




**DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE
DELAWARE MEDICAL ASSISTANCE PROGRAM
OUTPATIENT HOSPITAL PROVIDER SPECIFIC POLICY
MANUAL**

 <p>DELAWARE HEALTH AND SOCIAL SERVICES</p> <p>DIVISION OF MEDICAID & MEDICAL ASSISTANCE</p> <p><i>Delaware Medical Assistance Program</i></p>	<p>Outpatient Hospital Provider Specific Policy Manual</p> <p>Revision Table</p>
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Revision Date	Sections Revised	Description
10/14/03	3.11.4	This update provides outpatient hospitals with information regarding the billing of PET Scans.
11/21/05	5.2.1	Updated to reflect 4-digit revenue codes.
11/21/05	7.0	Removed Appendix A – Map 25. This form is provided by DMMA at the time of application. Renamed section Reserved.
09/18/08	Overview	Removed obsolete numbering.
03/11/09	5.3.2	Update to the policy which reflects the change in form numbers from UB92 (old form number) to UB04 (new form number).
9/21/09	5.4 and Appendix K	Effective 10/1/2009 (regardless of date of service) Outpatient hospitals are required to submit claims for drugs that are listed in Appendix K – <i>Medicaid Top 20 Physician-Administered Multiple Source Drugs</i> .
3/25/10	Appendix K	Updated the Medicaid Top 20 Physician-Administered Multiple Source Drugs
7/12/10	3.11.5 through 3.11.5.2.4	Addition of section regarding prior authorization for PET scans and computed tomographic colonography
7/12/10	3.12 through 3.12.2.2	Addition of section regarding Sleep Testing
7/12/10	Appendix E	Addition of form 50-36 Positron Emission Tomography (PET) Scans
1/12/11	Appendix K	Updated the Medicaid Top 20 Physician-Administered Multiple Source Drugs
9/9/11	3.2	Effective May 6, 2011, it is no longer necessary to submit prior notification to DMMA regarding outpatient facility and anesthesia charges for dental procedures under age 21 for codes 41899 and 00170.
1/9/12	3.2	Guidance regarding dental services provided in an outpatient setting.
2/7/12	3.2	Changed dental service section to reflect proper claim fields for billing accuracy.
02/21/2020	All	In compliance with the registered trademark of the American Medical Association added the ® symbol to each instance of CPT®.

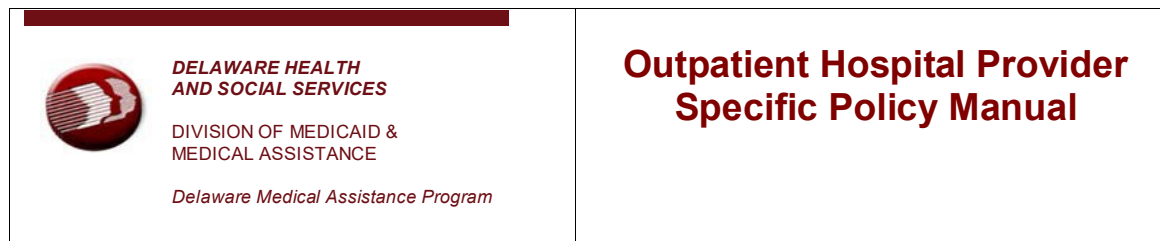


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Outpatient Hospital Provider Specific Policy Manual

Outpatient services are provided to the majority of Medicaid members through a Managed Care Organization (MCO). Outpatient services are included in the MCO benefits package. All Medicaid members who are enrolled with an MCO must receive outpatient services through the MCO.

This manual reflects the policies as they relate to Medicaid members who are exempt from managed care coverage (see list of those exempt from managed care coverage in the Managed Care section of the General Policy).

This manual is to be used in conjunction with the [General Policy Manual](#) and the [General Billing Manual](#) which are located on the [Delaware Medical Assistance Portal](#) for providers.

1.0 Overview

1.1 General Information

- 1.1.1 This manual contains information specifically applicable to outpatient hospital services.
- 1.1.2 An outpatient hospital, for the purpose of this policy manual, is defined as an institution which provides preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients in an institution licensed or formally approved as a hospital by an officially designated authority for state standard setting.
- 1.1.3 Except for requirements relating to medical supervision of nurse-midwives, the institution must meet requirements for participation in Medicare and Medicaid as a hospital and services must be furnished under the direction of a physician or a dentist.
- 1.1.4 A practitioner, for the purpose of this policy manual, is defined as a duly licensed Doctor of Medicine, Doctor of Dental Surgery, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, or Certified Nurse Midwife. Practitioner services whether furnished in the office, the member's home, a hospital or other outpatient facility, a skilled or intermediate nursing facility, clinic or elsewhere, are defined as services provided:
 - 1.1.4.1 Within the scope of practice as defined by state law
 - 1.1.4.2 By or under the personal supervision of an individual licensed under state law to practice medicine.
- 1.1.5 A "hospital outpatient" or "day patient" is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records an outpatient and receives services (rather than supplies alone) from the hospital. An inpatient of a hospital cannot be considered an outpatient of that or any other hospital.

However, an inpatient of a nursing facility may be considered an outpatient of a hospital.

- 1.1.6 Hospitals provide two distinct types of services to outpatients, namely, therapeutic services and diagnostic services.
 - 1.1.6.1 Therapeutic services provided by a hospital on an outpatient basis are those services and supplies (including the use of hospital facilities) that are incident to the services of physicians in the treatment of patients. Therapeutic services also include clinic services and emergency room services. Drugs and biologicals are covered if they are of the type that cannot be self-administered. Biologicals are defined as medicinal preparations made from living organisms and their products, including serums, vaccines, etc.
 - 1.1.6.1.1 To be covered as incident to physician's services, the services and supplies must be furnished as an integral, although incidental, part of the physician's professional service in the course of diagnosis or treatment of an illness or injury. The services and supplies must be furnished on a physician's order by hospital personnel and under the physician's supervision. This does not mean that each occasion of service by a non-physician need also be the occasion of the actual rendition of a personal professional service by the physician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen. An outpatient hospital service or supply would not be considered incident to a physician's service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of the course of treatment.
 - 1.1.6.2 Diagnostic services furnished to an outpatient by a hospital or by others under arrangements made by a hospital in facilities supervised by the hospital or its organized medical staff are covered when such services are ordinarily furnished by the hospital to its outpatients for the purpose of diagnostic study. A service may be regarded as "diagnostic" if it is an examination or procedure to which the patient is subjected or which is performed on materials derived from the patient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic X-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury.
 - 1.1.6.2.1 Covered diagnostic services to outpatients include the services of nurses, psychologists, and technicians, drugs and biologicals necessary for diagnostic study, and the use of supplies and equipment.

2.0 Programmatic Responsibilities

2.1 Outpatient Hospital Providers

- 2.1.1 All providers have the ethical and programmatic responsibility to direct members to the most appropriate, medically necessary, and cost-efficient care possible.
- 2.1.2 Practitioners should be aware of their responsibility when signing or completing an order or prescription for any service covered by the Delaware Medical Assistance Program (DMAP) on behalf of a Medicaid member. The decision to allow or deny some necessary services is based on the practitioner's assessment of the patient's condition. If the practitioner misrepresents or falsifies the essential information upon which federal/state funds is based, (s)he may, upon conviction, be subject to a fine and imprisonment under federal/state laws. In order to avoid potential prosecution, the practitioner must clearly and accurately represent his/her clinical assessment of the patient's condition and the functional status (s)he is using in prescribing the necessary services.
- 2.1.3 It is important that practitioners not refer patients to the emergency room(s) for routine matters. Practitioners should consider referrals to the outpatient emergency room(s) only when a potential life-threatening situation exists. "Practitioner-induced (outpatient) emergency room abuse" causes the cost of medical care to increase and adds an undue burden on everyone supporting and associated with the Medicaid Program.

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3.0 Outpatient Hospital Services

3.1 Observation Services

- 3.1.1 The DMAP covers outpatient observation services in acute care settings. Outpatient observation services must be physician-ordered services, provided by a facility which are reasonable and necessary to evaluate an outpatient's condition or determine the medical necessity of an inpatient admission.
- 3.1.2 Observation services are those hospital services furnished on a hospital's premises and are not required to be provided in the actual outpatient area or on a designated unit. The observation services can be provided in any area of the facility with periodic monitoring by the hospital staff.
- 3.1.3 Observation services are implemented for an anticipated short length of stay and must not exceed 48 continuous hours. The physician must indicate in the order that the patient should be moved to an observation bed or service. The patient is still considered an outpatient. The provider should clearly document the time at which the patient is admitted as an outpatient in observation status.
- 3.1.4 The following types of services are not covered as observation services:
- 3.1.4.1 Services that are not reasonable and necessary for the diagnosis of the patient
 - 3.1.4.2 Services provided for the convenience of the patient or provider
 - 3.1.4.3 Services that are not physician ordered
- 3.1.5 For patients who are admitted as an inpatient from observation services, all outpatient services rendered by the admitting facility prior to the admission are included in the inpatient discharge payment and may not be billed separately as an outpatient claim.

3.2 Dental Services

- 3.2.1 When medically necessary, eligible Medicaid members may receive dental services from an outpatient hospital emergency department or outpatient hospital clinic. The DMAP cannot pay for dental services provided in an Ambulatory Surgical Center.
- 3.2.1.1 The DMAP does not require facility prior authorization for dental services performed in an outpatient hospital emergency department or outpatient hospital clinic but must meet the DMAP's guidelines for medical necessity. These guidelines are located in the [General Provider Policy Manual](#) section 13.0 Appendix H.

- 3.2.2 Dental services are limited to members under age 21 years. Procedures that are purely dental in nature are not covered by the DMAP for members age 21 years and over in any setting.
- 3.2.3 Managed care organizations (MCOs) are responsible for all costs associated with the removal of bony impacted wisdom teeth. Follow the proper prior authorization procedures for the specific MCO.
- 3.2.4 When billing for anesthesia and facility costs, procedure code 41899 needs to be entered as a surgical procedure code at the detail level of the claim, (field 44 of the UB04 Form or loop 2300, Segment HI01-1 (qualifier) and HI01-2 (procedure code) for electronic billing)

3.3 Oral Surgery

- 3.3.1 Oral surgery is defined as surgery and services related to the surgery of the maxillo-facial area (jawbone). Oral surgery that is medical in nature is covered by the DMAP.

3.4 Laboratory Services

- 3.4.1 The Clinical Laboratory Amendments of 1988 (CLIA) were enacted by the U.S. Congress to improve the quality and reliability of clinical laboratory testing. CLIA applies to any provider who performs any laboratory test used for health purposes, no matter how simple or routine.
- 3.4.2 The DMAP reimburses enrolled providers for properly ordered, medically necessary, non-experimental/non-investigational, CLIA-certified laboratory services when properly performed, documented, and billed.
- 3.4.3 All tests performed by an outpatient hospital facility laboratory must be documented by a written order from the ordering practitioner. The signing of the practitioner's name by another individual or the use of facsimiles is not acceptable. Any telephone order for laboratory testing must be supported by a signed order from the practitioner.
- 3.4.4 An outpatient hospital facility laboratory may bill for those divisions of services for which they have been certified by CLIA. An outpatient hospital facility laboratory may use a reference laboratory that is CLIA- certified to perform a test for which the outpatient hospital facility lab is not certified.
- 3.4.5 Providers are never to redefine HCPCS procedure codes to meet the needs of their individual outpatient hospital facility laboratory.

- 3.4.6 Providers are reminded to choose their HCPCS procedure codes carefully. Do not use multiple procedure codes when a single procedure code accurately describes the services rendered.
- 3.4.7 The level of service billed must correspond to the definition of that particular code rather than the expected reimbursement amount. The documentation required to support the level of service billed must also be maintained by the provider.
- 3.4.8 Even though the DMAP uses HCPCS procedure codes as its instrument in facilitating payment to providers, this does not mean that all HCPCS procedure codes are covered by DMAP.
- 3.4.9 CLIA Certificate of Waiver Tests
- 3.4.9.1 Clinical diagnostic laboratory tests considered to be CLIA Certificate of Waiver tests are listed on the CLIA web site at <https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index>. These are the only procedure codes that may be billed to the DMAP by a provider who holds a CLIA Certificate of Waiver.
- NOTE: The DMAP does not cover any services relating solely to the treatment of infertility.
- 3.4.9.2 If there are specific product names and manufacturers listed, a provider who holds a CLIA Certificate of Waiver may only bill if the test is done using one of those specified. The modifier “QW” defined as “CLIA waived test” must be added to the procedure code when billing the DMAP for a waived test, using the specific product and manufacturer as listed.
- 3.4.10 CLIA Certificate for Provider-performed Microscopy Procedures (PPMP)
- 3.4.10.1 Clinical diagnostic laboratory tests considered CLIA provider-performed microscopy procedures are listed in Appendix H. A provider who holds a CLIA Certificate for Provider-performed Microscopy may bill the DMAP for these tests in addition to the Certificate of Waiver tests.
- NOTE: The DMAP does not cover any services relating solely to the treatment of infertility.
- NOTE: The DMAP considers some provider-performed microscopy procedures to be part of the physician evaluation and management service. Therefore, they are not separately reimbursable by DMAP (refer to Appendix H for specific tests).
- 3.4.11 CLIA Certificate of Registration Tests
- A provider who holds a CLIA Certificate of Registration may bill the DMAP for any clinical diagnostic laboratory test for which they have received CLIA certification.
- 3.4.12 Specific Billing Instructions

3.4.12.1 Refer to Appendix I for specific billing instructions for:

- Multiple Units of Service
- Pregnancy Tests
- Organ or Disease Oriented Panels
- Drug Testing
- Therapeutic Drug Assays
- Urinalysis
- Chemistry and Toxicology
- Hematology
- Immunology
- Microbiology

3.5 Voluntary Sterilization

3.5.1 The DMAP shall reimburse for a voluntary sterilization for both males and females. The DMAP shall reimburse the outpatient hospital for a voluntary sterilization if the criteria set by federal and state regulations are met. When a voluntary or elective sterilization is performed, the hospital *is required* to attach the DMAP's standardized Consent Form to the UB04 claim form. It is the responsibility of the hospital to secure a properly executed Consent Form from the operating surgeon. The DMAP does NOT cross-reference claims. Refer to Appendix B for a copy of the Consent Form.

3.6 Hysterectomies

3.6.1 The DMAP shall reimburse outpatient hospitals for medically necessary hysterectomies if the criteria set by federal and state regulations are met.

3.6.2 It is the responsibility of the hospital to secure a properly executed Awareness Form from the operating surgeon when a medically necessary hysterectomy procedure may result in sterilization.

3.6.3 The hospital *is required* to attach an Awareness Form to the UB04 claim form. The DMAP does NOT cross-reference claims. Refer to Appendix C for a copy of the Awareness Form.

3.7 Unilateral/Bilateral Sterilization Procedure Codes

- 3.7.1 Certain HCPCS procedure codes may describe a procedure which is performed for the purpose of voluntary sterilization or may describe a medically necessary procedure which may or may not result in sterilization. Claims for these procedures must be accompanied by either an Awareness or Consent Form depending on the exact nature of the surgery. A unilateral procedure requires an Awareness Form while a bilateral procedure requires a Consent Form. It is the responsibility of the hospital to secure a properly executed Consent or Awareness Form from the operating surgeon and attach the appropriate to the UB04. The DMAP does NOT cross-reference claims.

3.8 Sterilization of the Mentally Challenged

- 3.8.1 In accordance with 42CFR Subsection 441, Subpart F-Sterilization and the Delaware Budget Epilogue, Section 121(a)(ii), the DMAP does not reimburse for the sterilization of the mentally challenged.
- 3.8.2 Although the DMAP does not cover the sterilization of the mentally challenged, the appropriate parties may obtain this service through another source by petitioning the Court of Chancery in the county in which the person to be sterilized resides or in which the institution in which (s)he resides is located.

3.9 Abortions

- 3.9.1 Endangerment to Mother's Life
- 3.9.1.1 Federal regulation permits the DMAP to reimburse for abortions if the "life of the mother would be endangered by the pregnancy".
- 3.9.1.2 Effective November 13, 1997 Federal law enacted new Hyde Amendment requirements for federally-funded abortions. One of those requirements is that, in order for Medicaid to reimburse for an abortion, a physician must certify that a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.
- 3.9.1.3 The outpatient hospital facility must obtain an Abortion Justification Form from the attending physician that will detail the Hyde Amendment requirement (see Appendix J for a copy of the Abortion Justification Form).
- 3.9.1.4 In addition, to the Abortion Justification Form the outpatient hospital facility must attach the complete medical record to the UB04 claim form. The outpatient hospital facility shall obtain a copy of medical records from the attending practitioner.
- 3.9.2 Rape or Incest

- 3.9.2.1 Effective December 31, 1993, in compliance with the Hyde Amendment provision, the DMAP may reimburse for abortions to terminate pregnancies resulting from an act of rape or incest.
- 3.9.2.2 The outpatient hospital facility must submit a letter from the attending practitioner documenting that the request for the abortion was due to rape or incest and provide written documentation that the incident was reported to the police. In cases of incest where the victim is under 18 years of age, the incident must also have been reported to the Department of Services for Children, Youth and their Families.
- 3.9.2.3 If an adult has just cause for not reporting a rape to the police, the practitioner must document the reason in writing. The DMAP will consider coverage on a case-by-case basis.
- 3.9.2.4 When an outpatient hospital facility performs an abortion procedure, the following documents must be attached to the UB04 claim form:
- 3.9.2.4.1 A practitioner's letter that documents the abortion was due to rape or incest
 - 3.9.2.4.2 Documentation that certifies the rape or incest was reported to the appropriate authorities
 - 3.9.2.4.3 A practitioner's letter that documents the reason for not reporting a case of rape or incest in an adult situation.

3.10 Emergency Department

- 3.10.1 An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The emergency department must be available twenty-four (24) hours per day.
- 3.10.2 Emergency department services must be furnished under the direction of a practitioner, within the scope of practice of medicine or osteopathy as defined by state law.
- 3.10.3 The hospital-based facility may employ emergency room staff and include practitioner services under the facility provider number or the facility may contract with a physician/physician group to staff the emergency department. Practitioners who are employed by the facility are not required to be enrolled separately with the DMAP. Practitioners who deliver services and are paid fee-for-service must be enrolled with the DMAP.

3.11 Radiology

- 3.11.1 Radiology includes diagnostic radiology, diagnostic ultrasound, nuclear medicine, and radiation oncology.
- 3.11.2 Radiology services can be divided into two components - professional and technical. The professional component is the interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures. The technical component is the facility service needed to produce the x-ray film or other items that are interpreted by the radiologist. Providers can do either the professional or the technical component, or they can do both the professional and the technical components.
- 3.11.3 Radiology services are limited to those that are medically necessary and that are ordered by a physician.
- 3.11.4 PET Scans are covered when prior authorized by the DMAP Medical Management Unit.
 - 3.11.4.1 It is the responsibility of the referring practitioner to request prior authorization for the PET Scan.
 - 3.11.4.2 Before billing the DMAP for a PET Scan the facility must contact DXC Technology to inquire whether the service has been prior authorized. The facility may only bill if prior authorization has been requested and approved.
- 3.11.5 Prior authorization
 - 3.11.5.1 Positron Emission Tomography (PET) Scans
 - 3.11.5.1.1 All PET scans require prior authorization
 - 3.11.5.1.2 PET scans will be provided in accordance with Section 50-36 of the Medicare Coverage Issues Manual. Refer to Appendix E of this manual for Section 50-36 of the Medicare Coverage Issue Manual.
 - 3.11.5.1.3 Prior authorization must be requested by the referring physician and must include:
 - 3.11.5.1.4 Results of previous tests (Pathology/biopsy reports, CT scan, MRI, Ultrasound, X-ray, previous stress tests, etc.)
 - 3.11.5.1.5 Detailed medical history that documents the need for PET scan
 - 3.11.5.2 Computed Tomographic Colonography
 - 3.11.5.2.1 The DMAP may cover computed tomographic colonography in the following instances:
 - 3.11.5.2.2 For colonic evaluation of symptomatic patients with a known colonic obstruction
 - 3.11.5.2.3 For patients with an incomplete colonoscopy due to obstructive or stenosing colonic lesions
 - 3.11.5.2.4 For patients who are receiving chronic anticoagulation therapy that cannot be interrupted

3.12 Sleep Testing

- 3.12.1 The DMAP may cover Sleep Studies/Polysomnography for evaluation of sleep-related disorders.
- 3.12.2 Detailed medical history that documents the need for a Sleep Study/Polysomnography must be included with the prior authorization request.
 - 3.12.2.1 The detailed medical history must include but is not limited to: patient's complaints and symptoms, and the physician's findings.
 - 3.12.2.2 Requests for polysomnography with initiation of continuous positive airway pressure therapy or bi-level ventilation must be submitted with the results of the original study.

4.0 Reserved

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5.0 Billing

5.1 General Information

- 5.1.1 Services, which are rendered during the same visit, must appear on the same claim. All ancillary services associated with the visit must be on the same claim form. Example #1: A DMAP member comes to the emergency room and receives medication and an MRI. The same claim must contain all appropriate revenue codes and HCPCS for the emergency room, drugs, and radiology. Example #2: A DMAP member comes to the clinic and receives an injection. Both the visit and the injection must be on the same claim form. Otherwise, it may appear that the provider is duplicate billing for the same services.

5.2 Revenue Center and Diagnosis Codes

- 5.2.1 Providers of outpatient hospital services are required to use the UB04 or 837 Institutional billing form and to indicate revenue and ICD-10-diagnosis codes for charges. A revenue code is a four-digit code that identifies the service provided for the member. An ICD-10 diagnosis code is a common classification of a disease and related entities. It is used to describe the clinical picture of the patient. Both the revenue and ICD-10 diagnosis codes must be used accurately to describe the services provided and the diagnosis of the patient. All such codes are critical to receiving correct payment. Valid revenue codes can be found in the National Uniform Billing Data Element Specifications Manual developed by the National Uniform Billing Committee.

5.3 HCPCS Procedure Codes

- 5.3.1 The DMAP uses HCPCS procedure codes as its listing of descriptive terms and identifying codes for reporting medical services and procedures performed by providers. The purpose of the terminology is to provide a uniform language that will accurately designate medical, surgical, and diagnostic services. Refer to the General Policy for further information regarding HCPCS procedure codes.
- 5.3.2 Outpatient hospitals must use HCPCS procedure codes when billing the DMAP for laboratory, radiology, surgical and co-pay services. When billing the DMAP for laboratory/radiology procedures, the appropriate HCPCS code must appear in form locator 44 of the UB04 claim or in Loop 2400 (Service Line Number) of the 837 Institutional claim. When billing the DMAP for surgical procedures, the appropriate surgical HCPCS code(s) must appear in form locator 74 of the UB04 claim or in Loop 2300 (Other Procedure Information) of the 837 Institutional claim. Additionally, outpatient hospitals must use HCPCS procedure codes if the revenue code used is listed in the Billing Instructions of this manual.

5.4 Coding Requirements for Pharmacy Services

- 5.4.1 Outpatient hospitals must include an appropriate HCPCS procedure code and NDC when billing for services submitted with a revenue code in the 063X series.
- 5.4.1.1 Claims for drugs listed in Appendix K – Medicaid Top 20 Physician-Administered Multiple Source Drugs must be submitted using a revenue code from the 063X series along with the appropriate J-code and NDC.
- 5.4.2 Outpatient hospitals are not required to include a HCPCS code or NDC on claims billed with revenue codes in the 025X series.

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6.0 Reimbursement

An acute care outpatient hospital facility is reimbursed as follows:

6.1 Visits Services

Visit services are reimbursed using a prospective flat rate. Visit services include emergency room (emergency and non-emergency) visits, clinic visits and delivery/labor room (where appropriate).

6.1.1 Payment for drugs and supplies when used in conjunction with these services are included in the flat rate payment.

6.1.2 Each type of visit service is defined by a set of outpatient revenue codes. In addition, emergency room services must be associated with an ICD-10 diagnosis code. If the diagnosis code indicates a “true emergency”, the visit is paid at an emergency rate. If the diagnosis code does not indicate an emergency the visit is reimbursed at the non-emergency rate.

6.2 Stand-Alone Services

Stand-alone services encompass all other services provided (e.g., operating room, therapies, etc.) in the outpatient setting that cannot be grouped into a visit category. A stand-alone service is identified by a revenue code or a CPT® code.

6.2.1 The outpatient hospital facility is required to use the most appropriate revenue code for their facility for the services rendered.

6.2.2 Services such as radiology and laboratory are paid using a fee schedule.

6.3 Out-of-State Outpatient Hospital Facilities

Out-of-state outpatient hospital facilities are reimbursed based upon rates paid to a similar in-State facility.

6.3.1 The established rates and methodology for outpatient hospital facility reimbursement shall be reviewed annually by the DMAP and adjusted, as necessary.

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7.0 Reserved

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8.0 Appendix B - Consent Form

DELAWARE MEDICAL ASSISTANCE PROGRAM CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

_____. When I first asked for the information, I
(Doctor or Clinic)
was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT AND NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
I, _____, hereby consent of my own free will to be sterilized by _____
(Doctor)

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature _____ Date: _____
Month Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (Please Check)

- American Indian or Black (not of Hispanic origin)
 Alaska Native Hispanic
 Asian or Pacific Islander White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter _____ Date _____

DOC. NO. 35-07-01-89-08-02-ES-14

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the consent form,

I explained to him/her the nature of the sterilization operation

_____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal Funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of Person Obtaining Consent _____ Date _____

Facility _____

Address _____

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ on _____
Name of Individual to be Sterilized Date of Sterilization Operation

I explained to him/her the nature of the sterilization operation

_____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
 Individual's expected date of delivery:
 Emergency abdominal surgery:
(describe circumstances):

Physician _____ Date _____

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9.0 Appendix C - Awareness Form

441.255 Sterilization by hysterectomy

(a) FFP is not available in expenditures for a hysterectomy if --

(1) It was performed solely for the purpose of rendering an individual permanently incapable of reproducing, or

(2) If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing

(b) FFP is available in expenditure for a hysterectomy not covered by paragraph (a) of this section if --

(1) The person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing; and

(2) The individual or her representative, if any, has signed wither a written acknowledgement of receipt of that information.

Patient's Name: _____

Medicaid No. _____ Date of Surgery _____

Physician's Name: _____

Surgical Procedure: _____

Section A: Complete this section for patient's apparently presently capable of reproducing:

1. Patient acknowledgement:

It has been explained to me that the surgical procedure to be performed is medically necessary and as a result will render me permanently incapable of reproducing.

Date: _____

Patient's Signature (or Patient's Representative)

If required:

Date: _____

Interpreter's Signature

2. Physician Certification:

The surgical procedure to be performed on _____ is medically
Patient's Name

indicated and is not solely for the purpose of rendering her permanently incapable of reproducing.

Date: _____ Physician's Signature: _____

Section B: Complete this section for other patients:

The surgical procedure to be performed on this patient is medically necessary and is unrelated to her ability to reproduce for the following reasons:

_____ This patient was surgically sterilized on _____
approximate date

_____ This patient is post menopausal.

_____ This patient's reproductive capability will be maintained.

_____ Other as specified: _____

Date: _____ Physician's Signature: _____

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HCPSC Co-pay Procedure Codes

10.0 Appendix D - HCPSC Co-pay Procedure Codes

The following procedure codes are used when billing the DMAP for co-pay for dates of service prior to 7/1/02.

WW102	Emergency Room Co-pay
WW106	Outpatient Co-pay

For dates of service on and after 7/1/02 the provider must indicate the co-pay amount in the appropriate field of the 837 Institutional claim form.

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Reserved for Future Use

11.0 Appendix E—50-36 Positron Emission Tomography (PET) Scans

COVERAGE ISSUES - DIAGNOSTIC SERVICES 06-03

50-36 POSITRON EMISSION TOMOGRAPHY (PET) SCANS

I. General Description

Positron emission tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the [human] body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceuticals) such as ^{18}F Fluoro-D-Glucose (FDG), that are administered intravenously to the patient.

The following indications may be covered for PET under certain circumstances. Details of Medicare PET coverage are discussed later in this section. Unless otherwise indicated, the clinical conditions below are covered when PET utilizes FDG as a tracer.

NOTE: This manual section lists all Medicare-covered uses of PET scans. A particular use of PET scans is not covered unless this manual specifically provides that such use is covered. Although this section lists some non-covered uses of PET scans, it does not constitute an exhaustive list of all non-covered uses.

Clinical Condition	Effective Date	Coverage
Solitary Pulmonary Nodules (SPNs)	January 1, 1998	Characterization
Lung Cancer (Non Small Cell)	January 1, 1998	Initial staging
Lung Cancer (Non Small Cell)	July 1, 2001	Diagnosis, staging and restaging
Esophageal Cancer	July 1, 2001	Diagnosis, staging and restaging
Colorectal Cancer	July 1, 1999	Determining location of tumors if rising CEA level suggests recurrence
Colorectal Cancer	July 1, 2001	Diagnosis, staging and restaging
Lymphoma	July 1, 1999	Staging and restaging only when used as an alternative to Gallium scan
Lymphoma	July 1, 2001	Diagnosis, staging and restaging
Melanoma	July 1, 1999	Evaluating recurrence prior to surgery as an alternative to a Gallium scan
Melanoma	July 1, 2001	Diagnosis, staging and restaging; Non-covered for evaluating regional nodes
Breast Cancer	October 1, 2002	As an adjunct to standard imaging modalities for staging patients with distant metastasis or restaging patients

Clinical Condition	Effective Date	Coverage
		with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally advanced and metastatic breast cancer when a change in therapy is anticipated
Head and Neck Cancers (excluding CNS and thyroid)	July 1, 2001	Diagnosis, staging and restaging
Thyroid Cancer	October 1, 2003	Restaging of recurrent or residual thyroid cancers of follicular cell origin that have been previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan performed
Myocardial Viability	July 1, 2001 to Sept. 30, 2002	Covered only following inconclusive SPECT
Myocardial Viability	October 1, 2002	Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan
Refractory Seizures	July 1, 2001	Covered for pre-surgical evaluation only
Perfusion of the heart using Rubidium 82* tracer	March 14, 1995	Covered for noninvasive imaging of the perfusion of the heart
Perfusion of the heart using ammonia N-13* tracer	October 1, 2003	Covered for noninvasive imaging of the perfusion of the heart

*Not FDG-PET.

II. General Conditions of Coverage for FDG PET

A. Allowable FDG PET Systems

1. Definitions: For purposes of this section:
 - a. "Any FDA approved" means all systems approved or cleared for marketing by the FDA to image radionuclides in the body.
 - b. "FDA approved" means that the system indicated has been approved or cleared for marketing by the FDA to image radionuclides in the body.
 - c. "Certain coincidence systems" refers to the systems that have all the following features:
 - Crystal at least 5/8-inch thick;

- Techniques to minimize or correct for scatter and/or randoms; and
- Digital detectors and iterative reconstruction.

Scans performed with gamma camera PET systems with crystals thinner than 5/8-inch will not be covered by Medicare. In addition, scans performed with systems with crystals greater than or equal to 5/8-inch in thickness, but that do not meet the other listed design characteristics are not covered by Medicare.

2. Allowable PET systems by covered clinical indication:

Allowable Type of FDG PET System			
Covered Clinical Condition	Prior to July 1, 2001	July 1, 2001 through December 31, 2001	On or after January 1, 2002
Characterization of single pulmonary nodules	Effective 1/1/1998	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Initial staging of lung cancer (non small cell)	Effective 1/1/1998	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Determining location of colorectal tumors if rising CEA level suggests recurrence	Effective 7/1/1999,	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Staging or restaging of lymphoma only when used as an alternative to a gallium scan	Effective 7/1/1999	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Evaluating recurrence of melanoma prior to surgery as an alternative to a gallium scan	Effective 7/1/1999	Any FDA approved	FDA approved: Full ring Partial ring Certain coincidence systems
Diagnosis, staging, and restaging of colorectal cancer	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of esophageal cancer	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring

Allowable Type of FDG PET System			
Covered Clinical Condition	Prior to July 1, 2001	July 1, 2001 through December 31, 2001	On or after January 1, 2002
Diagnosis, staging, and restaging of head and neck cancers (excluding CNS and thyroid)	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of lung cancer (non small cell)	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of lymphoma	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Diagnosis, staging, and restaging of melanoma (noncovered for evaluating regional nodes)	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Determination of myocardial viability only following an inconclusive SPECT	Not covered by Medicare	Full ring	FDA approved: Full ring Partial ring
Presurgical evaluation of refractory seizures	Not covered by Medicare	Full ring	FDA approved: Full ring
Breast Cancer	Not covered	Not covered	Effective October 1, 2002, full and partial ring
Thyroid Cancer	Not covered	Not covered	Effective October 1, 2003, full and partial ring
Myocardial Viability Primary or initial diagnosis prior to revascularization	Not covered	Not covered	Effective October 1, 2002, full and partial ring

B. Regardless of any other terms or conditions, all uses of FDG PET scans, in order to be covered by the Medicare program, must meet the following general conditions prior to June 30, 2001:

1. Submission of claims for payment must include any information Medicare requires to assure that the PET scans performed were: (a) medically necessary, (b) did not unnecessarily duplicate other covered diagnostic tests, and (c) did not involve investigational drugs or procedures using investigational drugs, as determined by the Food and Drug Administration (FDA).

2. The PET scan entity submitting claims for payment must keep such patient records as Medicare requires on file for each patient for whom a PET scan claim is made.
- C. Regardless of any other terms or conditions, all uses of FDG PET scans, in order to be covered by the Medicare program, must meet the following general conditions as of July 1,2001:
1. The provider of the PET scan should maintain on file the doctor's referral and documentation that the procedure involved only FDA approved drugs and devices, as is normal business practice.
 2. The ordering physician is responsible for documenting the medical necessity of the study and that it meets the conditions specified in the instructions. The physician should have documentation in the beneficiary's medical record to support the referral to the PET scan provider.

III. Covered Indications for PET Scans and Limitations/Requirements for Usage

For all uses of PET relating to malignancies the following conditions apply:

1. Diagnosis: PET is covered 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 anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal, and colorectal cancers as well as in melanoma should be rare. PET is not covered for other diagnostic uses, and is not covered for screening (testing of patients without specific signs and symptoms of disease).
2. Staging and or Restaging: PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary 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 and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary 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.

3. **Monitoring:** Use of PET to monitor tumor response during the planned course of therapy (i.e., when no change in therapy is being contemplated) is not covered except for breast cancer. Restaging only occurs after a course of treatment is completed, and this is covered, subject to the conditions above.

NOTE: In the absence of national frequency limitations, contractors, should, if necessary, develop frequency requirements on any or all of the indications covered on and after July 1, 2001.

IV. Coverage of PET for Perfusion of the Heart

A. Rubidium 82

Effective for services performed on or after March 14, 1995, PET scans performed at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA-approved radiopharmaceutical Rubidium 82 (Rb 82) are covered, provided the requirements below are met.

Requirements:

- The PET scan, whether at rest alone, or rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT); or
- The PET scan, whether at rest alone or rest with stress, is used following a SPECT that was found to be inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. (For purposes of this requirement, an inconclusive test is a test(s) whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data and must be documented in the beneficiary's file.)
- For any PET scan for which Medicare payment is claimed for dates of services prior to July 1, 2001, the claimant must submit additional specified information on the claim form (including proper codes and/or modifiers), to indicate the results of the PET scan. The claimant must also include information on whether the PET scan was done after an inconclusive noninvasive cardiac test. The information submitted with respect to the previous

noninvasive cardiac test must specify the type of test done prior to the PET scan and whether it was inconclusive or unsatisfactory. These explanations are in the form of special G codes used for billing PET scans using Rb 82. Beginning July 1, 2001, claims should be submitted with the appropriate codes.

B. Ammonia N-13

Effective for services performed on or after October 1, 2003, PET scans performed at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA-approved radiopharmaceutical ammonia N-13 are covered, provided the requirements below are met.

Requirements:

- The PET scan, whether at rest alone, or rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT); or
- The PET scan, whether at rest alone or rest with stress, is used following a SPECT that was found to be inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. (For purposes of this requirement, an inconclusive test is a test whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data and must be documented in the beneficiary's file.)

(This NCD last reviewed April 2003.)

V. Coverage of FDG PET for Lung Cancer

The coverage for FDG PET for lung cancer, effective January 1, 1998, has been expanded. Beginning July 1, 2001, usage of FDG PET for lung cancer has been expanded to include diagnosis, staging, and restaging (see section III) of the disease.

- A. Effective for services performed on or after January 1, 1998, Medicare covers regional FDG PET chest scans, on any FDA approved scanner, for the characterization of single pulmonary nodules (SPNs). The primary purpose of such characterization should be to determine the likelihood of malignancy in order to plan future management and treatment for the patient.

Beginning July 1, 2001, documentation should be maintained in the beneficiary's medical file at the referring physician's office to support the medical necessity of the procedure, as is normal business practice.

Requirements:

- There must be evidence of primary tumor. Claims for regional PET chest scans for characterizing SPNs should include evidence of the initial detection of a primary lung tumor, usually by computed tomography (CT). This should include, but is not restricted to, a report on the results of such CT or other detection method, indicating an indeterminate or possibly malignant lesion, not exceeding four centimeters (cm) in diameter.
- PET scan claims must include the results of concurrent thoracic CT (as noted above), which is necessary for anatomic information, in order to ensure that the PET scan is properly coordinated with other diagnostic modalities.
- In cases of serial evaluation of SPNs using both CT and regional PET chest scanning, such PET scans will not be covered if repeated within 90 days following a negative PET scan.

NOTE: A tissue sampling procedure (TSP) is not routinely covered in the case of a negative PET scan for characterization of SPNs, since the patient is presumed not to have a malignant lesion, based upon the PET scan results. When there has been a negative PET, the provider must submit additional information with the claim to support the necessity of a TSP, for review by the Medicare contractor.

- B. Effective for services performed from January 1, 1998 through June 30, 2001, Medicare approved coverage of FDG PET for initial staging of non-small-cell lung carcinoma (NSCLC).

Limitations: This service is covered only when the primary cancerous lung tumor has been pathologically confirmed; claims for PET must include a statement or other evidence of the detection of such primary lung tumor. The evidence should include, but is not restricted to, a surgical pathology report, which documents the presence of an NSCLC. Whole body PET scan results and results of concurrent computed tomography (CT) and follow-up lymph node biopsy must be properly coordinated with other diagnostic modalities. Claims must include both:

- The results of concurrent thoracic CT, necessary for

anatomic information, and

- The results of any lymph node biopsy performed to finalize whether the patient will be a surgical candidate. The ordering physician is responsible for providing this biopsy result to the PET facility.

NOTE: Where the patient is considered a surgical candidate, (given the presumed absence of metastatic NSCLC unless medical review supports a determination of medical necessity of a biopsy) a lymph node biopsy will not be covered in the case of a negative CT and negative PET. A lymph node biopsy will be covered in all other cases, i.e., positive CT + positive PET; negative CT + positive PET; positive CT + negative PET.

- C. Beginning July 1, 2001, Medicare covers FDG PET for diagnosis, staging, and restaging of NSCLC. Documentation should be maintained in the beneficiary's medical file to support the medical necessity of the procedure, as is normal business practice.

Requirements: PET is covered in either/or both of the following circumstances:

- **Diagnosis -** PET is covered 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 anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal, and colorectal cancers as well as in melanoma should be rare.
- **Staging and/or Restaging -** PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary 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 and 2) clinical management of the patient would differ depending on the stage of the

cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary 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.

Documentation should be maintained in the beneficiary's medical record at the referring physician's office to support the medical necessity of the procedure, as is normal business practice.

VI. Coverage of FDG PET for Esophageal Cancer

- A. Beginning July 1, 2001, Medicare covers FDG PET for the diagnosis, staging, and restaging of esophageal cancer. Medical evidence is present to support the use of FDG PET in pre-surgical staging of esophageal cancer.

Requirements: PET is covered in either/or both of the following circumstances:

- Diagnosis - PET is covered 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 anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers as well as in melanoma should be rare.
- Staging and/or Restaging - PET is covered in clinical situations in which 1)(a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary 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, and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary 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.

Documentation should be maintained in the beneficiary's medical record at the referring physician's office to support the medical necessity of the procedure, as is normal business practice.

VII. Coverage of FDG PET for Colorectal Cancer

Medicare coverage of FDG PET for colorectal cancer where there is a rising level of carcinoembryonic antigen (CEA) was effective July 1, 1999 through June 30, 2001. Beginning July 1, 2001, usage of FDG PET for colorectal cancer has been expanded to include diagnosis, staging, and restaging of the disease (see part III).

- A. Effective July 1, 1999, Medicare covers FDG PET for patients with recurrent colorectal carcinomas, which are suggested by rising levels of the biochemical tumor marker CEA.
 - 1. Frequency Limitations: Whole body PET scans for assessment of recurrence of colorectal cancer cannot be ordered more frequently than once every 12 months unless medical necessity documentation supports a separate re-elevation of CEA within this period.
 - 2. Limitations: Because this service is covered only in those cases in which there has been a recurrence of colorectal tumor, claims for PET should include a statement or other evidence of previous colorectal tumor, through June 30, 2001.
- B. Beginning July 1, 2001, Medicare coverage has been expanded for colorectal carcinomas for diagnosis, staging and re-staging. New medical evidence supports the use of FDG PET as a useful tool in determining the presence of

hepatic/extrahepatic metastases in the primary staging of colorectal carcinoma, prior to selecting a treatment regimen. Use of FDG PET is also supported in evaluating recurrent colorectal cancer beyond the limited presentation of a rising CEA level where the patient presents clinical signs or symptoms of recurrence.

Requirements: PET is covered in either/both of the following circumstances:

- Diagnosis - PET is covered 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 anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal, and colorectal cancers as well as in melanoma should be rare.
- Staging and/or Restaging - PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary 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 and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary 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.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical record, as is normal business practice.

VIII. Coverage of FDG PET for Lymphoma

Medicare coverage of FDG PET to stage and re-stage lymphoma as alternative to a Gallium scan, was effective July 1, 1999. Beginning July 1, 2001, usage of FDG PET for lymphoma has been expanded to include diagnosis, staging and restaging (see section III) of the disease.

- A. Effective July 1, 1999, FDG PET is covered for the staging and restaging of lymphoma.

Requirements:

- PET is covered only for staging or follow-up restaging of lymphoma. Claims must include a statement or other evidence of previous diagnosis of lymphoma when used as an alternative to a Gallium scan
- To ensure that the PET scan is properly coordinated with other diagnostic modalities, claims must include the results of concurrent computed tomography (CT) and/or other diagnostic modalities when they are necessary for additional anatomic information.
- In order to ensure that the PET scan is covered only as an alternative to a Gallium scan, no PET scan may be covered in cases where it is done within 50 days of a Gallium scan done by the same facility where the patient has remained during the 50-day period. Gallium scans done by another facility less than 50 days prior to the PET scan will not be counted against this screen. The purpose of this screen is to assure that PET scans are covered only when done as an alternative to a Gallium scan within the same facility. We are aware that, in order to assure proper patient care, the treating physician may conclude that previously performed Gallium scans are either inconclusive or not sufficiently reliable.

Frequency Limitation for Restaging: PET scans will be allowed for restaging no sooner than 50 days following the last staging PET scan or Gallium scan, unless sufficient evidence is presented to convince the Medicare contractor that the restaging at an earlier date is medically necessary. Since PET scans for restaging are generally done following cycles of chemotherapy, and since such cycles usually take at least 8 weeks, we believe this screen will adequately prevent medically unnecessary scans while allowing some adjustments for unusual cases. In all

cases, the determination of the medical necessity for a PET scan for re-staging lymphoma is the responsibility of the local Medicare contractor.

Beginning July 1, 2001, documentation should be maintained in the beneficiary's medical record at the referring physician's office to support the medical necessity of the procedure, as is normal business practice.

- B. Effective for services performed on or after July 1, 2001, the Medicare program has broadened coverage of FDG PET for the diagnosis, staging and restaging of lymphoma.

Requirements: PET is covered in either/both of the following circumstances:

- Diagnosis - PET is covered 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 anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal, and colorectal cancers as well as in melanoma should be rare.
- Staging and/or Restaging - PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary 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, and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary 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.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical record, as is normal business practice.

IX. Coverage of FDG PET for Melanoma

Medicare covered the evaluation of recurrent melanoma prior to surgery when used as an alternative to a Gallium scan, effective July 1, 1999. For services furnished on or after July 1, 2001 FDG PET is covered for the diagnosis, staging, and restaging of malignant melanoma (see part III). FDG PET is not covered for the use of evaluating regional nodes in melanoma patients.

- A. Effective for services furnished July 1, 1999 through June 30, 2001, in the case of patients with recurrent melanoma prior to surgery, FDG PET (when used as an alternative to a Gallium scan) is covered for tumor evaluation.

Frequency Limitations: Whole body PET scans cannot be ordered more frequently than once every 12 months, unless medical necessity documentation, maintained in the beneficiaries medical record, supports the specific need for anatomic localization of possible recurrent tumor within this period.

Limitations: The FDG PET scan is covered only as an alternative to a Gallium scan. PET scans can not be covered in cases where it is done within 50 days of a Gallium scan done by the same PET facility where the patient has remained under the care of the same facility during the 50-day period. Gallium scans done by another facility less than 50 days prior to the PET scan will not be counted against this screen. The purpose of this screen is to assure that PET scans are covered only when done as an alternative to a Gallium scan within the same facility. We are aware that, in order to assure proper patient care, the treating physician may conclude that previously performed Gallium scans are either inconclusive or not sufficiently reliable to make the determination covered by this provision. Therefore, we will apply this 50-day rule only to PET scans done by the same facility that performed the Gallium scan.

Beginning July 1, 2001, documentation should be maintained in the beneficiary's medical file at the referring physician's office to support the medical necessity of the procedure, as is normal business practice.

- B. Effective for services performed on or after July 1, 2001 FDG PET scan coverage for the diagnosis, staging and restaging of melanoma (not the evaluation regional nodes) has been broadened.

Limitations: PET scans are not covered for the evaluation of regional nodes.

Requirements: PET is covered in either/both of the following circumstances:

- Diagnosis - PET is covered 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 anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal, and colorectal cancers as well as in melanoma should be rare.

- Staging and/or Restaging - PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary 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, and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary 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.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical file, as is normal business practice.

X. Coverage of FDG PET for Head and Neck Cancers

Effective for services performed on or after July 1, 2001, Medicare will provide coverage for cancer of the head and neck, excluding the central nervous system (CNS) and thyroid. The head and neck cancers encompass a diverse set of malignancies of which the majority is squamous cell carcinomas. Patients may present with metastases to cervical lymph nodes but conventional forms of diagnostic imaging fail to identify the primary tumor. Patients that present with cancer of the head and neck are left with two options either to have a neck dissection or to have radiation of both sides of the neck with random biopsies. PET scanning attempts to reveal the site of primary tumor to prevent the adverse effects of random biopsies or unneeded radiation.

Limitations: **PET scans for head and neck cancers are not covered for CNS or thyroid cancers** (prior to October 1, 2003). Refer to section XIV for coverage for thyroid cancer effective October 1, 2003.

Requirements: PET is covered in either/or both of the following circumstances:

- Diagnosis - PET is covered 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 anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal, and colorectal cancers as well as in melanoma should be rare.
- Staging and/or Restaging - PET is covered in clinical situations in which 1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or (b) the use of PET would also be considered reasonable and necessary 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, and 2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary 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.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical record, as is normal business practice.

XI. Coverage of FDG PET for Myocardial Viability

The identification of patients with partial loss of heart muscle movement or hibernating myocardium is important in selecting candidates with compromised ventricular function to determine appropriateness for revascularization. Diagnostic tests such as FDG PET distinguish between dysfunctional but viable myocardial tissue and scar tissue in order to affect management decisions in patients with ischemic cardiomyopathy and left ventricular dysfunction.

FDG PET is covered for the determination of myocardial viability following an inconclusive SPECT from July 1, 2001 through September 30, 2002. Only full ring PET scanners are covered from July 1, 2001 through December 31, 2001. However, as of January 1, 2002, full and partial ring scanners are covered.

Beginning October 1, 2002, Medicare covers FDG PET for the determination of myocardial viability as a primary or initial diagnostic study prior to revascularization, or following an inconclusive SPECT. Studies performed by full and partial ring scanners are covered.

Limitations: In the event that a patient has received a single photon computed tomography test (SPECT) with inconclusive results, a PET scan may be covered. However, if a patient received a FDG PET study with inconclusive results, a follow up SPECT is not covered.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical record, as is normal business practice.

(See §50-58 of the CIM for SPECT coverage.)

XII. Coverage of FDG PET for Refractory Seizures

Beginning July 1, 2001, Medicare will cover FDG-PET for pre-surgical evaluation for the purpose of localization of a focus of refractory seizure activity.

Limitations: Covered only for pre-surgical evaluation.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical record, as is normal business practice.

XIII. Breast Cancer

Beginning October 1, 2002, Medicare covers FDG PET as an adjunct to other imaging modalities for staging patients with distant metastasis, or restaging patients with locoregional recurrence or metastasis. Monitoring treatment of a breast cancer tumor when a change in therapy is contemplated is also covered as an adjunct to other imaging modalities.

Limitations: Effective October 1, 2002, Medicare continues to have a national non-coverage determination for initial diagnosis of breast cancer and staging of axillary lymph nodes. Medicare coverage for staging patients with distant metastasis or restaging patients with locoregional recurrence or metastasis; and for monitoring tumor response to treatment for women with locally advanced and metastatic breast cancer when a change in therapy is anticipated, is only covered as an adjunct to other imaging modalities.

Documentation that these conditions are met should be maintained by the referring physician in the beneficiary's medical record, as is normal business practice.

XIV. Thyroid Cancer

1. Effective for services furnished on or after October 1, 2003, Medicare covers the use of FDG PET for thyroid cancer only for restaging of recurrent or residual thyroid cancers of follicular cell origin that have been previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan performed.
2. All other uses of FDG PET in the diagnosis and treatment of thyroid cancer remain noncovered.

(This NCD last reviewed April 2003.)

XV. Soft Tissue Sarcoma - NOT COVERED

Following a thorough review of the scientific literature, including a technology assessment on the topic, Medicare maintains its national noncoverage determination for all uses of FDG PET for soft tissue sarcoma.

(This NCD last reviewed April 2003.)

XVI Dementia and Neurogenerative Diseases - NOT COVERED

Following a thorough review of the scientific literature, including a technology assessment on the topic and consideration by the Medicare Coverage Advisory Committee, Medicare maintains its national noncoverage determination for all uses of FDG-PET for the diagnosis and management of dementia or other neurogenerative diseases

(This NCD last reviewed April 2003.)

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Appendix F - Reserved for Future Use

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Appendix G - Reserved for Future Use

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CLIA Certificate of Provider-performed Microscopy Procedures (PPMP)

14.0 Appendix H - CLIA Certificate of Provider-performed Microscopy Procedures (PPMP)

Code	Description
81000	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy. (NOTE: May only be used when the lab is using an automated dipstick urinalysis instrument approved as waived.)
81015	Urinalysis; microscopic only
81020	Urinalysis; two or three glass test
89190	Nasal smear for eosinophils
G0026	Fecal leukocyte examination

NOTE: The DMAP considers the following provider-performed microscopy procedures to be part of the physician evaluation and management service. Therefore, the following are not separately reimbursable by DMAP:

Code	Description
Q0111	Wet mounts, including preparations of vaginal, cervical or skin specimen
Q0112	All potassium hydroxide (KOH) preparations
Q0113	Pinworm examinations

NOTE: The DMAP does not cover any services relating solely to the treatment of infertility. Therefore, the following provider-performed microscopy procedures are not reimbursable by DMAP:

Code	Description
Q0114	Fern test
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous
G0027	Semen analysis; presence and/or motility of sperm excluding Huhner test

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CLIA Certificate of Registration Tests

15.0 Appendix I - CLIA Certificate of Registration Tests

15.1 Multiple Units of Service

The following restrictions apply when billing for multiple units of service:

- Repetition of the same test on the same specimen must not be billed.
- When the same test is performed on separate specimens collected on the same day from the same patient, bill for multiple units of the appropriate HCPCS procedure code. In form locator (FL) 84 of the UB04 claim or in Loop 2300 (Claim Note) of the 837 Institutional claim, note the times that the specimens were collected.

EXAMPLE: If a glucose is drawn at 8 AM and again at 2 PM on the same day, bill for two units of 80002. In form locator (FL) 84 of the UB04 claim or in Loop 2300 (Claim Note) of the 837 Institutional claim, note that the specimens were collected at 8 AM and 2 PM.

- When different procedures are described by one HCPCS procedure code, bill for multiple units of service. In form locator (FL) 84 of the UB04 claim or in Loop 2300 (Claim Note) of the 837 Institutional claim, identify the procedures performed.

EXAMPLE: When both a wound culture and an eye culture are performed on the same day, bill for two units of 87070. In form locator (FL) 84 of the UB04 claim or in Loop 2300 (Claim Note) of the 837 Institutional claim, state that one wound culture and one eye culture were performed.

15.2 Pregnancy Tests

The following restrictions apply:

- HCPCS procedure code 81025 (Urine pregnancy test, by visual color comparison methods) should be used for pregnancy tests performed on urine samples that are reported as positive or negative by a visual color comparison.
- HCPCS procedure code 84703 (Gonadotropin, chorionic

[hCG]; qualitative) should be used for pregnancy tests reported as positive or negative.

- HCPCS procedure code 84702 (Gonadotropin, chorionic [hCG]; quantitative) should be used when determining the range of values of the beta sub-unit of the chorionic gonadotropin. **DO NOT USE THIS CODE FOR ROUTINE PREGNANCY TESTS.**

15.3 Organ or Disease oriented Panels

Panels are groups of laboratory tests that are performed and billed as a single unit. Providers must use the appropriate single procedure code that describes the group of tests being performed.

The CPT® codes for Organ or Disease Oriented Panels will be used for dates of service 7/1/02 and after.

The following billing instructions are to be used for billing Panel and Profile services for dates of service prior to 7/1/02.

The individual HCPCS procedure codes for the 22 tests listed below are NOT used by DMAP.

Name of Test	Individual HCPCS Procedure Codes Which Are Not Used
Alanine aminotransferase (ALT, SGPT)	84460
Albumin	82040
Aspartate aminotransferase (AST, SGOT)	84450
Bilirubin, direct	82248
Bilirubin, total	82247
Calcium	82310
Carbon dioxide content	82374
Chloride	82435
Cholesterol	82465
Creatine kinase (CK, CPK)	82550
Creatinine	82565
Glucose (sugar)	82947
Gammaglutamyltransferase (GGT)	82977
Lactate dehydrogenase (LD)	83615
Phosphatase, alkaline	84075
Phosphorus (inorganic phosphate)	84100
Potassium	84132
Protein, total	84155, 84160
Sodium	84295
Triglyceride	84478
Urea nitrogen (BUN)	84520
Uric acid	84550

HCPCS procedure codes 80002-80019 and G0058-G0060 have been deleted in the CPT® book, but Delaware Medicaid will continue to use this coding series for automated multichannel testing for billing dates of service prior to 7/1/02.

The CPT® codes for Organ or Disease Oriented Panel created in 1998 (and subsequent revisions and deletions) will not be used for billing dates of service prior to 7/1/02. Use the appropriate automated multichannel test in the 8002-80019 series. For example: for code 80048 use 80008, for 80053 use 80016, for 80069 use 80010.

When reporting any of these 22 tests, regardless of whether the tests are performed using manual or semi-automated methods, or on automated multichannel equipment, use the appropriate profile code 80002 - G0060 listed below:

Code	Description
80002	Automated multichannel test; 1 or 2 clinical chemistry tests
80003	Automated multichannel test; 3 clinical chemistry tests
80004	Automated multichannel test; 4 clinical chemistry tests
80005	Automated multichannel test; 5 clinical chemistry tests
80006	Automated multichannel test; 6 clinical chemistry tests
80007	Automated multichannel test; 7 clinical chemistry tests
80008	Automated multichannel test; 8 clinical chemistry tests
80009	Automated multichannel test; 9 clinical chemistry tests
80010	Automated multichannel test; 10 clinical chemistry tests
80011	Automated multichannel test; 11 clinical chemistry tests
80012	Automated multichannel test; 12 clinical chemistry tests
80016	Automated multichannel test; 13-16 clinical chemistry tests
80018	Automated multichannel test; 17-18 clinical chemistry tests
80019	Automated multichannel test; 19 clinical chemistry tests
G0058	Automated multichannel test; 20 clinical chemistry tests
G0059	Automated multichannel test; 21 clinical chemistry tests
G0060	Automated multichannel test; 22 clinical chemistry test

EXAMPLE: If a BUN and a glucose were run on the same specimen, the correct code would be one unit of 80002. If only a glucose was ordered, the correct code would still be one unit of 80002. If a glucose was run a 9 AM and again at 2 PM on the same day on different specimens, two units of 80002 would be billable.

EXAMPLE: If five of the above tests were ordered, the correct code would be one unit of 80005. Fifteen tests would be billed as one unit of 80016 while twenty-one tests would be one unit of G0059. In each case, the unit of service would be one, not the number of tests actually performed.

15.4 Drug Testing (80100-80103)

HCPCS procedure code 80100 (Drug screen, qualitative; multiple drug classes chromatographic method, each procedure) should be used for a qualitative drug screen that detects multiple drug classes in a single procedure. HCPCS procedure code 80101 (Drug screen, qualitative; single drug class method [e.g., immunoassay, enzyme assay], each drug class) should be used for a qualitative drug screen that detects a single drug class. HCPCS procedure code 80102 (Drug confirmation, each procedure) should be used for confirmation (by a second method) of any drugs detected in a drug screen.

HCPCS procedure code 83518 (Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; single step method [e.g., reagent strip]) should be used for a qualitative or semiquantitative immunoassay of an analyte other than an antibody. This includes quick screens, using low technology testing (e.g., reagent strips, dip stick, etc.).

Confirmed drugs may be quantitated using the appropriate code in the chemistry section (82000-84999) or therapeutic drug assay section (80150-80299).

15.5 Therapeutic Drug Assays (80150-80299)

Use the specific procedure code listed in the CPT® book for individual quantitative assay. For non quantitative testing, use codes 80100-80103.

15.6 Urinalysis (81000-81099)

Code 81000 is described as a complete urinalysis, non-automated. Code 81001 is a complete urinalysis, automated. Neither is to be used in conjunction with the following HCPCS procedure codes: 81002, 81003, 81005, and 81015. Any stick, dip, or tablet tests performed on a single specimen are considered to be part of the 81000 or 81001 and are not eligible for separate reimbursement. In order to bill for an 81000 or an 81001, a microscopy must be performed.

15.7 Chemistry And Toxicology (82000-84999)

For dates of service prior to 7/1/02, when billing for any specific chemistry test that is noted under the list of automated, multichannel tests, do not use the individual HCPCS procedure codes regardless of whether the tests are performed using manual methods or automated, multichannel equipment. The provider must bill using the appropriate profile code.

15.8 Hematology (85000 - 85999)

When billing codes for a complete blood count (CBC) or hemogram, identified as HCPCS procedure codes 85021, 85022, 85023, 85024, 85025, 85027, or 85031, do not bill for any code that is a component of a CBC for the same specimen. The following are the HCPCS procedure codes for components: 85007, 85008, 85013, 85014, 85018, 85041, 85048, 85585, 85590, and 85595.

Providers are reminded not to use multiple procedure codes when a single procedure code accurately describes the service rendered.

15.9 Immunology (86000 - 86999)

When there is no specific code for an immunology procedure, the code for the methodology is to be used. Certain codes can be used to describe many different tests. When two or more different tests are described by the same code and are performed on the same patient on the same day, bill on a single line using multiple units of service.

Identify the procedures performed in form locator (FL) 84 of the UB04 claim or in Loop 2300 (Claim Note) of the 837 Institutional claim.

15.10 Microbiology (87001 - 87999)

The following policies apply:

- A screening culture is one in which a single pathogen is isolated but may or may not be definitively identified (CPT® codes 87081 or 87084).

EXAMPLE: When a throat culture is screened for the presence or absence of group A beta streptococci using a low concentration bacitracin disc, bill for one unit of 87081. Identification aids such as bacitracin and neomycin discs are considered part of the screen and should not be billed in addition to the 87081.

- Presumptive identification of microorganisms is defined as identification by colony morphology, growth on selective media, Gram stains, or up to three tests (e.g., catalase, oxidase, indole urease). Codes 87040, 87045, 87046, 87070, 87071, 87073, 87075, 87076 or 87088 are presumptive codes.
- Definitive identification of microorganisms is defined as an identification to the genus or species level that requires additional tests (e.g., biochemical panels, slide cultures). Codes 806 and 87077 may be used in addition to the above presumptive codes, when additional testing has been performed.
- If additional studies involve molecular probes, chromatography, or immunologic techniques, these should be separately codes in addition to definitive identification codes (CPT® codes 87140, 87143, 87147, 87149, 87152 and 87158).
- Direct sensitivities are not reimbursable. A direct sensitivity is inoculated directly from the specimen at the time of the initial culture. DO NOT use HCPCS procedure codes 87181, 87184, 87186, or 87188 to describe direct sensitivities. Sensitivities will only be reimbursed after a pathogen has been isolated and set up for sensitivities.
- When performing chlamydia and GC by DNA Probe, bill for one unit of 87490 (Chlamydia trachomatis, direct probe technique) and one unit of 87590 (Neisseria gonorrhoeae, direct probe technique).

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Medicaid Top 20 Physician-Administered Multiple Source Drugs

17.0 Appendix K – Medicaid Top 20 Physician-Administered Multiple Source Drugs

2011 Top 20 Multiple Source Physician-Administered Drugs			
Item #	HCPCS CODE	SHORT DESCRIPTION	HCPCS DOSAGE
1	J0886	Epoetin alfa 1000 units ESRD	1000 UNITS
2	J9263	Oxaliplatin	0.5 MG
3	J2469	Palonosetron hcl	25 MCG
4	J0885	Epoetin alfa, non-esrd	1000 UNITS
5	J9206	Irinotecan injection	20 MG
6	J9265	Paclitaxel injection	30 MG
7	J9045	Carboplatin injection	50 MG
8	J0696	Ceftriaxone sodium injection	250 MG
9	J9217	Leuprolide acetate suspension	7.5 MG
10	J1566	Immune globulin, powder	500 MG
11	J1100	Dexamethasone sodium phos	1MG
12	J2820	Sargramostim injection	50 MCG
13	J1170	Hydromorphone injection	4 MG
14	J3010	Fentanyl citrate injection	0.1 MG
15	J1626	Granisetron hcl injection	100 MCG
16	J9025	Azacitidine injection	1 MG
17	J9000	Doxorubicin hcl injection	10 MG
18	J0640	Leucovorin calcium injection	50 MG
19	J0207	Amifostine	500 MG
20	J0894	Decitabine injection	1 MG