MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE

ISSUE DATE	EFFECTIVE DATE	NUMBER
January 3, 2006	February 1, 2006	*See Below

SUBJECT: Place of Service Review Procedures

BY James L. Hardy, Acting Deputy Secretary
Medical Assistance Programs

PURPOSE:

The purpose of this bulletin is to notify providers enrolled in the Medical Assistance (MA) Program that the listed procedures performed in a Place of Service (POS) 24 (Ambulatory Surgical Center) do not require prior authorization. In addition, services listed as mandatory review require prior authorization and physician review. This bulletin renders previous bulletin 06-92-02, 08-92-02, 11-92-13 obsolete.

SCOPE:

This bulletin applies to all acute care hospitals, Ambulatory Surgical Centers (ASCs), and Short Procedure Units (SPUs) enrolled in the MA Program which perform surgical procedures in the Fee-for-Service (FFS) delivery system.

BACKGROUND:

On August 11, 1992 providers were notified by MA Bulletin 06-92-02, 08-92-02 and 11-92-13 regarding SPU procedures that require prior authorization. Effective February 1, 2006 listed services in POS 24 or a lower level setting will no longer require prior authorization. Procedures should be submitted according to the billing guide and will be reimbursed according to the MA fee schedule. Procedures and services not mentioned in this bulletin continue to require prior authorization when performed in POS 24.

DISCUSSION:

In order to expedite the provision of services, the Office of Medical Assistance Programs (OMAP) is changing the prior authorization requirement for the listed procedures. Services may be performed and billed utilizing the billing guide instructions. The OMAP reserves the right to retrospectively review service documentation.

* 01-06-01, 02-06-01, 14-06-01, 31-06-01, 27-06-02

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap

PROCEDURE:

I. The listed procedures do not require prior authorization when completed in a POS 24 or a lower level setting. Procedures should be submitted according to the billing guide and will be reimbursed according to the MA fee schedule. **If the listed services are performed in an inpatient setting, prior authorization is required.**

Procedure Code	Service Type
19182	Mastectomy-subcutaneous
20680	Removal of wire/pin/screws….deep
30520	Septoplasty or submucous resection c/s cartilage contouring or replacement
42820	T&A under age 12
42821	T&A over age 12
42826	Tonsillectomy over age 12
42830	Adenoidectomy under age 12
43235	EGD with/without brushings
43239	EGD with biopsy-single or multiple
43248	EGD with insertion of guide wire and dilatation
45378	Colonoscopy with or without specimen collection
45380	Colonoscopy to splenic flexure with biopsy, single or multiple
45384	Colonoscopy with removal of tumors or polyps by hot biopsy or bipolar cautery
45385	Colonoscopy with removal of tumors or polyps with snare method
47562	Cholecystectomy-laparoscopic
49320	Abdominal laparoscopy-exploratory
49505	Inguinal hernia repair age 5 or over, reducible
50590	Lithotripsy-extracorporeal shock wave
58558	Hysteroscopy with biopsy of endometrium &/or polypectomy with or without D&C
58670	Laparoscopic fulguration of oviducts
59812	Treatment of incomplete abortion-completed surgically any trimester
59820	Treatment of missed AB surgically 1st trimester
62311	Epidural-lumbar
64721	Neuroplasty and/or transposition, median nerve@ carpal tunnel
66821	YAG Discission of secondary membrane (cataract)
66984	Extracapsular cataract removal with IOL insertion
69436	Tympanosotomy with Tubes-General Anesthesia

II. Hospital Special Treatment Room

The following procedure codes have been established for hospital Special Treatment Room (STR) support components, payable at the $200.00 fee. The services must be billed using bill type 141. Prior authorization is not required for services rendered in the STRs.

Procedure Code	**Service Type and Procedure Code** **(including but not limited to codes listed below)**
X0615-HSTRSC	Cystoscopy/Transurethral Procedures 52000, 52001, 52005, 52007, 52010, 52204, 52214, 52224, 52234, 52235, 52265, 52270, 52275, 52276, 52277, 52281, 52282, 52283, 52285, 52290, 52300, 52304, 52305, 52310, 52315, 52317, 52318, 52320, 52325, 52327, 52330, 52332, 52700, 52354
X0616-HSTRSC	Endoscopic Procedures 31237, 31615, 31620, 31622, 31623, 31624, 31625, 31628, 31629, 31630, 31631, 31632, 31633, 31635, 31636, 31637, 31638, 31640, 31641, 31643, 31645, 31646, 31656, 32601, 32602, 32603, 32604, 32705, 32606 43200, 43201, 43202, 43204, 43205, 43215, 43217, 43219, 43220, 43226, 43227, 43228, 43231, 43232, 91010, 43234, 43235, 43236, 43234, 43238, 43239, 43240, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, 43256, 43257, 43258, 43259, 43260, 43261, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272, 44360, 44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372, 44373, 44376, 44377, 44378, 44379, 44380, 44382, 44385, 44386, 44388, 44389, 44390, 44391, 44392, 44393, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392, 45315, 45317, 45320, 45334, 45335, 45336, 49320, 49321, 49322, 49323, 50555, 50557, 50561, 50570, 50572, 50574, 50575, 50576, 50580
X0617-HSTRSC	Laser Surgical Procedures 46917, 54057, 57513, 58555, 65855, 67105, 67145, 67210, 67228
X0618-HSTRSC	Administration of Chemotherapy Procedures 96412, 96414, 96420, 96423, 96425, 96440, 96445, W9640
X0619-HSTRSC	Breast Diagnostic Procedures 19101, 19120
X0620-HSTRSC	Injection/Nerve Block Procedures 62290, 62291, 62294, 62310, 62311, 62319, 20610, 62273, 62290, 62368, 61105, 64470, 64472, 64475, 64476, 64479, 64480, 64483, 64484, 64520, 64613, 64622, 64623, 64626, 64640
X0621-HSTRSC	Fetal Monitoring Procedures 59000, 59020, 59025
X0622-HSTRSC	Cardiac Catheterization Procedures 93508, 93526, 93529, 93510, 93543, 93526, 93527 93540, 93543, 93545, 93544, 92980, 92981, 92982, 92984

III. ASC/SPU Monitoring and Observation

The Department will pay a fee of $200.00 for procedure code X0597, for monitoring and observation in an ASC/SPU bed following select medical, medical diagnostic and radiological procedures certified by the Outpatient Prior Authorization process for the ASC/SPU setting. The facility must bill following the handbook instructions using the modifier SG and procedure code X0597 combination. For General Hospitals (including Outpatient Hospital Clinic, Emergency Room, Hospital Short Procedure Unit (SPU), Outpatient Rehabilitation Hospital providers) and Ambulatory Surgical Centers (ASCs) enter the 10-digit Prior Authorization Number in Form Locator 63 of the 837 Institutional/UB-92 Claim Form.

IV. Mandatory Review

The following services require prior authorization and physician review regardless of the POS unless otherwise indicated:

Service Type
Abdominoplasty/lipectomy/ventral hernia repair
Baclofen Pump (Permanent Pump Insertion)
Blepharoplasty
Bone Marrow Transplant
Carotid Stent Insertion
Dermabrasion
Gastric Bypass
Heart Transplant
Keloid Repair
Kidney Transplant
Lipoma excision
Liver Transplant
Lung Transplant
Mastectomy for Gynecomastia
Neurostimulators
Non emergent/urgent Out of State Services
Non neonatal circumcision
Orthognatic Surgical Procedures
Otoplasty
Panniculectomy
Reduction of labial minora
Reduction or augmentation Mammoplasty
Removal of spider angiomata
Rhinoplasty
Rhytidectomy
Scar Revision

Sclerotherapy
Skin Tag removal
Strabismus Repair in Adults
Urinary Incontinence Treatments
Uvulopalatopharyngoplasty

The list of services requiring physician review is subject to change based on current clinical practice and industry standards.

When calling the Outpatient Prior Authorization toll-free line to request prior approval to perform the service, providers must have the following information available:

- Recipient MA identification number.
- Prescribing physician MA provider identification number or, if the provider is not enrolled in the MA Program, the Pennsylvania license number and mailing address.
- Facility 13-digit provider identification number where the procedure will be performed. The service location number must be appropriate to the POS.
- ICD-9 diagnosis code.
- Procedure code for the service.
- Documentation of medical necessity

The information will be given to a physician for review. At the time of the call, the caller will be notified of the final determination, or informed of the additional information needed to make a determination. If additional information is needed, the request will be pended until the additional information is received. The caller will be notified of the final determination after the additional information is received. If the requested additional information is not received within 15 days, the request will be denied. If the service continues to be needed, the provider must submit a new request.

In all cases, written notice will be issued within 1 day after the decision is made, but no later than 18 days after receipt of the initial request.