Kansas
Medical Assistance
Program

September 2006 **Provider Bulletin Number 693b**

Professional 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 *Professional Provider Manual*, pages 8-8 through 8-11.

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.

8400. Updated 9/06

Explanation of Necessity for Hearing Aid Form
Providers must submit the "Explanation of Necessity for Hearing Aid" Form with the Prior Authorization request before approval for a replacement hearing aid will be considered. An example of this form is located in the 'Forms' section at the back of this manual.

Repairs
Repairs under $15.00 are **not** covered.

Repairs exceeding $75.00 must be **prior authorized** (refer to Section 4300). Approval will be given if in the opinion of the consultant, the repairs are not so extensive that good judgment indicates the fitting and dispensing of a new hearing aid.

Repairs must provide a warranty of six months.

Replacements
Hearing aids may be replaced every four years when a medical examination confirms the necessity.

Lost, broken, or destroyed hearing aids will be replaced **once** with PA during a four year period. The dispenser and consumer must sign a statement documenting the loss, breakage, or destruction of the hearing aid and submit it along with the PA request.

Replacement cords for hearing instruments and cochlear implants are covered with medical necessity documentation.

Testing and Examination
Consumers are required to have a medical examination by a physician for pathology or disease. This exam must be provided no more than six months prior to the fitting of a hearing aid, and documented on the "Explanation of Necessity for Hearing Aid" Form.

Cardiac Rehabilitation:

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Children and Family Services (CFS) Contractors:

Medicaid reimbursable services will not be paid by child welfare contractors. All services for children assigned to contractors, including behavior management and mental health, must be billed directly to the Kansas Medical Assistance Program and will be reimbursed at the approved Medicaid rate. Prior authorization and other restrictions apply.

Refer to Section 2900 of your General Benefits Provider Manual for an all-inclusive list of the categories of service covered under the CFS contract.

Community Mental Health Centers (CMHC):

When a physician desires to send a consumer to a Community Mental Health Center, he/she should call the center before making this referral. Each center has its own referral requirements, initial appointment procedures, and vary in services provided. Community Mental Health Center services are covered for outpatient treatment and partial hospitalization.

Consultations:

Only one initial consultation is covered within a sixty (60) day period per consumer by the same provider.

CPAP For KBH Participants:

Continuous positive airway pressure (CPAP) is a covered service for **KAN Be Healthy participants**. Prior authorization (PA) for medical necessity is required. Criteria for medical necessity is:

1) Infant Respiratory Distress Syndrome in newborns (e.g., Hyaline Membrane Disease) or
2) Morbid obesity with documented sleep apnea.
   - 30% over average weight for height, sex, and age,
   - Sleep study with documented arterial oxygen (O_2) saturation of 80% or less. A printout of the documented arterial O_2 saturation must be supplied by the provider upon request from the fiscal agent and/or the Adult and Medical Services.
   - Documented participation in a weight reduction program. This documentation must be supplied by the provider upon request from the fiscal agent and/or the Adult and Medical Services.

Dental:

For information about covered dental benefits, contact KMAP Dental Services at 1-800-933-6593. ~~Doral Dental Services at 1-800-436-5288 or www.doralusa.com~~

Orthodontia:

For information about covered orthodontia benefits, contact KMAP Dental Services at 1-800-933-6593. ~~Doral Dental Services at 1-800-436-5288 or www.doralusa.com~~

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Dietitian Services:

Dietitian services are covered for **KAN Be Healthy participants** when provided by a registered dietitian licensed through the Kansas Department of Health and Environment.

Dietitian services may only be rendered as the result of a medical or dental screening referral. Other insurance and Medicare are primary and must be billed first.

Individual focused services are limited to two units (30 minutes) of initial evaluation and 11 follow-up visits per consumer, per year. Additional visits may be covered with prior authorization (PA).

Group focused services are limited to an initial evaluation and 11 follow-up visits per consumer, per year. Additional visits may be covered with PA. (Refer to Appendix I for procedure codes.)

Group focused services are non-covered.

Documentation:

To verify services provided in the course of a postpayment review, documentation in the consumer's medical record must support the service (level of service) billed.

Autoauthentication (computerized authentication) of documentation for the medical record is acceptable documentation for the Kansas Medical Assistance Program. Autoauthentication must meet federal guidelines.

Federal regulation 42 CFR 482.24 (c) (1) (i) requires that there must be a method of determining that the physician authenticated the document after transcription. All entries must be legible and complete and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include the author's signature, written initials, or computer entry.

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Durable Medical Equipment (DME):

Durable medical equipment (DME) items require a written prescription from the physician. In addition, many DME items and medical supplies require prior authorization before they can be dispensed and payment made. Be sure to give the DME provider adequate information and adequate time to secure prior authorization.

Although an item is classified as DME, it may **not** be covered in every instance. Coverage is based on the fact that it is reasonable and necessary for treatment of an illness or injury, or will improve the physical functioning of the consumer. Medical equipment is primarily used for medical purposes and is not generally useful in the absence of illness or injury.

Electrocardiograms (EKGs):

Electrocardiograms (up to 12 leads) are considered medically necessary when the diagnosis and/or condition clearly indicates one or more of the following:

- Relevant cardiopulmonary diagnosis
- Significant electrolyte imbalance
- Drug induced EKG changes (identify the drug)
- Progressive renal disease
- Unstable thyroid disease
- Specific central nervous system (CNS) disorders causing EKG changes
- 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.