Cover
All other solid tumors	Cover	Cover

The following radiopharmaceuticals codes approved for use with PET for oncologic applications:

A4641	A9515	A9552	A9587	A9588
A9591	A9592	A9594	A9595	

PET Scan Codes are:

78608	78811	78812	78813	78814
78815	78816			

SCREENING, BRIEF INTERVENTION, AND REFERRAL FOR TREATMENT (SBIRT)

- SBIRT is an evidence-based approach for identifying patients who use alcohol and other substances at increased levels of risk, with the goal of reducing and preventing related health consequences, diseases, accidents, and injuries. SBIRT is designed to identify an individual who has an alcohol and/or other substance use disorder or is at risk for developing one by evaluating responses to questions about alcohol and/or other substance use.
- Practitioners providing SBIRT services to Medicaid-eligible patients in Kansas must meet the applicable KDADS requirements including the following:
    - Currently licensed and in good standing as an approved professional type
      Submission of an attestation (facility) or certificate (individual) as proof of completion of an approved SBIRT training
- Services to patients must be provided in an approved service location.

8400. Updated 07/24

SCREENING, BRIEF INTERVENTION, AND REFERRAL FOR TREATMENT (SBIRT) continued

- Reference the *Substance Use Disorder Provider Manual* on the Provider Manuals page of the KMAP website for additional information on practitioner, facility, code, billing, and documentation requirements.
- More information on SBIRT can be found on the SBIRT page of the SAMHSA website or the Policies and Regulations page of the KDADS website.

SLEEP STUDY (Attended and Unattended) and POLYSOMNOGRAPHY SERVICES

1. **Description of the Procedure, Product, or Service:** Sleep studies and polysomnography refer to attended services for the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six or more hours. Sleep studies and polysomnography are performed with physician review, interpretation and report. Sleep studies and polysomnography are performed to diagnose a variety of sleep disorders and to evaluate a member's response to therapies such as nasal continuous positive airway pressure (NCPAP). Sleep medicine services include procedures to evaluate adult and pediatric patients for a variety of sleep disorders. Sleep medicine testing services are diagnostic procedures using in-laboratory and portable technology to assess physiologic data and therapy.

1.1 Polysomnography

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

1.2 Sleep Study

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

1.2.1 Multiple Sleep Latency Test

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

1.2.2 Maintenance of Wakefulness Test

i. Measures daytime sleepiness.
ii. Involves multiple trials throughout a day of low-demand activity when the instructions are to resist sleep.

1.2.3 Attended Sleep Studies:

Attended sleep studies or nocturnal polysomnography (PSG) are indicated to assess the following sleep related disorders:

- Sleep related breathing disorders (obstructive sleep apnea and central sleep apnea).
- Narcolepsy and idiopathic hypersomnia.
- Parasomnias and seizure disorders.
- Periodic limb movement disorder.

8400. Updated 07/24

SLEEP STUDY (Attended and Unattended) and POLYSOMNOGRAPHY SERVICES continued

1.2.4 Unattended Sleep Studies (Home Sleep Test [HST]):

Unattended (home) sleep studies are considered medically necessary for patients with symptoms suggestive of obstructive sleep apnea (OSA) when the home sleep study is part of a comprehensive sleep evaluation using a Type II, Type III, or Type IV device measuring airflow.

Home sleep tests are considered inappropriate for testing people with co-morbid conditions, people suspected of having sleep disorders other than obstructive sleep apnea (OSA), and those not at high risk for moderate to severe OSA. However, there may be some situations in which home sleep tests may require follow-up with an attended test when the home test is negative or other factors contribute to a technical failure.

1.2.5 Types/Levels:

Sleep studies refer to the continuous and simultaneous recording of various physiological parameters of sleep followed by physician review and interpretation, performed in the diagnosis and management of sleep disorders. Sleep studies have been classified based on the number and type of physiologic variables recorded and whether or not the study is attended by a technologist or performed with portable equipment in the home or some other unattended setting.

The types of sleep studies are as follows:

Type (Level)	Description
I	Standard polysomnography (PSG) with a minimum of 7 parameters measured, including EEG, EOG, chin EMG, and ECG, as well as monitors for airflow, respiratory effort, and oxygen saturation. A sleep technician is in constant attendance.
II	Comprehensive portable PSG studies that measure the same channels as type I testing, except that a heart rate monitor can replace the ECG and a sleep technician is not necessarily in attendance.
III	Monitor and record a minimum of 4 channels and must record ventilation (at least two channels of respiratory movement, or respiratory movement and airflow), heart rate or ECG, and oxygen saturation. A sleep technician is not necessarily in constant attendance but is needed for preparation.
IV	Three or more channels, one of which is airflow. Other measurements include oximetry and at least 2 other parameters (e.g., body position, EOG, peripheral arterial tonometry (PAT) snoring, actigraphy, airflow). A sleep technician is not necessarily in attendance but is needed for preparation.

8400. Updated 07/24

SLEEP STUDY (Attended and Unattended) and POLYSOMNOGRAPHY SERVICES continued

2. **Eligible Members**

2.1 **General Provisions:** Kansas Medicaid members must be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Effective with dates of service on and after July 1, 2024, Medicaid will cover sleep studies as medically necessary for both adult and pediatric members.

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

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

~~****EPSDT and prior approval requirements**~~

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

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

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

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

Sleep Study (Attended and Unattended) and Polysomnography Services Criteria continued

3. When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria: Procedures, products, and services are covered when they are medically necessary for the following:

3.1.1 The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs.

3.1.2 The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide.

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

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

3.2.1 Narcolepsy

i. Narcolepsy is a syndrome that is characterized by abnormal sleep tendencies (excessive daytime sleepiness, disturbed nocturnal sleep, inappropriate sleep episodes or attacks).

ii. Polysomnography or sleep studies are covered as a diagnostic test for narcolepsy when the condition is severe enough to interfere with the member's well-being and health.

iii. Ordinarily, a diagnosis of narcolepsy can be confirmed by three sleep naps.

3.2.2 Sleep Apnea

i. Sleep apnea is a potentially lethal condition where the member stops breathing during sleep. The three types are central, obstructive, and mixed.

ii. Apnea is defined as a cessation of airflow for at least ten seconds.

iii. Hypopnea is defined as an abnormal respiratory event lasting at least ten seconds with at least a 30% reduction in thoracoabdominal movement or airflow with at least 4% oxygen desaturations.

3.2.3 Parasomnia

i. Parasomnia is a group of conditions that represent undesirable or unpleasant occurrences during sleep. These conditions may include sleepwalking, sleep terrors, and rapid eye movement (REM) sleep behavior disorders.

ii. Suspected seizure disorders as possible cause of the parasomnia are appropriately evaluated by standard or prolonged sleep EEG studies.

3.2.4 Periodic Limb Movement Disorder (PLMD)

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

3.2.5 Chronic Insomnia: At least one of the following conditions must be met.

i. Etiology is unknown
ii. Diagnosis is uncertain.
iii. Sleep-related breathing disorder or periodic limb movement disorder is suspected.
iv. A member is refractory to treatment.
v. Violent behaviors are comorbid.
vi. Circadian dysrhythmias complicate the clinical picture.

3.2.6 Snoring: At least one of the following conditions must be met.

i. Disturbed sleep patterns
ii. Excessive daytime sleepiness
iii. Unexplained awake hypercapnia
iv. Apneic breathing
v. Cognitive problems
vi. Excessive fatigue

4. When the Procedure, Product, or Service Is Not Covered

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

4.1 General Criteria

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

i. The member does not meet the eligibility requirements listed in Section 2.0.
ii. The member does not meet the medical necessity criteria listed in Section 3.0.
iii. The procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service.

4.2 Specific Noncovered Criteria

~~**4.2.1** Sleep studies and polysomnography are not covered when the service is an unattended home study.~~

4.2.1 Sleep studies and polysomnography are not considered medically necessary for the following indications:

i. Impotence.
ii. Chronic insomnia, except when an underlying physiology exists, such as those listed under **Subsection 3.2**.
iii. Snoring, except when an underlying physiology exists, such as those listed under **Subsection 3.2**.

8400. Updated 07/24

SLEEP STUDY (Attended and Unattended) and POLYSOMNOGRAPHY SERVICES continued

5. Requirements for and Limitations on Coverage

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

5.1 Prior Approval

5.1.1 Prior approval is required.

5.2 Previous Testing

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

5.3 General Requirements

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

5.4 Polysomnography Requirements

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

i. 1- to 4-lead electroencephalogram (EEG)
~~ii. Electro-oculogram (EOG)~~
ii. Submental electromyogram (EMG)
iii. Electrocardiogram (EKG)
iv. Airflow, ventilation, and respiratory effort
v. Oximetry and/or CO2 measurements
vi. Extremity muscle activity
vii. Extended EEG monitoring
viii. Gastroesophageal reflux
ix. Continuous blood pressure monitoring
x. Snoring
xi. Body positions

6. Providers Eligible to Bill for the Procedure, Product, or Service

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

6.1.1 Meet Kansas Medicaid qualifications for participation.

6.1.2 Be currently enrolled in Medicaid.

6.1.3 Bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7. Additional Requirements

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

7.1 Compliance

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

8400. Updated 07/24

SLEEP STUDY (Attended and Unattended) and POLYSOMNOGRAPHY SERVICES continued

8. Billing Information

Note: CPT codes, descriptors, and other data only are copyright 2022 American Medical Association. All rights reserved.

8.1 Diagnosis Codes

8.1.1 Providers must bill the diagnosis code(s) to the highest level of specificity that supports medical necessity. For professional claims, the diagnosis must be the primary or secondary diagnosis.

Use the following ICD-10 diagnosis codes:

~~E515~~	~~E518~~	~~E6601~~	~~E678~~	~~G40101~~	~~G40109~~	~~G40111~~	~~G40119~~	~~G40501~~	~~G40509~~
~~G40802~~	~~G40803~~	~~G40804~~	~~G40811~~	~~G40813~~	~~G40814~~	~~G4089~~	~~G40B01~~	~~G40B09~~	~~G40B11~~
~~G40B19~~	~~G4710~~	~~G4720~~	~~G4730~~	~~G4733~~	~~G47411~~	~~G47419~~	~~G47421~~	~~G47429~~	~~G4761~~
~~G478~~	~~R0600~~	~~R0609~~	~~R063~~	~~R0683~~	~~R0689~~	~~R0901~~	~~R0902~~	~~R400~~	~~R401~~
G4730	G4731	G4732	G4733	G4734	G4735	G4736	G4737	G4739	G47411
G47419	G47421	G47429	G4750	G4751	G4752	G4753	G4754	G4759	G4762
G4769									

8.2 Billing Codes

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

~~95782~~	~~95783~~	~~95805~~	~~95807~~	~~95808~~	~~95810~~	~~95811~~

95782	95783	95800	95801	95805	95806	95807
95808	95810	95811				

8.3 Modifiers

8.3.1 Providers are required to follow applicable modifier guidelines.

8.4 Billing Units

8.4.1 Polysomnography and sleep studies may be billed as a complete procedure or as professional and technical components.

i. Polysomnography and sleep studies are limited to one procedure per date of service by the same or different provider.

ii. The technical or the professional component cannot be billed by the same or different provider on the same date of service as the complete procedure is billed.

iii. The complete procedure is viewed as an episode of care that may start on one day and conclude on the next day. When billing for the complete procedure, the date that the procedure began is the date of service that should be billed. The complete procedure should not be billed with two dates of services.

iv. If components are billed, the technical and the professional components should be billed with the date the service was rendered as the date of service

8400. Updated 07/24

SLEEP STUDY (Attended and Unattended) and POLYSOMNOGRAPHY SERVICES continued

8.4.2 Separate reimbursement is not allowed for the following procedures on the same date of service by the same or different provider.

i. CPT codes 93224 through 93272 with CPT codes 95805 through 95811
ii. CPT codes 94760 and 94761 with CPT codes 95805 through 95811
iii. CPT code 94772 with CPT codes 95805 through 95806
iv. CPT code 94660 with CPT code 95811
v. CPT codes 95812 through 95827 with CPT codes 95808 through 95811
vi. CPT code 92516 with CPT codes 95808 through 95811

8.5 Place of Service

8.5.1 Inpatient hospital
8.5.2 Off campus outpatient hospital
8.5.3 On campus outpatient hospital
8.5.4 Physician's office

8.6 Covered Provider Types/Specialties:

Provider types allowed to bill and be reimbursed for sleep studies/polysomnography are as follows:

Allowable PT/PS
01/010 – Hospital (Global)
09/093 – APRN
09/094 – CRNA
10/100 – Physician Assistant
31/310 – Allergist
31/316 – Family Practitioner
31/318 – General Practitioner
31/322 – Internist
31/326 – Neurologist
31/332 – Otologist, Laryngologist, Rhinologist
31/336 – Physical Medicine and Rehab Practitioner
31/340 – Pulmonary Disease Specialist
31/341 – Radiologist
31/344 – General Internist
31/345 – General Pediatrician
31/351 – Indian Health Services

Note: Indian Health Centers (IHC) should receive their respective encounter rate. Sleep studies and polysomnography are not covered RHC/FQHC services.

8400. Updated 02/21

STERILIZATIONS

A copy of the Consent for Sterilization form **must** be attached to the surgeon's claim at the time of submission. The form is located on the public and secure websites on the Forms page under the Consent heading. It may be photocopied for your use. A copy of the Consent for Sterilization form does not have to be attached to related claims (anesthesia, assistant surgeon, hospital, or rural health clinic) at the time of submission. **However, a related claim will not be paid until the Consent for Sterilization form with the surgeon's claim has been reviewed and determined to be correct, unless the related claim has the correct Consent for Sterilization form attached.**

- Surgical procedures that render the member sterile (such as hysterectomies) but that are not performed for the purpose of sterilization do not require a Consent for Sterilization form.
- All requirements outlined in Hysterectomy Coverage Guidelines must be met, including the requirements related to the Hysterectomy Necessity form.

All Sterilizations Guidelines

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

1. The Consent for Sterilization form, mandated by federal regulation, is located on the Forms page of the public and secure websites. Instructions on how to complete the Sterilization Consent Form are attached with the form. Providers may photocopy this
2. form. All voluntary sterilization claims submitted without this specific Consent for Sterilization form will be denied. All fields must be completed, including the physician signature.
3. The Sterilization Consent Form must be signed at least 30 days prior to the date the sterilization is performed with the following exceptions:

Premature Delivery

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

STERILIZATIONS continued

Emergency Abdominal Surgery

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

Note: The three calendar days timeframe is used in the above exceptions to guarantee compliance with the minimum federal requirement of 72 hours.

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

STERILIZATION CODES

00840	00851	00921	55250	55450	58565	58579	58600	58605	58611
58615	58661	58670	58671	58700	58720	58940	0567T	0568T	

Transcervical Sterilizations

- Code 58579 is not covered for transcervical sterilization procedures. Codes 58565, 0567T, and 0568T should be used. The procedure must meet all sterilization requirements. PA is required.
- The Essure Kit is included in codes 58565, 0567T, and 0568T and should not be billed separately. The invoice does not need to be attached to the claim.
- If a member has had a transcervical hysteroscopy sterilization, a federal Consent for Sterilization form is required. Additionally, three months must have passed before performing code 58340. ICD-10 CM diagnosis code Z302 must be used. PA is not required.

STERILIZATIONS continued

Hysterectomy

- Hysterectomies are covered **only** for medically indicated reasons. Medicaid will reimburse for this service only if at least one of the following three conditions is met and documented.
    1. The Hysterectomy Necessity form is completed. The date requirements for the use of the Sterilization Consent Form do not apply to the use of the Hysterectomy Necessity Form.
       OR
    2. The physician shall certify in writing that the individual was already sterile and state the cause or reason for the sterility. This certification must be retained in the patient file and made available upon request. For the claim to process, a statement must be made on the claim indicating the member was sterile prior to the surgery. There is not a specific location to note this information on the claim, it just needs to be noted on the claim prior to submission for payment.
       OR
    3. The physician shall certify in writing that the surgery was performed under a life-threatening situation and individual certification was not possible, including a description of the nature of the emergency. This certification must be retained in the patient file and made available upon request. For the claim to process, a statement must be made on the claim indicating the situation was “life-threating." There is not a specific location to note this information on the claim, it just needs to be noted on the claim prior to submission for payment.
- A total hysterectomy and the removal of tubes/ovaries cannot be billed as separate procedures when performed by the same provider.

HYSTERECTOMY CODES

00846	00944	01962	01963	01969	51925	58150	58152	58180	58200
58210	58240	58260	58262	58263	58267	58270	58275	58280	58285
58290	58291	58292	58294	58541	58542	58543	58544	58548	58550
58552	58553	58554	58570	58571	58572	58573	58575	58951	58953
58954	58956	59135	59525						

Retroactive Eligibility

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

8400. Updated 12/23
SUBCUTANEOUS CONTINUOUS GLUCOSE MONITORS

Continuous Glucose Monitors (CGM) will be covered under the DME benefit. Codes are covered when billed by an allowable PT/PS, the following criteria are met, and all supporting documentation is maintained and available for review. A CGM is an FDA approved device that records glucose levels throughout the day and night, utilizing an appropriate sensor. The sensor must be able to determine tissue glucose levels at predetermined intervals and transmit the information to a device able to retain data and provide the patient with the needed information. Currently Dexcom and Freestyle Libre are FDA approved CGM devices, but other CGM devices may be used when approved by the FDA.

The member must be under the care of, and services must be prescribed by a physician or qualified practitioner who is managing the member's diabetes.

Professional Management Codes/Service Category:

- **95249** - (*Personal CGM - Startup/Training*) Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording. This code can be billed only once during the time the patient owns the manufacturer-provided display device.
- **95250** - (*Professional CGM*) Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording. Do not bill more than 1x/calendar month.
- **95251** - (*CGM Interpretation*) Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation, and report. Do not bill more than 1x/ calendar month.

Professional management codes will be allowed for the following PT/PS:

- 31/316 - Family Practitioner
- 31/317 - Gastroenterologist
- 31/318 - General Practitioner
- 31/328 - Obstetrician/Gynecologist
- 31/335 - Maternal Fetal Medicine
- 31/344 - General Internist
- 31/345 - General Pediatrician
- 31/349 - Exempt License Physician
- 31/350 - Preventative Medicine
- 31/351 - Indian Health
- 09/093 - Nurse Practitioner
- 09/094 - Certified Nurse Midwife
- 10/100 - Physician Assistant

8400. Updated 05/24

SUBCUTANEOUS CONTINUOUS GLUCOSE MONITORS continued

Criteria for CGM:

1. Short term use (three to seven days) for diagnostic purposes.
2. Long term use for the following clinical situations:
   i. Type 1 Diabetes with poor control requiring multiple changes in Insulin dosing and/or clinical symptoms related to hypo or hyperglycemia.
   ii. Type 2 Diabetes requiring Insulin administration in addition to other medication and/or despite being compliant with prescribed treatment have poorly controlled A1C, unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia or recurrent diabetic ketoacidosis.

Approval:
PA is required and will be valid for a period not to exceed 12 months.

Reauthorization Requirements:

1. Attestation by treating provider that device is medically necessary.
2. Attestation by treating provider of compliance and appropriate use of the device.

Replacement:

1. Replacement will be approved if the above criteria are met and the device is malfunctioning, out of warranty and cannot be repaired; and
2. Treating provider has assessed the individual and recommends continued use of this device with an order for replacement.

Diagnosis Codes:
Acceptable ICD-10 diagnosis codes for CGM devices are in the following ranges:

- Type 1 diabetes mellitus - E10-E10.9
- Type 2 diabetes mellitus - E11- E11.11 (This included hyperosmolarity and ketoacidosis)
- Type 2 diabetes mellitus with hypoglycemia and hyperglycemia - E11.64-E11.65

Covered CGM device codes:
Covered device codes will be allowed to bill by a DME/Medical Supply Dealer (PT/PS 25/250). The CGM is comprised of three parts:

- A disposable sensor (attaches to the skin and inserts a tiny wire into the subcutaneous tissue to measure glucose levels,
- The transmitter (attaches to the sensor and sends the data to a wireless receiver/monitor),
- A receiver/monitor (records and stores the data and alerts the beneficiary when glucose levels are too high or too low.

Code	Type	Max Units/Frequency
E2103	Non-Adjunctive	1 unit per 12 months
A4239	Non-Adjunctive	1 unit per month
E2102	Adjunctive	1 unit per 12 months
A4238	Adjunctive	1 unit per month

8400. Updated 05/24

SUBCUTANEOUS CONTINUOUS GLUCOSE MONITORS continued

Non -Adjunctive CGM systems (formerly therapeutic) are devices used to make treatment decisions without the need for a stand-alone blood glucose monitor (BGM) to confirm testing results (e.g., Dexcom, Freestyle Libre).

Providers may choose adjunctive devices or non-adjunctive devices, but only one device per coverage period. The DME supplier is required to obtain a renewal order from the treating physician every 12 months.

Note: Smart devices (e.g., smart phones, iPads, tablets, personal computers) used with a CGM are not classified as durable medical equipment and are not covered by Medicaid.

Covered CGM Accessories and Supply codes
Effective with dates of service on and retroactive January 1, 2024, disposable CGM accessories and supply codes will be allowed for ages 20 and under and billable by PT/PS 25/250.

Prior authorization is required.

Code	Max Units/Frequency
A9276	1 unit per day
A9277	4 Transmitters per year
A9278	1 per calendar year

Insulin Delivery System code
Effective with dates of service and retroactive to January 1, 2024, disposable insulin delivery system codes will be allowed for ages 20 and under and billable by PT/PS 25/250.

Prior Authorization is required.

Code	Max Units/Frequency
A9274	15 units per month

8400. Updated 08/21

SURGERY

Ambulatory/Outpatient Surgery

- Ambulatory surgical centers are allowed reimbursement for the use of operating room, recovery room, and supplies incurred for minor surgical procedures.
- The ambulatory surgical center must reference the facility number as the performing/rendering provider in Field 24J of the CMS 1500 paper or equivalent electronic claim form when billing. Charges for ancillary services (such as physician, anesthesiologist, and assistant surgeon) must be billed by those providers involved.
- Ambulatory surgical centers and outpatient hospitals will be reimbursed for multiple outpatient surgical procedures performed on the same day as follows: 100% of the current Medicaid rate for the highest value procedure; 50% of the current Medicaid rate for the second procedure; and 25% of the current Medicaid rate for all subsequent procedures.

Content of Service

- IVs, medications, supplies, and injections performed on the same day as an ambulatory outpatient surgery procedure are considered content of service of the surgery and cannot be reimbursed separately.
- Anesthesia equipment and supplies, drugs, surgical supplies, and other equipment of the operating room and the recovery room are considered content of service of the ambulatory/outpatient surgical procedure.
- Exploratory laparotomy and enterolysis of adhesions are considered content of service when performed in conjunction with another major surgery.

Breast Reconstruction

Breast reconstruction is covered when one of the breast reconstruction codes is billed with one or more of the covered breast cancer diagnoses, and the member had a mastectomy for breast cancer on or after March 1, 2005, using one of the mastectomy codes covered. Only the following breast reconstruction codes are covered. For the most current information and verification of coverage, access Reference Codes under the Provider tab on the public website or from the secure website under Pricing and Limitations.

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

Breast Reduction Surgery

When one of the breast reduction codes is billed. For the most current information and verification of coverage, access Reference Codes from the public or provider secure site.

Cosmetic Surgery

All surgeries cosmetic in nature (and related complications) are not covered. Any medically necessary procedure which could ever be considered cosmetic in nature must be prior authorized. (Refer to **Section 4300** of the *General Special Requirements Fee-for-Service Provider Manual*.)

Diagnostic and Surgical Procedures Performed Outpatient

Certain diagnostic and surgical procedures are reimbursed at a higher rate when performed in the physician's office, ambulatory surgical center, or outpatient general hospital unit.

Elective Surgery

- The Medicaid program will not reimburse for elective surgery unless medically necessary for a KBH-EPSDT member. (Refer to the *KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment Provider Manual*.)
- Certain procedures are reviewed on a post-payment, random sample basis. Retain all documentation supporting the nonelective nature of the surgery in your files for review.
- Documentation includes admission notes, history, and physical, operative report and pathology report.
- If documentation does not support the nonelective surgery, reimbursement for **all** claims relating to the surgery will be recovered.

Global Surgery

KMAP uses the following global surgery guidelines:

- 000 – Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; E&M services on the day of the procedure generally not payable
- 010 – Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; E&M services on the day of the procedure and during the 10-day postoperative period generally not payable
- 090 – Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount

Physicians who furnish less than the global surgical package

- When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians cannot exceed what would have been paid if a single physician provided all services. When physicians agree on a transfer of care during the global period, the following modifiers are used:
  - 54 – Surgical care only
  - 55 – Postoperative management only
- Both the bill for the surgical care only and the bill for the postoperative care only will contain the same date of service and the same surgical procedure code with the services distinguished by use of the appropriate modifier. If the physician who performed the surgery relinquishes care at the time of discharge, he or she needs only show the date of surgery when billing with modifier 54. However, if the surgeon also cares for the patient for some period following discharge, the surgeon must show the date of surgery and the date on which postoperative care was relinquished to another physician.

- The physician providing the remaining postoperative care must show the date care was assumed. This information is reported in Item 19 of the paper CMS 1500 Claim Form and in the DTP segment, Loop 2300 for ANSI X12N electronic claims.

- For surgeries billed with either modifier 54 or 55, the appropriate percentage of the fee amount as indicated in Fields 17-19 of the MFSDB (pre-, intra-, and post-operative) will be paid. This applies to major surgical procedures and minor surgeries with a postoperative period of 10 days. The intraoperative percentage includes postoperative hospital visits. Split global care does not apply to procedures with a global period of "000." It is to be assumed that a physician who bills with modifier 54 has provided pre-, intra- and post-operative hospital services. This physician should be paid the combined pre- and intra-operative portions of the fee amount.
- When more than one physician bills for the postoperative care, payment should be the postoperative percentage according to the number of days each physician was responsible for the member's care. Field 24G of the paper CMS 1500 Claim Form must reflect the total number of postoperative care days provided, with the cumulative total not to exceed the number of global days for the procedure being billed.

Services included in the global surgical package
- E&M services are considered part of the global surgical package.
- No separate payment will be made for additional procedure(s) with a global surgery fee period if performed during the postoperative period of a prior procedure, by the same provider, and if billed without modifier 58, 78, or 79.

Reimbursement for return trips to the operating room during the postoperative period
When treatment for complications requires a return trip to the operating room during the postoperative period, physicians must bill the CPT code that describes the procedure(s) performed during the return trip along with modifier 78. Payment for return trips to the operating room will be the intraoperative percent (Field 18 of the MFSDB) of the fee amount for the CPT code.

Services not included in the global surgical package
The following services are not included in the global surgical package and may be paid for separately:
- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery
- Services of other physicians except where the surgeon and the other physician agree on the transfer of care
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery

SURGERY continued

- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatment for complications
  Note: A new postoperative period begins with the subsequent procedure.
- Diagnostic tests and procedures
- Treatment for postoperative complications which require a return trip to the operating room
  Note: This does not include a member's room, a minor treatment room, a recovery room, or an intensive care unit.
- If a less extensive procedure fails and a more extensive procedure is required
  Note: The second procedure is payable.
- Immuno-suppressive therapy for organ transplants
- Critical care services unrelated to the surgery where a seriously injured or burned member is critically ill and requires constant attendance of the physician

- Physicians must bill modifiers 24, 25, 57, 58, 78, or 79 as appropriate. Separate payment may be made for services billed with these modifiers.
- Special guidelines must be followed for claims to process correctly using modifier 50 in conjunction with 54 or 55. Providers must bill these details with modifier 54 or 55 in the first modifier position and 50 in the second modifier position.

Team Surgery

There are times when the individual skills of more than two surgeons are required to perform surgery on the same patient during the same operative session. This is required due to the complexity and/or the patient's condition. In this situation, the additional physicians are not acting as assistants-at-surgery. If a team of surgeons (more than two surgeons of different specialties) is required to perform a specific procedure, each surgeon bills with a modifier 66 appended to the procedure. KMAP considers codes with CMS Team Surgery Indicators of 1 and 2 eligible for team surgery reimbursement. All claims received with a modifier must have sufficient medical documentation attached so that pricing can be considered "by report". When surgeons of different specialties are each performing a different procedure (with different CPT codes), team surgery rules for modifier 66 do not apply.

THERAPY

- Therapy treatments are not covered for psychiatric diagnosis.
- **Habilitative** – Therapy treatments performed in the LEA settings may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness. Therapy of this type is covered only for members aged zero to under the age of 21. Therapy **must** be medically necessary. The purpose of this therapy is to maintain maximum possible functioning for children. LEAs billing for therapy must have the ordering, referring, or prescribing provider's National Provider Identifier (NPI) on the claim. The provider must be enrolled with KMAP and have a valid NPI for claims to be considered for payment.

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

THERAPY continued

- **Rehabilitative** - All therapies **must** be physically rehabilitative. Therapies are covered only when rehabilitative in nature and provided following physical debilitation due to an acute physical trauma or physical illness and prescribed by the attending physician.
- Therapy services are limited to six months for non-KBH-EPSDT members (except the provision of therapy under HCBS), per injury, to begin at the discretion of the provider. There is no limitation for KBH-EPSDT members.
- Therapy codes must be billed as one unit equals one visit unless the description of the code specifies the unit.
- Providers of rehabilitative therapy can submit claims with a combination of the following rehabilitation therapy procedure codes and an appropriate diagnosis code.
  - Diagnosis code Z5189 can be used as the primary diagnosis.
  - Providers are required to submit a secondary diagnosis code to describe the origin of the impairment for which rehabilitative therapy is needed when one of these V-codes or Z5189 is billed as a primary diagnosis.

REHABILITATIVE THERAPY CODES

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

Occupational Therapy
Occupational therapy is covered when services are prescribed by a physician and performed by a licensed occupational therapist or a certified occupational therapist assistant working under the supervision of a licensed occupational therapist. When services are performed by a certified occupational therapy assistant, supervision must be clearly documented. This may include, but is not limited to, the licensed occupational therapist initializing each treatment note written by the or the licensed occupational therapist writing “Treatment was supervised” followed by his or her signature.

Physical Therapy
Physical therapy is covered when services are prescribed by a physician and performed by a licensed physical therapist or by a certified physical therapy assistant working under the supervision of a licensed physical therapist. When services are performed by a certified physical therapy assistant, supervision must be clearly documented. This may include, but is not limited to, the licensed physical therapist initializing each treatment note written by the certified physical therapy assistant, or the licensed physical therapist writing “Treatment was supervised” followed by his or her signature.

THERAPY continued

Speech Therapy
Speech therapy is covered when services are prescribed by a physician and performed by a certified speech pathologist.

Note: Rehabilitative physical, occupational, and speech/language therapy services may be provided in the following places of service: outpatient hospitals, rehabilitative hospitals, LEAs (early childhood intervention settings, Head Start, and school districts), home health, freestanding clinics, and physicians' offices. LEAs billing for speech therapy must have the ordering, referring, or prescribing provider's National Provider Identifier (NPI) on the claim. The provider must be enrolled with KMAP and have a valid NPI for claims to be considered for payment.

Providers must consider any place of service editing that pertains to their provider type and specialty and the population served.

Wheelchair Seating Assessments
Physical Medicine and Rehabilitation procedure codes 97542, 97755, and 97760 are covered as medically necessary for management of wheelchair seating assessments for all Medicaid members. Regardless of provider, reimbursement will not exceed $500 per member per year for seating assessment services. Reimbursement for wheelchair seating assessments is limited to the following approved Kansas Medicaid Seating Clinic providers:

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

TOBACCO CESSATION

Tobacco cessation counseling codes S9453, 99406, and 99407 are covered for all Medicaid populations. The appropriate ICD-10 diagnosis codes are below:

TOBACCO CESSATION ICD-10 DIAGNOSIS CODES

F17200	F17201	F17202	F17203	F17204	F17205	F17206	F17208	F17209	F17210
F17211	F17212	F17213	F17214	F17215	F17216	F17217	F17218	F17219	F17220
F17221	F17222	F17223	F17224	F17225	F17226	F17227	F17228	F17229	F17230
F17231	F17232	F17233	F17234	F17235	F17236	F17237	F17238	F17239	F17240
F17241	F17242	F17243	F17244	F17245	F17246	F17247	F17248	F17249	F17250
F17251	F17252	F17253	F17254	F17255	F17256	F17257	F17258	F17259	F17260
F17261	F17262	F17263	F17264	F17265	F17266	F17267	F17268	F17269	F17270
F17271	F17272	F17273	F17274	F17275	F17276	F17277	F17278	F17279	F17280
F17281	F17282	F17283	F17284	F17285	F17286	F17287	F17288	F17289	F17290
F17291	F17292	F17293	F17294	F17295	F17296	F17297	F17298	F17299	O99330
O99331	O99332	O99333	O99334	O99335	Z720				

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TRANSPLANTS

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

TRANSPLANTS - Heart, Heart-Lung, and Lung

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

Heart Transplant

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

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

Selection Criteria for Human Heart Transplantation

For members off protocol, **ALL** following criteria must be met.

- New York Heart Association (NYHA) Class III and Class IV for heart failure* (see table) ***Note:*** This does not apply to pediatric members.
- Member has potential for conditioning and rehabilitation after transplant (e.g. member is not moribund)
- Life expectancy (in the absence of cardiovascular disease) is greater than 2 years
- No malignancy (except for non-melanomatous skin cancers) or malignancy has been completely resected or (upon individual case review) malignancy has been adequately treated with no substantial likelihood of recurrence with acceptable future risks

TRANSPLANTS continued

- Adequate pulmonary, liver, and renal function
- Absence of active infections that are not effectively treated
- Absence of active or recurrent pancreatitis
- Absence of diabetes with severe end-organ damage (neuropathy, nephropathy with declining renal function, and proliferative retinopathy)
- No uncontrolled and/or untreated psychiatric disorders that interfere with compliance to a strict treatment regimen
- No active alcohol or chemical dependency that interferes with compliance to a strict treatment regimen

***NYHA Class III and Class IV for heart failure are defined as follows:**

Class III	Persons with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity (e.g., mild exertion) causes fatigue, palpitation, dyspnea, or anginal pain.
Class IV	Persons with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

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

- Presence of systemic diseases (e.g., autoimmune, collagen vascular disease)
- Presence of irreversible end-organ diseases (e.g., renal, hepatic, pulmonary)
- Presence of severe pulmonary hypertension with irreversibly high pulmonary vascular resistance
- Presence of a recent intra-cranial cerebrovascular event with significant persistent deficit
- Presence of bleeding peptic ulcer
- Presence of hepatitis B antigen
- Presence of diverticulitis
- Presence of life-threatening neuromuscular disorders
- Presence of HIV/AIDS with profound immunosuppression (CD4 count of less than 200 cells/mm3)
- Presence of amyloidosis
  Note: Although amyloidosis is considered a contraindication to heart transplantation, exceptions may be made in circumstances where curative therapy of amyloidosis has been performed or is planned (e.g., stem cell transplantation in primary amyloidosis, liver transplantation in familial amyloidosis).

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

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

The following CPT codes are covered: 33940 and 33945.

Heart-Lung Transplant

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

Examples of qualifying conditions include the following:

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

- Severe coronary artery disease or cardiomyopathy with irreversible pulmonary hypertension
- Severe pulmonary fibrosis with severe heart failure*

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

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

Selection Criteria

The member must meet the transplanting institution's selection criteria. In the absence of an institution's selection criteria, Kansas Medicaid considers heart-lung transplantation medically necessary when **ALL** the criteria below are met:

- Absence of chronic high-dose steroid therapy
  Note: Due to problems in bronchial healing, persons receiving high-dose steroids are considered inappropriate candidates.
- Absence of acute or chronic active infections that are not effectively treated
- Absence of malignancy (other than non-melanomatous skin cancers) or malignancy has been completely resected or (upon medical review) it is determined that malignancy has been treated with small likelihood of recurrence and acceptable future risks

- Adequate functional status
  Note: Active rehabilitation is considered important to the success of transplantation. Under established guidelines, mechanically ventilated or otherwise immobile persons are considered poor candidates for transplantation.
- Adequate liver and kidney function, defined as a bilirubin of less than 2.5 mg/dL and a creatinine clearance of greater than 50 ml/min/kg
- Life expectancy (in the absence of cardiopulmonary disease) of greater than 2 years
- No active alcohol or chemical dependency that interferes with compliance to a strict treatment regimen
- No uncontrolled and/or untreated psychiatric disorders that interfere with compliance to a strict treatment regimen
- Absence of uncontrolled HIV/AIDS, is defined by the following:
  - CD4 count greater than 200 cells/mm3 for more than 6 months
  - HIV-1 RNA (viral load) undetectable
  - On stable anti-viral therapy more than 3 months
  - No other complications from AIDS, such as opportunistic infections (e.g., aspergillus, tuberculosis, Pneumocystis carinii pneumonia, toxoplasmosis encephalitis, cryptococcal meningitis, disseminated coccidioidomycosis, other resistant fungal infections) or neoplasms (e.g., Kaposi's sarcoma, non-Hodgkin's lymphoma)

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

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

The follow CPT codes are covered for heart-lung transplantation: 33930 and 33935.

Lung Transplant

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

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

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

Outpatient Pulmonary Rehabilitation

Pulmonary rehabilitation means a physician-supervised program for chronic obstructive pulmonary disease (COPD) and certain other chronic pulmonary disease such as but not limited to; asthma, cystic fibrosis, bronchiectasis, interstitial lung disease, perioperative conditions (thoracic or abdominal surgery, lung transplantation, lung volume reduction surgery), and conditions that affect pulmonary function (lung cancer, Guillain-Barre syndrome, sarcoidosis) designed to optimize physical and social performance and autonomy.

Pulmonary rehabilitation includes all the following components:

- Physician-prescribed exercise (some aerobic exercise must be included in each pulmonary rehabilitation session).
- Education or training closely and clearly related to the individual's care and treatment which is tailored to the individual's needs, including information on respiratory problem management and, if appropriate, brief smoking cessation counseling.
- Psychosocial assessment: Written evaluation of an individual's mental and emotional functioning as it relates to the member's rehabilitation or respiratory condition.
- Outcome's assessment, including beginning and end evaluations, objective clinical measures of effectiveness, and self-reported measures of shortness of breath and behavior.

- An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician who is involved in the patient's care and has knowledge related to his or her condition, every 30 days.
- The outpatient Pulmonary Rehabilitation services are 94625 and 94626**.**

Disease-Specific Selection Criteria

- Lung transplant for CF is considered medically necessary for persons who meet the general selection criteria for lung transplantation and exhibit at least two of the following signs and symptoms of clinical deterioration:
    - Cycling intravenous antibiotic therapy
    - Decreasing forced expiratory volume in 1 second (FEV1)
    - Development of carbon dioxide (CO_2) retention (pCO_2 greater than 50 mm Hg)
    - FEV1 less than 30% predicted
    - Increasing frequency of hospital admission
    - Increasing severe exacerbation of CF, especially an episode requiring hospital admission
    - Initiation of supplemental enteral feeding by percutaneous endoscopic gastrostomy or parenteral nutrition
    - Noninvasive nocturnal mechanical ventilation
    - Recurrent massive hemoptysis
    - Worsening arterial-alveolar (A-a) gradient requiring increasing concentrations of inspired oxygen (FiO2)
- Lung transplant for emphysema (including alpha 1-antitrypsin deficiency) is considered medically necessary for persons who meet the general criteria for lung transplantation and both of the following clinical criteria:
    - Hospitalizations for exacerbation of COPD associated with hypercapnia in the preceding year. Hypercapnia is defined as pCO_2 greater than or equal to 50 mm Hg with hospitalizations and/or the following associated factors:
        - Declining body mass index
        - Increasing oxygen requirements
        - Reduced serum albumin
        - Presence of cor pulmonale (defined as clinical diagnosis by a physician or any two of the following:
        - Enlarged pulmonary arteries on chest X-ray
        - Mean pulmonary artery pressure by right heart catheterization of greater than 25 mm Hg at rest or 30 mm Hg with exercise
        - Pedal edema or jugular venous distention
        - Right ventricular hypertrophy or right atrial enlargement on EKG
    - FEV1 less than 30% predicted

- Lung transplant for Eisenmenger's complex is considered medically necessary for persons who meet the general criteria for lung transplantation and any of the following disease-specific criteria:
    - Marked deterioration in functional capacity (NYHA Class III)
    - Pulmonary hypertension with mean pulmonary artery pressure by right heart catheterization greater than 25 mm Hg at rest or 30 mm Hg with exercise
    - Signs of right ventricular failure, progressive hepatomegaly, ascites
- Lung transplant for pulmonary fibrosis is considered medically necessary for persons who meet the general criteria for lung transplantation and any of the following disease-specific criteria:
    - Diffusing capacity for carbon monoxide (DLCO) less than 60% predicted
    - Presence of Cor Pulmonale (indicative of severe pulmonary fibrosis) or pulmonary hypertension
    - Total lung capacity (TLC) less than 70% predicted
- Lung transplant for pulmonary hypertension is considered medically necessary for persons who meet the general criteria for lung transplantation plus any of the following criteria, and valvular disease has been excluded by echocardiography:
    - Persons who are NYHA III, failing conventional vasodilators (calcium channel blockers or endothelin receptor antagonists)
    - Persons who are NYHA III, and have initiated or being considered for initiation of parenteral or subcutaneous vasodilator therapy pulmonary hypertension with mean pulmonary artery pressure by right heart catheterization of greater than 25 mm Hg at rest or 30 mm Hg with exercise, or pulmonary artery systolic pressure of 50 mm Hg or more defined by echocardiography or pulmonary angiography.
      Note: NYHA Class III for heart failure is defined as: Persons with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity (i.e., mild exertion) causes fatigue, palpitation, dyspnea, or anginal pain.
- Lung transplant for sarcoidosis is considered medically necessary for persons who meet the general criteria for lung transplantation plus any of the following disease-specific criteria:
    - DLCO less than 60% predicted
    - Presence of Cor Pulmonale (indicative of severe pulmonary fibrosis) or pulmonary hypertension
    - Total lung capacity less than 70% predicted

General Selection Criteria

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

- Absence of acute or chronic active infection (pulmonary or non-pulmonary) that is not adequately treated
- Adequate cardiac status (e.g., no angiographic evidence of significant coronary artery disease, ejection fraction greater than 40%, no myocardial infarction in last 6 months, negative stress test). Persons with any cardiac symptoms may require heart catheterization to rule out significant heart disease
- Adequate functional status
  Note: Under established guidelines, active rehabilitation is considered important to the success of transplantation. Mechanically-ventilated or otherwise immobile persons are considered poor candidates for transplantation
- Adequate liver and kidney function, defined as a bilirubin of less than 2.5 mg/dL and a creatinine clearance of greater than 50 ml/min/kg
- Limited life expectancy of less than 2 years
    - No active alcohol or chemical dependency that interferes with compliance to a strict treatment regimen
      Note: Persons with a history of drug or alcohol abuse must be abstinent for at least 3 months before being considered an eligible transplant candidate.
    - No uncontrolled and/or untreated psychiatric disorders that interfere with compliance to a strict treatment regimen
    - Absence of inadequately controlled HIV/AIDS infection is defined as **ALL** the following:
        - CD4 count greater than 200 cells/mm3 for greater than 6 months
        - HIV-1 RNA (viral load) undetectable
        - No other complications from AIDS, such as opportunistic infection (e.g. aspergillus, tuberculosis, coccidioidomycosis, resistant fungal infections) or neoplasms (e.g. Kaposi's sarcoma, non-Hodgkin's lymphoma)
        - On stable antiviral therapy greater than 3 months

Contraindications

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

- Malignancy involving the lung (primary or metastatic)
  Note: Persons with a history of non-pulmonary cancer must be in remission before being considered a lung transplant candidate. Because of disappointing results, lung transplantation is considered experimental and investigational as a treatment for bronchioloalveolar carcinoma.

- Multi-system disease
  Note: Persons with potentially multisystem diseases such as systemic sclerosis (scleroderma), other collagen vascular diseases such as systemic lupus erythematosus, or sarcoidosis must be carefully evaluated to ensure that their disease is primarily confined to the lung. Persons with diabetes must be carefully evaluated to rule out significant diabetic complications such as nephropathy, neuropathy, or retinopathy.
- Other effective medical treatments or surgical options available
- Presence of gastrointestinal disease (e.g. bleeding peptic ulcer, chronic hepatitis, diverticulitis)
- Refractory uncontrolled hypertension
- Single-lung transplantation is contraindicated in persons with chronic pulmonary infections (e.g. bronchiectasis, chronic bronchitis, and cystic fibrosis)
- Smoking
  Note: Persons with a history of smoking must be abstinent for 6 months before being considered eligible for lung transplantation.

Other considerations

- Kansas Medicaid considers lobar (from living-related donors or cadaver donors) lung transplantation medically necessary for persons with end-stage pulmonary disease when selection criteria are met (see above).
- Kansas Medicaid considers lung xenotransplantation (e.g., porcine xenografts) experimental and investigational for any pulmonary conditions because of insufficient evidence in the peer-reviewed literature.
- Kansas Medicaid considers prophylactic anti-reflux surgery to improve lung function and survival in lung transplant recipients without gastroesophageal reflux disease as experimental and investigational because of insufficient evidence in the peer-reviewed literature.

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

Transplants - Renal Dialysis/Kidney

- When it has been determined a member has a chronic renal disease (CRD) requiring renal dialysis, the member or his representative must first apply for Medicare CRD eligibility.
- Medicare allows payment of claims for eligible members with chronic renal disease and will reimburse for maintenance dialysis the third month after the maintenance dialysis starts. Refer to the Medicare manual for CRD guidelines.
- Medicaid will reimburse claims for services related to chronic renal dialysis and/or kidney transplants only after proof has been attached to **one** claim that the member has applied for
- Medicare and coverage have been approved or denied. (The Medicare CRD eligibility information will be retained in the claims processing system. Therefore, subsequent claims do not need to have proof of Medicare application.)

8400. Updated 11/19

TRANSPLANTS continued

- Examples of acceptable proof of application by Medicare are:
  - Medicare EOMB/RA
  - Member health insurance card
  - Report of confidential Social Security benefit information
  - Letter from Medicare or Social Security explaining that the member has applied for Medicare whether the member is eligible

Hospitals Qualifying for Federal Renal Program

University of Kansas Medical Center
39th & Rainbow Boulevard
Kansas City, Kansas 66103

St. Francis Regional Medical Center
929 North St. Francis
Wichita, Kansas 67214

St. Luke's Hospital
44th and Wornall Road
Kansas City, Missouri 64111

Research Hospital & Medical Center
Meyer Boulevard & Prospect
Kansas City, Missouri 64132

St. Francis Hosp. & Health Center *
1700 West Seventh Street
Topeka, Kansas 66606

The Children's Mercy Hospital
24th at Gillham Road
Kansas City, Missouri 64108
(CAPD Training & Support Services)

Kansas City Dialysis & Training Center *
Located at Research Hospital
Meyer Boulevard & Prospect
Kansas City, Missouri 64132

Salina Regional Health Center
400 South Santa Fe
Salina, Kansas 67401

FOR VETERANS

Kansas City V.A. Hospital
4801 East Linwood Boulevard
Kansas City, Missouri 64128

Wichita V.A. Hospital
5500 East Kellogg Drive
Wichita, Kansas 67218

TUBERCULOSIS

- Inpatient services related to a Tuberculosis (TB) diagnosis, including physician and laboratory services, may be covered for members with the TB benefit plan.
- Inpatient hospitalization, including physicians' services for diagnostic evaluation of members highly suspected of TB, may be covered for completion of the diagnosis.
- Acute problems, which are present on admission or arise during hospitalization and are related to the diagnosis of TB, may be covered.
- Hospitalization for monitoring toxicity of anti-tuberculosis drugs is covered.
- Claims for inpatient or outpatient services may be billed directly to KMAP.

TUBERCULOSIS continued

- Coverage and payment of services provided to members on the TB benefit plan are coordinated by KDHE. Contact KDHE at 785-296-0739 for determination of coverage.
- Coverage and payment of inpatient or outpatient services are subject to compliance with infectious disease reporting requirements as directed by K.A.R. 28-1-2.
- Anti-tuberculosis drugs to treat the member and family members are provided at no cost by KDHE. Contact your local health department or KDHE at 785-296-2547.

UNLISTED PROCEDURE CODES

- Unlisted codes will be considered for coverage. If a claim contains an unlisted procedure code, it must include a complete description.
- For surgical procedures, the claim must contain an operative report. Documentation supporting medical necessity must also accompany the claim. All supporting documentation must accompany the claim so coverage and reimbursement can be determined.
- An unlisted procedure code can only be used when there is not a pure code to use. If an unlisted procedure code is billed and there is an appropriate pure code to use, the charges for the unlisted code will be denied, and the claim must be resubmitted with the appropriate pure code for consideration of payment.
- Not Otherwise Classified (NOC) drug codes may not be used when other appropriate codes are available (e.g. C-series or J-series codes), even if this results in using a code that is not covered by KMAP.
- NOC drug codes should only be used when no other appropriate drug code can be used based on the HCPCS Guidelines.
- C-series codes can only be reported for outpatient facilities.
- Billing of any HCPCS code is not a guarantee of coverage or payment status.

VACUUM ASSISTED WOUND CLOSURE THERAPY

Vacuum assisted wound closure therapy is covered for specific benefit plans. PA is required and criteria must be met. Refer to the *Durable Medical Equipment Fee-for-Service Provider Manual* for criteria. For questions about service coverage for a given benefit plan, contact the KMAP Customer Service Center at 1-800-933-6593. All PA must be requested in writing by a KMAP DME provider. All medical documentation must be submitted to the KMAP DME provider.

VAGAL NERVE STIMULATORS

- Vagal nerve stimulators (VNS) are covered for members with epileptic disorders, except for code 95970, all services must be prior authorized.
- VNS services must meet the following conditions:
  - VNS is restricted to members four years of age and older. The member's physicians are expected to determine if VNS surgery is appropriate, and to document those findings in the medical record.
  - The member must have an epileptic disorder. VNS will not be covered for members with progressive disorders.

8400. Updated 11/19

VAGAL NERVE STIMULATORS continued

- Mental retardation with epilepsy is not a contraindication for VNS but must be considered with other factors.
- All other courses of treatment must be documented, such as conventional and anticonvulsant drugs.
- Providers are expected to maintain adequate documentation, such as "decreased seizure activity" or "improvement in seizure condition."

- For the most current information and verification of coverage, access:
  - The public website under the Provider tab and Reference Codes
  - The secure website under Pricing and Limitations

VISION

- KMAP offers a variety of optical benefits.
  - Complete eye examination every four years.
  - Eyeglasses with certain limitations, see the *Vision Fee-for-Service Provider Manual.*
- Many vision services have specific limitations. For further information, the *Vision Fee-for-Service Provider Manual* can be found on the public website.

BENEFITS AND LIMITATIONS

8420. LOCAL HEALTH DEPARTMENT Updated 07/13

SERVICES DESCRIBED IN THIS SECTION ARE SPECIFIC TO LOCAL HEALTH DEPARTMENT PROVIDERS ONLY.

FAMILY PLANNING

Family planning is any medically approved treatment, counseling, drugs, supplies, or devices which are prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.

- Code S0610 is limited to one per member per lifetime. This includes complete physical examination, counseling, and follow-up.
- Code S0612 includes complete physical examination, counseling and follow-up.
- Code S4993 must be billed separately. Billing for contraceptive pills is limited to 13 times per 12 calendar months.
- For interim family planning visits (recheck of contraceptive method, modification of prescription, clinical problems and counseling), use T1001 and E&M codes 99211, 99212, 99213, and 99214 as appropriate.
  Note: An interim family planning visit is not allowed on the same day as an annual or initial family planning visit, regardless of the provider. The following codes apply to this restriction: S0610, S0612, S0613, 99211, 99212, 99213, 99214, and T1001.

SKILLED NURSING SERVICES

Code T1002 can only be provided by local health departments (LHD) when the services of a home health agency are not available in the county where the member resides. LHDs must notify the home health program manager in writing (Landon State Office Building, 900 Southwest Jackson, Room 900, Topeka, Kansas 66612) that the LHD is providing skilled nursing services in the absence of a home health agency in the member's county of residence. LHDs must use the current home health procedure code to bill for RN home health skilled nursing services provided to eligible members and must bill using their LHD provider number. LHDs will be subject to the same limits and rates as home health agencies for skilled RN services.

PRENATAL HEALTH PROMOTION AND RISK REDUCTION (PHP/RR)

Prenatal Health Promotion and Risk Reduction (PHP/RR) services are designed to reduce the incidence of poor pregnancy outcomes for the mother and newborn. PHP/RR facilitates the Medicaid member's access to nursing, nutrition and psycho-social assessments, interventions and referrals based on identified risks, and health promotion education.

Billing Codes
PHP/RR may be billed under H1000 for a single visit (with a maximum of three visits) or under code H1005, for a total package of three visits.

8420. Updated 07/13

PRENATAL HEALTH PROMOTION AND RISK REDUCTION (PHP/RR) continued

Service Periodicity
Services ideally occur once a trimester, with the initial assessment ideally taking place during the first trimester and follow-up visits occurring during the second and third trimester. Services, however, may be provided anytime during the pregnancy depending on when contact with the member is initiated.

Service Components
1. Data Base Collection and Risk Identification
2. Confirmation of participation in or referral to prenatal medical care
3. Notification of prenatal medical care provider of member participation in service and risks identified
4. Referral to appropriate support services
5. Follow-up face-to-face contact based on the member's risks/needs, to include health promotion education

Assessment Components
1. Obstetrical care provider name & compliance with care
2. Demographic data, e.g. marital status, age, race, emergency contact, other insurance
3. Medical history (family and self)
4. Past obstetrical history
5. Current obstetrical history and pregnancy status
6. Pre-pregnancy weight status and weight gain/loss
7. Psychosocial/environmental, e.g. attitude toward pregnancy, support systems, living arrangements, employment, emotional/stress factors
8. Nutrition Screen
    a. Frequency of meals/snacks, eating pattern, quantity and quality of food selections
    b. Unusual dietary practices, e.g. faddism, food avoidance, elective nutrient and/or vitamin supplementation
    c. Nutrition knowledge, e.g. expectation about weight gain/loss, management of morning sickness, constipation, heartburn
    d. Behavioral risk factors, e.g. alcohol and/or other substance use

Health Promotion Education
Education should be based on risks/needs. Coordination with the prenatal medical care provider and other members of the health care team is recommended. Education is to be provided during face-to-face contacts, with documentation by topic presented.

Topics for health education should include: prenatal care regimen; normal pregnancy, labor/delivery and postpartum course; maternal physiologic, social and emotional changes; risks for, prevention and identification of preterm labor and other changes of pregnancy status; nutritional needs of pregnancy/lactation; behavioral risks such as substance use, smoking, alcohol consumption; need for dental assessment/care; fetal growth and development; preparation for labor/delivery; importance of and preparation for breastfeeding; parenting and infant care skills; and family planning.

8420. Updated 07/13

PRENATAL HEALTH PROMOTION AND RISK REDUCTION (PHP/RR) continued

Referrals

Referrals should be made to WIC, Healthy Start, public health prenatal services and other health department services and/or other support services based on the member's needs/risks. Documentation of referrals should be made in the case record.

Provider of PHP/RR

RN or primary obstetrical care provider on agency staff or on contract with local agency.

Note: For additional guidance regarding nursing assessments, refer to the *Children, Youth and Families Health Services Manual, Volume I, Maternal & Infant/Perinatal*, Kansas Department of Health and Environment.

PRENATAL HEALTH PROMOTION/RISK REDUCTION – HIGH RISK NUTRITION SERVICES (PHP/RRHRN)

Prenatal Health Promotion Risk Reduction High Risk Nutrition (PHP/RRHRN) services facilitate access to nutrition assessments and interventions by a registered/licensed dietitian (RD/LD) based on the initial nutritional screen done by an RN or primary obstetrical care provider.

Billing Codes

Code S9470 may be billed **before** H1000 or H1005 are billed. Code S9470 must be billed on a separate claim form from other services since only the federal portion (FFP) is reimbursed by Medicaid. Reimbursement for these services may only be made to approved local agencies.

Service Periodicity

The frequency and spacing of visits must be determined by RD/LD based on the nutritional necessity indicators and may include both prenatal visits and one postpartum visit.

Indications

The initial nutritional screen done by the nurse or primary obstetrical care provider shall support nutritional necessity for referral to an RD/LD for high-risk nutrition services to be reimbursed.

Indicators of nutritional necessity include current diagnosis of any of the following conditions that jeopardize nutritional status: inappropriate weight gain/loss; existing diabetes or gestational diabetes; anorexia nervosa or bulimia; GI tract disease or conditions (e.g. celiac disease, regional ileitis, ulcers/ulcerative colitis); genetic disorders (e.g. cystic fibrosis, galactosemia, hyperlipidemia, PKU); HIV/AIDS; vitamin or mineral deficiencies.

Service Components

1. Nutrition Assessment Update, e.g. reassessment of anthropometric, dietary, and hematologic data
2. Development of nutritional care plan based on updated assessment
3. Provision of one-on-one nutritional counseling, in collaboration with the primary obstetrical care provider

8420. Updated 03/15

PRENATAL HEALTH PROMOTION/RISK REDUCTION – HIGH RISK NUTRITION SERVICES (PHP/RRHRN) continued

Providers of High-Risk Nutrition Services

RD/LD on agency staff or on contract with approved local agency.
Note: For additional guidance regarding nutrition assessments and interventions, refer to the *Children, Youth and Families Health Services Manual, Volume I, Maternal & Infant/Perinatal*, Kansas Department of Health and Environment.

PRENATAL HEALTH PROMOTION/RISK REDUCTION - ENHANCED SOCIAL WORK SERVICES (PHP/RRESW)

Prenatal Health Promotion/Risk Reduction Social Work Services (PHP/RRESW) are to provide access to professional social work services by licensed social workers for pregnant and postpartum women who are identified by an RN, licensed social worker and/or primary obstetrical care provider that support a psychosocial necessity.

Billing Codes

Code H1002 must be billed on a separate claim form from other services since only the federal portion (FFP) is reimbursed by Medicaid. Reimbursement for these services may only be made to approved local agencies. Services are to be billed per unit, with 1 unit equaling 1 visit.

Service Periodicity

Frequency and spacing of visits must be determined by a licensed social worker based on psychosocial necessity indicators. Maximum of 16 visits per calendar year, which may include prenatal and postpartum contacts.

Indications

The initial psychosocial screen must support a necessity for referral for enhanced social worker services to be reimbursed.
Indicators of psychosocial necessity include: situations that compromise the member's ability to enter, continue, and/or comply with prenatal care or make behavioral changes that would impact the pregnancy outcome; limited or lack of support systems; assessed to be at risk for abuse for or are in an abusive environment; and/or have concerns about the effect of the pregnancy on their life goals and pregnancy outcome.

Service Components

1. Psychosocial Needs/Risk Assessment Update, e.g. review of initial screen and completion of a professional social work intake
2. Development of social work care plan based on current assessment, e.g. prioritizing needs, setting clients goals, plans for follow-up
3. Provision of one-on-one counseling in collaboration with the primary obstetrical care provider and other team members

Provider of Enhanced Social Work Services

Licensed social workers (LASW, LBSW, LMSW, LCSW) on staff or on contract (appropriate to level of licensure) with approved local agencies.

PRENATAL HEALTH PROMOTION/RISK REDUCTION - ENHANCED SOCIAL WORK SERVICES (PHP/RRESW) continued

Note: For additional guidance regarding social work assessments, refer to the *Children, Youth and Families Health Services Manual, Volume I, Maternal & Infant/Perinatal*, Kansas Department of Health and Environment.

POSTPARTUM/NEWBORN HOME VISIT (PP/NBHV)

The Postpartum/Newborn Home Visit (PP/NBHV) provides a transition between the inpatient obstetrical newborn services and the mother's and infant's entry into postdelivery outpatient care.

Service Periodicity

One home visit/mother-baby unit, provided by an RN, is made within 28 days after the neonate's date of birth. No risk indicators are required to provide this home visit.

Billing Code

Code 99502 can be billed using either the mother's or newborn's current Medicaid number. If using the mother's Medicaid number, the claim form should also include the newborn's date of birth. If the newborn's name has not been determined, state "Baby Boy", "Baby Girl", or "Newborn" in the first name field and enter the newborn's last name.

Assessment Components

- Maternal – such as postpartum physiological, emotional status, and nutritional status; interaction with and care skills for newborn; family planning; follow-up medical care appointment(s); employment/education plans
- Newborn – such as physiological and nutritional status; weight assessment as indicated; appointment(s) for health care follow-up
- Parenting and home – such as parenting knowledge/skills; awareness of schedule for newborn/child health assessments/immunizations; home environment
- Support systems – source for primary health care; other support

Service Components

- Parenting and Health Promotion Education based on individual needs/risks
- Provision of information on well-child assessments and immunizations
- Provision of information on, at a minimum, SIDS prevention, car seat use, and shaken baby syndrome
- Referral based on individual needs/risks

Provider

RN on staff or on contract with local agency.

Note: For additional guidance regarding postpartum and newborn nursing assessments, refer to the *Children, Youth and Families Health Services Manual, Volume I, Maternal & Infant/Perinatal* and *Volume II, Children and Youth*, Kansas Department of Health and Environment.

Note: Midwives may bill for newborn home visits. Providers must ensure the codes are covered by KMAP.

8420. 12/19

IMMUNIZATION ADMINISTRATION

Administration of Vaccines for Children (VFC) vaccines are exempt from third-party liability (TPL). When vaccines are billed with an appropriate administrative code, providers do not have to bill the claim to the TPL carrier before Medicaid will process the claim for payment.

DENTAL SERVICES

Local health departments enrolled with Medicaid may bill for dental services provided to Medicaid members and must obtain a separate dental provider number to provide dental services through KMAP. Dental services are billed on the American Dental Association (ADA) form. Please contact Customer Service at 1-800-933-6593 for all dental-related questions. Providers can also refer to the *Dental Provider Manual* on the Provider Manuals page of the KMAP website. Information related to dental services provided by an Extended Care Permit (ECP) hygienist can be found in the **Provider Participation** section of the manual.

BENEFITS & LIMITATIONS

8430. KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT (KDHE) STATE LABORATORY Updated 07/13

COVERED SERVICES

KDHE laboratory services are covered for Medicaid members. The following laboratory services are covered:

- Neonatal Chemistry
- Virology/Serology
- Inorganic Chemistry
- Diagnostic Microbiology

Laboratory services billed by the KDHE lab shall be reimbursed at federal financial participation (FFP) only.

APPENDIX I
CODES

Updated 03/17

KDHE-DHCF requires KMAP professional billers to submit claims using the HCPCS. HCPCS is a combination of codes which includes CPT codes created and controlled by the American Medical Association (AMA); Centers for Medicare & Medicaid Services (CMS) codes created and controlled by CMS; and local codes created and controlled by the regional CMS office. HCPCS codes consist of a five-digit base code with the capability of being up to thirteen digits in length when modifiers are used. A modifier code is a two-digit code that identifies a specific type of service, for example, anesthesia, or a variation of the service identified by the base code. Charts have been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers Table and Ambulance Coding Modifiers Table are available on both the public and secure portions of the website. They can be accessed on the KMAP Reference Codes page. Information is available on the American Medical Association website.

Not all codes are covered. Please use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the member ID number or benefit plan.

- Information from the public website
- Information from the secure website under Pricing and Limitations

For further assistance, contact the Customer Service Center at 1-800-933-6593. (Refer to **Section 1000** from the *General Introduction Fee-for-Service Provider Manual*.)

All claims must be coded with the appropriate codes. Claims which only describe the service and do not provide the code will be denied. When a code is not available, the service is noncovered by KMAP. Not otherwise classified (NOC) codes are usually noncovered. (Refer to **Section 4200** of the *General Special Requirements Fee-for-Service Provider Manual.)*