

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 14, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 300, RADIOLOGY SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 300, Radiology Services, Sections 303.6A, Coverage and Limitations, 303.7, Sleep Study Services, and 303.8, Radiopharmaceuticals and Contrast Agents, were made to clarify and eliminate duplicative and outdated language.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective upon approval at public hearing.

MATERIAL TRANSMITTED

CL
CHAPTER 300 – RADIOLOGY SERVICES

MATERIAL SUPERSEDED

MTL 03/12
CHAPTER 300 – RADIOLOGY SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
303.7	Sleep Studies, Polysomnography, Multiple Sleep Latency Test (MSLT)	Description was minimized to include only the title.
303.7A	Coverage and Limitations	Section title was changed to Sleep Study Description was added to align with federal definition and the American Academy of Sleep Medicine (AASM) guidelines; reimbursement guidelines were moved; Coverage and Limitations was moved to section 303.7(C)

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
303.7B	Provider Responsibility	Provider Responsibility language was omitted; and Prior Authorization section was added to define prior authorization requirements more clearly.
303.7C	Recipient Responsibility	Recipient Responsibility language was omitted; and Coverage and Limitations was added to define sleep study settings and physician requirement.
303.7D	Unattended Sleep Studies	Language was added for clarity of unattended/in-home sleep study services.
303.7E	Non-Covered Sleep Study Services	Language was added for clarity of non-covered sleep study services.
303.8	Radiopharmaceuticals and Contrast Agents Description	Radiopharmaceuticals and Contrast Agents Description was minimized to include on the title.
303.8A	Radiopharmaceuticals and Contrast Agents Coverage and Limitations	Coverage and Limitations was omitted; Description was added to align with the Food and Drug Administration (FDA).
303.8B	Radiopharmaceuticals and Contrast Agents Provider Responsibility	Provider Responsibility language was deleted; and Coverage and Limitations was moved to this section.

DRAFT	MTL-03/12
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 303
MEDICAID SERVICES MANUAL	Subject: POLICY

Intraoperative neurophysiology/electrophysiologic monitoring of the nervous system is now widely used to help prevent complications and to identify structures during neurosurgical and other procedures. These techniques include EEG, evoked potentials, EMG and nerve conduction velocity (NCV) testing and monitoring.

303.6A **COVERAGE AND LIMITATIONS:**

MEG – The procedure is limited to localization of the seizure zone in medically intractable partial epilepsy for recipients being considered for surgical intervention.

Intraoperative electrophysiologic monitoring – EEG or SEP to monitor for cerebral ischemia; electrocorticography (ECoG) and SEP sensory cortex identification to define the limits of cortical resection; SEP spinal cord monitoring; Brainstem Auditory Evoke Potential (BAEP) and cranial nerve EMG monitoring during posterior fossa procedures; functional localization of cortex with direct cortical stimulation in expert hands; and EMG and compound muscle and nerve action potential measurements of various peripheral nervous system structures.

1. **COVERED DIAGNOSIS:**

Partial intractable epilepsy, without mention of impairment of consciousness.

See Billing Manual for prior authorization requirements.

2. **DOCUMENTATION REQUIREMENTS~~D~~**

Documentation supporting ~~the reasonableness and medical~~ necessity for any of the above procedures must be **clearly documented** in the ~~patient~~ **recipient's medical** record and submitted ~~with when at the~~ Prior Authorization (PA) ~~when is~~ required.

~~303.7 303.7—SLEEP STUDY~~IE~~ SERVICES,—POLYSOMNOGRAPHY,—MULTIPLE—SLEEP LATENCY TEST (MSLT)~~

303.7A SLEEP STUDY DESCRIPTION

1. According to the U.S. Department of Health and Human Services, National Institutes of Health (NIH), sleep studies are tests that measure how well someone sleeps and how the body responds to sleep problems. Sleep studies are necessary because untreated sleep disorders can raise risk for heart disease, high blood pressure, stroke, and other medical conditions. Sleep disorders have also been linked to an increased risk of injury, such as falling in the elderly and automobile accidents.

DRAFT	MTL-03/12
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 303
MEDICAID SERVICES MANUAL	Subject: POLICY

2. The following sleep study tests are covered benefits:
 - a. Polysomnography (PSG) is the scientific evaluation of sleep that involves a physiologic recording of brain waves, oxygen level in blood, heart rate and breathing, and eye and leg movements.
 - b. The multiple sleep latency test (MSLT) is performed to measure daytime sleepiness. Also known as a daytime nap study, the MSLT is the standard tool used to diagnose narcolepsy and idiopathic hypersomnia.
3. Sleep study services are performed with physician review, interpretation, and report.

~~DHCFP will reimburse covered medically necessary testing in a certified sleep disorder clinic. These facilities in which certain conditions are diagnosed through the study of sleep are either affiliated with a hospital or are under the direction and control of physicians.~~

303.7B PRIOR AUTHORIZATION

1. The PSG and MSLT sleep study tests are limited to two services in a 12 month period without prior authorization. If the services exceed limitations, a prior authorization is required.
2. Prior authorization for MSLT includes authorization for a PSG performed on the preceding night to be valid.
3. Documentation supporting medical necessity for sleep study services must be clearly documented in the recipient's medical record and submitted when a prior authorization is requested.

303.7AC COVERAGE AND LIMITATIONS

~~Sleep studies, polysomnograms, and multiple sleep latency testing are limited to 2 services in a 12 month period without prior authorization. If the services exceed the limitations, a prior authorization is required from the QIO like vendor.~~

1. Sleep studies are covered services in the following settings:~~A licensed physician or other licensed professionals working within the scope of their practice must request the appropriate test.~~
 - a. a certified or accredited sleep disorder facility; or
 - b. an in-home (unattended) setting in conjunction with a comprehensive sleep evaluation by a physician board certified in sleep medicine.

DRAFT	MTL-03/12
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 303
MEDICAID SERVICES MANUAL	Subject: POLICY

2. ~~A licensed physician or other licensed professional working within the scope of their practice must request the appropriate test. The need for diagnostic testing is confirmed by medical evidence, e.g., patient history, physician examination and other laboratory type tests.~~

3. The ordering provider is responsible for forwarding appropriate clinical data to the diagnostic facility.

~~3. Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered.~~

~~Diagnostic Testing Facilities for Sleep Disorders may be covered even in the absence of direct supervision by a physician, however, a trained qualified attendant must be present to assess and monitor the patient. A licensed physician must review and sign reports.~~

4. The need for diagnostic testing is confirmed by medical evidence, e.g. recipient history, physician examination, and other laboratory tests. ~~Diagnostic testing is covered only if the recipient has symptoms or complaints of one of the conditions:~~

5. Reference MSM Chapter 1300, Durable Medical Equipment, for coverage and limitation guidelines for the positive airway pressure device services.

DESCRIPTION

~~a. Morbid obesity.~~

~~b. Pickwickian syndrome.~~

~~c. Cataplexy and narcolepsy.~~

~~d. Various Insomnia's.~~

~~5. Obstructive Sleep Apnea (OSA) requires documentation of at least 30 episodes of apnea, each lasting a minimum of 10 seconds, and hypopnea with oxygen saturation levels below 85% during 6-7 hours of recorded sleep.~~

6. Polysomnography (PSM) minimum requirements include the following: ~~is distinguished from sleep studies by the inclusion of sleep staging.~~

~~a. The following are included:~~

~~1.a. EEG;~~

~~2.b. Electro-oculography (EOG); and~~

DRAFT	MTL-03/12
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 303
MEDICAID SERVICES MANUAL	Subject: POLICY

~~3.c.~~ EMG.

7. ~~b.~~ Additional parameters of sleep which may be monitored include:

~~1.a.~~ EKG;

~~2.b.~~ Airflow;

~~3.c.~~ Ventilation and respiratory effort;

~~4.d.~~ Gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis;

~~5.e.~~ Extremity muscle activity, motor activity-movement;

~~6.f.~~ Extended EEG monitoring;

~~7.g.~~ Penile tumescence;

~~8.h.~~ Gastroesophageal reflux;

~~9.i.~~ Continuous blood pressure monitoring;

~~10.j.~~ Snoring; and

~~11.k.~~ Body positions, etc.

~~7.8. For a study to be reported as a polysomnogram, sleep-A PSG must be recorded and staged. Adult testing includes a half night with continuous positive airway pressure (CPAP). Testing for children (0-12) must be reviewed and scored by physician to determine need for follow up with CPAP. Prior authorization may be included for this age group in the initial authorization.~~

~~8.9. MSLT's are covered only when symptoms suggest a diagnosis of narcolepsy. Multiple Sleep Latency studies are covered only if the symptoms or complaints suggest a diagnosis for Narcolepsy.~~

~~9. Prior authorization for MSLT includes authorization for a polysomnogram performed on the preceding night to be valid. For each nap, the latency between "lights out" and sleep onset is determined.~~

DRAFT	MTL-03/12
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 303
MEDICAID SERVICES MANUAL	Subject: POLICY

303.7BD UNATTENDED SLEEP STUDIES ~~PROVIDER RESPONSIBILITY~~

1. Portable monitoring (PM) for the diagnosis of obstructive sleep apnea (OSA) should be performed only in conjunction with a comprehensive sleep evaluation.
2. Clinical sleep evaluations following PM must be supervised and evaluation by a physician board certified in sleep medicine.
3. PM may be used as an alternative to PSG for the diagnosis of OSA in recipients with a high pretest probability to moderate to severe OSA.
4. PM should not be used for the following recipients:
 - a. with significant comorbid medical conditions that may degrade the accuracy of PM, including moderate to severe pulmonary disease, neuromuscular disorders, asthma, stroke, severe hypertension or congestive heart failure.
 - b. suspect of having other sleep disorders, including central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders or narcolepsy.
5. PM should not be used for general screening of asymptomatic recipients.
6. PM may be indicated for the diagnosis of OSA in recipients for whom in-laboratory PSG is not possible by virtue of immobility, safety, or critical illness.
7. At a minimum, the PM must record airflow, respiratory effort, and blood oxygenation. The type of biosensors used to monitor these parameters for in-laboratory PSG are recommended for use in PM.
8. Unattended sleep studies are considered medically necessary using one of the following diagnostic techniques for recipients with symptoms suggestive of OSA when the home sleep study is used as part of a comprehensive sleep evaluation:
 - a. Sleep monitoring using a Type II device, minimum of seven channels (e.g. electroencephalogram (EEG), electrooculogram (EOG), electromyogram (EMG), electrocardiogram (ECG) , airflow, respiratory effort, oxygen saturation);
 - b. Sleep monitoring using a Type III device, minimum of four monitored channels including ventilation or airflow (at least two channels of respiratory movement or airflow), heart rate or ECG, and oxygen saturation; or

DRAFT	MTL-02/11CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 303
MEDICAID SERVICES MANUAL	Subject: POLICY

- c. Sleep monitoring using a Type IV device, measuring at least three channels. Type IV devices must allow channels that allow direct calculation of an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) as the result of measuring airflow or thoracoabdominal movement.
9. An experienced sleep technician, sleep technologist or appropriately trained healthcare provider must perform the application of PM sensors or directly educate the recipient in correct application of the sensors.
10. Due to the known rate of false negative PM tests, in-laboratory PSG should be performed in cases where PM is technically inadequate or fails to establish the diagnosis of OSA in recipients with a high pretest probability.
11. If a PM test is technically inadequate or does not provide the expected result, in-laboratory PSG should be performed. Documentation supporting medical necessity for the repeat services must be clearly documented in the recipient's medical record.

303.7E NON-COVERED SLEEP STUDY SERVICES

1. Actigraphy and SleepStrip® are considered investigational/experimental and are not covered benefits.
2. Repeat studies are not covered when documentation for a repeat study does not indicate medical necessity (e.g. no new clinical documentation indicating the need for a repeat study).
- ~~4. Verify program eligible each month, (e.g., QMB, MCO's, etc) and comply with the program requirements. Example: A QMB only recipient does not require a prior authorization to receive service.~~
- ~~5. The provider will allow, upon request of proper representatives of the DHCFP, access to all records which pertain to Medicaid and CHIP recipients for regular review, audit or utilization review.~~
- ~~6. Documentation to support medically necessity for the procedures must be clearly documented in the clinical record. Submit documentation with the prior authorization request.~~
- ~~7.8. The ordering provider is responsible for forwarding appropriate clinical data to the diagnostic facility.~~

~~303.7C RECIPIENT RESPONSIBILITY~~

- ~~1. Present Medicaid or CHIP Card to Provider of Service at each encounter.~~

DRAFT	MTL-02/11CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 303
MEDICAID SERVICES MANUAL	Subject: POLICY

- ~~2. Notify providers immediately for any change in eligibility status, e.g., pending status changed to eligible or fee for service status changed to enrollment in a managed care organization.~~

303.8 RADIOPHARMACEUTICALS AND CONTRAST AGENTS

303.8A RADIOPHARMACEUTICALS AND CONTRAST AGENTS DESCRIPTION

1. According to the Food and Drug Administration (FDA), ~~R~~radiopharmaceuticals and contrast agents are used in diagnostic imaging procedures or for therapeutic purposes. Agents enhance the quality of MRI, MRA, CT scans, PET, x-ray and other modalities. ~~t~~Agents are also used to monitor treatment effect. ~~diagnose certain medical problems or treat certain diseases.~~ TheyRadiopharmaceuticals and contrast agents may be given dispensed to the ~~patient~~recipient in several different ways, i.e. ~~For example, they may be given~~ by mouth, or given by injection, or placed into the eye or ~~into the~~ bladder. They may also be used for nuclear medicine. ~~Intended to be included in the policy, but not limited to, are all radioactive compounds used for either imaging, diagnosis or treatment as well as other non-radioactive agents used to enhance radiologic imaging including x-ray, CT scans, MRI, PET and other modalities.~~

303.8AB COVERAGE AND LIMITATIONS

1. The DHCFP will reimburse covered, medically necessary radiopharmaceuticals and contrast agents.

~~303.8B PROVIDER RESPONSIBILITY~~

- ~~1. Verify program eligibility each month, (e.g., QMB, MCO, etc.) and comply with the program requirements. Example: A QMB only recipient never requires a Medicaid payment authorization.~~
- ~~2. The provider must allow, upon the request of proper representatives of the DHCFP, access to all records which pertain to Medicaid or CHIP recipients for regular review, audit, or utilization review.~~
- ~~3. Evidence to support medical necessity for the procedures must be clearly documented in the clinical record. Duplicative testing when previous results are still pertinent is not a covered benefit.~~
- ~~4. The ordering physician is responsible for forwarding appropriate clinical data to the diagnostic facility.~~