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6.1 Abortion

6.1.1 Description

Intentional termination of pregnancy (ITOP) as well as induced and surgical treatments of incomplete, missed abortions are covered by the Department of Human Services.

6.1.2 Amount, Duration and Scope

Surgical trays for abortions performed in the physician's office are covered.

6.1.3 Exclusions

A colposcopy (vaginocopy) done in conjunction with the abortion is not payable as it is considered part of the abortion procedure.

6.1.4 Limitations

Cervical dilation by laminaria insertion is covered as a separate procedure for abortion in the second trimester but not in the first trimester. Laminaria is payable as a supply of both first and second trimester abortions.

6.1.5 Authorization

Prior authorization is not required.

6.2 Amniocentesis

Medicaid covers amniocentesis and chromosome analysis when medically indicated. These services are discussed in Chapter 7: Laboratory and Pathology Services.

6.3 Anesthesiology Services

6.3.1 Description

Services that involve the administration of anesthesia include but are not limited to the following:

- General anesthesia.
- Regional (including supplementation of local anesthesia).
- Spinal, epidural or caudal anesthesia.

- Monitored Sedation with or without anesthesia.

6.3.2 *Amount, Duration and Scope*

The reporting of anesthesiology services is based upon anesthesia base units and time units. Anesthesia time begins with the preparation of the patient for the induction of anesthesia personally performed by the anesthesiologist in the operating room or an equivalent area and ends when the anesthesiologist is no longer in attendance and the patient is safely under postoperative supervision.

6.3.3 *Exclusions*

Services by anesthesiologists that are not covered include but are not limited to the following:

- Standby services.
- After hours, weekend and holiday differentials for services related to labor and delivery.

6.3.4 *Limitations*

a) Services included in the reimbursement for anesthesia will be denied if separately billed.

b) Services included in the reimbursement for anesthesia include but are not limited to the following:

- Pre-operative and immediate postoperative care.
- Endotracheal intubation.
- Insertion of an intravenous line and administration of the anesthetic and all fluids and/or blood products incident to the anesthesia or surgery.
- Regional blocks, digital blocks, local anesthesia, etc. that may be used during general anesthesia.
- Epidural, caudal or lumbar puncture associated with the induction of epidural, caudal, spinal anesthesia and/or general anesthesia.
- Placement of an epidural catheter for administration of postoperative pain control medications during the anesthesia time. The administration of postoperative pain control medication through the epidural catheter in the immediate postoperative period.

- The preoperative, postoperative and intraoperative monitoring of vital signs, including measurement and interpretation of oxygen saturation.
 - Interpretation of x-rays, electrocardiograms and rhythm strips, blood gases and other diagnostic tests. Only one base anesthesia value is allowed per surgical session. Therefore, when multiple surgical procedures are performed during the same period of anesthesia, only the primary surgical procedure (generally, this will be the procedure with the higher base anesthesia value) should be coded with the applicable anesthesia modifier. If more than one anesthesia procedure is billed, the procedure with the highest reimbursement will be reimbursed.
- c) Certain procedures are not included in the reimbursement for anesthesia and can be separately billed as surgical procedures. CPT-4 payment rules for surgery, multiple surgeries and “separate procedures” apply when the anesthesiologist performs a surgical procedure either associated with the anesthesia time or not connected with the administration of general anesthesia. Procedures which can be billed separately when performed with the administration of general anesthesia include but are not necessarily limited to:
- Insertion of a central venous pressure line.
 - Insertion of a Swan-Ganz catheter.
 - Insertion of arterial lines.
- d) Non-anesthesia services performed by anesthesiologists are paid based upon the customary fee for the procedure. Thus, no time factor is allowed and anesthesia modifiers should not be used.

6.3.5 *Authorization*

Prior authorization is required when the surgical procedure for which anesthesia is being administered requires authorization. If a surgical procedure requires authorization and authorization is not obtained, the surgeon, anesthesiologist and facility cannot be reimbursed.

6.3.6 *Coding and Claims Submittal*

a) CODING FOR SERVICES SUBMITTED PRIOR TO OCTOBER 25, 2002:

The following section details the instructions on use of codes, time units and modifiers applicable to claims submitted PRIOR to October 25, 2002.

T = Time units are as follows:

- F = First hour—each 15 minutes is equal to 1 unit
- A = After the first hour—each 10 minutes is equal to 1 unit

Anesthesia is reported with the CPT-4 code of the surgery following by a modifier.

Applicable modifiers are as follows:

- AA: Anesthesia personally performed by the anesthesiologist.
- AB: Anesthesia supervised by the anesthesiologist in conjunction with a certified nurse anesthetist (CNA) employed by a medical group or physician; the physician must be physically present in the operating room area and either available to take over the management of the patient or have made arrangements with another anesthesiologist who can take over management. Reimbursement is 75% of the supervising anesthesiologist's allowance.
- AC: Anesthesia supervised by the anesthesiologist in conjunction with a CNA who is employed by a hospital. The physician must be physically present in the operating room area and either available to take over the management of the patient or has made arrangements with another anesthesiologist who can take over management. Reimbursement is 50% of the supervising anesthesiologist's allowance.
- XC: Anesthesia with prone position or field avoidance (only applicable for procedures with anesthesia base units values of 3).
- AF: Total body hypothermia (only applicable when total body hypothermia is NOT normally performed with the specific surgical procedure).
- XD: Anesthesia complicated by extracorporeal circulation (only applicable when extracorporeal circulation is NOT normally performed with the specific surgical procedure).
- XE: Anesthesia complicated by hyperbaric pressurization/controlled hypotension (only applicable when hyperbaric pressurization/controlled hypotension is NOT normally performed with the specific surgical procedure).
- XF: Anesthesia for prolonged labor prior to vaginal or a cesarean section delivery.
- AG: Only allowed for general anesthesia in patients with severe systemic disease that is a constant threat to life or who are moribund.

The AG modifier is eligible for one (1) or two (2) additional units are provided depending on the nature of the disease. Generally 2 additional units are provided for the following conditions:

- Recent myocardial infarction (within 3 months).
- Severe atherosclerotic cardio-vascular disease (angina, severe congestive heart failure, arrhythmia, frequent PVCs, ventricular ectopy, PAT, etc.).
- Compromised airway.
- Severe lung disease (FEV1 less than 1.2, elevated PaCO₂, low PaO₂).
- Recent cardiovascular illness (stroke, aneurysm, etc. within 3 months).
- Massive trauma with severe blood loss.
- Severe liver disease (end stage with significant lab abnormality).
- Severe renal disease (or complete renal failure).
- Severe neurologic disorder (increased intracranial pressure, comatose).
- Burns over 35% of body area.
- Patients on chronic systemic steroids.

Generally 1 additional unit is provided for the following conditions:

- Chronic, stable, or mild congestive heart failure.
- Symptomatic atherosclerotic cardiovascular disease.
- Chronic liver disease with abnormalities in liver function tests.
- Hypertension prior to induction, (the blood pressure reading must be given).
- Chronic obstructive lung disease.
- Obesity with BMI greater than 30 kg/m², height and weight must be given.

- Acute blood loss that requires transfusion.
- Patient with full stomachs (recent meals, gastrointestinal obstruction); (not applicable for epidural/caudal anesthesia prior to normal vaginal delivery).
- Chronic neurologic disease (Examples: Multiple sclerosis, atrophic lateral sclerosis).
- Congenital heart disease.
- Rheumatic heart disease.
- Renal failure (elevated blood urea nitrogen and creatinine).
- Hypotension prior to induction, the blood pressure reading must be given.
- Electrolyte imbalance.
- Diabetes mellitus with systemic complications or poorly controlled.
- 2nd and 3rd degree burns over 18% of the body.
- Age under 1 year of age or over 70 years of age.
- Lower respiratory infection (pneumonia, pulmonary infiltration, etc.).

The modifier AG is used for patients with high risk, therefore no additional base units are given for CPT-4 "Physical Status Modifiers," P1 to P6.

- The modifiers AG, AF, XE, etc. are used to identify certain conditions, therefore no additional base units are given for CPT-4 "Qualifying Circumstances."

b) CODING FOR SERVICES SUBMITTED ON OR AFTER OCTOBER 25, 2002:

The following section details the instructions on the use of codes and time units applicable ON OR AFTER October 25, 2002. Claims submitted on or after October 25, 2002 must be submitted with American Society of Anesthesiologists (ASA) codes. These codes are identified as CPT-4 five-(5) digit procedure codes in the range of 00100 through 01999. Base units assigned to these codes are the base units assigned by Medicare Part B.

T = Time units are as follows:

- F = First hour—each 15 minutes is equal to 1 unit
- A = After the first hour—each 15 minutes is equal to 1 unit

Providers must submit time as minutes. Minutes must be entered in Form Locator (FL) 24G defined as “Days or Units.” Units (calculated as described above) should be entered under the ASA/CPT anesthesia code in Form Locator (FL) 24D defined as “Procedures, Services, or Supplies.”

MODIFIERS:

All ASA/CPT anesthesia codes must have appropriate anesthesia modifiers.

Allowable modifiers - The following modifiers must be used when applicable:

- AA – Anesthesia services performed personally by anesthesiologists
- QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- QS – Monitored anesthesia care service
- QY – Anesthesiologist medically directs one CRNA (Certified Registered Nurse Anesthetist)

NON-COVERED MODIFIERS AND PROCEDURE CODES:

- Physical Status Modifiers (CPT-4 modifiers P1 – P6) should not be reported
- No additional units/payment will be extended for “Qualifying Circumstances” for anesthesia (such as anesthesia risk or prone position)

- The following codes/modifiers will not be paid:
 - 1) AG
 - 2) XC
 - 3) AF
 - 4) XD
 - 5) XE
 - 6) 99100
 - 7) 99116
 - 8) 99135
 - 9) 99140

The following modifiers used prior to October 25, 2002 will be converted to HCPCs modifiers or codes:

- AB convert these to QK or QY
- AC convert these to QK or QY
- XF convert to code 01967

6.4 Family Planning Services

6.4.1 Description

Family Planning is covered with limitations. Male and female recipients, including minors, who are sexually active or of childbearing age are eligible for family planning services and supplies. Medical care given to minor females who may be pregnant or afflicted with a venereal disease or who are seeking family planning services must be provided in compliance with Hawaii Revised Statutes Chapter 577A. The use of family planning services or practices shall be entirely on a voluntary basis.

6.4.2 Amount, Duration and Scope

- a) Consultation and counseling supervised by a physician or prescribed by a physician.
- b) Laboratory examinations and tests (i.e., Pap smears, serology, G.C. smears, etc.).
- c) Medically approved methods, procedures, pharmaceuticals and devices to prevent conception; such as:
 - Implants, e.g., Norplant.
 - Diaphragms/Cervical Caps.

- Over-the-Counter Supplies such as contraceptive foam or gel, prophylactics (condoms), etc.
- Intrauterine Devices.
- Oral Contraceptives.
- d) Natural family planning methods.
- e) Diagnosis only for infertility.
- f) Sterilizations are covered by Medicaid if all federal consent requirements are met. See Sterilization in this Chapter 6.15 and in Appendix 3, Sterilization Required Consent Form 1146.

6.4.3 Exclusions

All drugs and procedures used for the purpose of inducing ovulation and enhancing fertility are not covered.

6.4.4 Limitations

Norplant

- 1) The Medicaid program will reimburse both the Norplant kit as a drug using the NDC number and the insertion of Norplant capsules using CPT-4 codes. Tax and other fees such as shipping and handling are not to be billed for the Norplant kit. No medical authorization is required for the kit used for the initial insertion.
- 2) The removal of the device with or without re-implantation is reimbursed under the appropriate CPT-4 code. If re-implantation is not performed at the time of removal, the re-implantation requires medical authorization on Form 1144 if it is performed less than five years after the initial implantation.

6.4.5 Authorization

Prior authorization is not required except when Norplant has been removed and a re-insertion is to be performed less than five years after the last insertion.

6.5 Hysterectomy

6.5.1 Description

Hysterectomy is defined as a medical procedure or operation for the purpose of removing the uterus. Hysterectomies must be medically necessary for the treatment of disease or illness. Hysterectomies are covered under the Medicaid program when rendered under strict Federal guidelines.

6.5.2 Amount, Duration and Scope

- a) Federal regulations expressly require that every female, regardless of age or medical condition, or her representative, if applicable, must be informed orally and in writing before the hysterectomy is performed that the procedure will render her permanently incapable of reproducing.
- b) The patient or her representative must acknowledge in writing her understanding and receipt of the above information by signing the Hysterectomy Acknowledgement Form 1145 (refer to Appendix 3 for a sample of this form). The form may be signed by the patient or her representative before or after the procedure is performed as long as the patient was informed prior to surgery of her subsequent inability to reproduce. However, it is strongly recommended that the form be signed before surgery if at all possible. If the Form 1145 is signed after the procedure is done, it must contain language, which clearly states that the patient was informed of the hysterectomy consequences before surgery. Proper completion of the form both by provider and the patient will insure that Federal requirements are met.
- c) Reasonable facsimiles of Form 1145 must contain all the information in the Hysterectomy Acknowledgement Form 1145, including the required signatures, date and patient information.
- d) A hospital surgery consent form should not be used to fulfill Federal requirements, as the forms have no provision for a patient's acknowledgement of her inability to bear children.

6.5.3 Exclusions

- a) Non-compliance with the regulations will result in non-payment of the hysterectomy and all related services. The Federally mandated Hysterectomy Acknowledgement Form 1145, or a reasonable facsimile, must be completed and signed as outlined in Appendix 3.
- b) No payment will be made for hysterectomies performed:
 - Solely for the purpose of rendering a patient permanently incapable of reproducing;

- When there is more than one purpose to the procedure, but sterilization was the primary intent;
- On mentally retarded persons unless medically necessary for the treatment of disease or illness. For those whose retardation is so severe that it prevents their understanding the importance of the acknowledgement form or the elements of informed consent, their representative must sign or countersign for them.

6.5.4 *Limitations*

Compliance with Federal/State regulations in completing the required Form 1145 is mandatory for payment of hysterectomies except in the following situations:

- The patient was already sterile prior to the hysterectomy. In these cases, the physician who performed the hysterectomy must affirm the patient's sterility in writing and state the cause of the sterility. In this context, "sterility" may be due to the post-menopausal state, a previous successful bilateral tubal sterilization procedure, or a known bilateral tubal blockage due to other disease. Not included is a simple lack of conception without demonstrated tubal blockage or other diseases or endocrine dysfunction interfering with ovulation; and
- The patient required a hysterectomy because of a life-threatening emergency situation in which the physician determined prior acknowledgement was not possible. "Life threatening emergency" means actual emergencies such as ruptured uterus or uteroplacental apoplexy or severe abdominal trauma. The physician must certify that the patient was in imminent danger of loss of life and could not receive the required information and describe the emergency situation. A hysterectomy, which becomes medically advised during an operative procedure, shall not be considered a life-threatening emergency. The possibility of an associated hysterectomy shall be considered in all pelvic or lower abdominal operative procedures and the proper tentative warning provided.

6.5.5 *Authorization*

- a) Prior authorization is not required; however, a copy or facsimile of the completed Hysterectomy Acknowledgement Form 1145 must be attached to the claim form in order to obtain payment. If the Hysterectomy Acknowledgement Form 1145 or its facsimile is not properly and completely filled out and/or attached to the claim form, payment will be denied.
- b) The Form 1145 should be completed whenever any abdominal or pelvic surgery is anticipated and for private patients who are not fully covered by a medical insurance program. This will preclude claim rejections due to lack of a required form if a hysterectomy becomes medically advisable during surgery, or a private patient applies for medical assistance.

- c) Hospital administrators have been advised to set up procedures to check for availability of a completed Form 1145 upon the admission of a female Medicaid patient scheduled for lower abdominal or pelvic surgery and for patients not fully covered by some other medical insurance program.
- d) Form 1145 has no expiration. However, the form should be completed and signed by the patient or her representative prior to surgery. The form shall be completed in the physician's office at the time the procedure is discussed with the patient and scheduled. Forms signed after the surgery are acceptable only if the patient was informed before the surgery that she would be unable to reproduce as a consequence of the surgery. Also, the form must contain language, which clearly states that the patient was informed of the procedure's consequences before the surgery.

6.6 Immunizations

6.6.1 Description

Medicaid covers immunizations and the administrative costs of the immunizations for adults and children. The Department of Health's Vaccines for Children (VFC) Program provides the injectable materials at no cost to enrolled physicians and clinics that immunize children covered by Medicaid. Therefore, no reimbursement is allowed for those vaccines covered by VFC.

6.6.2 Amount, Duration and Scope

a) Covered immunizations for adults include:

- Tetanus-diphtheria (Td) booster.
- Influenza and pneumococcus in high risk groups.
- Rubella if there is no evidence of immunity for women of childbearing age.
- Hepatitis B in high risk groups – household and sexual contacts of HBsAg positive persons.

b) Immunizations covered by the VFC Program for children are not reimbursed by Medicaid. They include:

- Diphtheria, tetanus and pertussis.
- Polio.
- Varicella (chicken pox).

- Hemophilus influenza B.
 - Hepatitis B.
 - Measles, mumps and rubella.
 - Tetanus and diphtheria booster.
 - Pneumococcal Conjugate and Heptavalent Vaccine.
- c) Other immune therapy for children:
- Human respiratory syncytial virus (RSV) immune globulin (RespiGam) or Synagis (See Appendix 6, Prevention of Serious Lower Respiratory Tract Infections caused by Respiratory Syncytial Virus (RSV Guidelines)).

6.6.3 Exclusions

- a) Immunizations for travel or work are not covered by Medicaid.
- b) Pneumococcal and annual influenza vaccines provided to nursing home residents who are Medicare beneficiaries will not be covered as Medicare covers 100 percent of the reasonable cost of these vaccines.
- c) Medicaid will not pay for vaccines that are available through the Department of Health Vaccines for Children (VFC) Program.

6.6.4 Limitations

- a) Only the administrative fee is payable for those vaccines available through the Department of Health's VFC Program. If immunizations to children are given as part of an EPSDT screening examination or catch-up screening, the administration fee is included within the EPSDT global fee.
- b) RespiGam should not be administered at the same time as routine childhood immunizations.

6.6.5 Authorization

Medicaid does not require prior authorization for medically necessary immunization services performed by FFS providers.

6.7 Mammography and Clinical Breast Exams

6.7.1 Description

Medicaid covers screening mammographies and clinical breast exams (CBE) for women according to the guidelines listed below.

6.7.2 Amount, Duration and Scope

a) Screening mammographies and clinical breast exams are covered:

- Age 40-49: One mammography once every one to two years, CBE annually.
- Age 50-69: One mammography every year, CBE annually.
- Age 70-74: One mammography once every one to two years, CBE annually.

b) A woman of any age with a history of breast cancer, or whose mother or sister has a history of breast cancer, is eligible for a screening mammography when ordered by a physician.

6.7.3 Exclusions

None if medically necessary or by history as noted above.

6.7.4 Limitations

As noted above.

6.7.5 Authorization

Prior authorization is not required.

6.8 Maternity

6.8.1 Description

a) Pregnancy and Delivery are covered as a global service that includes antepartum visits meeting the periodicity and standards currently recommended by the American College of Obstetricians and Gynecologists (ACOG), delivery (either vaginal or Cesarean section), postpartum care, and treatment of routine gynecological conditions. Health education concerning such topics as fetal development, nutrition, prenatal vitamins, exercise, smoking and substance abuse, family violence, breastfeeding, choosing a pediatrician, labor and delivery and screening for conditions which could make a pregnancy “high risk” are important components of antepartum care and not separately reimbursable.

- b) Maternity services are to be provided by licensed physicians and/or Certified Nurse Midwives.
- c) Medical care given to minor females who may be pregnant or afflicted with a venereal disease or who are seeking family planning services must be provided in compliance with Hawaii Revised Statutes Chapter 577A.

6.8.2 Amount, Duration and Scope

- a) Common conditions occurring during the pregnancy are considered related to pregnancy and therefore will not be paid outside of the global package. Some of those conditions include nausea, fatigue, UTI, URI, most low back/pelvic pain, vaginitis, Braxton-Hicks contractions and counseling for future methods of birth control. Common procedures such as routine dipstick urinalysis and blood pressure measurement and weight are included in the global package and will not be paid separately.
- b) Claims for evaluation and management of serious complications must be submitted with the appropriate diagnosis code for payment to be made separate from the global fee.
- c) No additional compensation will be paid for additional births.
- d) The postpartum period covers the forty-five (45) days from the date of delivery.
- e) The length of stay in the acute care hospital for labor and delivery may vary according to the complexity of the delivery. Length-of-stay is calculated from the time of actual delivery. The length of stay for a normal vaginal delivery is 48 hours or less and for a normal cesarean delivery 96 hours or less. Extended stays should be for a medical reason.

6.8.3 Exclusions

E/M visits for common pregnancy-related conditions are included in the global payment for antepartum care and not separately reimbursable.

6.8.4 Limitations

If a patient's maternity care is divided among providers, i.e. one provider doing the delivery and another doing the prenatal and/or postpartum care, the appropriate procedure codes must be used to describe the service provided. When maternity care (antepartum, delivery, and postpartum) is performed by more than one provider, the total payment available to providers for a normal pregnancy and delivery will not be more than the global fee.

6.8.5 *Authorization*

Prior authorization is not required for prenatal care or delivery.

6.9 Newborn Services

6.9.1 *Description*

Newborn Services are covered benefits under Medicaid.

6.9.2 *Amount, Duration and Scope*

a) Covered services include:

Newborn screening – newborn hearing assessment, newborn laboratory screening-phenylketonuria, hypothyroidism, and other metabolic diseases as specified by the Department of Health (DOH) and currently in effect. These services are included in the Medicaid payment to the acute care facility and not separately reimbursable.

b) Hospital stays for normal, term, healthy newborns up to 48 hours after normal vaginal delivery or up to 96 hours after cesarean section delivery following current guidelines or the American Academy of Pediatrics (AAP) and American College of Obstetrics and Gynecology (ACOG).

c) E/M services and EPSDT examinations

d) Circumcision for newborn males, if elected by parent(s).

6.9.3 *Exclusions*

None.

6.9.4 *Limitations*

For normal newborns, Medicaid will pay for only one initial history and examination CPT code. If other hospital visits are medically necessary, appropriate CPT codes should be used.

6.9.5 *Authorization*

Prior authorization is not required.

6.10 Physical Examinations and Screening Tests

6.10.1 Description

- a) Medicaid covers physical examinations and screening tests provided by a physician, PCP or other licensed practitioner within the scope of his/her practice. These services include age, appropriate physical examinations, clinical health risk assessments and screening tests, immunizations and health education.
- b) All federal and state requirements must be followed; for example, all women 20 years of age or over who are hospitalized in an inpatient setting are to be offered pap smears unless contraindicated by the attending physician or unless it has been performed within the previous year. The hospital must maintain records to document its compliance.
- c) For more detail on physical examinations, health risk assessments and screening tests for children please refer to Chapter 5 EPSDT Program and the EPSDT guidelines in Appendix 6. For adults, please refer to the guidelines in Appendix 6 (Adult Preventive Health Guidelines).

6.10.2 Amount, Duration and Scope

- a) Preventive risk assessments for adults are covered. They are reimbursed as procedures (examples are: laboratory test, radiologic tests and/or E & M services).
- b) For information on health assessments and testing for children up to age 21, please refer to Chapter 5 EPSDT Program.

6.10.3 Exclusions

Physical examinations for the following purposes are not covered :

- Life insurance or other insurance,
- As a requirement for continuing employment,
- For a driver's license, and
- For travel – foreign and domestic.

6.10.4 Limitations

- a) For adults, the following physical examinations are covered:
 - Pre-employment physical exams.

- Pre-admission and periodic physical exams required for care home residents.
- Pre-placement physical exams for adults entering family boarding homes.
- Routine physical exams no more than once in a two (2) year period.
- b) Disability examinations for the purpose of establishing eligibility for General Assistance Benefits may only be provided by the contractor specified by the Department of Human Services.
- c) For children, the following physical examinations are covered:
 - School health clearance and sports physical exams for sports clearance.
 - Preplacement/annual exams for children in foster care.
 - Pre-adoption physical exams.
 - Suspected child abuse exams.
 - Preplacement exams for day care.
 - EPSDT comprehensive periodic screens, partial screens, and interperiodic screens, and well childcare.

6.10.5 Authorization

Prior authorization is not required.

6.11 Podiatry Services

6.11.1 Description

Medicaid covers medically necessary podiatry services for eligible recipients. These services are for ailments or disorders of the foot and ankle when performed by doctors of podiatric medicine (DPM) licensed in the state of Hawaii.

6.11.2 Amount, Duration and Scope

- a) Services and items include but are not necessarily limited to treatment of conditions of the foot and ankle such as:

- Diagnostic radiology,
 - Surgical procedures,
 - Foot appliances,
 - Orthopedic shoes that are an integral part of a brace,
 - Casts if the casting is for the purpose of constructing or accommodating orthotics, and
 - Orthodigital prosthesis and casts.
- b) Podiatric services performed in the long-term care facility are limited to diabetic foot care only and must be ordered by the attending physician
- c) Other services in the inpatient hospital require prior authorization.

6.11.3 Exclusions

- a) Routine foot care; including debridement of nails, not related to treatment of infection or injury is not generally considered medically necessary and therefore is not covered with the exception of diabetic foot care in the inpatient hospital or long-term care setting. Routine foot care as defined for the purposes of this policy includes:
- The cutting or removal of corns or calluses,
 - The trimming of nails (including mycotic nails), and
 - Other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients.
- b) Any services performed in the absence of localized illness, injury or symptoms involving the foot and ankle are not covered.
- c) Bunionectomies are not covered if the sole indications are pain and difficulty finding appropriate shoes.
- d) The treatment of pes planus (flat feet) is not covered.
- e) Services performed in the home, care home or other non-institutional residence are not covered.

6.11.4 Limitations

- a) All care rendered by podiatrists is limited to the foot and ankle.
- b) Diagnostic radiology procedures are limited to the foot and ankle.
- c) All podiatry services to be provided in the inpatient hospital, outpatient hospital, or long-term care facility must be connected with the diagnosis of diabetes. All other inpatient hospital services not connected with the diagnosis of diabetes require approval by the DHS medical consultant or agent.
- d) Foot and ankle care related to the treatment of infection or injury is covered in the office or outpatient clinic setting.
- e) Bunionectomies are covered only when the bunion is present with overlying skin ulceration, or neuroma secondary to the bunion (neuroma to be removed at the same surgery and documented in the pathology report).

6.11.5 Authorization

- a) Inpatient hospital, outpatient hospital and office surgery in excess of \$100 in charges must be authorized by the DHS medical consultant or agent.
- b) Appliances of a non-emergency nature costing more than \$50 require prior authorization by the DHS medical consultant or agent.
- c) All other inpatient acute hospital services not connected with the diagnosis of diabetes must be approved for medical necessity by the DHS medical consultant or agent.

6.12 Professional Services

6.12.1 Description

Professional and technical services are covered as described in the following sections. Medicaid providers must meet all requirements.

6.12.2 Amount, Duration and Scope

6.12.2.1 Evaluation and Management (E & M) Services Covered

- a) Outpatient, office visits and hospital visits are covered without authorization. Coding for these visits must reflect the level of complexity of the service provided. There must be

written, signed, and dated documentation in the patient's medical record of the visit. Only one visit is allowed per patient per day per physician.

b) Consultations are covered services without authorization under the following circumstances:

- A physician (referring physician) requests the opinion or advice of another physician (consulting physician).
- A written report of the opinion rendered by the consulting physician is given to the referring physician. Coding for consultations reflects the level of complexity of the services provided. The referring physician's full name and Medicaid provider number is provided on the claim in Form Locator 17 and 17a of the CMS (formerly HCFA) 1500 claim form.
- Only one (1) initial consultation per patient is payable per spell of illness. More than one subsequent consultation(s) per patient is allowed as long as the physician provides opinions and advice and does not participate in the treatment or management of the patient.
- The referring party must be a physician.
- In most cases, the specialty or subspecialty of the referring physician cannot be the same as the specialty or subspecialty of the consulting physician.
- Written, signed, and dated documentation of the consultation(s) must be in the patient's medical record.
- At the point the consulting physician assumes total or partial management of the patient, the physician is NOT providing consultation.

c) Second opinion consultations are covered without authorization.

- Second opinion consultations are requested by a patient or his/her family. Coding for second opinion consultations reflects the level of complexity of the services provided.
- Written, signed, and dated documentation of the second opinion consultation must be in the patient's medical record.
- If a physician assumes total or partial management of the patient at the time of the visit, an outpatient, office, or hospital visit (not a second opinion consultation) has been rendered.

d) Neighbor Island services performed by physicians who visit a neighbor island are covered without authorization but with the following limitations.

- The visiting physician does not maintain a residence on the neighbor island.

- The visiting physician may provide consultation, diagnostic testing, and treatment. However, he/she cannot offer to provide services on Oahu or another island to neighbor island patients unless the specific service is not available for the patient on the neighbor island on which the patient resides.

If the above requirements are met, the visiting physician may include a travel charge (CPT-4 code 99080) for each patient seen in addition to the medical service charge.

e) Home visits are covered without authorization under the following circumstances:

- The home visit is made for the evaluation and management of a patient who is homebound. Homebound means an individual is temporarily or permanently confined to his or her place of residence because of a medical condition.
- Coding for the home visit reflects the level of complexity of the services rendered.
- Claims are submitted with place of service home and CPT codes for home services (99341 to 99345 and 99347 to 99350). Coding for the visit must reflect the level of complexity of the services rendered.
- Written, signed and dated documentation of the home visit is kept in the patient's medical record and a copy is submitted with the claim.
- Travel to and from the home visit, travel or detention time, and gas/mileage are not reimbursable.
- Home visits for psychiatric/psychological evaluation and therapy are not covered.

f) Care home/domiciliary visits by a physician or nurse practitioner are covered without authorization under the following circumstances:

- An acute medical problem exists and the resident is temporarily homebound as a result of that acute medical condition.
- Visits to a care home for routine physical examination and/or preventive health services are not covered.
- Claims are submitted with place of service custodial care facility and CPT codes for domiciliary, rest home or custodial care services (99321 to 99323 and 99331 to 99333). Coding for the visit must reflect the level of complexity of the services rendered. When the service provided is greater than that usually required for the listed procedure, it may be identified by the addition of modifier '22' to the usual procedure code.

- When the service provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-22' to the usual procedure number. Documentation of the care home visit should then be submitted with the claim.
- Written, signed and dated documentation of the care home/domiciliary visit is kept in the patient's medical record and a copy is submitted with the claim.
- Travel to and from the care home/domiciliary visit, travel or detention time, and gas/mileage are not reimbursable.
- Care home/domiciliary visits for psychiatric/psychological evaluation and therapy are not covered.
- g) Emergency room visits are covered without authorization when performed by both emergency room physicians and non-emergency room based physicians who provide services in a licensed general hospital.
- Physician direction of emergency medical systems (EMS) -- advanced life support (ALS), critical care, and cardiopulmonary resuscitation may be payable under the following conditions:
 - 1) A dated and signed report describing the service(s) rendered is submitted.
 - 2) For payment of physician direction of EMS, the physician must be in two-way voice communication with EMS ALS personnel and must direct the care given beyond that provided in EMS ALS protocols.
- Certain specific procedures are included in critical care. These procedures are listed in the current edition of CPT-4.
- Critical care is paid based on the time actually spent by the treating physician.
- The physician should clearly state the time actually spent in critical care and the specific services rendered.
- Critical care should not be billed with an E & M service provided by the same physician on the same day except in the following situations:
 - The patient received an appropriate E & M service, was stable, then suddenly decompensated and required critical care.

- The patient had more than one visit to the emergency department; one of which required critical care.
- h) Exclusions and limitations to emergency room services include:
- Additional payment for emergency room services rendered on holidays, weekends, and after 4:30 p.m. are allowed for physicians not assigned to the emergency room and not present in the hospital when called to see a patient in the emergency room. Payment is allowed for only one (1) “after hour” code per patient per day.
 - No additional payment for services rendered on holidays, weekends, and after 4:30 p.m. are allowed for emergency room physicians and physicians who are in the hospital when called to see a patient in the emergency room.
 - Procedures not directly performed by the physician are not payable. Examples: Injections, venipuncture, and urinary catheterization performed by nurses upon the instruction of the physician and intravenous infusion not administered and monitored by the physician.
 - Interpretation of x-rays and other radiologic studies in the CPT-4 code range 70000-79999 with or without a modifier –26 are not payable as these services are considered part of the emergency room E & M service.
 - Interpretation of laboratory and other diagnostic studies, tests, and measurements are not separately payable, as they are part of the E & M service. **Examples: Interpretation of blood chemistry studies, arterial blood gases, glucometer readings, and pulse oximeter readings.**
 - Digital blocks are not separately payable if associated with a surgical repair, and/or manipulative reduction of a fracture/dislocation. If used for pain reduction without an associated surgical procedure, they may be payable if justified in the physician’s notes.
 - Generally, when fractures/dislocations are reduced with manipulation or a surgical procedure is performed, an E & M emergency room service is payable. However, certain procedures are considered as a “service” and included in the E & M service. Therefore, separate reimbursement under fracture and/or dislocation CPT-4 codes is not extended for reduction of nursemaid’s elbow and all closed treatment of fractures/dislocations without manipulation. Payments for these procedures considered to be a “service” are made under the appropriate E & M service.
 - Casting and strapping (CPT-4 codes 29000-29590) are not covered for fractures/dislocations reduced with manipulation or when a surgical repair is performed because casting and strapping are included in the payment for the primary procedure. However, casting or

strapping (if performed by the physician) is payable for treatment of fractures/dislocations that are considered a “service” that are included in the E & M service.

- Interpretations of twelve (12) lead electrocardiograms (ECGs/EKGs) and rhythm strips performed in the emergency room are payable. If more than one (1) ECG/EKG is performed and interpreted, each subsequent ECG/EKG must be separately identified with the modifier – 76 (repeat procedure by the same physician). Only one interpretation can be paid for the same ECG/EKG. Therefore, the first claim submitted will be paid. All other claims for the interpretation of the same ECG/EKG will be denied or if paid, recovery will be taken.

6.12.2.2 Other Physician Services

- a) Critical Care Services are covered without authorization. There must be written documentation in the patient’s medical record of the time spent in critical care and the actual services rendered.
 - Certain specific procedures are included in critical care. These procedures are listed in the current edition of CPT-4.
 - Critical care is paid based on the time actually spent by the treating physician in providing critical care to the critically ill patient.
 - Critical care should not be billed with an E & M service provided by the same physician on the same day except when a patient who had been seen and considered stable suddenly de-compensated and required critical care.
 - Services for patients who are not critically ill but are in the critical care units are not critical care and must be reported using other appropriate E & M codes.
 - For critical care services provided in the emergency room, see g and h.
- b) Acute Waitlisted Level of Care visits includes patients in acute care beds, but not at the acute level of care. These patients are at the acute waitlisted Subacute, Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) levels of care (LOC). Visits made by attending physicians and consultants to patients at the acute waitlisted subacute, SNF and ICF levels of care will be covered under the following circumstances:
 - The visit is medically necessary; i.e. the patient has an active medical problem that requires evaluation and/or management including a history, examination and medical decision making. Daily or frequent routine visits to stable patients at the acute waitlisted subacute, SNF or ICF LOC will not be covered. Frequent routine visits made to stable ventilator-dependent patients for ventilation assist and management (94657) will not be covered. This code should only be used for visits to acute waitlisted ventilator-dependent patients when an

assessment and/or change in ventilation is medically necessary. The assessment and/or change must be documented in the patient's medical records and a copy of the documentation must be submitted with the claim.

- Claims are submitted with place of service hospital and CPT codes for inpatient services. Place of service nursing facility and CPT codes for nursing facility services are only appropriate for patients who have been discharged from the acute facility and admitted to a bed specifically designated as a subacute, SNF or ICF bed.
 - The documentation in the medical record and coding for the visit reflects the level of complexity of the services rendered.
- c) Long Term Care (LTC) facility visits are covered without authorization but with the following limitations:
- Routine visits to a patient at the Skilled Nursing Facility (SNF) level of care (LOC) are limited to two (2) visit per patient per month. Routine visits to a patient at the Intermediate Care Facility (ICF) LOC are limited to one (1) visit per month.
 - Additional visits for the evaluation and management of acute episodes are payable.
 - Written, signed, and dated documentation of all LTC visit(s) must be in the patient's medical record.
- d) Physical Exams are covered without authorization. See the section on physical exams in this chapter.
- e) Detention (also called prolonged physician services) is covered without authorization only in the following situations:
- The physician provides total and continuous active bedside care and there is written, signed, and dated documentation by the physician in the medical record of the specific care provided. To expedite claims processing, time should be indicated on the written documentation. A photocopy of the written documentation must accompany the claim. An E & M service at the appropriate level is also allowed.
 - No more than ½ hour of detention is payable for the pediatrician in attendance at a cesarean section delivery and there must be written, signed, and dated documentation by the physician in the medical record of the pediatrician's attendance. Other services provided by the pediatrician for the newborn may be separately billable. A photocopy of the written documentation must accompany the claim.

- There is no coverage for detention in which there is no face-to-face contact with the patient/family or for physician standby services.
- f) Multiple E & M visits on a single day are generally not covered if performed on the same patient by the same physician regardless of the place of service. Example: If a patient is seen in the physician's office and later admitted to the acute care hospital on the same day, only one visit (either the office visit or the hospital visit) will be paid.
- g) Interpretation of laboratory and other diagnostic studies, tests and measurements are not separately payable, as they are part of the E & M service. Examples: Interpretation of blood chemistry studies, arterial blood gases, glucometer readings and pulse oximeter readings. (See Section 6.12.2.1(h) for interpretations of emergency room.)
- h) Interpretations of twelve (12) lead electrocardiograms (ECGs/EKGs) and rhythm strips performed in the emergency room are payable. If more than one (1) ECG/EKG is performed and interpreted, each subsequent ECG/EKG must be separately identified with the modifier – 76 (repeat procedure by the same physician). Only one interpretation can be paid for the same ECG/EKG. Therefore, the first claim submitted will be paid. All other claims for the interpretation of the same ECG/EKG will be denied or, if paid, recovery will be taken. (See section 6.17.2.1(i) for ECG/EKG interpretations by emergency room physicians.)
- i) Additional payment for services rendered on holidays, weekends, and after 4:30 p.m. are covered without authorization in the following situations:
 - The physician is called to see a patient when he/she is NOT on the physical premises and not scheduled to be present on the premises.
 - If the physician schedules patients on holidays, weekends, and after 4:30 p.m., he/she cannot bill for additional payment.
 - If the physician chooses to see a patient in the office after 4:30 p.m. or if he/she visits a hospitalized patient on holidays, weekends, and after 4:30 p.m., no additional payment is allowed.
 - Payment is not extended for maternal service connected with a delivery.
 - Payment is allowed for only one (1) “after hour” code per patient per day.
- j) Requirements for the provider of service
 - The physician performs the services for which he/she submits a claim. Services provided by an employee or an associate who is not a Medicaid provider **MUST BE SUPERVISED** by

the physician. The supervising physician can bill for the employee/associate only under the following conditions:

- 1) The physician must provide direct supervision of the employee/associate. At a minimum, the physician must be physically in the same building in which the employee/associate is rendering the service, in contact with the employee/associate, and available to take over the care of the patient.
 - 2) The service performed by the employee/associate can only be billed under the CPT-4 code 99211.
- The physician cannot bill for E & M services performed on the same day for the same patient if a bill is submitted for services performed by the employee/associate under that physician's supervision.

6.12.3 Exclusions

Excluded physician services include but may not be limited to the following:

- Counseling and Risk Factor Reduction are considered part of physical examinations and other E & M visits and thus not separately covered.
- Temporary disability examinations for the General Assistance (GA) Program are performed by evaluators specifically contracted for these evaluations and not covered when done by non-contracted evaluators. Therefore, physicians who are not specifically contracted cannot be reimbursed for these examinations.
- Telephone calls, including long-distance calls, are not covered and cannot be billed to the Medicaid Program or to the patient.
- Collection and handling of specimens for laboratory analysis by independent laboratories, not involving venipuncture are considered part of the E & M service and not separately billable. Examples include: cervical swabs for Pap smears, throat swabs for throat cultures, clean catch urine for urine cultures, etc. The only exception is the collection of specimens for cultures performed by the Department of Health (DOH) with NO CHARGE to Medicaid or the patient. A collection and handling charge is allowable only when the provider clearly states on the attachment that the DOH will perform the culture and there will be NO CHARGE to Medicaid or the patient.
- Case management is included in the appropriate, allowed E & M service(s) and not separately reimbursable.

- Treatment of Hansen’s Disease and treatment of pulmonary tuberculosis caused by *Mycobacterium tuberculosis* after confirmed diagnosis of these conditions is not covered.
- Calling in and writing prescriptions for medications and supplies.
- Reviewing and signing plans of care.
- Standby services.

6.12.4 Limitations

As described above.

6.12.5 Authorization

As described above.

6.13 Respiratory Therapy

6.13.1 Description

Respiratory therapy is a Medicaid covered treatment service, provided by a licensed physician or Medicaid facility’s respiratory therapist to restore, maintain or improve respiratory functioning.

6.13.2 Amount, Duration and Scope

- a) Medicaid covers medically necessary respiratory services for all eligible recipients on both an inpatient and outpatient basis. Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation procedures; observing and monitoring signs and symptoms, general behavior and general physical response to respiratory care; diagnostic testing and treatment; and implementing appropriate reporting and referral protocols. Services require a physician’s order and may be administered in a hospital or outpatient setting.
- b) The usage of updraft, nebulizer and oxygen are part of respiratory services and should not be coded as Durable Medical Equipment, but as a respiratory service.

6.13.3 Exclusions

No direct payment is made to respiratory therapists.

6.13.4 Limitations

Payments for respiratory services are made directly to the facilities providing the service.

6.13.5 Authorization

Circadian Respiratory pattern recording requires prior authorization by the DHS medical consultant or agent.

6.14 Sleep Studies

6.14.1 Description

Sleep studies for the diagnosis and treatment of sleep disorders are covered with prior-authorization.

6.14.2 Amount, Duration and Scope

Studies must be ordered by a physician and at least three of the six following criteria must be met:

- History of snoring, syncope, fatigue.
- Restless sleep.
- Oxygen saturation less than 70%.
- Frequent falling asleep during the day.
- Apnea episodes at night verified by an observer.
- Above symptoms must be long-standing, i.e. at least one year duration.

6.14.3 Exclusions

Studies performed in a physician's office or recipient's home are not covered.

6.14.4 Limitations

Services must be provided in a sleep laboratory or sleep disorder center accredited by or in the process of receiving accreditation from the American Sleep Disorders Association or other appropriate national accrediting organization.

6.14.5 Authorization

Must be prior authorized.

6.15 Sterilization

6.15.1 Description

Sterilizations are covered by Medicaid when rendered following strict Federal guidelines.

6.15.2 Amount, Duration and Scope

- a) Every patient, male or female, requesting sterilization must give voluntary, knowing consent through the use of the Sterilization Required Consent Form 1146 (sample in Appendix 6), and acknowledge receipt of the following information at least thirty (30) days prior to sterilization:
- Advice that he/she may withdraw consent before the service is rendered without losing any federally funded program benefits to which he/she is entitled;
 - A description of alternative methods of family planning;
 - Advice that the procedure is considered irreversible;
 - A thorough explanation of the specific procedure to be performed;
 - A full description of the discomforts/risks that may accompany or follow the procedure, including an explanation of the type and possible effects of the anesthetic;
 - A full description of the benefits and advantages of the sterilization;
 - Advice that the sterilization will not be performed until at least thirty (30) days after he/she signs the consent form and not beyond one hundred eighty (180) days; and
 - An offer to answer any inquires concerning the sterilization.
- b) Patient Acknowledgement - Every patient to be sterilized must sign a completed Sterilization Required Consent Form 1146 acknowledging receipt of the required information at least thirty (30) days prior to the service being rendered. The patient must receive a copy of this completed form up to but not including the "Physician's Statement" which is completed after the procedure is performed. This form may not be substituted with any other form to fulfill this Federal requirement.

- c) Interpreters must be provided to insure that the information required in obtaining informed consent is effectively communicated to individuals who are blind, deaf or otherwise handicapped, and to individuals who are not proficient in the English language, to adequately comprehend the consent form or the surgical procedure.
- d) The Sterilization Required Consent Form 1146 must be completed and signed by the patient at least thirty (30) calendar days prior to the procedure being rendered. It is not valid beyond 180 days beyond the date of signature. In the event of premature delivery or emergency abdominal surgery performed less than 30 days from the signed consent, the provider must certify that the procedure was rendered at least 72 hours after informed consent was obtained. The expected date of delivery must be at least 30 days from the date signed by the patient or the circumstances surrounding emergency sterilization must be provided on the Sterilization Required Consent Form 1146.
- e) Medical exclusions to the consent form requirement are:
 - Sterilization due to an ectopic pregnancy resulting in the removal of a single **remaining** fallopian tube is not considered a primary sterilization procedure and the consent form is not required. The diagnosis of ectopic pregnancy must be clearly written on the claim to avoid unnecessary rejection of the claim; or
 - A vasectomy in association with a prostatectomy or other urinary tract surgery to prevent epididymitis is not considered a primary sterilization procedure, and the sterilization consent form is not required.

6.15.3 *Exclusions*

- a) Failure to comply with the regulations will result in non-payment of the sterilization and all related services. The federally mandated Sterilization Required Consent Form 1146 must be completed and signed as outlined in Appendix 3. No substitution for the Sterilization Required Consent Form 1146 will be accepted. A Sterilization Required Consent Form 1146 that has been corrected or modified will be considered invalid and result in a denial of payment for sterilizations.
- b) Ineligible sterilizations include:
 - Sterilizations for patients under 21 years of age;
 - Sterilizations for institutionalized patients;

- Sterilizations for patients judged mentally incompetent to comprehend the elements of the form or the significance to the surgical procedure;
 - Hysterectomies performed solely for the purpose of sterilization.
- c) The instances cited above are not covered by the Medicaid Program and will not be paid.

6.15.4 Limitations

Informed consent may not be obtained while the individual is:

- In labor or childbirth;
- Obtaining or seeking to obtain an abortion. This does not prevent a physician from performing a sterilization and abortion at the same time providing the patient was not known to be pregnant when the consent form was signed; or
- Under the influence of alcohol or other substance that affects the individual's state of awareness.

6.15.5 Authorization

Prior authorization is not required; however, a copy of the completely filled out Sterilization Required Consent Form 1146 must be attached to the claim form in order to obtain payment. If the Sterilization Required Consent Form 1146 is not properly and completely filled out and/or attached to the claim form, payment will be denied.

6.16 Surgery

6.16.1 Description

Surgery/surgical procedures are services rendered by Medicaid providers that include the actual procedure performed local or topical anesthesia, digital blocks, and the normal uncomplicated follow-up care. Most surgical procedures are identified by CPT-4 codes in the range 10000-69999.

6.16.2 Amount, Duration and Scope

6.16.2.1 Follow-up Care

Follow-up care, which is uncomplicated, is defined as follows:

- For diagnostic procedures

- a) Follow-up care includes only the care related to recovery from the diagnostic procedure.
- b) Care of medical conditions (whether associated or not associated with the medical condition for which the diagnostic procedure was performed) is not included in follow-up care.
- For therapeutic procedures
 - a) Follow-up care includes only that care which is usually a part of the surgical service.
 - b) Complications, exacerbations, recurrence, or the presence of other medical conditions are not included in the follow-up care for a specific surgical procedure.
- Follow-up care is generally expressed as follow-up days.
- Follow-up care for multiple surgical procedures.
 - a) If two or more procedures are performed during a surgical session, the follow-up days assigned will be the days associated with the procedure with the longest follow-up period. Example: Surgical follow-up period for procedure A is 90 days, follow-up period for procedure B is 45 days. The follow-up period is 90 days.
 - b) When additional procedures are performed within the follow-up period for a previous procedure, the follow-up days assigned to the additional procedures will be in effect. Example: Follow-up period for procedure A is 45 days, follow-up period for procedure B is 45 days. Procedure B was performed 40 days after procedure A, the follow-up period is 45 days from the date procedure B was performed.
 - c) Follow-up days used by the Medicaid Program are derived from the Medicare Standards for follow-up days.

6.16.2.2 Service

Certain procedures are considered a “service” and not directly reimbursable. These procedures should be billed and reimbursed as evaluation and management (E & M) services. Examples: separate reimbursement under fracture and/or dislocation CPT-4 codes is not extended for reduction of nursemaid’s elbow and all closed treatment of fractures/dislocations without manipulation.

6.16.2.3 Casting and Strapping

Casting and strapping (CPT-4 codes 29000-29590) are not covered for fractures/dislocations reduced with manipulation or when a surgical repair is performed because casting and strapping are included in the payment for the primary procedure. However, casting or strapping (if

performed by the physician) is payable for treatment of fractures/dislocations that are considered a “service” that are included in the E & M service.

6.16.2.4 Unusual Procedures

- a) CPT-4 identifies services rendered to a specific patient that are greater than the work generally required for a specific procedure with the modifier –22.
- b) Claims for all procedure codes submitted with modifier –22 require an operative report.
- c) The operative report is reviewed by a medical consultant who decides whether an additional allowance is extended.

6.16.2.5 Separate Procedures

- a) CPT-4 identifies surgical procedures that are carried out as components of a total service by the term “separate procedure.” The “separate procedure” indication is found in parenthesis following the description of the procedure code.
- b) “Separate procedures” are not reimbursable when reported with other surgical procedures.
- c) When the “separate procedure” is the only procedure performed or when it is unrelated and/or distinct from other covered procedure(s), it can be reimbursed.

6.16.2.6 Starred () Procedures*

- a) CPT-4 identifies starred procedures by a star (*) following the procedure code. Starred (*) procedures generally are minor surgical procedures.
- b) The following coding and reimbursement rules apply to starred procedures:
 - When the starred procedure is performed during a new patient visit and constitutes the major service provided, the E & M code 99025 is coded instead of the initial E & M visit/consultation code. Postoperative care is billable with the appropriate E & M code.
 - When the starred procedure is performed and significant E & M services are needed, the appropriate E & M service should be listed with the modifier –25. Postoperative care is billable with the appropriate E & M code.
 - When the starred procedure is performed during a hospitalization, the appropriate E & M hospital visit/consultation is allowed. Postoperative care is billable with the appropriate E & M code.

6.16.2.7 *Surgical Trays*

- a) Surgical trays include anesthetic agents, irrigating solutions, povidine iodine, syringes, needles, sutures, dressings, drapes, sterile gloves, instruments and equipment (disposable or non-disposable), used in the performance of the surgical procedure. Also, oral/rectal drugs for sedation and pain control during the surgical procedure are not separately billable and considered part of the payment made for surgical trays.
- b) Surgical trays are payable only in conjunction with surgical procedures personally performed in the office setting by Medicaid providers.
- c) Coding for surgical trays

Tray	Coding for the tray	Description
Small tray	A4550 with modifier 52	Suture removal, dressing change
Medium tray	A4550	Surgical procedures valued at less than 10 surgical units or allowance less than \$200.00.
Large tray	A4550 with modifier 22	Surgical procedures valued at more than 10 surgical units or allowance greater than \$200.00

- d) When the provider’s acquisition costs for special supplies used in the office surgical procedure exceed the allowances listed above, the code 99070 with the description of the supplies and the provider’s invoice can be submitted in addition to the surgical tray. Payment for specialized supplies will not exceed the actual cost to the provider.

6.16.2.8 *Co-Surgeons*

- a) Co-surgeons are identified by the modifier –62. Co-surgeons are reimbursed under one or more of the following circumstances:
 - Two surgeons of different surgical specialties are needed to complete the surgery. Both surgeons must be licensed physicians.
 - The surgical procedure requires two surgeons. Both surgeons must be licensed physicians.
 - The surgical procedure is a procedure that cannot be performed by one, independent surgeon or one independent surgeon and an assistant surgeon.
- b) Coding and claims submittal

- When two primary surgeons perform distinct portions of a single procedure, each surgeon should report the work he/she does using the same procedure code with a modifier –62. Additional procedures performed primarily by one surgeon are reported without the modifier. If the second surgeon has assisted in the additional procedures, he/she should use the procedure code with the modifier –80 or –81.
- Claims for all procedure codes submitted with the modifier –62, require an operative report.
- The co-surgeons must decide on the percentage of the total allowance that each will receive. This percentage must be indicated in form locator (FL) block 19 or 21 on the CMS (formerly HCFA) 1500 claim form.

c) Reimbursement:

- For procedures for which co-surgeons are appropriate, the reimbursement for the procedures is 125% of the Medicaid allowable.
- The percentage share of the total allowance, decided upon by the co-surgeons, is honored.

6.16.2.9 Assistant Surgeons

a) Assistant surgeons are identified by the modifiers 80, 81, and 82. Assistant surgeons must be physicians. Assistant surgeons are reimbursed under one or more of the following circumstances:

- The surgical procedure requires two surgeons and one of the surgeons is the primary surgeon.
- The surgical procedure is a procedure that cannot be performed by one independent surgeon without an assistant surgeon.

b) Coding and claims submittal

- Claims for assistant surgeons should be submitted with the same code used by the primary surgeon followed by one of the following modifiers.
 - 1) Modifier –80 is used for assistant surgeons at non-teaching hospitals.
 - 2) Modifier –81 is used for minimum assistant surgeons at non-teaching hospitals.
 - 3) Modifier –82 is used at teaching hospitals when qualified resident surgeons are not available.

- Special requirements for assistant surgeons at teaching hospitals.
 - 1) Assistant surgeons at teaching hospitals are allowed without additional documentation for procedures involving cardio-pulmonary bypass.
 - 2) In all other conditions, the use of an assistant surgeon must be approved by the hospital's appointed chief of the surgical specialty. This documentation must be attached to the claim.

c) Reimbursement

Reimbursement is 15% of the allowance for the primary surgeon.

6.16.2.10 Multiple Procedures

a) Coding and Claims submittal

- When two or more separately identifiable procedures are performed during a single surgical session, the procedure(s) that is/are not the primary code should be followed by the modifier -51.
- It is important for surgeons to review their claims and select the code(s) that best describe the procedures performed. Diagnostic "oscopies" should not be coded separately from the definitive procedure, as the diagnostic "oscopy" is included in the actual procedure performed. Example: laryngoscopy, direct, for aspiration (31515) should not be coded with laryngoscopy, diagnostic (31525).
- On a case by case basis, providers may be asked to provide operative reports when claims are submitted with two (2) or more procedures performed during a single surgical session and/or on the same day.

b) Reimbursement

Valid secondary procedures are reimbursed at 50% of the allowance for the procedure.

6.16.2.11 Bilateral Procedures

a) Coding and Claims submission

- When bilateral procedures are performed during a single surgical session, one side should be identified with the procedure code, the second side should be recorded on another line of the claim form using the same procedure code, followed by the modifier -50. Example:

First line: 69433 Tympanostomy (for right side)

Second line: 69433-50 Tympanostomy (for left side)

- Certain codes, by their description, are bilateral and in these cases, the modifier –50 must not be used.

b) Reimbursement

- The code without the –50 modifier is paid at the full Medicaid allowance.
- The code with the –50 modifier is paid at 50% of the Medicaid allowance.

6.16.3 Exclusions and Limitations

For a comprehensive listing of excluded or limited procedures see Appendix 1 (Services and Items Not Covered by the Hawaii Medicaid Program). The following are surgical procedures specifically excluded from the Medicaid Program:

- Acupuncture.
- Reversal of elective sterilization.
- Cosmetic, reconstructive, or plastic surgery performed primarily:
 - a) To improve or change physical appearance.
 - b) For psychological purposes.
 - c) As a result of the aging process.
 - d) Restore form but not correct or improve bodily function except when the procedure does the following:
 - 1) Correct a congenital anomaly.
 - 2) Restore body form following an accidental injury.
 - 3) Revise disfigurement or extensive scars resulting from neoplastic surgery or after an accident.
- Sex transformation treatments, procedures, and hormones.
- Paniclectomies and other body sculpturing procedures.

- Removal of tattoos.
- Hair transplants.
- Electrolysis.
- Insertion of testicular prosthesis, unilateral or bilateral.
- Jejunio-ileal bypass procedures for morbid obesity.
- Ear piercing.
- In vitro fertilization procedures.

6.16.4 Authorization

Authorization is required for certain surgical procedures. Please refer to Appendix 1 for a listing of types of procedures that require authorization. Procedures that require authorization include but are not limited to the following:

- Removal of benign skin lesions. Skin lesions that can be removed without prior authorization for medical necessity include but are not limited to chemocautery, removal of milia, miliaria molluscum contagiosum, palmar, plantar and venereal warts and hemangiomas, liquid nitrogen application to warts, lesions and milia.
- Surgical procedures that may be done for primarily cosmetic purposes (examples: rhinoplasty, septoplasty, blepharoplasty, mammoplasty, ventral/epigastric/umbilical herniorrhaphy, repair of strabismus, repair of pectus excavatum).
- Certain elective procedures (example: circumcision in males over one year of age, gastroplasty for morbid obesity).
- Certain surgical procedures associated with a diagnostic or therapeutic service that requires authorization (examples: implantation of a vagal nerve stimulator, implantation of a spinal nerve stimulator, placement of “halo” prior to proton beam therapy).