



Medicaid

Provider Bulletin

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Bringing Quality Healthcare to
Hawaii Medicaid Recipients

Evaluation and Management (E/M) Code Documentation Requirements

The following Evaluation and Management and Medicine CPT codes require that supporting documentation (e.g., progress note) be submitted with the claim unless the provider has been otherwise specifically instructed:

Code Number	Code Description
93701	Bioimpedance, Thoracic, Electrical
92950	Cardiopulmonary Resuscitation
99291 to 99296	Critical Care Service
99321 to 99333	Domiciliary, Rest Home (e.g. Boarding Home) or Custodial Care Services
99341 to 99350	Home Services
99354 to 99359	Prolonged Services

Note: A progress note justifying the use of the test is required for bioimpedance (93701). A printout of the parameters tested alone is not sufficient.

For more information, please call the Provider Inquiry Call Center at :
Oahu: 952-5570 or Neighbor Islands: 1-800-235-4378. ■

Multiple Emergency Department Visits on the Same Day

If a recipient is seen in the same emergency department on the same date of service for essentially the same problem(s) or diagnosis(es) by the same physician or by another physician, only one Emergency Department Service (99281 to 99285) charge will be reimbursed. The two visits should be treated as one and level of service coded accordingly.

If the recipient is seen in the same emergency department on the same date of service for two completely different problems/diagnoses, two charges may be reimbursed. Supporting documentation should be submitted with the claim. ■

IN THIS EDITION

E/M Code Documentation Requirements	1
Multiple Emergency Department Visits on the Same Day	1
Pass it On	1
Visits to Patients at Acute Waitlisted Levels of Care	2
Web Reminder	2
Anesthesia Claims with Time Over Ten Hours	2
Ventilation Assist and Management	2
Important Contact Information	2
Power and Specialized Manual Wheelchair Evaluations	3
Specialized and Custom Manual Wheelchairs	4
Hospital Beds	4
Durable Medical Equipment Serial Numbers	4

Pass It On!

Everyone needs to know the latest about Medicaid information. Be sure to route this to:

- Office Manager
- Billing Department
- Medical/Clinical Professionals
- Other Support Staff

Visits to Patients at Acute Waitlisted Levels of Care

The following was initially sent to Medicaid physician providers in the form of a memorandum on October 30, 2001 and is now being re-printed as a reminder:

Patients at the acute waitlisted subacute, SNF and ICF levels of care are those patients in acute care beds, but not at the acute level of care. Visits made by attending physicians and consultants to patients at acute waitlisted 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 level of care will not be covered. Frequent routine visits made to stable ventilator-dependent patients for ventilation assist and management (CPT code 94657) will also 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 record and a copy of the documentation must be submitted with the claim.
- Claims are submitted with place of service hospital (21) and CPT codes for inpatient services. Place of service skilled nursing facility (31) and nursing facility (32) 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 reflect the level of complexity of the services rendered.

For more information, please call the Provider Inquiry Call Center at : Oahu: 952-5570 or Neighbor Islands: 1-800-235-4378. ■

Anesthesia Claims with Time Over Ten Hours

The anesthesia record should be submitted when anesthesia time is in excess of ten hours (600 minutes). ■

Ventilation Assist and Management (94657)

A patient's need for mechanical ventilation alone does not justify the use of CPT code 94657. This code should be used when there is active assessment and management of mechanical ventilation; e.g., adjustment of ventilator settings. It should not be used when a patient's respiratory status and ventilator settings are stable. ■

Important Contact Information

Provider Inquiry Call Center
Oahu: 952-5570
Neighbor Islands: 1-800-235-4378

Eligibility Line (AVRS)
1-800-882-4608

Email Provider Inquiries to:
hi.providerrelations@acs-inc.com

Fax Provider Inquiries to:
(808) 952-5595

Fax Urgent Prior Authorization Requests to:
(808) 952-5562
(Not applicable to Medicaid Waiver Program)

Questions about HIPAA Transactions and Code Sets? Contact us at: hipaatcs@medicaid.dhs.state.hi.us

Mail Prior Authorization Requests to
(Not applicable to Medicaid Waiver Program):
ACS
P.O. Box 2561
Honolulu, HI 96804-2561

Mail Returned Checks to:
ACS
P.O. Box 1206
Honolulu, HI 96807-1220

We're on the web!
<http://www.MED-QUEST.US/>

Power and Specialized Manual Wheelchair Evaluations

In order to expedite the processing of a prior authorization request for a wheelchair or power operated vehicle (POV), the Med-QUEST Division (MQD) has developed a list of specific information that must be included in the evaluation of a Medicaid recipient's medical need for a POV, power or specialized wheelchair. The required information is listed below:

General Requirements for all Power and Specialized Manual Wheelchairs

- The recipient's current level of ambulation including the distance the recipient is able to ambulate and the type of adaptive equipment being used.
- The recipient will be independent in mobility with the use of the wheelchair or POV being requested.
- If the recipient currently has a manual wheelchair, documentation of the type of wheelchair the recipient currently is using, the age of the wheelchair, and why it is no longer appropriate is required.
- Signature of the requesting physician attesting that the evaluation was reviewed and that he/she concurs with the stated information and recommendations.
- The MQD is currently seeking providers to perform home assessments for POVs, power wheelchairs and other custom wheelchairs. Until providers are identified that are capable of providing these assessments, the wheelchair evaluator (if he/she does not conduct a home visit) must indicate in the evaluation that a review of measurements of widths of doorways and sizes of specific rooms provided by the recipient or caregiver was completed and that the wheelchair or POV can access these rooms and that sufficient turn around space exists.
- The recipient requires a power wheelchair, POV, specialized or custom wheelchair to access different rooms in his/her place of residence; i.e., that the recipient would be room-confined without the use of the wheelchair.

MQD is currently seeking providers to perform home assessments for POVs, power wheelchairs and other custom wheelchairs.



- In general, a wheelchair that is for community use only will not be considered to be medically necessary.
- The home is accessible by the wheelchair or POV being requested. In addition to the entry being accessible, the wheelchair or POV should be able to access the areas of the house that the recipient needs to access; e.g., bathroom. Preferably, the wheelchair evaluator should conduct a home visit with the recipient and wheelchair or POV being requested.
 - If specialized wheelchair options and/or accessories are required, the evaluation should state what is needed and provide justification as to why the options and/or accessories are necessary for the recipient to function in the home or to perform activities of daily living. If an option and/or accessory must be obtained from a manufacturer other than the manufacturer of the wheelchair base, justification as to why it must be obtained from a different manufacturer should be provided.
- In general only one wheelchair will be allowed. If the recipient has a wheelchair that is appropriate for his/her needs that was purchased with or without Medicaid funds, the MQD will deny a second wheelchair as not being medically necessary.
- All wheelchair evaluations must be performed by therapists working within their scope of practice and licensed in the State of Hawaii.

Continued on Page 4

Continued from Page 3

Power Wheelchairs And Power Operated Vehicles

- The recipient is not currently able to propel a manual wheelchair including a hemi-wheelchair or lightweight or ultra lightweight wheelchair with/without modifications.
- The MQD will not approve a power wheelchair or POV to prevent future injury to the recipient; e.g., injury to wrists and shoulders. The need for a power wheelchair should be based on what the recipient is capable of doing at the time of the evaluation.
- If a specific brand of power wheelchair or POV is recommended, the evaluator must provide justification for the recommendation.
- Documentation should include why the recipient is not able to use a POV, i.e., scooter (if the reason is not clearly evident).

Specialized and Custom Manual Wheelchairs

A prior authorization request for a specialized or custom manual wheelchair should include an evaluation with the following information:

- The recipient is not currently able to propel a standard manual wheelchair (if a lightweight or ultralightweight wheelchair is being requested).
- If the recipient will still require a full-time caregiver and/or will not be independent in mobility, the specialized wheelchair will not be considered to be medically necessary. The exception to this requirement is the specialized wheelchair that is used primarily to accommodate the special seating needs of the recipient.
- The expectation is that the patient was tested for his/her ability to use the category of wheelchair being requested. For example, if an ultralightweight wheelchair is being requested, then the evaluation should include the recipient's effective and safe use of an ultralightweight and not just a lightweight wheelchair. If the recommendation is for a different category from that in which the patient was tested, this should be clearly stated and reasons must be given as to why testing on the requested category of wheelchair was not carried out.



- A full wheelchair evaluation by a therapist is not needed for lightweight, heavy duty and extra heavy-duty wheelchairs. However, documentation indicating that the recipient is unable to propel a standard manual wheelchair is required for a lightweight wheelchair. Documentation of the recipient's weight is needed for a heavy-duty or extra heavy-duty wheelchair.■

HOSPITAL BEDS

In keeping in line with Medicare, the Med-QUEST Division will no longer be covering total electric beds, HCPCS codes E0265, E0266, E0296 and E0297. Medicare considers the electric height adjustment feature to be a convenience feature. Semi-electric beds with manual height adjustment and electric head and leg elevation adjustments are covered when medically necessary.■

Durable Medical Equipment Serial Numbers

If you have received a pend for "send Prod serial number for final app.", you must send that product serial number to ACS-Prior Authorization in addition to putting it on the claim. For custom items, such as wheelchairs, we are aware that you do not have a serial number until the item actually arrives. As soon as you unpack it, please send that serial number to ACS-Prior Authorization.■

Hawaii Medicaid

Look inside for these and other important updates:

- Page 1** Evaluation and Management (E/M) Codes, Multiple Emergency Visits on Same Day
- Page 2** Visits at Acute Waitlisted Levels of Care, Anesthesia Claims, Ventilation Assist
- Page 3** Power and Specialized Wheelchair Evaluations
- Page 4** Specialized and Custom Manual Wheelchairs, Hospital Beds, DME Serial Numbers

