DEFINITION OF CODES

There are four (4) groups of codings used in the list. They are:

- Category Codes: Identifies how the supply is used
- Asterisk Code: Identifies the supply in the surgical tray
- Place of Service Codes: Identifies where the supply is used
- Payment Codes: Identifies whether the supply is covered/noncovered

1) CATEGORY CODES:

CODES	DESCRIPTION
CDV	Cardiovascular System
DIG	Digestive System o = ostomy supply
DME	Durable Medical Supplies (DME)
DTS	Diabetic Testing Supplies
DX	Diagnostic Tests
EYE	Eye
EAR	Ear
FEM	Female System m = maternity
G	General usage: a = antiseptic d = dressing e = examination supply i = injection supply is = irrigation set/solution iv = iv administration s = surgery supply
I	Integumentary Sustem
LAB	Laboratory
MAL	Male System
MUS	Musculoskeletal System o = orthotics r = restraints
NER	Nervous System

PC	Personal Care
PK	Procedure Kit
RES	Respiratory System
URI	Urinary System e = end state renal disease (ESRD) i = incontinence supply
XRY	Radiology

2) ASTERISK CODE: * (preceding the description)

3) PLACE OF SERVICE (POS):

POS	ABBREV. HEADING	DESCRIPTION
8	LTCF USE =	Skilled Nursing Facility (SNF/ICF) Long term care facility (LTCF)
2	ER USE =	Emergency Room
2	TxRm USE =	Treatment Room
3	OFC USE =	Office
4	HME USE =	Home [includes Pharmacy and Home Health Agency (HHA)]

4) PAYMENT CODES

CODES	DESCRIPTION
Y =	Pay if medically necessary
N =	No pay
n/a =	Not applicable to POS
MA =	Medical Authorization (1144) is required.

NOTE: The "Y" (pay) indication may not apply if billing for the supplies are considered included in the procedure.

SECTION: Alphabetical Listing of Supplies (A)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
MUS-r	Abdominal binder	Y	n/a	n/a	n/a	n/a
G-d	Abdominal pads	N	N	N	N	Y
LAB	ABG syringe	n/a	N	N	N	n/a
G-d	Absorptive dressing (hydrocolloid) adhesive or non-adhesive (A4204)	Y	n/a	Y	Y	Y
DIG-o	Accuseal adapter (colostomy supply)	Y	n/a	n/a	n/a	Y
DTS	Accuset	N	N	N	N	Y
G-d	Ace bandages (A4460)	N	N	N	N	Y
RES	Acorn nebulizer	n/a	n/a	N	N	n/a
URI-e	Activated carobon filters for dialysis (A4680)	n/a	n/a	n/a	n/a	Y
?	Acudyne brush	n/a	n/a	N	N	n/a
PC	Adapted utensils, e.g. special custom made spoons, cutting boards, cups, nail clippers, etc.	N	N	N	N	N
RES	Adapter 6-N-1 connector	n/a	n/a	Y	Y	n/a
G-d	Adaptic, duoderm	Y	N	N	N	Y
G-d	*Adpatic dressing	Y	N	N	N	Y
G-iv	Add-A-Vial connector	Y	n/a	n/a	n/a	Y
URI-e	Adhesive, disc or foam pad (A5126)	n/a	Y	N	N	Y
DIG-o	Adhesive for ostomy or catheter liquid (spray, brush, etc.) cement, powder, or paste; any composition e.g. silicone latex, etc. per oz. (A4364)	Y	n/a	Y	Y	Y
DIG-o	Adhesive remover (stoma type only)	Y	n/a	n/a	n/a	Y
G-d	Adhesive remover or solvent [for tape, cement or other adhesive (A4455)]					
G-d	Adhesive tape	N	N	N	N	Y
G-iv	Admn. Set, piggyback	n/a	n/a	N	N	n/a
RES	Admn. Set w/airway	n/a	n/a	N	N	n/a
G-iv	Admn. Set w/3 way	n/a	n/a	N	N	n/a
RES	Aerosol mask pediatric/adult	n/a	n/a	N	N	n/a
EAR	Aid battery	Y	n/a	n/a	n/a	Y
MUS-o	Air cast	n/a	n/a	Y	Y	n/a
RES	Air life cannula (A4615)	Y	Y	Y	Y	Y
RES	Air life tubing	Y	Y	Y	Y	Y
MUS-r	Aire stirrup air cast	N	n/a	n/a	n/a	Y
RES	Airway nasopharyngeal cath	Y	n/a	Y	Y	Y
RES	Airway oral (infant, sm, med, lge)	Y	n/a	Y	Y	Y
RES	Airway oral peds	Y	n/a	Y	Y	Y
RES	Albuterol inhal	n/a	Y	n/a	n/a	n/a
G-a	Alcohol pads	N	N	N	N	Y
G-a	Alcohol/peroxide, Pt. (A4244)	N	N	N	N	Y

SECTION: Alphabetical Listing of Supplies (A)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
G-a	Alcohol swab/wipes (100) (A4245) billed with insulin syringe	N	N	N	N	Y
G-a	Alkaline gargles/mouthwash	N	N	N	N	N
G-s	All purpose tray (surgical tray)	N	N	N	N	n/a
URI-e	Ammonia test paper, per box (A4774)	n/a	n/a	n/a	n/a	MA
FEM	Amniocentisis Tray (surgical tray)	N	Y	Y	Y	n/a
G-s	*Anesthetic agents, e.g. lidocain, marcaine, xlyocaine, etc.	N	N	N	N	n/a
G-iv	Angio cath needle	Y	n/a	Y	Y	MA
XRY/DX	Angio cath/angiocath needle	N	N	N	N	n/a
MUS-r	Ankle brace	Y	Y	Y	Y	Y
CDV	Anti embolism stocking	Y	n/a	n/a	n/a	Y
G-a	Antiseptic soaps	N	N	N	N	N
G-a	*Antiseptic solutions (e.g. hydrogen peroxide)	N	N	N	N	Y
URI-E & DIG-o	Appliance cleaner, incontinence and ostomy appliances, per 16 oz. (A5131)	n/a	n/a	n/a	n/a	n/a
G-d	Applicator cotton tip (non sterile)	N	N	N	N	N
G-d	Applicator cotton tip (sterile)	N	N	N	N	Y
G	Aquatherm constant ice	n/a	n/a	N	N	n/a
G	Arm board	n/a	n/a	N	N	n/a
MUS-o	Arm immobilizer	n/a	Y	Y	Y	Y
MUS-o	Arm sling	N	Y	Y	Y	Y
MUS-o	Arm Support	n/a	N	N	N	n/a
LAB	ART blood gas draw supplies	n/a	N	N	N	n/a
CDV	Aut Don (self donor of blood to be used for upcoming surgery)	n/a	N	N	Y	n/a
DTS	Autoclix	N	N	n/a	n/a	Y
URI-e	Automatic blood pressure monitor (A4670)	N	n/a	n/a	n/a	MA
G-iv	A-Vial connector	Y	n/a	Y	Y	Y

SECTION: Alphabetical Listing of Supplies (B)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
PC	Baby oil and powder	N	N	N	N	N
URI-i	Bag closed urinary drain	Y	n/a	Y	Y	Y
URI-i	Bag leg	Y	n/a	Y	Y	Y
URI	Bag urin leg MD	n/a	n/a	Y	Y	n/a
URI	Bag, urinary drain	Y	n/a	N	N	Y
URI-i	Bag urinary or with measure	Y	Y	n/a	n/a	Y
G-d	*Bandaide strip	N	N	N	N	N
G-d	*Band aid	N	N	N	N	?
G-d	*Band spandage stretch	N	N	Y	Y	Y
G-d	*Band stretch gauze	N	N	Y	Y	Y
G-d	*Band stretch roll kerlix	N	N	Y	Y	Y
G-d	*Bandage gauze, roll	N	N	Y	Y	Y
G-d	*Bandages and tape, all types, all sizes (A4454)	N	N	Y	Y	Y
G-d	Bandage, triangle (triangle sling)	N	N	Y	Y	Y
URI	BARD monopty biopsy kit (surgical tray)	n/a	Y	Y	Y	n/a
DIG	Barium Enema Kit	N	N	Y	Y	Y
CDV	Barron ligator set (surgical tray)	n/a	Y	Y	Y	n/a
RES	Basic set up - includes oxygen tubing and mask (used with updraft)	n/a	n/a	N	N	n/a
DME	Bath bench (E0245)	N	n/a	n/a	n/a	Y
DME	Bath seat with back (E0245)	N	n/a	n/a	n/a	Y
DME	Batteries, replacement, medically necessary TENS owned by patient (A4630)	n/a	n/a	n/a	n/a	MA
DME	Batteries, replacement, medically necessary electronic wheelchair owned by patient (A4331)	n/a	n/a	n/a	n/a	MA
DME	Battery, heavy duty; replacement for pt. owned ventilaor (A4612)	MA	n/a	n/a	n/a	MA
DME	Battery cables; replacement for pt. owned ventilator (A4612)	MA	n/a	n/a	n/a	MA
DME	Battery charger; replacement for pt. owned ventilator (A4613)	MA	n/a	n/a	n/a	MA
URI	Baxter travenel urethral straight catheter with tray	Y	n/a	n/a	n/a	n/a
DME	Bed pans	N	N	N	N	Y
PC	Bed sheet (all kinds)	N	N	N	N	N
DME	Bedside commode without wheels	N	n/a	N	N	Y

SECTION: Alphabetical Listing of Supplies (B)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
DIG	Bedside drainage bag, day or night with or without anti refulx device with or without tube (A4357)	Y	n/a	n/a	n/a	Y
URI-e	Bedside drainage bottle; rigid or expandable (A5102)	n/a	n/a	n/a	n/a	n/a
DIG-o	Belt ostomy Hollister	Y	n/a	Y	Y	Y
DIG-o	Belt ostomy Greer	Y	n/a	Y	Y	Y
PK	Bennett Kit (includes tube & mask)	N	Y	Y	Y	n/a
G-a	*Betadine	N	N	N	N	Y
G-a	*Betadine douche/solution	N	N	N	N	Y
G-a	*Betadine phisodex (A4246)	N	N	N	N	Y
G-a	*Betadine phisodex wipes (A4247)	N	N	N	N	Y
URI-e	Bicarbonate dialysate solution, ea. (A4705)	n/a	n/a	n/a	n/a	n/a
G-s	Biopsy tray (Surgical tray)	n/a	Y	Y	Y	n/a
G-s	*Bite block endo	n/a	n/a	N	N	n/a
?	Black Occluder	N	N	N	N	Y
G-s	*Blade surg	n/a	N	N	N	n/a
G-iv	Bld fltr leukrc 50	n/a	n/a	Y	Y	n/a
G-iv	Bld filter Lk/Pl	n/a	n/a	Y	Y	n/a
?	Blood bank chg R/bld or Blood proc & storage	n/a	n/a	Y	Y	n/a
LAB	Blood gas kit	N	N	N	N	n/a
URI-e	Blood pressure curr only (A4663)	n/a	n/a	n/a	n/a	MA
CDV	Blood pressure kit	N	N	N	N	Y
URI-e	Blood testing supplies, e.g. vacutainers and tubes (A4770)	N	N	N	N	N
URI-e	Blood tubing, arterial or venous, each (A4750)	Y	n/a	Y	Y	n/a
URI-e	Blood tubing, arterial or venous, combined (A4755)	Y	n/a	Y	Y	n/a
G-d	Blue pad	n/a	n/a	N	N	n/a
MUS-o	Body jacket (L1000, L1300, L1210, L1499)	Y	Y	Y	Y	n/a
PC	Body Powder	N	N	N	N	N
PK	Bone Marrow Kit includes: jamshidi needle, Illinois needle, anesthetic agents, e.g. lodocaine/xylocaine, all surgical dressings, slides, basic biopsy tray, lumbar tray	n/a	n/a	Y	Y	n/a
MUS	Bone Marrow Tray (surgical tray)	n/a	Y	Y	Y	n/a
PC	Bottle Peri Wash	N	N	N	N	N
G-s	*Bovie cautery, instrument	N	N	N	N	n/a

SECTION: Alphabetical Listing of Supplies (B)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
PC	Bowl solution dispenser	N	N	N	N	N
CDV	B/P (blood pressure) cuff (A4663)	n/a	N	N	N	MA
MUS-o	Braces	Y	Y	Y	Y	Y
DME	Breast pump, - electric	n/a	n/a	n/a	n/a	MA
	- manual	n/a	n/a	n/a	n/a	Y
RES	Breathing circuit (A4618)	N	N	N	N	Y
PC	Brush bath	N	N	N	N	N
URI	B/T irrigation cap tip	Y	n/a	n/a	n/a	Y
G-d	Burn garment dressing e.g. Jobst	Y	Y	Y	Y	Y
I	Burn treatment	n/a	Y	Y	Y	n/a

SECTION: Alphabetical Listing of Supplies (C)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
DME	Canes (D0100, E0105)	Y	n/a	Y	Y	Y
DIG	Canister with isolyser containter to gather fluid; isolyser used to solidify contents	Y	n/a	n/a	n/a	n/a
DIG	Canister with tubes	Y	n/a	n/a	n/a	MA
FEM	*Canister Suct	n/a	N	N	N	n/a
RES	Cannula mask	n/a	n/	N	N	n/a
CDV	Cardiac monitor	N	N	N	N	n/a
CDV	Cardiocassettes	N	N	N	N	n/a
CDV	Cardioverter	N	N	N	N	n/a
MUS	Cast hinges	Y	Y	Y	Y	n/a
MUS	Cast pad	N	N	N	N	n/a
MUS	Cast saw	n/a	n/a	N	N	n/a
MUS	Cast supplies/plaster (A4580)	Y	Y	Y	Y	n/a
MUS	Cast materials special type e.g. hexcelite and light cast (A4590)	Y	Y	Y	Y	n/a
URI-i	Cath coude tip	Y	Y	Y	Y	Y
URI-i	Cath coude tip foley	Y	Y	Y	Y	Y
URI	Cath ext, male disposable	Y	n/a	n/a	n/a	Y
URI	Cath female kit (A4352)	Y	Y	Y	Y	Y
URI-i	Cath foley	Y	Y	Y	Y	Y
URI-i	Cath folley, latex	Y	Y	Y	Y	Y
URI	Cath kit/tray	n/a	n/a	Y	Y	MA
URI	Cath med external male	Y	Y	n/a	Y	Y
URI-i	Cath Nelaton rubber	Y	Y	Y	Y	Y
URI	Cath silicone	Y	Y	Y	Y	Y
RES	Cath suction	n/a	n/a	Y	Y	n/a
URI	Cath tray sil	n/a	n/a	Y	Y	n/a
URI	Cath word barth gland 10 Fr	n/a	n/a	Y	Y	n/a
URI	Catheterization w/bag supplies	n/a	n/a	N	N	n/a
URI	Catheter, external	Y	n/a	n/a	n/a	Y
URI	Catheter freedom mentor (NDC #81317 0803 00)	Y	n/a	n/a	n/a	Y
G-iv	Catheter, IV placement	n/a	n/a	Y	Y	n/a
RES	Catheter thoracic	n/a	n/a	Y	Y	n/a
URI	Catheter Tray	N	Y	Y	Y	Y
URI-i	Catheter uridrain	Y	n/a	n/a	n/a	Y
URI-i	Catheter uro-sheath	Y	n/a	n/a	n/a	Y
G-s	Cautery hot temp	n/a	n/a	Y	n/a	n/a
URI-e	Centrifuge (includes calibrated microcappilary Tubes and sealease) (A4650)	n/a	n/a	n/a	n/a	N

SECTION: Alphabetical Listing of Supplies (C)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
MUS-o	Cervical collar (L0120, L0140, L0150 L0170, L0180, L0190, L0200)	Y	Y	Y	Y	Y
DME	Cervical pillow (E0943)	N	N	N	N	N
MUS	Cervical traction kit (#0960)	n/a	n/a	n/a	n/a	Y
DTS	Chemostrips	N	N	N	N	Y
DIG-o	Clamp drain bag	Y	n/a	n/a	n/a	Y
MUS-o	Clavicle brace	Y	Y	Y	n/a	Y
MUS-O	Clavicle strap	Y	Y	Y	Y	Y
PK	Clean catch kit	N	N	N	N	N
URI-e	Cleansing agents for equipment for dialysis only (A4790)	n/a	n/a	n/a	n/a	Y
DME	Clinitron bed	MA	n/a	n/a	n/a	MA
DIG-o	Clip binder	Y	n/a	n/a	n/a	Y
URI-i	Closed drainage bag	Y	Y	Y	Y	Y
G-d	Coban wrap bandage	Y	Y	Y	Y	Y
CDV	Code 500 cart	N	N	N	N	n/a
?	Cold compress	n/a	n/a	N	N	n/a
G-d	Cold packs	N	N	Y	Y	Y
URI	Collect toilet spec urine measurer	N	N	N	N	Y
RES	Collector specimen trap	N	N	N	N	MA
URI	Collector, urine	n/a	n/a	N	N	n/a
DIG-o	Colostomy bags	Y	n/a	n/a	n/a	Y
DIG-o	Colostomy irrigator	Y	n/a	n/a	n/a	Y
PC	Comb	N	N	N	N	N
?	Composite padding (roll) (A4454)	N	N	N	N	Y
URI-i	Condom catheter	Y	n/a	n/a	n/a	Y
?	Conductive paste or gel (A4558)	N	N	N	N	Y
RES	Connectors simms, straight, 5-1-y	Y	n/a	n/a	n/a	Y
?	Cont. evacuat	n/a	n/a	N	N	n/a
EYE	Contact lens solution	N	N	N	N	Y
RES	Contin flow 3 Y-site	n/a	n/a	Y	Y	n/a
DIG-o	Continent device; plug for continent stoma (A5081)	Y	n/a	n/a	n/a	Y
DIG-o	Continent device; catheter for continent stoma (A5082)	Y	n/a	n/a	n/a	Y
URI-e	Continuous ambulatory peritoneal dialysis (CAPD) supply kit (A4900)	n/a	n/a	n/a	n/a	Y
URI-i	Continuous bladder irrigation set	Y	n/a	n/a	n/a	Y

SECTION: Alphabetical Listing of Supplies (C)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
URI-e	Continuous cycling peritoneal dialysis (CCPD) supply kit (A4901)	n/a	n/a	Y	Y	Y
URI-e	Contracts, repair & maintenance for home dialysis equp (A4870)	n/a	n/a	n/a	N	N
DTS	Cotton/cotton balls	N	N	N	N	Y
G-s	*Cotton/cotton balls	N	N	N	N	n/a
?	Covaderm, sterile	n/a	n/a	Y	Y	MA
G	Cover cryogel (reuseable ice pack)	n/a	n/a	N	N	n/a
G-s	*Cover mayo	n/a	n/a	N	N	n/a
RES	CPR supplies	n/a	n/a	N	N	n/a
DIG-i	Cream Uniderm	Y	n/a	n/a	n/a	Y
DME	Crutches/accessories	Y	N	Y	Y	Y
DME	Crutch – forearm	n/a	n/a	n/a	n/a	Y
G-s	*Cryotherapy unit	n/a	N	N	N	n/a
XRY	CT IV administration	n/a	N	N	N	n/a
CDV	Cuff, BP Adt	N	N	N	N	MA
FEM	Culdocentesis (surgical tray) includes vaginal speculu, canister suct, suction suction curette, Tis-U/tissue trap	n/a	Y	Y	Y	n/a
G-e	Culturette (culture swab)	N	N	N	N	n/a
CDV	Cutdown Tray (surgical tray)	N	Y	Y	Y	n/a
URI	Cysto intermittent irrigation	Y	Y	Y	Y	n/a
URI	Cysto pack (surgical tray)	n/a	Y	Y	Y	n/a
URI	Cystoscopy Tray (surgical tray)	n/a	Y	Y	Y	n/a

SECTION: Alphabetical Listing of Supplies (D)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
G-d	D-adaptic	n/a	n/a	N	N	n/a
G-d	D4x4 10/S	n/a	n/a	N	N	n/a
G-d	D-stretch	n/a	n/a	Y	Y	n/a
G-d	D/tube	n/a	1) allow if billed			n/a
MUS-o	Delta-lite (synthetic casting) Small (A4580)	n/a	with Mgt. & Evtln 2) deny if billed			n/a
MUS-o	Delta-lite (fiberglass casting tape)	n/a	withcast appl. (29000-29590), and/or billed with any surgical procedures in the Musculosketal System.			n/a
PC	Denture cleanser	N	N	N	N	N
DIG-o	Deodorant ("Ostozyme, Ozium, Banish II, Otoway")	N	N	N	N	N
G-iv	Dextrose – water or solution	Y	n/a	Y	Y	MA
G-is	Dextrose H20 – used for irrigation	Y	n/a	Y	Y	MA
XRY/DX	Dextrose H20	n/a	N	N	N	n/a
DTS	Dextrostick or glucose test strips, per box (A4772)	N	N	N	N	Y
URI-e	Dialysate concentrate additives each (A4765)	n/a	n/a	n/a	n/a	Y
URI-e	Dialysate standard testing solution, supplies, (A4760)	n/a	n/a	n/a	n/a	Y
URI-e	Dialyzer's (artificial kidney) all brands, all sizes per unit (A4690)	n/a	n/a	n/a	n/a	Y
URI-e	Dialyzer holder, each (A4919)	n/a	n/a	n/a	n/a	Y
URI-i	Diapers	N	n/q	n/a	n/a	MA
CDV	DINAMAPP (bld. Pressure monitor machine)	n/a	n/a	N	N	n/a
DTS	Dipsticks	N	n/a	n/a	n/a	Y
CVD	Disp cardiac supplies	n/a	n/a	N	N	n/a
URI-e	Disposable catheter caps (A4860)	n/a	n/a	n/a	n/a	Y
G-e	Disposable underpads, all sizes e.g. chux's (A4554)	N	N	N	N	Y
G-is	Distilled water irrigation solution	Y	N	Y	Y	Y
DIG	Disposable enemas (e.g. Fleets)	Y	Y	Y	Y	Y
URI-i	Disposable underpads	N	N	N	N	Y
?	Donaldson tubes	n/a	Y	?	?	n/a
FEM	Douche bags/cans or tray	N	N	N	N	N
FEM	Douche solution	Y	N	N	N	Y

SECTION: Alphabetical Listing of Supplies (D)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
G-e	Draw Sheet	N	N	N	N	n/a
G-s	*Drapes	N	N	N	N	n/a
G-d	*Dressing if no office visit charged and/or not part of surgical tray	N	Y	Y	Y	Y
C-d	Dressing, Bioc	Y	n/a	N	N	Y
FEM	Dressing, TRA	n/a	n/a	Y	Y	n/a
G-d	Duoderm, occlusive	Y	N	Y	Y	Y
G-d	Dynaflex elastic (A4460) - allow if no procedure in the office, emergency room or treatment room.	Y	Y	Y	Y	Y

SECTION: Alphabetical Listing of Supplies (E)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
EAR	Ear loop	Y	n/a	n/a	n/a	Y
EAR	Ear mold	Y	n/a	n/a	n/a	Y
EAR	Ear plugs for recurrent middle ear infection - 1 set per year billed by ENT specialist	Y	N	n/a	n/a	Y
EAR	Ear syringe bulb	n/a	n/a	n/a	n/a	Y
EAR	Ear wicks (merocel	N	N	N	N	n/a
?	Easy test strips	n/a	n/a	n/a	n/a	Y
DME	Egg crate mattress/pad	N	N	N	N	Y
RES	8 (eight) trach disposable inner cannula	Y	n/a	n/a	n/a	Y
CDV	EKG monitor	n/a	n/a	N	N	n/a
MUS o	Elastic bandage, per roll e.g. compression bandage (A4460)	Y	Y	Y	Y	Y
MUS-o	Elbow/Dyna splint	Y	Y	Y	Y	Y
CDV	Electrode	n/a	N	N	N	n/a
?	Electrode connector (part of equipment; e.g. cystometrogram)	n/a	N	N	N	n/a
CDV	Electrode silvon ECG	n/a	n/a	N	N	n/a
?	Electrodes (e.g. apnea monitor) (A4556)	N	N	N	N	MA
DME	Elevated toilet seat	n/a	n/a	n/a	n/a	Y
CDV	Embolism stockings	Y	n/a	n/a	n/a	Y
G	Emesis basin disposal (A4352)	N	N	N	N	N
G-s	*Endoscopic instruments	n/a	N	N	N	n/a
G-s	*Endoscopic supply	n/a	N	N	N	n/a
RES	Endrotracheal tray (surgical tray)	n/a	n/a	Y	Y	n/a
RES	Endrial c02 detector	n/a	n/a	N	N	n/a
DIG	Enema cleansing set	Y	n/a	Y	Y	Y
DIG	Enema oil	Y	n/a	n/a	n/a	Y
DIG	Enema phosphate	Y	n/a	Y	Y	Y
DIG	Ensure (food supplement)	N	n/a	n/a	n/a	MA
RES	ENT aspirator pump	Y	N	N	N	Y
DIG	Enteral gravity gavage set	N	n/a	n/a	n/a	Y
DIG	Enteral nutrition pump	Y	n/a	n/a	n/a	Y
DIG	Enteral nutrition pump III	Y	n/a	n/a	n/a	Y
DIG	Enteral pump	Y	n/a	n/a	n/a	Y
DIG	Enteral pump gavage set	Y	n/a	n/a	n/a	Y
G-d	Epi-lock	N	Y	Y	Y	Y
RES	Epitaxis anterior cauterization (surgical tray)	n/a	Y	Y	Y	n/a
G-s	*Evacuation subungual hematoma	n/a	N	N	N	n/a
PC	Exercise gripper (exercise putty or tube grip, exercise tubing)	N	N	N	N	N

SECTION: Alphabetical Listing of Supplies (E)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
XRY/DX	Ext tube w/inj site	n/a	N	N	N	n/a
URI	External catheter (uridrain)	Y	n/a	n/a	n/a	Y
URI	External catheter starter set, male/female, includes catheters/urinary collection device, bag/pouch and accessories (tubing, clamps, etc.) excludes lubricant disposables. 7 day supply (A4329)	Y	Y	Y	Y	Y
MAL	External male mentor (A4326)	Y	n/a	n/a	n/a	n/a
URI	External urethral clamp orcompression device (not to be used for catheter clamp) (A4356)	n/a	n/a	n/a	n/a	n/a
G-d	Eye pack	n/a	n/a	n/a	n/a	n/a
EYE & EAR	EYE/ENT tray (surgical tray)	n/a	Y	N	N	n/a

SECTION: Alphabetical Listing of Supplies (F)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
RES	Face tent	n/a	n/a	n/a	n/a	n/a
DIG	Feeding pump set	Y	n/a	n/a	n/a	Y
DIG	Feeding tube, e.g. enteral, Dobbhoff, Keofeed (B4082)	N	n/a	Y	Y	Y
FEM	Female external urinary collection device; metal cup, ea. (A4327)	N	N	N	N	N
FEM	Female external urinary collection device; pouch, ea (A4328)	n/a	N	N	N	Y
FEM	Female cath (indwelling catheter)	Y	n/a	Y	Y	Y
G-iv	Fenwall pressure infusion	Y	n/a	n/a	n/a	Y
MUS-r	Fiberglass tape	n/a	Y	Y	Y	n/a
G-iv	Filter blood pall	n/a	Y	Y	Y	n/a
G-iv	Filter leuk/bld	n/a	Y	Y	Y	n/a
G-iv	Filter leukocyte RBC	n/a	Y	Y	Y	n/a
G-iv	Filter straw	n/a	n/a	Y	n/a	n/a
MUS	Finger tip protector	n/a	n/a	n/a	n/a	Y
URI-e	Fistula cannulation set for dialysis only (a4730)	n/a	n/a	n/a	n/a	Y
DIG	Flavor extract	N	N	N	N	N
DIG	Flex eay feed w/bag (10/93)	Y	n/a	n/a	n/a	Y
RES	Flexing tubing	n/a	n/a	Y	Y	n/a
XRY/DX	Flexing tubing	n/a	N	N	N	n/a
G-iv	Flow control	Y	n/a	Y	Y	Y
EYE	Flrurescein angiogram supplies	n/a	N	n/a	N	n/a
MUS	Folding walker – adjustable (E0135)	n/a	n/a	n/a	n/a	Y
URI-i	Foley catheter	Y	n/a	Y	Y	Y
URI	Foley insert	N	n/a	n/a	n/a	Y
URI	Foley insertion tray (A4357)	N	n/a	n/a	n/a	n/a
PK	Foley Kit (complete	N	Y	Y	Y	Y
URI	Foley cath silastic	n/a	n/a	N	N	n/a
URI	Foley silicoat, sterile (A4344)	Y	Y	Y	Y	Y
URI	Foley S22FR	Y	n/a	n/a	n/a	Y
URI	Foley tray (A4311)	N	n/a	n/a	n/a	Y
DIG	Food supplement (if liquid nutrition, require 1144)	N	N	N	N	N
MUS-o	Futuro super socks	n/a	n/a	n/a	n/a	Y

SECTION: Alphabetical Listing of Supplies (G)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
DIG	Gastric lavage	n/a	n/a	Y	Y	n/a
DIG	Gastric lavage kit (surgical tray) all as A4550 small tray	n/a	Y	Y	Y	n/a
DIG	*Gastroscope (instrument)	N	N	N	N	n/a
DIG	Gastrostomy button (or gastro-button)	n/a	Y	Y	Y	n/a
G-d	Gauze (drain tube type)	N	N	N	N	Y
G-d	Gauze bandage, elastic (A4202)	N	N	Y	Y	Y
G-d	*Gauze bandage, non-elastic (A4203)	N	N	Y	Y	Y
G-d	*Gauze dressing, e.g. adaptic, fine mesh, surgery telfa	N	N	Y	Y	Y
G-d	*Gauze dressing vaseline	N	N	Y	Y	Y
G-d	*Gauze pad (A4200)	N	N	Y	Y	Y
G-d	*Gauze pkg, e.g. folded, oxycel pad, surgical, plain strip	N	N	Y	Y	Y
G-d	*Gauze pkg strip iodoform	Y	N	Y	Y	Y
G-d	*Gauze pkg strip vaseline	N	N	Y	Y	Y
G-d	*Gauze products, sterile or non-sterile (A4200)	N	N	Y	Y	Y
G-s	*Gauze sponges	N	N	N	N	n/a
G-d	*Gauze unmedicated	N	N	N	N	Y
MUS-r	Ger Harn (harness to restrain)	n/a	N	N	N	n/a
DIG	Geviabon (food supplement)	N	n/a	n/a	n/a	MA
DIG	Gevral T (food supplement)	N	n/a	n/a	n/a	MA
URI-i	*Gloves, sterile or non-sterile, vinyl, per (A4927)	N	N	N	N	Y
DTS	Glucola	N	N	n/a	n/a	n/a
DTS	Glucometer (NDC #53885-0325-01)	N	N	N	N	Y
DIG	Glucose Polymers (food supplement)	N	N	n/a	n/a	N
DTS	Glucose or dextrostick test strips, per box (A4772)	N	N	N	N	Y
DTS	Glucose or hemastrix test strips per box (A4773)	N	N	N	N	Y
DIG	Gomco drain bottle	N	n/a	N	N	Y
DIG	Gomco intermittant pump	N	Y	Y	Y	Y
G	Grab bar (E0241)	n/a	n/a	n/a	n/a	Y
?	Gravlee Jet washer	n/a	n/a	n/a	n/a	n/a

SECTION: Alphabetical Listing of Supplies (H)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
PC	Health foods	N	N	N	N	N
G	Heating pad	N	n/a	n/a	n/a	Y
MUS-o	Heel lift (L3300, L3310, L3320, L3330, L3332, L3334)	MA	n/a	n/a	n/a	Y
MUS-o	Heel Protectors (E0190)	N	n/a	Y	Y	Y
DTS	Hemastrix or glucose test strips, per box (A4773)	N	N	n/a	n/a	Y
URI-e	Hemodialysis kit supplies	n/a	n/a	n/a	n/a	Y
?	Hemostatic cellulose, any size e.g. surgical (A4216)	Y	Y	Y	Y	Y
G-s	*Hemostats	N	N	N	N	n/a
URI-e	Hemostats with rubber tips for dialysis (A4850)	n/a	n/a	n/a	n/a	Y
URI-e	Heparin for dialysis	n/a	n/a	n/a	n/a	Y
G-iv	Heparin IOU tubex	Y	n/a	Y	Y	n/a
XRY/Dx	Heparin IOU tubex	n/a	N	N	N	n/a
G-iv	Heparin lock	Y	n/a	Y	Y	Y
XRY/DX	Heplock	n/a	N	N	N	n/a
G-iv	Hickman catheter 3100	n/a	n/a	n/a	Y	n/a
PC	High top sneakers	N	N	N	N	N
URI-i	Holder incontinence sheath	Y	n/a	n/a	n/a	Y
URI	Hollister urostomy pouch	Y	n/a	n/a	n/a	Y
PC	Hot water bottle	N	N	N	N	N
G-iv	Huber needle, tubing PCA ext Y type	n/a	n/a	n/a	Y	n/a
RES	Humidifier	n/a	n/a	N	N	n/a
RES	Humidifier with adapter	Y	n/a	n/a	n/a	Y
G	Hydrogen peroxide/distilled water compount	N	N	N	N	Y
G-s	Hyfracator tip	n/a	N	N	N	n/a
G-i	*Hypodermic needles/syringes	N	N	N	N	Y

SECTION: Alphabetical Listing of Supplies (I)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
?	IA pack – invoice is required	n/a	n/a	n/a	n/a	n/a
G	Ice bag	N	N	N	N	Y
G	Ice pack/constant	N	N	N	N	N
URI	Ileal bladder pouch (A5063)	Y	n/a	n/a	n/a	Y
?	Imed pump set	Y	Y	Y	Y	Y
MUS-o	Immob knee dressing	Y	Y	Y	Y	Y
MUS-o	Immob shoulder dressing	Y	Y	Y	Y	Y
CDV	Implantable vascular access porta/catheter (venous arterial or peritoneal) (A4300)	N	N	Y	Y	N
URI-i & DIG-o	ncontinence/ostomy supply; posey incont Sheet, miscellaneous (A5149)	n/a	n/a	n/a	n/a	Y
URI	Incontinence clamp	Y	n/a	n/a	n/a	Y
URI-i	Incontinence supply, miscellaneous (A4335) e.g. Depend Undergarments, Serenity	N	n/a	n/a	n/a	Y
URI	Indwelling catheter, foley type two-way for continuous irrigation (A4344)	Y	Y	Y	Y	Y
URI	Indwelling catheter, foley type three-way for continuous irrigation (A4346)	Y	Y	Y	Y	Y
URI	Indwelling catheter; foley type two-way latex with coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.) (A4338)	Y	Y	Y	Y	Y
URI	Indwelling catheter; specialty type, e.g. coude, mushroom, wing, etc. (A4340)	Y	Y	Y	Y	Y
FEM-m	Infsn ctrnl flow	n/a	n/a	Y	Y	n/a
G-iv	Infusion pump, cormed pump, bag and tubing - pay in ER/TxRm only if no infusion procedure is charged.	Y	n/a	Y	Y	Y
G-iv	Infusion Quest pump - pay in ER/TxRm only if no infusion proceure is charged.	Y	n/a	Y	Y	Y
G-i	Injectable material from Dept. of Health (DOH)	N	N	N	N	N
G-iv	Injection cap	Y	Y	Y	Y	Y
G-i	Injection site	n/a	n/a	Y	Y	n/a
G-i	Injections/immunizations	Y	Y	Y	Y	n/a
G-iv	Inline Buretrol	Y	Y	Y	Y	Y
MUS	Innersole	n/a	Y	Y	Y	n/a

SECTION: Alphabetical Listing of Supplies (I)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
URI	Insertion tray without drainage bag and without chateter (accessories only) (A4310)	N	N	N	N	Y
URI	Insertion tray without drainage bag with indwelling catheter, foley type two-way latex with coating (teflon, silicone elastomer or hydrophilic, etc.) (A4311)	N	n/a	Y	Y	Y
URI	Insertion tray without drainage bag with indwelling cathether, foley type, two-way, all silicone (A4312)	N	n/a	Y	Y	Y
URI	Insertion tray without drainage bag with indwelling catheter, foley type, three-way for continuous irrigation (A4313)	N	n/a	Y	Y	Y
URI	Insertion tray with drainage bag with indwelling catheter, foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.) (A4314)	N	n/a	Y	Y	Y
URI	Insertion tray with drainage bag with indwelling catheter, foley type, two-way all silicone (A4315)	N	n/a	Y	Y	Y
URI	Insertion tray with drainage bag with indwelling catheter foley type, three-way for continuous irrigation (A4316)	N	n/a	Y	Y	Y
URI	Insertion tray with drainage bag but without catheter (A4354)	N	n/a	Y	Y	Y
URI-e	Intermittent peritoneal dialysis (IPD) supply kit (A4905)	n/a	n/a	Y	Y	Y
URI	Intermittent urinary catheter straight tip (A4351)	Y	Y	Y	Y	Y
URI	Intermittent urinary catheter; coude (curved) tip (A4352)	Y	Y	Y	Y	Y
XRY/DX	Intracath IV	n/a	N	N	N	n/a
EYE	Intraocular lens	n/a	n/a	n/a	n/a	n/a
RES	Intubation supplies	N	n/a	N	N	n/a
RES	Intubation tray	N	n/a	N	N	n/a
PC	Invalid cushion	N	N	N	N	N
RES	IPPB pack	n/a	n/a	Y	Y	Y
I	Irrigation cap tip	Y	n/a	n/a	n/a	Y

SECTION: Alphabetical Listing of Supplies (I)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
G-is	Irrigation continuous overheard set	Y	n/a	n/a	n/a	Y
G-is	Irrigation supply; bags (A4398)	Y	n/a	n/a	n/a	Y
G-is	Irrigation supplies; cone/catheter (A4399)	Y	n/a	n/a	n/a	Y
G-is	Irrigation supply; drainage tube attachment device (A4398)	Y	n/a	n/a	n/a	Y
G-is	Irrigation supply; sleeve (A4397)	Y	n/a	n/a	n/a	Y
URI	Irrigation syringe, bulb or piston (A4322)	Y	n/a	n/a	n/a	Y
URI	Irrigation tray (for bladder irrigation with bulb or piston syringe disposable (A4320)	N	n/a	n/a	n/a	Y
URI	Irrigation tubing set for continuous bladder irrigation through a 3-way indwelling foley catheter (A4355)	Y	n/a	n/a	n/a	Y
G-is	Irrigaion TUR set	Y	n/a	n/a	n/a	n/a
DIG-o	Irrigator colostomy	Y	n/a	n/a	n/a	Y
G-s	Irrijet	n/a	n/a	N	N	n/a
DIG	Isocal (liquid nutrition)	N	n/a	n/a	n/a	MA
XRY	Isovue (a4648)	n/a	Y	n/a	Y	n/a
FEM	IUD	n/a	Y	n/a	n/a	n/a
G-iv	IV 0.9% N/S500 cc	n/a	n/a	Y	Y	n/a
G-IV	iv 5% dext	Y	n/a	Y	Y	MA
G-iv	IV 5% DX L/R	Y	n/a	Y	Y	MA
G-iv	IV add a-flo	Y	n/a	Y	Y	MA
g-iv	IV additive prim 2 port	Y	n/a	n/a	n/a	Y
G-iv	IV additive set	Y	n/a	Y	Y	n/a
XRY/Dx	IV additive set	n/a	N	N	N	n/a
G-iv	IV adm accuset cassette	Y	n/a	n/a	n/a	Y
G-iv	IV adm set McGaw	n/a	n/a	N	N	n/a
G-iv	IV administration set (IVAC)	n/a	n/a	N	N	n/a
G-iv	IV cath angio	N	N	N	N	n/a
XRY	IV cath prot	n/a	N	N	N	n/a
XRY/Dx	IV catheter	n/a	N	N	N	n/a
G-iv	IV catheter plug or saline lockplug	Y	n/a	Y	Y	MA\
XRY/Dx	IV catheter plug	n/a	N	N	N	n/a

SECTION: Alphabetical Listing of Supplies (I)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
G-iv	IV dial-a-flow	Y	n/a	N	N	Y
G-iv	IV infusion pump	Y	n/a	N	N	Y
G-iv	IV jelco cath	N	n/a	Y	Y	MA
G-iv	IV master flo-20 hookup set	Y	n/a	n/a	n/a	n/a
G-iv	IV master flo-CV-60 G	Y	n/a	n/a	n/a	n/a
G-iv	IV med adm.	n/a	n/a	N	N	n/a
G-iv	IV multi-med kit tripple	N	n/a	n/a	n/a	n/a
G-iv	IV needles, e.g. IV start sets, intracth, Start Pack	N	N	N	N	n/a
G-iv	IV osmitral	Y	n/a	Y	Y	n/a
G-iv	IV piggyback	n/a	n/a	N	N	n/a
G-iv	IV primary pump set	Y	n/a	Y	Y	Y
G-iv	IV pump	n/a	n/a	N	N	n/a
G-iv	IV second vent	n/a	n/a	Y	Y	MA
G-iv	IV secondary set V-McGaw	Y	n/a	n/a	n/a	Y
XRY/Dx	IV series set	n/a	N	N	N	n/a
G-iv	IV set (includes tubing & needle) (saftiset)	N	Y	Y	Y	Y
G-iv	IV set minor	n/a	n/a	Y	Y	MA
G-iv	IV sets, except IV start sets	Y	Y	Y	Y	Y
XRY/Dx	IV Sl .9% NCL	n/a	N	N	N	n/a
G-iv	IV solution	n/a	n/a	Y	Y	n/a
G-iv	IV start kit	n/a	n/a	N	N	n/a
G-iv	IV start master flow	n/a	n/a	N	N	n/a
G-iv	IV start pack	N	n/a	N	N	MA
G-iv	IV stopcock w/ext tube	Y	n/a	n/a	n/a	n/a
XRY/Dx	IV team supply	n/a	N	N	N	n/a
G-iv	IV tubing and butterfly	N	Y	Y	Y	n/a
G-iv	IV tubing, stopcocks, filters	Y	n/a	Y	Y	Y
G-iv	IVSK [start pack (D)]	N	N	N	N	Y

SECTION: Alphabetical Listing of Supplies (J)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
G-iv	J-loop	n/a	n/a	Y	Y	n/a
G-iv	Jelco IV cath	N	n/a	Y	Y	MA
PC	Jogging shoes	N	N	N	N	N
I	Jobst stockings – payable for burn patients	Y	Y	Y	Y	Y
G	Juzo surgical compression stockings (A4495)	Y	n/a	n/a	n/a	Y

SECTION: Alphabetical Listing of Supplies (K)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
G-d	Kaltostat	Y	Y	Y	Y	Y
G-d	*Kerlix 6 ply 4.5x147 (NDC #8080 3324 00)	N	n/a	Y	Y	Y
G-s	Kerlix conforming gauze (A4202)	N	N	Y	Y	Y
DME	Kin Air Bed	MA	n/a	n/a	n/a	MA
G-s	Kling gauze (A4202)	N	N	Y	Y	Y
G-s	*Kling wrap dressing	n/a	N	N	N	n/a
G-iv	K/M IV catheter plug	Y	n/a	n/a	n/a	n/a
G-iv	K/M primary IV-2 inj	Y	n/a	n/a	n/a	n/a
G-iv	K/M secondary IV	Y	n/a	n/a	n/a	n/a
G-d	*Knee dressing, post op (sterile dressing & pad)	n/a	N	N	N	n/a
MUS-r	Knee support	n/a	Y	Y	Y	Y

SECTION: Alphabetical Listing of Supplies (L)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
LAB	Lab draw supplies	n/a	N	N	N	n/a
FEM	Laminaria set (surgical tray)	n/a	Y	Y	Y	n/a
G-s	Lancets, per box (A4259)	N	n/a	n/a	n/a	Y
RES	Laryngectomy or tracheostomy tube (A4622) - allow in ER/TxRm only if no procedure charged	Y	n/a	Y	Y	Y
RES	*Laryngoscopy/direct flex B (surgical instrument)	n/a	N	N	N	n/a
DIG	Lavacuator – if billed with "lavage", pay only one item	n/a	n/a	Y	Y	n/a
DIG	Lavage – if billed with "lavacuator", pay only one item	n/a	n/a	Y	Y	n/a
DIG	Lavage bag, gastric	n/a	n/a	Y	Y	n/a
PC	Laxto clips (nose clip)	N	N	N	N	N
RES	Lead wires; e.g. apnea monitor (A4557)	N	n/a	n/a	N	Y
DIG	Lecithin (liquid nutrition)	n/a	n/a	n/a	n/a	MA
MUS-r	Leg strap; latex, per set (A51130	Y	n/a	n/a	n/a	Y
MUS-r	Leg strap; form or fabric, per set (A5114)	Y	n/a	n/a	n/a	Y
G-iv	Leukocyte filter-blood	n/a	n/a	Y	Y	n/a
DTS	Lifescan one touch basic (NDC # 53885 0325 01) same as glucometer	n/a	n/a	n/a	n/a	Y
DIG	Light corn syrup	N	N	N	N	N
PK	Linen disposable basic pack	N	N	N	N	N
PK	Linen disposable burn pack	N	N	N	N	N
PK	Linen disposable ENT pack	N	N	N	N	n/a
PK	Linen disposable gown pack	N	N	N	N	n/a
PK	Linen disposable GYN pack	N	N	N	N	n/a
PK	Linen disposable lap pack	N	N	N	N	n/a
PK	Linen disposable split pack	N	N	N	N	N
G-i	Liquids for reconstitution injectables	Y	N	N	N	Y
G-s	*Local anesth	n/a	N	N	N	n/a
URI-e	Local/topical anesthetics for dialysis only	n/a	n/a	n/a	N	MA
XRY	Low osmolar contrast material supply (non-ionic) (A4648)	N	Y	n/a	Y	n/a
G	Lubricant(A4402)	N	N	N	N	Y
URI	Lubricath foley (A4338)	Y	Y	Y	Y	Y
MUS-o	Lumbarsacral support (L0500, L0510, L0520, L0530, L0540, L0550, L0560)	Y	n/a	Y	n/a	Y
PC	Lip balms	N	N	N	N	N
DIG	Liquid nutrition	N	n/a	n/a	n/a	Y
NER	Lumbar puncture tray (surgical tray)	n/a	Y	Y	Y	n/a

SECTION: Alphabetical Listing of Supplies (M)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
MAL	Male external catheter, with or without adhesive, with our without ani-reflux device, per dozen (A4347)	Y	n/a	n/a	n/a	Y
MAL	Male external catheter, specialty type, e.g. inflatable, faceplate, etc. each (A4326)	Y	Y	Y	Y	Y
MUS	Malleolar screw	n/a	n/a	n/a	n/a	n/a
RES	Manifold	n/a	n/a	N	N	n/a
RES	Mask 02	n/a	n/a	N	N	n/a
G-iv	Master flo CV	n/a	n/a	Y	Y	n/a
PC	Mattress covers (plastic)	N	N	N	N	N
RES	Maxi-nebulizer/inhalation kit	n/a	Y	Y	Y	Y
RES	Maximyst accessory kit including tubing and nebulizer for use with Maximyst machine	n/a	Y	Y	Y	Y
RES	Maximyst pack	n/a	n/a	Y	Y	Y
G	Measuring cylinder, any size, each (A4921)	N	N	N	N	N
G-e	Medical photography clinic slides	N	N	N	N	N
G	Medication supplies to be used in durable medical equipment	N	N	N	N	Y
G	Medicine dripper/measur device (A4649)	N	N	N	N	Y
URI	Mentor catheter (self cath) –female (A4352)	n/a	n/a	n/a	n/a	Y
DIG	Meritene Powder (liquid nutrition)	N	n/a	n/a	n/a	MA
MUS	Met pad (metatarsal pad)	n/a	n/a	n/a	n/a	Y
G-d	Metraflex	Y	Y	Y	Y	Y
G-d	Metraflex plus	Y	Y	Y	Y	Y
G-d	Metraflex SC	Y	Y	Y	Y	Y
?	Microbore burette	n/a	n/a	Y	Y	n/a
G-iv	Microdrip 1447	n/a	n/a	Y	Y	n/a
RES	Micronebulizer	n/a	n/a	N	N	n/a
DIG	Milk substitutes - covered only for bottle fed infants that have milk allergy	n/a	n/a	n/a	n/a	Y
URI-e	Miscellaneous dialysis supplies, not identified elsewhere BY REPORT (A4913)	n/a	n/a	n/a	n/a	MA
RES	Misty ox disp neb	n/a	n/a	n/a	n/a	Y
PC	Modess pads	N	N	N	N	N
CDV	Monitor/cont	n/a	n/a	N	N	n/a
G-s	*Mouth piece	N	N	N	N	N
PC	Mouth washes	N	N	N	N	N

SECTION: Alphabetical Listing of Supplies (N)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
G-is	NaCl irrigation solution	Y	Y	Y	Y	Y
RES	Nasal aspirator	n/a	n/a	n/a	n/a	Y
RES	Nasal can ped	Y	n/a	N	N	n/a
RES	Nasal Cannula (A4615) (same as Oxygen adm/cannula)	Y	n/a	N	N	n/a
G	NDL, GRPR (A4215)	N	N	N	N	n/a
RES	Nebulizer---hand held	n/a	n/a	N	N	n/a
RES	Nebulizer with compressor	n/a	n/a	n/a	n/a	Y
G-s	*Needle, chiba	n/a	N	N	N	n/a
G-i	Needle disp e.g. jelco	N	N	N	N	Y
G-i	Needle-free injection device (A4210)	N	N	N	N	Y
G-i	Needle holder	N	N	N	N	Y
G-iv	Needle huber	N	n/a	Y	Y	MA
G-s	*Needle intra-ossceous	n/a	N	N	N	n/a
G-s	*Needle, surecut	n/a	N	N	N	n/a
URI-e	Needles and syringes for dialysis (A4215)	n/a	n/a	n/a	n/a	Y
G-i	*Needles only, sterile any size (A4215)	N	N	N	N	Y
PC	New life (for baldness)	N	N	N	N	N
DIG	N/G tubing without stylet	n/a	n/a	Y	Y	n/a
G-d	Non-absorptive dressing, adhesive or non-adhesive (A4205)	N	N	N	N	Y
CVD	Non-invasive BP monitor	N	N	N	N	n/a
URI-e	Non-medical supplies for dialysis e.g. scale, scissors, stopwatch, etc. (A4910)	n/a	n/a	n/a	n/a	N
?	Normal, low and high calibrator solution/clips	n/a	n/a	n/a	n/a	Y
G-s	*Normal saline	N	N	N	N	n/a
G-i	Normal saline – used to reconstitute medication for intramuscular (IM) injection	N	N	N	N	Y
G-iv	Normal saline	N	n/a	Y	Y	Y
G-iv	N/S QL plastic bag	n/a	n/a	Y	Y	MA
G-d	Nu gauze (iodoform)	Y	Y	Y	Y	Y
?	Nutren 1.5 enteral supply, single dose	n/a	N	N	N	n/a

SECTION: Alphabetical Listing of Supplies (O)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
RES	02 cont	n/a	n/a	N	N	n/a
G-d	Occlusive	Y	N	Y	Y	Y
DTS	One touch basic monitoring kit	N	N	N	N	Y
DTS	One touch glucose supplies	n/a	N	N	N	Y
DTS	One tough test strips – NDC #53005 0285 50	N	N	N	N	Y
G-d	Opsite	Y	N	Y	Y	Y
DIG	Optifast (liquid nutrition)	N	n/a	n/a	n/a	N
RES	Optihaler inhalant device holder	n/a	n/a	n/a	n/a	Y
RES	Optihaler inhalation aerosal spacing device	n/a	n/a	n/a	n/a	Y
G	Oral syringe (A4649)	N	N	N	N	Y
MUS-o	Ort/cast ped	n/a	n/a	Y	Y	n/a
MUS-o	Ort/ocl-P/Sp	n/a	n/a	Y	Y	n/a
MUS-o	Ort/sh immob M/M	n/a	n/a	Y	Y	n/a
MUS-o	Ort/slg/canvas	n/a	n/a	Y	Y	n/a
MUS-o	Ort/stock/Ft 3	n/a	n/a	Y	Y	n/a
?	Ost triple care wash	Y	n/a	n/a	n/a	Y
DIG-o	Ostomy accessory, convex insert (A5093)	Y	n/a	n/a	n/a	Y
DIG	Ostomy, belt (A4367)	Y	n/a	n/a	n/a	Y
DIG-o	Ostomy clamp	N	N	N	N	Y
DIG-o	Ostomy deodorant (e.g. Ozium Air, Banish Nilcodor, etc.)	N	N	N	N	Y
DIG-o	Ostomy face plate (A4361)	Y	n/a	n/a	n/a	Y
DIG-o	Ostomy irrigation set (A4400) (DO NOT USE with A4367, A4398, A4399, A4403)	Y	n/a	n/a	n/a	Y
DIG-o	Ostomy rings (A4404)	Y	n/a	n/a	n/a	Y
DIG-o	Ostomy supplies, miscellaneous adhesive removal pad (100) (A4421)	Y	n/a	n/a	n/a	Y
DIG	Ostomy waf, colpst – reject if used for other than colostomy cases	n/a	n/a	Y	Y	n/a
RES	Oximeter check	N	n/a	N	N	n/a
RES	Oximeter without card monitor	n/a	n/a	N	N	n/a
RES	Oxisensor, NELL n25, D20, etc.	N	N	N	N	N
RES	Oxygen used in ER/TxRm	n/a	n/a	N	N	n/a
RES	Oxygen and containers – E, H, K, S, Cylinders (compressed air) refill	Y	n/a	n/a	n/a	Y
RES	Oxygen adm/cannula (A4615) (same as nasal cannula)	Y	N	Y	Y	Y
RES	Oxygen humidifier	Y	n/a	n/a	n/a	Y
RES	Oxygen mask	n/a	n/a	N	N	n/a
RES	Oxygen mask high flow	n/a	n/a	N	N	n/a
RES	Oxygen tubing – allow if no respirtory therapy is charged	n/a	n/a	N	N	n/a

SECTION: Alphabetical Listing of Supplies (P)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
CDV	Pack angio	n/a	n/a	N	N	n/a
G-s	Pack strip	N	N	N	N	n/a
G-s	Packing iodoform	n/a	N	N	N	n/a
G-s	Packing, plain	n/a	N	Y	Y	n/a
G-d	Pad ABD	N	N	N	N	Y
DME	Pad APP Bed	N	N	N	N	MA
DME	Pad decubicare	n/a	n/a	n/a	n/a	Y
DME	Pad Dermcare sheepskin	N	n/a	n/a	n/a	Y
DME	Pad Duotherm	N	n/a	n/a	n/a	MA
DME	Pad Duotherm arm	N	n/a	n/a	n/a	MA
DME	Pad eggcrate foam bed	N	n/a	n/a	n/a	MA
EYE	Pad eye oval	N	N	N	N	Y
DME	Pad heel and foot protector	N	n/a	n/a	n/a	MA
DME	Pad Hypo-hyperthermia	N	n/a	n/a	n/a	MA
DME	Pad lapidus foam	N	n/a	n/a	n/a	n/a
DME	Pad self adhesive foam	N	n/a	n/a	n/a	n/a
MUS-o	Pad thigh/leg ring sling	N	n/a	n/a	n/a	Y
URI-i	Pad underpad, unigard	N	n/a	n/a	n/a	Y
G-s	*Pads V sterile	n/a	N	N	N	n/a
G	Pall red cell filters	n/a	n/a	Y	Y	n/a
URI-i	Pampers/Chux	N	N	N	N	Y
URI-i	Pants,Unigard 9briefs)	N	n/a	n/a	n/a	Y
G-s	Paracentesis Tray (surgical tray)	n/a	Y	Y	Y	n/a
NER	Paracervical Block Tray (surgical tray)	M	M	Y	Y	n/a
G	Paraffin (A4265)	N	N	N	N	N
XRY	Paramagnetic contrast material supply, (non-ionic) e.g. gadolinium (magnavist) (A4647)	N	N	N	Y	N
RES	Parjet nebulizer system including tubing & mouthpiece	N	N	N	N	Y
DIG-o	Paste stomahesive	Y	n/a	N	N	Y
MUS-o	Pavlik harness	n/a	N	n/a	n/a	Y
RES	Peak flow meter (NDC 08080 2646 00)	n/a	n/a	N	n/a	Y
DME	Pelvic pad	N	N	N	N	n/a
DTS	Penlet II device by Lifescan (to check sugar level)	n/a	n/a	n/a	n/a	Y
PC	Peri wash (A9190)	N	N	N	N	N
DIG	Perianal fecal collection poich with adhesive (A4330)	N	N	N	N	Y
G-i	Peripheral nerve block	n/a	n/a	Y	n/a	n/a
PC	Personal comfort items e.g. radio, TV, telephone, etc.	N	N	N	N	N

SECTION: Alphabetical Listing of Supplies (P)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
FEM	Pessary (A4560)	Y	Y	N	N	Y
G-d	Petrolatum	N	N	N	N	N
CDV	Phlebotomy donor set	n/a	n/a	Y	Y	n/a
CDV	Phlebotomy st (surgical tray)	n/a	Y	Y	Y	n/a
CDV	Phlebotomy, therapeutic	n/a	n/a	Y	Y	n/a
G	Pill container	N	N	N	N	N
G	Pill crusher	n/a	n/a	n/a	n/a	Y
PC	Plaque remover	N	N	N	N	N
MUS	Plaster paris bandage (A4580)	Y	Y	Y	Y	n/a
MUS	Pliers/spreaders	n/a	n/a	N	N	n/a
URI-e	Plumbing and/or electrical work for home dialysis equip. (A4870)	n/a	n/a	n/a	N	MA
PC	Polarized sun glasses (sun guide)	N	N	N	N	N
DIG	Polycose (liquid nutrition)	N	N	N	N	MA
G-d	Porcine skin dressing – allow if for skin graft	n/a	Y	Y	Y	Y
G	Portable Xray	na	n/a	N	N	n/a
DIG	Portagen (liquid nutrition)	N	N	N	N	MA
URI	Posey incontinent sheath holder	n/a	n/a	n/a	n/a	Y
MUS	Posture cushion with strap	n/a	n/a	n/a	n/a	Y
URI	Pouch closed; with barrier attached (1 piece) (A5051)	Y	n/a	n/a	n/a	Y
URI	Pouch closed; without barrier attached (1 piece) (A5052)	Y	n/a	n/a	n/a	Y
URI	Pouch closed; for use on face plate (A5053)	Y	n/a	n/a	n/a	Y
URI	Pouch closed; for use on barrier with flange (2 piece) (A5054)	Y	n/a	n/a	n/a	Y
URI	Pouch drainable, with barrier attached (1 piece) (A5061)	Y	n/a	n/a	n/a	Y
URI	Pouch drainable; without barrier attached (1 piece) (A5062)	Y	n/a	n/a	n/a	Y
URI	Pouch drainable; for use onbarrier with flange (2 piece system (A5063)	Y	n/a	n/a	n/a	Y
URI	Pouch drainage (A5063)	Y	n/a	n/a	n/a	Y
URI	Pouch urinary; with barrier attached (1 piece) (A5071)	Y	n/a	n/a	n/a	Y
URI	Pouch urinary; without barrier attached (1 piece) (A5072)	Y	n/a	n/a	n/a	Y
URI	Pouch, urinary; for use on barrier with flange (2 piece) (A5073)	Y	n/a	n/a	n/a	Y
URI	Pouch urinary; with faceplate attached, plastic or rubber (A5074)	Y	n/a	n/a	n/a	Y
URI	Pouch urinary; for use on face-lift, plastic or rubber (A5075)	Y	n/a	n/a	n/a	Y

SECTION: Alphabetical Listing of Supplies (P)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
DIG-o	Powder dermaguard	Y	n/a	n/a	n/a	Y
PC	Powder talcum	N	N	N	N	N
PK	Preparation kit (A4914)	N	n/a	n/a	n/a	MA
FEM-m	Prim set w/ck	n/a	n/a	Y	Y	n/a
G-s	*Primary surgical dressing kit, e.g. sterile dressings, pads	N	N	N	N	Y
URI	PRN access-gard AG-300	N	n/a	n/a	n/a	n/a
RES	Probe oximeter	N	N	N	N	n/a
RES	Probe pediatric (A4649) – same as pulse oximeter probe	N	N	N	N	N
RES	Probe pulse oxisensor	N	N	N	N	n/a
DIG	Procto Tray (surgical tray)	n/a	N	Y	Y	n/a
G-s	*Prolene (100) (A4927)	n/a	N	N	N	n/a
EYE	Prosthetic eye – the prosthesis is inserted during acute care stay. Billing may be submitted on physician or hospital claim.	n/a	n/a	n/a	n/a	n/a
DIG-o	Protective barrier film	n/a	n/a	n/a	n/a	Y
G	Protectop disposable gloves small	N	N	N	N	Y
DIG	Protein powder – liquid nutrition	N	n/a	n/a	n/a	MA
	- food supplement	N	N	N	N	N
G-a	Providone iodine douche	Y	N	N	N	Y
G-a	Providone iodine ointment	Y	N	N	N	Y
RES	Pulse oximeter	N	N	N	N	N
RES	Pulse oximeter peak flow meter	N	N	N	N	N
RES	Pulse oximeter probe (A4649) - same as probe pediatric	N	N	N	N	N

SECTION: Alphabetical Listing of Supplies (R)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
XRY	Rad, CT tri pac	n/a	N	N	N	n/a
DME	Rail, bath tub – NDC # 08-225-2786-00	n/a	n/a	n/a	n/a	Y
MUS-o	Rainbow cas sandle	n/a	N	Y	Y	Y
PC	Razor, disposable	N	N	N	N	N
MUS-o	Reese shoe – diagnosis of fracture	n/a	Y	Y	Y	n/a
G	Ref/Maint of port pump	n/a	n/a	n/a	N	n/a
DME	Replacement handgrip, cane, crutch, or walker each (4636)	N	n/a	n/a	n/a	Y
DME	Replacement tip, cane crutch, walker, each (A4367)	N	n/a	n/a	n/a	Y
DME	Replacement pad for use with medically necessary alternating pressure pad owned by patient (A4640)	N	n/a	n/a	n/a	MA
RES	Respigard pack	n/a	Y	Y	Y	Y
CVD	Resusc bag mask	n/a	n/a	N	N	n/a
G-s	*Retractors	N	N	N	N	n/a
MUS-o	Risser jacket supplies (A4581)	MA	MA	N	N	n/a
MUS-o	Rib belt (A4572)	Y	Y	Y	Y	Y
PC	Ridigent (dental retainer)	N	N	N	N	N
DIG-o	Ring-drain bag	Y	n/a	n/a	n/a	Y
DIG	Ross G-tube 26 frenc (B4082)	Y	n/a	n/a	n/a	Y

SECTION: Alphabetical Listing of Supplies (S)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
MUS	Sacro cush support	n/a	n/a	n/a	n/a	Y
DIG	Salt substitute	N	N	N	N	N
PC	Sandals (non orthopedic)	N	N	N	N	N
PC	Sanitary belt	N	N	N	N	N
PC	Sanitary napkins/pads	N	N	N	N	N
G-s	*Scalpel	N	N	N	N	n/a
G	*Scissors	N	N	N	N	n/a
MUS-o	Scotch cast, 2 casting tape, small (A4580)	n/a	1) allow if billed with Mgt. & Evltn svcs. 2) deny if billed with cast appli. (29000-29590) and/or billed with any surgical procedures in the Musculoskeletal System.			n/a
G-s	*Scopes (all surgical scope instruments)	N	N	N	N	n/a
MAL	Scrotal support – allow post vasectomy surgery	n/a	n/a	n/a	n/a	Y
URI-i	Self cath	Y	n/a	Y	Y	Y
LAB	Serum clotting time tube, per box (A4771)	N	N	N	N	N
LAB	Set blood component	n/a	n/a	Y	Y	n/a
G-iv	Set vein infusion	n/a	n/a	N	N	n/a
PC	Shampoo – non medicated	N	N	N	N	N
G-a	- Medicated	N	N	N	N	N
DME	Sharps container	N	N	N	N	Y
G-s	Shave and prep tray	N	N	N	N	n/a
PC	Shaving cream	N	N	N	N	N
I	Sheepsking bedding	N	n/a	n/a	n/a	Y
MUS-o	Shoulder immobilizer	Y	Y	Y	Y	Y
URI-e	Shunt accessories for dialysis	n/a	n/a	n/a	n/a	Y
G-d	Silastic gel sheeting	n/a	Y	Y	Y	n/a
G-d	Silvadene/betadine solution	N	N	N	N	Y
G-s	Simple set (surgical tray	N	Y	Y	Y	n/a
G-s	*Single wrap inst	N	N	N	N	n/a
DIG	Sitz bath (E0160/E0162)	n/a	n/a	n/a	n/a	Y

SECTION: Alphabetical Listing of Supplies (S)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
I	Skin barrier with flange (solid flexible or accordion) any size convitec wafer (A5123)	Y/a	n/a	n/a	n/a	Y
I	Skin barrier; liquid (spray, brush, etc.) powder or paste per oz. (A4363)	Y	n/a	n/a	n/a	Y
I	Skin barrier; solid, 4x4 or equivalent, ea. (A4362)	Y	n/a	n/a	n/a	Y
I	Skin barrier; solid, 6x6 or equivalent, each (5121)	Y	n/a	n/a	n/a	Y
I	Skin barrier; solid, 8x8 or equivalent, each (5122)	Y	n/a	n/a	n/a	Y
I	Skin barrier; wipes,50 per box (A5119)	Y	n/a	n/a	n/a	Y
PC	Skin cleanser septisoft	N	N	N	N	N
PC	Skin/body lotions	N	N	N	N	N
DIG-o	Skin prep aerosol (L for ostomies)	Y	N	N	N	Y
G-d	Skin preprations/bulk medications used to treat local lesions.	N	N	N	N	Y
G-s	*Skin staple	n/a	N	N	N	n/a
DIG-o	Sleeve irrigation with ring	Y	n/a	n/a	n/a	Y
G-s	*Slick stylette guid	n/a	n/a	N	N	n/a
PC	Slim Fast	N	N	N	N	N
MUS-r	Slings (A4565)	Y	Y	Y	Y	Y
PC	Slippers	N	N	N	N	N
EYE	Slit lamp tray (surgical tray)	n/a	Y	Y	Y	n/a
G-iv	Small vein cath IQ	n/a	n/a	N	n/a	n/a
G-a	Soap, medicated	N	N	N	N	MA
PC	Soap, castile	N	N	N	N	N
G-s	*Sodium chloride	N	N	N	N	n/a
G-i	Sodium chloride	N	N	N	N	Y
G-iv	Sodium chloride	N	n/a	Y	Y	Y
G-s	Soft tissue biopsy tray with needle (surgical tray)	N	Y	Y	Y	n/a
G-d	Sofwick sponges fr tracheostomy	Y	n/a	n/a	n/a	Y
XRY/Dx	Solution5% dextrose water	n/a	N	N	N	n/a
G-iv	Solution IV lactated ring	n/a	n/a	N	N	n/a
RES	Spacer bag or reservoir with or without mask, for use with metered dose inhaler (A4627)	Y	n/a	n/a	n/a	Y

SECTION: Alphabetical Listing of Supplies (S)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
G-d	Specialist bandage – box of 12 small (A4460)	N	n/a	n/a	n/a	Y
MUS	Specialist cast padding, regular (small)	n/a	1) allow if billed Mgt. & Evltn svcs. 2) deny if billed with cast appli. (29000-29590), and/or billed with any surgical procedures in the Musculoskeletal system.			n/a
MUS-O	Speciality splints (small) (A4570)	Y	Y	Y	Y	Y
G	Specimen pan	N	N	N	N	N
FEM	*Speculum vag MD	n/a	N	N	N	n/a
URI-e	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope (A4660)	n/a	n/a	N	N	Y
G-s	*Spinal needle disp	n/a	n/a	N	N	n/a
G-s	Spinal puncture tray (surgical tray)	n/a	n/a	Y	Y	n/a
RES	Spiro-flo – allow if no respiratory therapy is charged	n/a	n/a	N	N	MA
MUS-r	Splints (A4570) – allow only if prescribed by physio/occupational therapist, MD or podiatrist.	Y	Y	Y	Y	Y
G-d	*Sponge gauze, e.g.fluff, stretch or non-stretch	N	N	N	N	Y
G-s	*Sponges	N	N	N	N	N
G	*Stainless steel cup	N	N	N	N	N
URI-e	Standard dialysate solution, each (A4700)	n/a	n/a	n/a	n/a	Y
G-s	*Staple removal supplies/dressing	N	Y	Y	Y	n/a
?	Stat 2 control device	Y	n/a	n/a	n/a	?
RES	Steam inhaler	n/a	n/a	n/a	n/a	Y
G-s	Steel blades	N	N	N	N	n/a
G-s	*Sterilant—to sterilize instruments	N	N	N	N	n/a
G-s	*Sterile saline irrigation solution 1000 ml	Y	n/a	Y	Y	Y
G-i	*Sterile water or saline, (A4214 or A4712)	Y	n/a	Y	Y	Y
G-s	*Steile tray (A4555)	N	Y	Y	Y	n/a
URI-e	Sterilizing agent for dialysis, per gallon (A4780)	n/a	n/a	n/a	n/a	Y
G-s	*Sterilizing agent	N	N	N	N	Y
G-d	Stero pad	n/a	n/a	n/a	n/a	Y

SECTION: Alphabetical Listing of Supplies (S)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
MUS	Stockinette	n/a	Y	Y	Y	n/a
CDV	Stocking anti embolic	Y	n/a	n/a	n/a	Y
MUS-r	Stockings (A4490, A4495, A4500, A4510) also known as "ted" hose support hose/stocking, jobst stockings or jobst burn garment for diagnosis of circulatory, venous problems, varicositis.	Y	n/a	n/a	n/a	Y
DIG-o	Stoma cap	Y	n/a	n/a	n/a	Y
DIG-o	Stomahesive Convac (pouch)	Y	n/a	n/a	n/a	Y
G-iv	Stopcock	n/a	n/a	Y	Y	n/a
XRY	Stopcock	n/a	N	N	N	n/a
G-iv	Stopcock disp	n/a	n/a	Y	Y	n/a
G-iv	Stopcock 3 way custom	n/a	n/a	Y	Y	n/a
URI-e	Storage tanks utilized in connection with water purificaiton system, replacement tanks for dialysis (A4880)	n/a	n/a	n/a	n/a	Y
MUS-o	Strap meek clavicle brace	Y	N	N	N	Y
DTS	Strips for home glucose (50 strips) (A4253)	n/a	n/a	n/a	n/a	Y
MUS-o	Stump soaks/shrinkers for amputees	n/a	n/a	n/a	n/a	Y
G	Sublingual drops	N	N	N	N	n/a
G	Suction apparatus	n/a	n/a	N	N	n/a
G	Suction canister	n/a	n/a	N	N	n/a
G	Suction cath	n/a	n/a	N	N	n/a
G	Suction connecting with tubing	n/a	n/a	Y	Y	n/a
XRY/Dx	Suction cont. w/tubing	n/a	n/a	N	N	n/a
FEM	*Suction curette	n/a	N	N	N	n/a
RES	Suction kit – contains suction valve, gloves, cup	N	n/a	n/a	N	n/a
DIG	Suction set	n/a	n/a	N	N	n/a
RES	Suction tip yankaur	n/a	n/a	N	N	n/a
PC	Sunguide polarized glasses	N	N	N	N	N
MUS-o	Supports e.g. elastic bandages, lumbo-sacral or rib belts	Y	Y	Y	Y	Y
URI	Surfit night drainage set	n/a	n/a	n/a	n/a	Y
MUS-o	Surgical support stockings, above knee length, each (A4490)	Y	n/a	n/a	n/a	Y
MUS-o	Surgical support stockings, thigh length, each (A4495)	Y	n/a	n/a	n/a	Y

SECTION: Alphabetical Listing of Supplies (S)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
MUS-o	Surgical stockings, below knee length, each (A4500)	Y	n/a	n/a	n/a	Y
MUS-o	Surgical support stockings, full length, each (A4510)	Y	n/	n/a	n/a	Y
G-s	Surgical supply, miscellaneous (A4649)	n/a	N	Y	Y	Y
G-s	Surgical tray: - SUPPLIES INCLUDED IN THE SURGICAL TRAYS ARE PRECEDED WITH AN ASTERISK (8) THROUGHOUT THE SUPPLY LIST. - Surgical supplies are not limited to this list.	n/a	Y	Y	Y	n/a
G-s	*Sutr chrme	n/a	N	N	N	n/a
G-s	*Sutr nurl sutr	n/a	N	N	N	n/a
G-s	*Sutr prolne	n/a	N	N	N	n/a
G-s	*Suture-atraum, ties, fn	n/a	N	N	N	n/a
G-s	*Suture-nylon, absorable	N	N	N	N	n/a
G-s	*Suture single	n/a	N	N	N	n/a
G-s	*Suture single supplies	n/a	N	N	N	n/a
G-s	*Suture vicryl	N	N	N	N	n/a
G-s	*Swab culturette	n/a	N	N	N	n/a
G-s	*Swab/swab stick (e.g. alcohol, betadine providne)	N	N	N	N	Y
G-s	Syringe cath	n/a	n/a	N	N	n/a
G-is	*Syringe catheter tip	N	N	N	N	Y
G-i	*Syringe disposable	N	N	N	N	Y
G-i	*Syringe glass	N	N	N	N	Y
G-i	*Syringes with needles (100) (A4206)	N	N	N	N	Y
G-i	*Syringe with needle 2cc (A4207)	N	N	N	N	Y
G-i	*Syringe with needle, sterile 3cc (A4208)	N	N	N	N	Y
G-i	*Syringe with needle, sterile 5cc (A4209)	N	N	N	N	Y
G-i	*Syringe, sterile, 20cc or greater (A4213)	N	N	N	N	Y

SECTION: Alphabetical Listing of Supplies (T)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
MUS-o	3m casting products – synthetic casting padding (small) (4580)	n/a	Y	Y	Y	n/a
G-is	T connector	n/a	n/a	Y	Y	n/a
RES	Tank 02 used in Er/TxRm	n/a	n/a	N	N	n/a
G-d	Tape; e.g. Dermicel, Microfoam, Micropore, Montgomery adhesive strap	N	N	N	N	Y
G	Teaspoon merasurer (A4649)	N	N	N	N	Y
G-d	Tegaderm, occlusive	Y	N	Y	Y	Y
G	Thermometer oral sheath	N	N	N	N	Y
G	Thermometer oral without sheath	N	N	N	N	Y
G	Thermometer rectal sheath	N	N	N	N	Y
G	Thermometer rectal without sheath	N	N	N	N	Y
G	Thermometer oral or rectal, reusable	N	N	N	N	Y
G	Thermophore moist heat (NDC # 40337 0007 60)	n/a	n/a	n/a	n/a	Y
RES	Thoracentesis tray (surgical tray)	n/a	Y	Y	Y	n/a
RES	Thoracostomy tray (surgical tray)	n/a	Y	Y	Y	n/a
RES	Throat culture tube	N	N	N	N	n/a
G-s	*Tissue trap	n/a	N	N	N	n/a
G-s	*Tissue trap, flex	n/a	N	N	N	n/a
G-s	*Tis-U or Tissue Tray	n/a	N	N	N	n/a
PC	Tissue, facial	N	N	N	N	N
G-e	Tongue blade ns	N	N	N	N	N
G-e	Tongue blade st	N	N	N	N	N
G-e	Tongue depressors	N	N	N	N	N
PC	Tooth brush	N	N	N	N	N
PC	Tooth paste	N	N	N	N	N
PC	Toothette	N	N	N	N	N
G-iv	Total parenteral nutrition (TPN) pump; set; solution	Y	n/a	n/a	n/a	Y
PC	Towelettes	N	N	N	N	N
G-s	*Towel barrier	n/a	N	N	N	n/a
PC	Towels st disposable	N	N	N	N	N

SECTION: Alphabetical Listing of Supplies (T)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
RES	Trach care	N	n/a	Y	Y	n/a
RES	Tracheostomy bib	N	n/a	n/a	n/a	n/a
RES	Traceostomy care or cleaning starter kit (A4625)	N	n/a	n/a	n/a	Y
RES	Tracheostomy cleaning brush, each (A4626)	Y	n/a	n/a	n/a	Y
RES	Tracheostomy, inner cannula (replacement only) (A4623)	Y	n/a	n/a	n/a	Y
RES	Traheostomy or laryngectomy tube (A4622)	Y	n/a	Y	n/a	Y
RES	Tracheostomy ties	Y	n/a	n/a	n/a	Y
RES	Tracheostomy tube standby tray	N	N	N	N	n/a
RES	Tracheostomy tubes	Y	Y	Y	Y	Y
RES	Tracheostomy mask or collar (A4621)	Y	n/a	n/a	n/a	Y
G-iv	Transfusion set	n/a	Y	Y	Y	n/a
G-d	Transparent film (A4190) (special dressing)	Y	Y	Y	Y	Y
G-s	*Transpose tape	n/a	N	N	N	n/a
PC	Travelettes	N	N	N	N	N
XRY	Tray omipaque	n/a	n/a	N	N	n/a
G-s	*Trays containing surgical supplies, e.g. gauze, dressing, sponges, antiseptic solutions with/without eligible supplies, e.g. catheters and tracheostomy tubes	N	N	N	N	n/a
URI-e	Treated water (deionized, distilled, reverse osmoses) for use in dialysis system (A4712)	n/a	n/a	n/a	n/a	Y
DIG	Tr/lavage (teatement)	n/a	n/a	N	N	n/a
DIG	Tr/lavage tray	n/a	n/a	Y	Y	n/a
G-d	Triangle bandage/sling	N	Y	Y	Y	Y
RES	Triflo	N	N	N	N	n/a
DIG	Tube, e.g. rectal, stomach levine, endotrach, laryngectomy, trach	Y	n/a	Y	Y	Y
DIG/ RES/ CDV	Tube (e.g. cantor, connector, duodenal levine, endotrach, esophageal blakemore, feeding enteral, feeding Dobbhoff, feeding Keofeed)	N	n/a	Y	Y	Y
G-iv	Tube extension 3 way	n/a	n/a	Y	Y	MA
XRY/Dx	Tube extension 3 way	n/a	N	N	N	n/a
DIG	Tube feeding (B4082)	n/a	n/a	Y	Y	n/a
DIG	Tube lavauator 32 FR	n/a	n/a	Y	Y	n/a
DIG	Tube salem silastic	n/a	n/a	Y	Y	n/a
DIG	Tube salem sump	n/a	n/a	Y	Y	n/a
G-iv	Tubing additive non-vented	n/a	Y	Y	Y	n/a
G-iv	Tubing PCA ext. –Deltec	n/a	n/a	Y	Y	n/a
G-iv	Tubing secondary vents	n/a	Y	Y	Y	n/a
G-iv	Tubing, unspecified length, each (A4616)	N	n/a	n/a	n/a	Y
DIG	Tuck pads	N	N	N	N	Y

SECTION: Alphabetical Listing of Supplies (U)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
DME	Under arm pad, crutch replacement each (A4635)	N	n/a	n/a	n/a	Y
G-e	Underpad chux	n/a	N	N	N	Y
URI-i	Underpads, disposable (A4554)	N	N	N	N	Y
G-d	Uniflex	Y	n/a	n/a	n/a	Y
MUS-o	Unna boot	n/a	Y	Y	Y	n/a
RES	Updraft	n/a	n/a	N	N	n/a
URI	Urethral cath	Y	n/a	n/a	n/a	Y
URI	Urethral cath restraint	N	n/a	n/a	n/a	Y
URI	Urethral cath tray with foley	N	n/a	Y	Y	n/a
URI	Urethral tray without foley	n/a	n/a	N	N	n/a
URI	Uridrain	Y	n/a	n/a	n/a	Y
URI	Urinal	N	N	N	N	Y
URI	Urinary drain bag, closed	Y	n/a	n/a	n/a	Y
URI	Urinary drainage bag (A4357)	Y	n/a	n/a	n/a	Y
URI	Urinary leg bag; vinyl, with or without tube (A4358)	Y	n/a	n/a	n/a	Y
URI	Urinary suspensory; with leg bag with or without tube (A5105)	Y	n/a	n/a	n/a	Y
URI	Urinary suspensory without leg bag (A4359)	Y	n/a	n/a	n/a	Y
URI	Urine collector (E0325, E0326, E0330)	N	N	N	N	n/a
DTS	Urine test reapent strips (100 tabs or strips) (A4250)	N	n/a	n/a	n/a	Y
URI	UroCare leg bag	N	n/a	n/a	n/a	Y
G-s	*Urojet	N	N	N	N	n/a
URI	Urostomy pouch (A5072)	Y	n/a	n/a	n/a	Y
RES	USN/aerosol supplies – allow if inhalation service not billed	n/a	n/a	N	N	n/a

SECTION: Alphabetical Listing of Supplies (V)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
FEM	Vabra aspirator	N	N	N	N	n/a
G	Vacuum bottle	N	N	N	N	N
G-s	*Vacurette bottle	N	N	N	N	n/a
FEM	Vag speculum	n/a	N	N	N	n/a
FEM	Vaginal applicator	N	N	N	N	N
FEM	Vaginal pack (sterile)	n/a	N	Y	n/a	n/a
RES	Vaporizers	n/a	N	N	N	Y
RES	Variable concentration mask (A4620)	Y	n/a	Y	n/a	Y
URI-e	Vas cath tray (surgical tray)	n/a	n/a	n/a	Y	n/a
G-d	Vaseline	N	N	N	N	N
CDV	Venous pressure clamps, each (A4918)	Y	n/a	n/a	n/a	Y
MUS-r	Vest restraints	n/a	n/a	N	N	n/a
NUS-o	Visoheel	n/a	N	n/a	n/a	Y

SECTION: Alphabetical Listing of Supplies (W)

CATEGORY CODE	DESCRIPTION	LTCR USE	OFC USE	ER USE	TxRm USE	HME USE
DIG-o	Wafer Surfit	Y	n/a	n/a	n/a	Y
CDV	Warm breast pack	N	N	N	N	N
G	Wash basin	N	N	N	N	N
DIG-o	Washer karaya	Y	n/a	n/a	n/a	Y
G	Water bottle	n/a	n/a	n/a	n/a	Y
PC	Water pike to water pike system	N	N	N	N	N
G	Webril roll	n/a	n/a	n/a	n/a	n/a
PC	Weighing scale	N	N	N	N	N
EAR	Wick, otc	n/a	n/a	n/a	n/a	Y
MUS-o	Wooden shoe	n/a	n/a	n/a	n/a	Y
G-s	*Wound irrig	n/a	n/a	N	N	n/a

Drug Coverage Criteria

Prior Authorization Criteria

Unless specifically stated, prior authorization requirements of a class of drugs apply to all NEW drugs added to the class.

Aciphex (Rabeprazole)

See Proton Pump Inhibitors

Allegra (fexofenadine)

See Anti-Histamines

Amphetamines

Indications: treatment of hyperkinesis (Diagnosis Code 314 or 429.82), attention deficit disorders (Diagnosis Code 314) or narcolepsy (Diagnosis Code 347)

Restriction Criteria: The diagnosis must appear on the prescription and the claim.

Anabolic Steroids

Prior authorization requirement: FDA indications.

Androgens

Exclusion: establishment of gender reassignment (transsexual) unless the individual's sex was changed by court order.

Restriction Criteria: A diagnosis is required on all prescriptions and claims for androgens when prescribed for patients under 40 years of age.

Anti-Cancer agents

Medicaid will normally reimburse claims for oral anti-cancer agents except in certain instances for Medicare/Medicaid dual eligible recipients.

1. Cancer. If the patient is dual eligible, Medicare will pay for these oral anti-cancer agents when they are used to treat cancer, and Medicare must be billed first. The diagnosis code range for Cancer is 239.0-239.9. Claims for oral anti-cancer agents for Medicare/Medicaid recipients will be denied without a diagnosis code.

2. Other than cancer. Please provide the diagnosis code: i.e. Arthritis diagnosis code is 716.9. This will prevent unnecessary denials of these claims by Medicaid.

3. Off label uses. Oral chemotherapy (anti-cancer) drugs methotrexate and cyclophosphamide have been identified by HCFA as drugs that may also be used in immunosuppressive therapy for patients who have had organ transplants. If the patient is dual eligible, Medicare will pay for these anti-cancer agents when they are used in immunosuppressive treatment. Medicare must be billed first. Medicaid claims for transplant recipients with a diagnosis code for transplants: V42.0 – V42.9, 996.0-996.52, 996.8 will be denied. If claims are submitted to the Medicaid program without a diagnosis code, they will be rejected to bill Medicare first.

Anti-Epileptics

To avoid any generic substitutions for anti-epileptic indications and to comply with the HCFA regulations, prescribers should note on the prescription if the brand is medically necessary.

Note:
Refer to the Provider Manual, Chapter 8, Billing and Authorization Requirements, Federal Upper Limit (FUL) for general policy.

Anti-Histamines

Single source non-sedating oral drugs:

Allegra (fexofenadine)
Claritin (Loratadine)
Zyrtec (Cetirizine)
Combination products of the above

Indications:

Relief of allergic rhinitis or chronic urticaria.

Note:

1. OTC product(s) listed on the OTC formulary are available without prior authorization for FDA approved indications (Appendix);

2. Generic prescription products are available without prior authorization for FDA approved indications;

Prior Authorization requirement:

For single source prescription oral non-sedating anti-histamines:

1. At least 2 generically available products have shown to be ineffective;

2. Serious side effects have developed or are likely to develop with available generic agents. These side effects are included in the prior authorization form;

3. Diagnosis is allergic rhinitis or chronic urticaria.

4. Patient's age is 6 years or older.

Note: Once a prior authorization has been approved for one of the drugs in this class, another agent may be tried if it was listed on the prior authorization form originally as an alternative.

Anti-Leprotic Medications

Medications, which are prescribed for the treatment of leprosy, are not cover by the Medicaid Program. The Hansen's Disease Program which is part of the Department of Health, provides these medications free-of-charge to recipients. Prescribers should refer their patients to the Hansen's Disease Program for follow-up and medications.

Note: If these medications are being used to treat other conditions, a diagnosis code, other than for Hansen's Disease (030.0-030.3, 030.8-030.9), is required for the claim to be processed. If no diagnosis code is provided, the claim will be rejected.

Appetite Suppressants (Anorexiants)

Prior Authorization Requirements:

1. Patient's height and weight or BMI;

2. Patient's program for weight loss.

3. For additional and/or specific criteria for Meridia and Xenical, look under specific drug name.

Arava (Leflunomide)

Indications:
Active rheumatoid arthritis (Diagnosis Code 714.0)

Restriction Criteria:
Arava is available without prior authorization if prescribed by a rheumatologist for the diagnosis of rheumatoid arthritis (diagnosis code 714.0).

Prior Authorization Requirements:

1. Diagnosis of active rheumatoid arthritis and

2. Treatment with methotrexate and at least one (1) other disease modifying anti-rheumatic drug (DMARD) including antimalarials, gold, D-penicillamine, and azathioprine is not adequate, effective or medically appropriate.

3. Provide the following information on the Request for Medical Authorization (Form 1144):

   A. State treatment with methotrexate has not been adequate or effective or is not medically appropriate. If not medically appropriate, explain.

   B. Provide the name of at least one (1) other DMARD that has not been effective.

Atypical Anti-Psychotics

Drugs: Clozapine (generic Clozaril)
Geodon (Ziprasidone)
Risperdal (Risperidone)
Seroquel (Quetiapine)
Zyprexa (Olanzapine)

Indications:

1. Psychotic disorders: management of severely ill schizophrenic patients who fail to respond adequately to standard anti-psychotic drug treatment.

2. Refractory or non-refractory schizophrenics

Restriction Criteria:

Only providers recognized by Medicaid as psychiatrists may prescribe of Clozapine (generic Clozaril), Risperdal, Zyprexa, Seroquel, and Geodon without a prior authorization. Refer to the provider specialty listing in Appendix 6. All other providers must submit a prior authorization request prior to prescribing this class of medication.

Prior Authorization Criteria:

1. For the initial request of Risperdal, Zyprexa, Seroquel, or Geodon,

   A. A DHS Form 1162 - Use of Clozapine (generic Clozaril), Risperdal, Zyprexa, Seroquel, or Geodon - must be attached to the prior authorization request. Indicate the drug being requested;

   B. A Brief Psychiatric Rating Scale (BPRS) report must be attached to the prior authorization request;

   C. A prior authorization request is submitted prior to prescribing this class of medication.

2. After the initial approval for two (2) months, subsequent requests may be made for six (6) month periods. The submission of BPRS must be submitted with the prior authorization request on each subsequent request. Semi-annual narrative reports are required as well.

3. If there is no improvement after three (3) months of using Risperdal, Zyprexa, Seroquel, or Geodon, or if the patient cannot tolerate at least one of these agents due to severe side effects, Clozapine (generic Clozaril) may be approved. Seek initial request of Clozapine (generic Clozaril) as outlined in above in Prior Authorization Criteria 1. A., 1. B., and 1. C. Indicate Clozapine (generic Clozaril) on DHS form 1162 - Use of Clozapine (generic Clozaril), Risperdal, Zyprexa, Seroquel, or Geodon. Document the lack of improvement, on the specific drug, for the time period of use, and/or the severe side effects experienced on the specific drug.

Clozapine (generic Clozaril)

Indication:
Psychotic disorders: Management of severely ill schizophrenic patients who fail to respond adequately to standard anti-psychotic drug treatment.

Geodon (Ziprasidone)

Indications:
Treatment of schizophrenia.

Risperdal (Risperidone)

Indications:
Psychotic disorder: Management of the manifestations of psychotic disorders.

Seroquel (Quetiapine)

Indications:
Psychotic disorder: Management of the manifestations of psychotic disorders.

Zyprexa (Olanzapine)

Indications:

1. Schizophrenia: Management of the manifestations of psychotic disorders;

2. Bipolar mania: short-term treatment of acute manic episodes associated with Bipolar I disorder.

Avonex (Interferon Beta-1)

Indication:
Relapsing Multiple Sclerosis

Prior Authorization Requirement:
For the above indication only.

Axid (Nizatidine)

See H2-antagonists

Azelex (Azelaic acid)

Indication:
Mild to moderate acne

Prior Authorization Requirement:

1. Diagnosis for mild to moderate acne; and

2. Documentation noting other less costly alternatives have been ineffective or inappropriate and these are included in the prior authorization form.

Betaseron (Interferon Beta)

Indication:
Relapsing, remitting multiple sclerosis for ambulatory patients only.

Prior Authorization Requirement:
Documentation for the above indication only.

Bextra (Valdecoxib)

Indication:

1. Osteoarthritis or degenerative joint diseases (Diagnosis code 715.9);

2. Rheumatoid Arthritis (Diagnosis code 714.0); and

3. Primary Dysmenorrhea

Restriction Criteria: Bextra will be available without prior authorization if the following are appropriate:

1. The recipient is over age 60;

2. With a diagnosis code of osteoarthritis or degenerative joint disease (Diagnosis code 715.90 or rheumatoid arthritis (Diagnosis code 714.0); and

3. The recipient's age and the diagnosis code must be submitted with the claim.

Prior Authorization Requirement:

1. For osteoarthritis or rheumatoid arthritis for recipients 60 years of age and under:

    a) Diagnosis of for osteoarthritis or degenerative joint disease or rheumatoid arthritis or primary dysmenorrhea.

2. At least one of the following documented under "Justification" on the Request for Medical Authorization (Form 1144):

    a) History of gastrointestinal bleed or gastric or duodenal ulcer;
    b) History of symptoms of peptic ulcer disease, gastritis, or gastroesophageal reflux (GERD) while on conventional NSAID(s);

    c) Concurrent use of corticosteroids;

    d) Concurrent use of warfarin or heparin; or

    e) History of platelet dysfunction or coagulopathy.

Camptosar (Trinotecan)

Indications:

1. Treatment of colorectal cancer in patients whose disease has recurred or progressed following 5-FU-based therapy; and

2. First-line therapy in combination with the standard treatment, 5-Fluorouracil and leucovorin (5-FU/LV), for metastatic colorectal cancer.

Prior Authorization Requirement:
Documentation of one of the above indications.

Capaxone (Glatiramer)

Indication:
Relapsing, remitting multiple sclerosis

Prior Authorization Requirement:
Documentation for the above indication only.

Celebrex (Celecoxib)

Indications:

1. Osteoarthritis or degenerative joint disease (Diagnosis Code 715.9)

2. Rheumatoid Arthritis (Diagnosis Code 714.0)

3. Familial Adenomatous Polyposis (Diagnosis Code 211.3)

Restriction Criteria: Celebrex is available without prior authorization if the following are appropriate:

1. The recipient is over age 60; and

2. With a diagnosis of osteoarthritis or degenerative joint disease (Diagnosis Code 715.9) or rheumatoid arthritis (Diagnosis Code 714.0) or Familial Adenomatous Poylposis (Diagnosis Code 211.3).

3. The diagnosis code and the recipient's age must be included on the claim.

Prior Authorization Requirements:

A. For Osteoarthritis or Rheumatoid Arthritis for recipients 60 years of age and under:

   1. Diagnosis of osteoarthritis or degenerative joint disease or rheumatoid arthritis and

   2. At least one of the following documented under "Justification" on the Request for Medical Authorization (Form 1144):

      a) History of gastrointestinal bleed or gastric or duodenal ulcer,

      b) History of symptoms of peptic ulcer disease, gastritis, or gastroesophageal reflux (GERD) while on conventional NSAID(s),

      c) Concurrent use of corticosteroids,

      d) Concurrent use of warfarin or heparin, or

      e) History of platelet dysfunction or coagulopathy.

B. For Familial Adenomatous Polyposis in recipients 60 years of age and under:

1. Diagnosis of familial adenomatous polyposis

2. At least one of the following documented under "Justification" on the Request for Medical Authorization (Form 1144):

   a) History of gastrointestinal bleed or gastric or duodenal ulcer,

   b) History of symptoms of peptic ulcer disease, gastritis, or gastroesophageal reflux (GERD) while on conventional NSAID(s),

   c) Concurrent use of corticosteroids,

   d) Concurrent use of warfarin or heparin, or

   e) History of platelet dysfunction or coagulopathy.

Cholestyramine

See Questran

Clozapine (generic Clozaril)

See Atypical Anti-psychotics

Concerta

Indications: treatment of hyperkinesis (Diagnosis Code 314 or 429.82) attention deficit disorders (Diagnosis Code 314)

Restriction Criteria: The diagnosis must be submitted on the claim. The recipient must be between 6 and 12 years of age.

Cyclophosphamide

See Anti-Cancer and Immunosuppressants

Daunoxone (Daunorubicin liposone)

Indication:
First-line cytotoxic therapy for Advanced HIV-related Kaposi's sarcoma. It is not recommended for any patient with less than an advanced case.

Prior Authorization Requirement:
For the above indication only

Enbrel (Etanercept)

Indication:
Moderate to severe active rheumatoid arthritis (Diagnosis Code 714.0)

Restriction Criteria:
Enbrel is available without prior authorization if prescribed by a rheumatologist for the diagnosis of rheumatoid arthritis (diagnosis code 714.0).

Prior Authorization Requirements:

1. Diagnosis of moderate to severe active rheumatoid arthritis and

2. Treatment with methotrexate and at least one (1) other disease modifying anti-rheumatic drug (DMARD) including antimalarials, gold, D-penicillamine, and azathioprine is not adequate, effective or medically appropriate.

3. Provide the following information on the Request for Medical Authorization (Form 1144):

   A. State treatment with methotrexate has not been adequate or effective or is not medically appropriate. If not medically appropriate, explain.

   B. Provide the name of at least one (1) other DMARD that has not been effective.

Estrogens

Exclusion: for establishment of gender reassignment (transsexual) unless the individual's sex was changed by court order.

Restriction Criteria: A diagnosis is required on all prescriptions and claims for estrogens when prescribed for patients under 40 years of age.

Flolan (Epoprostenol)

Indication:
Long term IV treatment of primary pulmonary hypertension in patients with Congestive Heart Failure (CHF) rated New York Heart Association NYHA) Class III (patient only comfortable at rest) or Class IV (continuous symptoms of CHF)

Prior Authorization Requirements:
Documentation of the above indication

Gemzar (Gemcitabine)

Indication:

First-line treatment for locally advanced (non-resectable Stage II or III) or 2.Metastatic (Stage IV) adenocarcinoma of the pancreas.

Prior Authorization Requirement:
Documentation of one of the above indications. Prior authorization criteria for Gemzar (gemcitabine HCl) have been updated to include approval in combination with cisplatin for Stage IIIA, IIIB, or IV non-small cell lung cancer. Other approved indications include Stage II, III, and IV adenocarcinoma of the pancreas.

Genotropin (Somatropin)

See Growth Hormone

Geodon (Ziprasidone)

See Atypical Anti-psychotics

Gonadotropin-Releasing Hormone Analog

Drugs:
Lupron (Leuprolide Acetate)
Viadur (Leuprolide Acetate)

Indications:

1. Prostate Cancer;

2. Endometriosis;

Note:
Zoladex is available without prior authorization for any of the above indications. Zoladex is also indicated for the diagnosis of advanced breast cancer without prior authorization.

Prior Authorization Requirements:

A. For Lupron approval:

1. Documented failure of Zoladex; OR

2. Documented side effects of significant nature with use of Zoladex; OR

3. Diagnosis of Central precocious puberty (CPP) for children**;** OR

4. Diagnosis of Uterine leiomyomata (fibroids) for women.

B. For Viadur approval:

1. Diagnosis of advanced prostate cancer; and

2. Documented successful trial with Zoladex or Lupron depot.

Growth Hormone

Drugs: Genotropin (Somatropin)
Humatrope (Somatropin)
Norditropin (Somatropin)
Nutropin (Somatropin)
Saizen (Somatropin)
Serostim (Somatropin)

Indication:

Somatropin-deficient adults who meet the following criteria:

1. Biochemical diagnosis of somatropin deficiency by means of a negative response to standard growth hormone stimulation test.

2. This deficiency either alone or with multiple hormone deficiencies as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma.

Pediatric criteria:

1. Diagnosis of neurosecretory growth hormone dysfunction or lack of adequate endogenous growth hormone;

2. Diminished peak serum growth hormone response of less than seven (7) mg/ml to, at least, two (2) provocative stimuli;

3. Growth rate less than 4.5cm per year between ages of 0-12;

4. For ongoing therapy, there must be evidence of growth of 1-2' per year to continue therapy;

5. Chronic renal insufficiency resulting in reduced growth hormone and provocative stimuli is not required for this condition.

Prior Authorization Requirement:
Documentation of all of the above criteria.

Serostim (Somatropin)

Indication:
Treatment of AIDS wasting syndrome and cachexia

Prior Authorization requirements:
Documentation of the above diagnosis.

H2-antagonists

Drug: Axid (Nizatidine)
Pepcid (Famotidine)
Zantac (Raniditine)

Indication:

1. Peptic ulcer disease/ gastritis /duodenitis
   - acute dosage up to 2 months
   - maintenance dosage up to one year

   (See the DUR Board Criteria, Appendix 6)

2. GERD (gastroesophageal reflux disease)
   - acute dosage up to 3 months
   - maintenance dosage may be authorized for up to one year

   (See the DUR Board Criteria, Appendix 6)

3. Hypersecretory States (Zollinger-Ellison Syndrome)

4. Others
   - Depends on the situation, medical necessity must be documented on the prior authorization form.

Restriction Criteria:

1. Over-the -counter products which are listed on the OTC Formulary are available without prior authorization (see Appendix 6);

2. Claims for these products will be reimbursed if the diagnosis is one of the following:

   - Peptic Ulcer Disease ICD-9 Code 536.8;
   - Gastroesophageal Reflux Disease (including erosive esophagitis) ICD-9 Code is 530.11;
   - Hypersecretory States (Zollinger-Ellison Syndrome) ICD-9 Code is 251.5.
   - Note: A diagnosis code for heartburn or acid indigestion will not be accepted.

3. If no diagnosis code is provided, the claim will be rejected.

4. Acute dosing must be for limited periods of time with subsequent reduced maintenance dosing. For example:

   Zantac Acute Therapy Guidelines:
   Peptic ulcer/gastritis/duodenitis- Zantac 300mg x 60 days
   GERD- Zantac 600mg x 90 days

   Zantac Maintenance Therapy Guidelines:
   Peptic ulcer/gastritis/duodenitis- Zantac 150mg x up to 1 year
   GERD- Zantac at less than 600mg/day x up to 1 year

Prior Authorization Requirements:

1. Other Prescription Histamine H2 Antagonists will be considered:

   - If cimetidine has been tried at adequate doses for at least 2 weeks unless serious side effects have developed or have a true potential of developing. On the Prior Authorization form, please specify what the side effects were or are projected to be. If cimetidine was ineffective, please note the dose and the period of time it was used.

   - For those patients who are seriously ill and on medications that have a low therapeutic ratio.

   - Some exceptions may be made for school age children.

2. Liquid Zantac (Ranitidine)

   A. Adult:

      1. Documented gastrostomies;

      2. Documented need for H2 antagonist and unable to take cimetidine because of drug-drug interactions (such as cytochrome P-450 pathway, when adjustment of dosage of anti-convulsant medications is not feasible);

      3. Up to 1 year of prior authorization approval.

   B. Children 21 years of age and Under:

      1. Up to 1 year of prior authorization approval;

      2. For maintenance therapy of documented GERD (Gastroesophageal reflux disease);

3. Prior authorizations are not needed for dosage changes during the approved period.

Note: Cimetidine is not totally contraindicated for patients who are also taking other medications, which are metabolized, via the cytochrome P-450 pathway but dose adjustments of these agents may be necessary.

Note: Once prior authorization has been approved for one of the products in this category, the drug may be changed to another product in this class within the approved time period without a new request. However, the alternative(s) must be listed on the original Prior Authorization form.

Herceptin (Trastuzumb)

Indications:

1. Treatment as a single agent for metastatic breast cancer in patients whose tumors over-express the HER2 protein and who have received one or more chemotherapy regimens for their disease

2. Treatment in combination with paclitaxel for metastatic breast cancer in patients whose tumors over express HER2 and who have not received any chemotherapy for their disease

Prior Authorization Requirements:

1. Significant HER2 protein over-expression must be present. The HER2 overexpression test results must be included on the prior authorization form; and

2. Documentation of one of the above indications.

Humatrope (Somatropin)

See Growth Hormone

Hycamtin (Topotecan)

Indication:
Treatment of metastatic carcinoma of the ovary after failure of initial or subsequent chemotherapy. This is not first-line therapy.

Prior Authorization Requirement:
For the above indication only

Immunosuppressant Drugs

Drugs: oral cyclophosphamide,
oral methotrexate, and
oral prednisone

Indications:

1. FDA approved indications; and

2. Immunosuppressive therapy for patients who have had organ transplants.

Restriction Criteria for Medicare/Medicaid dual eligible recipients:

1. FDA approved indications other than to prevent transplant rejections:

    - A diagnosis code must be on the claim to prevent unnecessary rejection of Medicaid Fee-for-service claim processing;

    - Two (2) examples are as follow.

        1. Diagnosis code for Arthritis is 716.9;

        2. Diagnosis code for Asthma is 493.9.

    - All strengths of these agents are included (i.e. Prednisone 1mg, 5mg, 10mg, 20mg, etc.)

2. For Medicare-covered organ transplants:

    - Medicare will pay for immunosuppressants (all strengths) if used to prevent transplant rejection and Medicare must be billed first;

    - Medicaid will deny claims for immunosuppressant drugs unless an appropriate rejection from Medicare is attached with the claim;

    - Include on Medicaid claims for transplant recipients the diagnosis code for transplants: V42.0 – V42.9; 996.0-996.52, 996.8

    - If claims are submitted to the Medicaid program without a diagnosis code, they will be rejected to bill Medicare first.

Isoniazid

Indications:
FDA approved indications other than pulmonary tuberculosis

Restriction Criteria:
For chemoprophylasis of tuberculosis for children (Diagnosis Code 795.5)

1. Under 19 years of age; and

2. At least one positive tuberculin skin test; and

3. A negative chest x-ray; and

4. Claims for isoniazid must be for products of manufacturers who participate in the Federal Drug Rebate Program; and

5. The diagnosis code 795.5 (tuberculin skin test converter) must be included on the claim for payment to be considered.

Prior Authorization Requirements:
FDA approved indication other than pulmonary tuberculosis (ICD-9 codes: 10.0, 10.8-10.9, 11.0 -11.2, 11.4,11.8,11.9)

Note:
Recipients who have active tuberculosis must continue to be treated at Lanakila Health Center, Leahi Hospital or Local Health Department Tuberculosis Clinics on the Outer Islands. Follow-up of contacts of tuberculin positive individuals is also considered to be the responsibility of the Department of Health.

Lac-hydrin (Ammonium Lactate)

Indication:
Dermatological conditions other than simple dry skin

Restriction Criteria:
Physicians who are registered with Medicaid with the subspecialty of Dermatology will not need a prior authorization.

Prior Authorization Requirement:
Documentation of the dermatological condition.

Lotrisone Cream (Clotrimazole and Betamethasone)

Indication:
FDA approved indications.

Restriction Criteria:
Physicians who are registered with Medicaid with the subspecialty of Dermatology do not need a prior authorization.

Note:

1. The individual ingredients in this combination will be available for compounding in the generic or OTC forms only without prior authorization.

2. If the pharmacist receives approval from the physician to dispense the two (2) single ingredients instead of the Lotrisone, the two (2) products must be compounded together and billed as a single compounded prescription. The pharmacy must supply the NDC numbers and the quantities used, etc., and may bill Medicaid for one dispensing fee plus one compounding fee of $1.50 for mixing the two (2) agents together.

Prior Authorization Requirement:
Documentation of failure or side effects from the compound of the two (2) single ingredients.

Lupron (Leuprolide Acetate)

See Gonadotropin-Releasing Hormone Analog

Meridia (Sibutramine)

Indications:

1. Weight loss in patients with an initial Body Mass Index (BMI) greater than or equal to 30kg/m^2 **OR** greater than or equal to 27kg/m^2 in the presence of at least one other risk factor such as hypertension, sleep apnea, diabetes, dyslipidemia, coronary heart disease or other artherosclerotic diseases;

2. Maintenance of weight loss

Prior Authorization Requirements:

1. Must be for one of the indications noted above; and

2. Used in conjunction with a reduced calorie diet.

3. Provide the following information on the Request for Medical Authorization (Form 1144):

   A. For initial weight loss, state the recipient's BMI or provide the height and weight. If the BMI is equal to or greater than 27kg/m^2 but less than 30kg/m^2, state at least one risk factor;

   B. For subsequent weight loss or for maintenance of weight loss, provide the initial and current BMI; and

   C. State recipient is on a reduced calorie diet.

Note:
Initial approval will be for a maximum of 3 months. If there is weight loss or the recipient has been able to maintain prior weight loss during this initial period, subsequent prior authorization requests may be approved up to a maximum of 6 months.

Methylphenidates

Indications:
Treatment of hyperkinesis (Diagnosis Code 314 or 429.82) attention deficit disorders (Diagnosis Code 314) or narcolepsy (Diagnosis Code 347)

Restriction Criteria:
The diagnosis must appear on the prescription and the claim.

Neo-Calglucon (Liquid Calcium)

Indication:
Calcium deficiency

Prior Authorization Criteria:

1. Replacement of calcium in documented calcium deficient patients that require tube feedings of calcium, etc.

2. Up to 1 year of prior authorization approval.

Nexium (Esomprazole)

See Proton Pump Inhibitors

Nonsteroidal Anti-Inflammatory Drugs

Indications:
FDA approved indications

Note:

1. Over-the-counter products listed on the OTC Formulary are available without prior authorization for FDA approved indications;

2. Generic products are available without prior authorization for FDA approved indications;

3. Based on diagnosis codes and age, selective COX-2 inhibitors are available without prior authorization.

Prior Authorization Criteria:

1. For single source prescription nonsteroidal anti-inflammatory drugs

   A. At least two (2) generically available products have been given adequate trials and have proven ineffective; and

   B. Documentation of the drug, the dose and the length of time for each generic tried is included on the prior authorization form;

   C. If serious side effects developed or have a real potential of developing, document them on the prior authorization form.

2. For selective COX-2 inhibitors, see

   A. Celebrex (Celecoxic)

   B. Vioxx (Rofecoxib)

Note:
Once Prior Authorization has been approved for a single source product in this class, the drug may be changed to another single source product within the approved time period without a new request. However, the alternative(s) must be listed on the original prior authorization form.

Exception:
Toradol (Ketorolac tromethamine) is **not** included in this category since it is generally used for pain and is only authorized for a 5-day supply.

Examples of oral products that were single source but have generics available today are:

Daypro (Oxaprozin)
EC-Naprosyn (Naproxen delayed release)
Lodine (Etodolac)
Oruvail (Ketoprofen SR)
Voltaren (Diclofenac)

Examples of oral products that are single source prescription nonsteroidal anti-inflammatory agents are:

Mobic (Meloxicam)
Relafen (Nabumetone)

Note: Once prior authorization has been approved for one of the products in this category, the drug may be changed to another product in this class within the approved time period without a new request. However, the alternative(s) must be listed on the original Prior Authorization form

Norvasc (Amlodipine)

Indication:

1. Angina

2. May be considered for Hypertension if Adalat CC or other calcium channel blockers have proven to be ineffective after at least a 2-week trial.

3. If Adalat or other calcium channel blocker was discontinued due to significant side effects, note these on the 1144 form. If these were ineffective, please note the dose and the length of time used.

Norditropin (Somatropin)

See Growth Hormone

Nutropin (Somatropin)

See Growth Hormone

Ontak (Denileukin diftitox)

Indications:
Persistent or recurrent cutaneous T-cell lymphoma (CTCL) that's malignant cells expresses the CD25 component of the IL-2 receptor.

Prior Authorization Requirements:

1. Documentation of malignant cells testing positive for CD25 expression;

2. Significant reduction in tumor size should be seen prior to the fourth (4^{th}) course of treatment. Three (3) treatment cycles (of 5 days each) will be approved initially.

Over the counter (OTC) products

See OTC Formulary, Appendix 6.

Pancretin (Alitretinoin)

Indication:
Topical treatment of cutaneous lesions due to AIDS-related Kaposi's Sarcoma (KS)

Prior Authorization Requirement:

1. Systemic anti-KS treatment is not needed. Note on the prior authorization form that no systemic KS treatment is indicated.

2. Systemic treatment would be indicated in such instances of more than ten (10) new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS or symptomatic visceral involvement.

Note: Approval period = 14 weeks. Maximum quantity for the approval period = 3 tubes. Submit another Prior Authorization 1144 form with justification if therapy is needed for longer.

Pepcid (Famotidine)

See H2-antagonists

PHOTOFRIN (Porfimer Sodium)

Indications:

1. Palliation of patients with partially or completely obstructing esophageal cancer who cannot be satisfactorily treated with Nd:YAG laser therapy; and

2. Treatment of microinvasive endobronchial non-small cell lung cancer in patients for whom surgery and radiotherapy are not indicated

Prior Authorization Requirements:
Documentation of one of the above indications

Prevacid (Lansoprazole)

See Proton Pump Inhibitors

Prilosec (Omeprazole)

See Proton Pump Inhibitors

Procardia XL (Nifedipine XL)

Indications:

1. Angina

2. Hypertension if Adalat CC is not effective or was discontinued due to side effects.

Prior authorization requirements:

1. Diagnosis of angina

2. Considered for hypertension if Adalat CC has proven to be ineffective after a trial of at least 2 weeks.

3. If Adalat CC was discontinued due to side effects, note these on the 1144 form. If Adalat CC was ineffective, please note the dose and the length of time used.

Protonix (Pantoprazole)

See Proton Pump Inhibitors

Proton Pump Inhibitors

Drugs: Aciphex
Nexium
Prevacid
Prilosec
Protonix

Restriction Criteria:

1. A 14-day supply of PPIs may be provided without a prior authorization if a diagnosis of H.Pylori is noted on the prescription and claim. ICD-9 codes 008.43 or 041.86 are acceptable diagnosis codes. Any other diagnosis or for a greater length of therapy, prior authorization approval is required.

2. Internists or pediatricians with a subspecialty of Gastroenterology may prescribe PPIs without prior authorization if a diagnosis of gastroesophageal reflux disease (GERD) ICD-9 code = 530.81 is noted on the prescription and the claim. The prescriber's specialty must be registered with the Medicaid program. PPIs prescribed for any other diagnosis regardless of prescriber specialty requires prior authorization approval.

Note:

1. H2 blockers do not have to be tried first for prior authorization of PPIs to be approved for Gastroesophageal Reflux Disease (GERD).

2. If a PPI is prescribed concurrently with a histamine H2-receptor antagonist (Zantac, Pepcid, Axid or Tagamet) or sucralfate (Carafate), it will be considered duplicative therapy and will not be reimbursed if both medications are dispensed by the same provider.

Indications:

1. Duodenal ulcer

2. Erosive or ulcerative GERD

3. Hypersecretory condition

4. Others – depends on the situation; medically necessity must be documented

Prior authorization requirements:

- Duodenal ulcers – 20mg daily for 4 to 8 weeks
- Erosive or ulcerative GERD – 20mg daily for 4 to 8 weeks (an additional 8 weeks may be considered); maintenance 20mg daily
- Hypersecretory conditions
- Other – depends on medical necessity

Note:

❖ If additional lengths of therapy are needed, please justify and provide the long term treatment plan.

❖ If prescribed concurrently with a histamine H2-receptor antagonist (Zantac, Pepcid or Axid) or sucralfate (Carafate), this will be considered duplicative therapy and will not be reimbursable.

NEXIUM (Esomeprazole)

Indications: 1. GERD
2. Erosive esophagitis
3. H. Pylori
4. Others – depends on the situation; medically necessity must be documented

Prior authorization requirements:

- GERD – 20mg daily for 4 to 8 weeks
- Erosive Esophagitis – up to 40mg daily for 4 to 8 weeks; maintenance 20mg daily
- H. Pylori – greater than 14 days supply
- Other – depends on medical necessity

Note:

- ❖ If additional lengths of therapy are needed, please justify and provide the long term treatment plan.

- ❖ If prescribed concurrently with a histamine H2-receptor antagonist (Zantac, Pepcid or Axid) or sucralfate (Carafate), this will be considered duplicative therapy and will not be reimbursable.

PREVACID (Lansoprazole)

Indications:

1. GERD

2. Duodenal Ulcer 3. H. Pylori

3. Gastric Ulcer

4. Erosive esophagitis

5. Hypersecretory Conditions

6. Others - depends on the situation and medical necessity must be documented.

Prior authorization requirements:

- GERD - 30mg daily for up to 8 weeks (an additional 8 weeks if needed) for treatment and 15 mg daily for maintenance.

- Duodenal Ulcer - 15mg daily for 30 days

- H. Pylori – if greater than 14 days of therapy

- Gastric Ulcer – 30mg daily for up to 8 weeks

- Erosive esophagitis – 30mg daily for 8 weeks (an additional 8 weeks if needed) for treatment and 15mg daily for maintenance

- Hypersecretory conditions

- Other conditions – depends on medical necessity

Note:

- ❖ If additional lengths of therapy are needed, please justify and provide the long term treatment plan.

- ❖ If prescribed concurrently with a histamine H2-receptor antagonist (Zantac, Pepcid or Axid) or sucralfate (Carafate), this will be considered duplicative therapy and will not be reimbursable.

PRILOSEC (Omeprazole)

Indications:

1. GERD
2. Duodenal ulcer
3. H. Pylori
4. Gastric ulcer
5. Severe erosive esophagitis
6. Hypersecretory conditions
7. Others – depends on medical necessity

Prior authorization requirements:

- GERD without esophageal lesions – 20mg daily for up to 4 weeks
- GERD with erosive esophagitis -20mg daily for 4 to 8 weeks
- Duodenal Ulcer- 20mg daily for month of therapy (an additional 4 weeks may be considered)
- H. Pylori – longer than 14 days of treatment
- Gastric Ulcer – 40mg daily for 4 to 8 weeks

- Severe erosive esophagitis – 20mg daily 4 to 8 weeks for treatment; 20mg daily for maintenance

- Hypersecretory conditions

- Others – depends on medical necessary

Note:

❖ If additional lengths of therapy are needed, please justify and provide the long term treatment plan.

❖ If prescribed concurrently with a histamine H2-receptor antagonist (Zantac, Pepcid or Axid) or sucralfate (Carafate), this will be considered duplicative therapy and will not be reimbursable.

Protonix (Pantoprazole)

Indications:
Short-term treatment (up to 8 weeks) in the healing and symptomatic relief of erosive esophagitis associated with GERD. For those patients who have not healed, and additional 8 weeks of treatment may be considered

Prior authorization requirements:
Documentation of the above diagnosis

Provide the following information on the Request for Medical Authorization (Form 1144):

1. Diagnosis of erosive esophagitis

2. Initial therapy or second course

The approval will be for a maximum of 40mg daily for 8 weeks per treatment and the number of treatments limited to two per episode.

Note:

- If additional lengths of therapy are needed, please justify and provide the long term treatment plan.

  If prescribed concurrently with a histamine H2-receptor antagonist (Zantac, Pepcid or Axid) or sucralfate (Carafate), this will be considered duplicative therapy and will not be reimbursable.

Protopin (Somatrem)

See Growth Hormone

Provigil

Indications:
Treatment of narcolepsy (Diagnosis Code 347)

Restriction Criteria:
The diagnosis must appear on the prescription and the claim.

Questran (Cholestyramine)

All forms except bulk powder or granular dosage forms were removed from the Formulary. Bars, chewable forms or pre-measured packets were excluded based on the comparable high cost per dose.

Ranitidine

See H2 antagonists

Rebetron (Rebetol [Ribavirin] with Intron A)

Indication:
Treatment of chronic hepatitis C in-patients with compensated liver disease previously untreated with alfa interferon or who have relapsed following alpha interferon therapy

Prior authorization requirements:
All of the following must be present:

1. Compensated Chronic Hepatitis C; and

2. HCV Antibody Positive; and

3. Elevated ALT level

Regranex (Becaplerium)

Indication:
Lower extremity diabetic neuropathic ulcers

Prior authorization requirements:
Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue and beyond and have an adequate blood supply.

Relenza (Zanamivir)

Restriction Criteria:
Five (5) day maximum supply

REMICADE (Infliximab):

Indications:

1. Moderate to severe and fistulating Crohn's Disease

2. Rheumatoid Arthritis (Diagnosis Code 714.0)

Restriction Criteria:
Remicade is available without prior authorization if prescribed by a rheumatologist for the diagnosis of rheumatoid arthritis (diagnosis code 714.0).

Prior Authorization Requirements:

1. For Crohn's Disease

   A. Diagnosis of moderate to severe or fistulating Crohn's Disease

   B. Other conventional agents such as sulfasalazine, mesalamine derivatives, steroids, azathioprine, 6-mercaptopure, or metronidazole are ineffective or are not medically appropriate.

   C. Limits for treatment:

      1) For moderate to severe: maximum one (1) dose only

      2) For fistulating: Maximum three (3) doses

2. For Rheumatoid Arthritis

   A. Diagnosis of rheumatoid arthritis and

   B. Treatment with methotrexate and at least one (1) other disease modifying anti-rheumatic drug (DMARD) including antimalarials, gold, D-penicillamine, and azathioprine is not adequate, effective or medically appropriate.

   C. Provide the following information on the Request for Medical Authorization (Form 1144):

      1) State treatment with methotrexate has not been adequate or effective or is not medically appropriate. If not medically appropriate, explain.

      2) Provide the name of at least one (1) other DMARD that has not been effective.

Note: If the infusion is to be done in the home setting, home pharmacy services and supplies related to the infusion of Remicade must be prior authorized.

RespiGam (Human respiratory syncitial virus [RSV] immune globulin)

Indication:
Prevention of Serious Lower Respiratory Tract Infections caused by Respiratory Syncytial Virus (RSV)

The following guidelines for the prevention of RSV and coverage of this agent by Hawaii QUEST medical plans and the fee-for-service Medicaid Program have been developed by the medical directors in consultation with the University of Hawaii School of Medicine's Pediatric Infectious Disease Group.

Recommended Guidelines

Patients who should be considered for RSV prophylaxis should be in one or more of the following groups:

- Premature infants with BPD and who are on supplemental oxygen and less than eight (8) months chronological age [corrected age of less than six (6) months] as of December of the year of their birth.

- Infants born at less than 32 weeks gestation with a history of one or more respiratory tract infections which required hospitalization who are under eight (8) months age [corrected age of less than six (6) months] as of December of the year of their birth.

- Infants 28 weeks gestation or less and who are less than twelve (12) months of age at the start of the RSV season.

- Infants and children less than two (2) years of age at the start of the RSV season with chronic lung disease (CLD) who were receiving long term medical therapy for treatment of their CLD within six (6) months before the anticipated RSV season.

Recommended Treatment

- Maximum of four (4) monthly doses to start as early as late October and to end no later than March.

- RespiGam is indicated for the PREVENTION of RSV and should NOT be used in-patients who have RSV infections.

Additional Considerations

- The physician must weigh the side effects of this agent against the benefit gained from preventing RSV infections.

- RespiGam should not be administered at the same time as routine childhood immunizations and may interfere with response to immunizations.

- RespiGam is not approved by the Food and Drug Administration (FDA) for use in-patients with congenital heart disease (CHD). RespiGam is contraindicated in cyanotic CHD.

Retin A (Tretinoin)

Indication:
Medically indicated skin conditions including acne and other dermatoses. Retin A is not reimbursable for wrinkles.

Restriction criteria:
Must be for a medically indicated skin condition or dermatoses. Wrinkles are not included.

Risperdal (Risperidone)

See Atypical Anti-psychotics

Rituxan (Rituximab)

Indication:
Relapsed of refractory low-grade or follicular, CD20+, B-cell Non Hodgkin's Lymphoma

Prior authorization requirements:
Documentation of the above diagnosis

Saizen (Somatropin)

See Growth Hormone

Seroquel (Quetiapine)

See Atypical Anti-psychotics

Serostim (Somatropin)

Indication:
Treatment of AIDS wasting syndrome and cachexia (Also see Growth Hormone)

Prior Authorization requirements:
Documentation of the above diagnosis.

Synagis (Palvizumab)

Indication:
Prevention of serious lower respiratory tract infections caused by Respiratory Syncytial Virus (RSV)

The following guidelines for the coverage of this agent by the fee-for-service Medicaid Program have been developed by the medical directors in consultation with the University of Hawaii School of Medicine's Pediatric Infectious Disease Group.

Recommended Guidelines
Patients who should be considered for RSV prophylaxis should be in one or more of the following groups:

- Premature infants with BPD and who are on supplemental oxygen and less than eight (8) months chronological age [corrected age of less than six (6) months] as of December of the year of their birth.

- Infants born at less than 32 weeks gestation with a history of one or more respiratory tract infections which required hospitalization who are under eight (8) months age [corrected age of less than six (6) months] as of December of the year of their birth.

- Infants 28 weeks gestation or less and who are less than twelve (12) months of age at the start of the RSV season.

- Infants and children less than two (2) years of age at the start of the RSV season with chronic lung disease (CLD) who were receiving long term medical therapy for treatment of their CLD within six (6) months before the anticipated RSV season.

Recommended Treatment
- Maximum of four (4) monthly doses to start as early as late October and to end no later than March.

- Synagis is indicated for the PREVENTION of RSV and should NOT be used in patients who have RSV infections.

Additional Considerations
- The physician must weigh the side effects of this agent against the benefit gained from preventing RSV infections.

- Synagis is not approved by the Food and Drug Administration (FDA) for use in-patients with congenital heart disease (CHD).

- As Synagis is given intramuscularly, it must be used with caution in-patients with thrombocytopenia and coagulation disorders.

- A second (2^{nd}) course of Synagis therapy in the following season is rarely indicated.

Tamiflu (Oseltamivir phosphate)

Restriction Criteria:
Authorized for a 5-day supply.

Taxotere (Docetaxel)

Indications:

1. Anthracycline resistant breast cancer

2. Treatment of locally advanced ore metastatic non-small cell lung cancer after failure of prior platinum-based chemotherapy

Prior Authorization Requirements:
Documentation of one of the above indications

Toradol (Ketorolac tromethamine)

Indications:
Treatment of acute pain

Restriction Criteria:
Authorized for a 5-day supply per thirty days.

Tritec (ranitidine bismuth citrate)

Indications:
Treatment of active duodenal ulcer associated with H. Pylori infection and used in conjunction with an antibiotic (like Biaxin or other antibiotic) deemed necessary by the prescriber. This is not intended to be prescribed alone.

Restriction criteria:

Tritec is available without prior authorization if the following are appropriate:

1. Diagnosis for H.Pylori (041.86 or 008.43) and

2. Days supply does not exceed 28 days

This information must be included on the claim.

Prior authorization requirements:

- Any diagnosis other than H.Pylori

- If treatment for H.Pylori will last longer than 28 days, justification for the extended therapy must be documented.

Note: In cases of multiple treatments, pharmacists are encouraged to use appropriate drug utilization review considerations.

Valstar (Valrubicin)

Indication:
Bladder Cancer – for intravesical therapy of BCG-refractory carcinoma in situ (CIS) of the urinary bladder in-patients for whom immediate cystectomy would be associated with unacceptable morbidity or mortality.

Prior authorization requirements:
Documentation of the above diagnosis.

Vesanoid (Tretinoin)

Indication:
Acute Promyeloytic Leukemia (APL) for a maximum of 90 days

Prior Authorization requirements:
Documentation for the above diagnosis and period of time

Viadur (Leuprolide Acetate)

See Gonadotropin-Releasing Hormone Analog

Vicoprofen (Hydrocodone w/ibuprofen)

Indications:
Analgesia, acute or chronic

Prior authorization requirements:

1. Documentation of trial and failure on other similar combination products which are much less expensive; and

2. Documentation of acute or chronic pain.

Vioxx (Rofecoxib)

Indications:
1. Osteoarthritis or degenerative joint disease

2. Primary dysmenorrhea

3. Acute pain

Restriction Criteria:

Vioxx is available without prior authorization if the following are appropriate:

1. The recipient is over age 60; and

2. Has a diagnosis of osteoarthritis or degenerative joint disease (Diagnosis Code 715.9). The diagnosis code and the recipient's age must be included on the claim.

Prior authorization requirements for recipients 60 years of age and under:

1. Diagnosis of osteoarthritis or degenerative joint disease, primary dysmenorrhea or acute pain and

2. At least **one** of the following documented under "justification" on the Request for Medical Authorization (Form 1144):

   a.) History of gastrointestinal bleed or gastric or duodenal ulcer,

   b) History of symptoms of peptic ulcer disease, gastritis, or gastroesophageal reflux disease while on conventional NSAID(s),

   c) Concurrent use of corticosteroids,

   d) Concurrent use of warfarin or heparin, or

   e) History of platelet dysfunction or coagulopathy.

Note: For recipients with a diagnosis of acute pain, Vioxx will only be prior authorized for a MAXIMUM of three (3) months. After this time period, the pain will be considered chronic and other management strategies should be considered.

Vitamin B12

Indications:
Vitamin B_{12} Deficiencies

Restriction criteria:
No prior authorization is required if one of the following diagnoses is appropriate:

Malabsorption syndrome of Vitamin B_{12} due to gastrectomy	579.3
Pernicious anemia	281.0
Other Vitamin B_{12} anemias	281.1
Vitamin B_{12} and Folate anemia	281.3
Vitamin B_{12} deficiency	266.2

The diagnosis code must be included on the claim.

Prior authorization requirements:
Document the diagnosis of vitamin deficiency and medical necessity.

Vitamin C

Indications:

1. Scurvy – treatment

2. Acidify the urine for urinary tract infection

Restriction criteria:
No prior authorization is required if the appropriate diagnosis is Urinary Tract Infection. Use one of the following ICD-9 codes: 582.0-582.9; 590.0-590.01; 590.9; 595.1; 595.2.

The diagnosis code must be included on the claim.

Prior authorization requirements:
Document the diagnosis and medical necessity.

VITAMINS, MULTIPLE

Indications:

Restriction criteria:
No prior authorization is required if:

a. The appropriate diagnosis (with ICD-9 code)is:

- Pregnancy or lactation (V22.0-V22.2, V23, 611.6, 675.2, 676.4-676.6, 676.8, or 676.9);or

- End stage renal disease (ESRD) (585)

The diagnosis code must be included on the claim

b. The recipient is residing in a LTC facility;

c. Children under 12 years of age for pediatric multivitamins including those with fluoride

Prior authorization criteria:

Document the diagnosis of a vitamin deficiency and medical necessity with one of the following diagnoses/conditions (with ICD-9 code):

Mental retardation;
Spastic quadriplegia with GI problems;
Tube fed;
Low body weight;
Osteoporosis;
Child under the age of 12 years;
Compromised physical condition such as an elderly patient with poor nutrition, alcoholism with cirrhosis, or an electrolyte imbalance; or
in a SNF on a long-term basis.

XENICAL (Orlistat)

Indications:

1. For patients with an initial Body Mass Index (BMI) greater than or equal to 30kg/m^2 **OR** greater than or equal to 27kg/m^2 in the presence of at least one other risk factor such as hypertension, sleep apnea, diabetes, dyslipidemia, coronary heart disease or other artherosclerotic diseases; and

2. Maintenance of weight loss

Prior Authorization Requirements:

1. Must be for one of the indications noted above; and

2. Used in conjunction with a reduced calorie diet

Provide the following information on the Request for Medical Authorization (Form 1144):

1. For initial weight loss, state the recipient's BMI or provide the height and weight. If the BMI is equal to or greater than 27kg/m^2 but less than 30kg/m^2, state at least one risk factor ;

2. For subsequent weight loss or for maintenance of weight loss, provide the initial and current BMI; and

3. State recipient is on a reduced calorie diet

Note: Initial approval will be for a maximum of 3 months. If there is weight loss or the recipient has been able to maintain prior weight loss during this initial period, subsequent prior authorization requests may be approved up to a maximum of 6 months**.** A daily

multivitamin is recommended while taking Xenical but is not a requirement for prior authorization. A multivitamin will be approved if used in conjunction with Xenical. If a multivitamin is not included on the prior authorization with Xenical and a separate request is submitted, please state it is being used in conjunction with Xenical to expedite approval.

ZANTAC (Ranitidine)

See H2 Antagonists

Zyprexa (Olanzapine)

See Atypical Anti-psychotics

Zyrtec (Cetirizine)

See Antihistamines, non-sedating

DRUG USE REVIEW PROGRAM

Medicaid Program
State of Hawaii

Executive Summary

Section 1927(g) of the Social Security Act requires that a drug use review program be established for covered outpatient drugs to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes. The Drug Use Review (hereinafter "DUR") Program assesses data on drug use against predetermined standards which are consistent with widely recognized compendia and the peer reviewed medical literature. The DUR Program is comprised of four major components.

Prospective DUR

Prospective DUR involves screening for drug therapy problems before each prescription is filled or dispensed at the point of sale. As part of prospective DUR, based upon standards established by applicable State law and/or DUR Board, a pharmacist must offer to counsel Medicaid patients or caregivers concerning matters, which the pharmacist considers significant. In addition, the pharmacist must make reasonable efforts to maintain patient profiles.

Retrospective DUR

Retrospective DUR involves using existing Medicaid information systems or other systems to implement ongoing periodic assessments of drug claims data, based upon predetermined standards, to monitor for therapeutic appropriateness and specific problems specified in the statute.

Educational Program

A vital component of Retrospective DUR is the educational program conducted through DUR Board guidance. General information dissemination and interventions are intended to improve prescribing and dispensing practices, and educate practitioners on common and serious drug therapy problems.

DUR Board

An advisory board must be appointed whose members must have expertise as specified in the statute, and must include licensed actively practicing physicians and pharmacists. Activities of the DUR Board include retrospective DUR, application of standards, and ongoing education and interventions, as well as preparation of an annual report to the State.

GENERAL REQUIREMENTS

Effective Date

DUR Program requirements must be met no later than January 1, 1993.

Nursing Facility Residents

Drugs dispensed to nursing facilities residents are subject to all requirements of the DUR program except those relating to Patient Counseling.

Organized Health Care Setting Exemption

1. A hospital dispensing outpatient drugs is exempt from the DUR Program if it uses a drug formulary and bills Med-QUEST at no more than its purchasing costs.
2. Covered outpatient drugs dispensed by health maintenance organizations are not subject to the requirements of the DUR Program.

Predetermined Standards

The DUR Program assesses drug use against predetermined standards found in the three compendia specified below and the peer reviewed medical literature.

1. American Medical Association Drug Evaluations
2. United States Pharmacopeia Drug Information
3. American Hospital Formulary Service Drug Information

Compliance with this statutory requirement (see §1927(g)(1)(B) of the Act) is based on the considerations that follow.

1. **Definition:** Predetermined standards include:
   a. Criteria: These are predetermined elements of health care based upon professional expertise, prior experience, and the professional literature with which the quality, medical necessity, and appropriateness of health care services may be compared.

   b. Standards: These are professionally developed expressions of the range of acceptable variation from a criterion.

2. **Source of Standards**: Predetermined standards may be developed by the DUR Board *de novo*, may be acquired from vendors of prospective or retrospective DUR, and may also be obtained from academic researchers or other organizations.

3. **Approval of Standards**: Standards to be applied in the prospective and retrospective DUR sections must be approved by the DUR Board prior to implementation. This includes both the establishment of new and the revision of existing standards. This applies to clinical standards, which serve as the basis for prospective and retrospective DUR software but not to algorithms based upon those standards. DUR Board approval is also required for policy for establishing written criteria that must be used by pharmacies conducting prospective DUR without computers. The Board may also require that it approve specific written criteria used by such pharmacies.

4. **Standards Requirements**: Clinically acceptable predetermined standards must also meet the following requirements for DUR Board approval.

    a. Predetermined standards must be based upon the three specified compendia and the peer reviewed medical literature, which includes medical, pharmaceutical, or scientific publications where manuscripts are chosen for publication based upon critical review by unbiased independent experts.

    b. Differences between source materials must be resolved by the Board through a consensus process.

    c. Predetermined standards are nonproprietary and readily available to providers of service and the public.

    d. Predetermined standards must be clinically valid and scientifically based.

    e. Predetermined standards must be tested against claims data prior to implementation to assess the level of identifiable significant therapeutic problems.

    f. Predetermined standards applied in prospective and retrospective DUR must not be inconsistent.

    g. Predetermined standards must be subjected to ongoing evaluation, with inclusion of provider feedback and modification where necessary.

5. **Review Requirements**: The review based on clinical criteria uses predetermined standards to determine the population at risk of a clinically significant adverse medical result and applies standards, appropriate to this population, across providers and patients to determine the provider outliners whose prescribing, dispensing, or consumption practices may not conform to accepted standards of care. Various statistical measures may be applied to the data. Standards may be considered in deciding if an in-depth review is needed to determine whether to intervene once the potential therapeutic problems have been identified through the use of clinical criteria.

State Plan Assurance

Assurance that predetermined standards that meet all requirements have been approved by the DUR Board must be based on written documentation (e.g., Board minutes, memorandum).

Confidentiality

The DUR Program will ensure the confidentiality of patient related data consistent with Federal confidentiality requirements (see 42 CFR 431, Subpart F).

DRUG USE REVIEW (DUR) BOARD

General Requirements

See DUR Board Constitution and Bylaws (Appendix I).

Membership Requirements

DUR Board Members include health professionals with knowledge and expertise in one or more of the following areas:

1. Clinically appropriate prescribing of covered outpatient drugs;

2. Clinically appropriate dispensing and monitoring of covered outpatient drugs;

3. Drug utilization review, evaluation, and intervention;

4. Medical quality assurance.

See also the DUR Board Bylaws, Section II (Appendix I).

Medicaid Program/DUR Board Relationship

The DUR Board is an advisory body to the Hawaii Medicaid Program. The Medicaid Program has the authority to reject recommendations or decisions of the DUR Board. In the event of such rejections, the Medicaid Program will notify the DUR Board, in writing, of the reasons for such action and allow the DUR Board to reconsider its recommendation or decision.

DUR Board Activities

In addition to the broad purpose of the DUR Board stated in the Constitution, Article III (Appendix I), Section 1927 (g)(3)(c) of the Social Security Act assigns three specific activities to the Board. These activities are the application of standards, retrospective DUR, and ongoing interventions with pharmacists and physicians concerning therapy problems identified in the course of retrospective DUR.

1. **Application of Standards**

   a. **Retrospective DUR:** The DUR Board approves predetermined standards (criteria and standards) presented to it and those that the DUR Board develops. Board approval is required both for the implementation of new standards and for revision or elimination of existing standards.

      The Medicaid Program will generate reports on the application of standards to claims adjudicated through the State MMIS. Such reports provide he basis both for evaluation of standards by the DUR Board and for selection of interventions to be carried out by the DUR Board. Such reports will be generated no less frequently than quarterly and must indicate the number of claims run for each criterion, the incidence of screen failures for each criterion and for each provider, and the reasons for the failure. Reports will also aggregate failures, grouped by criterion for each provider and for each Medicaid recipient.
      The DUR Board, based upon review of the reports, evaluates experience with the use of predetermined standards and makes recommendations concerning modification or elimination of existing standards.

   b. **Prospective DUR:** The DUR Board reviews DUR databases to determine if they are based on accepted standards and contain the required screens. This does not mean that the Board must review and approve each database used by individual pharmacies. The responsibility of the DUR Board is limited to becoming familiar with DUR software, and approving the criteria for the DUR standards, which make up that software. It is the responsibility of the pharmacies to ensure that the databases they are using meet the DUR Board approved criteria.

The DUR Board review process is limited to the review of prospective DUR software databases known to the DUR Board and to evaluations requested by commercial vendors. The Board also develops policy guidelines for the use of written predetermined standards by pharmacies not using prospective DUR database software to conduct prospective DUR.

The Hawaii Medicaid Program submits information on prospective DUR database software to the DUR Board for evaluation. Upon notification of the results of this evaluation (unless an ECM system is established for prospective DUR), the Medicaid Program will provide information through provider bulletins to participating pharmacies concerning the acceptability of commercial prospective DUR database packages. As part of the compliance monitoring function, the DUR Program will ensure that participating pharmacies use acceptable prospective DUR database software or comply with guidelines on written criteria.

2. **Retrospective DUR**

The DUR Board approves predetermined standards and reviews reports on the results of the application of standards to develop recommendations concerning the modification or elimination of existing standards and the need for new ones.

Reports on the application of specific standards are generated which identify patterns of inappropriate and medically unnecessary care in terms of screen failures associated with specific physicians, pharmacists, and Medicaid recipients. These reports provide the basis for standards modifications and for education and intervention activities.

3. **Education and Intervention Program**

The Medicaid Program, through the DUR Board, educates practitioners with regard to common therapy problems to improve prescribing and dispensing practices. Intervention activities will include, but not be limited to:

a. Information dissemination;

b. Written, oral or electronic reminders;

c. Face-to-face discussions, and

d. Intensified review or monitoring.

Based upon in-depth reviews of the reports on the application of standards, the DUR Board engages in the following activities.

a. Recommend general education topics and develop educational materials matched to the drug therapy problems identified;

b. Share education topics with other entities involved in continuing education of pharmacists and physicians;

c. Recommend the mix of each type of provider specific intervention method (e.g., written, oral, electronic reminders, face-to-face discussion, increased review/monitoring), that would most effectively lead to improvement in the quality of drug therapy;

d. Make recommendations as to which mix of the interventions would most effectively lead to improvement in the quality of drug therapy;

e. Re-evaluate no less often than semiannually the appropriateness of existing intervention methods and make changes as appropriate.

The only direct role that the Hawaii Medicaid Program has in conducting education and interventions is to provide application of standards reports to the DUR Board.

Annual Report Requirement

The DUR Board prepares an annual report to the Hawaii Medicaid Program, which in turn is required to submit an annual report for the overall DUR Program to the Secretary of the Health Care Financing Administration (HCFA) no later than March 31st of each calendar year. The report provides the basis for evaluating the effectiveness of Hawaii's DUR Program.

DUR Board Annual Report Content

1. The report includes a description of the nature and scope of the retrospective DUR Program. It identifies the frequency of claims data screening, and the criteria and standards used. Copies of clinical criteria are enclosed with the report. Each succeeding year, only new or revised criteria and deleted criteria are required.

2. A summary is presented of non-patient/provider specific educational activities, e.g., continuing education meetings held and examples of written materials used. It includes information on the use of each type of intervention. It also assesses the effectiveness of each type of intervention on changes in prescribing/dispensing practices.

3. An evaluation of the adequacy of prospective DUR database software and details on policy guidelines adopted by the DUR Board pertaining to written criteria that pharmacies not using computer prospective DUR database may use is required.

STATE ANNUAL DUR PROGRAM REPORT

This report includes the DUR Board annual report and adds the following information:

1. A description of the prospective DUR Program, which indicates whether, prospective DUR is performed at the pharmacy site or is included in the ECM system. Included are details concerning State standards for counseling, requirements on maintenance of profiles, and, when applicable, documentation of DUR and counseling activities.

2. Cost savings estimates accrued to the DUR program. This includes a detailed specification of the methodology used to prepare the cost estimates. The cost estimates will distinguish between drug product cost savings and total Medicaid savings. Total Medicaid savings include estimation of savings resulting from reduced physician visits and hospital admissions related to the problems associated with the use of prescription drugs. Cost savings will also distinguish between savings attributable to prospective and retrospective DUR. Reports will focus on aggregate savings, not on changes associated with particular interventions or changes involving particular drugs or therapeutic classes of drugs, and will be adjusted for the impact of price increases, drug product rebates, and enrollee profiles.

DRUG USE REVIEW PROGRAM

Medicaid Program
State of Hawaii

PROSPECTIVE DUR

CLINICAL SCREENING

Prospective review of drug therapy is required for each prescription submitted by a Medicaid recipient before the prescription is filled or delivered at the point of sale or distribution. This review requires screening, based upon predetermined standards, for the following potential drug therapy problems:

- **Therapeutic duplication**: the prescribing and dispensing of two or more drugs from the same therapeutic class such that the combined daily dose puts the recipient at risk of an adverse medical result or incurs additional program costs without additional therapeutic benefit.

- **Drug disease contraindications**: the potential for, or the occurrence of, an undesirable alteration of the therapeutic effect of a given drug because of the presence, in the patient for whom it is prescribed, of a disease condition or the potential for, or the occurrence of, an adverse effect of the drug on the patient's disease condition.

- **Drug-drug interactions**: the potential for, or occurrence of, a clinically significant adverse medical effect as a result of the recipient using two or more drugs together.

- **Incorrect drug dosage or duration**: the dosage lies outside the daily dosage specified in predetermined standards as necessary to achieve therapeutic benefit. Dosage is the strength multiplied by the quantity dispensed divided by day's supply. Incorrect duration is when the number of days of prescribed therapy exceeds or falls short of the recommendations contained in the predetermined standards.

- **Drug allergy interactions**: the significant potential for, or the occurrence of, an allergic reaction as a result of drug therapy.

- **Clinical abuse/misuse**: the occurrence of situations referred to in the definitions of abuse, gross overuse, over-utilization, and under-utilization, as defined below, and incorrect dosage and duration, as defined previously.

a. **Abuse**: provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR 455.2)

b. **Gross overuse**: repetitive over-utilization without therapeutic benefit.

c. **Over-utilization**: use of a drug in a quantity, strength, or duration that is greater than necessary to achieve a desired therapeutic goal or that puts the recipient at risk of a clinically significant undesirable effect, or both.

d. **Under-utilization**: use of a drug in insufficient quantity, strength, or duration to achieve a desired therapeutic goal or that puts the recipient at risk of a clinically significant undesired effect, or both.

All definitions in this section are found in 42 CFR (Code of Federal Regulations) §456 unless specified otherwise.

1. **On Site Pharmacy Screening**: It is the sole responsibility of individual pharmacies participating in the Medicaid Program to undertake on site prospective DUR screening. Pharmacies may use prospective DUR software databases that are able to screen for the therapeutic problems listed above and do so on explicit standards. It is not expected that these databases will contain patient-specific diagnosis or allergy information. When, in the pharmacist's professional judgement, obtaining such information is essential, he/she should consult the patient or the patient's health care provider.

   Pharmacies without computers, or those which choose not to use prospective DUR database packages, must apply prospective DUR drug therapy screening that is consistent with the criteria included in references such as the American Hospital Formulary Service Drug Information (AHFS DI), the American Medical Association Drug Evaluations, the United States Pharmacopoeia Drug Information (USP DI), or peer reviewed medical or pharmaceutical literature.

2. **Electronic Claims Management (ECM) Based Screening**: It is anticipated that prospective DUR screening as a component of an approved ECM system (sometimes referred to as "point of sale") will eventually become the standard. At a minimum, an ECM system must screen for the problems specified above against drug claims history recorded in the Medicaid Management Information System (MMIS) or other drug claims processing system. Electronic alerts concerning potential therapeutic problems will be transmitted to the pharmacy where they serve as an aid to the pharmacist in the exercise of his or her professional judgement in filling the prescription.

PATIENT COUNSELING

Standards for counseling by pharmacists must be established under applicable State law. Applicable State law is defined as the State Pharmacy Practice Act or State Board of Pharmacy policy incorporated into State law by reference. There are no such precedents in the State of Hawaii, so patient-counseling standards will be established by the DUR Board.

The Offer to Counsel

1. The *offer* to counsel shall be made by the pharmacist in a face-to-face communication with each Medicaid patient or caregiver who presents a new or refill prescription, unless the offer is refused, matters which, in the pharmacist's professional judgement, are deemed significant.

2. The *offer to counsel* may be delegated to ancillary personnel.

3. In certain non-routine instances, it would be permissible for the *offer to counsel* to be made in a written communication, by telephone, or in a manner determined by the pharmacist as appropriate and reasonable, such as:

    a. in cases of language barriers or hearing impairments.

    b. in the case of mail order delivery, home health care delivery, or other instances where direct contact with the patient is not available, a toll-free number should be provided for counseling by a pharmacist. The patient should be informed of the availability of counseling and provided with the telephone number. A toll-free number is not necessary if most patients can access the pharmacy by a local or toll-free exchange or if most prescriptions are distributed in the pharmacy.

4. A refusal to accept an offer of counseling must be documented.

5. In no circumstances should the burden to receive counseling be shifted to the patient.

The Conduct of Counseling

The pharmacist must personally perform counseling with the patient or caregiver. This responsibility cannot be delegated to ancillary personnel. The content of counseling is governed solely by the professional judgement of the pharmacist. Topics for discussion may include:

1. Name and description of the medication;

2. Dosage form, dosage, route of administration and duration of therapy;

3. Special directions, precautions for preparation, administration and use by the patient;

4. Common and severe side effects, adverse effects or interactions, and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;

5. Techniques for self-monitoring drug therapy;

6. Proper storage;

7. Prescription refill information; and

8. Action to be taken in the event of a missed dose.

The counseling list is NOT to be interpreted as a checklist of information to be provided with each prescription. The pharmacist should use professional judgement to determine which information is most necessary in each case.

The pharmacist may supplement oral information with written information but may not use written information alone to fulfill the counseling requirement.

Patient Profiles

The pharmacist shall make reasonable efforts to obtain, record, and maintain information on Medicaid patients receiving prescriptions except when the pharmacist has reasonable belief that the patient will not continue to obtain prescription medications from that pharmacy. The collection, recording and maintenance of patient profiles may be delegated to ancillary personnel; however, the pharmacist is directly responsible for reviewing and interpreting patient profiles, and seeking clarification where confusing or conflicting information is present. It is expected that the pharmacist will be guided by professional judgement as to whether and when individual history information should be sought from the physician or other health care providers. Such profiles are to include at least the following information:

1. Patient name, address and phone number;

2. Date of birth (or age) and gender;

3. Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices currently in use by the patient;

4. Pharmacist comments relevant to the individual's drug therapy.

The patient profiles shall be maintained for at least three years from the date when the last prescription was filled.

Compliance Monitoring

Compliance with the requirements for prospective screening, counseling and maintenance of patient profiles will be monitored with the following techniques.

1. The *DUR Bulletin* will notify pharmacies of prospective DUR statutory and regulatory requirements.

2. Professional association communications such as the *Hawaii Medical Journal* and newsletters of the Hawaii Pharmaceutical Association will be used periodically to inform providers of prospective DUR standards, processes and results.

3. As part of the routine quarterly retrospective DUR profile screening, pharmacies showing high incidence of therapeutic problems detectable by prospective DUR screening will be identified.

4. Once a year, all Medicaid recipients will be informed of their rights to receive counseling through a Board mailing, and request feedback as to whether counseling was offered and received.

5. Pharmacy site inspections by the Compliance Section to review records documenting interventions as a result of prospective DUR screening and to review documentation on counseling and the maintenance of patient profiles will be performed yearly on a sample of no less than 2% of pharmacies, or upon specific recommendations of the DUR Board.

RETROSPECTIVE DUR

Pattern Analysis

There is an ongoing periodic screening of claims data, no less frequently than quarterly, to identify patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care. It is not necessary to screen against all predetermined standards as part of each periodic screening.

The objective of screening is to identify patterns of behavior involving physicians, pharmacists, and individual Medicaid recipients, or patterns associated with specific drugs or groups of drugs. Analysis of patterns involves identification of the incidence of screen failure associated with a particular provider or a particular drug, and may also involve analysis of individual screen failure associated with a specific recipient and one or more providers.

Screening Requirements

Screens used in conducting pattern analyses are based on explicit predetermined standards and involve monitoring at least the following:

- Therapeutic appropriateness
- Over and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug interactions
- Incorrect dosage or duration of therapy
- Clinical abuse/misuse

In applying the predetermined standards to monitor for the problems listed above, therapeutic criteria determine the population at risk. Normative standards are used to statistically determine outliners where prescribing or dispensing practices may not conform to acceptable standards of care.

As a result of the application of standards, remedial strategies may be introduced (when appropriate) to improve the quality of care and conserve personal or program funds. These strategies may include additional educational programs, intensified monitoring, changes in predetermined standards, or other actions that the DUR Board deems appropriate.

Education and Intervention

The DUR Board will maintain an active ongoing education and intervention program that addresses drug therapy problems using data obtained through the retrospective DUR process. The purpose of the program is to educate practitioners on significant drug therapy problems to improve prescribing and dispensing practices.

The education and intervention program includes but it is not limited to:

1. **General Information Dissemination**: Information about the DUR Board, specific standards, common therapeutic problems associated with specific drugs or drug classes, and other matters concerning the operation of the DUR Program that the Board considers appropriate is disseminated. This non-provider and non-patient specific information can be disseminated by means of provider bulletins, seminars, videos, continuing education or other appropriate media and occurs at intervals satisfactory to the DUR Board. Information dissemination should be consistent with State continuing education requirements for physicians and pharmacists.

2. **Provider/Patient Specific Information Dissemination**: When circumstances dictate, the DUR Board directs provider or patient specific interventions. These communications may be through written, oral, or electronic reminders, as well as face-to-face discussions between health professionals concerning therapeutic problems and changes needed to achieve optimal prescribing, dispensing and pharmaceutical care.

3. **Intensified Review or Monitoring**: This involves monitoring specific drug prescribers or dispensers of drugs. The DUR Board establishes selection criteria for intensified review and monitoring of providers.

WORKING RELATIONSHIPS

1. **Surveillance and Utilization Review System (SURS):** SURS is the responsibility of the Compliance Section of the Med-QUEST Division. Screeners review claims data quarterly for inappropriate utilization based on recipient-driven, provider-driven and treatment analysis (diagnosis)-driven reports produced by the Medicaid Management Information System (MMIS). Follow-up and intervention are performed when detailed review warrants, and compliance checks performed when indicated.

   In respect to drug therapy, Compliance screeners should bring significant problems to the attention of the DUR Program so they may be considered for retrospective review by the DUR Board. Conversely, when the DUR Board independently establishes criteria and standards for retrospective review, the Compliance Branch will be consulted to determine if there are possibilities to adopt existing SURS methodology and share resources.

2. **Medicaid Investigation Division:** When it is suspected, during the course of drug use review, that an intentional deception or misrepresentation has been made by a person, a recommendation can be made to the Branch] Compliance Section to conduct a preliminary investigation. If the investigation confirms the suspicion, the Compliance Section can make a

referral to the Medicaid Investigations Division of the Department of the Attorney General.

3. **Medicine and Pharmacy Professional Associations:** The Hawaii Medical Association (HMA) and the Hawaii Pharmaceutical Association (HPhA) and the Hawaii Society of Hospital Pharmacists (HSHP) will be the principal professional liaisons to physician and pharmacist providers. They will be consulted for DUR Board nominees and serve as sounding boards for obtaining feedback on criteria and standards ratification.

EPSDT COMPLETE DENTAL SCREEN GUIDELINES

EPSDT complete periodic dental screens, to be completed by the dentist, shall include but are not limited to:

- Oral examination, diagnosis and assessment of any oral diseases or injuries;
- Oral hygiene instructions;
- Injury prevention counseling for orofacial trauma and oral habits;
- Dietary counseling related to dental health;
- Appropriate reading materials;
- Toothbrush.

As recommended by the AAPD, the periodicity of examination, preventive dental services and oral treatment shall be as follows:

A. Age 12 months (Optional examination at 6 months)

1. Complete the clinical oral exam and appropriate diagnostic tests to assess oral growth and development and/or pathology;
2. Provide oral hygiene counseling for parents, guardians and caregivers;
3. Remove supra- and subgingival stains or deposits as indicated;
4. Assess the child's systemic fluoride status and provide fluoride supplementation if indicated, following drinking water analysis;
5. Assess appropriateness of feeding practices;
6. Provide dietary counseling related to oral health;
7. Provide injury prevention counseling for orofacial trauma (play objects, pacifiers, car seats, etc.);
8. Provide counseling for oral habits (digit, pacifiers, etc.);
9. Provide diagnosis and required treatment for any oral diseases or injuries;

10. Provide anticipatory guidance for parent/guardian.

B. Ages 12 to 24 months

1. Repeat 6 to 12 month procedures every six months as indicated by individual patient's needs/susceptibility to disease;

2. Assess topical fluoride status and give parental counseling;

3. Provide injury prevention counseling for orofacial trauma (learning to walk, run, etc.)

C. Ages 2 to 6 years:

1. Repeat 12-24 month procedures every six months or as indicated by individual patient's needs/susceptibility to disease;

2. Provide age-appropriate oral hygiene instructions;

3. Complete a radiographic assessment of pathology and/or abnormal growth and development, as indicated for individual patient's needs;

4. Scale and clean the teeth every six months or as indicated by the individual patient's needs;

5. Provide topical fluoride treatments every six months or as indicated by the individual patient's needs;

6. Provide pit and fissure sealants for primary and permanent teeth as indicated by individual patient's needs;

7. Provide counseling and services (athletic mouth guards) as needed for orofacial trauma prevention;

8. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient's needs;

9. Treat any oral diseases/habits/injuries as indicated.

D. Ages 6 to 12 years:

1. Repeat 2 to 6 year procedures every six months or as indicated by individual patient's needs/susceptibility to disease;

2. Provide injury prevention counseling/services for orofacial trauma (sports activities);

3. Provide substance abuse counseling (smoking, smokeless tobacco, etc.)

E. Ages 12 to 20 years:

1. Repeat 6 to 12 year procedures every six months or as indicated by individual patient's needs/susceptibility to disease;

2. At an age determined by patient, parent and dentist, refer the patient to a general dentist for continuing dental treatment.

HOME PHARMACY SERVICES

CODE	DESCRIPTION	COMMENTS
W9078	Global IV hydration Services & Supplies Per Day	
W9079	Global IV Anti-Infective Services & Supplies Per Dose	
W9079-52	Global Multiple IV Anti-Infective Services & Supplies Per Dose (for each additional IV anti-infective after the first	Can be used more than once but each anti-infective agent and each code must be authorized
W9076	Global IV or SubQ (with PCA device) or Epidural Chronic Pain Management Services & Supplies Per Day	
W9073	Global Intrathecal Pain Management (Via An Implantable Infusion Pump) Services and Supplies Per Pump Fill	
W9074	Reprogramming of Implantable Infusion Pump	
W9640	Global IV Chemotherapy Services & Supplies Per Day	
W9640-51	Global Multiple IV Chemotherapy Services & Supplies Per Day (for each additional IV Chemotherapy agent after the first)	Can be used more than once but each agent and each code must be authorized
W9075	Global Miscellaneous IV Therapy Services & Supplies Per Day	
W9075-51	Global Miscellaneous IV Therapy Services & Supplies Per Day	Can be used more than once but each agent and each code must be authorized

CODE	DESCRIPTION	PAYMENT	COMMENTS
W4084	Global Implanted Single Lumen Vascular Access Device Services & Supplies When Not In Use	$ 7.50 per day	Ex.: Port-A-Cath. Maximum of 2 per week
W4085	Global Implanted Double Lumen Vascular Access Device Services & Supplies When Not in Use	$ 12.00 per day	Maximum of 2 per week
W4087	Global Single Lumen Tunneled External Vascular Access Device Services & Supplies When Not in Use	$ 5.00 per day	Ex.: Hickman, Groshong, Broviac. Maximum of 30 per month
W4088	Global Double Tunneled External Vascular Access Device Services & Supplies When Not in Use	$ 7.50 per day	Maximum of 30 per month
W4089	Global Peripherally Inserted Central Catheter Services & Supplies When Not in Use	$ 2.00 per day	Ex.: PICC, Midline Catheter. Maximum of 30 per month
W4090	Midline & PICC Line Insertion Supplies	$ 80.00	Must be authorized. Cannot be used with W4091
W4091	Midline & PICC Line Full Service	$120.00	Must be authorized. Cannot be used with W4090
	ENTERAL NUTRITION THERAPY		
B4150	Enteral Formula, Category I; Semi-synthetic Protein/Protein Isolates; 100 Calories = 1 unit	$ 0.54 per 100 cal.	
B4151	Enteral Formula, Category I; Natural Intact Protein/Protein Isolates; 100 Calories = 1 unit	$ 1.26 per 100 cal.	
B4152	Enteral Formula, Category II; Intact Protein/Protein Isolates (Calorically Dense); 100 Calories = 1 unit	$ 0.47 per 100 cal	
B4153	Enteral Formula, Category III; Hydrolyzed Protein/Amino Acids; 100 Calories = 1 unit	$. 1.53 per 100 cal.	
B4154	Enteral Formula, Category IV; Defined Formula For Special Metabolic Need; 100 Calories = 1 unit	$ 1.12 per 100 cal.	

B4154	Enteral Formula, Category IV; Defined Formula For Special Metabolic Need; 100 Calories = 1 unit	$ 1.12 per 100 cal.	
B4155	Enteral Formula, Category V; Modular Components (Protein, Carbohydrates, Fat); 100 Calories = 1 unit	$ 0.87 per 100 cal.	
B4155	Enteral Formula, Category V; Modular Components (Protein, Carbohydrates, Fat); 100 Calories = 1 unit	$ 0.87 per 100 cal.	
B4156	Enteral Formula, Category V; Standardized Nutrients; 100 Calories = 1 unit	$ 1.24 [per 100 cal.	
B4034	Enteral Feeding Supply Kit; Syringe, Per Day	$ 5.00 per day	
B4035	Enteral Feeding Supply Kit; Pump Fed, Per Day	$ 6.52 per day	
B4036	Enteral Feeding Supply Kit; Gravity Fed, Per Day	$ 9.87 per day	
B4081	Nasogastric tubing With Stylet	$ 18.43 each	
B4082	Nasogastric tubing Without Stylet	$ 12.98 each	
B4083	Stomach Tube—Levine Type	$ 2.09 each	
B4084	Gastrostomy/Jejunostomy Tubing	$ 15.00 each	
B4085	Gastrostomy Tube, Silicone With Sliding Ring	$ 35.00 each	
W4081	Button G tube Replacement Kit	$125.00 each	Ex.: MIC-Key; Hide-A-Port
W4082	Extension Set For Button Type Tube; Decompression Tube	$ 8.50 each	

CODE	DESCRIPTION	PAYMENT	COMMENTS
	PARENTERAL NUTRITION THERAPY		
B4189-52	Parenteral Nutrition Solution; Compounded Amino Acid & Carbohydrates with Electrolytes, Trace Elements, and Vitamins, Including Preparation, Any Strength, 1-9 Grams of Protein	$120.00 each	
B4189	Parenteral Nutrition Solution; Compounded Amino Acid & Carbohydrates with Electrolytes, Trace Elements, and Vitamins, Including Preparation, Any Strength, 10-51 Grams of Protein; Premix	$140.00 each	
B4193	Parenteral Nutrition Solution; Compounded Amino Acid & Carbohydrates with Electrolytes, Trace Elements, and Vitamins, Including Preparation, Any Strength, 52-73 Grams of Protein; Premix	$190.00 each	
B4197	Parenteral Nutrition Solution; Compounded Amino Acid & Carbohydrates with Electrolytes, Trace Elements, and Vitamins, Including Preparation, Any Strength, 74-100 Grams of Protein; Premix	$230.00 each	
B4199	Parenteral Nutrition Solution; Compounded Amino Acid & Carbohydrates with Electrolytes, Trace Elements, and Vitamins, Including Preparation, Any Strength, Over 100 Grams of Protein; Premix	$270.00	
B5000	Parenteral Nutrition Solution; Compounded Amino Acid & Carbohydrates with Electrolytes, Trace Elements, and Vitamins, Including Preparation, Any Strength, Renal; Premix	$ 10.00 per gram	

CODE	DESCRIPTION	PAYMENT	COMMENTS
B5100	Parenteral Nutrition Solution; Compounded Amino Acid & Carbohydrates with Electrolytes, Trace Elements, and Vitamins, Including Preparation, Any Strength, Hepatic; Premix	$ 3.90 per gram	
B5200	Parenteral Nutrition Solution; Compounded Amino Acid & Carbohydrates with Electrolytes, Trace Elements, and Vitamins, Including Preparation, Any Strength, Stress; Premix	By report	
B4220	Parenteral Nutrition Supply Kit; Premix, Per Day	$ 6.50 per day	
B4224	Parenteral Nutrition Administration Kit; Per Day	$ 20.00 per day	
	EXTERNAL NON-DISPOSABLE PUMPS & IV POLES		
B9000-RR	Enteral Nutrition Infusion Pump—Without Alarm; Rental	$ 99.75 per month	Maximum of 15 months rental
B9000-NU	Enteral Nutrition Infusion Pump—Without Alarm; Purchase New	$1197.00	
B9002-RR	Enteral Nutrition Infusion Pump—With Alarm	$ 99.75 per month	Maximum of 15 months rental
B9002-NU	Enteral Nutrition Infusion Pump—With Alarm; Purchase New	$1197.00	
B9000-MS B9002-MS	Maintenance & Servicing of Enteral Nutrition Infusion Pump; Per 6 Months	$ 99.75 each time	Includes rental of pump during maintenance & servicing; Starts after the warranty period ends on a purchased pump or after 15 months of rental

CODE	DESCRIPTION	PAYMENT	COMMENTS
B9004-RR	Parenteral Nutrition Infusion Pump—Portable; Rental	$300.00 per month	Maximum of 15 months rental
B9004-NU	Parenteral Nutrition Infusion Pump—Portable; Purchase New	$3000.00	
B9006-RR	Parenteral Nutrition Infusion Pump—Stationary; Rental	$300.00	Maximum of 15 months rental
B9006-NU	Parenteral Nutrition Infusion Pump—Stationary; Purchase New	$3000.00	
B9004-MS B9006-MS	Maintenance & Repair of Parenteral Nutrition Infusion Pump; Per 6 months	$300.00 each time	Includes rental of pump during maintenance & servicing; Starts after the warranty period ends on a purchased pump or after 15 months of rental
W9006	Additional Pump Repairs or Servicing	$300.00 each time	For use if repairs or servicing is needed more than once per 6 months; includes the rental of pump during repairs/servicing
E0779-RR	Ambulatory Infusion Pump, mechanical, reusable, for infusion 8 hours or greater	$ 17.71 per month	
E0780-NU	Ambulatory Infusion Pump, mechanical, reusable, for infusion less than 8 hrs.	$ 10.68 per pump	
E0781-RR	Ambulatory Infusion Pump, Single or Multiple Channels, With Administrative Equipment, Worn By Patient; Rental	$300.00 per month	Maximum of 15 months rental
E0781-NU	Ambulatory Infusion Pump, Single or Multiple Channels, With Administrative Equipment, Worn By Patient; Purchase New	$3000.00	

CODE	DESCRIPTION	PAYMENT	COMMENTS
E0791-RR	Parenteral Infusion Pump Stationary, Single or Multiple Channel; Rental	$ 300.00 per month	Maximum of 15 months rental
E0791-NU	Parenteral Infusion Pump Stationary, Single or Multiple Channel; Purchase New	$3000.00	
E0781-MS E0791-MS	Maintenance & Servicing of Infusion Pump; Per 6 months	$ 300.00	Includes rental of pump during maintenance & servicing; Starts after the warranty period ends on a purchased pump or after 15 months of rental
E0776-RR	IV Pole or Stand; Rental	$ 15.00 per month	Maximum of 6 months rental
E0776-NU	IV Pole or Stand; Purchase New	$ 90.00	
K0455-RR	Infusion pump used for uninterrupted administration of epoprostenol	$300.00 per month	Maximum of 15 months rental
K0455-MS	Maintenance & Servicing of Infusion Pump; Per 6 months	$ 300.00	Includes rental of pump during maintenance & servicing; Starts after the warranty period ends on a purchased pump or after 15 months of rental

MEDICAID GUIDELINES FOR HOME HEALTH THERAPY SERVICES (PHYSICAL, OCCUPATIONAL & SPEECH THERAPY)

I. General Principles Governing Reasonable and Necessary Physical Therapy, Speech Therapy and Occupational Therapy

A. Services of physical, speech or occupational therapists are covered if the inherent complexity of the service is such that it can be performed safely and/or effectively only by a skilled therapist. The covered therapy services must be reasonable and necessary to treat the patient's illness or injury or to restore function affected by the illness or injury. It must be determined whether individual therapy services are covered and whether, in view of the patient's overall condition, skilled management of the services is needed even though many or all of the specific services needed to treat the illness or injury do not require the skills of a therapist.

B. Development, implementation, management and evaluation of patient care plan based on the physician's orders are covered when the patient's condition requires that services be provided by a skilled therapist to meet the patient's needs, promote recovery and ensure medical safety. When the skills of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program due to an identified danger to the patient, services are covered even if the skills of a therapist are not needed to carry out the activities performed as part of the maintenance program.

C. A patient's diagnosis or prognosis should never be the sole factor in deciding whether a service is skilled. While a patient's medical condition is a valid factor in deciding if therapy services are needed, the key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether services can be carried out by non-skilled personnel.

D. Services ordinarily considered non-skilled may be considered covered therapy services when there is a clear documentation that, because of special medical complications, skilled rehabilitation personnel must perform or supervise the service or observe the patient. The importance of a particular service to a patient or the frequency performed does not, by itself, make a non-skilled service into a skilled service.

E. The skilled therapy services must be reasonable and necessary to treat the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

1. The service must be appropriate for the nature and severity of the illness or injury, and the patient's particular medical needs. The amount, frequency and duration of the services must also be reasonable;

2. Services must be considered, under accepted standards of medical practice, to be specific and effective treatment for the patient's condition; and

3. Based on the physician's assessment of the patient's rehabilitation potential, the services are:

   a. Expected to improve the patient's condition.

   b. Necessary to the establishment of a safe and effective maintenance program.

4. Services of skilled therapists to teach the patient or the patient's family or caregivers necessary techniques, exercises or precautions are covered when they are reasonable and necessary to treat illness or injury.

5. Services for regression prevention are allowed when there is no caregiver or the caregiver is unable, unwilling or incapable of providing the necessary therapy. The therapy must be necessary to maintain the patient's current level of function or prevent institutionalization of the patient.

II. Application of the Principle to Physical Therapy Services

The skilled physical therapy services principles in I. above are applied to the following commonly questioned physical therapy services.

A. Assessment - The skills of a physical therapist to asses a patient's rehabilitation needs and potential, or to develop and/or implement a physical therapy program are covered when reasonable and necessary because of the patient's condition. Skilled rehabilitation services concurrent with the management of a patient's care plan include objective tests and measurements such as, but not limited to, range of motion, strength, balance coordination endurance or functional ability.
B. Therapeutic Exercises – Therapeutic exercises performed by or under the supervision of a qualified physical therapist in order to ensure the safety of the patient and the effectiveness of the treatment are covered when required due to the type of exercise employed or the patient's condition.

C. Gait Training – Gait evaluation and training furnished to a patient whose ability to walk is impaired by neurological, muscular or skeletal abnormality which require the skills of a qualified physical therapist are covered. Services are considered reasonable and necessary if they can be expected to improve the patient's ability to walk.

   Gait evaluation and training furnished to a patient whose ability to walk is impaired by a condition other than a neurological, muscular or skeletal abnormality may be covered when physical therapy is reasonable and necessary to restore the lost function.

D. Range of Motion – Only a qualified physical therapist may perform covered range of motion tests if they are part of an active treatment for a specific disease state, illness, or injury which resulted in loss or restriction of mobility. This must be evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored.

Range of motion exercises which are not related to the restoration of a specific loss of function may be provided safely and effectively by non-skilled individuals. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by non-skilled persons do not constitute skilled physical therapy. However, as indicated in section I.D., when there is clear documentation that a patient's special medical complications (e.g., susceptible to pathological bone fractures), require the skills of a therapist to provide the services, the services would be covered.

E. Regression Prevention – When repetitive services to maintain function involved the use of complex and sophisticated procedures, the judgment and skill of a physical therapist may re required to safely and effectively treat the illness or injury. These services would be covered as physical therapy services/

Establishment of a maintenance program is a covered therapy service when the specialized knowledge and judgement of a qualified physical therapist is required for the program to be safely carried out and the treatment aims of the physician achieved.

While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate the patient's condition and adjust any exercise program the patient is expected to carry out himself or with the aid of supportive personnel to maintain the function being restored.

Regression prevention therapy is allowed when there is no caregiver or the caregiver is unable, unwilling or incapable of providing necessary therapy; and the therapy is needed to prevent regression of function or institutionalization of the patient.

F. Ultrasound, Shortwave and Microwave Diathermy Treatments – These treatments must always be performed by or under the supervision of a qualified physical therapist and are covered.

G. Hot Pack, Infra-Red Treatment, Paraffin Baths and Whirlpool – Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge and judgment of a qualified physical therapist to provide such treatments or baths may be required in particular cases, e.g., the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complications. The skills of a physical therapist may be needed to teach these treatments to the patient or caregiver.

III. Application of the General Principles to Speech Language Pathology Services

The principles in I. above are applied to the following commonly questioned speech language pathology services.

A. The skills of a speech language pathologist are required to assess a patient's rehabilitation needs (including the causal factors and the severity of the speech and language disorders, and rehabilitation potential). Reevaluation would only be considered reasonable and necessary if the patient exhibited a change in functional speech or motivation, clearing of confusion or the remission of some other medical; condition that previously contraindicated speech language pathology services.

B. The services of a speech language pathologist are covered if needed as a result of an illness or injury and directed toward specific speech/voice production or the assessment and treatment of dysphagia.

C. Speech language pathology is covered when the service can only be provided by a speech language pathologist and it is reasonable expected that the service will improve the patient's ability to independently carry out any one or combination of communicative activities of daily living in a measurably higher level than prior to the initiation of services.

D. The services of a speech language pathologist to establish a hierarchy of speech-voice-language communication task and cueing that directs a patient towards speech-language communication goals in the plan of care are covered speech language pathology.

E. The services of a speech language pathologist to train the patient's family or other caregivers to augment the speech-language communication treatment or to establish an effective maintenance program is covered speech therapy.

F. The service of a speech language pathologist to assist patients with asphasia in rehabilitation of speech and language skills is covered when needed by a patient.

G. The services of a speech therapist to assist individuals with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production are covered when needed by a patient.

IV. Application of the General Principles to Occupational Therapy

The Principles in section I. above are applied to the following commonly questioned skilled occupational therapy services.

A. Assessment – The skills of an occupational therapist to assess and reassess a patient's rehabilitation needs and potential, or to develop and/or implement an occupational therapy program are covered when they are reasonable and necessary due to the patient's condition.

B. Planning, Implementation and Supervision of Therapeutic Programs – The planning, implementation and supervision of therapeutic programs including, but not limited to, those listed below are skilled occupational therapy services which are covered if reasonable and necessary to treat the patient's illness or injury.

1. Selecting and teaching task oriented therapeutic activities designed to restore sensory-integrative function.

2. Planning, implementing and supervising therapeutic tasks and activities designed to restore sensory-integrative function.

3. Planning, implementing and supervising individualized therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness. (I – IV have been adapted from the Medicare Home Health Agency Manual Sec 205.2 1989 Revision.)

V. Medical Authorization

Requests for physical, occupational and speech therapy should specify the proposed plan of care, frequency of home visits, duration of therapy and goals. Initial physical therapy evaluations and occupational therapy evaluations may be provided without medical authorization if done to assess the medical need for therapy and/or to formulate a plan of care. All other home visits for physical and occupational therapy services (therapy and reevaluations) require medical authorization. Speech evaluations and therapy also require medical authorization.

Manual

For

Early and Periodic Screening, Diagnosis

and Treatment

Medically Fragile Case Management

and Expanded EPSDT Services

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VII. Authorization Process for Expanded EPSDT Services

VIII. Claim Filing Limitations for Expanded EPSDT Services

MEDICALLY FRAGILE CASE MANAGEMENT
FOR EPSDT INDIVIDUALS

I. GENERAL INFORMATION

A. What is Medicaid?

1. State/Federal funded program to provide medical care/services/items to Medicaid recipients:

   Fee-for-service: Aged, Blind and Disabled (ABD)

   Managed Care: QUEST Health Plans

   Includes mandatory and optional benefits

2. Role of Med-QUEST Division (MQD), Department of Human Services (DHS)

   Authorizes and reimburses for Medicaid services.

   Does not provide direct-care services.

B. What is EPSDT?

Medicaid's child health services for Medicaid individuals under 21 years of age.

Specifics about the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program:

1. Informing of families

2. OBRA 1989 Requirements:

   Services obtained through an EPSDT screen

   No limitations on frequency and/or amount if the service is medically necessary

No limitations on services IF the service is allowable under Medicaid's EPSDT rules & regulations

3. The following optional services are also available to EPSDT individuals, (but not to Medicaid recipients age 21 and older):

   a. Case Management

   b. Skilled Nursing

   c. Personal Care

   d. Chiropractic services

C. What is the definition of Case Management as used by the Medicaid Program

Sections 1905(a)(19) and 1915(g)(2) of the Social Security Act (the Act) define case management as services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services. Activities commonly understood to be allowable include: (1) assessment of the eligible individual to determine service needs, (2) development of a specific care plan, (3) referral and related activities to help the individual obtain needed services, and (4) monitoring and follow-up.

Assessment: This component includes activities that focus on need identification. Activities include assessment of an eligible individual to determine the need for any medical, educational, social, and other services. Specific assessment activities include taking client history, identifying the needs of the individual, and completing related documentation. It also includes gathering information from other sources such as family members, medical providers, and education, if necessary, to form a complete assessment of the Medicaid-eligible individual.

Care Planning: This component builds on the information collected through the assessment phase, and, includes activities such as ensuring the active participation of the Medicaid-eligible individual, and working with the individual and others to develop goals and identify a course of action to respond to the assessed needs of the Medicaid-eligible individual. The goals and actions in the care plan should address medical, social, educational, and other services needed by the Medical-eligible individual.

Referral and Linkage: This component includes activities that help link Medicaid-eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services. For

example, making referrals to providers for needed services and scheduling appointments may be considered case management.

Monitoring and Follow-up: This component includes activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the Medicaid-eligible individual. The activities and contacts may be with the Medicaid-eligible individual, family members, providers, or other entities. These may be as frequent as necessary to help determine such things as (i) whether services are being furnished in accordance with a Medicaid-eligible individual's care plan, (ii) the adequacy of the services in the care plan, and (iii) changes in the needs or status of the Medicaid-eligible individual. This function includes making necessary adjustments in the care plan and service arrangements with providers.

D. Who Qualifies for Medically Fragile (MF) Case Management Services?

Medically Fragile Case Management is covered when an individual meets the following conditions:

a. Eligible for medical assistance from the Department and under 21 years of age;

b. Determined medically fragile and has a medical need for case management due to the medical condition of the individual, and the need for coordination of multiple medical services/items;

c. Able to safely reside in a home or foster home and does not need to be cared for in a facility for medical reasons;

d. Unable to and cannot reside safely in a home without receiving specialized medical services/items in the home; and

e. The provisions of such services will improve the care the family and service providers furnish to the individual, and enable the individual to remain in the home safely.

E. Qualifications of the Medically Fragile Case Management Provider

1. The MF case manager IS THE PRIMARY CASE MANAGER OF THE EPSDT INDIVIDUAL and must be a Medicaid provider.

2. The MF case management provider must be an entity that employs licensed professional nurses, and/or licensed physicians. The nurse must work with a physician. The physician may by an employer, a consultant to the nursing staff, an employee, or the recipient's physician.

3. In all cases, the primary case manager must be a licensed professional nurse or a licensed physician.

4. Although case management services may be provided by the staff of the entity, the licensed professional nurse and/or physician must supervise, consult, and/or advise the staff providing the activities.

5. The assessment of the patient's medical condition must be performed by a licensed professional nurse or licensed physician.

F. Responsibilities of the Medically Fragile Case Manager

1. Assessment:

Medically fragile children in the community and their families have specialized needs that may change over time as the child grows and develops, and the family's circumstance changes. Therefore:

a. For new referrals of ventilator dependent and tracheostomized children from acute care facilities, the MF Case Manager must participate in the assessment of the patient and the family to ensure that the child can be safely cared for in the community. The assessment will involve the participation in the discharge planning with the hospital staff and physicians, all working together in assessing the family's ability to perform the nursing care needed by the child, the suitability of the family residence, and ensuring that the services and supplies (needed by the child) can be provided.

b. The MF case manager is responsible to the MQD. He/she must have a clear understanding of the Medicaid Program, its requirements, and covered benefits. For those children who have been authorized to receive medically fragile case management services, and are living in the community, the MF Case Manager must work with the child's physician and other agencies in ensuring that the services and supplies provided to the child meets his/her current needs, and promote the child's safety in his/her home and community setting.

2. Development and Implementation of the Plan of Care

a. The MF Case Manager works closely with the attending physician, discharging facility, family, community physician, and other health care providers (i.e., home health service providers, providers of durable medical equipment and supplies) in the development and implementation of the plan of care.

b. The plan of care should detail the specific services and items involved in the care of the child.

c. The MF Case Manager organizes and plays a leadership role in meetings with the family and key health care providers in which the plan of care is reviewed, revised, and evaluated.

3. Advocacy

The MF Case Manager also serves as an advocate for the child and family. Advocacy should be directed at improving the child's quality of life and the quality of care he/she receives and assisting the family in understanding the child's needs and increasing the family's ability to advocate for their child.

4. Liaison

a. The MF Case Manager works closely with the MQD's EPSDT coordinator and medical consultants to ensure that the child receives (in a timely and appropriate manner) administrative approval for the services and supplies he/she needs to safely reside in his/her home.

b. The MF Case Manager works closely with the child's primary care physician (PCP), hospitals and hospital based physicians, and other medical specialists to ensure that parents and other caregivers clearly understand the child's plan of care and that the child receives the services he/she needs while in the home.

c. The MF Case Manager works closely with the MQD's fiscal agent to ensure that the authorization of services and supplies needed by the child, are given in a timely and appropriate manner.

d. The MF Case Manager works closely with physicians, nurses, agencies, and suppliers to link them with the MQD and ACS-Medicaid personnel who are able to help the providers settle problems relating to authorizations/claims for services.

e. The MF Case Manager is knowledgeable about the health care, social, and educational services available in the community and helps the child and family access educational services and other community resources which are appropriate for and available to the child and family.

5. Coordination of Care

The MF Case Manager works in collaboration with public health nurses, physicians, and other community providers in coordinating the care the child will need when he/she is in the home. The services/supplies to be coordinated include but are not limited to:

a. Physician services.

b. Services of ancillary health care professionals—speech therapy, physical therapy, occupational therapy

c. Services and supplies provided by vendors of durable medical equipment and medical supplies such as ventilator, ventilator supplies, oximeters, apnea monitors, suction machines, custom wheelchairs and seating arrangements, gastrostomy related supplies, dressings, incontinence supplies, etc.

d. Skilled nursing services and personal care services.

e. Transportation to and from medical care.

f. Non-health care services such as educational services, and recreational services.

g. Support services provided by other agencies.

6. Quality

a. The MF Case Manager works with the child's physician to ensure that the services provided in the home are of good quality.

b. Specifically, the MF Case Manager evaluates and monitors the quality of nursing services being provided to the child in the home

and in other community settings. Also, the MF Case Manager assesses the competency of the persons providing services and ensures that the services do not compromise the safety of the child. Concerns should be reported to the child's physician.

c. The MF Case Manager teaches the family to recognize and report problems affecting the quality of services. Also, the MF Case Manager helps the family assess the child's current needs for services in the home.

d. The MF Case Manager teaches the family to understand when the physician should be contacted and how to obtain medical care for the child on weekends, holidays, and after hours.

e. The MF Case Manager teaches the family to recognize and report problems with equipment and medical supplies used by the child and to contact appropriate suppliers for maintenance, repairs, replacement, and delivery.

G. Expectations

1. Records

The MF Case Manager must keep written documentation of his/her case management activities (assessment/reassessment, plan of care development, implementation, changes, advocacy, liaison, coordination of care, and quality).

a. Records must be dated and signed.

b. All State and Federal privacy and confidentiality requirements must be met.

2. Visits/Contacts (by phone/fax/e-mail)

The number of visits/contacts are dependent on the child's and family's needs. The expectations listed below are specific to the level of MF case management authorized.

II. FIVE LEVELS OF MEDICALLY FRAGILE CASE MANAGEMENT

A. Medically Fragile Case Management for Anticipated Tracheostomy and/or Ventilator individuals WHILE STILL IN ACUTE CARE HOSPITAL:

1. Only for initial discharge from acute care facility to a home/community based non- institutional setting:

a. At least one visit to the family and home prior to discharge must be made. Included in the evaluation of the home is the adequacy of the power (electrical) outlets, safety for oxygen use, working telephone, need for special setting, bed/crib, whether the home is large enough to accommodate the equipment the child needs, etc. Also, an evaluation of the family and its capability to care for the child identifying resources such as relatives, church group, involvement with other community service groups, etc.

b. Visits to the child and family while in the hospital to understand and learn the child's care plan. Evaluation of the family's ability to implement the care plan. No maximum number of visits.

c. All transportation, meals & lodging expenses for MF case management providers who come from neighbor islands are the responsibility of that provider.

2. Preparation for initial discharge from hospital

a. The MF case manager must work with the hospital discharge planner for discharge, including the arrangements for transportation of the patient and any hospital-based professional staff who will accompany the patient.

b. The MF case manager must ensure that the equipment/supplies are in the home and functioning prior to the child's arrival at home and be present when the child arrives from the hospital.

B. Medically Fragile Case management for ventilator-dependent or tracheostomized individuals after initial discharge from hospital

1. For the initial discharge from the hospital, the MF case manager must be present in the home upon arrival of the patient.

2. The nurse case manager must make at least three(3) home visits, and contact the family by telephone, FAX or e-mail at least four (4) times, in the first two (2) weeks following initial discharge from hospital; following subsequent hospitalizations which result in substantial changes in the patient's care plan or home care requirements; or whenever the child has an acute inter-current illness requiring intervention by the child's treating physician.

3. Otherwise, the nurse case manager must visit the patient in the home at least weekly, and contact the family by telephone or FAX at least twice per week, once the child is stable, and the caregivers in the home have demonstrated their ability to provide good care.

C. Medically Fragile Case Management for Medically Fragile individuals who are not ventilator dependent or tracheostomized.

1. This type of case management is of lesser intensity than the previous. It begins upon notification that a Medicaid child, who has been hospitalized, is being prepared for discharge to the home and is in need of case management.

2. It can also begin when a Medicaid child needing case management is identified in the community.

3. Upon authorization of MF Case Management for this client, the following are expected:

Visits and Contacts

a. Initial assessment by the nurse case manager within two days of initial discharge from the hospital.

b. Initial assessment by a nurse case manager within 1 week of acceptance of a child already in the community.

c. Weekly visits by the nurse case manager for the 2 weeks; Contact with the family at least 2 times a week by phone or fax for the first 2 weeks.

d. After the first 2 weeks, if the patient is stable and doing well: One nurse case manager visit every two (2) weeks, once a week contact with family by phone, fax or e-mail.

D. Case management for those Medically Fragile individuals who have been stable (either vent/trach or other) and have not required frequent

assessments, care plan modifications, and whose families need only intermittent assistance to access services

Visits and Contacts

One nurse case manager visit a month: twice a month contact with child and family by phone, fax or e-mail.

E. Additional case management hours provided with W9882 and W9883 to address changing medical needs.

III. CODING REQUIREMENTS FOR MF CASE MANAGEMENT SERVICES

Medically Fragile Case Management services for EPSDT individuals are identified by specific codes that are only valid for providers certified as Medically Fragile Case Management providers.

Five levels of MFCM acuity have been established for reimbursement purposes. A Medically Fragile Case Management Scoring Tool (Attachment 2) has been developed to document MFCM clinical eligibility and determine the appropriate level of acuity and procedure code. A supplemental report must be attached to the Form 1144 for Code W9884 (Attachment 1).

CODE	Description
W9880	Anticipated tracheostomy and/or ventilator dependence following discharge; no acuity-based requirements or modifiers
W9881	Tracheostomy and/or ventilator dependence, and total acuity score (TAS) of 90 or more, including at least 60 from "Medical Problems"
W9882	Non-ventilator/non-tracheostomy dependent patients with a TAS of 60 or more, including at least 30 from "Medical Problems"
W9883	Non-ventilator/non-tracheostomy dependent patient with a TAS of 40-59, including at least 20 from "Medical Problems"
W9884	Additional case management hours provided with W9882 and W9883 to address changing medical needs)

IV. AUTHORIZATION PROCESS FOR MF CASE MANAGEMENT SERVICES

The client's physician must make a prior authorization request for MF case management service. The request for approval by the Department's medical consultant(s) must include the following completed and signed documentation:

1. Form 1144, Request for Medical Authorization, signed and dated by the referring physician indicating the physician's selection of MFCM provider;

2. Medically Fragile Case Management Scoring Tool (Attachment 2);

3. Supplemental Report for Medically Fragile Case management Code W9884 when indicated (Attachment 1);

4. Medical history and discharge summary;

5. Social summary; and

6. Attach photocopy of current Prior Authorization.

V. CLAIM FILING LIMITATIONS FOR MF CASE MANAGEMENT SERVICES

Clarification of specific claims filing issues:

A. If the child requires acute care hospitalization, MF case manager services previously authorized on the form 1144 (codes W9881 and W9882) can be billed for a maximum of 1 month regardless of the length of stay at the acute care hospital. (Example: if a child is hospitalized for less than 1 month, authorized MF case manager services can be billed for one month; if a child is hospitalized for 3 months, only 1 month can be billed).

B. MF case management services for ventilator-dependent tracheostomized children (W9881) can be authorized for one month after the closure of a tracheostomy.

C. Billing for MF case management should be submitted on the Form 1500 using units. Enter 1 in Field 24G.

D. Procedure Code W9880 is allowed once per the lifetime of an individual.

E. Billing for Procedure Codes W9881, W9882 and W9883 should be monthly units on the Form 1500. Enter 1 in Field 24G.

F. No more than 10 points are allowed for Procedure Code W9884 when billed with Procedure Code W9882.

G. No more than 5 points are allowed for Procedure Code W9884 when billed with Procedure Code W9883.

VI. EXPANDED EPSDT SKILLED NURSING AND PERSONAL CARE SERVICES

A. Authorization Process

Anticipated Discharge from Acute Facility

The client's physician must make prior authorization request for Skilled Nursing (SN) or personal care (PC) service. The request for approval must include the following completed and signed documentation:

1. Form 1144 Request for Medical Authorization, signed and dated by the referring physician indicating the physician's selection of SN or PC provider,

2. Home Skilled Nursing Scoring Tool (See Attachment 3);

3. Medical History and Discharge summary; and

4. Social summary.

B. Service Hour(s) Authorization

1. The service hours may vary depending on the medical needs of the client, and generally, does not exceed 40 hrs. Per week. Generally, personal care is not authorized with skilled nursing services.

2. Ventilator dependent individuals maybe authorized for a maximum of 70 hrs. per week.

3. Tracheostomized individuals without ventilators maybe authorized for a maximum of 56 hours per week.

4. For other individuals, the number of hours varies; and generally does not exceed 40 hours per week.

C. Medically Fragile Individuals Residing In the Community

1. Documentation required for Initial Referral and Continuing Services

   a. Completed Form 1144 signed by the physician with designated SN or PC provider who will be providing the service, including medical justification for the services. Complete one line for each month of service requested and each procedure code, not to exceed a total of five months per Form 1144. Amount completed in quantity section should be total quantity for one month.

   b. Home Skilled Nursing Scoring Tool (See Attachment 3);

   c. Medical History/Summary;

   d. Social Summary; and

   e. Photocopy of current Prior Authorization.

D. Assessment for Services

1. MF case manager must assess the family/caretaker's need for the number of hours requested. Factors such as school attendance, improvement in condition, increased number of trained family/caregivers, the changing needs of the family unit, etc., must be considered in the assessment.

2. MF case manager must also assess the bonding of the family/caregiver and the child. Services requested and authorized must not undermine the parent/caregiver and child relationship.

3. Most ventilator dependent children may require 70 hours of skilled nursing hours for the first year after the initial discharge from the hospital. However, as the child becomes more stable, the case manager must prepare the family/caregiver that a reduction in the skilled nursing hours provided by Medicaid may occur.

VII. CLAIM FILING LIMITATIONS FOR EXPANDED EPSDT SERVICES

A. Using From 1500, bill each claim on a monthly basis, using the last date of the month for each service line. Itemization of service dates is not required on the claim since the billing is monthly. However, the medical records must accurately document the exact dates and time of the services.

B. Enter the authorization number in block 23-Prior Authorization Number.

C. Bill using the appropriate procedure code in block 24D.

D. The number of service units must be a whole number. Fractions are not accepted. If the number of hours rendered includes a fraction, round up to the next whole number if it is greater than or equal to .5 and round down if the fraction is less than 5.

E. Enter "E" in block 24H to designate that the service is in treatment for a condition discovered during an EPSDT examination.

F. If tax is charged, use procedure code Z9020. This must be the last line item on the claim.

G. Bill using the Medicaid provider number for expanded EPSDT service appropriate to the location. The provider number on the claim must match the provider number on the Form 1144.

ATTACHMENT 1

Department of Human Services
Med-QUEST Division
Medical Standards Branch

State of Hawaii

P.O. Box 700190
Kapolei, HI 96709-0190

Medically Fragile Case Management Acuity Levels

Code	Description
W9880	Anticipated tracheostomy and/or ventilator dependence following discharge; no acuity-based requirements or modifiers
W9881	Tracheostomy and/or ventilator dependence, and total acuity score (TAS) or 90 or more, including at least 60 from "Medical Problems"
W9882	Non-Ventilator/non-tracheostomy dependent patients with a TAS or 60 or more, including at least 30 from "Medical Problems"
W9883	Non-ventilator/non-tracheostomy dependent patient with a TAS of 40-59, including at least 20 from "Medical Problems"
W9884	Additional case management hours provided with W9882 and W9883 to address changing medical needs

Physician's signature: _____ Date: _____

Supplemental Report for
Medically Fragile Case Management W9884

Patient's Name (Last, First, M.I.)	Medicaiid ID Number	Reporting Period

Case Management Service	Points	Comments/Clarification
New Problem(s)		
Worsening of existing problem(s)		
Increase in care coordination needs due to medical or social reasons		
Increase in assistance with accessing physician/other medical professional services		

Case Management Service	Points	Comments/Clarification
Increase in assistance with accessing supplies/DME		
Increase in assistance with accessing educational/social services		
TOTAL POINTS		

POINTS A point is a measure of the extra work done by the Case Management Agency in managing care and assisting the patient/family for a given month. A point is given for each issue/problem/condition addressed. More than 1 point can be given if the issue/problem/condition is complex and justified by the Comments/Clarification you provide.

For **W9882,** no more than **10** points are allowed; For **W9883**, no more than **5** points are allowed.

Additional information/comments (optional). Please use the back of the form for additional comments/clarification.

Case Manager's signature:_____ Date _____

ATTACHMENT 2

Department of Human Services
Med-QUEST Division
Medical Standards Branch

State of Hawaii

P.O. Box 700190
Kapolei, HI 96709-0190

Medically Fragile Case Management Scoring Tool

NAME: Last	First	M.I.	Birthdate	I.D. Number

	Medical Condition	**Frequency/Complexity**	**Points**	
1	Ventilator	Continuous	50	
		Intermittent	30	
2	Tracheostomy (with or without ventilator)		40	
3	Oxygen therapy	Continuous	20	
		Intermittent	10	
4	Oropharyngeal/nasopharyngeal suctioning*	More than TID	5	
		TID or less	3	
5	Nebulization therapy	More than TID	5	
		TID or less	3	
6	Vascular access catheter	Central	25	
		Peripheral	15	
7	Parenteral nutrition	Continuous	15	
		Intermittent	10	
8	Gastrostomy/jejunostomy/nasogastric tube		10	
9	Continuous pump feeding		10	
10	Specialized oral feeding system		5	
11	Orthopedic appliance	Splint/cast	5	
		Complex	10	
12	Urinary bladder catheterization	Intermittent or continuous	5	
13	Ileostomy/colostomy		5	
14	Isolation/reverse isolation		10	
15	Oral medications	Less than 12 doses/day	2	
		12 or more doses/day	5	
16	IM/SQ medications	Less than 4 doses/day	2	
		4 or more doses/day	5	
17	Intravascular medications	Less than 4 doses/day	5	
		4 or more doses/day	8	
18	Monitors	Cardiorespiratory	10	
		Apnea	5	
		Pulse oximeter	5	
19	Restorative therapy (PT, OT, Speech)		5	
		Subtotal		

Modifiers

Circumstance		**Points**	
1	Non-English speaking	10	
2	Poor communication skills (less than 5th grade level)	10	
3	Single parent/caregiver	10	
4	Remote location (outer island, or >10 miles from primary care site)	10	
5	No automobile	5	
6	Family turmoil/dysfunction	15	
7	Following initial discharge from hospital	50**	
8	Re-admission illness requiring physician intervention	50**	
9	Intercurrent illness requiring physician intervention	20***	
10	Stable (no intercurrent illness or change in care plan for >3 months	-50	
	Subtotal		
	Total Points (Medical Condition + Modifiers)		

*In non-trach patients **For 2 weeks following discharge ***Minimum 2 weeks, until patient back to baseline health

Additional information/comments:_____

_____

Provider: _____ _Date: _____

ATTACHMENT 3

Department of Human Services
Med-QUEST Division
Medical Standards Branch

State of Hawaii

P.O. Box 700190
Kapolei, HI 96709-0190

Home Skilled Nursing Scoring Tool

NAME: Last	First	M.I.	Birthdate	I.D. Number

	Nursing Intervention	**Frequency/Complexity**	**Points**	
1	Ventilator	Continuous	50	
		Intermittent	30	
2	Tracheostomy		30	
3	Oxygen therapy		20	
4	Nebulized Medications	TID or less	10	
		>TID	20	
5	Vascular access catheter		40	
6	Parenteral nutrition	Continuous	40	
		Intermittent	30	
7	Gastrostomy/jejunostomy/nasogastric tube	Gravity feedings	20	
		Pump feedings	30	
8.	Ileostomy/colostomy		10	
9	Urinary bladder catheterization	Intermittent or continuous	10	
10	Orthopedic appliance	Splint/cast (each)	05	
		Complex (describe)	10	
11	Isolation/reverse isolation		30	
12	Enteral Medications	8 doses/day or less	05	
		>8 doses/day	10	
13	IM/SQ medications	4 doses/day or less	10	
		>4 doses/day	15	
14	IV medications	4 doses/day or less	15	
		>4 doses/day	20	
15	Monitor (Apnea, Pulse Oximeter, C-R)		20	
16.	Special Skin Care (Burn, decubiti)	Localized	05	
		Extensive (describe)	10	
17.	Wound Care (describe)		10	
18.	Less than 6 months since initial discharge (discharge date:_____)		40	
19	Less than 3 months since subsequent discharge (discharge date:_____)		30	
20	Other Specialized nursing interventions: _____ _____			
	A. Total Points			

School Attendance Information:

1. Does the child attend school? ☐Yes ☐No
2. If "Yes", number of hours per day:____ Days per week:____
3. Months per year, including Winter and Spring vacation:____
4. ***Is the child's transportation to/from school provided by the Department of Education? ☐Yes ☐No***

Comments and explanations:

_____

_____

_____

Provider: _____ ***Date:*** _____

Foreign Language List

Languages available

a) Asian Languages
- Cambodian
- Cantonese
- Japanese
- Korean
- Indonesian
- Laotian
- Mandarin
- Myanmar/Burmese
- Teochew
- Thai
- Vietnamese

b) European Languages
- French
- German
- Hungarian
- Italian
- Russian

c) Micronesian Languages:
- Kosraen
- Marshallese
- Ponapean
- Samoan
- Tongan
- Trukese/Chuukese

d) Philippines
- Ilocano
- Pangasinan
- Tagalog
- Visayan/Cebuano

e) Spanish

f) Hawaiian

g) American Sign Language

Appendix IV
OPIOID TREATMENT AGREEMENT

Patient Name: _____

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work.

To the doctor: Keep signed originals in your files; give a photocopy to patient. Renew at least every 6 months.

I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with Dr. _____.

1. I understand that I have the following responsibilities:

    a. I will take medications only at the dose and frequency prescribed.
    b. I will not increase or change medications without the approval of this doctor.
    c. I will actively participate in RTW efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
    d. I will not request opioids or any pain medicine from physicians other than from this doctor. This doctor will approve or prescribe all other mind and mood altering drugs.
    e. I will inform this doctor of all other medications that I am taking.
    f. I will obtain all medications from one designated pharmacy, and give this doctor consent to speak with the pharmacist about m prescription needs.
    g. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications from children.
    h. I agree to participate in psychiatric or psychological assessments, if necessary.
    i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This doctor may ask me to follow through with a program to address this issue. Such programs may include the following:
        - 12 step program and securing a sponsor
        - Individual counseling
        - Inpatient or outpatient treatment
        - Other

2. I understand that in the event of an emergency, this doctor should be contacted and the problem will be discussed with the emergency room or other treating physician. I will sign a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other physician without this doctor's approval.
3. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.
4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.
5. I understand that this doctor may stop prescribing opioids or change the treatment plan if:

    a. I do not show any improvements in pain from opioids or my physical activity has not improved.
    b. My behavior is inconsistent with the responsibilities outlined in #1 above.
    c. I give, sell, or misuse the opioids medications.
    d. I develop rapid tolerance or loss of improvement from the treatment.
    e. I obtain opioids from other than this doctor except as allowed in #2 above.
    f. I refuse to cooperate when asked to get a drug screen.
    g. An addiction problem is identified as a result of prescribed treatment or any other addictive substance.
    h. I am unable to keep follow-up appointments.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

OPIOID TREATMENT AGREEMENT (continued)

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS:

You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

SIDE EFFECTS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Sleepiness or drowsiness
- Aggravation of depression
- Breathing too slowly – overdose can stop your breathing and lead to death
- Vomiting
- Dry mouth
- Abruptly stopping of opiates after regular use may cause withdrawal symptoms such as:

  Runny Nose, Diarrhea, Sweating, etc
  Difficulty sleeping for several days
  Abdominal cramping
  "Goose bumps"
  Rapid heart rate
  Nervousness

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL

RISKS:

- Psychological dependence. This means it is possible that stopping the drug will cause you to miss or crave it.
- Tolerance. This means you may need more and more drug to get the same effect
- Addiction. A small percentage of patient may develop addiction problems based on genetic or other factors
- Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss with our physician.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, and their effectiveness and any side effects you may be having
- Use of a medication box that you can purchase at a pharmacy that is already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

I have read this document, understand it and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above.

_____ _____

Patient Signature Date Physician Signature Date

Laxatives

- Bisacodyl
  - All forms
- Bowel evacuation kits
- Citrate of magnesia
  - Liquid
- Docusate calcium or sodium (DSS)
  - All forms
- DSS with casanthranol
  - All forms
- Glycerin
  - Suppositories
- Milk of Magnesia
  - All forms
- Phosphate enema
  - Pediatric, adult
- Psyllium
  - All forms
- Senna
  - All forms

Antidiarrheals

- Bismuth subsalicylate
  - Liquid
- Kaolin with pectin
  - Liquid
- Liquid pediatric electrolyte replacement
  - (i.e. Pedialyte)
- Loperamide
  - All forms

Analgesics

- Acetaminophen
  - All forms
- Aspirin
  - Including buffered, enteric coated, chewable
- Ibuprofen
  - All forms
- Phenazopyridine
  - Tablets

Ophthalmics

Artificial tears ointment
Regular or preservative-free
Artificial tears solution
Regular or preservative-free

Otic products

Carbamide peroxide

Antihemorroidals

Hamaelis/glycerin medicated pads
(i.e. Tucks)
Hydrocortisone cream
Pramoxine ointment
Resorcinal combinations
Suppositories
Shark liver oil combinations
All forms (i.e. Preparation H)

Miscellaneous

Activated charcoal
All forms
Benzoyl peroxide
All forms
Contraceptives
All forms
Glucose tablets
All strengths
Insulin
All forms
Ipecac syrup
Permethrin
All forms (i.e. Nix)
Sodium chloride
Solution for diluting bronchodilator solutions
Tablets
Meclizine
Tablets
Nasalcrom 40mg/ml
Nasal spray

Miscellaneous Topicals

Hydrocortisone
Cream, ointment
Estar gel
Denorex shampoo
Denorex extra strength shampoo

Topical Antibacterials/Antifungals

- Bacitracin
  - All forms
- Miconazole
  - All forms
- Polymixin B sulfate, bacitracin zinc, neomycin
  - Single entity and combination
  - All forms
- Povidone-iodine
  - All forms
- Tolnaftate
  - All forms
- Clotrimazole 1%
  - Cream, solution
- Terbinafine 1%
  - Cream

Iron Supplement

- Ferrous sulfate
  - All forms

Vitamin/Minerals

- For children under 12 years
  - Age restricted
- For end stage renal disease
- For pregnant and lactating women
  - Diagnosis code required
- One multivitamin daily
  - Long term care recipients
- Vitamin C
  - All forms
  - For urinary tract infections
  - Diagnosis code required

Minerals

- Calcium carbonate
  - All forms
- Magnesium
  - Tablets
- Niacin
  - Tablets
- Phosphates
  - Packets
  - Tablets
- Zinc
  - Tablets

Cough and Cold

Chlopheniramine
- All forms

Guiafenesin with/without dextramethorphen
- All strengths
- Liquid

Pseudoephedrine
- All forms

Brompheniramine with Pseudoephedrine
- Tablets, liquid

Diphenhydramine
- All forms

Antacids

Aluminum hydroxide
- All forms

Magnesium and aluminum hydroxides with/without simethicone
- All forms

Sodium bicarbonate
- Tablets

Gastrointestinal

H2 antagonists
Coverage without prior authorization approval limited to the following:
For peptic ulcer disease (PUD),
Hypersecretory disease (Zollinger-Ellison syndrome),
Gastroesophageal reflux disease (GERD)

Cimetidine
- Tablets

Famotidine
- Tablets
- (Pepcid AC) only package sizes of 50 or larger
- (Mylanta AR) only package size #30 or larger

Nizatidine
- (Axid) only 75mg in the 30 tablet size or larger

Ranitidine
- (Zantac) only 75mg in the 20 tablet size or larger

BENJAMIN J. CAYETANO
GOVERNOR

SUSAN M. CHANDLER, M.S.W., Ph.D.
DIRECTOR

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STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Medical Standards Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

MEMORANDUM

TO: Acute Care Hospitals, Home Health Agencies, Long Term Care (LTC) Facilities and Other UB92 Users

FROM: Dr. Lynette Honbo, Administrator

SUBJECT: OUTPATIENT SUPPLIES BILLED UNDER REVENUE CODE 27X AND CODE 29X

Medicaid Newsletter 92-04 (dated November 3, 1992) informed providers that effective December 1, 1992, revenue codes 27X and 29X should be itemized using applicable Health Care Financing Administration (HCFA) codes. The Medicaid Program appreciates the efforts of hospitals and other UB-92 users in complying with this requirement.

In November and December, 1993, the Med-QUEST Division's (formerly HCAD) medical consultants met with representatives of various hospitals to address their concerns. The following is a summary of the issues discussed and Medicaid clarification.

1. Providers generally agreed that although coding of medical supplies and equipment required much time and effort, this requirement could be met for outpatient claims submitted on hard copy.

2. The medical consultants suggested the following guidelines to decrease the number of supplies which require coding:

    a. All out patient surgery and ambulatory surgical center (ASC) claims are reimbursed at ASC group grates which include routine supplies. Therefore, separate reimbursement for revenue codes 27X and 29X is not made unless they are for items not part of the ASC rate. If so, they must be itemized, HCPCS coded, and described.

b. Supplies used in radiology procedures are usually part of the reimbursement for the technical component of the radiology service and not separately reimbursed. Examples are items such as IV start sets, extension tubing, ionic contrast material, needles, syringes, and wipes.

c. Standard emergency room supplies and equipment are considered an integral part of the emergency room service and are not separately reimbursed. Examples of these are blood pressure monitoring devices, sheets, underpads, gomco machines, sutures, scissors, oximeters, bed pans, and thermometers.

1) Certain non-standard supplies, supplies that are disposable or require autoclaving, and those unique to the individual patient are reimbursable and must be itemized with the appropriate HCFA and revenue codes. Examples are IV tubing, intracatheters, gastric tubes, and blood administration sets.

2) Reimbursement for supplies associated with procedures are generally included in the payment of the procedure; therefore, they should not be billed. Examples are clean catch kits when urinalyses and/or cultures are done, electrodes when ECG's are done, blood specimen containers when blood gases or blood tests are ordered. Usage of updraft, nebulizer, and oxygen are not supplies but respiratory services and should be billed under revenue code 41X.

d. If no HCFA code adequately describes the supply, you may use a miscellaneous code 99070 or A4649. However, a description which identifies the supply must be provided or a turnaround document (TAD) requesting a description will be sent to providers.

e. Attached is an alphabetical list of supplies and their coverage status in different settings. Claims should be submitted only for items payable by Medicaid.

3. The following were also discussed with regard to expediting the handling of supplies on outpatient claims.

a. Providers should review the list of supplies. A provider's list of frequently used supplies not included in the Medicaid list can be submitted to the Med-QUEST (MQD) for review and possible inclusion into an updated list which will be circulated to providers. The provider's list should include the name of the item and a brief description including usage.

b. Electric Media Claims (EMC) providers should make efforts to identify itemized supplies with valid HCFA codes instead of miscellaneous codes to that they may be billed electronically and thus prevent generation of turnaround documents for description.

We wish to thank the hospital staffs who met with MQD's medical consultants for their suggestions and cooperation. We will address the concerns raised and we welcome comments and suggestions from other UB92 users. Please contact Mr. Eric Rolseth at 586-5386, Dr. John Sheedy at 692-8066 or Dr. Lynette Honbo at 692-8106 for clarification, questions or comments.

_____
Administrator

Attachment

BENJAMIN J. CAYETANO
GOVERNOR

SUSAN M. CHANDLER, M.S.W., Ph.D.
DIRECTOR

ELIZABETH KENT
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Medical Standards Branch
P. O. Box 700190
Honolulu, Hawaii 96709-0190

August 6, 2001

MEMORANDUM M01-15

TO: Home Health Agencies and Suppliers of Durable Medical Equipment, Prosthetic and Orthotic Devices and Medical Supplies

FROM: Aileen Hiramatsu, Med-QUEST Division Administrator

SUBJECT: CLARIFICATION OF AUTHORIZATION OF MANUAL VERSUS SEMI-ELECTIC HOSPITAL BEDS

The purpose of this memorandum is to rescind the Med-QUEST Division's (MQD's) decision to stop the authorization of a manual hospital bed when a semi-electric hospital bed is requested.

In the past, Hawaii Medical Service Association (HMSA)-Medicaid would authorize a manual bed when a semi-electric bed was requested if medical necessity criteria were met for a manual bed and not met for a semi-electric bed. After being informed that most vendors no longer carry manual hospital beds as part of their inventory and that the difference in reimbursement between a manual bed and semi-electric bed was minimal, the MQD made a decision to stop the authorization of a manual hospital bed when a semi-electric bed was requested. Therefore, if a Medicaid recipient met Medicare criteria for a manual hospital bed, a semi-electric bed would be authorized.

The MQD has since become aware that there is a significant difference in the reimbursement for a manual hospital bed and a semi-electric bed. The MQD has instructed HMSA-Medicaid to resume the authorization of a manual bed when a semi-electric bed is requested if medical necessity criteria are met for a manual bed and not met for a semi-electric bed. The Medicaid authorization requirements are included with this memorandum.

For questions and further clarification regarding this memorandum, please call Dr. Joy F. Murakami at 692-8121.

Aileen Hiramatsu
Med-QUEST Division Administrator

Attachments

MEDICAID AUTHORIZATION REQUIREMENTS

ITEM/PROCEDURE:

MANUAL HOSPITAL BED (FIXED HEIGHT HOSPITAL BED)—A manual hospital bed is one with manual head and leg elevation adjustments, but no height adjustment.

HCPCS CODES:

- EO250—Hospital bed, fixed height, with any type side rails, with mattress.

AUTHORIZATION REQUIREMENTS:

Indications 1, 2, 3 and/or 4 must be met:

1. Recipient requires positioning of body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed.

2. Recipient requires positioning of the body for the alleviation of pain in ways not feasible with an ordinary bed.

3. Recipient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed.

4. Recipient requires special attachments that cannot be fixed and used on an ordinary bed.

PHYSICIAN DOCUMENTATION REQUIREMENTS:

Diagnosis(es) resulting in the need for a hospital bed.

2. Reason recipient requires a hospital bed. See recipient requirements through 4 above.

3. If the recipient requires the head of the bed to be elevated, indicate that pillows and wedges have been tried and have failed.

APPROVAL PERIOD:

- Initial request: 2 months rental

- 1-year rental for recipients with documented chronic condition

ADDITIONAL INFORMATION/COMMENTS:

When the cumulative rental payments for the bed equal the payment for the purchase of the bed, rental payments will cease and the bed will be considered purchased.

REFERENCE(S):

CIGNA HealthCare, Medicare Administration DMERC Region D Supplier Manual.

EFFECTIVE DATE:

July 1, 2001

ADDITIONAL INFORMATION/COMMENTS:

1. When the cumulative rental payments for the bed equal the payment for the purchase of the bed, rental payments will cease and the bed will be considered purchased.

2. In certain cases, indication 6 alone may justify a semi-electric hospital bed. Examples of conditions that may meet the indications for a variable height hospital bed include (but are not limited to):

   Severe arthritis and injuries to lower extremities (e.g., fractured hip) when the variable height feature enables the recipient to ambulate by allowing him/her to place feet on the floor while sitting on the edge of the bed.

   Spinal cord injury, multiple limb amputation, and stroke when the variable height feature enables the recipient to transfer from bed to wheelchair.

   - Other severely debilitating diseases and conditions when the variable height feature enables the recipient to ambulate.

REFERENCE(S):

CIGNA HealthCare, Medicare Administration DMERC Region D Supplier Manual.

EFFECTIVE DATE:

July 1, 2001.

BENJAMIN J. CAYETANO
GOVERNOR

SUSAN M. CHANDLER, M.S.W., Ph.D.
DIRECTOR

ELIZABETH KENT
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Medical Standards Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

January 11, 2002

TO: Physicians, Pharmacies and Providers of Durable Medical Equipment and Medical Supplies M02-01

FROM: Aileen Hiramatsu, Med-QUEST Division Administrator

SUBJECT: OSTOMY SUPPLIES

The Med-QUEST Division (MQD) has decided to modify its reimbursement procedures for ostomy products in order to ensure that Medicaid recipients who need ostomy products are able to obtain them from Hawaii Medicaid providers.

Thus, beginning on January 1, 2002, the Medicaid payment rates for ostomy products will be based on the July 2001 Medicare fee schedule. The July 2001 Medicare rates appear low for 5 items. Therefore, the MQD has decided to reimburse these items, when modified with a "-22," at a rate higher than Medicare.

In addition, the MQD has decided to increase the maximum units for items based on Medicare's maximums. Please understand that patients must receive only the quantity of the supplies they need and that generally, most patients do not need the maximum quantities of the various covered ostomy supplies. (A listing of Medicaid payment rates and maximum units is attached.)

Also, ostomy supplies must be requested on a physician's prescription. We encourage you to advise Medicaid recipients to obtain their ostomy supplies from one provider. In addition, MQD advises that providers of ostomy products obtain a patient certification statement, signed by the patient, attesting that he/she has not received ostomy products from other suppliers during the same period that he/she is asking for ostomy supplies from you. This certification is of special importance for patients new to the provider of ostomy products and will ensure that the provider will not be denied payment when the patient gives false information and receives more than the maximum supplies by using multiple ostomy providers. This certification should be kept in the ostomy provider's files. If the patient is known to the ostomy provider, the MQD expects that the provider will check its records to ensure that it has not provided more ostomy products than

the maximum without obtaining prior authorization. Attached is a copy of a memorandum addressed to patients explaining the need for certification and a certification form that can be used for this purpose. Please feel free to photocopy this form or to use a certification that you develop.

To expedite claims processing and eliminate some of the administrative work related to providing ostomy supplies, effective January 1, 2002, the MQD will remove all prior authorization requirements for ostomy supplies as long as the maximum units are not exceeded. If the maximum units are exceeded, prior authorization with justification for the units needs to be provided.

Finally, the MQD will reimburse $5.00 a month to cover the mailing/handling costs for Oahu providers who mail ostomy products to patients on neighbor islands. Local code W9902 should be used for "handling, conveyance, and mailing of ostomy products from Oahu to a Medicaid recipient on a neighbor island." Only Oahu providers with no branch(es) on the neighbor island to which the item is mailed can be reimbursed for mailing/handling costs.

If you need clarification or have questions concerning these changes, please call Dr. Lynette Honbo, MQD's Medical Director, at 692-8106.

/s/

Aileen Hiramatsu
Med-QUEST Division Administrator

Enclosures

Please complete the following if you are contacted by a Medicaid recipient who asks for assistance in finding a Medicaid provider of **OSTOMY PRODUCTS**:

Name: _____

Medicaid ID No.: _____ Recipient's Age: _____

Area and Island of Residence *(example: Hilo, Hawaii)*: _____

Telephone No.: _____

If the recipient has no phone no., please give the name and phone no. of a relative or friend who can take a message for the recipient:

Name: _____

Telephone No.: _____

Physician's Name: _____

Physician's Phone No.: _____

Your Name: _____

Your Division and Branch: _____

Your Telephone No.: _____

[ ] CHECK here if recipient says that he/she will run out of ostomy products in a week or less

FAX this form to the MSB at 692-8131.

Ostomy Products
Maximum Quantities

	A	B	E
1	**Code**	**Description**	**Max. units**
2	A4357	Bedside drainage bag, w/wo anti-reflux , w/wo tube, each	2/m
3	A4361	Ostomy faceplate, each	3/6m
4	A4362	Skin Barrier; solid 4x4, each	20/m
5	A4364	Adhesive, liquid	4/m
6	A4365	Adhesive remover wipes per 50	1box/m
7	A4367	Ostomy belt, each	2/m
8	A4368	Ostomy filter, each	20/m
9	A4369	Ostomy skin barrier, liquid per oz	2oz/m
10	A4370-22	Ostomy skin barrier, paste per oz	4oz/m
11	A4371-22	Ostomy skin barrier, pwd. per oz	10oz/6m
12	A4372	Ostomy skin barrier, solid 4x4, standard wear w.convexity	20/m
13	A4373	Ostomy skin barrier, with Flange, standard wear w. convexity, each	20/m
14	A4374	Ostomy skin barrier, with Flange, extended wear w. convexity, each	20/m
15	A4375	Ostomy pouch, drainable w. faceplate, plastic, each	20/m
16	A4376	Ostomy pouch, drainable w. faceplate, rubber, each	20/m
17	A4377	Ostomy pouch,drainable, use on faceplace, plastic, each	10/m
18	A4378	Ostomy pouch,drainable, use on faceplace, rubber, each	20/m
19	A4379	Ostomy pouch, urinary w. faceplate attached,plastic, each	20/m
20	A4380	Ostomy pouch, urinary w. faceplate attached,rubber, each	20/m
21	A4381	Ostomy pouch, urinary, use on faceplate, plastic, each	10/m
22	A4382	Ostomy pouch, urinary, use on faceplate, heavy plastic,, each	20/m
23	A4383	Ostomy pouch, urinary, use on faceplate, rubber, each	20/m
24	A4384	Ostomy faceplace equivalent, silicone ring, eac	20/m
25	A4385	Ostomy skin barrier, solid 4x4, extended wear, no convexity, each	20/m
26	A4386	Ostomy skin barrier, w. flange, extended wear, no convexity, each	20/m
27	A4387	Ostomy pouch closed, w. standard wear barrier w. convexity	60/m
28	A4388	Ostomy pouch, drainable, with extended wear barrier, no convexity (1 piece)	20/m
29	A4389	Ostomy pouch drainable, w. standard wear barrier w. convexity	20/m
30	A4390	Ostomy pouch, drainable, with extended wear barrier, w.convexity (1 piece)	20/m
31	A4391	Ostomy pouch, urinary, with extended wear barrier, no convexity (1 piece)	20/m
32	A4392	Ostomy pouch, urinary, with standard wear barrier, w. convexity (1 piece)	20/m
33	A4393	Ostomy pouch, urinary, with extended wear barrier, w.convexity (1 piece)	20/m
34	A4394	Ostomy deordorant for use in pouch, liquid, per oz.	2oz/m
35	A4395	Ostomy deordorant for use in pouch, solid, per tablet	90/m

Ostomy Products
Maximum Quantities

	A	B	E
1	**Code**	**Description**	**Max. units**
36	A4396	Ostomy belt with peristomal hernia support	2/3m
37	A4397-22	Irrigation supply; sleeve, each	4/m
38	A4398-22	Ostomy irrigation supply,bag, each	2/6m
39	A4399	Ostomy irrigation supply,cone/catheter, including brush	2/6m
40	A4400	Ostomy irrigation set	1/lifetime
41	A4402	Lubricant, per oz	4oz/m
42	A4404	Ostomy ring, each	10/m
43	A4421	Ostomy supply; miscellaneous	2/m
44	A4455	Adhesive Remover or Solvent (for tape; cement or other adhesive)/oz	16/6m
45	A5051	Pouch, closed; with barrier (1 piece)	60/m
46	A5052	Pouch, closed; no barrier (1 piece)	60/m
47	A5053	Pouch, closed; use w. faceplate	60/m
48	A5054	Pouch closed, use on barrier w. flange (2 piece)	60/m
49	A5055	Stoma cap	31/m
50	A5061	Pouch, drainable; w. barrier (1 piece)	20/m
51	A5062	Pouch, drainable; no barrier (1 piece)	20/m
52	A5063	Pouch, drainable; use on barrier w. flange (2 piece)	20/m
53	A5064	Pouch, drainable; w. faceplate, plastic or rubber	10/m
54	A5071-22	Pouch, urinary w. barrier (1 piece)	20/m
55	A5072	Pouch, urinary no barrier (1 piece)	20/m
56	A5073	Pouch, urinary use on barrier W. flange (2 piece)	20/m
57	A5074	Pouch, urinary w. faceplate, plastic or rubber	10/m
58	A5075	Pouch, urinary use on faceplate, plastic or rubber	10/m
59	A5081	Continent device; plug for continent stoma	31/m
60	A5082	Continent device; catheter for continent stoma	4/m
61	A5093	Ostomy accessory, convex insert	10/m
62	A5102	Bredside drainage bottle with or without tubing; rigid or expandable, each	2/6m
63	A5119	Protective wipes per 50	3 boxes/6m
64	A5121	Skin Barrier; solid 6x6 or equivalent, each	20/m
65	A5122	Skin Barrier; solid 8x8 or equivalent, each	20/m
66	A5123	Skin Barrier; with Flange (solid, flexible or accordian) any size, ea.	20/m
67	A5126	Adhesive or non-adhesive; disc or foam pad	20/m
68	A5131	Appliance cleaner, incontinence/ostomy. Per 16 oz.	1(16oz)/m

Medicaid/QUEST Guidelines* for Medication Management of Chronic Non-Cancer Pain

OVERALL GUIDELINES

ASSESSMENT– is the patient an appropriate candidate for medication use? (see Appendix I)

↓

IF PATIENT IS AN APPROPRIATE CANDIDATE FOR MEDICATION USE:

- Select appropriate medication to trial for 4 to 8 weeks – (see Appendix II)
- Set up system to document function and comfort improvements
- Set up treatment agreement (see Appendix IV)

↓

SET UP RE-EVALUTION VISIT SCHEDULE:

- Q 2 – 3 weeks during medication trial
- Q 2 – 8 weeks after trial
  - ✓ Analgesic effect → reasonable degree of comfort?
  - ✓ Physical and psychosocial capabilities→ is patient experiencing a higher level of functioning in daily activities than before therapy started?
  - ✓ Side effects→ being managed or interfering with function?
  - ✓ Aberrant drug related behaviors→ any recognized illegal/aberrant/abuse behaviors?

↓

DETERMINE ROLE FOR LONG-TERM MEDICATION MANAGEMENT:

- Significant improvement in function and comfort
- Adherence to treatment agreement
- Lack of adverse effects
- Contingency plans with opioid treatment – (see Appendix III)

↓

DOCUMENT, DOCUMENT, DOCUMENT

*Courtesy of Gregory Holmquist, Pain Management & Palliative Care Pharmacist Specialist, Palliative Care Strategies "RXRELIEF@aol.com. Accepted by QUEST Medical Directors meeting 08/03/00

Medicaid/QUEST Guidelines* for Medication Management of Chronic Non-Cancer Pain

OVERALL GUIDELINES

APPENDIX I: ASSESSMENT–Is the patient an appropriate candidate for medication?

A. Efficacy Issues?

- **Conditions that may show improvement with the use of medications:**

  - ✓ Patient has taken some form of medication therapy in either the acute or sub acute phase and has demonstrated at least some improvement in comfort and function:

    - Simple analgesics (acetaminophen, NSAIDs, adjuvants)
    - Opioids
    - Adjuvant medications (antidepressants, anticonvulsants, muscle relaxants)

  - ✓ The patient's pain diagnosis is nociceptive pain (e.g. arthritis, tissue destruction) or neuropathic pain (e.g. post herpetic neuralgia, sciatica, phantom limb pain, etc.) or is a mixed syndrome of nociceptive and neuropathic.

- **Conditions that probably will not show improvement with the use of medications:**

  - ✓ Patient has taken some form of medication therapy (with adequate dosing and agent selection) in either the acute or sub acute phase and has demonstrated NO improvement in comfort and function**.**

  - ✓ Patient's pain diagnosis falls into the category of somatoform disorder.

Medicaid/QUEST Guidelines* for Medication Management of Chronic Non-Cancer Pain

OVERALL GUIDELINES

B. Safety Issues?

- **Is the patient likely to abuse opioids or have other adverse outcomes?**

  - The risk of abuse or adverse outcome is high if any of the following is present:

    - ✓ History of alcohol/ other substance abuse, or a history of chronic, high dose benzodiazepine use.
    - ✓ Active alcohol or other substance abuse.
    - ✓ Borderline personality disorders.
    - ✓ Mood disorders (e.g. depression) or psychotic disorders
    - ✓ Other disorders that are primarily depressive in nature.
    - ✓ Off work for more than 6 months.
    - ✓ Poor response to opioids in the past.

Note: When special circumstances seem to warrant the use of these drugs in the types of patients noted above, referral for review is indicated.

Medicaid/QUEST Guidelines* for Medication Management of Chronic Non-Cancer Pain

OVERALL GUIDELINES

APPENDIX II: MEDICATION SELECTION FOR OUTPATIENT TREATMENT OF CHRONIC NON-CANCER PAIN

1. **Simple analgesics (NSAIDS, acetaminophen)**

   - **Principles of prescribing:**

     - ✓ Not more that 2-4 gms per day of acetaminophen on a chronic basis
     - ✓ If failure with one NSAID, try alternate NSAID from different class
     - ✓ Monitor for potential of liver, renal, GI toxicities

   - **Best candidates:**

     - ✓ Mild to moderate pain in the acute/sub-acute
     - ✓ Inflammatory component to pain syndrome
     - ✓ As co- analgesics

   Worst candidates:

   History of GI bleed
   Severe pain if prescribed alone

2. **Opioids**

   - **Principles for prescribing:**

     - ✓ Single prescribing physician with single pharmacy when possible
     - ✓ Start with lowest possible dose – but be willing to titrate upwards if needed
     - ✓ Use long acting opioids for maintenance of continuous pain (e.g. controlled release oxycodone; methadone, if closely monitored)
     - ✓ Minimize use of short acting opioids for break through pain (e.g. hydrocodone, codeine)
     - ✓ Avoid meperidine, mixed agonist/antagonists (e.g. pentazocine (Talwin), butorphanol (Stadol), nalbuphine (Nubain), dezocine (Dalgan), propoxyphenes (Darvon, Darvocet)

   - **Best candidates:**

     - ✓ Moderate to severe nociceptive pain in the acute/sub acute phase
     - ✓ In conjunction with adjuvants for moderate to severe neuropathic pain in the sub acute and chronic phase

   Worst candidates

   Migraine pain
   Demanding of parenteral route
   Concurrent enzodiazepines
   Anxiety, PTSD, psychiatric disorders

Medicaid/QUEST Guidelines* for Medication Management of Chronic Non-Cancer Pain

OVERALL GUIDELINES

3. **Adjuvants**

- **Principles for prescribing:**

  - ✓ One adjuvant at a time, targeted to the specific symptom

    - Tricyclic antidepressants (amitriptyline, nortriptyline, desipramine, venlafaxine) for pain described as "constant pain"
    - Anticonvulsants (gabapentin, carbamazepine, clonazepam) for pain described as "shooting, stabbing, electric shock pain"
    - Baclofen for muscle spasms
    - Dicyclomine, oxybutynin for smooth muscle cramping

- **Best candidates:**

  - ✓ Neuropathic pain
  - ✓ Visceral pain
  - ✓ Opioid non-responsive pain

Worst candidates:

Elderly (due to side effects)

Medicaid/QUEST Guidelines* for Medication Management of Chronic Non-Cancer Pain

OVERALL GUIDELINES

APPENDIX III: CONTINGENCY PLANNING WITH OPIOID THERAPY

1. **Patients who may have "opioid prescription problems"**

   (Recommendations listed below are adapted from the Washington State Department of Labor and Industries Guidelines for Outpatient Prescription of Oral Opioids for Injured Workers with Chronic NonCancer Pain, January 20,2000)

   The following may be a useful monitoring tool in managing chronic pain patients in your office setting. A patient may qualify as a prescription abuser by meeting three or more of the criteria listed below. Physicians are encouraged to seek consultation (addictionologist, pain clinic, etc.) if three or more of these criteria are met. The patient:

   a. Displays an overwhelming focus on opioid issues. For example, discussion of opioids occupies a significant portion of the visit and impedes progress with other issues regarding the patient's pain. This behavior persists beyond the third clinic session.
   b. Has a pattern of early refills (3 or more) or escalating drug use in the absence of physician direction to do so.
   c. Generates multiple telephone calls or visits to the office to request more opioid, early refills or problems associated with the opioid prescription. A patient may qualify with fewer visits if he or she creates a disturbance with the office staff.
   d. Demonstrates pattern of prescription problems for a variety of reasons that may include lost medications or stolen medications.
   e. Has supplemental sources of opioid obtained from multiple providers, emergency rooms or illegal sources.
   f. Have illicit drugs on urine screen.

2. **Failure to obtain therapeutic improvement**

   Patients failing to obtain improvement in function and/or comfort in a 6-8 weeks trial of opioid therapy will need to be weaned off the opioids to prevent withdrawal reactions. Discuss this aspect of the Treatment Agreement (see 5.a.) with the patient.

3. **Failure to adhere to treatment agreement**

   While any violation of the treatment agreement should be considered serious, the first violation or a rare repeated violation should be evaluated within the context of the patient's situation. Patients should be counseled and the agreement should be re-evaluated.

Patients who repeatedly ignore or violate the intent and/or the content of the treatment agreement need referral to an addictionologist for evaluation and possible discontinuance of the opioid therapy with appropriate weaning of opioid therapy.

Comprehensive Non-Acute Rehabilitative Services For Children 0 – 6 Years Old

Rehabilitative services include physical therapy, occupational therapy and speech therapy. Speech therapy includes the services of a speech therapist or pathologist. In order to determine the medical necessity for these services it is important to assess the child's general development particularly with regard to the neurological status. Various procedures as outlined below are to be used in assessing children 0-6 years of age to determine the medical necessity of carrying out rehabilitative services.

I. Reasonable and Necessary

All rehabilitative services must be considered reasonable and necessary.

A. Reasonable and Necessary – To be considered reasonable and necessary the following conditions must be met:

1) The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition. Experimental therapies are excluded from coverage.

2) There must be an expectation that the condition will improve significantly in a reasonable (and generally predictable period of time based on the assessment made by the physician or the patient's rehabilitative potential after any needed consultation with the qualified therapist, or services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific developmental or disease state).

3) The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified therapist/pathologist or under the immediate supervision of a therapist.

4) The amount, frequency, and duration of the services must be reasonable, although there is no limitation on the number of sessions allowed as long as significant progress is being made.

5) Referrals for therapeutic services must be made by a physician. The physician is expected to employ clinical

judgment, the history and physical, testing, etc. in determining the medical necessity of rehabilitative services. The Denver Child Development and/or the Milani Comparetti Neurological scales are generally accepted screening tools that may be used to aid the physician in assessing the developmental level of a patient and the medical necessity of evaluation by the therapists.

6) Evaluation of the patient's developmental or therapeutic status shall be measured and expressed in objective, unambiguous concise language which possess as much reliability as possible. The language which meets this criteria best is that of numbers (See IV. Plan of Care). Reliable assessment is not based on subjective, qualitative, or emotional assessments. The results of tests as well as goals, and therapeutic results should be recorded on appropriate forms that will be submitted for review and necessary action.

II. Application of Procedures for Rehabilitation Services

A. Assessment

1. Motor

- Movement Assessment of Infants
- Upper Extremity Motor Development Test
- Lower Extremity Motor Development Test
- Amiel-tison Neurological
- Peabody Motor Scales

2. Speech/Language

- Receptive Expressive Emergent Language Scale
- Sequence Inventory of Communication Development
- Preschool Language Assessment Instrument
- Clinical Evaluation of Language Functions
- Detroit Tests of Learning Aptitude

3. Multi-Domain Tools

- Bayley Scales of Infant Development
- Gesell Developmental Schedules
- Hawaii Early Learning Profile

Appropriate tests as stated above but not limited to the above are to determine the patient's condition and needs.

III. Rehabilitation Therapy

A. Therapy will be deemed appropriate if an evaluation justifies intervention and clear goals with a time frame are given.

B. A child will be authorized to receive continued therapy where there is clear progress toward meeting the objective for habilitation as stated in the plan of care.

C. Speech therapists/pathologists, physical therapists and occupational therapists may provide initial assessments without prior Medicaid medical authorization upon referral by a physician for children aged 0-6 years old.

D. Medical authorizations (Form 1144) are required for therapy and/or for a therapeutic program taught by a qualified therapist. The physician refers the patient for therapy. He should sign the 1144 form and attach a copy of the plan of care (see Section IV).

E. An alternate system will be recommended for intervention at another level of caregiver, e.g. nurse, assistant or aide, or parent or relative when there is regression or no change in status after a reasonable trial of direct therapy. Periodic re-evaluation by a qualified therapist is appropriate.

F. A child will be discontinued from therapy when the therapeutic goals are met (which may be less than the chronological age) or where continued therapy will not result in further improvement as determined by the physician in consultation with the therapist.

IV. Plan of Care

For therapy to be provided, a plan of care should include (1) time frame for re-evaluation, (2) long-range goals, (3) short-term objectives, and (4) frequency of treatment. Also included should be the results of the administered developmental tests (listed under II.A.1). Since many institutions have different methods for recording these evaluations, it is recommended that a uniform format be adopted for children aged 0-6. The following examples can be used to assess gross motor, fine motor, and speech development. They are based on the concept of looking at the developmental age compared with the chronological age.

A. Delay by Months

0	No function present
0.5	Delay more than 2 years
1.0	Delay 1-2 years
2.0	Delay 5 months - 1 year
3.0	Delay 3 months – 6 months
4.0	Delay less than 3 months
5.0	No delay

B. Developmental Age
Chronological Age x 100 = %

0	No function
0.5	less than 10 %
1.0	10 – 25 %
2.0	25 – 50 %
3.0	50 – 75 %
4.0	75 – 99 %
5.0	100%

By using a grading scheme for various modalities, a base line developmental level can be determined. The Plan of Care can reference this grading scheme in establishing therapeutic goals. When the patient has achieved the desired goal or is no longer improving, then a maintenance plan can be completed and further therapy transferred to the family or nursing staff as appropriate.

Since the evaluations prior to provisions of therapy are extensive and include objective developmental testing and a plan of care with clear objectives and goals, it is Medicaid's decision to reimburse evaluations that conform to the guidelines at a flat rate of $15.00 per 15 minutes not to exceed one hour and a half (a total of six 15 minute periods) per evaluation. In keeping with existing protocols for the services to children ages 0 to 6, only one such extensive evaluation can be reimbursed every six months for each therapeutic service. To qualify for the enhanced reimbursement, the following codes should be used:

W9775-X6	Physical Therapy Evaluation
W9777-X6	Occupational Therapy Evaluation
92506-X6	Speech Evaluation

Re-evaluations performed more frequently will be reimbursed at existing customary rates. The following codes should be used for these re-evaluations:

W9776	Physical Therapy Re-evaluation
W9777	Occupational Therapy Re-evaluation
92506	Speech Re-evaluation

The above codes, at this writing, are considered local codes and will be changed at a later date in order to meet HIPPA compliance.

Since reimbursement will be based on 15-minute blocks of time, please enter the appropriate units in Form Locator Block 24F of the HCFA 1500 billing form or 52 on UB82 billing form. Thus a 45-minute evaluation will be coded as three (3) units.

Adult Preventive Health

Preventive health risk assessment and screening test services for non-hospitalized adults include, but are not limited to:

- Hypertension screening (once every two years if normal, every year or more frequently if abnormal),
- Total cholesterol measurement (For females age 45-65 and males age 35-65 once every five years, additional tests based on history),
- Diabetes screening (once, additional tests based on history),
- Mammography (annually after age 40),
- Cervical cytology (annually for sexually active women or age 18-65; after 3 successive normal annual exams the test may be every 3 years),
- Colon cancer screening (digital rectal exam and stool blood test annually after age 50; sigmoidoscopy at age 50 and then every ten years),
- Sexually transmitted disease screenings (at least once during pregnancy, other based on history),
- Rubella serology or vaccination history for women of child bearing age,
- Tuberculosis screening (once, additional testing based on history and Department of Health (DOH) guidelines),
- Immunizations (Refer to Chapter 6: Medical/Surgical Services),
- Prostate screening (digital rectal exam and prostate specific antigen (PSA) annually after age 50, screening is recommended annually for males 40 and older who are at high risk due to immediate family history),
- Weight/height measurements once every two years,
- Physical examinations and periodic health examinations or assessments designed to: Determine risk of disease, provide early detection of disease, detect the presence of injury or disease, establish a treatment plan, and/or evaluate the results or progress of the treatment plan or the disease,
- Health education and counseling concerning drugs, alcohol, smoking, domestic violence, injury prevention, i.e. seat belts, dental health, depression and health promotion including exercise, nutrition and other topics based on history,
- Chemoprophylaxis such as folic acid for pregnant women and women actively trying to become pregnant; counseling for all peri- and post-menopausal women about the potential benefits and risks of hormone prophylaxis.

PREVENTION OF SERIOUS LOWER RESPIRATORY TRACT INFECTIONS CAUSED BY RESPIRATORY SYNCYTIAL VIRUS (RSV)

This memorandum updates and supercedes the guidelines for the coverage of RespiGam and Synagis originally issued as Memorandum M98-41 on December 31, 1998. Changes to the original memorandum are underlined.

RespiGam [human respiratory syncitial virus (RSV) immune globulin], administered intravenously, and Synagis (Palvizumab), administered intramuscularly, are agents approved by the FDA for the prevention of serious lower respiratory tract infections in infants RSV.

The following guidelines for the prevention of RSV and coverage of these agents by Hawaii QUEST medical plans and the fee-for-service Medicaid Program have been developed by the medical directors in consultation with the University of Hawaii School of Medicine's Pediatric Infectious Disease Group.

General Prevention:

Parents and caregivers of former premature infants, infants with bronchopulmonary dysplasia (BPD), and infants with congenital heart disease should receive education in the following:

- Strict Hand Washing Techniques;
- Avoidance of exposure of their infants to crowds;
- Avoidance of exposure of their infants to smoke and dust; and
- Avoidance of exposure of their infants to all sick persons.

Recommended Guidelines for Use of RespiGam and Synagis

Patients who should be considered for RSV prophylaxis should be in one or more of the following groups:

- Premature infants with BPD and who are on supplemental oxygen and less than eight (8) months chronological age [corrected age of less than six (6) months] as of December of the year of their birth.
- Infants born at less than 32 weeks gestation with a history of one or more respiratory tract infections which required hospitalization who are under eight (8) months age [corrected age of less than six (6) months] as of December of the year of their birth.
- Infants 28 weeks gestation or less and who are less than twelve (12) months of age at the start of the RSV season.
- Infants and children less than two (2) years of age at the start of the RSV season with chronic lung disease (CLD) who were receiving long term medical therapy for treatment of their CLD within six (6) months before the anticipated RSV season.

Recommended Treatment

- Maximum of four (4) monthly doses to start as early as late October and to end no later than March.
- RespiGam and Synagis are indicated for the PREVENTION of RSV and should NOT be used in patients who have RSV infections.

Additional Considerations

- The physician must weigh the side effects of these agents against the benefit gained from preventing RSV infections.
- RespiGam should not be administered at the same time as routine childhood immunizations and may interfere with response to immunizations.
- Neither RespiGam nor Synagis is licensed by the Food and Drug Administration (FDA) for use in patients with congenital heart disease (CHD). RespiGam is contraindicated in cyanotic CHD.
- As Synagis is given intramuscularly, it must be used with caution in patients with thrombocytopenia and coagulation disorders.
- A second (2^{nd}) course of Synagis therapy in the following season is rarely indicated.

PERSONS WITH SERIOUS MENTAL ILLNESS

Definition

The seriously mentally ill are defined as persons who, as the result of a mental disorder, exhibit emotional, cognitive, or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, mental disability is severe and persistent resulting in a long term limitation in their functional capacities for primary activities of daily living such as interpersonal relationships, self-care, homemaking, employment, and recreation.

Conditions such as mental retardation or substance abuse may cause similar problems or limitations, and are not to be included in this definition unless, in addition to one or more of these disorders, the person has a severe and persistent mental disorder.

Criteria

Assessment:

The person has undergone a comprehensive professional clinical assessment sufficient to establish a diagnosis of mental disorder and a quantitative functional assessment. The combination of diagnosis and level of functioning establishes eligibility for public services through a formula stated below.

Eligible Diagnoses:

The person meets the latest DSM edition criteria for mental disorder in Category I, II, or III.

CATEGORY I

- ❑ Schizophrenic Disorders (295.1, 295.2, 295.3, 295.6, 295.9)
- ❑ Delusional Disorders (297.1)
- ❑ Psychotic Disorders Not Elsewhere Classified
  - Schizo-affective Disorders (295.7)
  - Psychotic Disorders NOS (298.9)
- ❑ Mood Disorders
  - Bipolar Disorders (296.4, 296.5, 296.6, 296.7)
  - Depressive Disorders (296.2, 296.3)

- Substance Related Disorders Persisting Three Months After Detoxification and Stabilization

    - Psychotic Disorders (291.3, 291.5, 292.11, 292.12)
    - Mood Disorders (291.89 for mood only, 292.84)

CATEGORY II

- Mental Disorders Due to a General Medical Condition

    - Psychotic Disorder Due to a General Medical Condition with Delusions (293.81)
    - Psychotic Disorder Due to a General Medical Condition with Hallucinations (293.82)
    - Mood Disorder Due to a General Medical Condition (293.83)

- Anxiety Disorders

    - Panic Disorder with Agoraphobia (300.21)
    * Panic Disorder without Agoraphobia (300.01)
    - Post Traumatic Stress Disorder (309.81)
    - Obsessive Compulsive Disorder (300.3)
    - Alcohol induced anxiety disorder/mood disorder with depressive features (291.81)

- Personality Disorders (these conditions exempted from provisionally qualifying conditions)

    - Schizoid (301.20)
    - Schizotypal (301.22)
    - Borderline Personality Disorder (301.83)

CATEGORY III (these conditions exempted from provisionally qualifying conditions)

- Other Disorders Not Listed Above and Not Excluded Below

PERSONS WITH A PROVISIONALLY QUALIFYING CONDITION

These persons are defined as those who have a substance abuse condition and are suspected to suffer from a qualifying condition due to their symptoms and functional limitations. These persons have on-going and recent substance abuse which prevents the clinician from making a definitive qualifying diagnosis.

Excluded Diagnoses:

Unless an eligible disorder listed above is also present, the following disorders are excluded from eligibility under the Adult Behavioral Health Managed Care Plan.

- ❑ Delerium, Dementia, and Amnestic and other Cognitive Disorders
- ❑ Disorders Usually First Diagnosed in Infancy, Childhood, or Adolesence, i.e., Mental Retardation, Pervasive Developmental Disorders, Learning Disorders, Motor Skills Disorder, Communication Disorders.
- ❑ Substance Induced Disorders except as otherwise described above.
- ❑ Substance Dependence Disorders
- ❑ Psychotic Disorders Not Elsewhere Classified. Only the following diagnosis in this category is excluded:
    - Brief Psychotic Disorder (298.8)
- ❑ Sexual and Gender Identity Disorders
- ❑ Factitious Disorders
- ❑ Impulse Control Disorders Not Elsewhere Classified
- ❑ Adjustment Disorders
- ❑ Psychological Factors Affecting Medical Conditions
- ❑ V Codes

Comorbidity:

Patients with a substance abuse diagnosis must also meet the diagnostic criteria for an above accepted mental illness to be considered potentially SMI. Those patients who are suspected to suffer from a qualifying conidtion yet currently are using substances, thus precluding the clear determination of an eligible diagnosis will be provisionally accepted as suffering from a qualifying condition. For those individuals with a dual diagnosis of substance abuse and a severe and persistent mental disorder, the assessment will also need to include a rating using the most current American Society of Addiction Medicine (ASAM) placement criteria. The assessment for dual diagnosis individuals must also include a history of the patient's past and present substance use sufficient to identify and describe its effects on cognitive, psychological,

behavioral, and physiological function; a general medical and psychiatric history and psychiatric examination; a history of prior psychiatric treatments and outcomes; a family and social history; screening of blood, breath, or urine for abused substances. This assessment will be considered if the available information is sufficient to document the patient's appropriateness for SMI status and support a determination. A copy of any recent hospital or treatment facility admission and discharge summaries will aid the MQD reviewer in making a determination.

Patients with DD/MR in addition to an allowable diagnosis will have to be at worst in the mild range (317.00) for eligibility.

Impaired Level of Functioning:

Assessment of impaired role functioning is achieved by the administration of an instrument such as the Client Assessment Record (CAR). At the minimum the Global Assessment of Functioning (GAF) will be provided to the MQD reviewer. A GAF score below 50 will be considered as supportive of an impaired level of functioning in conjunction with the CAR caculated score by the MQD reviewer. If the CAR instrument was used by the provider, CAR scales would be limited to: Medical/Physical, Family/Living Situation, Interpersonal Relations, Role Performance, Socio-Legal, and Self-Care/Basic Needs. The person is assigned to one of the four following levels of impaired functioning:

Level A:

3 or more CAR scale scores of 40 and above or
4 or more CAR scale scores of 30 and above.

Level B:

2 or more CAR scale scores of 40 and above or
3 or more CAR scale scores of 30 and above.

Level C_1:

1 CAR scale score of 40 and above or
2 CAR scale scores of 30 and above.

Level C_2:

Clinical evidence indicates that level of functioning would rate at the C_1 level or lower in the absence of treatment.

Eligibility Determination Formula:

1. a) The patient meets Diagnostic Category 1 and any of the Impaired Role Functioning Levels (A, B, C1 or C2).

   b) The patient meets Diagnostic Category II and Impaired Role Functioning Levels A or B.

   c) The patient meets Diagnostic Category III and Impaired Role Functioning Level A.

2. As part of the assessment of chronic mental illness, documentation should be provided on historical duration of illness and disability and/or on the presence of risk factors making it likely that the disorder and disability will be present into the foreseeable future.

   a, b, or c above must have been present for at least 6 months or must have a 6 month minimal expected duration or must have a combined present and expected duration of 6 months.

Accessible Services:

The person with a clear SMI diagnosis is judged to be in need of a comprehensive planned package of supportive and treatment services requiring intensive case management and interdisciplinary supervision of long-term or indefinite duration. Those with a provisional diagnosis due to limited functioning secondary to substance abuse are judged to be in need of the above services for a limited-term duration in order to establish a clear SMI diagnosis.

Evaluation Process for Determination of Eligibility for the Behavioral Health Managed Care (BHMC) Plan for Seriously Mentally Ill (SMI) Adults

1.) **INPATIENTS**

a) Adults on Oahu

If, after reviewing relevant clinical information, the QUEST plan or referring fee-for-service provider determines that a member meets the criteria for a Serious Mental Illness (SMI), they should complete and fax to the MQD the referral form entitled Referral for Serious Mental Illness. This form is self-explanatory, must be completed entirely, and should be submitted at least two (2) working days before anticipated discharge to:

MQD/Medical Standards Branch
Attention: Barbara Respicio, R.N.
Fax: (808) 692-8131

If the patient is discharged in advance of his/her projected discharge date, please inform the MQD Psychiatric Consultant at 692-8115 and use the process described under "OUTPATIENTS."

b) Adults on Neighbor Islands

Use the process described under "OUTPATIENTS".

2) **OUTPATIENTS** - The QUEST plans or referring provider should mail or fax to the MQD, the "Referral for SMI" form, the forms for the assessment of Mental States and Functional Scales. In addition, to expedite the processing of SMI referrals, it is asked that as much of the following information, as possible, be included:

a) Personal history, family history, social history and history of drug use.

b) Mental health history and educational history.

c) History of past hospitalizations and other prior psychiatric care.

d) Local hospital admission and discharge summaries (including medical and psychiatric histories and physical examinations).

e) Most current psychiatric and psychological assessments to include pertinent history, behavioral observation and presentation, diagnostic impression, reports of psychological/psychiatric testing, Global Assessment of Functioning (GAF) scores and substance abuse information using ASAM placement criteria (if applicable).

f) Pre-signed option letters for patients who are or have Medicaid or Medicaid/Medicare insurance. (Note: Patients having Medicare only, are not eligible for SMI services.)

3) For QUEST plans, the MQD expects that the Medical Directors of the plans will review and sign all referrals for SMI and any information (such as the assessment of mental state and functional scales) which may have been completed by health plan staff. Thus, the MQD will not make a determination that a member is SMI (if referred by the plan) without the signature of the plan's Medical Director. Referrals for fee-for-service recipients can be made by providers other than the QUEST plans but need to be signed by a psychiatrist or psychologist.

4) The MQD's psychiatric consultant will make a decision based on the information submitted.

5) The Referral Form with the MQD's decision will be returned to the referring provider in most cases within seven (7) business days and not more than 30 days after receipt. The MQD makes one of the following four determinations:

a) SMI - yes, full acceptance

b) Provisional SMI - yes, provisional acceptance for limited period

c) SMI – no

d) Additional Information Needed

6) Provisional SMI are those individuals who have a substance abuse condition and are suspected to suffer from a qualifying condition due to their symptoms and functional limitation. These persons have on-going and recent substance abuse which prevents the clinician from making a definitive qualifying diagnosis.

7) If the member is determined to be SMI or provisional SMI, the BHMC plan will receive a copy of all pertinent information submitted by the referring provider. In addition, the MQD's Enrollment Call Center will be notified to add the member's eligibility status to the member's eligibility file.

8) If a member was not determined to be SMI or if additional information is needed, the MQD will indicate the reason for this decision or the additional information needed on the referral form.

9) After a referral has been submitted to the MQD and before the referring provider is notified of a decision, referring provider shall update the MQD in situations including but not limited to the following:

   a) The patient was admitted to the hospital.

   b) The patient has an urgent need for behavioral health managed care services.

   c) The referring provider has not received a determination seven (7) working days or more after submission of the referral.

Additional clarification which applies to both INPATIENTS and OUTPATIENTS:

1) For the BHMC Plan only, if the member is not included in the tape for the month after enrollment, please contact the Med-QUEST Finance Office at 692-7957.

2) If no records of prior hospitalizations are available, outpatient treatment services will be considered by the MQD Psychiatric consultant in determining whether a member had an SMI diagnosis. The following criteria will be used for the determination: Treatment for at least 6 months or must have a 6 month minimal expected duration, or must have a combined present and expected duration of 6 months.

3) Those members with a qualifying condition will be accepted provisionally into the behavioral health managed care plan for six months to allow for a complete assessment and intensive case management. A case review by the BHMC will begin four months after enrollment for members in this category. Once an SMI diagnosis is established the member will be changed to an SMI category. If the member does not have an SMI diagnosis the member will be disenrolled from the behavioral health managed care plan. It is the responsibility of the referring provider to determine the continued treatment needs of those recipients determined not to have an SMI diagnosis and is in treatment for substance abuse at the time of disenrollment.

4) Do not refer the following types of members as they **DO NOT** meet **SMI** requirements:

   a) Adults with SMI diagnosis or who (in the absence of a diagnosis) have documentation of displaying SMI symptoms for less than a combined and expected duration of at least 6 months.

b) Adults whose serious mental illness is not expected to last more than 6 months.

c) Adults with substance abuse diagnosis(es) only and NO independent psychiatric diagnosis that would otherwise qualify for SMI consideration. Referrals can be made for those adults with a substance abuse diagnosis and a probable SMI diagnosis which is unclear due to the patients' recent and sustained substance abuse.

d) Adults with psychiatric diagnosis(es) and developmental disabilities (DD)/mental retardation (MR) (other than mild DD/MR).

e) Patients with SMI diagnosis(es) who are functioning well in the community.

f) Patients who do not have Medicaid insurance.

5) To expedite processing, the MQD will return only the referral forms. If a provider wishes to have a determination reconsidered, all applicable information should be resubmitted. A decision on the reconsideration will be rendered within seven (7) working days of receipt in most cases and as stated in the RFP, not more than 30 days after receipt.

6) If a provider questions a determination, he/she should contact the MQD psychiatric consultant at 692-8115.

7) Other individuals such as psychiatrists and psychologists can also make referrals for SMI evaluation.

8) If the referring provider needs clarification or has questions on SMI referrals, contact Ms. Barbara Respicio, R.N. at 692-8127.

Date:_____

_____
_____
_____

Case No. _____**(If Available)**
Client No. _____**(CCS#:)**

Dear _____:

If you are a recipient of SSI (Social Security Income) or SSDI (Social Security Disability Income) and you are on **Medicaid**, you may choose to continue to receive your mental health services through CCS. If you make this choice, your medical care will be covered under Medicaid, while your mental health services will be covered under CCS.

Medicaid Fee-for Service for Mental Health	**CCS Coverage for Mental Health**
Inpatient stays - limited days may apply	Inpatient stays - no limit on days
Case Management through the State Community Mental Health Centers (CMHC)	Case Management through the same agency you are now receiving the service, including the CMHCs
Outpatient Psychotherapy	Outpatient Psychotherapy
Appointments for medication	Appointments for medication
	Residential treatment
	Intensive Outpatient treatment
	Psycho-social Rehabilitation services

Staying in CCS gives you more benefits. THE CHOICE IS YOURS. If you do not make a choice you will receive your mental health services through Medicaid Fee-for Service.

Please put an "X" next to your choice (choose only one).

X I choose CCS for my mental health coverage. ☐ A copy of Medicaid Card or Award letter attached.

_____ I choose Medicaid Fee-for Service for my mental health coverage**.**

Sign your name: X_____

Date: X_____

If you have any questions, please call your case manager or care coordinator.

810-A N. Vineyard Boulevard * Honolulu, Hawaii 96817 * Telephone 845-7771 * Facsimile 845-7955 * Toll Free (800) 947-8881

COMMUNITY CARE SERVICES
A project of HMSA

Date:

_____
_____
_____

Case No. _____**(If Available)**
Client No. _____**(CCS #:)**

Dear _____:

If you are a recipient of SSI (Social Security Income) or SSDI (Social Security Disability Income) or are approved for **MEDICARE**, you may choose to continue to receive your mental health services through CCS. If you make this choice, your medical care will be covered under the fee-for-service program, while your mental health services will be covered under CCS. You must agree to use only CCS providers for your care.

Staying in CCS gives you more benefits. For example:

Medicare Fee-for Service for Mental Health	**CCS Coverage for Mental Health**
Inpatient stays - limited days may apply	Inpatient stays - no limit on days
Case Management through the State Community Mental Health Centers (CMHC)	Case Management through the same agency you are now receiving the service, including the CMHCs
Outpatient Psychotherapy	Outpatient Psychotherapy
Appointments for medication	Appointments for medication
	Residential treatment
	Intensive Outpatient treatment
	Psycho-social Rehabilitation services

THE CHOICE IS YOURS. If you do not make a choice you will receive your mental health services through the Medicare-fee-for-service program.

Please put an "X" next to your choice (choose only one).

X I choose CCS for my mental health coverage. ☐ A copy of Medicare Card or Award letter attached.

_____ I choose Medicare-Fee-for-Service for my mental health coverage.

Sign your name: **X** _____

Date: **X** _____

If you have any questions, please call your CCS case manager or care coordinator.

810-A N. Vineyard Boulevard * Honolulu, Hawaii 96817 * Telephone 845-7771 * Facsimile 845-7955 * Toll Free (800) 947-8881

Recipient Name: _____ Recipient I.D. No.: _____

I. **MENTAL STATES**

A. *GENERAL:*

1. Appearance: Within normal limits [ ] Other [ ] _____
2. Dress: Appropriate [ ] Bizarre [ ] Clean [ ] Dirty [ ]
3. Grooming: Neat [ ] Disheveled [ ] Needs Improvement [ ]

B. BEHAVIOR:

1. Eye Contact: Good [ ] Fair [ ] Poor [ ]
2. Posture: Good [ ] Slumped [ ] Rigid [ ] Other [ ] _____
3. Body Movement: None [ ] Involuntary [ ] Akathisia [ ] Other [ ] _____

C. *SPEECH:* Clear [ ] Mumbled [ ] Rapid [ ] Whispers [ ] Monotone [ ]
Slurred [ ] Slow [ ] Loud [ ] Constant [ ] Mute [ ]
Other [ ] _____

D. *MOOD:* Anxious [ ] Fearful [ ] Friendly [ ] Euphoric [ ] Calm [ ]
Aggressive [ ] Hostile [ ] Depressed [ ]
Other [ ] _____

E. *AFFECT:* Full Range [ ] Flat [ ] Constricted [ ] Inappropriate[ ]
Other [ ] _____

F. THOUGHT:

1. Process or Form: Loose associations [ ] Poverty of content [ ] Flight of ideas [ ]
Neologism [ ] Perseveration [ ] Blocking [ ]
2. Content: Delusions [ ] Thought broadcasting [ ]
Thought insertion [ ] Thought withdrawal [ ] Other [ ] _____

G. *PERCEPTION - HALLUCINATIONS:*

Auditory [ ] Tactile [ ] Somatic [ ] Other [ ] _____

H. REALITY ORIENTATION:

1. Mark all areas which the recipient can name:
Time: Day [ ] Month [ ] Year [ ]
Place: (can describe location) Yes [ ] No [}
Person: Self [ ] Family or friend [ ]
2. Memory: Recent intact? Yes [ ] Remote intact? Yes [ ]
No [ ] No [ ]

I. *INSIGHT:* Aware of illness [ ] Denies illness [ ] Other [ ] _____

J. *JUDGMENT:* Good [ ] Fair [ ] Poor [ ]

Recipient Name: _____ Recipient I.D. No.: _____

II. **FUNCTIONAL SCALES:** *(check and specify any problem(s) in the following areas)*

[ ] Medical/Physical

_____

_____

[ ] Family/Living

_____

_____

[ ] Interpersonal Relations

_____

_____

[ ] Role Performance

_____

_____

[ ] Socio-Legal

_____

_____

[ ] Self-Care/Basic Needs

_____

_____

III. **ADDITIONAL COMMENTS**: Please supply any additional information which would be of assistance in reaching a decision with regard to this patient's evaluation.

Signed: _____ Date: _____

Reporting Psychiatrist/Psychologist *(Print Name):* _____

Reporting Psychiatrist/Psychologist Phone No.: _____

REFERRAL FOR SERIOUS MENTAL ILLNESS (SMI) OR SERIOUS EMOTIONAL DISTURBANCE (SED)

Med-QUEST Division - Phone: 692-8127 Fax: 692-8131

NAME: _____, _____ ☐ Male ☐Female
Last *First* *MI*

HOME ADDRESS: _____ Phone No. _____

_____ Case No. _____

MAILING ADDRESS: _____ Client ID No. _____

_____ SSN: __ __ __ / __ __ / __ __ __ __

DOB: __ __ / __ __ / __ __ Age: _____ COUNTY: ☐ Oahu ☐ Hawaii ☐ Maui ☐ Kauai

HEALTH PLAN: ☐ AlohaCare ☐ HMSA ☐ Kapiolani ☐ Kaiser ☐ Queens ☐ Straub ☐ Medicaid ☐ Medicaid/Medicare

DATE OF REFERRAL: __ __ / __ __ / __ __

PRIMARY DIAGNOSIS: _____ DSMIV CODE __ __ __.__ __

SECONDARY DIAGNOSIS: _____ DSMIIV CODE __ __ __.__ __

CURRENT MEDICAL CONDITIONS (Indicate, if none) _____

_____. NAME OF PCP: _____ PCP NOTIFIED: Y / N

HOSPITALIZATIONS	**CURRENTLY AT: ☐Castle ☐ Queen's ☐ _____ Admitted on ___/___/___**			
PAST HOSPITALIZATIONS:				
Facility	*Location*	*Date Admitted*	*Date Discharged*	*Diagnoses*

NAME OF MEDICATION	STRENGTH	DOSAGE	START DATE	END DATE

OUTPATIENT TREATMENT		DATES	
THERAPIST	DIAGNOSES	From	To

Section below to be completed by Evaluation Panel

Date of Evaluation: __ __/__ __/__ __ Date of Report __ __/__ __/__ __ Date of Enrollment/Disenrollment __ __/__ __/__ __

SMI: ☐ Yes ☐ No ☐ Additional Information Needed: _____

SED: ☐ Yes ☐ No _____

Reason for denial/comments: _____

_____

Revised 5/2001