

## Ceiling Track Lifts Criteria

<b>Iowa Medicaid Program:</b>	Prior Authorization	<b>Effective Date:</b> 11/18/2013
<b>Revision Number:</b>	2	<b>Last Review Date:</b> 10/16/2015
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b> 10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b> 10/21/2015

**Criteria:**

For Prior Authorization (PA) of Ceiling Track Lifts, the member must meet **ALL** of the following criteria:

1. There must be an order for the ceiling track lift from a physician, physician's assistant or nurse practitioner.
2. There must be a letter of medical necessity from the physician, physical therapist, or occupational therapist, or medical records that document **ALL** of the following:
  - a. The member requires assistance with transfer between bed and chair, wheelchair, bath, or commode **and** without the use of a lift, the member would be confined to bed;
  - b. The member's weight and height;
  - c. The member's diagnoses;
  - d. Reasons why an electric patient lift will not work for the member;
  - e. Documentation that the member's home has been evaluated for the ceiling track lift and that it will meet the member's needs in the home.

**References Used:**

Iowa Administrative Code 441 Chapter 78.10(5)H

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
10/17/14	Medical Director	Grammatical and formatting changes	1
10/16/15	CAC	Added last paragraph in References Used	2



Jason Kessler, MD

## Electric Patient Lifts Criteria

<b>Iowa Medicaid Program:</b>	Prior Authorization	<b>Effective Date:</b> 11/18/2013
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<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b> 10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b> 10/21/2015

**Criteria:**

For Prior Authorization (PA) of Electric Patient Lifts, the member must meet **ALL** of the following criteria:

1. An order from a physician, physician assistant, or nurse practitioner for the electric lift.
  
2. There must be a letter of medical necessity from the physician, physician assistant, nurse practitioner, physical therapist, or occupational therapist, or medical records that document **ALL** of the following:
  - a. The member requires assistance with transfer between bed and chair, wheelchair, bath, or commode **and** without the use of a lift, the member would be confined to bed;
  - b. The member's weight and height;
  - c. The member's diagnosis(es);
  - d. Reason(s) why a manual patient lift will not work for the member;
  - e. Successful trial of the electric lift.

**References Used:**

Iowa Administrative Code 441 Chapter 78.10(5)H

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**Change History:**

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10/17/14	Medical Director	Grammatical and formatting changes	1
10/16/15	CAC	Added last paragraph in References Used	2



Jason Kessler, MD

## Hemangioma Removal Criteria

<b>Iowa Medicaid Program:</b>	Prior Authorization	<b>Effective Date:</b>	9/11/2009
<b>Revision Number:</b>	3	<b>Last Review Date:</b>	10/16/2015
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b>	10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b>	12/15/2015

### Criteria:

1. **AT LEAST ONE** of the following (a-e):
  - a. Congenital hemangioma that requires treatment due to location or associated problems
  - b. Presence of pain
  - c. Presence of ulceration
  - d. The hemangioma is life-threatening: Such as airway hemangioma, CNS hemangioma, hepatic hemangioma (diffuse), visceral hemangioma
  - e. The hemangioma is threatening to vital function:
    - i. Vision: Any periocular hemangioma with risk of causing obstructive amblyopia and/or astigmatism, (requires evaluation and close follow-up by ophthalmology) **OR**
    - ii. Feeding: Any perioral or perinasal hemangioma that disrupts the ability of an infant to suck and/or feed well
2. Documentation of medical necessity:
  - a. Must submit pictures that clearly identify the location of the hemangioma (those midline, periocular, perioral or perinasal or special concern); **AND**
  - b. Must include measurements (may omit for periocular hemangiomas that may impact vision); **AND**
  - c. For periocular hemangiomas, documentation of ophthalmology assessment is required.

### Exclusions:

Hemangioma removal will not be covered if **ANY OF** the following apply:

- a. Removal is for cosmetic purposes
- b. Removal is simply the preference or for the convenience of the provider, patient, or family
- c. Documentation does not support medical necessity for removal

### CPT Codes:

11400 - 11471 Excisions of benign lesions

11600 - 11646 Excisions of malignant lesions

When done for diagnoses of hemangioma D18.00 - D18.09

### References Used:

Specialist consultation:

[Segmental hemangiomas of the upper airway.](#)

O TM, Alexander RE, Lando T, Grant NN, Perkins JA, Blitzer A, Waner M.

Laryngoscope. 2009 Nov;119(11):2242-7.

PMID: 19806648 [PubMed - indexed for MEDLINE]

[Management of cutaneous hemangiomas in pediatric patients.](#)

Musumeci ML, Schlecht K, Perrotta R, Schwartz RA, Micali G.  
Cutis. 2008 Apr;81(4):315-22. Review.  
PMID: 18491478 [PubMed - indexed for MEDLINE]

[Vascular malformations. Part II: associated syndromes.](#)

Garzon MC, Huang JT, Enjolras O, Frieden IJ.  
J Am Acad Dermatol. 2007 Apr;56(4):541-64. Review.  
PMID: 17367610 [PubMed - indexed for MEDLINE]

[Vascular malformations: Part I.](#)

Garzon MC, Huang JT, Enjolras O, Frieden IJ.  
J Am Acad Dermatol. 2007 Mar;56(3):353-70; quiz 371-4. Review.  
PMID: 17317485 [PubMed - indexed for MEDLINE]

World Health Organization, ICD-10-CM, The Complete Official Draft Code Set, 2015, Optum, Salt Lake City, UT, 2014.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
10/18/13	CAC	Criterion #3-c changed ophthalmology involvement to ophthalmology assessment.	1
10/17/14	Medical Director	Grammatical and formatting changes	2
10/9/15	Medical Director	Descriptions of CPT codes and addition of ICD-10 diagnosis codes. Formatting and reference changes.	3



Jason Kessler, MD

## Home and Vehicle Modification Criteria

<b>Iowa Medicaid Program:</b>	Waiver Prior Authorization	<b>Effective Date:</b>	10/21/2011
<b>Revision Number:</b>	2	<b>Last Review Date:</b>	10/16/2015
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b>	10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b>	10/30/2015

**Criteria:** **ALL OF** the following must be met:

1. Member is eligible for a Home and Community Based Services Waiver that designates Home and Vehicle Modification (HVM) as an allowable service option.
2. Physical modifications to the home and/or vehicle must directly address the member's medical or remedial need when eligible for any waiver.
3. Modifications must be necessary to provide for the health, welfare, or safety of the member.
4. Functional impairment can be remediated or decreased by the HVM.
5. Each home and vehicle modification request must fall within the definition of allowable items set forth in the Iowa Administrative Code as it pertains to each individual waiver.
6. The total amount of the requested item must fall within the allowable costs of each individual waiver.
7. HVM will meet the medical needs of the member and be completed for reasons other than the convenience of the member or the member's practitioner or caregiver.
8. Medical need cannot be met by service or item available through the state plan.
9. Services are the least costly type which would reasonably meet the medical need of the member. Pricing includes a designation of **ONE OF** the following: manufacturer's suggested retail price, dealer cost, or wholesale price.
  - Manufacturer's suggested retail price = price minus 15 percent
  - Dealer Cost = price plus 10 percent
  - Wholesale price = price minus 10 percent
13. Above requirements are evidenced by documentation, which includes:
  - Completed medical necessity form
  - Three comparable invoices from the manufacturer provided by a Medicaid provider, or three comparable estimates from a Medicaid provider
  - Designation on estimate if cost is manufacturer's suggested retail price, dealer cost, or wholesale price.
  - Comprehensive functional assessment
  - Case manager and/or service worker service plan
  - Denial for state plan durable medical equipment, if applicable
14. Exclusions include those modifications:
  - Necessary or desirable without regard to the member's medical or remedial need
  - Expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence

- Not specifically identified within Iowa Administrative Code
- Purchasing or leasing of a motorized vehicle
- Home and vehicle repairs unless authorized by the department.

**References Used:**

Iowa Administrative Code 441-78.27(249A)  
 Iowa Administrative Code 441-78.34(9)  
 Iowa Administrative Code 441-78.41(4)  
 Iowa Administrative Code 441-78.37(9)  
 Iowa Administrative Code 441-78.43(5)  
 Iowa Administrative Code 441-78.46(2)  
 Iowa Administrative Code 441-78.38(9) e(4)  
 DHS Informational Letters NO. 951 and NO.1039

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
10/16/15	CAC	Removed criteria #2, #6 and #7. Added last paragraph in References Used.	1
10/30/15	Policy Staff	Criterion #2 replaced "Intellectual Disability waiver" with "any waiver". Criterion #13 replaced "social worker" with "service worker". Criterion #14 added home and vehicle repairs "unless authorized by the department".	2

  
 Jason Kessler, MD

## Mobility Related Device Purchase

<b>Iowa Medicaid Program:</b>	Prior Authorization; Claims Pre-pay	<b>Effective Date:</b>	7/10/2006
<b>Revision Number:</b>	2	<b>Last Review Date:</b>	10/16/2015
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b>	10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b>	10/21/2015

**Criteria:**

1. For a member over age 21 years Medicare’s criteria for mobility devices is followed.
  - a. The Medicare website updated on a regular basis and should be reviewed.
2. If the member is age 3 through 21, an Individual Educational Plan (IEP) from the member’s school must be requested, if applicable.
  - a. Federal regulations require that schools address the special needs for supplementary aids and services to enable member with disabilities to participate with their non-disabled peers to the maximum extent possible in the academic environment as well as in extracurricular services and activities.
  - b. The child’s IEP must identify the special services, adaptive technology and equipment necessary to meet those needs. Medicaid may be used as a resource for funding special services and equipment.
  - c. Medicaid, therefore, considers a child’s academic environment in determining the need for medical items, but not to the exclusion of the above general requirements.
3. Canes, crutches, walkers, manual wheelchairs and power wheelchairs are all mobility devices in that all serve the same function of enabling a person to be mobile.
  - a. Duplicate forms of mobility devices are not covered. For example, manual wheelchairs are a duplicate item for persons who can ambulate with a cane, crutches or walker. A power wheelchair is a duplicate item for someone who can use a manual wheelchair.
4. Repair: If a mobility device is a replacement, the cost of repairs to the existing device must exceed 2/3 of the cost of new device for a new device to be covered. Reimbursements are based on Medicaid’s reimbursements of allowed charges, not the submitted charges. If the member is going from a manual wheelchair to a power wheelchair **OR** an accessory is medically needed that cannot be added to current wheelchair, then 2/3 of the repair costs comparison is not required.
5. A wheelchair or power operated vehicle might be approved on a rental basis due to the member’s prognosis or diagnosis based on individual review.

**HCPCS Code:**

Adult Manual Wheelchairs K0001-K0009, E1161

Pediatric Manual Wheelchairs E1229-E1238

Power Mobility Devices K0813-K0886

**References Used:**

Medicare’s Criteria for Manual Wheelchairs

[https://www.noridianmedicare.com/dme/coverage/docs/lcds/current\\_lcds/manual\\_wheelchair\\_bases.pdf](https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/manual_wheelchair_bases.pdf)

Medicare’s Criteria for Power Wheelchairs/Power Operated Vehicle/Scooters

[https://www.noridianmedicare.com/dme/coverage/docs/lcds/current\\_lcds/power\\_mobility\\_devices.pdf](https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/power_mobility_devices.pdf)

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**Change History:**

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10/17/14	Medical Director	Grammatical and formatting changes	1
10/16/15	CAC	Added last paragraph in References Used	2



Jason Kessler, MD

## Nipple Tattooing Criteria

<b>Iowa Medicaid Program:</b>	Claims Pre-pay	<b>Effective Date:</b>	5/14/2008
<b>Revision Number:</b>	3	<b>Last Review Date:</b>	10/16/2015
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b>	10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b>	10/21/2015

**Criteria:** For approval of nipple tattooing procedures **ALL OF** the following criteria must be met:

1. Breast reconstruction must have occurred within 12 months of the mastectomy procedure.
2. Mastectomy must have been performed due to breast cancer or the genetic risk as documented by genetic testing.
3. No previous nipple tattooing has occurred.
  - a. If previous nipple tattooing has occurred, further physician review is required.

**Codes:**

1. Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less – 11920
2. Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.00 sq cm – 11921
3. Each additional 20.0 sq cm, or part thereof
  - a. List separately in addition to code for primary procedure - 11922

**References Used:**

Medicare NCD 140.2 for breast reconstruction following mastectomy.

<http://www.cms.gov/medicare-coverage-database/details.ncd-details.aspx?NCDid=64&ncdver=1&DocID=140.2&bc=gAAAAAgAAAA&>

Accessed 8/18/14

Women’s Health and Cancer Rights Act (WHCRA). [http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra\\_factsheet.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html)

Accessed 8/18/14

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**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
10/17/14	Medical Director	Formatting changes and addition of references	1

**Change History (cont.):**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
10/17/14	CAC	Criterion #2 added "or genetic risk as documented by genetic testing".	2
10/9/15	Medical Director	Added clarifying wording in introduction and reference addendum	3



Jason Kessler, MD

## Non-Invasive Prenatal Testing for Aneuploidy Using Cell Free DNA (cfDNA)

<b>Iowa Medicaid Program:</b>	Prior Authorization	<b>Effective Date:</b>	12/15/2015
<b>Revision Number:</b>		<b>Last Review Date:</b>	10/16/2015
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b>	10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b>	12/15/2015

### Criteria:

#### **At least one of the following:**

1. Maternal age 35 years or older at delivery
2. Fetal ultrasonographic findings indicating an increased risk of aneuploidy
3. History of a prior pregnancy with a trisomy
4. Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a quadruple screen.
5. Parental balanced Robertsonian translocation with increased risk of fetal trisomy 13 or trisomy 21

### References:

ACOG Committee on Genetics, Committee Opinion No. 640, September 2015. "Cell-free DNA Screening for Fetal Aneuploidy. <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Genetics/Cell-free-DNA-Screening-for-Fetal-Aneuploidy> Accessed 9/3/15.

ACOG Committee on Genetics, "Noninvasive Prenatal Testing for Fetal Aneuploidy" December 2012. <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Genetics/Noninvasive-Prenatal-Testing-for-Fetal-Aneuploidy.aspx> Accessed July 2013.

Aetna Coverage policy: [http://www.aetna.com/cpb/medical/data/400\\_499/0464.html](http://www.aetna.com/cpb/medical/data/400_499/0464.html)  
United HealthCare coverage criteria (also parallels  
ACOG): [https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools and Resources/Policies and Protocols/Medical Policies/Medical Policies/Noninvasive Prenatal Diagnosis of Fetal Aneuploidy.pdf](https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/Noninvasive%20Prenatal%20Diagnosis%20of%20Fetal%20Aneuploidy.pdf)  
[http://www.health.ny.gov/health\\_care/medicaid/program/update/2014/oct14\\_mu.pdf](http://www.health.ny.gov/health_care/medicaid/program/update/2014/oct14_mu.pdf) (p. 6 of this document)

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**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>



Jason Kessler, MD

## Nutritional Counseling Criteria

<b>Iowa Medicaid Program</b>	Retrospective Review	<b>Effective Date:</b>	7/1/2005
<b>Revision Number:</b>	4	<b>Last Review Date:</b>	10/16/2015
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b>	10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b>	12/15/2015

**Criteria:**

Nutritional counseling services provided by licensed dietitians are covered when a nutritional problem or a condition of such severity exists that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For children under age 5, medical necessity for nutritional counseling services exceeding those otherwise available through the WIC program must be documented.

Diagnoses that may be appropriate for nutritional counseling are:

1. Chronic gastrointestinal tract problems, such as chronic constipation, colitis, liver dysfunction, ulcers, tumors, gastro-esophageal reflux, malabsorption disorders or chronic diarrhea associated with nutrient loss, short bowel syndrome, or celiac disease.
2. Chronic cardiovascular problems and blood and renal diseases, such as kidney failure, heart disease, or hypertension.
3. Metabolic disorders, such as diabetes, insulin resistance, electrolyte imbalance and errors of metabolism, such as phenylketonuria (PKU).
4. Malnutrition problems, such as protein, mineral, vitamin, and energy deficiencies; failure to thrive; anorexia nervosa; or bulimia.
5. Gastrointestinal and/or autoimmune disease.
6. Other problems and conditions, such as food allergy or intolerance, anemias, pregnancy, drug-induced dietary problems, baby bottle tooth decay, BMI > 25 or > 85<sup>th</sup> percentile BMI for children, inadequate or inappropriate techniques of feeding, inadequate or excessive weight gain, neoplasms, cleft palate, or cleft lip.

Other diagnoses may be considered with full documentation of medical need.

**CPT code:**

97802 Medical nutrition therapy: initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.

97803 Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97804 Group (2 or more individuals), each 30 minutes

**References Used:**

- 441 IAC 78.1(14)
- 441 IAC 78.18 (7)
- 441 IAC 78.31(4)"h"

**References Used (cont.):**

American Medical Association, 2015 Current Procedural Terminology (CPT) Professional Edition, 2014 AMA.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
1/18/13	CAC	Criteria - 1 <sup>st</sup> paragraph removed "age 20 and under". 3 <sup>rd</sup> paragraph removed and new information added. CPT Code - Added two codes.	1
3/22/13	Policy staff	Criteria - removed "individuals 20 years and younger". Removed licensed dietician must be employed or under contract "with the hospital in which these services are rendered". Added "For children under age 5" medical necessity through WIC must be documented. Additions to criteria and references used to replace the provider manual and reflect the details contained in 441 IAC 78.1(14); 78.18(7); and 78.31(4)"h".	2
10/17/14	Medical Director	Grammatical and formatting changes	3
10/9/15	Medical Director	Addition of CPT code descriptions and references	4



Jason Kessler, MD

## Pain Management Criteria

<b>Iowa Medicaid Program:</b>	Retrospective Review	<b>Effective Date:</b>	7/1/2005
<b>Revision Number:</b>	3	<b>Last Review Date:</b>	10/16/2015
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b>	10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b>	12/15/2015

### **Criteria:**

In addition to certification by the Department of Human Services, pain management programs must also be approved by the Commission on Accreditation of Rehabilitation Facilities (CARF).

### General characteristics

A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for members with pain interfering with physical, psychosocial, and vocational functioning.

### Treatment staff

Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are:

- A physician (M.D. or D.O.),
- A registered nurse,
- A licensed physical therapist and
- A licensed clinical psychologist or psychiatrist.

The number of staff should be appropriate to the patient volume of the facility.

### Admission criteria

Iowa Medicaid members who are candidates for the program must meet all of the following guidelines:

- The member must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.
- The member must be free of any underlying psychosis or severe neurosis.
- The member cannot be toxic on any addictive drugs.
- The member must be capable of self-care; including being able to get to meals and to perform activities of daily living.

### Plan of treatment

- For each member there is a written comprehensive and individualized description of treatment to be undertaken.
- The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

- The member's perception of needs and, when appropriate and available, the family's perception of the member's needs shall be documented.
- The member's participation in the development of the treatment plan is sought and documented.
- Each member is reassessed to determine current clinical problems, needs, and responses to treatment.
- Changes in treatment are documented.

### Discharge plan

For each member before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

1. The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.
2. The plan is in accordance with the patient's reassessed needs at the time of transfer.
3. The plan is developed in collaboration with the patient and with the family members, as appropriate and available, with the patient's written verbal permission.
4. The plan is implemented in a manner acceptable to the patient and the need for confidentiality.
5. Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

### Restriction and limitations on payment

- Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.
- A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

### **References Used:**

441 IAC 78.31(4)"e" Hospital outpatient services

e. Pain Management

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches. The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs. The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

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**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
1/18/13	CAC	Added information to Criterion #3.	1
2/27/13	Policy Staff	Replaced criteria from the provider manual with revised criteria to reflect details contained in 441 IAC 78.31(4)"e"	2
10/9/15	Medical Director	Minor wording changes and insertion of text of IAC reference	3



**Jason Kessler, MD**

## Panniculectomy Criteria

<b>Iowa Medicaid Program:</b>	Prior Authorization; Claims Pre-pay	<b>Effective Date:</b>	7/1/2008
<b>Revision Number:</b>	6	<b>Last Review Date:</b>	10/16/2015
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b>	10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b>	10/21/2015

### Criteria:

**ALL OF** the following must be documented:

1. A recent six-month or longer period of conservative measures attempted to alleviate the active symptoms and the results of these treatments.
2. Recent pictures demonstrating the degree of excessive skin and any skin irritations.
3. Current stable BMI.
4. If status post bariatric surgery, must be at least one year post-op.
5. Panniculus hangs at or below symphysis pubis
6. Two of the following:
  - History of chronic back pain
  - Chronic abdominal pain (including of the panniculus itself)
  - Intertriginous skin infections and/or dermatitis involving the panniculus and adjacent areas
  - Impaired ambulation due to the panniculus itself or its effect on body mechanics or body structures
  - Difficulty performing ADLs or IADLs due to the panniculus itself or its effect on body mechanics or body structures

May also request a hernia repair at same time. If reviewer approves panniculectomy, then approve hernia repair.

Hernia repairs alone DO NOT require a PA.

### CPT/HCPCS Codes:

15830 – Panniculectomy

15847 – Abdominoplasty (This code may or may not be requested at the same time. If it is, approve both codes if above criteria met)

AS – Assistant Surgeon

### References Used:

[http://www.cigna.com/assets/docs/health-care-professionals/coverage\\_positions/mm\\_0027\\_coveragepositioncriteria\\_abdominoplasty\\_and\\_panniculectomy.pdf](http://www.cigna.com/assets/docs/health-care-professionals/coverage_positions/mm_0027_coveragepositioncriteria_abdominoplasty_and_panniculectomy.pdf). Accessed 1/17/13.

[https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/BodyContouring\\_CD.pdf](https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/BodyContouring_CD.pdf). Accessed 1/17/13.

<http://www.mass.gov/eohhs/docs/masshealth/guidelines/mg-panniculectomy.pdf>

[http://www.aetna.com/cpb/medical/data/200\\_299/0211.html](http://www.aetna.com/cpb/medical/data/200_299/0211.html). Accessed 1/17/13.

**References Used (cont):**

LCD L30733 - <http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=30733&ContrId=144&ver=30&ContrVer=1&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=SAD%7cEd&PolicyType=Final&s=All&KeyWord=panniculectomy&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&bc=IAAAABAAAAAAA%3d%3d&>. Accessed 10/17/14.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
1/18/13	CAC	Re-order and added information to Criteria #1-#6. Added information under References.	1
3/22/13	Policy Staff	Added criterion #7.	2
10/17/14	CAC	Removed criterion #7.	3
10/17/14	Medical Director	Added reference LCD L30733.	4
11/3/14	Policy Staff	In criteria section - hernia repairs (added "alone") do not require a PA.	5
10/9/15	Medical Director	Minor wording changes and formatting for clarity and addition of development reference	6



**Jason Kessler, MD**

## Pediatric Skilled Nursing Facility Level of Care Criteria

<b>Iowa Medicaid Program:</b>	Long Term Care	<b>Effective Date:</b>	7/1998
<b>Revision Number:</b>	2	<b>Last Review Date:</b>	10/16/2015
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b>	10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b>	10/23/2015

### Criteria:

These criteria apply to Skilled Nursing Facility (SNF) members or Medicaid members who are residing in their homes with skilled care needs who are aged 17 and under.

### Skilled Nursing Facility Level of Care

In order for the SNF level of care to be approved, **ALL FIVE** of the following conditions must be met.

1. The member must require skilled nursing services or skilled rehabilitation services.
2. The member must require and receive these skilled services on a daily basis.
  - a. Nursing services must be provided seven days a week.
  - b. Therapy services must be provided at a minimum, five days a week.

The daily skilled services can not be provided at a lower level of care, such as an Intermediate Care Facility (ICF).
3. Skilled services must be provided as a result of licensed practitioner's orders and must be reasonable and necessary for the treatment of the Member's illness or injury.
4. The member will have at least one deficit in at least one of the nine systems/categories identified below.
5. The member must require another individual to complete the service. Cares performed by the member independently are not skilled cares.
  - o Skilled cares may be performed by non-skilled persons with direct training from skilled persons only with documentation of direct supervision, refresher training, and/or review of the skilled service every six months by licensed skilled professionals.

Skilled services must include **AT LEAST ONE** of the following:

#### **(1) Musculoskeletal**

- A. Physical therapy with developmental and/or restorative goals (crawling, rolling, strengthening, gait training, transfer techniques) provided daily by or under the direction and/or supervision of a licensed physical therapist. Progress notes must be present for all encounters.
- B. Member is ambulating assisted or supervised (with or without assistive devices) an appropriate distance, progressing according to his/her plan of care. This must be used in conjunction with 'A' to qualify for skilled.
- C. Physical therapy with developmental and/or restorative goals for gross motor skills, ROM, postural tone, and weight bearing ability is provided daily as prescribed under the direction/supervision of a licensed physical therapist. Daily progress notes must be present.
- D. Occupational therapy with developmental and/or restorative goals for coordination, fine motor skills, and self-help skills are provided daily under the direction and/or supervision of a licensed occupational therapist. Daily progress notes must be present.
- E. Hydrotherapy is provided as prescribed for the member with rheumatoid and dermatomyositis diagnosis.
- F. Member requires continuous traction (Bryants, pelvic, sternal traction). Skin care is given at frequent intervals, pressure is relieved through the use of sheepskin pad(s), flotation mattress, etc.
- G. **HOME CARE:** OT/PT plan is in place with caregiver and/or parent providing daily services under the direction and/or supervision of an occupational and/or physical therapist. Appropriate therapist visits as established by written care plan. If this is the only criterion met, refer to physician reviewer.

H. Physical and/or occupational therapy is necessary for the establishment of a safe and effective maintenance program. (Review for progress in seven days.) Inconsistent follow-through of therapy plan is evident. Advise and review for appropriate follow-through within three days.

**(2) Skin**

- A. Decubitus(i) ulcer/pressure ulcer/extensive skin lesion (Grade 3\*\* or greater) is/are present on admission requiring treatment prescribed by the attending physician. Prescription medications/ dressings are applied using sterile or aseptic technique at least daily. Member is repositioned at least every two hours and measures to relieve pressure are utilized (sheepskin pad[s], flotation mattress, etc.). Weekly documentation should note location and size, nature and amount of drainage, inflammation, or necrosis.
- B. Post-operative wound care that requires sterile packs, sterile dressings, and/or sterile irrigations is/are provided on a daily basis. Weekly documentation should note healing process and skin status. See documentation guidelines listed for criterion A.
- C. Member requires strict isolation due to contagious/infectious or immune deficiency disease or susceptibility. Professional monitoring and evaluation for prevention of cross contamination is necessary.
- D. Decubitus(i) ulcer/pressure ulcer/extensive skin lesion (Grade 3 or greater) developed after admission to this setting requiring treatment prescribed by the attending physician. Prescription medications and/or sterile dressings are applied using sterile technique at least daily. Member is repositioned at least every two hours and measures to relieve pressure are utilized (sheepskin pad[s], flotation mattress, etc.). Weekly documentation should note location and size, nature and amount of drainage, inflammation, or necrosis.
- E. Member has severe physical limitations/deformities requiring position changes and nursing assessment every one to two hours. Member is repositioned at least every two hours and measures to relieve pressure are utilized (sheepskin pad[s], flotation mattress, etc.). If this is the only criterion met, refer to physician reviewer.
- F. Dressings are applied to infected wounds by professional staff involving prescription medications and/or aseptic or sterile technique.
- G. **HOME CARE:** Caregiver and/or parent is providing services as ordered by the attending physician.

**(3) Respiratory Status**

- A. Naso-pharyngeal and/or tracheostomy suctioning by licensed professional staff is provided at least daily validated by nurse's notes.
- B. Ventilatory support is required on an intermittent or continuous basis for maintenance of the member's respiratory status.
- C. Respiratory therapy is provided daily under the direction/ supervision of a licensed professional with evaluation and consultation by a respiratory therapist at least monthly. If this is the only criterion met, refer to a physician reviewer.
- D. Member receives oxygen that requires physician monitoring and frequent blood gases at least weekly, as well as, ongoing nursing monitoring of the member's response.
- E. Member exhibits apnea/bradycardia episodes that require the use of an apnea monitor and stimulation for maintenance of respiratory and/or cardiac status.
- F. **HOME CARE:** Respiratory care plan is in place with caregiver and/or parent providing daily services under the direction and/or supervision of an RN/respiratory therapist. Licensed professional visits as established by written care plan.

**(4) Elimination**

- A. Member requires daily intermittent catheterization due to chronic deficit.
- B. Indwelling urethral catheter is present. Licensed professional staff provides daily perineal and catheter cares. Daily replacement and/or irrigation is ordered specifically by physician. Drainage bag is used. Evaluation of inability to bladder train or contraindication of bladder training must be present in long-term use of the indwelling catheter.
- C. Physician, nurse practitioner, or physician's assistant has ordered a program of intermittent catheterization or bowel/bladder training following a cerebrovascular accident, neurological accident, or deficit of sudden onset. Such a program must be carried out and evaluated by professional nursing staff. Review after seven days if this is the only skilled criterion met.
- D. Daily care (irrigations and evaluation of elimination status) for member with an ostomy is provided under the direction/supervision of a licensed professional nurse.
- E. Member has chronic severe constipation requiring daily monitoring by a professional nurse. If this is the only criterion met, refer to physician reviewer.
- F. A qualified licensed nurse as ordered by the physician performs chronic ambulatory peritoneal dialysis (CAPD). Not reimbursable by Medicare/Medicaid if this is the only criterion met.
- G. Supra-pubic catheter is present. Daily care and evaluation is required and performed by licensed professional staff.
- H. **HOME CARE:** Caregiver and/or parent is providing services as ordered by the attending physician
- I. Colostomy/ileostomy/ileoconduit is present in early post-operative period requiring professional monitoring and evaluation in addition to daily care until stable. Physician documentation justifies need for skilled nursing care.

**(5) Activities of Daily Living**

- A. Occupational therapy plan has been written for retraining or establishing skill patterns, services are provided daily by or under the direction/supervision of an occupational therapist. Daily progress notes must be present.
- B. Occupational therapy is provided for bed activity skills (rolling, sitting, dangling, use of trapeze, reaching for bedside articles), as appropriate for age. This must be used in conjunction with 'A' to qualify for skilled.
- C. Occupational therapy is provided for dressing/undressing skills, as appropriate for age. This must be used in conjunction with 'A' to qualify for skilled.
- D. Occupational therapy is provided for personal hygiene skills, as appropriate for age. This must be used in conjunction with 'A' to qualify for skilled.
- E. Occupational therapy is provided for hand activity skills (use of telephone, writing, use of bed signal lights, adaptive equipment, domestic skills, etc.), as appropriate for age. This must be used in conjunction with 'A' to qualify for skilled.
- F. Member is totally dependent on nursing staff to provide all feedings. Member is confused/unresponsive, totally involuntary of bowel function, and incontinent of urine or has indwelling catheter in place. Member's condition is not stable and needs daily assessment and evaluation by professional nursing staff.
- G. **Home Care:** Occupational therapy plan is in place with caregiver/parent providing daily service under the direction of an occupational therapist. Appropriate therapist visits as established by the written care plan.

**(6) Nutritional Status/Fluid Balance**

- A. Occupational therapy plan has been written to retrain or establish skill patterns in eating. Services are provided daily or under the direction/supervision of an occupational therapist. Daily progress notes must be present. Review for progress within 30 days. If this is the only criterion met after 30 days, refer to physician reviewer.
- B. Member is difficult to feed by mouth due to aspiration, emesis, or other substantial feeding problem requiring feeding and continuous monitoring by professional staff.
- C. Member has a fluctuating fluid and/or electrolyte status that require continuous observation and evaluation by professional staff.
- D. Member requires tube feedings including insertion and maintenance by qualified licensed nurses. Oral intake is inadequate to meet the member's nutritional needs. Intake should be documented daily. Appropriate placement of tube must be assured prior to administration of feeding. Head should be elevated.
- E. Documented plan is present to remove the naso-gastric tube and reintroduce oral foods. Review for progress within 30 days. If this is the only criterion met after 30 days, refer to physician reviewer.
- F. Member receives hyperalimentation administered by qualified licensed nurses.
- G. **HOME CARE:** Nutritional plan is in place with caregiver and/or parent providing for nutritional needs as directed by the attending physician.
- H. Nutritional status is maintained through IV infusions administered by qualified licensed nurses,

**(7) Drug Therapy**

- A. Medications are given via IV route by qualified licensed nurses. Not for nutritional purposes.
- B. Medications are given via tube by qualified licensed nurses. If this is the only criterion met, refer to physician reviewer.
- C. I.M. or subcutaneous excluding insulin medications are administered at least daily.
- D. Insulin is administered that requires frequent at least daily adjustment in dosage determined by blood glucose levels as ordered by the physician. If this is the only criterion met, refer to physician reviewer.
- E. Medications are administered that require physician monitoring and frequent lab values if appropriate, as well as, ongoing professional nursing monitoring of the member's response.
- F. Anticonvulsant blood levels and medication adjustments are required routinely and PRN, as well as, ongoing nursing monitoring of the member's response. If this is the only criterion met, refer to physician reviewer.
- G. Cardiotonics/cardiogenics/diuretics blood levels and medication adjustments are required routinely and PRN, as well as, ongoing nursing monitoring of the member's response. If this is the only criterion met, refer to physician reviewer.
- H. **HOME CARE:** Caregiver and/or parent administers medications as ordered by the attending physician. If this is the only criterion met, refer to physician reviewer.
- I. Central venous lines/ports are utilized for infusion of IV medications, chemotherapy, or blood products administered by qualified licensed nurses.
- J. Oral medications are administered that require daily professional nursing evaluations of member's response. If this is the only criterion met, refer to physician reviewer.
- K. Central access line/port is in place and is irrigated less than daily to maintain patency. If this is the only criterion met, refer to physician reviewer.
- L. Continuous intrathecal narcotic infusion is provided for the terminal member with intractable pain. Member is monitored for respiratory and central nervous system depression (CNS) depression. Care of the infusion device and catheter, as well as, injection of the narcotic is performed by qualified licensed nurses.

**(8) Sensory - Motor**

- A. Speech therapy plan has been written for retraining or establishing skills in communication. Services are provided daily by a speech therapist. Therapy must be appropriate to condition. Therapy must either be diagnostic and evaluative or therapeutic.
- B. **HOME CARE:** Occupational Therapy and Physical Therapy plan is in place with caregiver and/or parent providing daily services under the direction/supervision of a speech therapist. Appropriate therapist visits as established by the written plan.

**(9) Teaching/Care Plan Management and Evaluation**

- A. Individualized teaching and training programs have been initiated by licensed professionals to teach member/caregiver how to properly perform and manage his/her treatment regimen, including preventative and infection control measures. NOTE: Reviewer should indicate the appropriate area of teaching by using letters B - J below. Review for response in 14 days. If this is the only criterion met, refer to physician reviewer.
- B. Teaching and training activities are provided to learn general mobility/extremity function skills (transfer techniques, gait training, use and care of assistive devices, etc.).
- C. Teaching and training activities are provided to learn dressing change techniques, irrigation, or preventative skin care.
- D. Teaching and training activities are provided to learn use and care of respiratory equipment and/or self-administration of treatment (oxygen, tracheostomy care, respirator, etc.).
- E. Teaching and training activities are provided to learn care of bowel and bladder appliances and equipment or self-administration of treatment (catheterization, irrigation, stoma care, etc.).
- F. Teaching and training activities are provided to retrain or establish new skill patterns in activities of daily living.
- G. Teaching and training activities are provided to comply with prescribed diet or self-administration of tube feedings/hyperalimentation.
- H. Teaching and training activities are provided regarding medications including self-administration techniques, precautions, mechanism of action, indications, dosage, and side effects.
- I. Teaching and training activities are provided to retrain and establish new skill patterns in communication speech therapy, voice simulator, communication board, etc. Inconsistent implementation of teaching plan is evident. Advise and review in three days.
- J. Development, management, and evaluation of a member care plan is required and provided daily by a licensed professional to meet the member's needs, promote recovery and/or medical stability, and ensure medical safety. If this is the only criterion met, refer to physician reviewer.

**References Used:**

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
10/17/14	Medical Director	Under Skilled Nursing Facility level of care #3 changed "physician orders" to "licensed practitioner" and added #4. Before criteria listing, added "skilled services must include at least one of the following". Grammatical and formatting changes	1
10/16/15	Medical Director	Added criterion #4. Under #3B changed respirator to ventilator support. Removed #3E. Removed referral to physician review on #4D and #4F. Added referral to physician review to #7D and #7H. Removed #9H. Added reference addendum.	2



Jason Kessler, MD

## Power Wheelchair Attendant Controls Criteria

<b>Iowa Medicaid Program:</b>	Prior Authorization	<b>Effective Date:</b> 11/18/2013
<b>Revision Number:</b>	1	<b>Last Review Date:</b> 10/16/2015
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b> 10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b> 10/21/2015

For Prior Authorization (PA) of Power Wheelchair Attendant Controls, the member must meet criterion #1 with a, b, **OR** c below:

**Criteria:**

1. Power wheelchair attendant controls can be approved when the member has a power wheelchair and;
  - a. Has a sip' n puff attachment or head array to control the wheelchair; **OR**
  - b. The medical documentation demonstrates the member would be unable to maneuver the wheelchair in tight spaces (provider should document an example of a situation where this would occur); **OR**
  - c. The medical documentation demonstrates that the member becomes fatigued in a short period of time operating the wheelchair under normal operating conditions.

**References Used:**

Iowa Administrative Code 441 Chapter 78.10(5)I(1)(2)(3)

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
10/9/15	Medical Director	Formatting changes for clarity and development reference	1

  
**Jason Kessler, MD**

## Prevocational Services Criteria

<b>Iowa Medicaid Program:</b>	Waiver Prior Authorization	<b>Effective Date:</b>	10/3/2011
<b>Revision Number:</b>	2	<b>Last Review Date:</b>	10/16/2015
<b>Reviewed By:</b>	Clinical Advisory Committee	<b>Next Review Date:</b>	10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b>	10/21/2015

### Criteria:

Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but are not job-task oriented. The purpose of Prevocational services is to provide skill building interventions that have a more generalized result as opposed to teaching job skills for a specific job. These services include teaching the member concepts of job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training. Prevocational services include more generalized habilitative goals and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

Prevocational services must comply with Iowa Administrative Code (IAC) 441-79.9(2). This requires that all services covered by Medicaid shall:

- A. Be consistent with the diagnosis and treatment of the patient's condition
- B. Be in accordance with the standards of good medical practice
- C. Be required to meet the medical need of the patient and for the reasons other than the convenience of the patient or the patient's practitioner or caregiver
- D. Be the least costly type of service which would reasonably meet the medical need of the patient

Initial Services: For prior authorization of initial prevocational services **ALL** of the following must be met:

1. The member is eligible for the Home and Community Based Services Intellectual Disability **OR** Brain Injury Waiver.
2. The member is preparing for paid or unpaid employment.
3. The member is not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year without supported employment.
4. The member has a service plan that includes teaching job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.
  - a. The service plan goals must be measurable and time limited.
  - b. The service plan is directed at individual member needs.
5. Compensation for work done by the member as part of prevocational training, if provided, is less than 50 percent of the minimum wage.
6. The following documentation must be submitted:
  - a. Service Plan
  - b. Prevocational Assessment(s), if applicable
  - c. Prevocational Training Plan
  - d. Targeted Case Manager Comprehensive Assessment
  - e. Transitional Plan

- f. Prevocational Goals, Objectives, and Results, if applicable
  - g. IEP, if applicable
7. The following do not support prevocational services and cannot be approved::
- Job task oriented training or specific education directed at teaching specific job skills or explicit employment objectives
  - Vocational training for a specific job or supported employment
  - Services intended to address general behavioral issues
  - Services intended to be a funding source for sheltered workshop
  - Services providing for employment or activity due to lack of other available opportunities
  - Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404[16] and [17]) that are otherwise available to the consumer through a state or local education agency.
  - Vocational rehabilitation services that are otherwise available to the consumer through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Continued Services: For authorization of continued prevocational services **ALL** of the following must be met:

1. The initial service criteria continue to be met.
2. There is demonstrated and measurable progress relative to the prevocational goals.
3. There is demonstrated evidence of movement toward paid or unpaid employment.
4. The services are reflected in the comprehensive service plan and are directed to habilitative goals and objectives rather than specific employment goal and objectives.
5. Submitted documentation includes:
  - Service Plan
  - Prevocational Assessment(s)
  - Prevocational Training Plan
  - Targeted Case Manager Comprehensive Assessment
  - Transitional Plan
  - Prevocational Goals, Objectives, and Results
  - IEP, if applicable

**References Used:**

Iowa Administrative Code 441-78.43(11)  
Iowa Administrative Code 441-78.41(13)  
Iowa Administrative Code 441-79.9(2)  
DHS Informational letter NO. 408  
42 Code of Federal Regulations 440.180(c)(2)(i)  
Iowa Medicaid Provider Manual

**References Used (cont.)**

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
10/17/14	Medical Director	General reformatting and grammatical changes	1
10/9/15	Medical Director	Formatting changes for clarity and addition of development reference	2



Jason Kessler, MD

## Virtual Colonoscopy

<b>Iowa Medicaid Program</b>	Exception to Policy Review	<b>Effective Date:</b>	11/20/2009
<b>Revision Number:</b>	3	<b>Last Review Date:</b>	10/16/2015
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b>	10/2016
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b>	10/21/2015

**Criteria:**

Must meet **ONE** of the following:

1. Documentation of colonic obstruction due to obstructive or stenosing lesions which would inhibit passing of the colonoscope.
2. Failed previous attempt at colonoscopy.
3. Documentation of the member's inability to safely tolerate the sedation required for conventional colonoscopy **AND** barium enema is contraindicated.

**Codes:**

74261 CT colonography, diagnostic, including image postprocessing without contrast material

74262 CT colonography, diagnostic, including image postprocessing with contrast material(s) including non-contrast images, if performed

74263 CT colonography, screening, including image postprocessing

**References Used:**

American Medical Association, Current Procedural Terminology (CPT) manual, professional edition, 2014.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
7/19/13	CAC	Change criteria to must meet ONE of the following. Combine criteria #2 and #3.	1
10/17/14	Medical Director	Inclusion of codes and references	2
10/9/15	Medical Director	Formatting changes for clarity and addition of development reference.	3



**Jason Kessler, MD**