| **Kansas Medical Assistance Program** | health wave *moving forward with health care for kansans* | HEALTHCONNECT *Kansas* |

Hospital Providers

Cardiac Rehabilitation Coverage

Effective with processing date September 1, 2006, and retroactive to dates of service on and after October 17, 2005, KMAP will cover Phase II Cardiac Rehabilitation using procedure code 93798. This procedure is covered when performed in an outpatient or cardiac rehabilitation unit setting, with the following criteria:

- Beneficiary must have a recent cardiology consultation within three months of starting the cardiac rehabilitation program.
- Beneficiary must have completed Phase I Cardiac Rehabilitation.
- Beneficiary must have one or more of the following diagnoses/conditions:
    - Acute myocardial infarction (410.00 – 410.92, 414.8) within the preceding three months, post inpatient discharge
    - Coronary bypass (V45.81) surgery within the preceding three months, post inpatient discharge
    - Stable angina pectoris (413.9 and 413.0) within three months post diagnosis

Information about the Kansas Medical Assistance Program as well as provider manuals and other publications are on the KMAP Web site at https://www.kmap-state-ks.us. For the changes resulting from this provider bulletin, please view the *Hospital Provider Manual*, pages 8-3 and 8-4.

If you have any questions, please contact the KMAP Customer Service Center at 1-800-933-6593 (in-state providers) or (785) 274-5990 between 7:30 a.m. and 5:30 p.m., Monday through Friday.

EDS is the fiscal agent and administrator of the Kansas Medical Assistance Program for the Kansas Health Policy Authority

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- Congenital disorders causing EKG changes
- Symptomatic hypothermia
- Shortness of breath
- Fainting spells
- Monitoring the effects of psychotropic drugs for potential cardiac effects (identify the drug)

Preoperative EKGs are medically necessary for patients over age 40, or those patients under 40 with a history of cardiac problems. It may be necessary to contact the ordering physician for medical necessity information.

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Chest X-Rays:

Chest X-rays are determined medically necessary if:

- History or indication of cardiopulmonary disease, malignancy, cardiovascular accident (CVA), or long bone fracture
- Recent thoracic surgery
- Thoracic injury
- Chronic cough of over one month duration
  - (Specify as chronic in the diagnosis field. If this designation is not supplied, the condition will be considered acute and the X-ray denied.)

Pre-operative and routine admission chest X-rays are non-covered unless documentation of medical necessity (one or more of the following factors) is noted on the claim:

- Sixty years of age or older
- Pre-existing or suspected cardiopulmonary disease
- Smoker over age forty
- Acute medical/surgical conditions such as malignancy or trauma

8200.

Claims denied because other factors are listed, will be reconsidered if appealed (refer to Section 5300).

It may be necessary to contact the ordering physician for medical necessity information.

CT Scans - Abdominal:

A CT scan of the abdomen is medically necessary if the diagnosis indicates a malignant neoplasm of the intra-abdominal cavity, lung or genital organs, lymphoma, diseases of the spleen, liver abscess, peritonitis, pancreatitis, abdominal trauma, or abdominal mass.

A CT scan of the abdomen <u>may</u> be medically necessary for abdominal pain, abdominal aneurysm, acute lymphocytic leukemia, or any malignant neoplasm not located in the intra-abdominal cavity, lung or genital organs. Inclusion of the following documentation will assist in the adjudication of your claim.

> <u>Abdominal Pain</u>: Indicate the severity and chronicity of the pain, presenting symptoms and suspected conditions or complications.
> <u>Abdominal Aneurysms</u>: Indicate the presenting symptoms and suspected complications.
> <u>Acute Lymphocytic Leukemia</u>: Indicate the presenting symptoms and a detailed description of area(s) involved.
> <u>Malignant Neoplasm not located in the Intra-Abdominal Cavity, Lung or Genital Organs</u>: Indicate pertinent symptoms and if performed as part of staging the disease process.

It may be necessary to contact the ordering physician for medical necessity information.

CT Scans - Head or Brain:

CT scan of the head or brain is medically necessary if the diagnosis indicates intracranial masses/tumors, intracranial congenital anomalies, hydrocephalus, brain infarcts, parencephalic cyst formation, open or closed head injury, progressive headache with or without trauma, intracranial bleeding, aneurysms, or the presence of a neurological deficit.

A CT scan of the head or brain may also be medically necessary with the indication of headache, epilepsy, syncope, dizziness, or acute lymphocytic leukemia. Inclusion of the following documentation will assist in adjudication of your claim:

> <u>Headache</u> - Indicate length of chronicity and any accompanying Central Nervous System (CNS) symptoms.
> <u>Epilepsy</u> - Specify if initial or repeat scan, indicate if suspected injury occurred during seizure.
> <u>Syncope</u> - Specify if recurrent or single episode.
> <u>Dizziness</u> - Specify if recurrent or single episode.
> <u>Acute Lymphocytic Leukemia</u> - Indicate any accompanying CNS symptoms.

It may be necessary to contact the ordering physician for medical necessity information.