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Medical Services

This chapter of the Idaho Medicaid Provider Handbook covers Medicaid services provided by:

- All physician specialties;
- Certified nurse midwife;
- Certified registered nurse anesthetists (CRNA);
- Clinical Nurse Specialist;
- Nurse practitioners;
- Pharmacists; and
- Physician assistants.

This chapter of the handbook refers to physicians, certified nurse midwives, clinical nurse specialists, nurse practitioners, pharmacists, and physician assistants collectively as healthcare providers. Services or situations that only apply to a specific provider type will be specified where applicable.

Should the handbook ever appear to contradict relevant provisions of Idaho or federal regulations, the regulations prevail. Any paper or digital copy of these documents is considered out of date except the version appearing on Gainwell Technologies' [Idaho Medicaid](#) website. Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed throughout the handbook for provider convenience. Handbook sections that always apply to these provider types include the following:

- [General Billing Instructions](#);
- [General Information and Requirements for Providers](#); and
- [Glossary](#).

Handbooks can only be used properly in context. Providers must be familiar with the handbooks that affect them and their services. The numbering in handbooks is also important to make note of as subsections rely on the content of the sections above them.

Example

Section 1.2.3.a The Answer requires the reader to have also read Section 1, Section 1.2 and Section 1.2.3 to be able to properly apply Section 1.2.3.a.

References are included throughout the handbook for provider and staff convenience. Not all applicable references have been incorporated into the handbook. Not all references provided are equal in weight.

- **Case Law:** Includes references to court cases that established interpretations of law that states and providers would be required to follow.
- **CMS Guidance:** These references reflect various Centers for Medicare and Medicaid Services (CMS) publications that Idaho Medicaid reviewed in the formulation of their policy. The publications themselves are not required to be followed for Idaho Medicaid services.
- **Federal Regulations:** These references are regulations from the federal level that affected policy development. Usually these include the Code of Federal Regulations, the Social Security Act and other statutes. They are required to be followed.
- **Idaho Medicaid Publications:** These are communications from Idaho Medicaid to providers that were required to be followed when published. These are included in the handbook for historical reference. The provider handbook supersedes other communications unless the documents are listed in the [Policies, Procedures and Waivers](#) webpage under policies in the [Medicaid Policies library](#).

- **Idaho State Plan:** The State Plan is the agreement between the State of Idaho and the Centers for Medicare and Medicaid Services on how the State will administer its medical assistance program.
- **Professional Organizations:** These references reflect various publications of professional organizations that Idaho Medicaid reviewed in the formulation of their policy. Providers may or may not be required to follow these references, depending on the individual reference and its application to a provider's licensure and scope of practice.
- **Scholarly Work:** These references are publications that Idaho Medicaid reviewed in the formulation of their policy. The publications themselves are not required to be followed for Idaho Medicaid services.
- **State Regulations:** These references are regulations from the state level that affected policy development. They usually include statute and IDAPA. They are required to be followed.

Some citations may not be available on the internet. Copies of the documents may be requested with a [public records request](#). Guidance for public records requests is available on the Department's website.

1. Important Contacts

The [Directory](#), Idaho Medicaid Provider Handbook contains a comprehensive list of contacts. The following contacts are presented here for provider convenience.

1.1. Gainwell Technologies

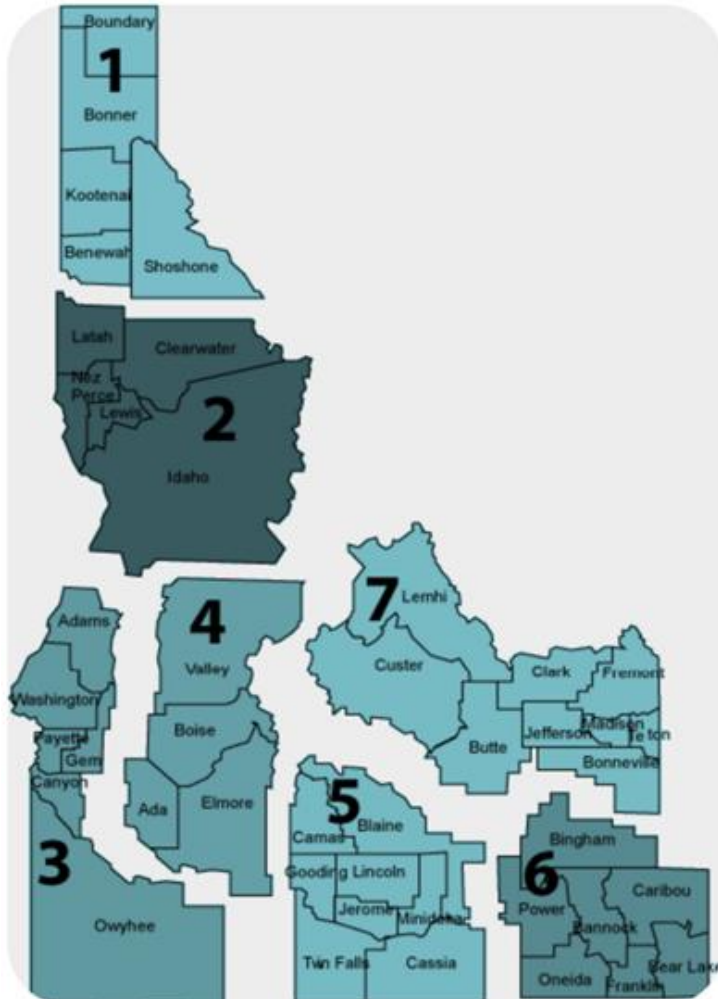
[Gainwell Technologies](#) is Idaho Medicaid's fiscal agent that handles all claims processing and customer service issues for participants not receiving services through a managed care plan.

Gainwell Technologies Contact Information
<p>Gainwell Technologies Provider Services P.O. Box 70082 Boise, ID 83707 Phone: 1 (866) 686-4272 Fax: 1 (877) 661-0974 IDProviderServices@gainwelltechnologies.com</p> <p>The Medicaid Automated Call Service (MACS) is available 24 hours a day, seven days a week. Provider service representatives are available Monday through Friday, 7:00 A.M.-7:00 P.M. MT.</p>
<p>Provider Enrollment P.O. Box 70082 Boise, ID 83707 Phone: 1 (866) 686-4272 Fax: 1 (877) 517-2041 IDProviderEnrollment@gainwelltechnologies.com</p>
<p>Technical Services Phone: 1 (866) 686-4272 Fax: 1 (877) 517-2040 IDEDISupport@gainwelltechnologies.com</p>

1.2. Provider Relations Consultants

Gainwell Technologies Provider Relations Consultants help keep providers up-to-date on billing changes required by program policy changes implemented by the Division of Medicaid. Provider Relations Consultants accomplish this by:

- Conducting provider workshops;
- Conducting live meetings for training;
- Visiting a provider’s site to conduct training; and
- Assisting providers with electronic claims submission



Region 1 and the state of Washington
1 (208) 202-5735
Region.1@gainwelltechnologies.com

Region 2 and the state of Montana
1 (208) 202-5736
Region.2@gainwelltechnologies.com

Region 3 and the state of Oregon
1 (208) 202-5816
Region.3@gainwelltechnologies.com

Region 4
1 (208) 202-5843
Region.4@gainwelltechnologies.com

Region 5 and the state of Nevada
1 (208) 202-5963
Region.5@gainwelltechnologies.com

Region 6 and the state of Utah
1 (208) 593-7759
Region.6@gainwelltechnologies.com

Region 7 and the state of Wyoming
1 (208) 609-5062
Region.7@gainwelltechnologies.com

1.3. Medicaid

The Medical Care Unit is Idaho Medicaid's team that reviews prior authorizations for some services.

Medical Care Unit
PO Box 83720
Boise, ID 83720-0009
Phone 1 (866) 205-7403
MedicalCareUnit@dhw.idaho.gov

The status of a prior authorization request submitted to the Medical Care Unit may be checked online at the [Gainwell Technologies](#) portal under "Authorization Status", using your National Provider Identifier (NPI). If you have questions on a Denial, click on the Notes, which will explain the reason for the Denial.

1.4. Telligen, Inc.

Telligen, Inc. is Idaho Medicaid's quality improvement organization (QIO) that reviews [prior authorization \(PA\) requests](#) for some services and surgical procedures as listed on the [Numerical Fee Schedule](#) or when a prior authorization would otherwise be indicated. They also conducted reviews of inpatient stays and laboratory services.

Telligen, Inc.
670 E Riverpark Ln. Suite 120
Boise, ID 83706
Phone: 1 (866) 538-9510
E-mail: idmedicaidsupport@telligen.com

See the [QIO Provider Manual](#) for a listing of diagnoses and procedures that require PA and details regarding review processes.

2. Provider Qualifications: General

Healthcare providers in any state are eligible to become Medicaid providers. Providers must be licensed or certified in the state services are performed or be under an interstate compact that accepts the provider's license or certification. Services must be within the scope of practice, licensure, and training of the provider rendering them. The provider must have a National Provider Identifier (NPI) to be eligible for enrollment. Enrollment as an Idaho Medicaid provider and entering into a provider agreement must be completed prior to providing services for Idaho Medicaid participants, however, emergency circumstances may create an exception. Healthcare providers acting as contractors for other providers must still enroll and bill directly for their services.

The following providers are eligible to be ordering, prescribing, referring, and rendering providers:

- Physicians (including bridge-year, residents and international medical graduates);
- Certified Nurse Midwives;
- Certified Registered Nurse Anesthetists;
- Clinical Nurse Specialists;
- Nurse practitioners;
- Operating Room Technicians;
- Pharmacists;
- Physician assistants; and
- Radiologic Technologist (Diagnostic).

Clinical nurse specialists and nurse practitioners with a certification in psychology/mental health must provide a copy of their certificate with their enrollment.

All provider handbook and applicable state and federal regulations must be followed to maintain eligibility for reimbursement. See the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

2.1. References: Provider Qualifications – General

2.1.1. Idaho Medicaid Publications

"Physician and Non-Physician Practitioner Contractors." *MedicAide Newsletter*, September 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf>.

2.1.2. State Regulations

Certified Registered Nurse Anesthetist, Idaho Code 54-1421 (2025). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title54/T54CH14/SECT54-1421>.

"Conditions for Payment." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 025. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Individual Provider Requirements." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 020. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Provider." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 007.10. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Provider Agreements." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 022. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Provider Application Process." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 021. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

2.2. Physicians

Physicians in any state are eligible to participate in the Idaho Medicaid Program, including those in a bridge year, international medical graduates and residents. They must have a Doctorate of Medicine or Osteopathy. Physicians are eligible to be ordering, prescribing, referring, and rendering providers. First year residents are also eligible to be ordering, prescribing, referring, and rendering providers but claims for their services are submitted under the supervising physician's National Provider Identifier (NPI). Second year residents and beyond are enrolled as full providers and may submit claims under their own NPI.

2.2.1. References: Physicians

(a) Federal Regulations

"Definitions: Physician Services." Social Security Act, Sec. 1905(a)(5) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

(b) Idaho Medicaid Publications

"Physician and Non-Physician Practitioner Contractors." *MedicAide Newsletter*, September 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf>.

"Policy Update: Ordering, Referring, and Prescribing (ORP) Providers." *MedicAide Newsletter*, April 2023, <https://www.idmedicaid.com/MedicAide%20Newsletters/April%202023%20MedicAide.pdf>.

(c) State Regulations

"Individual Providers – Requirements." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 020. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(i) (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Provider." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 007.10. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160310.pdf>.

2.3. Mobile Clinics and Imaging Units

Mobile Clinics can be enrolled with Idaho Medicaid as a service location under a multi-specialty group. A service location does not have to be enrolled for each vehicle but there must be an enrolled service location for each base of operations used by a mobile clinic. Providers must maintain a current roster of vehicles for the service location in their files for audit purposes. Clinics must provide and maintain a staff affiliation roster with signatures. Providers are required to have professional and general liability insurance.

If a radiology technician owns, leases, or rents mobile radiology equipment, they must:

- Enroll as a Technologist, Technician & Other Tech Service provider type.
- Maintain proof of ownership, lease, or rental agreements for the mobile radiology equipment.
- Bill for mobile imaging unit services with POS **15** (Mobile Unit).

2.3.1. References: Mobile Clinics and Imaging Units

"Individual Providers – Requirements." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 200. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Provider." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 012.09. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

2.4. Operating Room Technician

Operating room technicians must have one (1) of the following qualifications:

- Has successfully completed a one (1) year education program for operating room technicians accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in cooperation with the Joint Review Committee on Education for the Operating Room Technician;
- Meets the requirements for certification (CST) by the Association of Surgical Technologists; or
- Is licensed as a practical (vocational) nurse in the state of Idaho and meets the training requirements of the Idaho State Board of Nursing.

2.4.1. References: Operating Room Technician

"Individual Providers – Requirements." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 200. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Provider." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 012.09. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

2.5. Pharmacists

Pharmacists can bill directly for their services or be listed as a rendering provider on the claim. Pharmacist services billed under a pharmacy or clinic's National Provider Identifier (NPI) must list the pharmacist as the referring provider on the claim. Pharmacists are eligible to provide evaluation and management services and can provide services in most outpatient settings including those provided at an Indian Health Services (IHS) clinic, Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

Usual and customary fees for most services are paid up to the 85% of the Medicaid maximum allowance listed in the [Numerical Fee Schedule](#). Pharmacists receive full reimbursement for durable medical equipment, immunizations, laboratory services, medication therapy management (MTM), and physician-administered drugs.

2.5.1. References: Pharmacists

(a) Idaho Medicaid Publications

"Attention Pharmacists: Enrollment with Idaho Medicaid." *MedicAide Newsletter*, July 2020, <https://www.idmedicaid.com/MedicAide%20Newsletters/July%202020%20MedicAide.pdf>.

"Attention Pharmacy Providers." *MedicAide Newsletter*, September 2020, <https://www.idmedicaid.com/MedicAide%20Newsletters/September%202020%20MedicAide.pdf>.

"Enhancement to Pharmacist Providers – Enrollment and Billing Changes." *MedicAide Newsletter*, August 2024, <https://www.idmedicaid.com/MedicAide%20Newsletters/August%202024%20MedicAide.pdf>.

"New Codes Available for Pharmacy Services." *MedicAide Newsletter*, September 2020, <https://www.idmedicaid.com/MedicAide%20Newsletters/September%202020%20MedicAide.pdf>.

"Pharmacist Addition to Evaluation and Management." *MedicAide Newsletter*, April 2024, <https://www.idmedicaid.com/MedicAide%20Newsletters/April%202024%20MedicAide.pdf>.

"Pharmacist Billing Clarification." *MedicAide Newsletter*, January 2024, <https://www.idmedicaid.com/MedicAide%20Newsletters/January%202024%20MedicAide.pdf>.

"Pharmacist Evaluation and Management." *MedicAide Newsletter*, October 2023, <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202023%20MedicAide.pdf>.

(b) State Regulations

"Individual Providers – Requirements." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 020. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(ii) (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Provider." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 007.10. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160310.pdf>.

2.6. Radiologic Technologist (Diagnostic)

A radiologic technologist must have one of the following qualifications:

- A graduate of a two (2) year education program accredited by the Council on Medical Education of the American Medical Association in cooperation with the Joint Review Committee on Education in Radiologic Technology;
- Meet the requirements for registration by the American Registry of Radiologic Technologists or by the American Registry of Clinical Radiography Technologists, and has one (1) year of experience as a radiologic technologist within the last three (3) years;
- Has successfully completed an educational program in radiologic technology in a military service, and has one (1) year of experience in radiologic technology within the last three (3) years; or
- Has two (2) years of pertinent radiologic equipment experience within the last five (5) years, and has achieved a satisfactory grade on a proficiency examination in radiologic technology approved by the Secretary of Health and Human Services, except that such determination of proficiency will not apply with respect to persons initially licensed by a state or seeking initial qualification as a radiologic technologist after December 21, 1977.

2.6.1. References: Radiologic Technologist (Diagnostic)

"Individual Providers – Requirements." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 200. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Provider." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 012.09. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

3. Participant Eligibility

Medical services are a benefit of Idaho Medicaid plans. Not all participants are eligible for all medical services. Services are available based on the participant's enrollment eligibility. Providers must check participant eligibility prior to delivery of the service by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies [Idaho Medicaid](#) website.

Refer to the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for coverage restrictions based on the participant's enrollment.

3.1. References: Participant Eligibility

3.1.1. Federal Regulations

Persons to Whom Services will be Provided, 42 CFR 136.12 (2002). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2024-title42-vol1/pdf/CFR-2024-title42-vol1-sec136-12.pdf>.

3.2. Referrals

Information on referrals can be found in the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook.

4. Covered Services and Limitations: General

4.1. Abortions

An abortion is the interruption or termination of pregnancy before the fetus is viable. CMS does not consider abortion to be a family planning service. The FP modifier is not used for abortions.

Professional and facility services related to non-covered abortions such as pre and post-operative care, visits, facility fees, supplies, drugs including preventive antibiotics and Rho-GAM, anesthesia and laboratory tests are not reimbursable. Services that are reimbursable related to a non-covered abortion are pregnancy tests, pap smears, urinalysis, testing for sexually transmitted diseases and charges related to complications.

Claims with one of the following diagnoses and a CPT®/HCPCS in the [Abortion Procedures Appendix](#) require documentation attached.

Claims Requiring Documentation	
Diagnosis	Description
O04.X	Complications following (induced) termination of pregnancy
O07.X	Failed attempted termination of pregnancy
Z33.2	Encounter for elective termination of pregnancy

4.1.1. Induced Abortion

An induced abortion is a voluntary, or elective, surgical or medical termination of a pregnancy. Idaho Medicaid only covers induced abortions in instances of rape or incest. Required documentation must be attached to the claim as a requirement for payment. Required documentation includes:

- A copy of the court determination of rape or incest; or
- In instances without a court determination, a copy of the report filed with a law enforcement agency or child protective services indicating rape or incest; or
- In instances without a court determination or a filed report, a certification in writing by a licensed physician, advanced practice registered nurse, certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or clinical nurse specialist must provide that, in their professional opinion, the woman was unable, for reasons related to her health, to report the rape or incest. The certification must contain the name and address of the woman. Medical records are not a substitution for a certification.

4.1.2. Medical Abortion

Medical abortions are an alternative to surgical procedures using prescription drugs to terminate a pregnancy. Only Mifeprex and Hemabate are covered for medical abortions. Mifeprex is an FDA approved drug for medical abortion through ten (10) weeks gestation. Hemabate is an FDA approved intramuscular injection for medical abortion within the thirteenth and twentieth week of pregnancy. Mifeprex is billed with S0190 (Mifepristone oral 200mg) and S0191 (Misoprostol oral 200mcg). Hemabate (carboprost tromethamine) is billed with J0675.A prior authorization is required for all medical abortions.

The participant must receive a copy of the mifepristone or carboprost medication guide and give informed consent before the drug is administered. Administration of the drug must be in a physician's office, a clinic or hospital under the supervision of a physician with a manufacturer's

prescriber agreement. The physician must determine and document the duration of the gestation and discern if the pregnancy is ectopic or not. The physician must be able to provide or arrange immediate necessary intervention including surgery and blood transfusion in the case of complications, incomplete abortion, infection or severe bleeding. Follow-up must include an ultrasound to ensure complete evacuation and a pregnancy test with a negative result. Mifepristone is not covered for any other indication.

Services rendered to a recipient using Mifeprex for a medical abortion should be billed under a global period with code S0199. The global period is performed over an eighteen (18) day period and includes all office visits, pelvic ultrasounds, laboratory studies, urine pregnancy tests and recipient education. Services rendered using Hemabate for a medical abortion should be billed separately as it is not under a global period.

Medical abortions are only covered in the case of rape, incest or to save the life of the mother. See [Induced Abortion](#) and [Therapeutic Abortion](#) for coverage requirements.

4.1.3. Spontaneous Abortion

A spontaneous abortion, otherwise known as a miscarriage, occurs when the fetus is lost before the twentieth week of pregnancy without apparent cause. Services for a spontaneous abortion are covered including dilation and curettage.

4.1.4. Therapeutic Abortion

A therapeutic abortion is a surgical or medical abortion performed when the termination of a pregnancy is necessary to save the life of the mother. Documentation must be attached to claims when an abortion was performed to save the life of the mother. A licensed physician, advanced practice registered nurse, certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or clinical nurse specialist must certify in writing that the woman may die if the fetus is carried to term. Under no circumstance are medical records a substitution for certification. The certification must also contain the name and address of the woman. A copy of the documentation should be provided to the hospital for their billing purposes. Therapeutic abortions are also covered for the following:

(a) Blighted Ovum

A blighted ovum occurs when the embryo degenerates or is absent from the ova. Services are covered to remove a blighted ovum.

(b) Ectopic Pregnancy

An ectopic pregnancy is caused by implantation of the ovum outside the cavity of the uterus in the abdominal viscera, cervix, fallopian tubes, ovaries or peritoneum. Services for aborting an ectopic pregnancy are covered.

(c) Incomplete Abortion

Incomplete abortion is a pregnancy that is associated with vaginal bleeding, dilatation of the cervical canal, and passage of some but not all the products of conception. If the retained products become infected it is considered a septic abortion. Services for incomplete abortions are covered.

(d) Missed Abortion

Missed abortion is the prolonged retention of an embryo or fetus that died in the first twenty (20) weeks of the pregnancy. It would include an empty gestational sac, blighted ovum, but not a spontaneous or induced abortion, or delivery. Services for a missed abortion are covered.

(e) Molar Pregnancy

Hydatidiform mole is a rare condition that occurs when the placenta undergoes degenerative cystic, edematous changes that resembles a cluster of grapes. Services are covered to treat a molar pregnancy.

(f) Septic Abortion

A septic abortion occurs when the lining of the uterus and products of conception become infected. Services for septic abortions are covered.

(g) Sample Documentation for Abortions to Save the Life of the Mother

I, _____ (Name of healthcare provider), attending provider to
 _____ (Name of participant), certify that in my professional judgment, allowing this woman's existing pregnancy to be carried to term will endanger her life.

Date: _____

Signature of provider: _____

Name of participant: _____

Address of participant: _____

4.1.5. References: Abortions**(a) Case Law**

Supreme Court of The United States (2022). *Dobbs, State Health Officer of Mississippi Department of Health, Et AL. v. Jackson Women's Health Organization Et AL.*
https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf.

(b) CMS Guidance

"Chapter 3 – Eligibility." *The State Medicaid Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services,
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

"Chapter 4 – Services." *The State Medicaid Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services,
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

State Medicaid Director Letter December 28, 1993. Center for Medicaid and State Operations, Department of Health and Human Services.

State Medicaid Director Letter February 12, 1998. Center for Medicaid and State Operations, Department of Health and Human Services, <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd021298.pdf>.

State Medicaid Director Letter# 01-018 (2001). Center for Medicaid and State Operations, Department of Health and Human Services, <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd033001.pdf>.

(c) Federal Regulations

Abortions, 42 C.F.R. 441 Subpart E (1987). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part441-subpartE.pdf>.

"Definitions." Social Security Act, Sec. 1905(a)(4)(c) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Definitions." Social Security Act, Sec. 2110(a)(16) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title21/2110.htm.

Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019. H.R. 6157 (2018). Government Printing Office, <https://www.govinfo.gov/content/pkg/BILLS-115hr6157enr/pdf/BILLS-115hr6157enr.pdf>.

Executive Order No. 13535: Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act, 3 C.F.R. 15599 (2010). Government Printing Office, <https://www.govinfo.gov/content/pkg/FR-2010-03-29/pdf/2010-7154.pdf>.

Further Consolidated Appropriations Act, 2020. H.R. 1865 (2019). Government Printing Office, <https://www.congress.gov/bill/116th-congress/house-bill/1865/text>.

Limitations on coverage: Abortions, 42 C.F.R. 457.475 (2001). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec457-475.pdf>.

The Patient Protection and Affordable Care Act. H.R. 3590 (2010). Government Printing Office, <https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

Payment for Covered Outpatient Drugs, 42 U.S.C. §1396r-8 (1993). Government Printing Office, <https://www.govinfo.gov/content/pkg/USCODE-2008-title42/pdf/USCODE-2008-title42-chap7-subchapXIX-sec1396r-8.pdf>.

"Payments to States." Social Security Act, Sec. 2105(c) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title21/2105.htm.

(d) Idaho Medicaid Publications

Information Release MA02-29 (2/1/2002). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Reminder: Medicaid Coverage of Abortions." *MedicAide Newsletter*, February 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/February%202018%20MedicAide.pdf>

(e) State Regulations

"Abortion and Contraceptives." *Idaho Code Title 18, Chapter 6, "Crimes and Punishments."* Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title18/t18ch6>.

Authority to Sign or Verify, Idaho Code 54-1420 (2020). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title54/T54CH14/SECT54-1420>.

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Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Medical Services: Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 111. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Medical Services: Procedural Requirements." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 113. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.2. Acupuncture

Acupuncture services are not a covered benefit under Idaho Medicaid. These services are considered experimental and investigational. They are not eligible for coverage under EPSDT. The treatment of complications, consequences or repair of acupuncture services received by the participant are not covered by Idaho Medicaid unless they are deemed life threatening.

4.2.1. References: Acupuncture

(a) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

“Service Categories Not Covered.” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 060.01(a). Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

“Types of Treatments and Procedures Not Covered.” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 060.02(f). Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.3. Advance Directives

Advanced directives (CPT® 99497 and 99498), or advanced care planning, is a covered benefit. Advance directives are documents appointing an agent and/or documenting the participant's decisions regarding their medical treatment should they lack the capability to communicate their wishes in the future. Planning may include Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, or Medical Orders for Life-Sustaining Treatment. See the Advance Directives section of the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook, for more information including requirements and billing.

4.4. Albumin Replacement in the Office

Idaho Medicaid will cover albumin replacement (P9045- P9047) in an office setting when provided by a healthcare provider. Participants must meet the coverage criteria for claims to be reimbursable.

Coverage is available with any of these diagnoses:

Preapproved Diagnoses	
ICD-10-CM	Description
K70.11	Alcoholic hepatitis with ascites
K70.31	Alcoholic cirrhosis of liver with ascites
K71.51	Toxic liver disease with chronic active hepatitis with Ascites

Participants with diagnosis R18.8 (Other Ascites) are eligible when they have one of the following:

Preapproved Diagnoses When Combined with R18.8	
ICD-10-CM	Description
B16.0	Acute hepatitis B with delta-agent with hepatic coma
B16.1	Acute hepatitis B with delta-agent without hepatic coma
B16.2	Acute hepatitis B without delta-agent with hepatic coma
B16.9	Acute hepatitis B without delta-agent and without hepatic coma
B17.0	Acute delta-(super) infection of hepatitis B carrier
B17.10	Acute hepatitis C without hepatic coma
B17.9	Acute viral hepatitis, unspecified
I82.0	Budd-Chiari syndrome
K70.2	Alcoholic fibrosis and sclerosis of liver
K74.1	Hepatic sclerosis
K74.3	Primary biliary cirrhosis
K74.60	Unspecified cirrhosis of liver
K74.69	Other cirrhosis of liver (includes cryptogenic)
K75.81	Nonalcoholic steatohepatitis (NASH)
P78.81	Congenital cirrhosis (of liver)

Participants with a diagnosis not included on the Preapproved Diagnosis list can receive albumin replacement in an office setting based on a healthcare provider's clinical judgement. Such claims must be billed with a KX modifier. Albumin replacement after large volume paracentesis for malignancy-related ascites is excluded from this exception and is considered not covered. Research suggests that albumin replacement is not usually necessary in patients with malignancy-related paracentesis as they are not at risk of hemodynamic sequelae or circulatory failure.

4.4.1. References: Albumin Replacement in the Office

(a) Idaho Medicaid Publications

"Albumin Replacement in the Office." *MedicAide Newsletter*, January 2021, <https://www.idmedicaid.com/MedicAide%20Newsletters/January%202021%20MedicAide.pdf>.

(b) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.5. Allergy Injections

Reimbursement for office visits is included in the reimbursement for allergy injections. Office visits may only be billed if there is a separately identifiable service, such as treatment for an ear infection.

4.5.1. References: Allergy Injections

(a) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.6. Behavioral Health Services

Medicaid covers preventive, diagnostic, therapeutic, rehabilitative, or palliative behavioral health and substance use disorder services in an inpatient or outpatient setting. Medicaid participants are automatically enrolled in the [Idaho Behavioral Health Plan](#) to obtain behavioral health and substance use disorder services. These benefits are administered by [Magellan Healthcare, Inc.](#) (Magellan). Claims with a primary behavioral health or substance use disorder diagnosis as detailed in the Appendix of the [Behavioral Health and Social Services](#), Idaho Medicaid Provider Handbook, must be billed to Magellan. There are a few exemptions. Providers with an exemption are encouraged, but not required, to enroll with Magellan and may continue to bill Gainwell Technologies for all services.

Provider services that are exempted from billing Magellan are:

- Federally Qualified Health Centers (FQHC) primary care encounters;
- Indian Health Services (IHS);
- Neurologist services;
- Physician-administered drug services;
- Healthcare provider services (EXCEPT those providing services through a behavioral health clinic, psychiatrists and providers with a behavioral health or addiction specialty.); and
- Rural Health Clinics (RHC) primary care encounters.

Providers delivering services through a behavioral health clinic, psychiatrists and providers with a behavioral health or addiction specialty are not exempted from billing their services through the Idaho Behavioral Health Plan. When the primary diagnosis code listed on the claim is listed in the Appendix of the Behavioral Health and Social Services, Idaho Medicaid Provider Handbook, the services must be billed to Magellan.

Physicians exempted from billing Magellan may provide psychotherapy (CPT® 90839 and 90840) via virtual care to participants in crisis. The medical record of the participant must support a crisis service was provided for the full duration billed and demonstrate that an urgent assessment of the participant's mental state was necessary, or their health or safety was at risk. The service must be focused on the participant as demonstrated by the participant being in the room for most of the service. CPT® 90839 is a stand-alone code and is not to be reported with psychotherapy or psychiatric diagnostic evaluation codes, the interactive complexity code, or any other psychiatry section code. Different requirements may apply when services are billed through the [Idaho Behavioral Health Plan](#) and Magellan.

4.6.1. References: Behavioral Health Services

(a) *Idaho Medicaid Publications*

"Behavioral Health Services", *Information Release MA24-10* (06/06/2024). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=30100&dbid=0&repo=PUBLIC-DOCUMENTS>.

(b) *State Regulations*

"Behavioral Health Services: Coverage and Limitations." *IDAPA 16.03.26*, "Medicaid Plan Benefits," Sec. 232. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.7. Cardiac Rehabilitation, Outpatient

Cardiac Rehabilitation (CR) in the outpatient setting is a medically supervised program with the goal of preventing future cardiac events. CR is aligned with Medicare's policy.

4.7.1. Cardiac Rehabilitation: Participant Eligibility

Outpatient cardiac rehabilitation is available for participants with a diagnosis of:

Covered Diagnoses for Cardiac Rehabilitation	
ICD-10-CM	Description
I20.1 – I20.9	Angina pectoris
I21.01 – I21.4	Acute myocardial infarction
I22.0 – I22.9	Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction
I25.111 – I25.119	Atherosclerotic heart disease of native coronary artery with angina pectoris
I25.2	Old myocardial infarction
I25.5	Ischemic cardiomyopathy
I25.6	Silent myocardial ischemia
I25.700 – I25.812	Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris
I25.89	Other forms of chronic ischemic heart disease
I25.9	Chronic ischemic heart disease, unspecified
I50.22	Chronic systolic (congestive) heart failure
I50.32	Chronic diastolic (congestive) heart failure
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.812	Chronic right heart failure
I50.814	Right heart failure due to left heart failure
I50.82 – I50.89	Heart Failure
Z48.21	Encounter for aftercare following heart transplant
Z48.280	Encounter for aftercare following heart-lung transplant
Z48.812	Encounter for surgical aftercare following surgery on the circulatory system
Z94.1	Heart transplant status
Z94.3	Heart and lungs transplant status
Z95.1 – Z95.5	Presence of cardiac and vascular implants and grafts
Z96.89	Presence of other specified functional implants
Z98.61	Coronary angioplasty status
Z98.890	Other specified postprocedural states

4.7.2. Coverage and Limitations: Cardiac Rehabilitation

Cardiac Rehabilitation is only reimbursable for an eligible participant when provided by an eligible provider, and in compliance with all Medicaid requirements. A physician must be immediately available and accessible for medical consultations and emergencies at all times.

Covered Cardiac Rehabilitation CPT® Codes	
Code	Description
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

Cardiac rehabilitation program sessions are limited to a maximum of two, one-hour sessions per day for up to 36 sessions, over a period of 36 weeks with the option for an additional 36 sessions over an extended period with prior authorization. Participation in another outpatient cardiac rehabilitation program in the absence of another qualifying cardiac event is considered investigational. Intense Cardiac Rehabilitation is not covered.

CR can be provided in places of service:

- 11 – Office;
- 19 – Off Campus – Outpatient Hospital; and
- 22 – On Campus – Outpatient Hospital.

Programs that only offer supervised exercise training are not considered cardiac rehabilitation. Physical and/or occupational therapy are not medically necessary in conjunction with cardiac rehabilitation unless performed for an unrelated diagnosis.

4.7.3. References: Outpatient Cardiac Rehabilitation

(a) CMS Guidance

“Cardiac and Pulmonary Rehabilitation Programs.” *Noridian Healthcare Solutions*, 09 December 2023,

<https://med.noridianmedicare.com/web/jeb/specialties/cardiology/cardiac-and-pulmonary-rehabilitation-programs>.

“Chapter 32 – Billing Requirements for Special Services.” *Medicare Claims Processing Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services,

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf>.

Decision Memo for Cardiac Rehabilitation (CR) Programs - Chronic Heart Failure (CAG-00437N) (2/18/2014). Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=270>.

(b) Federal Regulations

Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage, 42 C.F.R. Sec. 410.49 (2009). Government Printing Office,

<https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol2/pdf/CFR-2019-title42-vol2-sec410-49.pdf>.

(c) Idaho Medicaid Publications

“Outpatient Cardiac Rehabilitation.” *MedicAide Newsletter*, April 2015,

<https://www.idmedicaid.com/MedicAide%20Newsletters/April%202015%20MedicAide.pdf>.

(d) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.8. Cervical Cancer Screening

Cervical cancer screenings must be billed with Preventive Medicine CPT® Codes and the appropriate ICD-10-CM diagnosis code. Screening with cervical cytology (i.e. pap smear) is a covered benefit for female participants between the ages of 21 and 65 and allowed every three years. Female participants between the ages of 30 and 65 may receive high-risk human papillomavirus (hrHPV) testing every five years with or without cervical cytology at the same visit (i.e. co-testing). Participants over the age of 65 are covered for continued screenings if they have experienced spontaneous regression or management for a precancerous lesion within the past 20 years.

The sample collection for the pap smear is part of the pelvic examination and is not separately reimbursable. The Pap smear is reimbursable only to the provider who performs the service, reads the Pap smear, and issues the written report. Requirements for billing a global laboratory code, and the use of modifiers 26 and TC in the [Laboratory Services](#), Idaho Medicaid Provider Handbook apply.

Female participants diagnosed with a compromised immune system, high-grade precancerous cervical lesion or cervical cancer, or exposure to diethylstilbestrol in utero may receive screenings outside of age and frequency limitations. Participants with a hysterectomy including removal of the cervix are not eligible for screening unless there are indications of a high-grade precancerous lesion or cervical cancer.

4.8.1. References: Cervical Cancer Screening

(a) Idaho Medicaid Publications

"Coverage for Cervical Cancer Screening." *MedicAide Newsletter*, July 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/July%202019%20MedicAide.pdf>.

(b) Professional Organizations

"Cervical Cancer: Screening." *U.S. Preventive Services Task Force*, 21 August 2018, <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cervical-cancer-screening2>.

(c) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.9. Clinic Services

Clinic services are a covered benefit of Idaho Medicaid. Covered services include preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician and which may include those services provided by community health centers. There is no limit on the number of clinic visits a participant can access, however, patterns of abuse may result in a participant being entered into the locked-in program. Services received within a clinic are subject to all limitations the service would have in other settings. See the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook, for more information on the Lock-In Program.

Healthcare providers performing services in hospital owned outpatient clinics must bill their services on the CMS-1500 form with place of service 22, outpatient hospital. The reimbursement for these claims will be subject to the [site of service differential](#).

4.9.1. References: Clinic Services

(a) Idaho Medicaid Publications

"Attention: Institutional and Professional Providers." *MedicAide Newsletter*, March 2009.

"Revenue Codes 0510, 0456, 0760, and 0761", *Information Release MA12-21* (12/21/2012).
Division of Medicaid, Department of Health and Welfare, State of Idaho,
<https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=13291&dbid=0&repo=PUBLIC-DOCUMENTS>.

4.10. Consultations

Idaho Medicaid does not recognize or reimburse for consultation services (CPT® codes 99241–99245 and 99251–99255). Providers can bill for the services rendered as appropriate evaluation and management codes with a location of office, other outpatient services, hospital or nursing facility. Because Idaho Medicaid does not reimburse for consultation codes, more than one physician is allowed to bill an evaluation and management code.

4.10.1. References: Consultations

(a) Idaho Medicaid Publications

Changes to Medicaid’s Reimbursement of CPT Codes, Information Release MA10-07 (6/10/2010). Division of Medicaid, Department of Health and Welfare, State of Idaho.

4.11. Critical Care Services

Critical care includes the care of critically ill participants, in a variety of medical emergencies which requires the constant attention of the physician. Critical care is usually, but not always, given in a critical care area, such as the Coronary Care Unit, Intensive Care Unit, Respiratory Care Unit, or the Emergency Department.

The following services, performed during the critical period, are included in the global reporting and billing of critical care:

- Interpretation of cardiac output measurements.
- Interpretation of chest x-rays.
- Pulse oximetry.
- Blood gases and information data stored in computers (e.g., electrocardiogram [ECG]), blood pressure, hematologic data.
- Gastric intubation.
- Temporary transcutaneous pacing.
- Ventilator management.
- Vascular access procedures.

Other procedures not directly connected to critical care management (the suturing of laceration, setting of fractures, reduction of joint dislocations, lumbar puncture, peritoneal lavage, bladder tap, etc.) are not included in the critical care and should be reported separately.

4.11.1. References: Critical Care Services

(a) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.12. Diabetes Education and Training

Medicaid covers individual and group counseling for diabetes education and training as a supplement to healthcare provider services when all requirements of this section are met. Diabetes education and training includes diet, nutrition, medications, home glucose monitoring, insulin administration, foot care and other complications of the disease. The healthcare provider is responsible to furnish basic diabetic care and instruction to the participant and may not use a formally structured program, or a Certified Diabetes Educator (CDE), as a substitute. Healthcare provider responsibility includes the disease process and pathophysiology of diabetes mellitus, and dosage administration of agents for glycemic management.

An order and referral from the participant's primary care provider are required before initiation of services. Services must be conducted between a qualified provider and the participant via telehealth or in the provider's office or outpatient hospital department. Reimbursement is limited to 12 hours per participant every five years for individual counseling, and 24 hours per participant every five years for group counseling.

4.12.1. References: Diabetes Education and Training

(a) Idaho Medicaid Publications

"Diabetes Education and Training." *MedicAide Newsletter*, December 2024, <https://www.idmedicaid.com/MedicAide%20Newsletters/December%202024%20MedicAide.pdf>.

"Idaho Medicaid and Diabetes." *MedicAide Newsletter*, June 2003.

(b) State Regulations

"Diabetes Education and Training Services: Coverage and Limitations." *IDAPA 16.03.26*, "Medicaid Plan Benefits," Sec. 132. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Diabetes Education and Training Services: Procedural Requirements." *IDAPA 16.03.26*, "Medicaid Plan Benefits," Sec. 133. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." *IDAPA 16.03.26*, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.12.2. Provider Qualifications: Diabetes Education and Training

Providers must have a diabetes management program recognized by the American Diabetes Association (ADA) or the Association of Diabetes Care and Education Specialists (ADCES). The program must be administered by a state-licensed health professional who is also a Certified Diabetes Educator (CDE) through the Certification Board for Diabetes Care and Education (CBDCE), formerly the National Certification Board for Diabetes Educators (NCBDE), a dietitian

or pharmacist. The billing provider must maintain proof and submit to Gainwell Technology's provider enrollment the CDE's current certification with the CBDCE/NCBDE and demonstrate their program is recognized by the ADA or ADCES.

(a) References: Provider Qualifications – Diabetes Education and Training

(i) Idaho Medicaid Publications

"Idaho Medicaid and Diabetes." *MedicAide Newsletter*, June 2003.

(ii) State Regulations

"Diabetes Management Program." *IDAPA 16.03.26*, "Medicaid Plan Benefits," Sec. 134.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.12.3. Participant Eligibility: Diabetes Education and Training

Participants covered for this service must have:

- A diagnosis of diabetes within the past 90 days, and have not received prior diabetes education;
- Uncontrolled diabetes manifested by two (2) or more fasting blood sugar levels of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c greater than eight percent (8%), or random blood sugar levels greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations; or
- Recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or non-healing wounds.

(a) References: Participant Eligibility - Diabetes Education and Training

(i) State Regulations

"Participants with Diabetes." *IDAPA 16.03.26*, "Medicaid Plan Benefits," Sec. 131.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.12.4. Reimbursement: Diabetes Education and Training

Services must be billed under the dietitian, hospital or physician's clinic provider number.

Covered Codes for Diabetes Education and Training	
HCPCS	Description
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, group session (two or more), per 30 minutes

(a) References: Reimbursement – Diabetes Education and Training

(i) State Regulations

Provider Payment, Idaho Code 56-265 (2020). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265>.

4.13. Durable Medical Equipment

Idaho Medicaid allows ordering healthcare providers who are also the durable medical equipment supplier to meet documentation requirements in the medical record without writing a separate order. Providers are still required to be compliant with the Physician Self-Referral Law. Physicians acting as suppliers are required to follow the Durable Medical Equipment, Prosthetics, Orthotics and Supplies, Idaho Medicaid Provider Handbook, for these services.

4.13.1. References: Durable Medical Equipment

(a) CMS Guidance

"Order Requirements When Prescribing Practitioner is also the Supplier and is Permitted to Furnish Specific Items of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)." *MLN Matters MM10984, October 2018*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10984.pdf>.

(b) Federal Regulations

"Limitation on Certain Physician Referrals." Social Security Act, Sec. 1887 (2003). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1877.htm.

(c) Idaho Medicaid Publications

"Ordering DMEPOS When You're Also the Supplier." *MedicAide Newsletter*, July 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/July%202019%20MedicAide.pdf>.

4.14. Excluded and Non-Covered Services

For information regarding excluded and non-covered procedures, please see the *Excluded Services* section and the Non-Covered section in the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook.

4.15. Gender Transition Services

Effective July 1, 2024, Idaho Medicaid coverage and reimbursement for gender transition services ceased, consistent with Idaho law.

4.15.1. References: Gender Transition Services

(a) Idaho Medicaid Publications

Gender Transition Services, Information Release MA24-19 (07/16/2024). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=30467&dbid=0&repo=PUBLIC-DOCUMENTS>.

(b) State Regulations

Crimes and Punishments – No Public Funds for Gender Transition, Idaho Code 18-8901 (2024). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title18/t18ch89/sect18-8901>.

No Public Funds for Gender Transition, House Bill 0668 (2024). Idaho State Legislature, <https://legislature.idaho.gov/sessioninfo/2024/legislation/H0668>.

Public Assistance Law – Prohibition on Reimbursement and Coverage, Idaho Code 56-273 (2024). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-273>.

"Types of Treatments and Procedures Not Covered." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 060.02(i). Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.16. Family Planning

Idaho Medicaid covers contraceptive supplies as family planning services, including condoms, creams, foams and jellies, prescription diaphragms, intrauterine devices (IUDs), implants, injections, contraceptive patches, oral emergency contraceptives and oral contraceptives. Oral contraceptives are limited to a six-month supply and must be provided by a pharmacy. Emergency contraceptives are not considered abortion services. Idaho Medicaid does not pay a physician's office for take-home contraceptives. Family planning services and supplies are excluded from co-payment requirements. See the [Sterilization Procedures](#) section for information about the surgical procedure.

Family planning services, devices and prescriptions **must** be billed with the **FP modifier**, and any applicable NDCs. The FP modifier allows the State of Idaho to receive 90% federal reimbursement for family planning services. If the modifier is not utilized by providers, it may lead to a civil monetary penalty from the Medicaid Program Integrity Unit. Claims with multiple services should have the FP modifier only on lines for the family planning service. Evaluation and management services for family planning services should include the FP modifier as well.

IUD insertion is a covered service and includes any fees for the office visit. A separate office exam may only be billed for treatment of an unrelated diagnosis. Modifier 25 must be attached to the evaluation and management code. Insertion is also covered following a delivery, including in an inpatient setting. Insertion for any other indication in an inpatient setting is not reimbursable. IUD insertion must be billed with the ICD-10-CM diagnosis Z30.430 and FP modifier.

If Depo-Provera and Lunelle are used for any purpose other than contraception, or for dosages up to 100 mg, use J3490 (Unclassified Drug) and indicate the NDC, quantity dispensed, and units of measure.

Co-payments do not apply to family planning services or supplies. Participants under the age of 19 or eligible for Medicare are exempt from Third Party Liability requirements for Family Planning Services and supplies. All other participants are subject to the requirements of the Third Party Liability section in [General Billing Instructions](#), Idaho Medicaid Provider Handbook.

Reimbursement for contraceptive supplies is limited to the estimated acquisition cost.

4.16.1. References: Family Planning

(a) CMS Guidance

Medicaid Family Planning Services and Supplies, SHO#16-008 (6/14/2016). Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf>.

(b) Federal Regulations

"Definitions." Social Security Act, Sec. 1905(a)(4)(C) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

Limitations on Premiums and Cost Sharing, 42 C.F.R. Sec. 447.56 (1978). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec447-56.pdf>.

The Patient Protection and Affordable Care Act. H.R. 3590 (2010). Government Printing Office, <https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(23)(B) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

Sterilizations, 42 C.F.R. Subpart F (1978). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol4/pdf/CFR-2023-title42-vol4-part441-subpartF.pdf>.

(c) Idaho Medicaid Publications

"Intrauterine Device (IUD)." *MedicAide Newsletter*, August 2015. <https://www.idmedicaid.com/MedicAide%20Newsletters/August%202015%20MedicAide.pdf>.

"Reminder: Family Planning Services Require the FP Modifier." *MedicAide Newsletter*, September 2018. <https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf>.

Reporting Family Planning Services, Information Release MA03-63 (10/20/2003). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Use FP Modifier When Billing Family Planning Services." *MedicAide Newsletter*, September 2005.

(d) Professional Organizations

"Emergency Contraception." *The American College of Obstetricians and Gynecologists*, August 2019, <https://www.acog.org/womens-health/faqs/emergency-contraception>.

(e) State Regulations

"Family Planning Services: Coverage and Limitations." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 222. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Family Planning Services: Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 221. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Family Planning Services: Procedural Requirements." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 223. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Family Planning Services: Provider Reimbursement." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 225. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Limitations of Quantities." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 212.07(b). Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.17. Fertility Services

Fertility services are considered non-covered under Idaho Medicaid. This includes:

- Artificial insemination;
- Consultations;
- Counseling;
- Donation of ovum, sperm, or surrogate womb;
- Genetic testing and/or counseling for family planning;
- In vitro fertilization;
- Office exams;
- Penile implants;
- Reversal of sterilization; and
- Testing.

The treatment of complications, consequences or repair of fertility services received by the participant are not covered by Idaho Medicaid unless deemed life threatening.

4.17.1. References: Fertility Services

(a) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

“Service Categories Not Covered.” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 060.01(e). Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

“Types of Treatments and Procedures Not Covered.” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 060.02(f). Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.18. Fluoride Treatments

Physicians may provide in their office the application of topical fluoride varnish using CPT® 99188 for participants up to the age of 15. Dentists must bill services through the Idaho Smiles program.

4.18.1. References: Fluoride Treatments

(a) Idaho Medicaid Publications

"Attention Physicians: new Code for Application of Fluoride Varnish." *MedicAide Newsletter*, January 2015.

<https://www.idmedicaid.com/MedicAide%20Newsletters/January%202015%20MedicAide.pdf>.

(b) State Regulations

"Covered Drug Products." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 212.03. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.19. Focus Case Review

Services may be covered under a focused case review on a case-by-case basis for participants of any age with a life-threatening medical illness and no other available treatment options. See the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook section on Exceptions to Non-Covered and Excluded Services for information.

4.20. Forensic Examinations and Interviews

A forensic medical examination is a head-to-toe examination to determine injuries and taking of samples that may be used as evidence in a police investigation and any subsequent prosecution. A forensic interview is a structured conversation with a participant intended to elicit detailed information about a possible event(s) that the participant may have experienced or witnessed. Forensic examinations and interviews conducted for the sole purpose of gathering evidence of an alleged crime are considered not covered and are not billable to the participant. However, services, such as evaluation and management or comprehensive diagnostic assessments, may be billed to Idaho Medicaid if they are medically necessary to establish a plan of care and meet the criteria of the billed code.

A medically necessary service performed by a healthcare provider must be billed with the appropriate level evaluation and management CPT® code (99202–99215) or psychiatric diagnostic evaluation (90791–90792). Psychiatric diagnostic evaluations may be performed by a mental health practitioner using their individual provider number. Any photographs taken during the examination are included in reimbursement for the covered codes.

4.21. Hyperbaric Oxygen Therapy

Hyperbaric Oxygen (HBO) therapy is a technique of delivering higher pressures of oxygen to the tissues. Only systemic HBO therapy is a covered service.

Topical HBO therapy is a technique of delivering 100% oxygen directly to an open, moist wound at a pressure slightly higher than atmospheric pressure. Topical HBO therapy is considered investigational and is not covered by Idaho Medicaid.

Systemic HBO therapy includes the patient being entirely enclosed in a pressurized chamber and breathing oxygen at a pressure greater than one atmosphere (the pressure of oxygen at sea level). Idaho Medicaid follows Medicare criteria found in [National Coverage Determination \(NCD\) 20.29](#). Conditions not listed as covered in National Coverage Determination 20.29 are considered investigational and are not covered by Idaho Medicaid.

4.21.1. References: Hyperbaric Oxygen Therapy

(a) Idaho Medicaid Publications

"Attention: Providers of Hyperbaric Oxygen Treatment." *MedicAide Newsletter*, December 2009.

"Medicaid Coverage of Hyperbaric Oxygen Treatment." *MedicAide Newsletter*, November 2017. <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202017%20MedicAide.pdf>.

(b) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.22. Immunization and Vaccines

Universal immunization is a crucial piece of an equitable and quality health care system. Removing or reducing barriers through education and providing access to immunizations for infants, children, and adults is critical for improving health related outcomes. Providers can administer vaccines in a variety of healthcare settings such as, but not limited to, healthcare facilities, provider offices, public health clinics, and school-based and community settings. Vaccination has reduced many vaccine-preventable diseases and incidence of childhood disease over time and continues to be a valuable investment for improving population health and our health care system.

Idaho Medicaid covers medically necessary immunization and vaccines for all ages. Vaccines must be FDA approved and conform to the [Advisory Committee on Immunization Practices \(ACIP\)](#) guidelines. The claim should include the following information:

- The CPT® or HCPCS code for the vaccine.
- The CPT® code that accurately reflects the administration of the vaccine(s).

If there is a significant, separately identifiable service performed at the time of the vaccine administration, an E/M visit may also be billed with modifier 25. Documentation in the participant's record must reflect the additional services rendered.

Some vaccines may be supplied at no cost to the provider by a state or federal government agency, such as the Vaccine for Children (VFC) program, which offers a free-vaccine program for children under 19 years old. When a provider administers a government supplied no cost vaccine, the CPT® code for the vaccine should be billed with modifier SL at a zero-dollar amount (\$0.00). Provider purchased vaccines will not be reimbursed when a free vaccine is available. When a provider purchased vaccine(s) is administered, the CPT® code for the vaccine should be billed at the usual and customary rate. No modifier is required.

Co-payments do not apply to immunizations. Participants under the age of 19 or eligible for Medicare are exempt from Third Party Liability requirements for medically necessary vaccines and their administration. All other participants are subject to the requirements of the Third Party Liability section in [General Billing Instructions](#), Idaho Medicaid Provider Handbook. If the primary payer combines payment for the administration with the cost of the vaccine, a separate administration fee is not reimbursable. Some vaccines have limitations including:

COVID-19 vaccinations are covered for participants six (6) months of age and older.

FluMist™ billed with CPT® 90660 is covered for non-pregnant, healthy participants between 2-49 years of age.

Tetanus, diphtheria, and pertussis vaccine (Tdap) is covered for participants seven (7) years of age and older.

Pharmacies can submit claims for reimbursement for vaccines through the Prime Point of Sale (POS) system.

See the [Stand-Alone Vaccine Counseling](#) section for more information. See the [Wellness Examinations](#) section for the complete schedule of age-appropriate health history and health screening services.

4.22.1. References: Immunization and Vaccines

(a) CMS Guidance

Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost-Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program. Center for Medicaid and State Operations, Department of Health and Human Services, <https://www.medicaid.gov/sites/default/files/2022-05/covid-19-vaccine-toolkit-05062022.pdf>.

(b) Federal Regulations

"Definitions." Social Security Act, Sec. 1905(a)(13) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Definitions." Social Security Act, Sec. 1905(r)(1) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Mandatory coverage of COVID-19 vaccines and administration and treatment under Medicaid." *H.R. 1319, "American Rescue Plan Act of 2021,"* Sec. 9811. Department of Administration, State of Idaho, <https://www.govinfo.gov/content/pkg/BILLS-117hr1319eas/pdf/BILLS-117hr1319eas.pdf>.

Vaccines for Children Program, 42 C.F.R. Sec. 441.600 – 441.615 (2012). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartL.pdf>.

(c) Idaho Medicaid Publications

"Attention: Providers of Flu Vaccine." *MedicAide Newsletter*, January 2008.

"Attention: Providers of Immunization Services." *MedicAide Newsletter*, October 2011. <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202011%20MedicAide.pdf>.

"Billing for Immunization Services." *MedicAide Newsletter*, June 2008.

Change in Policy on Billing for Immunizations, *Information Release MA06-39* (11/22/2006). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"COVID-19 Vaccinations." *MedicAide Newsletter*, May 2023. <https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf>.

"Reminder: Immunizations." *MedicAide Newsletter*, October 2023. <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202023%20MedicAide.pdf>.

"State-Supplied Vaccine Claims." *MedicAide Newsletter*, June 2012. <https://www.idmedicaid.com/MedicAide%20Newsletters/June%202012%20MedicAide.pdf>.

"Well Child Visits." *MedicAide Newsletter*, October 2002.

(d) Professional Organizations

ACIP Recommendations. Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention, Department of Health and Human Services, <https://www.cdc.gov/acip/vaccine-recommendations/index.html>.

Immunization Schedules. Centers for Disease Control and Prevention, Department of Health and Human Services, <https://www.cdc.gov/vaccines/hcp/imz-schedules/index.html>.

(e) State Regulations

Health and Safety – Immunization, Idaho Code 39-4801 (2021). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title39/t39ch48/sect39-4801>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.22.2. Stand-Alone Vaccine Counseling

Stand-alone vaccine counseling can be helpful in addressing parental concerns about vaccine hesitancy and can provide education and vaccine confidence to participants and their families. Stand-alone counseling refers to when a participant, or caregiver, receives counseling for a vaccine from a health care professional and possibly other services, but during the same visit the participant doesn't receive an immunization. Counseling can also serve as an important educational tool to participants for all vaccine types in addition to the COVID-19 vaccine.

Participants under the age of 21 are covered under the Early and Periodic Screening and Diagnostic Treatment (EPSDT) services and are eligible for stand-alone vaccine counseling. Coverage under the following codes applies to all covered immunizations.

Vaccine Stand-Alone Counseling Codes	
HCPCS	Description
G0310	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 5 to 15 mins time.
G0311	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 16-30 mins time.
G0312	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 5 to 15 mins time.
G0313	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16-30 mins time.
G0314	Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 16-30 mins time.
G0315	Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 5-15 mins time.

Qualified health care professionals must adhere to the proper billing practices for these benefits. There are no cost-sharing requirements (i.e. copayments or deductibles) for these services. Stand-alone vaccine counseling is also reimbursable when delivered as virtual care services. See the Virtual Care Services section of the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook, for more details.

(a) **References: Stand-Alone Vaccine Counseling**

(i) **CMS Guidance**

COVID-19 Stand-alone Vaccine Counseling-Specific HCPCS Codes. Center for Medicaid and State Operations, Department of Health and Human Services, <https://www.medicaid.gov/sites/default/files/2022-06/stnd-vacc-cou-spec-hcpcs-codes.pdf>.

State Health Official Letter# 22-002. Center for Medicaid and State Operations, Department of Health and Human Services, <https://www.medicaid.gov/sites/default/files/2022-05/sho22002.pdf>.

4.23. Injections Administered as Part of a Procedure

Idaho Medicaid will not reimburse for administration fee(s) when an injection is part of a procedure (i.e., allergy injections, therapeutic, and diagnostic radiology, etc.).

4.24. Instrument-Based Ocular Screening

Idaho Medicaid covers instrument-based ocular screening (99174) (e.g., photo screening, automated-refraction) for children between three (3) to five (5) years of age, who are unable to cooperate with routine acuity screening (e.g., intellectual disability, developmental delay or severe behavioral disorders). Ocular screening is covered when completed by a healthcare provider. Standard vision screening methods are included in the reimbursement for the age-appropriate wellness examination.

Screening services generally are not covered by Idaho Medicaid due to statutory requirements for medical necessity. The Affordable Care Act requires coverage of certain screening services including services with an "A" or "B" recommendation from the U.S. Preventive Services Task Force (USPSTF).

The USPSTF gives a "B" recommendation for vision screening of all children at least once at the age of three and once again at the age of four (4) or five (5) years of age, to detect the presence of amblyopia or its risk factors. The USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of vision screening for children less than three years of age. These services are non-covered.

Additional information on screening services is available under the Medical Necessity section in the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook.

4.24.1. References: Instrument-Based Ocular Screening

(a) Federal Regulations

The Patient Protection and Affordable Care Act. H.R. 3590 (2010). Government Printing Office,
<https://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

(b) Idaho Medicaid Publications

"Idaho Medicaid Helps to Prevent Early Childhood Vision Loss." *MedicAide Newsletter*, June 2014,
<https://www.idmedicaid.com/MedicAide%20Newsletters/June%202014%20MedicAide.pdf>.

"Screening Services Not Mandated are Statutorily Excluded from Reimbursement." *MedicAide Newsletter*, March 2018,
<https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf>.

(c) Professional Organizations

Vision in Children Ages 6 Months to 5 Years: Screening. United States Preventive Services Task Force.
<https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/vision-in-children-ages-6-months-to-5-years-screening>.

(d) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.25.Laboratory Coverage

See the [Laboratory Services](#), Idaho Medicaid Provider Handbook for coverage and criteria of laboratory services including specimen collection.

4.26. Lung Cancer Screening

Idaho Medicaid covers lung cancer screening (71271 and G0296) that meets the criteria of this section. Screening services generally are not covered by Idaho Medicaid due to statutory requirements for medical necessity. The Affordable Care Act requires coverage of certain screening services including services with an “A” or “B” recommendation from the U.S. Preventive Services Task Force (USPSTF).

The USPSTF gives a “B” recommendation for the annual screening of lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years, who currently smoke 20 packs or more a year or who have quit within the past 15 years. Participants are not eligible for screening when they:

- Are under 50 or over 80 years old;
- Have not smoked in at least 15 years;
- Have a health condition that substantially limits life expectancy; or
- Lack the ability to, or will not, participate in curative lung surgery.

Claims must have one of the preapproved diagnoses to be eligible for reimbursement.

Preapproved Diagnoses for Lung Cancer Screening	
ICD-10-CM	Description
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.213	Nicotine dependence, cigarettes, with withdrawal
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
Z87.891	Personal history of nicotine dependence

4.26.1. References: Lung Cancer Screening

(a) Federal Regulations

The Patient Protection and Affordable Care Act. H.R. 3590 (2010). Government Printing Office,

<https://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

(b) Idaho Medicaid Publications

“Lung Cancer Screening Coverage Update.” *MedicAide Newsletter*, April 2021.

<https://www.idmedicaid.com/MedicAide%20Newsletters/April%202021%20MedicAide.pdf>.

“New Codes: G0296 and G0297.” *MedicAide Newsletter*, January 2017.

<https://www.idmedicaid.com/MedicAide%20Newsletters/January%202017%20MedicAide.pdf>.

“Screening Services Not Mandated are Statutorily Excluded from Reimbursement.” *MedicAide Newsletter*, March 2018,

<https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf>.

(c) Professional Organizations

Lung Cancer: Screening. United States Preventive Services Task Force.

<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening>.

(d) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.27. Mammography Services

Idaho Medicaid covers biennial screening mammograms for participants forty (40) to seventy-four (74) years of age. Participants forty (40) to forty-nine (49) require shared decision-making and education about the risks of screening. Diagnostic mammograms are available to all participants when medically necessary and ordered by a qualified provider. Services must be performed with mammography equipment and by staff considered certifiable or certified by the Bureau of Laboratories, or equivalent for other states.

Digital breast tomosynthesis (CPT® 77061-77063) is considered covered when provided with a diagnostic or screening mammogram except where otherwise noted. Codes for these services should be billed in addition to the standard mammography codes. Reimbursement for digital breast tomosynthesis is considered bundled into the screening or diagnostic mammogram provided. Additional reimbursement for digital tomosynthesis beyond the standard mammography fee is not provided. Co-payments do not apply to mammography services.

Screening services generally are not covered by Idaho Medicaid due to statutory requirements for medical necessity. The Affordable Care Act requires certain screening services be required including services with an "A" or "B" recommendation from the U.S. Preventive Services Task Force (USPSTF). The USPSTF gives a "B" recommendation for women aged forty (40) to seventy-four (74) years of age. The USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of screenings for the following non-covered services:

- People over the age of seventy-four (74);
- Digital breast tomosynthesis (DBT) as a primary screening method;
- Adjunctive screening for breast cancer using breast ultrasonography, magnetic resonance imaging, DBT, or other methods in women identified to have dense breasts on an otherwise negative screening mammogram.

Additional information on screening services is available under the Medical Necessity section in the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook.

4.27.1. References: Mammography Services

(a) Federal Regulations

The Patient Protection and Affordable Care Act. H.R. 3590 (2010). Government Printing Office,
<https://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

(b) Idaho Medicaid Publications

"CORRECTION to Idaho Medicaid Mammography Benefit: Provider Handbook Update."
MedicAide Newsletter, February 2023,
<https://www.idmedicaid.com/MedicAide%20Newsletters/February%202023%20MedicAide.pdf>

(c) Professional Organizations

Breast Cancer: Screening. United States Preventive Services Task Force.
<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening>.

(d) State Regulations

"Screening Mammograms." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 112.04. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.28. National Diabetes Prevention Program

Idaho Medicaid covers the National Diabetes Prevention Program (NDPP) for eligible participants, once every five (5) years. Idaho Medicaid covers preventive services as mandated by the Affordable Care Act (ACA) and recommended by the US Preventive Services Task Force (USPSTF) with an "A" or "B" recommendation, or when listed in the American Academy of Pediatrics Bright Futures periodicity schedule. The USPSTF has made a "B" recommendation for referring patients with prediabetes to preventive interventions.

Weight management services can also be accessed through the Preventive Health Assistance program with a prior authorization if the participant has exhausted their regular benefit or doesn't meet the usual criteria for the program, but is considered at-risk for pre-diabetes. A prior authorization is necessary for a participant who started the program but did not finish and wishes to try again. Services can be delivered via virtual care.

4.28.1. References: National Diabetes Prevention Program

(a) Idaho Medicaid Publications

"National Diabetes Prevention Program." *MedicAide Newsletter*, July 2023, <https://www.idmedicaid.com/MedicAide%20Newsletters/July%202023%20MedicAide.pdf>.

(b) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.28.2. Provider Qualifications: NDPP

Providers must meet the requirements of the National Diabetes Prevention Program (NDPP) to be eligible to provide services under Idaho Medicaid.

(a) References: Provider Qualifications – NDPP

(i) State Regulations

"The National Diabetes Prevention Program." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 134.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.28.3. Participant Eligibility: NDPP

Participants over the age of 18 and a BMI > 25 (or 23 for Asian Americans) with a diagnosis of pre-diabetes are eligible for the service. Participants at-risk of pre-diabetes are only eligible for coverage through Idaho Medicaid through the use of the Preventive Health Assistance Program.

(a) **References: Participant Eligibility - NDPP**

(i) **Idaho Medicaid Publications**

"National Diabetes Prevention Program." *MedicAide Newsletter*, July 2023, <https://www.idmedicaid.com/MedicAide%20Newsletters/July%202023%20MedicAide.pdf>.

(ii) **State Regulations**

"Concurrent Diagnosis." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 132.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Participants with Pre-Diabetes." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 131.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.28.4. **Reimbursement: NDPP**

Idaho Medicaid follows Medicare guidelines for billing NDPP services with the following exceptions. NDPP services are provided under employment or contract of a physician, clinic, hospital, public health district and should be billed by those providers. ICD-10-CM R73.03 (Prediabetes) must be listed on the claim for reimbursement. Idaho Medicaid does not allow for the billing of G9882-G9885, G9890 or G9891.

Covered Codes for National Diabetes Prevention Program	
HCPCS	Description
G9873	First Medicare Diabetes Prevention Program (MDPP) core session was attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions
G9874	Four total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions.
G9875	Nine total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions
G9876	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9.

Covered Codes for National Diabetes Prevention Program	
HCPCS	Description
G9877	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12.
G9878	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9.
G9879	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12.
G9880	The MDPP beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight in months 1-12 of the MDPP services period under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by an in-person weight measurement at a core session or core maintenance session.
G9881	The MDPP beneficiary achieved at least 9% weight loss (WL) from his/her baseline weight in months 1-24 under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by an in-person weight measurement at a core session, core maintenance session, or ongoing maintenance session.

(a) References: Reimbursement - NDPP

(i) Idaho Medicaid Publications

"National Diabetes Prevention Program." *MedicAide Newsletter*, July 2023, <https://www.idmedicaid.com/MedicAide%20Newsletters/July%202023%20MedicAide.pdf>.

(ii) State Regulations

Provider Payment, Idaho Code 56-265 (2020). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265>.

4.29. Naturopathic Services

Naturopathic services are not reimbursable by Idaho Medicaid. These services are considered experimental and investigational. They are not eligible for coverage under EPSDT. The treatment of complications, consequences or repair of naturopathic services received by the participant are not covered by Idaho Medicaid unless deemed life threatening.

4.29.1. References: Naturopathic Services

(a) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

“Service Categories Not Covered.” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 060.01(b). Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.30. Nutritional Services

Nutritional services include intensive nutritional education, counseling, and monitoring. Services must be medically necessary and ordered by a provider acting within the scope of their practice, such as a physician, nurse practitioner, physician assistant or nurse midwife. Nutritional services are not available for incarcerated individuals or otherwise ineligible non-citizens.

Services can be delivered by any provider acting within their scope of practice, such as a registered dietician. These services may also be provided by an individual who has a baccalaureate degree from an accredited college or university and meets the academic and professional requirements in dietetics of the American Dietetic Association (ADA). There is a limitation of two (2) visits per calendar year; additional visits require a prior authorization from Telligen, Inc.

If a dietician works for a hospital, the facility must bill for their services. A dietician not employed by a hospital can bill directly for nutritional services.

Nutritional Service Billing Codes		
Service	Revenue Code	HCPCS Code
Nutritional counseling, dietician visit.	0942	S9470

4.30.1. References: Nutritional Services

(a) State Regulations

"Individual Providers – Requirements." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 200. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(d)(iv) (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Nutritional Services." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 150. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Persons to Whom Services will be Provided, 42 CFR 136.12 (2002). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2024-title42-vol1/pdf/CFR-2024-title42-vol1-sec136-12.pdf>.

"Provider." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 007.10. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.31. Obstetric Care

Obstetric (OB) care must be billed as a global charge unless the attending healthcare provider did not render all components of the care. [Antepartum](#) and [postpartum](#) care may only be billed separately from the delivery when the delivery is performed by a person outside the rendering provider's practice. Providers eligible for a global charge may not separately bill per-visit antepartum or postpartum visits.

The global charge includes antepartum, intrapartum and postpartum care, a cesarean section or vaginal delivery, with or without episiotomy, with or without forceps, or breech delivery. Prenatal diagnostic laboratory charges, such as a complete urinalysis, are not included in the global charge, and may be billed according to the [Laboratory Services](#), Idaho Medicaid Provider Handbook. Any surgical procedures must also abide by the [Covered Services and Limitations – Surgery](#) section.

Charges for total OB care must be billed after the delivery using the date of delivery as the to and from date. When the Medicaid participant has active eligibility that begins on the date of delivery or any point prior, the global CPT® must be billed to Idaho Medicaid. Any previously collected payment from the participant for antepartum care must be refunded to the participant. The place-of-service on the claim should reflect where the delivery occurred. The initial office examination for diagnosis of a pregnancy may be billed separate from the total OB charges if that is the provider's standard practice for all OB participants. The initial examination must be identified as such and billed with the appropriate Evaluation and Management (E/M) CPT® code.

Claims for deliveries for a participant under the age of 13 will be denied. Providers may submit a claim review request and a request for Medicaid review of a claim determination. Requests for reviews must include medical documentation demonstrating a pregnancy under the age of 13. The process for requesting a review is detailed in the [General Billing Instructions](#), Idaho Medicaid Provider Handbook.

See the [Surrogates](#) section for information about participants providing surrogacy services. See the [Family Planning](#), [Hysterectomy](#) and [Sterilization Procedures](#) sections for information about providing these services at the conclusion of delivery and during the postpartum periods. Please, see the [Abortions](#) section under Covered Services and Limitations – General. See the [Behavioral Health and Social Services](#), Idaho Medicaid Provider Handbook for pregnancy-related services available to women beyond healthcare provider services.

4.31.1. References: Obstetric Care

(a) Idaho Medicaid Publications

"Global Charge for Total Obstetric (OB) Care." *MedicAide Newsletter*, August 2017, <https://www.idmedicaid.com/MedicAide%20Newsletters/August%202017%20MedicAide.pdf>.

"New Limitation on Claims for Deliveries." *MedicAide Newsletter*, March 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/March%202019%20MedicAide.pdf>.

"Obstetric and Maternity Billing, When to Bill or Not Bill the Global Surgical CPT." *MedicAide Newsletter*, November 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf>.

(b) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.31.2. Antepartum Care

Antepartum care includes recording weight, blood pressure and fetal heart tones, routine dipstick urinalyses and maternity counseling. Providers that also provide intrapartum and postpartum services to the participant must bill a global charge per the main [Obstetric Care](#) section. They are not eligible to bill antepartum care.

Antepartum care may only be billed separately if the delivery and/or postpartum is provided by a person outside of the healthcare provider's practice. When billing for the first three visits, use the appropriate evaluation and management CPT® codes. When billing for four or more visits use CPT® codes 59425 (Antepartum care only; 4-6 visits) and 59426 (Antepartum care only; 7 or more visits), as appropriate, with one unit and the total charge for all visits on one line. Do not split out each visit after the third visit as they are bundled into these two codes. Claims should use the first date the participant was seen in both the **from** and **to** date fields. If billing a paper CMS-1500 claim form, note the date for each additional visit in field 19.

(a) References: Antepartum Care

(i) Idaho Medicaid Publications

"Obstetric and Maternity Billing, When to Bill or Not Bill the Global Surgical CPT." *MedicAide Newsletter*, November 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf>.

4.31.3. Cesarean Section

Cesarean sections must be billed under the mother's Medicaid Identification Number (MID), with the appropriate diagnosis code indicating the reason for the cesarean section and the appropriate procedure code.

See the [ICD-10 Diagnosis Codes Accepted by Idaho Medicaid Supporting Medical Necessity for Cesarean Section](#) Appendix for a list of preapproved diagnoses for a cesarean section. Procedures conducted for reasons not on the preapproved list require a prior authorization from the Quality Improvement Organization (QIO), [Telligen](#). Approved prior authorizations can use the same authorization number on claims for facility and professional services.

In the event of an emergency situation that prevents a prior authorization request, providers may follow the Medicaid Review (DHW review) process as detailed in the [General Billing Instructions](#), Idaho Medicaid Provider Handbook. The provider must attach supporting documentation showing medical necessity from the evaluation which demonstrates the surgery is recommended over the operative report.

Approved procedures have a four-day length of stay (LOS) without additional QIO review for the mother when a claim is billed under the newborn MID with a diagnosis in the table below. If a participant with a preapproved diagnosis is not discharged after the third day and a C-section delivery surgical procedure is not indicated on the mother's claim, or a C-Section diagnosis is not indicated on the newborn's claim, a QIO review is required.

Contact Telligen at 1 (866) 538-9510 for a review or fax your requests to 1 (866) 539-0365.

Cesarean Diagnoses for Newborn	
ICD-10-CM Diagnosis Code	Description
P03.4	Newborn affected by Cesarean delivery
Z38.01	Single liveborn infant, delivered by cesarean
Z38.31	Twin liveborn infant, delivered by cesarean
Z38.62	Triplet liveborn infant, delivered by cesarean
Z38.64	Quadruplet liveborn infant, delivered by cesarean
Z38.66	Quintuplet liveborn infant, delivered by cesarean
Z38.69	Other multiple liveborn infant, delivered by cesarean

(a) **References: Cesarean Section**

(i) **Idaho Medicaid Publications**

"Attention Hospitals: Cesarean Diagnoses for Inpatient Stays." *MedicAide Newsletter*, November 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf>.

"Cesarean Section: 4-day Length of Stay." *MedicAide Newsletter*, January 2006.

"Cesarean Section Procedure and Anesthesia Diagnoses Restriction." *MedicAide Newsletter*, February 2020, <https://www.idmedicaid.com/MedicAide%20Newsletters/February%202020%20MedicAide.pdf>.

Hospital Providers, *Information Release MA03-72* (2003). Division of Medicaid, Department of Health and Welfare, State of Idaho.

4.31.4. Delivery of the Placenta

When delivery has occurred without the direct physical assistance of the provider, and the provider is present to deliver the placenta (as documented in the medical record) CPT code 59414 delivery of placenta (separate procedure) should be submitted with the appropriate CPT codes for antepartum and/or postpartum care, rather than a global CPT which includes labor and delivery.

(a) References: Delivery of the Placenta**(i) Idaho Medicaid Publications**

"Obstetric and Maternity Billing, When to Bill or Not Bill the Global Surgical CPT." *MedicAide Newsletter*, November 2018,
<https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf>.

4.31.5. Dilation and Curettage

All dilation and curettage procedures require documentation in the form of an operative or emergency department report, or office notes. Applicable documentation must be attached to the claim.

4.31.6. High Risk Pregnancy Case Management Services

High risk pregnancy case management services are available for coordination of in-home and community support services to pregnant women who are at risk of premature labor or congenital issues of the fetus. To make a referral, contact Telligen at 1 (866) 538-9510 and request Case Management Services.

4.31.7. Lactation Counseling

Idaho Medicaid reimburses for individual or group lactation counseling when provided by a healthcare provider acting within their scope of practice, registered nurse (RN) certified lactation consultant, or certified lactation consultant. Lactation services are covered for one (1) initial antepartum session within two (2) weeks of the expected date of delivery and two (2) postpartum visits within the first month of delivery. Lactation counseling is reimbursable in addition to services covered under the global billing for obstetric care.

Providers may bill for less complex lactation counseling services by utilizing the following Preventative Medicine Counseling CPT® codes (99401–99404) or Lactation Classes HCPCS (S9443), when billed with ICD-10-CM diagnosis code (Z39.1) Encounter for care and examination of lactating mother.

Approved Group Lactation Counseling Services	
Code	Description
S9443	Lactation classes, nonphysician clinician, per session
Approved Individual Lactation Counseling Services	
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes

Providers acting within the scope of their license such as a physician, certified nurse midwife, clinical nurse specialist, nurse practitioner, pharmacists, physician assistant, and RN certified lactation consultants can bill for more complex cases beyond routine counseling services utilizing the following evaluation and management (E&M) CPT® codes (99202-99205, 99212–99215, 99341, 99342, 99347-99349). These services would include taking the woman’s history, examining her breasts and nipples, observing a breastfeeding, and making a diagnosis and treatment plan for the woman. Only the diagnoses in the below table are approved for E&M visits. The level of service billed must be supported by adequate documentation and meet E&M billing requirements.

Approved ICD-10-CM diagnosis codes for Breast and Nipple Issues:	
Code	Description
Breast/Nipple Infection	
O91.02	Infection of nipple associated with puerperium
O91.03	Infection of nipple associated with the lactation
Nipple Abscess/Breast Abscess	
O91.12	Abscess of breast associated with puerperium
O91.13	Abscess of breast associated with lactation
Mastitis NOS	
O91.22	Nonpurulent mastitis associated with the puerperium
O91.23	Nonpurulent mastitis associated with lactation
Retracted Nipple	

Approved ICD-10-CM diagnosis codes for Breast and Nipple Issues:	
Code	Description
O92.02	Retracted nipple associated with the puerperium
O92.03	Retracted nipple associated with lactation
Cracked Nipple	
O92.12	Cracked nipple associated with the puerperium
O92.13	Cracked nipple associated with lactation
Others	
O92.29	Other disorders of breast associated with pregnancy and the puerperium
O92.3	Agalactia
O92.4	Hypogalactia
O92.5	Suppressed lactation
O92.6	Galactorrhea
O92.70	Unspecified disorders of lactation
O92.79	Other disorders of lactation (puerperal galactocele, engorgement)
Q83.8	Other congenital malformations of breast
R20.3	Hyperesthesia (burning)
B37.2	Candidiasis of skin and nail
L01.00	Impetigo, unspecified

If a participant is seen by a healthcare provider and the RN certified lactation consultant at the same time, the provider will report a single Evaluation and Management (E&M) code for both services. The code level selected would be based on the combined level of service by the two clinicians and supported by adequate documentation.

For coverage of breast pumps see the [Durable Medical Equipment, Prosthetics, Orthotics and Supplies](#), Idaho Medicaid Provider Handbook.

(a) References: Lactation Counseling

(i) Idaho Medicaid Publications

"Lactation Consultants." *MedicAide Newsletter*, May 2025, <https://www.idmedicaid.com/MedicAide%20Newsletters/May%202025%20MedicAide.pdf>.

"Medicaid Covers Services to Promote Breastfeeding." *MedicAide Newsletter*, November 2014, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202014%20MedicAide.pdf>.

(ii) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.31.8. Multiple Deliveries

Delivery of the first baby should be billed with the appropriate CPT® code, one (1) unit, and only the charges for the first delivery. All antepartum or postpartum care for all delivered babies is included in the delivery code for the first baby. Delivery of any additional babies is billed with a delivery code (59409, 59514, 59612, or 59620), modifier 51 and 59, and one (1) unit per baby. If multiple babies are delivered by cesarean, then only one CPT® with one unit is billed for all cesarean deliveries as only one cesarean was performed.

Example 1

A woman was pregnant for the first time with triplets. The delivering provider provided all antepartum and postpartum care. All three babies were vaginal deliveries. The claim would be billed with the following codes:

- *Baby 1: 59400, 1 unit*
- *Baby 2 and 3: 59409, Modifier 51 and 59, 2 units*

Example 2

A woman was pregnant for the first time with triplets. The delivering provider provided all antepartum and postpartum care. All three babies were cesarean deliveries. The claim would be billed with the following code:

- *Baby 1, 2 and 3: 59510, 1 unit*

Example 3

A woman was pregnant for the first time with triplets. The delivering provider provided all antepartum and postpartum care. The first baby was a vaginal delivery, and the other two babies were delivered via cesarean. The claim would be billed with the following codes:

- *Baby 1: 59400, 1 unit*
- *Baby 2 and 3: 59514, Modifier 51 and 59, 1 unit*

(a) References: Multiple Deliveries

(i) Idaho Medicaid Publications

"Multiple Deliveries." *MedicAide Newsletter*, May 2023,
<https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf>.

4.31.9. Postpartum Care

Postpartum care includes home, hospital and office visits, and contraceptive counseling until the end of the month in which 60 days have passed from delivery. Postpartum care (CPT® 59430) may only be billed separately if the delivery is provided by a physician from a different practice. All visits for postpartum care are bundled into one unit of 59430. Enter the first date the participant was seen for postpartum care in both the **from** and **to** date fields. Postpartum care includes, but is not limited to:

- Exploration of the uterus;
- Episiotomy and repair;
- Repair of cervical, vaginal, or perineal lacerations; and
- Placement of a hemostatic pack or agent.

The use of evaluation and management codes for postpartum visits is prohibited. See [Family Planning](#) for more information on contraceptive counseling.

(a) References: Postpartum Care

(i) Federal Regulations

Pregnant Women Eligible for Extended or Continuous Eligibility, 42 C.F.R. Sec. 435.170 (2016). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec435-170.pdf>.

(ii) Idaho Medicaid Publications

"Obstetric and Maternity Billing, When to Bill or Not Bill the Global Surgical CPT." *MedicAide Newsletter*, November 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf>.

"Postpartum Care." *MedicAide Newsletter*, January 2009.

4.31.10. Presumptive Eligibility (PE) Services

Services are limited for participants covered by Medicaid under Presumptive Eligibility programs. T1023 may be billed for the PE determination. Please see the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for more information about billing requirements for these participants.

4.31.11. Resuscitation – Newborn

Resuscitation of the newborn infant is covered separately if billed under the infant’s name and Medicaid identification (MID) number.

4.31.12. Risk Reduction Follow-up

Risk reduction follow-up services are covered for pregnant women and include assisting the participant in obtaining medical, educational, social, and other services necessary to assure a positive pregnancy. Pregnant women and women in the postpartum period up to the end of the calendar month following sixty-days after delivery covered under the Medicaid Basic or Enhanced Plan are eligible to receive services. Services must be ordered by a physician or practitioner of the healing arts. A prior authorization is required for this service. Risk reduction follow-up may be provided by a licensed social worker, registered nurse, nurse midwife, physician, nurse practitioner or physician's assistant. Reimbursement is limited to a single payment for each month of service.

(a) References: Risk Reduction Follow-up

(i) Idaho Medicaid Publications

"Pregnant Women Coverage Limitations." *MedicAide Newsletter*, March 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/March%202019%20MedicAide.pdf>.

(ii) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Pregnancy-Related Services: Coverage and Limitations." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 362. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Risk Reduction Follow-Up." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 362.06. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Pregnancy-Related Services: Provider Reimbursement." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 365. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.31.13. Surrogates

Women party to a gestational agreement and pregnant with a child who is not inheriting a reproductive cell from either the participant or their spouse's gamete, is a surrogate. Idaho requires all gestational agreements to include reasonable healthcare expenses. Providers are required to collect payment from all responsible third parties per the Third Party Liability section of the [General Billing Instructions](#), Idaho Medicaid Handbook, prior to billing. Services for surrogates must be billed with the ICD-10 diagnosis code Z33.3 for all pregnancy and delivery-related claims. Claims for these services will be denied. Providers can follow the process for billing the participant for non-covered services per the Participant Financial Responsibility section of the [General Information and Requirements for Providers](#), Idaho Medicaid Handbook. Claims not for pregnancy or delivery-related services with diagnosis Z33.3 should be submitted with documentation supporting that the service was not related to the gestational agreement. These claims will be pended and reviewed by Idaho Medicaid to determine eligibility for reimbursement. If a gestational agreement is terminated for a pregnant woman, providers may submit a claim review request and a request for Medicaid review of the claim determination with documentation of the terminated agreement. The process for requesting a review is detailed in the [General Billing Instructions](#), Idaho Medicaid Provider Handbook.

(a) References: Surrogates

(i) Idaho Medicaid Publications

"Gestational Agreements Act." *MedicAide Newsletter*, June 2023, <https://www.idmedicaid.com/MedicAide%20Newsletters/June%202023%20MedicAide.pdf>.

(ii) Federal Regulations

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(25) (2020). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

"Strengthening Medicaid Third-Party Liability." H.J.R. 59, "Continuing Appropriates Resolution, 2014," Sec. 202. Government Printing Office, <https://www.congress.gov/bill/113th-congress/house-joint-resolution/59>.

Third Party Liability, 42 CFR 433 Subpart D (2013). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol4/pdf/CFR-2023-title42-vol4-part433-subpartD.pdf>.

"Third Party Liability in Medicaid and CHIP." H.R. 1892, "Bipartisan Budget Act of 2018," Sec. 53102. Government Printing Office, <https://www.congress.gov/bill/115thcongress/house-bill/1892/text>.

(iii) State Regulations

"Gestational Agreements Act." *Idaho Code Title 7, Chapter 16, "Special Proceedings."* Idaho Legislature, <https://legislature.idaho.gov/wp-content/uploads/statutesrules/idstat/Title7/T7CH16.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.32. Ophthalmology

Please see the [Eye and Vision Services](#), Idaho Medicaid Provider Handbook for ophthalmology services.

4.33. Physician-Administered Drugs

A physician-administered drug (PAD) is an outpatient drug other than a vaccine that is administered by a health care provider or any agent of a provider's office. Except as otherwise specified PAD are billed through the medical benefit.

Certain PAD always require prior authorization (PA) by the Idaho Medicaid Pharmacy Unit. Please refer to the [Numerical Fee Schedule](#) on the DHW website. The pharmacy request forms can be found at <https://healthandwelfare.idaho.gov/providers/pharmacy-providers/idaho-medicaid-pharmacy-program>. If there is no PA form listed for the specific PAD given, use the Universal PA form. At the top of the form please write "Physician Administered Drug" so the PA is directed to the correct authorizing entity.

4.33.1. Reporting National Drug Codes

Federal law requires professional claims for drugs with HCPCS include the appropriate national drug code (NDC) of the drug supplied, units dispensed, and basis of measurement for each HCPCS drug. This requirement applies to drugs with HCPCS codes, whether submitted electronically, on a paper CMS-1500 claim form, or as a Medicare cross-over claim.

The HCPCS drugs that require NDC information are listed in the current HCPCS Manual, *Appendix 1*, and are listed alphabetically by generic, brand, or trade name with corresponding HCPCS codes. Claims with incomplete NDC information will be denied.

4.33.2. Compound Drugs

Paper Claims: Attach the [NDC Detail Attachment](#).

Electronic Claims: To designate the claim as a compound drug claim combining two or more ingredients (one of which is a covered Medicaid product), a compound indicator value of two (2) is required.

If one or more of the ingredients billed is a non-covered item and the pharmacy has chosen to be paid for the covered ingredients only, use a submission clarification code equal to eight (8). This will post a zero payment to the non-covered ingredient(s) and process the rest of the covered ingredients to pay at the applicable allowed amount.

Required for All Compound Claims:

- National Drug Code for each individual ingredient
- Drug name and strength
- Quantity of each ingredient
- A unit of measure for each individual ingredient of the compound:
 - Each (EA)
 - Grams (GM)
 - Milliliters (ML, CC)
- Ingredient cost for each ingredient (if no value is entered, no payment will be made)

4.33.3. Vitamin Injections

Vitamin injections are covered if medically necessary. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination.

(a) References: Vitamin Injections**(i) State Regulations**

"Covered Drug Products." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 212.03(b). Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Injectable Vitamins." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 112.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.33.4. Reimbursement: Physician-Administered Drugs

Reimbursement to providers that are not 340B covered entities is listed on the [Numerical Fee Schedule](#). If manually priced, payment will be made at wholesale acquisition cost (WAC). See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for information on 340B drug programs and manually priced goods and services, which includes drugs without an average sales price (ASP) or WAC price.

(a) References: Reimbursement – Physician-Administered Drugs**(i) State Regulations**

"Pharmacy Reimbursement." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 215.01(c). Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Provider Payment, Idaho Code 56-265 (2020). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265>.

4.34. Prolonged Services

Prolonged services (CPT® 99354, 99355, 99356, 99357, 99415, 99416 and 99417) are a covered service. Services before or after direct patient care (CPT® 99358 or 99359) on a given date are not separately reportable, as the work involved is included in the evaluation and management codes.

4.34.1. References: Prolonged Services

(a) Idaho Medicaid Publications

"Prolonged Services Before or After Direct Patient Care – CPT® 99358 and 99359." *MedicAide Newsletter*, October 2018,

<https://www.idmedicaid.com/MedicAide%20Newsletters/October%202018%20MedicAide.pdf>.

4.35. Radiology

Idaho Medicaid covers diagnostic imaging services, and limited preventive services, using CPT® codes 70010–79999 as identified on the [Numerical Fee Schedule](#). A referral is not required. Most radiology services include both a [Professional Component](#) and a [Technical Component](#). The complete radiology procedure may be billed without a modifier if the healthcare provider owns the equipment, and supervises and interprets the procedure. If these requirements are not met, the claim for the procedure must be broken down into the two components.

Portable imaging services are available in POS:

- 12 – Home
- 13 – Assisted Living Facility
- 14 – Group Home
- 31 – Skilled Nursing Facility
- 32 – Nursing Facility
- 33 – Custodial Care Facility

Mobile imaging unit services are billed with place of service (POS) 15 (Mobile Unit). See [Mobile Clinics and Imaging Units](#) for more information on becoming a mobile imaging unit.

4.35.1. References: Radiology

(a) State Regulations

“Radiology Services.” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 203.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.35.2. Technical Component

The technical component is billed with a TC modifier, and includes charges for:

- Personnel
- Material, including usual contrast media* and drugs
- Film or xerograph
- Space, equipment, and other facility charges

The technical component does not include radioisotopes or non-iodine contrast media. List the separate charges for radioisotopes with the appropriate HCPCS. Invoices must be attached to claims to identify the cost of the radioisotope, the manufacturer, and the strength and dosage administered. This information is necessary to price each claim because of variations in costs to providers and radioisotopes.

Radiology technicians can have their own provider number and bill for the technical component if they own, rent, or lease the equipment used for the radiology service. If the radiology technician does not own, rent, or lease the equipment, the technical component is billed by the healthcare professional, clinic, or facility owning the equipment.

4.35.3. Professional Component

The professional component represents services to interpret and report on the procedure. Unless there is a procedure code for *Supervision and Interpretation Only*, identify a charge for the professional component using modifier 26. This component is applicable in any situation in which the physician does not provide the technical component.

4.36. Skin Substitute Products

Skin substitute products on the [Numerical Fee Schedule](#) are covered by Idaho Medicaid. Services must be medically necessary and the least costly available product to meet the participant's need. Idaho Medicaid follows criteria established by Medicare in the local coverage determination [L39764: Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers](#) or its successor. Additionally, Idaho Medicaid considers the following treatment indications to be medically necessary:

- A non-healing diabetic lower-extremity ulcer as demonstrated by standard wound care for two weeks or more with less than a 20% reduction in wound area;
- Breast reconstruction;
- Burns, including partial-thickness and full-thickness burns;
- Dystrophic epidermolysis bullosa when standard wound therapy has failed;
- Stevens-Johnson syndrome; or
- The following ophthalmic indications:
 - Corneal ulcers and melts;
 - A persistent epithelial defect that with conservative treatment has failed to close completely within 5 days or decrease in size after 2 days;
 - Neurotrophic keratitis; or
 - Pterygium repair.

Any other use is considered investigational and non-covered. If the initial treatment episode is not successful, reapplications are non-covered. More information regarding investigational and non-covered services can be found in the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook.

Services are restricted to 10 applications per year without a prior authorization.

Skin Substitute Application Codes	
CPT®	Description
15271	Application of skin substitute graft to wound of trunk, arms, or legs, 25.0 sq cm or less of wound 100.0 sq cm or less
15272	Application of skin substitute graft to wound of trunk, arms, or legs, each additional 25.0 sq cm of wound 100.0 sq cm or less
15273	Skin substitute graft to wound 100.0 sq cm or more of trunk, arms, or legs, 100.0 sq cm or 1% body area for infants and children, or less
15274	Skin substitute graft to wound 100.0 sq cm or more of trunk, arms, or legs, each additional 100.0 sq cm or 1% body area for infants and children, or less
15275	Application of skin substitute graft to wound of face, scalp, eyelids, mouth, neck, ears, around eyes, genitals, hands, feet, fingers, or toes, 25.0 sq cm or less of wound 100.0 sq cm or less
15276	Application of skin substitute graft to wound of face, scalp, eyelids, mouth, neck, ears, around eyes, genitals, hands, feet, fingers, or toes, each additional 25.0 sq cm of wound 100.0 sq cm or less
15277	Skin substitute graft to wound 100.0 sq cm or more of face, scalp, eyelids, mouth, neck, ears, around eyes, genitals, hands, feet, fingers, or toes, 100.0 sq cm or 1% body area for infants and children, or less
15278	Skin substitute graft to wound 100.0 sq cm or more of face, scalp, eyelids, mouth, neck, ears, around eyes, genitals, hands, feet, fingers, or toes, each additional 100.0 sq cm or 1% body area for infants and children, or less

Only select skin substitute products are eligible for coverage.

Covered Skin Substitute Codes	
CPT®	Description
Q4101	Apligraf, per square centimeter
Q4102	Oasis wound matrix, per square centimeter
Q4103	Oasis burn matrix, per square centimeter
Q4104	Integra bilayer matrix wound dressing (bmwd), per square centimeter
Q4105	Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter
Q4106	Dermagraft, per square centimeter
Q4107	Graftjacket, per square centimeter
Q4108	Integra matrix, per square centimeter
Q4110	Primatrix, per square centimeter
Q4111	Gammagraft, per square centimeter
Q4112	Cymetra, injectable, 1 cc
Q4113	Graftjacket xpress, injectable, 1 cc
Q4114	Integra flowable wound matrix, injectable, 1 cc
Q4115	Alloskin, per square centimeter
Q4116	Alloderm, per square centimeter
Q4117	Hyalomatrix, per square centimeter
Q4121	Theraskin, per square centimeter
Q4123	Alloskin rt, per square centimeter
Q4124	Oasis ultra tri-layer wound matrix, per square centimeter
Q4132	Grafix core and grafixpl core, per square centimeter
Q4133	Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter
Q4134	Hmatrix, per square centimeter
Q4135	Mediskin, per square centimeter
Q4136	Ez-derm, per square centimeter
Q4137	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter
Q4138	Biodfence dryflex, per square centimeter
Q4139	Amniomatrix or biodmatrix, injectable, 1 cc
Q4140	Biodfence, per square centimeter
Q4141	Alloskin ac, per square centimeter
Q4142	Xcm biologic tissue matrix, per square centimeter
Q4143	Repriza, per square centimeter
Q4145	Epifix, injectable, 1 mg
Q4146	Tensix, per square centimeter
Q4147	Architect, architect px, or architect fx, extracellular matrix, per square centimeter
Q4148	Neox cord 1k, neox cord rt, or clarix cord 1k, per square centimeter

Covered Skin Substitute Codes	
CPT®	Description
Q4149	Excellagen, 0.1 cc
Q4151	Amnioband or guardian, per square centimeter
Q4154	Biovance, per square centimeter
Q4159	Affinity, per square centimeter
Q4168	Amnioband, 1 mg
Q4186	Epifix, per square centimeter
Q4187	Epicord, per square centimeter
Q4310	Procenta, per 100 mg

4.36.1. References: Skin Substitute Products

(a) CMS Guidance

Local Coverage Determination (LCD): Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers (L39764). Jurisdiction F – Medicare Part A and B. Noridian Healthcare Solutions, <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39764>.

(b) Idaho Medicaid Publications

“Criteria for Prior Authorization of EpiFix® and EpiCord®.” *MedicAide Newsletter*, April 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/April%202019%20MedicAide.pdf>.

(c) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.37. Tamper Resistant Prescription Requirements

To comply with federal law, Idaho Medicaid will only reimburse for outpatient drugs through fee-for-service if the prescription for the covered drug is tamper-resistant. If the prescription cannot be faxed, phoned, or electronically sent to the pharmacy, then providers must ensure the prescription form meets all of the following requirements:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

The intent of this requirement is to reduce forged and altered prescriptions and to deter drug abuse. Emergency fills for prescriptions written on non-tamper resistant pads are permitted only when the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.

4.37.1. References: Tamper Resistant Prescription Requirements

(a) CMS Guidance

State Medicaid Director Letter# 07-012. Center for Medicaid and State Operations, Department of Health and Human Services, <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081707.pdf>.

(b) Federal Regulations

"Payment for Covered Outpatient Drugs." Social Security Act, Sec. 1927(k)(2) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1927.htm.

U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007. P.L. 110-28 (2007). Government Printing Office, <https://www.govinfo.gov/content/pkg/PLAW-110publ28/pdf/PLAW-110publ28.pdf>.

(c) Idaho Medicaid Publications

"Attention: All Prescribers and Outpatient Pharmacy Providers." *MedicAide Newsletter*, September 2008.

"Attention Pharmacy, Physicians, and Midlevel Practitioner Providers: New Federal Regulations for Tamper-Resistant Prescription Pads." *MedicAide Newsletter*, March 2008.

Tamper-Resistant Prescription Forms, Information Release MA07-21 (10/1/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho.

4.38. Tobacco Cessation

Tobacco cessation benefits are available to all eligible Idaho Medicaid participants. Benefits include nicotine replacement, such as gum, lozenges and patches, bupropion SR, and services such as cessation counseling. Items listed on the Preferred Drug List on the [Idaho Medicaid Pharmacy Program](#) webpage do not require a prior authorization. Non-preferred drugs require a prior authorization from the Pharmacy Unit.

4.38.1. References: Tobacco Cessation

(a) Idaho Medicaid Publications

"How Medicaid Beneficiaries Can Obtain Tobacco Cessation Products." *MedicAide Newsletter*, March 2014, <https://www.idmedicaid.com/MedicAide%20Newsletters/March%202014%20MedicAide.pdf>.

(b) State Regulations

"Covered Drug Products." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 212.03(a). Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.39. Transcranial Magnetic Stimulation

Transcranial Magnetic Stimulation (TMS) is a non-invasive method of delivering electrical stimulation to the brain. A magnetic field is delivered through the skull, where it induces electric currents that affect neuronal function. TMS is only covered under the [Idaho Behavioral Health Plan](#).

4.39.1. References: Transcranial Magnetic Stimulation

(a) Idaho Medicaid Publications

"Transcranial Magnetic Stimulation." *MedicAide Newsletter*, September 2012, <https://www.idmedicaid.com/MedicAide%20Newsletters/September%202012%20MedicAide.pdf>.

4.40. Virtual Care Services

Healthcare providers are eligible for reimbursement for virtual care services. See the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for covered services and requirements.

4.41. Wellness Examinations

Routine well checks are an important part of preventive health services and are covered by Idaho Medicaid at age-appropriate intervals. Wellness examinations should include age-appropriate developmental screenings, anticipatory guidance, review of immunization status, screenings for depression, tobacco, alcohol, and possible opioid use. Reimbursement for these activities is bundled into the wellness examination. Providers are encouraged to bill G8431 for a positive depression screen or G8510 for a negative depression screen. Value care organizations should consider appropriate use of these codes in support of their quality measures. The exception to bundled reimbursement is [Maternal Postpartum Depression Screening](#), which is a service performed on an individual other than the participant for the benefit of the participant. Other services provided during a wellness examination are separately reimbursable such as diagnostic tests, [Fluoride Treatments](#), [Immunization and Vaccines](#), [Laboratory Services](#) such as lead screening, and [Radiology](#). These are services represented by a specific CPT® code that is not considered bundled into preventive medicine codes or listed as bundled in this handbook, and has a rate on the [Numerical Fee Schedule](#).

Wellness examinations must be billed with the Preventive Medicine CPT® Codes. The CPT® codes **96110** should be billed when using a standardized tool (such as the Ages & Stages Questionnaire) to screen development and behavior. Co-payments do not apply to wellness examinations and immunizations. See the [Adult Wellness Exams](#) and [Child Wellness Exams](#) sections for specific information regarding those age groups.

Physical exams for life activities such as sports participation, camp attendance, employment, driving licensure, admission to an educational institution, military recruitment, insurance coverage, paternity determination, adoption, immigration (except for refugees), or marriage are not considered medically necessary and are not covered by Idaho Medicaid. Non-covered physicals may be rendered as incidental to a Medicaid-covered service, but only the Medicaid-covered service is reimbursable. No additional payment will be made for the physical exam.

Administrative exams required by Idaho Medicaid are a covered service. Examples of covered administrative exams are health risk assessments and preventive physical examinations for refugees entering the country and participants in the Developmental Disability program. Examinations and laboratories for refugee immigration should be billed with Z02.89 (Encounter for other administrative examinations) as the primary diagnosis and modifier U7. When an exam and/or report is required by the Department of Health and Welfare (DHW) for an adult participant, including annual history and physical exams for adults living in an Intermediate Care Facility (for Developmentally Disabled)/Intellectually Disabled (ICF/ID), use ICD-10-CM code Z02.89 as the primary diagnosis.

If providers perform a problem-focused evaluation and management service during a wellness examination, the provider may bill for both visits by appending [Modifier 25](#) to the problem-focused visit.

4.41.1. References: Wellness Examinations

(a) CMS Guidance

Review of Opioid Use during the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV), MLN Matters Number: SE18004 (08/28/2018). Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18004.pdf>.

(b) Federal Regulations

Refugee Medical Assistance – Medical Screening, 45 C.F.R. Sec. 400.107 (1989). Government Printing Office, https://www.ecfr.gov/cgi-bin/text-idx?SID=0a34f4d3cf26941ec1bdafbbe551e398&mc=true&node=se45.2.400_1107&rqn=div8.

(c) Idaho Medicaid Publications

“Depression Screening.” *MedicAide Newsletter*, April 2024, <https://www.idmedicaid.com/MedicAide%20Newsletters/April%202024%20MedicAide.pdf>.

“Physicals for Non-Medical Reasons are Not Covered.” *MedicAide Newsletter*, December 2017, <https://www.idmedicaid.com/MedicAide%20Newsletters/December%202017%20MedicAide.pdf>.

“Wellness Examinations for Refugee Screening.” *MedicAide Newsletter*, July 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/July%202019%20MedicAide.pdf>.

(d) Professional Organizations

Immigrant and Refugee Health. Centers for Disease Control and Prevention, Department of Health and Human Services. <https://www.cdc.gov/immigrant-refugee-health/index.html>.

(e) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

“Refugee Medical Assistance,” IDAPA 16.03.06. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160306.pdf>.

4.41.2. Adult Wellness Exams

Adult wellness exams are annual preventive exams to assess the health status of adult participants. Participants are eligible for one exam every calendar year. [Wellness exams](#), [immunizations](#), and [family planning services](#) are excluded from co-payment. The content of the exam is expected to be similar to an Annual Wellness Visit (AWV) through Medicare. Screenings are covered if they have received an "A" or "B" recommendation from the [U.S. Preventive Services Task Force](#) (USPSTF). Elements of an adult wellness exam include:

- A health risk assessment;
- Review of medical and family history (including opioid use and review of all current medications);
- A list of providers the participant receives services from;
- Measurement of weight, BMI and blood pressure;
- Survey of potential risk factors for depression and other mood disorders;
- Detection of cognitive impairment;
- A screening schedule aligned with USPSTF "A" and "B" recommendations;
- Review of risk factors;
- Personalized health advice;
- Laboratory and diagnostic orders; and
- Any necessary referrals to other medical professionals.

(a) **References: Adult Wellness Exams**

(i) **CMS Guidance**

Medical Wellness Visits. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html>.

(ii) **Federal Regulations**

Coverage of Preventive Health Services, 45 C.F.R. Sec. 147.130 (2017). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title45-vol1/pdf/CFR-2018-title45-vol1-sec147-130.pdf>.

Provision of EHB, 45 C.F.R. Sec. 156.115(a)(4) (2018). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title45-vol1/pdf/CFR-2018-title45-vol1-sec156-115.pdf>.

(iii) **Idaho Medicaid Publications**

"Adult Wellness Examinations." *MedicAide Newsletter*, July 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/July%202019%20MedicAide.pdf>.

"Adult Wellness Visits." *MedicAide Newsletter*, January 2024, <https://www.idmedicaid.com/MedicAide%20Newsletters/January%202024%20MedicAide.pdf>.

(iv) **Professional Organizations**

USPSTF A and B Recommendations. U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P&qrades%5B%5D=A&grades%5B%5D=B&searchterm=.

(v) State Regulations

"Adult Physicals." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 112.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.41.3. Child Wellness Exams

This section of wellness examinations applies to all participants under 21 years of age. Participants should receive regular wellness exams from their primary care provider (PCP). Services for participants such as wellness examinations, are considered [EPSDT](#) under federal law. Baby and child [wellness exams](#), [immunizations](#), and [family planning services](#) are excluded from co-payment. Federal law requires wellness exams include:

- Appropriate immunizations;
- Appropriate vision and hearing testing;
- Appropriate developmental and behavioral health screenings;
- Comprehensive physical and mental health and developmental history;
- Comprehensive unclothed physical exam;
- Health education including anticipatory guidance; and
- Laboratory tests as indicated in the American Academy of Pediatrics (AAP) periodicity schedule.

Federal law requires all Medicaid eligible participants be tested for lead poisoning at 12 and 24 months of age, as part of their wellness exam. Participants over the age of 24 months and under 21 years of age should receive a screening blood lead test if there is no record of a previous test. See the Lead Screening section of the [Laboratory Services](#), Idaho Medicaid Provider Handbook, for more information.

Coverage is also available for [maternal postpartum depression screening](#).

Idaho Medicaid has adopted the [American Academy of Pediatrics \(AAP\) periodicity schedule](#) as the recommended frequency for wellness exams, and the [American Academy of Pediatric Dentistry periodicity schedule](#) for dental care. If a participant has not received the recommended care previously, the schedule should be brought up to date at the earliest possible time. Additionally:

- If the PCP has never seen the participant before and they are establishing care, or the PCP has no record of their wellness exam or the age-appropriate screenings, a wellness exam/age-appropriate screening (as indicated on the AAP periodicity schedule) can be provided at any time;
- If the participant is an established patient, the scheduling of the wellness exam or the interim exam is at the discretion of the provider; and
- If a concern with an existing condition worsens or a new one presents, then an interperiodic exam would be covered.

Interperiodic screens can be performed when it is medically necessary to determine if a participant has a physical or mental illness or a condition which requires further assessment, diagnosis, or treatment. Interperiodic screens may be provided to participants who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary. They may also be performed for an illness or condition suspected or identified outside the wellness exam.

If a PCP determines during a wellness exam or an interperiodic screen that a participant needs a medically necessary service or product not covered under their Medicaid benefits, the PCP should consult the Early Periodic Screening and Diagnostic and Treatment (EPSDT) benefit section of the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for coverage and prior authorization information.

Participants younger than 37 months of age with a physical or mental condition that has a high probability of developmental delay are eligible for Early Intervention Services through the Infant Toddler Program. See the Early Intervention Services section of the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for more information.

Weight management is a covered benefit for participants five (5) years of age and older, with a Body Mass Index (BMI) that falls in either the overweight, obese, or the underweight category as calculated using the [Centers for Disease Control \(CDC\) Child and Teen BMI Calculator](#). If a PCP determines a participant may benefit from a weight management program, they should review the *Preventive Health Assistance (PHA)* section of the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for more information.

(a) References: Child Wellness Exams

(i) Federal Regulations

Coverage of Preventive Health Services, 45 C.F.R. Sec. 147.130 (2017). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title45-vol1/pdf/CFR-2018-title45-vol1-sec147-130.pdf>.

Provision of EHB, 45 C.F.R. Sec. 156.115(a)(4) (2018). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title45-vol1/pdf/CFR-2018-title45-vol1-sec156-115.pdf>.

(ii) Professional Organizations

USPSTF A and B Recommendations. U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P&grades%5B%5D=A&grades%5B%5D=B&searchterm=.

(iii) State Regulations

"EPSDT Services: Coverage and Limitations," IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 352. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"EPSDT Services: Definitions," IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 350. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"EPSDT Services: Participant Eligibility," IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 351. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"EPSDT Services: Provider Qualifications and Duties," IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 354. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

4.41.4. Child Wellness Exam: Maternal Postpartum Depression Screening

Maternal postpartum depression screening may be billed for the mother of an infant under 12 months of age if a standardized screening instrument is used. Acceptable screening instruments are:

- Edinburgh Postnatal Depression Scale (EPDS);
- Patient Health Questionnaire – 9 (PHQ-9) Screener; and
- Beck Depression Inventory (BDI).

Claims should be billed under the infant’s Medicaid ID number with HCPCS G8431 for a positive depression screen or G8510 for a negative depression screen. No additional diagnosis codes should be added for this service. If a screening is positive for depression, mothers with:

- Active Medicaid coverage should be directed to contact [Magellan Healthcare, Inc.](#) Member Line at (855) 202-0973 for assistance finding a provider;
- Other insurance should be directed to contact their carrier for a list of available providers; or
- No insurance should be directed to contact community resources in their area.

Reimbursement for the screening is limited to four (4) per infant.

(a) References: Child Wellness Exam – Maternal Postpartum Depression Screening

(i) Idaho Medicaid Publications

“Attention Pediatric Care Providers: Postpartum Depressions Screening During an EPSDT Well-Child Visit as of January 1, 2018.” *MedicAide Newsletter*, December 2017, <https://www.idmedicaid.com/MedicAide%20Newsletters/December%202017%20MedicAide.pdf>.

(ii) Professional Organizations

Perinatal Depression: Preventive Interventions. United States Preventive Services Task Force (2019). <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/perinatal-depression-preventive-interventions>.

5. Covered Services and Limitations – Surgery

Medicaid pays all surgical fees based on the global fee concept as defined by CMS and the Current Procedural Terminology (CPT®) Manual. The global surgical package includes all preoperative, intraoperative and postoperative services normally a usual and necessary part of the procedure. It also includes all medical and surgical services during the postoperative period to treat complications that do not require a return to the operating room. The following services are always included in the global fee payment for the procedure:

- Access to the site;
- Local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia;
- Subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of the procedure (including history and physical);
- Supplies, except those identified as exclusions by Medicare;
- Miscellaneous services such as:
 - Dressing changes;
 - Local incisional care;
 - Removal of cutaneous sutures, lines, wires, tubes, drains, casts and splints;
 - Insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, and nasogastric and rectal tubes; and
 - Changes to and removal of tracheostomy tubes.
- Administration of fluids and drugs during the procedure;
- Immediate postoperative care, including dictating operative notes and talking with the family and other physicians;
- Writing orders;
- Evaluating the patient in the post anesthesia recovery area;
- Postoperative visits and miscellaneous services related to the surgery including, but not limited to, the application of casts, splints, and straps; and
- Postoperative pain management provided by the surgeon.

When a provider, outside of the performing surgeon’s practice, delivers part of the global components listed above, they must bill the appropriate CPT® code for the actual services delivered with the appropriate modifier.

Some surgeries may require a prior authorization. Surgeries requiring a prior authorization require an authorization for both the professional component and the facility, but only a single request needs to be submitted for both.

Reconstructive and plastic surgery always require a prior authorization. See the [Prior Authorization \(PA\)](#) section for more information on determining if a procedure requires a prior authorization.

5.1. References: Covered Services and Limitations – Surgery

5.1.1. CMS Guidance

“Chapter 1 – General Correct Coding Policies.” *National Correct Coding Initiative Policy Manual for Medicaid Services (2024)*, Centers for Medicare and Medicaid Services, Department of Health and Human Services,
<https://www.cms.gov/files/document/01-chapter1-ncci-medicaid-policy-manual-2025finalcleanpdf.pdf>.

Global Surgery Booklet. Centers for Medicare and Medicaid Services, Department of Health and Human Services (2024), <https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf>.

5.1.2. Idaho Medicaid Publications

"Global Surgery Policy." *MedicAide Newsletter*, October 2008.

"**Medicaid Program Integrity:** Casting, Splinting, or Strapping During Post-Operative Period." *MedicAide Newsletter*, January 2020, <https://www.idmedicaid.com/MedicAide%20Newsletters/January%202020%20MedicAide.pdf>.

"**Medicaid Program Integrity:** Services Included in Global Surgical Packages." *MedicAide Newsletter*, March 2014, <https://www.idmedicaid.com/MedicAide%20Newsletters/March%202014%20MedicAide.pdf>.

5.1.3. State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

5.2. Provider Preventable Conditions

Idaho Medicaid is prohibited from reimbursing providers for provider preventable conditions (PPC) including:

- Wrong Surgical or other invasive procedure performed on a patient;
- Surgical or other invasive procedure performed on the wrong body part or patient; and
- Any service addressing the consequence of a provider preventable condition unless the condition was pre-existing before the provider assumed care of the participant.

Any provider involved in the procedure, including the site of service, are not eligible for reimbursement and cannot bill the participant for their services. Providers are required to append the appropriate modifier below to any claim line that represents services for a provider preventable condition or its consequences with the exception of pre-existing consequences for providers new to the participant. All claim lines for PPC will be denied.

Provider-Preventable Condition Modifiers	
Modifier	Description
PA	Surgical or other invasive procedure on wrong body part
PB	Surgical or other invasive procedure on wrong patient
PC	Wrong surgery or other invasive procedure on patient

5.2.1. References: Provider Preventable Conditions

(a) Federal Regulations

"Payment Adjustment for Health Care-Acquired Conditions." H.R. 3590, "The Patient Protection and Affordable Care Act," Sec. 2702. Government Printing Office, <https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

"Prohibition on Payment for Provider-Preventable Conditions." 42 C.F.R. 447.26 (2019). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec447-26.pdf>.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(4) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

(b) Idaho Medicaid Publications

Payment Reduction for Hospital Acquired Conditions (HACs), Information Release MA12-08 (06/29/2012). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=13282&dbid=0&repo=PUBLIC-DOCUMENTS>.

"Payment Reduction for Provider-Preventable Conditions." *MedicAide Newsletter*, December 2012, <https://www.idmedicaid.com/MedicAide%20Newsletters/December%202012%20MedicAide.pdf>.

(c) Idaho State Plan

"Attachment Page 4.19B – Other Provider Preventable Conditions (OPPCs)." State Plan, Attachment 4.19-B. Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Payment Adjustment for Provider Preventable Conditions." State Plan, Attachment 4.19-A.
Division of Medicaid, Department of Health and Welfare, State of Idaho.

5.3. Hospital Admissions

If the surgery is elective or non-trauma, the hospital admission is reimbursed in the surgical fee. If the surgery is the result of an emergency or trauma situation, the hospital admission can be paid in addition to the surgery. Indicate in field **24C** of the CMS-1500 claim form or in the electronic claim form emergency indicator when the admission is emergency or trauma related.

See [Inpatient Stay Reviews](#) for information on Telligen, Inc. requirements and penalties.

5.4. Anesthesiology

Anesthesia claims must include the CPT® anesthesia code for the surgical procedure that was performed on the participant. Base units will be added by the system automatically and should not be billed separately. Units are equal to Medicare base units multiplied by fifteen (15). A list of Idaho Medicaid base units may be found in the [Numerical Fee Schedule](#). Base units include preoperative evaluation, reviewing the participant's medical record, and post-operative visits.

Anesthesia time begins when the anesthesiologist physically starts to prepare the participant for the induction of anesthesia in the operating room, or equivalent area, and ends when the anesthesiologist is no longer in personal attendance. Units are equal to the total amount of time in one (1) minute increments, and any necessary modifiers. Only time spent in personal attendance in the room with the participant should be counted. The anesthesiologist may account for discontinuous time by adding time before and after interruptions of personal attendance. Documentation of personal attendance should be maintained as part of the participant's record.

Idaho Medicaid limits reimbursement for anesthesia procedures to once per day. The anesthesia start date is the only date that should be used. Do not date span. A repeat anesthesia procedure on the same day that is billed with the CPT® modifier **76** or **77** will be considered included in the original payment. Medicaid considers that a second separate session of anesthesia has occurred when a patient is returned to surgery after spending time in another unit of the hospital. In these cases, Medicaid will reimburse both CPT® anesthesia codes plus the total time for both sessions, with adequate documentation.

Medicaid does not pay for supervision of anesthesia services. The provider who administers the anesthesia, either a physician or Certified Registered Nurse Anesthetist (CRNA), is paid 100 percent of the allowed amount for the procedure.

Postoperative pain management is included in the surgeon's global payment when related to the procedure. An anesthesiologist may only render services if they are separate, medically necessary and the surgeon does not have the skill or experience for treatment. The surgeon is responsible to document in the medical record the referral to the anesthesia practitioner, and why.

Ancillary services provided for a non-covered service are not eligible for reimbursement. Claims for anesthesia services may require a prior authorization number when the primary service requires a prior authorization. Anesthesia providers should obtain the prior authorization number from the facility the procedure is performed at.

Anesthesia Modifiers	
A repeat anesthesia procedure on the same day which is billed with the CPT® modifier 76 or 77 will be paid at \$0.00.	
AA	Anesthesia services personally performed by an anesthesiologist. The AA modifier is used for all basic procedures
AD	Medical supervision by a physician, more than four concurrent anesthesia procedures.
P1	Normal healthy patient.
P2	Patient with mild systemic disease
P3	Patient with severe systemic disease
P4	Patient with severe systemic disease that is a constant threat to life

Anesthesia Modifiers	
P5	Moribund patient who is not expected to survive without the operation.
QS	Monitored anesthesia care service (can be billed by CRNA or a physician). Modifier QS (Monitored Anesthesia Care) is for informational purposes. Please report actual monitoring time on the claim form. This modifier must be billed with another modifier to show that the service was personally performed or medically directed.
QX	CRNA service, with medical direction by a physician.
QZ	CRNA service, without medical direction by a physician.

5.4.1. **References: Anesthesiology**

(a) CMS Guidance

Anesthesia and Pain Management. Jurisdiction F – Medicare Part B. Noridian Healthcare Solutions.

<https://med.noridianmedicare.com/web/jfb/specialties/anesthesia-pain-management>.

Anesthesia Services Webinar. Noridian Healthcare Solutions, February 2016. Webinar.

“Chapter 2 – Anesthesia Services.” *Medicaid NCCI Policy Manual (2025)*, Centers for Medicare and Medicaid Services, Department of Health and Human Services,

<https://www.cms.gov/files/document/02-chapter2-ncci-medicaid-policy-manual-2025finalcleanpdf.pdf>.

“Chapter 12 – Physicians/Nonphysician Practitioners.” *Medicare Claims Processing Manual (2025)*, Centers for Medicare and Medicaid Services, Department of Health and Human Services,

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>.

(b) Idaho Medicaid Publications

All Anesthesia Providers, Information Release MA02-24 (8/01/2002). Division of Medicaid, Department of Health and Welfare, State of Idaho.

All Physicians and Mid-Level Practitioners, Information Release MA00-54 (2000). Division of Medicaid, Department of Health and Welfare, State of Idaho.

Anesthesia Providers, Information Release MA02-19 (1/01/2002). Division of Medicaid, Department of Health and Welfare, State of Idaho.

Anesthesia Providers, Information Release MA04-01 (2004). Division of Medicaid, Department of Health and Welfare, State of Idaho.

“**Medicaid Program Integrity Unit: Billing Anesthesia Services.**” *MedicAide Newsletter*, July 2016,

<https://www.idmedicaid.com/MedicAide%20Newsletters/July%202016%20MedicAide.pdf>.

(c) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

5.4.2. Certified Registered Nurse Anesthetist

Payments may be made directly to the certified registered nurse anesthetist (CRNA) under their individual provider number, or through an anesthesiologist group. The services of a CRNA may be billed on a UB-04 if the hospital has received an exemption from Medicare. The hospital must send Idaho Medicaid an application with a copy of the valid CRNA license and exemption attached. Exemptions must be updated annually.

(a) References: Certified Registered Nurse Anesthetist

(i) CMS Guidance

Anesthesia and Pain Management. Jurisdiction F – Medicare Part B. Noridian Healthcare Solutions.

<https://med.noridianmedicare.com/web/jfb/specialties/anesthesia-pain-management>.

Anesthesia Services Webinar. Noridian Healthcare Solutions, February 2016. Webinar.

“Chapter 2 – Anesthesia Services.” *Medicaid NCCI Policy Manual (2025)*, Centers for Medicare and Medicaid Services, Department of Health and Human Services,

<https://www.cms.gov/files/document/02-chapter2-ncci-medicaid-policy-manual-2025finalcleanpdf.pdf>.

“Chapter 12 – Physicians/Nonphysician Practitioners.” *Medicare Claims Processing Manual (2024)*, Centers for Medicare and Medicaid Services, Department of Health and Human Services,

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>.

(ii) Idaho Medicaid Publications

All Physicians and Mid-Level Practitioners, Information Release MA00-54 (2000). Division of Medicaid, Department of Health and Welfare, State of Idaho.

5.4.3. Obstetrical Anesthesia

Time for epidural anesthesia services rendered during labor is counted differently from other anesthesia services. Obstetrical neuraxial anesthesia/epidural, CPT 01967 for vaginal delivery time is not counted like general anesthesia time. Obstetrical epidural time is counted in minutes from beginning to end even if the anesthesiologist is not physically in the room. This is allowed because the anesthesiologist may attend more than one patient concurrently under continuous epidural analgesia for obstetrical deliveries.

Medications for pain relief given during the time of the epidural anesthesia are included and must not be billed as a separate procedure. Only one provider will be paid for epidural services. Medicaid does not pay for supervision of anesthesia services. The provider who administers the anesthesia, either a physician or Certified Registered Nurse Anesthetist (CRNA), is paid 100 percent of the allowed amount for the epidural procedure.

Anesthesia for Cesarean Delivery Following a Planned Vaginal Birth

Coding for scheduled cesarean deliveries can be done on a single claim line. When a delivery is planned as a vaginal delivery, but concludes as a cesarean delivery, two claim lines are required to fully describe the services. CPT codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. When an appropriately licensed and enrolled rendering/performing provider starts a planned vaginal delivery (CPT code 01967) which results in a cesarean delivery (CPT code 01968), both procedures may be billed. Do not report CPT 01968 for "standing-by" if the patient elects natural childbirth and the physician/provider doesn't perform an epidural.

Anesthesia for Sterilization at the Time of Delivery

Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session. If the sterilization and delivery are performed during different operative sessions, the time is calculated separately. All sterilization consent and documentation requirements must be met.

5.4.4. References: Obstetrical Anesthesia

(a) Idaho Medicaid Publications

"Anesthesia for Obstetrical/Maternity Services." *MedicAide Newsletter*, November 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf>.

5.5. Circumcision

Idaho Medicaid covers medically necessary circumcision. Circumcision for religious or cultural reasons are considered not covered. Common medical reasons to have a circumcision is to protect against infections of the urinary tract and the foreskin, prevent cancer, lower the risk of getting sexually transmitted diseases and prevent phimosis. Prior authorization is not required. Claims billed with circumcision CPT® codes 54150, 54160, or 54161, and related charges are reimbursable when billed with a diagnosis code listed below, or with documentation of medical necessity attached to the claim.

Preapproved Diagnoses for Circumcision	
ICD-10 Diagnoses	Description
C60.0	Malignant neoplasm of prepuce
C60.8	Malignant neoplasm of overlapping sites of penis
C63.7	Malignant neoplasm of other specified male genital organs
C63.8	Malignant neoplasm of overlapping sites of male genital organs
C79.82	Secondary malignant neoplasm of genital organs
D07.61	Carcinoma in situ of scrotum
D07.69	Carcinoma in situ of other male genital organs
D29.0	Benign neoplasm of penis
N47.0 – N47.8	Disorders of prepuce
N48.0 – N48.29	Other disorders of penis
S31.21XA – S31.25XS	Open wound of penis
S38.221A – S38.222S	Amputation of the Penis
S39.848A – S39.848S	Other specified injuries of external genitals

5.5.1. References: Circumcision

(a) Idaho Medicaid Publications

Change in Medicaid Coverage for Male Circumcision, Information Release MA05-22 (6/22/2005). Division of Medicaid, Department of Health and Welfare, State of Idaho.

(b) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

“Medical Necessity (Medically Necessary).” IDAPA 16.03.26, “Medicaid Plan Benefits,” Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

5.6. Hysterectomy

A hysterectomy is a medical procedure for removing the uterus. Hysterectomies are not covered for the sole purpose of rendering the participant unable to reproduce. Therefore, they are not considered for coverage under the [sterilization](#) policy. Hysterectomies must be prior authorized (PA) by Telligen for coverage. In addition, one of the following circumstances and supporting documentation must be met for the procedure to be reimbursed:

- The participant was advised both verbally and in writing that the hysterectomy would result in permanent sterility and the inability to bear children. Providers may either create their own form or use the [Sterilization Consent Form](#) available on Gainwell Technologies' website. If a provider elects to create their own form, they must treat it as any other standalone informed consent form. In addition to the language the provider drafts for the form, it must also contain the language verbatim in the handbook example below, the participant's name and signature, date of the surgery, Medicaid ID number or date of birth, and the date it is signed. The Medicaid ID number and date of birth can be prepopulated or printed on the form. The date of signature can be electronically populated if the participant signs electronically. Either form used must be signed by the participant, regardless of the participant's age or reproductive capabilities, and submitted with claims for the procedure. The provider may not use a copy of the handbook page in place of a consent form.
- The participant was sterile before the hysterectomy. The physician must certify this in writing and include the prior cause of sterility. The certification must be attached to claims for the procedure. Medical records are not a substitution for certification.
- The hysterectomy was necessary for a life-threatening emergency in which prior acknowledgement was not possible. The physician must certify this in writing and include a description of the emergency. The certification must be attached to claims for the procedure. Medical records are not a substitution for certification.

Medicaid may cover a hysterectomy for a participant found to be retroactively eligible for Medicaid benefits. Prior authorization requests must be submitted to Telligen retroactively. Instructions for retroactive eligibility in the [General Billing Instructions](#), Idaho Medicaid Provider Handbook must be also be followed. In the event of retroactive eligibility, one of the three scenarios above must be met for reimbursement, or additionally, if applicable, the physician may submit a written statement certifying that the participant was informed before the hysterectomy that the procedure would make them permanently incapable of reproducing. The certification must be attached to claims for the procedure. Medical records are not a substitution for certification.

If using the Sterilization Consent Form, the field for "*operation known as*" should be completed with "hysterectomy" and the form should be signed and dated by the participant.

If using a form that meets the required elements below for hysterectomy consent, but not the Sterilization Consent Form, the form may be signed either before or after the surgery has been performed. Sterilization Consent Forms must be completed before the procedure. If the hysterectomy specific form is signed after the surgery has been performed, the participant (or their documented legal guardian) must sign a statement clearly stating that they were informed, both verbally and in writing, before the surgery was performed, that the hysterectomy would render them sterile.

Example of Hysterectomy Consent Form Requirements

I have been informed orally and in writing that the hysterectomy will render me permanently incapable of reproducing. I was informed of these consequences prior to the surgery being performed.

Patient's Name: _____

Patient's Medicaid ID number or birth date: _____

Date of Surgery: _____

Signature: _____

Date of Signature: _____

Codes that require documentation attached to the claim are listed in the [Hysterectomy Procedures Appendix](#).

5.6.1. References: Hysterectomy

(a) Federal Regulations

Sterilizations, 42 C.F.R. Subpart F (1978). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol4/pdf/CFR-2023-title42-vol4-part441-subpartF.pdf>.

(b) Idaho Medicaid Publications

"Hysterectomies and Sterilizations." *MedicAide Newsletter*, May 2023, <https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf>.

"Hysterectomy Form Requirements." *MedicAide Newsletter*, May 2021, <https://www.idmedicaid.com/MedicAide%20Newsletters/May%202021%20MedicAide.pdf>.

"Hysterectomy Form Update." *MedicAide Newsletter*, January 2024, <https://www.idmedicaid.com/MedicAide%20Newsletters/January%202024%20MedicAide.pdf>.

(c) State Regulations

"Family Planning Services: Coverage and Limitations." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 222. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01(d).
Department of Administration, State of Idaho,
<https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Sterilization Procedures." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 221.01.
Department of Administration, State of Idaho,
<https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

5.7. Oral and Maxillofacial Surgery

An oral surgeon who is also enrolled as a dental provider, when performing medical surgical procedures is required to bill the appropriate CPT® code on the CMS-1500 claim form with their physician provider number and submit to Gainwell Technologies.

Extractions must be billed under the provider's dental provider number to Idaho Smiles. Idaho Smiles may require authorization for some extractions. Please call Idaho Smiles provider services at 1 (855) 233-6262 for more information.

Claims for certain dental implants must have the prior authorization documentation from Idaho Smiles attached to the claim when submitted to Gainwell Technologies.

Codes Requiring Claim Attachments from Idaho Smiles	
CPT®	Description
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete

5.7.1. References: Oral and Maxillofacial Surgery

(a) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

5.8. Subcutaneous Cardiac Rhythm Monitor

Subcutaneous cardiac rhythm monitors are only covered when a participant meets these criteria:

- Evidence of recurrent transient loss of consciousness (TLOC);
- A comprehensive evaluation with 30 days of noninvasive ambulatory cardiac monitoring that was unable to find a cause for TLOC, but cardiac arrhythmia is suspected; and
- There is likely to be a recurrence of TLOC within the battery life of the device.

Covered Codes for Subcutaneous Cardiac Rhythm Monitor	
Code	Description
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming

5.8.1. References: Subcutaneous Cardiac Rhythm Monitor

(a) Idaho Medicaid Publications

"Criteria for Subcutaneous Cardiac Rhythm Monitor." *MedicAide Newsletter*, April 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/April%202019%20MedicAide.pdf>.

(b) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

5.9. Sterilization Procedures

A sterilization is any procedure performed for the purpose of rendering a participant permanently incapable of reproducing. Sterilization coverage includes tubal ligation (by cauterization, occlusion, or ligation), salpingectomy and vasectomy as a benefit under Idaho Medicaid for participants 21 years of age and older, who are mentally competent and not institutionalized. Opportunistic salpingectomies, which are effective for sterilization and can prevent future ovarian cancer, are also covered if provided during a cesarean section or hysterectomy. Institutionalized participants are those that are involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, such as a mental hospital or other facility for the care and treatment of mental illness. Participants voluntarily committed to an inpatient program for mental health services are also considered institutionalized. [Hysterectomies](#) are not considered sterilizations under this policy.

Sterilizations do not require prior authorization from Idaho Medicaid or Telligen; however, [informed participant consent](#) and an [interpreter's statement](#), if applicable, must be obtained with strict adherence to federal regulations including mandatory waiting times. All supporting documentation must use the same name for the participant in all three (3) name fields. Claims will be denied if consent is not documented correctly. Providers may not bill the participant for errors related to completing the form.

Sterilization claims must include the consent form, court order, if applicable, and an [interpreter's statement](#), if applicable, and the ICD-10-CM code Z30.2. Procedures, other than hysterectomies, performed for a purpose other than sterilization, but that result in sterilization, instead require attached chart notes and an operative report to the claim. Codes that require documentation attached to the claim are listed in the [Sterilization Procedures Appendix](#). Should the claim deny for lack of sterilization diagnosis code Z30.2, a claim review request as detailed in the *Claim Review Request* section of [General Billing Instructions](#), Idaho Medicaid Provider Handbook, will be required for successful processing.

5.9.1. References: Sterilization Procedures

(a) Federal Regulations

Sterilizations, 42 C.F.R. Subpart F (1978). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol4/pdf/CFR-2023-title42-vol4-part441-subpartF.pdf>.

(b) Idaho Medicaid Publications

"Hysterectomies and Sterilizations." *MedicAide Newsletter*, May 2023, <https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf>.

Sterilization Consent Form Requirements, *Information Release MA06-30* (07/14/2006). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Sterilizations Incidental to Medical Procedure." *MedicAide Newsletter*, December 2017, <https://www.idmedicaid.com/MedicAide%20Newsletters/December%202017%20MedicAide.pdf>.

(c) State Regulations

"Family Planning Services: Coverage and Limitations." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 222. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Sterilization Procedures." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 221.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

5.9.2. Informed Participant Consent

A sterilization consent form must be signed by the participant, the person obtaining consent and the physician performing the procedure. An interactive Sterilization Consent Form can be downloaded from the [Gainwell Technologies Medicaid](#) website. The form, HHS-687, is available in English and Spanish. Three copies are needed – one for the patient, one for the physician, and one must be attached to the claim. Providers are required to use these forms or other forms that have been approved by the Secretary of Health and Human Services. Providers are encouraged to use these forms to prevent any possible discrepancies that may affect reimbursement.

Prior to the procedure, the participant must voluntarily sign and date the consent form in the presence of the person obtaining the consent. The participant must be at least 21 years of age, and mentally competent before signing. Mentally competent means the participant has not been declared mentally incompetent by a Federal, State or local court, unless the court has ruled the participant is competent to give consent for sterilization. All communications must be provided in a manner the participant can understand including accommodations for participants, who are blind, deaf, handicapped or speak a language other than English as their primary language. Consent does not qualify as informed if the participant is:

- In active labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other mind-altering substances.

Before the participant signs and dates the consent form, they must be advised that other medical care and federal benefits will not be withheld based on their decision to be or not be sterilized. The person obtaining consent must offer to answer any of the participant's questions about the procedure and provide a copy of the consent form. The person obtaining consent must also communicate and then certify the following occurred:

- The requirements on the consent form were verbally explained to the participant;
- The participant was advised of alternative options for birth control;
- The participant was informed that sterilization procedures are considered irreversible;
- A thorough explanation to the participant of the procedure being performed including a full description of the discomforts, risks, benefits and advantages of the procedure;
- Explain that the procedure cannot be performed except after the mandatory waiting time; and
- To the best of the person obtaining consent's knowledge and belief, the participant appeared mentally competent and knowingly and voluntarily consented to the sterilization.

The person obtaining consent may sign the form any time on or after the date the person giving consent signed the form. If the physician obtains the participant's signature, then the physician must sign both statements on the form, once as the person obtaining the consent and again as the physician performing the surgery.

The physician who performs the surgery does not need to be the physician who obtains the consent from the participant. However, the physician who performs the surgery must also sign the consent form. The performing surgeon's signature must be obtained either within three days prior to surgery or any time after the surgery. The performing physician must perform and certify that shortly before the procedure, the physician:

- Reviewed the consent form with the participant;
- Reiterated the required components performed by the person obtaining consent;
- Received a copy of a court order requiring the sterilization, if applicable, and

- To the best of the physician’s knowledge and belief, the participant appeared mentally competent and knowingly and voluntarily consented to the sterilization.

There must be a lapse of 30 days between the time the participant signs the consent form and the time the sterilization is performed. This allows the participant time to reconsider the decision to be sterilized. The form expires 180 days after the participant’s signature if the procedure is not performed.

Date signed	Participant signs form. This does not count as the first day.
Day 1	Count begins, and 30 days must lapse. This counts as the first day.
Day 31	First day surgery can be performed.
Day 180	Last day surgery can be performed.

The sterilization may be performed 72 hours after the signature if premature delivery occurs or emergency abdominal surgery is required. In the event of a premature delivery, the informed consent must be signed 30 days or more before the expected due date to qualify as a premature delivery. The surgeon must certify the reason for the exception in paragraph two of the physician’s statement of the consent form with either:

- The expected delivery date; or
- The emergency nature of the abdominal surgery.

If the participant, person obtaining consent or physician fails to complete the statement correctly, all claims regarding the sterilization, including physician, hospital, and anesthesiologist charges, may be denied. Corrections to the participant signature and signature date are not allowed. Corrections are allowed for other fields of the form.

(a) References: Informed Participant Consent

(i) Federal Regulations

Sterilizations, 42 C.F.R. Subpart F (1978). Government Printing Office,
<https://www.govinfo.gov/content/pkg/CFR-2023-title42-vol4/pdf/CFR-2023-title42-vol4-part441-subpartF.pdf>.

(ii) Idaho Medicaid Publications

“Federal Sterilization Consent Form, HHS-687.” *MedicAide Newsletter*, January 2019,
<https://www.idmedicaid.com/MedicAide%20Newsletters/January%202019%20MedicAide.pdf>.

“Sterilization Consent Form.” *MedicAide Newsletter*, September 2012,
<https://www.idmedicaid.com/MedicAide%20Newsletters/September%202012%20MedicAide.pdf>.

Sterilization Consent Form Requirements, *Information Release MA06-30* (07/14/2006).
 Division of Medicaid, Department of Health and Welfare, State of Idaho.

(iii) State Regulations

“Exceptions to Sterilization Time Requirements.” *IDAPA 16.03.26*, “*Medicaid Plan Benefits*,”
 Sec. 222.03. Department of Administration, State of Idaho,
<https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

“Family Planning Services: Procedural Requirements.” *IDAPA 16.03.26*, “*Medicaid Plan Benefits*,”
 Sec. 223. Department of Administration, State of Idaho,
<https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Sterilization." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 222.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Sterilization Procedures." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 221.01 Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

5.9.3. Interpreter's Statement

An interpreter must be provided to ensure that information is effectively communicated to any individual to be sterilized who is blind, deaf, or otherwise handicapped. An interpreter must also be provided if the participant does not understand either the language used on the consent form or spoken by the person obtaining the consent. Providers may bill Idaho Medicaid for reimbursement for oral or sign language interpreter services provided for participants. Interpreters may not bill Medicaid directly for their services.

The interpreter must certify, sign and date the consent form signed by the participant that they:

- Translated the information and advice presented orally;
- Read the consent form to the participant, and explained its contents to the participant being sterilized; and
- To the best of the interpreter's knowledge and belief, the participant understood the interpreter.

See the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for additional information about billing interpretive services.

(a) References: Interpreter's Statement

(i) Federal Regulations

Consent Form Requirements, 42 C.F.R. Sec. 441.258 (1978). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf>.

Informed Consent, 42 C.F.R. Sec. 441.257 (1978). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-part441-subpartF.pdf>.

(ii) State Regulations

"Family Planning Services: Procedural Requirements." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 223. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

5.10. Surgical Procedures for Weight Loss

Medicaid will cover bariatric surgeries, abdominoplasty, or panniculectomy when all conditions listed below are met.

- The participant must meet criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than 40, or greater than 35 with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities. The serious comorbid medical condition must be documented either by the primary physician who refers the patient for the procedure, or by a physician specializing in the participant's comorbid condition. The physician who refers the participant must not be associated by a clinic or other affiliation with the surgeons who will perform the surgery.
- The obesity is caused by a serious comorbid condition, or the obesity could aggravate the participant's cardiac, respiratory, or other systemic disease.
- The participant must have a psychiatric evaluation to determine the stability of personality at least 90 days prior to the date a request for prior authorization is submitted.
- The procedure is prior authorized by Telligen, Inc. If approval is granted, Telligen, Inc. will issue the authorization number and conduct any necessary length-of-stay reviews.
- The procedure(s) must be performed in an Idaho Medicaid-enrolled hospital that is also Medicare certified.
- Physician and hospital practices must meet national medical standards for weight loss surgery.

5.10.1. References: Surgical Procedures for Weight Loss

(a) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Weight Loss Surgical Procedures." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 114.03. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

5.10.2. Abdominoplasty or Panniculectomy

Abdominoplasty or panniculectomy is covered only with medical necessity, and a prior authorization (PA) from Telligen, Inc. Idaho Medicaid does not cover procedures for cosmetic purposes. The documentation that must accompany a request for PA includes, but is not limited to:

- Photographs of the front, side, and underside of the participant's abdomen.
- Treatment of the ulceration and skin infections involving the panniculus.
- Failure of conservative treatment, including weight loss.
- That the panniculus severely inhibits the participant's walking.
- That the participant is unable to wear a garment to hold the panniculus up.
- Other detrimental effects of the panniculus on the participant's health such as severe arthritis in the lower body.

(a) References: Abdominoplasty or Panniculectomy**(i) State Regulations**

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255>.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Types of Treatments and Procedures Not Covered." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 060.02(b). Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Weight Loss Surgical Procedure." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 112.06. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

5.11. Transplants

See the [Hospital](#), Idaho Medicaid Provider Handbook for information and coverage of organ transplants.

6. Inpatient Stay Reviews

Idaho Medicaid contracts with a Quality Improvement Organization (QIO) to conduct review on a preadmission basis for selected diagnoses and procedures and a concurrent length of stay review on hospital stays that exceed a specified number of days for facilities not under APR-DRG reimbursement.

All inpatient admissions for non-APR-DRG facilities must be reviewed by the QIO if the stay exceeds three days, except for a qualifying cesarean delivery (admitting or principal diagnosis) which needs review if the stay exceeds four days. If the patient is not discharged by the end of the third day (count the day of the admission as day one), a review must be obtained on day four, and thereafter at intervals determined by the QIO. If the review due date falls on a weekend or a holiday, the review is due by the next business day.

The QIO performs retrospective reviews for services that were not reviewed in a timely manner (penalties may apply). Retrospective reviews may also be requested from the QIO for services requiring prior authorization (PA) and for admissions longer than three days when the patient receives retroactive eligibility.

The QIO conducts post payment retrospective medical necessity and DRG validation reviews for inpatient stays for facilities under APR-DRG reimbursement.

The participant's physician or the treating facility may initiate the request for PA. Both providers are equally responsible for obtaining authorization. See procedures and instructions detailed in the [QIO Provider Manual](#) or contact the QIO.

6.1. References: Inpatient Stay Reviews

6.1.1. State Regulations

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01(d). Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"Retrospective Review." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 007.20. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

7. Prior Authorization

See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for information on billing prior authorized services.

8. Documentation

All providers are required to generate records at the time the service is delivered and to maintain documentation that supports reimbursement for services. Individual services may have additional documentation requirements. General requirements for documentation and signatures can be found in [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook, including standard retention requirements. Records limited to checklists with attendance/appointments, procedure codes, and units of time are insufficient to meet this requirement. Documentation must be signed and dated by the person delivering the service with their name clearly printed.

Healthcare providers are required to use the most recent evaluation and management (E&M) documentation guidelines to document E&M office and outpatient visits.

Documentation must be made available immediately upon request by Department personnel acting in their official capacity. Services delivered without adequate documentation are not eligible for reimbursement. Providers should only submit records for utilization management when requested by the Department. Documentation sent unsolicited, or not for a service requiring prior authorization, may not be reviewed by the Department. Unreviewed documentation does not constitute approval or authorization of a service.

8.1. References: Documentation

8.1.1. CMS Guidance

Evaluation and Management Services Guide. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf>.

8.1.2. Idaho Medicaid Publications

"Evaluation and Management Codes." *MedicAide Newsletter*, December 2020, <https://www.idmedicaid.com/MedicAide%20Newsletters/December%202020%20MedicAide.pdf>.

8.1.3. State Regulations

Administrative Remedies, Idaho Code §56-209h(3) (2018). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-209h>.

"Documentation of Services and Access to Records." *IDAPA 16.05.07*, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct," Sec. 101. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160507.pdf>.

"Records." *IDAPA 16.03.26*, "Medicaid Plan Benefits," Sec. 035. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

9. Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Idaho Medicaid reimburses healthcare provider services on a fee-for-service basis except for services provided in Rural Health Clinics (RHC), Federally Qualified Health Clinic (FQHC), or Indian Health Services (IHS). Usual and customary fees are paid up to the Medicaid maximum allowance listed in the [Numerical Fee Schedule](#). The Medicaid maximum allowance is set at 100% of the Medicare fee schedule for primary care procedures, and 90% of the Medicare fee schedule for all others. Rates are set when the code becomes covered by Idaho Medicaid, if available. Rate updates require legislative approval. Most certified nurse midwife, clinical nurse specialist, lactation consultant, nurse practitioner, pharmacist, physician assistant and registered nurse lactation consultant services are reimbursed up to 85% of the allowed maximum.

See the [IHS, FQHC and RHC Services](#), Idaho Medicaid Provider Handbook for information on encounter fees for services provided in an RHC, FQHC or IHS.

See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook regarding billing, manually priced services, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid.

Some services may be subject to a co-payment. See the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payment.

9.1. References: Reimbursement

9.1.1. Idaho Medicaid Publications

Co-payments (Co-pays), Information Release MA11-29 (11/22/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho.

House Bill 260 Budget Reductions – Provider Payments, Information Release MA11-19 (05/26/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho.

9.1.2. State Regulations

"Conditions for Payment." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

"General Payment Procedures." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 030. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Provider Payment, Idaho Code 56-265 (2020). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265>.

9.2. Modifiers

See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for requirements on using modifiers.

Modifiers Affecting Reimbursement		
Modifier	Percentage of Fee Schedule	Modifier Description
50	150%/75%	Bilateral Procedure
51	100%/50%/25%	Multiple Procedures
53	75%	Discontinued Procedure
54	80%	Surgical care only
55	20%	Post-op management only
58	100%	Staged or Related Procedure or Service By the Same Physician During the Postoperative Period
62	62.5% each	Two surgeons
78	80%	Unplanned return to operating room for a related procedure following initial procedure for related procedure during post-op period
80	20%	Assistant physician surgeon
81	20%	Minimum assistant physician surgeon
82	10%	Assistant physician surgeon when qualified resident surgeon not available
AS	20% of 85%	Assistant surgeon is a physician assistant, nurse practitioner, or clinical nurse specialist

9.3. Site of Service Differential

Idaho Medicaid reduces provider's reimbursement when certain procedures are provided in a facility setting. For these procedure codes there is a 30 percent reduction for physicians and podiatrists, and a 40 percent reduction of the Idaho Medicaid [Numerical Fee Schedule](#) for certified nurse midwives, clinical nurse specialists, nurse practitioners, pharmacists, and physician assistants in the following places of service (POS):

- 19 Outpatient Hospital-Off Campus;
- 21 Inpatient Hospital;
- 22 Outpatient Hospital;
- 23 Emergency Room – Hospital;
- 24 Ambulatory Surgical Center;
- 26 Military Treatment Facility;
- 31 Skilled Nursing Facility;
- 34 Hospice – Inpatient Care;
- 41 Ambulance – Land;
- 42 Ambulance – Air or Water;
- 51 Inpatient Psychiatric Facility;
- 52 Psychiatric Facility - Partial Hospitalization;
- 53 Community Mental Health Center;
- 56 Psychiatric Residential Treatment Center;
- 61 Comprehensive Inpatient Rehabilitation Facility; and
- 62 Comprehensive Outpatient Rehabilitation Facility.

If the space and supplies are provided by the hospital, and are included in the hospital's cost settlement, the healthcare provider or podiatrist can bill under their own provider number on the 1500 form, and there is a site of service deduction. The facility fees are billed by the hospital on their UB-04 form under the hospital provider number.

There is no site of service reduction if office space is rented from the hospital and the healthcare provider provides their own supplies. The hospital cannot use the same space, etc. to bill for services under their hospital provider number.

Refer to CMS and their Idaho regional Medicare contractor, Noridian, for a list of codes the differential affects except for virtual care services.

9.3.1. References: Site of Service Differential

(a) Idaho Medicaid Publications

"Places of Service with Site of Service Reductions." *MedicAide Newsletter*, August 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/August%202019%20MedicAide.pdf>.

"Site of Service Differential." *MedicAide Newsletter*, September 2003.

"Site of Service Differential Applied to Mid-Level Providers' Claims." *MedicAide Newsletter*, February 2015, <https://www.idmedicaid.com/MedicAide%20Newsletters/February%202015%20MedicAide.pdf>

"Site of Service Differential Will be Applied to Mid-Level Providers' Claims." *MedicAide Newsletter*, September 2014,

<https://www.idmedicaid.com/MedicAide%20Newsletters/September%202014%20MedicAide.pdf>.

"Site of Service Reduction List." *MedicAide Newsletter*, April 2018,
<https://www.idmedicaid.com/MedicAide%20Newsletters/April%202018%20MedicAide.pdf>.

9.4. Employees

Services provided by employees of a healthcare provider may not be billed directly to Idaho Medicaid. However, psychological testing services provided by a licensed psychologist or social worker who are employees of the physician, may be billed under the physician's provider number. This exception applies to testing only.

Occupational, Physical or Speech therapy services that are provided by a physician may be billed with that physician's provider number. If services are provided by a licensed therapist employed by the physician, the therapist must apply for a separate Idaho Medicaid provider number and the services billed with that number.

9.5. Misrepresentation of Services

Any representation that a service provided by a nurse practitioner, nurse midwife, licensed midwife, physical therapist, physician assistant, psychologist, social worker, or other non-physician professional was rendered as a physician service is prohibited. For the purposes of misrepresentation of services, the Department considers a non-physician professional to be any professional with a provider type or specialty enrolled by Idaho Medicaid. All providers, of a provider type and specialty eligible for enrollment, must submit claims using their own National Provider Identifier (NPI) number. Idaho rule and policy requires payment be made only for claims submitted by the enrolled provider who is physically present (not simply on-site) and performing the service.

Examples of misrepresentation of services prohibited by Idaho Medicaid includes, but is not limited to:

- 'Incident to' billing of services performed by a non-physician provider of a type or specialty enrolled by Idaho Medicaid under a physician's NPI;
- Global billing when services are rendered by two different provider types in the same group practice;
- By any provider not enrolled with Idaho Medicaid, under the NPI of any enrolled provider;
- Students or unlicensed aides of an Idaho Medicaid provider;
- Unenrolled subcontractors to an Idaho Medicaid provider; and
- For supervision of services rendered by any other provider of medical services or supplies, whether or not enrolled with Idaho Medicaid.

9.5.1. References: Misrepresentation of Services

(a) State Regulations

"Misrepresentation of Services." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 114.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

9.6. Out-of-Idaho Care

Out-of-state providers in the United States of America, who are enrolled in the Idaho Medicaid Program and have an active Idaho Medicaid provider number may render services to Idaho Medicaid participants without receiving out-of-state prior approval. All medical care provided outside the state of Idaho is subject to the same utilization review, coverage requirements, and restrictions as medical care provided within Idaho.

Idaho Medicaid does not cover services outside of the United States of America.

9.7. Locum Tenens and Reciprocal Billing Arrangements

Idaho Medicaid allows physicians to bill for locum tenens and reciprocal billing arrangements. Arrangements are not required to be in writing and may be made with one or more substitute physicians. The absent physician continues to bill and receive payment for the substitute physician's services as though they were performed by the absent physician.

Locum tenens and reciprocal billing arrangements are allowed when:

- The regular physician is unavailable to provide the services.
- The participant has arranged or seeks to receive services from their regular physician.
- The regular physician identifies the services provided by a substitute physician by appending the appropriate modifier to the procedure code on claims.
- The regular physician maintains a record of each service provided by the substitute physician and their National Provider Identifier (NPI). Records must be available to DHW upon request.
- Services are not reported separately as substitute services for an operation and/or post-operative care covered by a global fee.

Locum tenens arrangements occur when the substitute physician covers the regular physician during absences for illness, pregnancy, vacation, or continuing education. The regular physician pays the substitute physician for their services on a per diem, or similar fee-for-time basis. Locum tenens arrangements cannot exceed a period of 90 continuous days. The regular physician must use the Q6 modifier on claims for services provided by the substitute physician in a locum tenens arrangement.

Reciprocal billing arrangements occur when the substitute physician covers the regular physician during occasional absences such as on-call coverage. The absent physician agrees to cover the substitute physician later in exchange for their services. Arrangements are not to exceed a period of 14 continuous days. The regular physician must use the Q5 modifier on claims for services provided by the substitute physician in a reciprocal billing arrangement.

9.7.1. References: Locum Tenens and Reciprocal Billing Arrangements

(a) *Idaho Medicaid Publications*

All Hospitals and Physicians, *Information Release MA01-19* (2001). Division of Medicaid, Department of Health and Welfare, State of Idaho.

"Locum Tenens and Reciprocal Billing Arrangements." *MedicAide Newsletter*, December 2017, <https://www.idmedicaid.com/MedicAide%20Newsletters/December%202017%20MedicAide.pdf>.

(b) *State Regulations*

"Locum Tenens Claims and Reciprocal Billing." *IDAPA 16.03.26*, "Medicaid Plan Benefits," Sec. 114.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160326.pdf>.

Appendix A. ICD-10 Diagnosis Codes Accepted by Idaho Medicaid Supporting Medical Necessity for Cesarean Section

The following ICD-10-CM diagnosis codes have been identified as preapproved covered conditions for cesarean sections. Codes not listed require a prior authorization from Telligen.

Preapproved Diagnoses for Cesarean Sections	
ICD-10 Code	Description
A60.03	Herpesviral cervicitis
A60.04	Herpesviral vulvovaginitis
A60.9	Anogenital herpesviral infection, unspecified
O10.02	Pre-existing essential hypertension complicating childbirth
O10.12	Pre-existing hypertensive heart disease complicating childbirth
O10.22	Pre-existing hypertensive chronic kidney disease complicating childbirth
O10.32	Pre-existing hypertensive heart and chronic kidney disease complicating childbirth
O10.42	Pre-existing secondary hypertension complicating childbirth
O11.4	Pre-existing hypertension with pre-eclampsia, complicating childbirth
O12.04	Gestational edema, complicating childbirth
O12.24	Gestational edema with proteinuria, complicating childbirth
O13.4	Gestational (pregnancy-induced) hypertension without significant proteinuria, complicating childbirth
O14.04	Mild to moderate pre-eclampsia, complicating childbirth
O14.13	Severe pre-eclampsia, third trimester
O14.14	Severe pre-eclampsia complicating childbirth
O14.24	HELLP syndrome, complicating childbirth
O15.03	Eclampsia in pregnancy, third trimester
O15.1	Eclampsia in labor
O26.72	Subluxation of symphysis (pubis) in childbirth
O28.0	Abnormal hematological finding on antenatal screening of mother
O30.002 – O30.003	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second or third trimester
O30.012 – O30.013	Twin pregnancy, monochorionic/monoamniotic, second or third trimester
O30.022 – O30.023	Conjoined twin pregnancy, second or third trimester
O30.032 – O30.033	Twin pregnancy, monochorionic/diamniotic, second or third trimester
O30.042 – O30.043	Twin pregnancy, dichorionic/diamniotic, second or third trimester

Preapproved Diagnoses for Cesarean Sections	
ICD-10 Code	Description
O30.092 – O30.093	Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, second or third trimester
O30.102 – O30.103	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second or third trimester
O30.112 – O30.113	Triplet pregnancy with two or more monochorionic fetuses, second or third trimester
O30.122 – O30.123	Triplet pregnancy with two or more monoamniotic fetuses, second or third trimester
O30.132 – O30.133	Triplet pregnancy, trichorionic/triamniotic, second or third trimester
O30.192 – O30.193	Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, second or third trimester
O30.202 – O30.203	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second or third trimester
O30.212 – O30.213	Quadruplet pregnancy with two or more monochorionic fetuses, second or third trimester
O30.222 – O30.223	Quadruplet pregnancy with two or more monoamniotic fetuses, second or third trimester
O30.232 – O30.233	Quadruplet pregnancy, quadrachorionic/quadra-amniotic, second or third trimester
O30.292 – O30.293	Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, second or third trimester
O30.802 – O30.803	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, second or third trimester
O30.812 – O30.813	Other specified multiple gestation with two or more monochorionic fetuses, second or third trimester
O30.822 – O30.823	Other specified multiple gestation with two or more monoamniotic fetuses, second or third trimester
O30.832 – O30.833	Other specified multiple gestation, number of chorions and amnions are both equal to the number of fetuses, second or third trimester
O30.892 – O30.893	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, second or third trimester
O32.0XX0 – O32.0XX9	Maternal care for unstable lie
O32.1XX0 – O32.1XX9	Maternal care for breech presentation
O32.2XX0 – O32.2XX9	Maternal care for transverse and oblique lie
O32.3XX0 – O32.3XX9	Maternal care for face, brow and chin presentation
O32.4XX0 – O32.4XX9	Maternal care for high head at term

Preapproved Diagnoses for Cesarean Sections	
ICD-10 Code	Description
O32.6XX0 – O32.6XX9	Maternal care for compound presentation
O32.8XX0 – O32.8XX9	Maternal care for other malpresentation of fetus
O33.0	Maternal care for disproportion due to deformity of maternal pelvic bones
O33.1	Maternal care for disproportion due to generally contracted pelvis
O33.2	Maternal care for disproportion due to inlet contraction of pelvis
O33.3XX0 – O33.3XX9	Maternal care for disproportion due to outlet contraction of pelvis
O33.4XX0 – O33.4XX9	Maternal care for disproportion of mixed maternal and fetal origin
O33.5XX0 – O33.5XX9	Maternal care for disproportion due to unusually large fetus
O33.6XX0 – O33.6XX9	Maternal care for disproportion due to hydrocephalic fetus
O33.7XX0 – O33.7XX9	Maternal care for disproportion due to other fetal deformities
O33.8	Maternal care for disproportion of other origin
O34.12 – O34.13	Maternal care for benign tumor of corpus uteri, second or third trimester
O34.211	Maternal care for low transverse scar from previous cesarean delivery
O34.212	Maternal care for vertical scar from previous cesarean delivery
O34.29	Maternal care due to uterine scar from other previous surgery
O34.32 – O34.33	Maternal care for cervical incompetence, second or third trimester
O34.42 – O34.43	Maternal care for other abnormalities of cervix, second or third trimester
O34.512 – O34.513	Maternal care for incarceration of gravid uterus, second or third trimester
O34.522 – O34.523	Maternal care for prolapse of gravid uterus, second or third trimester
O34.532 – O34.533	Maternal care for retroversion of gravid uterus, second or third trimester
O34.592 – O34.593	Maternal care for other abnormalities of gravid uterus, second or third trimester
O34.62 – O34.63	Maternal care for abnormality of vagina, second or third trimester
O34.72 – O34.73	Maternal care for abnormality of vulva and perineum, second or third trimester
O34.82 – O34.83	Maternal care for other abnormalities of pelvic organs, second or third trimester
O40.2XX0 – O40.3XX9	Polyhydramnios

Preapproved Diagnoses for Cesarean Sections	
ICD-10 Code	Description
O41.02X0 – O41.03X9	Oligohydramnios
O41.1220 – O41.1239	Chorioamnionitis
O41.1420 – O41.1439	Placentitis
O41.8X20 – O41.8X39	Other specified disorders of amniotic fluid and membranes
O42.012 – O42.013	Preterm premature rupture of membranes, onset of labor within 24 hours of rupture, second or third trimester
O42.112 – O42.113	Premature rupture of membranes, onset of labor more than 24 hours following rupture, second or third trimester
O43.012 – O43.013	Fetomaternal placental transfusion syndrome, second or third trimester
O43.022 – O43.023	Fetus-to-fetus placental transfusion syndrome, second or third trimester
O43.112 – O43.113	Circumvallate placenta, second or third trimester
O43.122 – O43.123	Velamentous insertion of umbilical cord, second or third trimester
O43.192 – O43.193	Other malformation of placenta, second or third trimester
O43.212 – O43.213	Placenta accreta, second or third trimester
O43.222 – O43.223	Placenta increta, second or third trimester
O43.232 – O43.233	Placenta percreta, second or third trimester
O43.812 – O43.813	Placental infarction, second or third trimester
O43.892 – O43.893	Other placental disorders, second or third trimester
O44.02 – O44.03	Placenta previa specified as without hemorrhage, second or third trimester
O44.12 – O44.13	Placenta previa with hemorrhage, second or third trimester
O44.22 – O44.23	Partial placenta previa NOS or without hemorrhage, second or third trimester
O44.32 – O44.33	Partial placenta previa with hemorrhage, second or third trimester
O44.42 – O44.43	Low lying placenta NOS or without hemorrhage, second or third trimester
O44.52 – O44.53	Low lying placenta with hemorrhage, second or third trimester
O45.012 – O45.013	Premature separation of placenta with afibrinogenemia, second or third trimester

Preapproved Diagnoses for Cesarean Sections	
ICD-10 Code	Description
O45.022 – O45.023	Premature separation of placenta with disseminated intravascular coagulation, second or third trimester
O45.092 – O45.093	Premature separation of placenta with other coagulation defect, second or third trimester
O45.8X2 – O45.8X3	Other premature separation of placenta, second or third trimester
O46.012 – O46.013	Antepartum hemorrhage with afibrinogenemia, second or third trimester
O46.022 – O46.023	Antepartum hemorrhage with disseminated intravascular coagulation, second or third trimester
O46.092 – O46.093	Antepartum hemorrhage with other coagulation defect, second or third trimester
O46.8X2 – O46.8X3	Other antepartum hemorrhage, second or third trimester
O61.0 – O61.8	Failed induction of labor
O62.0 – O62.2	Abnormalities of forces of labor
O62.4 – O62.8	Abnormalities of forces of labor
O64.0XX0 – O64.0XX9	Obstructed labor due to incomplete rotation of fetal head
O64.1XX0 – O64.1XX9	Obstructed labor due to breech presentation
O64.2XX0 – O64.2XX9	Obstructed labor due to face presentation
O64.3XX0 – O64.3XX9	Obstructed labor due to brow presentation
O64.4XX0 – O64.4XX9	Obstructed labor due to shoulder presentation
O64.5XX0 – O64.5XX9	Obstructed labor due to compound presentation
O64.8XX0 – O64.8XX9	Obstructed labor due to other malposition and malpresentation
O65.0 – O65.8	Obstructed labor due to maternal pelvic abnormality
O66.0 – O66.3	Other obstructed labor
O66.41 – O66.8	Other obstructed labor
O67.0 – O67.8	Labor and delivery complicated by intrapartum hemorrhage
O68	Labor and delivery complicated by abnormality of fetal acid-base balance
O69.0XX0 - - O69.89X9	Labor and delivery complicated by umbilical cord complications

Preapproved Diagnoses for Cesarean Sections	
ICD-10 Code	Description
O71.02 – O71.1	Rupture of uterus before or during labor
O75.1	Shock during or following labor and delivery
O75.3	Other infection during labor including sepsis
O75.81	Maternal exhaustion complicating labor and delivery
O76	Abnormality in fetal heart rate and rhythm complicating labor and delivery
O77.0 – O77.8	Other fetal stress complicating labor and delivery
O88.02	Air embolism in childbirth
O88.12	Amniotic fluid embolism in childbirth
O88.22	Thromboembolism in childbirth
O88.32	Pyemic and septic embolism in childbirth
O88.82	Other embolism in childbirth
O98.72	Human immunodeficiency virus [HIV] disease complicating childbirth
O99.354	Diseases of the nervous system complicating childbirth
O99.42	Diseases of the circulatory system complicating childbirth
O99.52	Diseases of the respiratory system complicating childbirth
O99.824	Streptococcus B carrier state complicating childbirth
O9A.12	Malignant neoplasm complicating childbirth
Q42.3	Congenital absence, atresia and stenosis of anus without fistula

Appendix B. Abortion Procedures

The following CPT®/HCPCS codes have been identified as requiring documentation attached to the claim when billed with a diagnosis code identified in the [Abortions](#) section.

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
00864	Anesthesia for total removal of bladder
01966	Anesthesia for induced abortion
36415	Insertion of needle into vein for collection of blood sample
58545	Removal of growth of uterus using an endoscope, 250.0 g or less
58546	Removal of growth of uterus using an endoscope, more than 250.0 g
58555	Diagnostic exam of uterus using an endoscope
58558	Biopsy of lining of uterus and/or removal of polyp using an endoscope
58559	Release of scar tissue of uterus using an endoscope
58560	Release of scar tissue of uterus and release or removal and septum using an endoscope
58561	Removal of growth of muscle of uterus using an endoscope
58562	Removal of foreign body in uterus using an endoscope
58563	Exam of uterus with destruction of lining of uterus using an endoscope
59072	Occlusion of fetal umbilical cord using ultrasound guidance
59200	Insertion of dilator device into cervix
59200	Insertion of dilator device into cervix
59412	Turning of fetus through external manipulation
59425	Predelivery care, 4 to 6 visits
59426	Predelivery care, 7 or more visits
59430	Post delivery care
59830	Treatment of miscarriage from infection
59840	Induced abortion by dilation and scraping of uterine
59841	Induced abortion by dilation
59850	Induced abortion by amniotic fluid injection
59851	Induced abortion by injection into amniotic fluid with dilation and removal of pregnancy contents
59852	Induced abortion by injection into amniotic fluid
59855	Induced abortion by insertion of vaginal suppository
59856	Induced abortion by insertion of vaginal suppository with dilation and removal of pregnancy contents
59857	Induced abortion by insertion of vaginal suppository with incision of uterus
74018	X-ray of abdomen, 1 view
74019	X-ray of abdomen, 2 views
74021	X-ray of abdomen, minimum of 3 views
74022	X-ray series of abdomen with single X-ray of chest
74150	CT scan of abdomen without contrast

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
74160	CT scan of abdomen with contrast
74170	CT scan of abdomen before and after contrast
74174	CT scan of blood vessels of abdomen and pelvis with contrast
74175	CT scan of blood vessels of abdomen with contrast
74176	CT scan of abdomen and pelvis without contrast
74177	CT scan of abdomen and pelvis with contrast
74178	CT scan of abdomen and pelvis before and after contrast
74181	MRI scan of abdomen without contrast
74182	MRI scan of abdomen with contrast
74183	MRI scan of abdomen before and after contrast
74185	MRI scan of blood vessels of abdomen
74190	Review by radiologist of abdominal cavity lining image
74740	Review by radiologist of uterine tube and ovary image
74742	Review by radiologist of image from placement of uterine tube
74775	Imaging of anogenital region
75580	Analysis of data from CT study of heart blood vessels to assess severity of heart artery disease, with interpretation and report
76700	Complete ultrasound scan of abdomen
76705	Limited ultrasound scan of abdomen
76770	Complete ultrasound scan behind abdominal cavity
76775	Limited ultrasound scan behind abdominal cavity
76776	Ultrasound scan of transplanted kidney
76820	Ultrasound scan of fetal umbilical artery blood flow rate
76821	Ultrasound scan of fetal brain artery blood flow rate
76825	Ultrasound scan of fetal heart
76826	Follow-up ultrasound scan of fetal heart
76827	Ultrasound scan of fetal heart blood flow
76828	Follow-up ultrasound scan of fetal heart blood flow
76830	Ultrasound scan of uterus, ovaries, tubes, cervix and pelvic area through vagina
76831	Ultrasound scan of uterus and uterine cavity
76856	Complete ultrasound scan of pelvis
76857	Limited ultrasound scan of pelvis
76932	Ultrasonic guidance for biopsy of heart muscle
76936	Ultrasound guided compression repair of blood vessel
76937	Ultrasonic guidance for blood vessel access
76940	Ultrasound guidance for tissue removal
76941	Ultrasonic guidance for fetal transfusion or umbilical blood sampling
76942	Ultrasonic guidance for needle placement
76945	Ultrasonic guidance for testing placental tissue
76946	Ultrasonic guidance for removal of amniotic fluid

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
76948	Ultrasonic guidance for retrieval of egg
76965	Ultrasonic guidance for administration of radiation therapy
76975	Review by radiologist of ultrasound of digestive tract using an endoscope
76977	Ultrasound scan of bone for measuring loss
76981	Ultrasound scan of organ tissue for measuring elasticity
76982	Ultrasound scan of growth for measuring elasticity, first growth
76983	Ultrasound scan of growth for measuring elasticity, each additional growth
76984	Ultrasound of chest aorta during surgery
76987	Ultrasound of heart during surgery to evaluate for congenital heart disease, including placement and manipulation of transducer, image acquisition, and interpretation and report of results
76988	Ultrasound of heart during surgery to evaluate for congenital heart disease, including placement and manipulation of transducer and image acquisition
76989	Ultrasound of heart during surgery to evaluate for congenital heart disease, interpretation and report of results only
76998	Ultrasonic guidance during surgery
80047	Blood test, basic group of blood chemicals (Calcium, ionized)
80048	Blood test, basic group of blood chemicals (Calcium, total)
80051	Blood test panel for electrolytes (sodium potassium, chloride, carbon dioxide)
80053	Blood test, comprehensive group of blood chemicals
80055	Obstetric blood test panel
80061	Blood test, lipids (cholesterol and triglycerides)
80069	Kidney function blood test panel
80074	Acute hepatitis panel
80076	Liver function blood test panel
80143	Measurement of acetaminophen
80145	Measurement of adalimumab
80150	Amikacin (antibiotic) level
80151	Measurement of amiodarone
80155	Caffeine level
80156	Carbamazepine level, total
80157	Carbamazepine level, free
80158	Cyclosporine level
80159	Clozapine level
80161	Measurement of carbamazepine-10,11-epoxide
80162	Digoxin level, total
80163	Digoxin level, free
80164	Valproic acid level, total
80165	Valproic acid level, free
80167	Measurement of felbamate
80168	Ethosuximide level

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
80169	Everolimus level
80170	Gentamicin (antibiotic) level
80171	Gabapentin level
80173	Haloperidol level
80175	Lamotrigine level
80176	Lidocaine level
80177	Levetiracetam level
80178	Lithium level
80179	Measurement of salicylate
80180	Mycophenolate (mycophenolic acid) level
80181	Measurement of flecainide
80183	Oxcarbazepine level
80184	Phenobarbital level
80185	Phenytoin level, total
80186	Phenytoin level, free
80187	Measurement of posaconazole
80188	Primidone level
80189	Measurement of itraconazole
80190	Procainamide level
80192	Procainamide level, with metabolites
80193	Measurement of leflunomide
80194	Quinidine level
80195	Sirolimus level
80197	Tacrolimus level
80198	Theophylline level
80199	Tiagabine level
80200	Tobramycin (antibiotic) level
80201	Topiramate level
80202	Vancomycin (antibiotic) level
80203	Zonisamide level
80204	Measurement of methotrexate
80210	Measurement of rufinamide
80220	Measurement of hydroxychloroquine
80230	Measurement of infliximab
80235	Measurement of lacosamide
80280	Measurement of vedolizumab
80285	Measurement of voriconazole
80299	Quantitation of therapeutic drug
80400	Hormonal panel for adrenal gland assessment (adrenal gland insufficiency)

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
80402	Hormone panel for adrenal gland assessment (21 hydroxylase deficiency)
80406	Hormone panel adrenal gland assessment (3 beta-hydroxydehydrogenase deficiency)
80408	Aldosterone suppression evaluation panel
80410	Calcitonin stimulation panel
80412	Adrenal gland stimulation panel
80414	Reproductive hormone panel (testosterone)
80415	Reproductive hormone panel (estradiol)
80416	Renal vein renin (kidney enzyme) stimulation panel
80417	Peripheral vein renin (kidney enzyme) stimulation panel
80418	Anterior pituitary gland evaluation panel
80420	Dexamethasone (steroid) suppression evaluation panel, 48 hour
80422	Glucagon (hormone) tolerance panel to evaluate for insulinoma (pancreatic tumor)
80424	Glucagon (hormone) tolerance panel to evaluate for pheochromocytoma (adrenal gland tumor)
80426	Gonadotropin releasing hormone (reproductive hormone) panel
80428	Growth hormone stimulation panel
80430	Growth hormone suppression panel
80432	Insulin-induced C-peptide (protein) suppression panel
80434	Insulin tolerance panel for ACTH (adrenal gland hormone) insufficiency
80435	Insulin tolerance panel for growth hormone deficiency
80436	Metyrapone (hormone antibody) panel
80438	Thyrotropin releasing hormone (TRH) (hypothalamus hormone) stimulation panel, 1 hour
80439	Thyrotropin releasing hormone (TRH) (hypothalamus hormone) stimulation panel, 2 hour
80503	Pathology clinical consultation for clinical problem, 5-20 minutes
80504	Pathology clinical consultation for moderately complex clinical problem, 21-40 minutes
80505	Pathology clinical consultation for complex clinical problem, 41-60 minutes
80506	Pathology clinical consultation, additional 30 minutes
81000	Manual urinalysis test with examination using microscope, non-automated
81001	Manual urinalysis test with examination using microscope, automated
81002	Urinalysis, manual test
81003	Automated urinalysis test
81005	Analysis of urine, except immunoassays
81007	Urinalysis for bacteria
81015	Urinalysis using microscope
81020	Urinalysis, 2 or 3 glass test
81050	Urine volume measurement
81161	Gene analysis (dystrophin)
81200	Gene analysis (aspartoacylase)

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
81203	Gene analysis (adenomatous polyposis coli), duplication or deletion variants
81205	Gene analysis (branched-chain keto acid dehydrogenase E1, beta polypeptide)
81208	Translocation analysis (BCR/ABL1) other breakpoint
81209	Gene analysis (Bloom syndrome, RecQ helicase-like)
81221	Gene analysis (cystic fibrosis transmembrane conductance regular) known familial variants
81222	Gene analysis (cystic fibrosis transmembrane conductance regular) duplication or deletion variants
81225	Gene analysis (cytochrome P450, family 2, subfamily C, polypeptide 19) common variants
81226	Gene analysis (cytochrome P450, family 2, subfamily D, polypeptide 6) common variants
81227	Gene analysis (cytochrome P450, family 2, subfamily C, polypeptide 9) common variants
81244	Gene analysis (fragile X syndrome, X-linked intellectual disability) for characterization of alleles
81246	Test for detecting genes associated with blood cancer
81253	Gene analysis (gap junction protein, beta 2, 26kda, connexin 26), known familial variants
81261	Gene rearrangement analysis (immunoglobulin heavy chain locus) to detect abnormal clonal population amplified methodology
81262	Gene rearrangement analysis (immunoglobulin heavy chain locus) to detect abnormal clonal population direct probe methodology
81263	Gene rearrangement analysis (immunoglobulin heavy chain locus), variable region somatic mutation analysis
81287	Gene analysis (O-6-methylguanine-DNA methyltransferase) for promoter methylation
81287	Gene analysis (O-6-methylguanine-DNA methyltransferase) for promoter methylation
81293	Gene analysis (mutL homolog 1, colon cancer, nonpolyposis type 2) known familial variants
81296	Gene analysis (mutS homolog 2, colon cancer, nonpolyposis type 1) known familial variants
81316	Translocation analysis (PML-RARA regulated adaptor molecule 1) single breakpoint
81318	Gene analysis (postmeiotic segregation increased 2 [S cerevisiae]) known familiar variants
81322	Gene analysis (phosphatase and tensin homolog), known familial variant
81325	Gene analysis (peripheral myelin protein 22), full sequence analysis
81326	Gene analysis (peripheral myelin protein 22), known familial variant
81340	Gene analysis (T cell antigen receptor beta) amplification methodology
81341	Gene rearrangement analysis detection abnormal clonal population (T cell antigen receptor beta) direct probe methodology
81349	Genome-wide microarray analysis for copy number and loss-of-heterozygosity variants
81355	Gene analysis (vitamin K epoxide reductase complex subunit 1) common variants
81370	HLA class I and II typing low resolution HLA-A, -B, -C, -DRB1/3/4/5 and -DQB1
81371	HLA class I and II typing, low resolution HLA-A, -B, and -DRB1
81375	HLA class II typing low resolution HLA-DRB1/3/4/5 and -DQB1
81500	Genetic profiling on oncology biopsy of ovarian lesions, assays of two proteins

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
81503	Genetic profiling on oncology biopsy of ovarian lesions, assays of five proteins
81504	Genetic profiling on oncology biopsy lesions
81506	Endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, hba1c, insulin, hs-crp, adiponectin, ferritin, interleukin 2-receptor alpha), utilizing serum or plasma, algorithm reporting a risk score
81508	Fetal congenital abnormalities, biochemical assays of two proteins (papp-a, hcg [any form]), utilizing maternal serum, algorithm reported as a risk score
81509	Fetal congenital abnormalities, biochemical assays of three proteins (papp-a, hcg [any form], dia), utilizing maternal serum, algorithm reported as a risk score
81510	Fetal congenital abnormalities, biochemical assays of three analytes (afp, ue3, hcg [any form]), utilizing maternal serum, algorithm reported as a risk score
81511	Fetal congenital abnormalities, biochemical assays of four analytes (afp, ue3, hcg [any form], dia) utilizing maternal serum, algorithm reported as a risk score
81512	Fetal congenital abnormalities, biochemical assays of five analytes (afp, ue3, total hcg, hyperglycosylated hcg, dia) utilizing maternal serum, algorithm reported as a risk score
81515	Test for detection of bacteria causing vaginosis and vaginitis
81523	Next-generation sequencing of breast cancer profiling 70 content genes and 31 housekeeping genes
82009	Ketone bodies analysis, qualitative
82010	Ketone bodies analysis, quantitative
82013	Acetylcholinesterase (enzyme) level
82016	Chemical analysis for genetic disorder
82017	Chemical test for genetic disorder
82024	Adrenocorticotrophic hormone (ACTH) level
82030	Adenosine, 5-monophosphate, cyclic (cyclic AMP) level
82040	Albumin (protein) level
82042	Cerebrospinal fluid, or amniotic fluid albumin (protein) level
82043	Urine microalbumin (protein) level
82044	Urine microalbumin (protein) analysis
82045	Albumin (protein) level related to restricted heart blood flow
82075	Measurement of alcohol level in breath specimen
82085	Aldolase (enzyme) level
82088	Aldosterone hormone level
82103	Alpha-1-antitrypsin (protein) blood test, total
82104	Alpha-1-antitrypsin (protein) blood test, phenotype
82105	Alpha-fetoprotein (AFP) level, serum
82106	Alpha-fetoprotein (AFP) level, amniotic fluid
82107	Alpha-fetoprotein (AFP) analysis
82108	Aluminum level
82120	Vaginal fluid chemical analysis for bacteria
82127	Amino acid analysis, qualitative, each specimen
82128	Amino acid analysis, multiple amino acids, qualitative, each specimen
82131	Amino acid analysis, quantitative, each specimen

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
82135	Aminolevulinic acid (protein) level
82136	Amino acid level, 2 to 5 amino acids, quantitative, each specimen
82139	Amino acid level, 6 or more amino acids, quantitative, each specimen
82140	Ammonia level
82143	Amniotic fluid scan
82150	Amylase (enzyme) level
82154	Androstanediol glucuronide (hormone) level
82157	Androstenedione (hormone) level
82160	Androsterone (hormone) level
82163	Angiotensin II (protein) level
82164	Angiotensin I - converting enzyme (ACE) level
82166	Test for anti-mullerian hormone
82175	Arsenic level
82180	Ascorbic acid (Vitamin C) level, blood
82190	Measurement of substance using spectroscopy (light)
82232	Beta-2 microglobulin (protein) level
82233	Test for beta-amyloid 1-40
82234	Test for beta-amyloid 1-42
82239	Bile acids level, total
82240	Bile acids level, cholyglycine
82247	Bilirubin level, total
82248	Bilirubin level, direct
82252	Stool analysis for bilirubin
82261	Biotinidase (enzyme) level
82270	Stool analysis for blood to screen for colon tumors
82271	Specimen analysis for blood
82272	Stool analysis for blood, by peroxidase activity
82274	Stool analysis for blood, by fecal hemoglobin determination by immunoassay
82286	Bradykinin (protein) level
82300	Cadmium level
82306	Vitamin D-3 level
82308	Calcitonin (hormone) level
82310	Calcium level, total
82330	Calcium level, ionized
82331	Calcium level, after calcium infusion test
82340	Urine calcium level
82355	Analysis of stone
82360	Chemical analysis of stone
82365	Infrared analysis of stone

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
82370	X-ray analysis of stone
82373	Carbohydrate deficient transferrin (protein) level
82374	Carbon dioxide (bicarbonate) level
82375	Carboxyhemoglobin (protein) level
82376	Carboxyhemoglobin (protein) analysis
82378	Carcinoembryonic antigen (CEA) protein level
82379	Carnitine level
82380	Carotene level
82382	Catecholamines (organic nitrogen) urine level
82383	Catecholamines organic nitrogen blood level
82384	Catecholamines (organic nitrogen) level
82387	Cathepsin-D (enzyme) level
82390	Ceruloplasmin (protein) level
82397	Analysis using chemiluminescent technique (light and chemical)reaction
82415	Chloramphenicol level
82435	Blood chloride level
82436	Urine chloride level
82438	Chloride level
82441	Screening test for chlorinated hydrocarbons
82465	Cholesterol level
82480	Cholinesterase (enzyme) level, to test for exposure to chemical or liver disease
82482	Cholinesterase (enzyme) level
82485	Chondroitin B sulfate (protein) level
82495	Chromium level to test for poisoning or deficiency
82507	Citrate level
82523	Collagen cross links test, (urine test to evaluate bone health)
82525	Copper level
82528	Corticosterone (hormone) level
82530	Cortisol (hormone) measurement, free
82533	Cortisol (hormone) measurement, total
82540	Creatine measurement
82542	Chemical analysis using chromatography technique
82550	Creatine kinase (cardiac enzyme) level, total
82552	Creatine kinase (cardiac enzyme) level, isoenzymes
82553	Creatine kinase (cardiac enzyme) level, MB fraction only
82554	Creatine kinase (cardiac enzyme) level, isoforms
82565	Blood creatinine level
82570	Creatinine level to test for kidney function or muscle injury
82575	Creatinine clearance measurement to test for kidney function

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
82585	Cryofibrinogen (protein) level
82595	Cryoglobulin (protein) measurement
82600	Cyanide measurement
82607	Cyanocobalamin (vitamin B-12) level
82608	Cyanocobalamin (vitamin B-12) level, unsaturated binding capacity
82615	Cystine and homocystine (amino acids) analysis
82626	Dehydroepiandrosterone (DHEA) hormone level
82627	Dehydroepiandrosterone (DHEA-S) hormone level
82633	Desoxycorticosterone, 11 (hormone) level
82634	Deoxycortisol, 11 (hormone) level
82638	Dibucaine number (enzyme) measurement
82642	Measurement of dihydrotestosterone
82652	Dihydroxyvitamin D, 1, 25 level
82653	Measurement of pancreatic elastase (enzyme) in stool
82656	Detection of pancreatic elastase (enzyme) in stool
82657	Enzyme activity measurement, nonradioactive substrate
82658	Enzyme activity measurement, radioactive substrate
82664	Electrophoresis, laboratory testing technique
82668	Erythropoietin (protein) level
82670	Measurement of total estradiol (hormone)
82671	Estrogen analysis, fractionated
82672	Estrogen analysis, total
82677	Estriol (hormone) level
82679	Estrone (hormone) level
82693	Ethylene glycol (antifreeze) measurement
82696	Etiocholanolone (testosterone byproduct) level
82705	Stool fat or lipids analysis, qualitative
82710	Stool fat or lipids analysis, quantitative
82715	Stool fat differential measurement, quantitative
82725	Fatty acids measurement
82726	Very long chain fatty acids level
82728	Ferritin (blood protein) level
82731	Fetal fibronectin (protein) analysis
82735	Fluoride level
82746	Folic acid level, serum
82747	Folic acid level, RBC
82757	Semen fructose (carbohydrate) level
82759	Galactokinase (enzyme) level
82760	Galactose (carbohydrate) level

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
82775	Galactose-1-phosphate uridyl transferase (enzyme) level
82776	Galactose-1-phosphate uridyl transferase screening test
82784	Gammaglobulin (immune system protein) measurement
82785	IgE (immune system protein) level
82787	Gammaglobulin (immune system protein) measurement, immunoglobulin subclasses
82800	Blood pH level
82803	Blood gases measurement
82805	Blood gases measurement, with O2 saturation
82810	Blood gas, oxygen saturation measurement
82820	Hemoglobin-oxygen affinity measurement
82930	Gastric acid analysis
82938	Gastrin (GI tract hormone) level, after secretin stimulation
82941	Gastrin (GI tract hormone) level
82943	Glucagon (pancreatic hormone) level
82945	Glucose (sugar) level on body fluid
82946	Glucagon (pancreatic hormone) tolerance test
82947	Blood glucose (sugar) level
82948	Blood glucose (sugar) measurement using reagent strip
82950	Blood glucose (sugar) level after receiving dose of glucose
82951	Blood glucose (sugar) tolerance test, 3 specimens
82952	Blood glucose (sugar) tolerance test, each additional beyond 3 specimens
82955	G6PD (enzyme) level
82960	G6PD (enzyme) screening test
82962	Blood glucose (sugar) test performed by hand-held instrument
82963	Glucosidase (sugar enzyme) measurement
82965	Glutamate dehydrogenase (enzyme) measurement
82977	Glutamyltransferase (liver enzyme) level
82978	Glutathione (protein) level
82979	Glutathione reductase (enzyme) level
82985	Glycated protein level
83001	Gonadotropin, follicle stimulating (reproductive hormone) level
83002	Gonadotropin, luteinizing (reproductive hormone) level
83003	Human growth hormone level
83009	Blood test analysis for helicobacter pylori
83010	Haptoglobin (serum protein) level
83012	Haptoglobin (serum protein) measurement
83013	Breath test analysis for helicobacter pylori
83014	Administration of drug for helicobacter pylori
83015	Heavy metal screening test

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
83018	Heavy metal level
83020	Hemoglobin analysis and measurement, electrophoresis
83021	Hemoglobin analysis and measurement, chromatography
83026	Hemoglobin level
83030	Fetal hemoglobin level
83033	Fetal hemoglobin analysis
83036	Hemoglobin A1C level
83037	Hemoglobin A1C level, by device for home use
83045	Methemoglobin (hemoglobin) analysis, qualitative
83050	Methemoglobin (hemoglobin) analysis, quantitative
83051	Plasma hemoglobin level
83060	Sulfhemoglobin (hemoglobin) level
83065	Thermolabile (heat sensitive) hemoglobin level
83068	Screening test for unstable hemoglobin
83069	Urine hemoglobin level
83070	Hemosiderin (hemoglobin breakdown product) analysis
83080	b-Hexosaminidase (enzyme) level
83088	Histamine (immune system substance) level
83090	Homocysteine (amino acid) level
83150	Homovanillic acid (organic acid) level
83491	Hydroxycorticosteroids, 17 (adrenal gland hormone) level
83497	Hydroxyindolacetic acid (product of metabolism) level
83498	Hydroxyprogesterone, 17-D (synthetic hormone) level
83500	Hydroxyproline (amino acid) measurement, free
83505	Hydroxyproline (amino acid) measurement, total
83516	Analysis of substance using immunoassay technique, multiple step method
83518	Analysis of substance using immunoassay technique, single step method
83519	Measurement of substance using immunoassay technique, by radioimmunoassay
83520	Measurement of substance using immunoassay technique
83521	Measurement of immunoglobulin light chains
83525	Insulin measurement, total
83527	Insulin measurement, free
83528	Intrinsic factor (stomach protein) level
83540	Iron level
83550	Iron binding capacity
83570	Isocitric dehydrogenase (enzyme) level
83582	Ketogenic steroids (hormone) measurement
83586	Ketosteroids, 17 (hormone) measurement, total
83593	Ketosteroids, 17 (hormone) measurement, fractionation

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
83605	Lactic acid level
83615	Lactate dehydrogenase (enzyme) level
83625	Lactate dehydrogenase (enzyme) measurement
83630	Stool lactoferrin (immune system protein) analysis
83631	Stool lactoferrin (immune system protein) level
83632	Human placental lactogen (placental hormone) level
83633	Urine lactose (carbohydrate) analysis
83655	Lead level
83661	Fetal lung maturity assessment, lecithin sphingomyelin (L/S) ratio
83662	Fetal lung maturity assessment, foam stability test
83663	Fetal lung maturity assessment, fluorescence polarization
83664	Fetal lung maturity assessment, lamellar body density
83670	Leucine aminopeptidase (enzyme) level
83690	Lipase (fat enzyme) level
83695	Lipoprotein (A) level
83698	Lipoprotein-associated phospholipase A2 (enzyme) level
83700	Lipoprotein level, electrophoretic separation and quantitation
83701	Lipoprotein measurement
83704	Lipoprotein level, quantitation of lipoprotein particle number(s)
83718	HDL cholesterol level
83719	VLDL cholesterol level
83721	LDL cholesterol level
83727	Luteinizing releasing factor (reproductive hormone) level
83735	Magnesium level
83775	Malate dehydrogenase (enzyme) level
83785	Manganese (heavy metal) level
83789	Mass spectrometry (laboratory testing method)
83825	Mercury level
83835	Metanephrines level
83857	Methemalbumin (protein) level
83861	Microfluid analysis of tears
83864	Mucopolysaccharides (protein) level
83872	Joint fluid diagnostic test
83873	Myelin basic protein (nerve protein) level, spinal fluid
83874	Myoglobin (muscle protein) level
83876	Myeloperoxidase (white blood cell enzyme) measurement
83880	Natriuretic peptide (heart and blood vessel protein) level
83883	Nephelometry, test method using light
83884	Test for neurofilament light chain

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
83885	Nickel level
83915	Nucleotidase 5' (enzyme) level
83916	Measurement of immune substance (oligoclonal bands)
83918	Organic acids level
83919	Organic acids analysis
83921	Organic acid level
83930	Blood osmolality (concentration) measurement
83935	Urine osmolality (concentration) measurement
83937	Osteocalcin (bone protein) level
83945	Oxalate level
83950	HER-2 oncoprotein (cancer related gene) measurement
83951	Oncoprotein (cancer related gene) measurement
83970	Parathormone (parathyroid hormone) level
83986	Body fluid pH level
83987	pH exhaled breath
83993	Stool calprotectin (protein) level
84030	Phenylalanine, PKU (amino acid) level
84035	Phenylketones (ketone) analysis
84060	Phosphatase (enzyme) measurement, acid, total
84066	Phosphatase, prostatic (prostate enzyme) level
84075	Phosphatase (enzyme) level, alkaline
84078	Phosphatase (enzyme) level, alkaline, heat stable
84080	Phosphatase (enzyme) measurement, alkaline, isoenzymes
84081	Phosphatidylglycerol (amniotic fluid organic acid) level
84085	Phosphogluconate, 6, dehydrogenase (enzyme) level
84087	Phosphohexose isomerase (enzyme) level
84100	Phosphate level
84105	Urine phosphate level
84106	Urine porphobilinogen (metabolism substance) analysis
84110	Urine porphobilinogen (metabolism substance) level
84112	Cervicovaginal secretion of placenta protein
84119	Urine porphyrins (metabolism substance) analysis
84120	Urine porphyrins (metabolism substance) measurement
84126	Stool porphyrins (metabolism substance) level
84132	Blood potassium level
84133	Urine potassium level
84134	Prealbumin (protein) level
84135	Pregnanediol (reproductive hormone) level
84138	Pregnanetriol (reproductive hormone) level

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
84140	Pregnenolone (reproductive hormone) level
84143	17-hydroxypregnenolone (hormone) level
84144	Progesterone (reproductive hormone) level
84145	Procalcitonin (hormone) level
84146	Prolactin (milk producing hormone) level
84150	Prostaglandin (hormone) level
84152	PSA (prostate specific antigen) measurement, complexed
84153	PSA (prostate specific antigen) measurement, total
84154	PSA (prostate specific antigen) measurement, free
84155	Total protein level, blood
84156	Total protein level, urine
84157	Total protein level, body fluid
84160	Total protein level
84163	Pregnancy-associated plasma protein-A level
84165	Protein measurement, serum
84166	Protein measurement, body fluid
84181	Protein measurement
84182	Protein measurement, immunological probe for band identification
84202	Protoporphyrin (metabolism substance) level
84203	Protoporphyrin (metabolism substance) screening test
84206	Proinsulin (pancreatic hormone) level
84207	Vitamin B-6 level
84210	Pyruvate (organic acid) level
84220	Pyruvate kinase (enzyme) level
84228	Quinine (drug) level
84233	Estrogen receptor analysis
84234	Progesterone (reproductive hormone) receptor analysis
84235	Hormone receptor analysis
84238	Chemical receptor analysis
84244	Renin (kidney enzyme) level
84252	Vitamin B-2 (riboflavin) level
84255	Selenium (vitamin) level
84260	Serotonin (hormone) level
84270	Sex hormone binding globulin (protein) level
84275	Sialic acid (organic acid) level
84285	Silica (silicon) level
84295	Blood sodium level
84300	Urine sodium level
84302	Sodium level

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
84305	Somatomedin (growth factor) level
84307	Somatostatin (growth hormone inhibitor) level
84311	Chemical analysis using spectrophotometry (light)
84315	Specific gravity (liquid weight) measurement
84375	Carbohydrate (sugar) analysis
84376	Carbohydrate analysis, single qualitative
84377	Carbohydrate analysis, multiple qualitative
84378	Carbohydrate analysis, single quantitative
84379	Carbohydrate analysis, multiple quantitative
84392	Urine sulfate (acid) level
84393	Test for phosphorylated Tau protein
84394	Test for total Tau protein
84402	Testosterone (hormone) level, free
84403	Testosterone (hormone) level, total
84410	Testosterone level
84425	Vitamin B-1 (thiamine) level
84430	Thiocyanate (organic sulfur substance) level
84431	Urine analysis for thromboxane (lipid)
84432	Thyroglobulin (thyroid related hormone) level
84433	Evaluation of thiopurine S-methyltransferase (TPMT)
84436	Thyroxine (thyroid chemical), total
84437	Thyroxine (thyroid chemical), requiring elution
84439	Thyroxine (thyroid chemical), free
84442	Thyroxine binding globulin (thyroid related protein) level
84443	Blood test, thyroid stimulating hormone (TSH)
84445	Thyroid stimulating immune globulins (thyroid related protein) level
84446	Vitamin E level
84449	Transcortin (cortisol binding protein) level
84450	Liver enzyme (SGOT), level
84460	Liver enzyme (SGPT), level
84466	Transferrin (iron binding protein) level
84478	Triglycerides level
84479	Thyroid hormone evaluation
84480	Thyroid hormone, T3 measurement, total
84481	Thyroid hormone, T3 measurement, free
84482	Thyroid hormone, T3 measurement, reverse
84484	Troponin (protein) analysis, quantitative
84485	Trypsin (pancreatic enzyme) measurement, intestinal fluid
84488	Trypsin (pancreatic enzyme) analysis, stool

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
84490	Stool trypsin (pancreatic enzyme) analysis, 24-hour collection
84510	Tyrosine (amino acid) level
84512	Troponin (protein) analysis, qualitative
84520	Urea nitrogen level to assess kidney function, quantitative
84525	Urea nitrogen level to assess kidney function, semiquantitative
84540	Urea nitrogen level to assess kidney function, urine
84545	Urea nitrogen level to assess kidney function, clearance
84550	Uric acid level, blood
84560	Uric acid level
84577	Urobilinogen (metabolism substance) level, stool
84578	Urobilinogen (metabolism substance) analysis, urine
84580	Urobilinogen (metabolism substance) level, urine
84583	Urobilinogen (metabolism substance) measurement, urine
84585	Urine vanillylmandelic acid
84586	Vasoactive intestinal peptide (intestinal hormone) level
84588	ADH (antidiuretic hormone) level
84590	Vitamin A level
84591	Vitamin measurement
84597	Vitamin K level
84600	Volatile chemical measurement
84620	Xylose (carbohydrate) absorption test of blood and/or urine
84630	Zinc level
84681	C-peptide (protein) level
84702	Gonadotropin, chorionic (reproductive hormone) level
84703	Gonadotropin (reproductive hormone) analysis
84704	Gonadotropin, chorionic (reproductive hormone) measurement
84830	Ovulation tests
85002	Bleeding time
85004	White blood cell count
85007	Microscopic examination for white blood cells with manual cell count
85008	Microscopic examination for white blood cells
85009	Manual white blood cell count and evaluation
85013	Red blood cell hemoglobin concentration
85014	Red blood cell concentration measurement
85018	Blood count, hemoglobin
85025	Complete blood cell count (red cells, white blood cell, platelets), automated test and automated differential white blood cell count
85027	Complete blood cell count (red cells, white blood cell, platelets), automated test
85032	Manual blood cell count
85041	Red blood cell count, automated test

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
85044	Red blood count, manual test
85045	Red blood count, automated test
85046	Red blood count automated, with additional calculations
85048	Automated white blood cell count
85049	Platelet count, automated test
85060	Blood smear interpretation by physician with written report
85097	Bone marrow, smear interpretation
85130	Assessment of blood clotting function
85170	Blood clot evaluation, (retraction time)
85175	Blood clot evaluation, (clot dissolving time)
85210	Clotting factor II prothrombin, measurement
85220	Clotting factor V (AcG or proaccelerin) measurement
85230	Clotting factor VII (proconvertin, stable factor)
85240	Clotting factor VIII (AHG) measurement
85244	Clotting factor VIII related antigen measurement
85245	Clotting factor VIII (VW factor) measurement
85246	Clotting factor VIII (VW factor) antigen
85247	Clotting factor VIII (von Willebrand factor) measurement
85250	Clotting factor IX (PTC or Christmas) measurement
85260	Clotting factor X (Stuart-Prower) measurement
85270	Clotting factor XI (PTA) measurement
85280	Clotting factor XII (Hageman) measurement
85290	Clotting factor XIII (fibrin stabilizing) measurement
85291	Clotting factor XIII (fibrin stabilizing) screening test
85292	Fletcher factor (clotting factor) measurement
85293	Fitzgerald factor (clotting factor) measurement
85300	Antithrombin III antigen (clotting inhibitor) activity
85301	Antithrombin III antigen (clotting inhibitor) level
85302	Protein C, (clotting inhibitor) activity
85303	Protein C antigen (clotting inhibitor) measurement
85305	Protein S (clotting inhibitor) level
85306	Protein S (clotting inhibitor) measurement
85307	Activated protein resistance assay
85335	Clotting factor inhibitor test
85337	Thrombomodulin (coagulation protein) measurement
85345	Coagulation time measurement, Lee and White
85347	Coagulation time measurement, activated
85348	Coagulation time measurement, other methods
85360	Euglobulin lysis (clot dissolving) measurement

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
85362	Coagulation function analysis, agglutination slide, semiquantitative
85366	Coagulation function measurement, paracoagulation
85370	Coagulation function measurement, quantitative
85378	Coagulation function measurement, qualitative or semiquantitative
85379	Coagulation function measurement, D-dimer; quantitative
85380	Coagulation function measurement, ultrasensitive, qualitative or semiquantitative
85384	Fibrinogen (factor 1) activity measurement
85385	Fibrinogen (factor 1) antigen detection
85390	Coagulation function screening test with interpretation and report
85397	Measurement of blood coagulation and fibrinolysis (clot dissolving) function
85400	Plasmin (fibrinolytic factor) measurement
85410	Alpha-2 antiplasmin (factor inhibitor) measurement
85415	Plasminogen activator (fibrinolytic factor) measurement
85420	Plasminogen (fibrinolytic factor) measurement
85421	Plasminogen antigenic (factor inhibitor) measurement
85441	Evaluation of red blood cell defect (Heinz bodies), direct
85445	Evaluation of red blood cell defect (Heinz bodies), induced
85460	Fetal hemoglobin or red blood cells measurement for assessment of fetal-maternal circulation, differential lysis
85461	Fetal hemoglobin or red blood cells measurement for assessment of fetal-maternal circulation, rosette
85475	Measurement of hemolysin (red blood cell destructive substance)
85520	Heparin assay
85525	Heparin neutralization test
85530	Heparin therapy assessment
85536	Blood smear for iron
85540	White blood cell alkaline phosphatase (enzyme) measurement with cell count
85547	Red blood cell fragility measurement
85549	White blood cell enzyme activity measurement
85555	Red blood cell fragility measurement, unincubated
85557	Red blood cell fragility measurement, incubated
85576	Platelet aggregation function test
85597	Platelet function test
85598	Phospholipid test
85610	Blood test, clotting time
85611	Blood test, clotting time, substitution
85612	Clotting factor X assessment test, undiluted
85613	Clotting factor X assessment test, diluted
85635	Blood coagulation screening test
85651	Red blood cell sedimentation rate, to detect inflammation, non-automated

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
85652	Red blood cell sedimentation rate, to detect inflammation, automated
85660	Red blood cell sickling measurement
85670	Thrombin time, fibrinogen screening test, plasma
85675	Thrombin time, fibrinogen screening test, titer
85705	Thromboplastin inhibition (circulating anticoagulant) measurement
85730	Coagulation assessment blood test, plasma or whole blood
85732	Coagulation assessment blood test, substitution, plasma fractions
85810	Blood viscosity measurement
86000	Measurement of antibody to infectious organism
86001	Measurement of antibody (IgG) to allergic substance, each allergen
86003	Measurement of antibody (IgE) to allergic substance, crude allergen extract, each
86005	Measurement of antibody (IgE) to allergic substance, multiallergen screen
86008	Measurement of antibody (IgE) to allergic substance, recombinant or purified component, each
86015	Measurement of Actin (smooth muscle) antibody
86021	Antibody identification test for white blood cell antibodies
86022	Antibody identification test, platelet antibodies
86023	Antibody identification test, platelet associated immunoglobulin assay
86036	Screening test for antineutrophil cytoplasmic antibody
86037	Antineutrophil cytoplasmic antibody titer
86038	Screening test for autoimmune disorder
86039	Measurement of antibody for assessment of autoimmune disorder, titer
86041	Test for acetylcholine receptor binding antibody
86042	Test for acetylcholine receptor blocking antibody
86043	Test for acetylcholine receptor modulating antibody
86051	ELISA detection of aquaporin-4 (neuromyelitis optica [NMO]) antibody
86052	Cell-based immunofluorescence (CBA) detection of aquaporin-4 (neuromyelitis optica [NMO]) antibody
86053	Flow cytometry detection of aquaporin-4 (neuromyelitis optica [NMO]) antibody
86060	Measurement for Strep antibody (strep throat)
86063	Screening test for Strep antibody (strep throat)
86077	Blood bank physician services for cross match and/or evaluation and written report
86078	Blood bank physician services for investigation of transfusion reaction with written report
86079	Blood bank physician services with written report
86140	Measurement C-reactive protein for detection of infection or inflammation
86141	Measurement C-reactive protein for detection of infection or inflammation, high sensitivity
86146	Beta 2 glycoprotein 1 antibody (autoantibody) measurement
86147	Cardiolipin antibody (tissue antibody) measurement
86148	Phospholipid antibody (autoimmune antibody) measurement

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
86152	Cell enumeration using immunologic selection and identification in fluid specimen
86153	Cell enumeration using immunologic selection and identification in fluid specimen, physician interpretation and report
86155	Measurement of white blood cell function
86156	Measurement of cold agglutinin (protein) to screen for infection or disease
86157	Measurement of cold agglutinin (protein) to detect infection or disease
86160	Measurement of complement (immune system proteins), antigen,
86161	Measurement of complement function (immune system proteins)
86162	Measurement of complement (immune system proteins), total hemolytic
86171	Measurement of complement fixation tests (immune system proteins)
86200	Measurement of antibody for rheumatoid arthritis assessment
86215	Measurement of DNA antibody
86225	Measurement of DNA antibody, native or double stranded
86226	Measurement of DNA antibody, single stranded
86231	Detection of endomysial antibody (EMA)
86235	Measurement of antibody for assessment of autoimmune disorder, any method
86255	Screening test for antibody to noninfectious agent
86256	Measurement of antibody to noninfectious agent
86258	Detection of gliadin (deamidated) (DGP) antibody
86277	Measurement of growth hormone antibody
86280	Measurement of immune system protein
86294	Immunologic analysis for detection of tumor antigen, qualitative or semiquantitative
86300	Immunologic analysis for detection of tumor antigen, quantitative; CA 15-3
86301	Immunologic analysis for detection of tumor antigen, quantitative; CA 19-9
86304	Immunologic analysis for detection of tumor antigen, quantitative; CA 125
86308	Screening test for mononucleosis (mono)
86309	Mononucleosis antibody level, titer
86310	Mononucleosis antibody level, titers after absorption
86316	Analysis for detection of tumor marker
86317	Detection of infectious agent antibody, quantitative
86318	Test for detection of infectious agent antibody, qualitative or semiquantitative
86320	Immunologic analysis technique on serum
86325	Immunologic analysis technique on body fluid
86329	Immunologic analysis technique, unspecified
86331	Immunologic analysis for detection of antigen or antibody
86332	Immune complex measurement
86334	Immunologic analysis technique on serum (immunofixation)
86335	Immunologic analysis technique on body fluid, other fluids with concentration
86336	Inhibin A (reproductive organ hormone) measurement

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
86337	Insulin antibody measurement
86340	Intrinsic factor (stomach protein) antibody measurement
86341	Islet cell (pancreas) antibody measurement
86343	White blood cell histamine (immune system chemical) release test
86344	White blood cell function measurement
86352	Analysis of cell function and analysis for genetic marker
86353	White blood cell function measurement, mitogen or antigen induced blastogenesis
86355	Total cell count for B cells (white blood cells)
86357	Total cell count for natural killer cells (white blood cell)
86359	T cells count, total
86360	T cell count and ratio, including ratio
86361	T cell count and ratio
86362	Cell-based immunofluorescence (CBA) detection of myelin oligodendrocyte glycoprotein (MOG-IgG1) antibody
86363	Flow cytometry detection of myelin oligodendrocyte glycoprotein (MOG-IgG1) antibody
86364	Measurement of tissue transglutaminase
86366	Test for muscle-specific kinase antibody
86367	Stem cells count, total
86376	Microsomal antibodies (autoantibody) measurement
86381	Measurement of mitochondrial antibody
86382	Viral neutralization test to detect viral antibody level
86384	Nitroblue tetrazolium dye test to measure white blood cell function
86386	Protein test for diagnosis and monitoring of bladder cancer
86403	Screening test for presence of antibody
86406	Antibody level measurement
86430	Rheumatoid factor analysis
86431	Rheumatoid factor level
86480	Tuberculosis test, gamma interferon
86481	Tuberculosis test, enumeration of T-cells
86485	Skin test for candida (yeast)
86510	Skin test histoplasmosis (parasite infection)
86580	Skin test for tuberculosis
86581	Test for streptococcus pneumonia antibody
86590	Measurement of antibody to streptokinase (enzyme)
86592	Syphilis detection test
86593	Syphilis test
86596	Measurement of voltage-gated calcium channel antibody
86602	Analysis for antibody to actinomyces (bacteria)
86603	Analysis for antibody to adenovirus (respiratory virus)

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
86606	Analysis for antibody to aspergillus (fungus)
86609	Analysis for antibody bacteria
86611	Analysis for antibody to Bartonella (bacteria)
86612	Analysis for antibody to blastomyces (fungus)
86615	Analysis for antibody bordetella (respiratory bacteria)
86617	Confirmation test for antibody to Borrelia burgdorferi (Lyme disease bacteria)
86618	Analysis for antibody Borrelia burgdorferi (Lyme disease bacteria)
86619	Analysis for antibody to Borrelia (relapsing fever bacteria)
86622	Analysis for antibody to Brucella (bacteria)
86625	Analysis for antibody to Campylobacter (intestinal bacteria)
86628	Analysis for antibody to Candida (yeast)
86631	Analysis for antibody to Chlamydia (bacteria)
86632	Analysis for antibody (Igm) to Chlamydia (bacteria)
86635	Analysis for antibody to Coccidioides (bacteria)
86638	Analysis for antibody to Coxiella burnetii (Q fever bacteria)
86641	Analysis for antibody to Cryptococcus (yeast)
86644	Analysis for antibody to Cytomegalovirus (CMV)
86645	Analysis for antibody (IgM) to Cytomegalovirus (CMV)
86648	Analysis for antibody to Diphtheria (bacteria)
86651	Analysis for antibody to La crosse (California) virus (encephalitis causing virus)
86652	Analysis for antibody to Eastern equine virus (viral encephalitis)
86653	Analysis for antibody to St. Louis virus (viral encephalitis)
86654	Analysis for antibody to Western equine virus (viral encephalitis)
86658	Analysis for antibody to Enterovirus (gastrointestinal virus)
86663	Analysis for antibody to Epstein-Barr virus (mononucleosis virus), early antigen
86664	Analysis for antibody to Epstein-Barr virus (mononucleosis virus), nuclear antigen
86665	Analysis for antibody to Epstein-Barr virus (mononucleosis virus), viral capsid
86666	Analysis for antibody to Ehrlichia (bacteria transmitted by ticks)
86668	Analysis for antibody to Francisella tularensis (bacteria transmitted by rodents)
86671	Analysis for antibody to fungus
86674	Analysis for antibody to Giardia lamblia (intestinal parasite)
86677	Analysis for antibody to Helicobacter pylori (gastrointestinal bacteria)
86682	Analysis for antibody to helminth (intestinal worm)
86684	Analysis for antibody to Haemophilus influenza (respiratory bacteria)
86687	Analysis for antibody to Human T-cell lymphotropic virus, type 1 (HTLV-1)
86688	Analysis for antibody to Human T-cell lymphotropic virus, type 2 (HTLV-2)
86689	Confirmation test for antibody to Human T-cell lymphotropic virus (HTLV) or HIV
86692	Analysis for antibody to Hepatitis D virus
86694	Analysis for antibody to Herpes simplex virus

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
86695	Analysis for antibody to Herpes simplex virus, type 1
86696	Analysis for antibody to Herpes simplex virus, type 2
86698	Analysis for antibody to histoplasma (fungus)
86701	Analysis for antibody to HIV -1 virus
86702	Analysis for antibody to HIV-2 virus
86703	Analysis for antibody to HIV-1 and HIV-2 virus
86704	Hepatitis B core antibody measurement
86705	Hepatitis B core antibody (IgM) measurement
86706	Hepatitis B surface antibody measurement
86707	Hepatitis Be antibody measurement
86708	Measurement of Hepatitis A antibody
86709	Measurement of Hepatitis A antibody (IgM)
86710	Analysis for antibody to Influenza virus
86711	Analysis for antibody to john cunningham virus
86713	Analysis for antibody to Legionella (waterborne bacteria)
86717	Analysis for antibody to Leishmania (parasite)
86720	Analysis for antibody to Leptospira
86723	Analysis for antibody to Listeria monocytogenes (bacteria)
86727	Analysis for antibody to lymphocytic choriomeningitis virus (viral meningitis)
86732	Analysis for antibody to mucormycosis (fungus)
86735	Analysis for antibody to mumps virus
86738	Analysis for antibody to Mycoplasma (bacteria)
86741	Analysis for antibody to Neisseria meningitidis (bacterial meningitis)
86744	Analysis for antibody to Nocardia (bacteria)
86747	Analysis for antibody to parvovirus
86750	Analysis for antibody to Plasmodium (malaria parasite)
86753	Analysis for antibody to protozoa (parasite)
86756	Analysis for antibody to respiratory syncytial virus (RSV)
86757	Analysis for antibody to Rickettsia (bacteria)
86759	Analysis for antibody to Rotavirus (intestinal virus)
86762	Analysis for antibody to Rubella (German measles virus)
86765	Analysis for antibody to Rubeola (measles virus)
86768	Analysis for antibody to Salmonella (intestinal bacteria)
86771	Analysis for antibody to Shigella (intestinal bacteria)
86774	Analysis for antibody to tetanus bacteria (Clostridium tetanus)
86777	Analysis for antibody to Toxoplasma (parasite)
86778	Analysis for antibody (IgM) to Toxoplasma (parasite)
86780	Analysis for antibody, Treponema pallidum
86784	Analysis for antibody to Trichinella (worm parasite)

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
86787	Analysis for antibody to varicella-zoster virus (chicken pox)
86788	Analysis for antibody (IgM) to West Nile virus
86789	Analysis for antibody to West Nile virus
86790	Analysis for antibody to virus
86793	Analysis for antibody to Yersinia (bacteria)
86800	Thyroglobulin (thyroid protein) antibody measurement
86803	Hepatitis C antibody measurement
86804	Confirmation test for Hepatitis C antibody
86805	Immunologic analysis for autoimmune disease, with titration
86806	Immunologic analysis for autoimmune disease, without titration
86807	Transplant antibody measurement, standard method
86808	Transplant antibody measurement, quick method
86812	Immunologic analysis for autoimmune disease, A, B, or C, single antigen
86813	Immunologic analysis for autoimmune disease, A, B, or C, multiple antigens
86816	Immunologic analysis for autoimmune disease, DR/DQ, single antigen
86817	Immunologic analysis for autoimmune disease, DR/DQ, multiple antigens
86821	Immunologic analysis for autoimmune disease, lymphocyte culture, mixed
86825	Immunologic analysis for organ transplant, first serum sample or dilution
86826	Immunologic analysis for organ transplant, each additional serum sample or sample dilution
86828	Assessment of antibodies to Class I and Class II human leukocyte antigens (HLA) antigens
86829	Assessment of antibodies to Class I or Class II human leukocyte antigens (HLA) antigens
86830	Assessment of antibody to human leukocyte antigens (HLA) with antibody identification by qualitative panel using complete HLA phenotypes, HLA class I
86831	Assessment of antibody to human leukocyte antigens (HLA) with antibody identification by qualitative panel using complete HLA phenotypes, HLA class II
86832	Assessment of antibody to human leukocyte antigens (HLA) with high definition qualitative panel for identification of antibody specificities, HLA class I
86833	Assessment of antibody to human leukocyte antigens (HLA) with high definition qualitative panel for identification of antibody specificities, HLA class II
86834	Assessment of antibody to human leukocyte antigens (HLA), HLA class I
86835	Assessment of antibody to human leukocyte antigens (HLA) with solid phase assays, HLA class II
86850	Screening test for red blood cell antibodies
86860	Removal of antibodies from surface of red blood cell
86870	Identification of red blood cell antibodies
86880	Red blood cell antibody detection test, direct
86885	Red blood cell antibody detection test, indirect
86886	Red blood cell antibody level
86890	Processing and storage of blood unit or component, predeposited
86891	Processing and storage of blood unit or component, intra- or postoperative salvage
86900	Blood group typing (ABO)

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
86901	Blood typing for Rh (D) antigen
86902	Screening test for compatible blood unit, using reagent serum
86904	Screening test for compatible blood unit, using patient serum
86905	Blood typing for red blood cell antigens
86906	Blood typing Rh phenotyping
86910	Blood typing for paternity testing (ABO, Rh and MN)
86911	Blood typing for paternity testing, each additional antigen system
86920	Blood unit compatibility test, immediate spin technique
86921	Blood unit compatibility test, incubation technique
86922	Blood unit compatibility test, antiglobulin technique
86927	Thawing of fresh frozen plasma unit
86930	Freezing of blood unit
86931	Thawing of blood unit
86932	Freezing and thawing of blood unit
86940	Red blood cell antibody screening test
86941	Red blood cell antibody measurement
86965	Pooling of platelets or other blood products
87003	Animal inoculation, small animal with observation and dissection
87015	Concentration of specimen for infectious agents
87040	Bacterial blood culture
87045	Stool culture
87046	Stool culture, additional pathogens
87070	Bacterial culture, any other source except urine, blood or stool, aerobic
87071	Bacterial culture and colony count
87073	Bacterial culture and colony count for anaerobic bacteria
87075	Bacterial culture, any source, except blood, anaerobic
87076	Bacterial culture for anaerobic isolates
87077	Bacterial culture for aerobic isolates
87081	Screening test for pathogenic organisms
87084	Screening test for pathogenic organisms with colony count
87086	Bacterial colony count, urine
87088	Bacterial urine culture
87101	Fungal culture (mold or yeast) of skin, hair, or nail
87102	Fungal culture (mold or yeast)
87103	Fungal blood culture (mold or yeast)
87106	Fungal culture, yeast
87107	Culture for identification of yeast
87109	Mycoplasma culture
87110	Culture for chlamydia

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
87116	Culture for acid-fast bacilli
87118	Identification of mycobacteria (TB or TB like organism)
87140	Identification of organisms by immunologic analysis, immunofluorescent method
87143	Identification of organism using chromatography
87147	Identification of organisms by immunologic analysis, other than immunofluorescence method
87149	Identification of organisms by genetic analysis, direct probe technique
87150	Identification of organisms by genetic analysis, amplified probe technique
87152	Identification of organism by pulse field gel typing
87153	Identification of organisms by nucleic acid sequencing method
87158	Microbial identification
87164	Dark field microscopic examination for organism, includes specimen collection
87166	Dark field microscopic examination for organism, without collection
87168	Macroscopic examination (visual inspection) of insect
87169	Macroscopic examination (visual inspection) of parasite
87172	Pinworm test
87176	Tissue preparation for culture
87177	Smear for parasites
87181	Evaluation of antimicrobial drug (antibiotic, antifungal, antiviral), agar dilution method
87184	Evaluation of antimicrobial drug (antibiotic, antifungal, antiviral)
87185	Detection of antimicrobial drug (antibiotic, antifungal, antiviral)
87186	Evaluation of antimicrobial drug (antibiotic, antifungal, antiviral), microdilution or agar dilution
87187	Evaluation of antimicrobial drug (antibiotic, antifungal, antiviral), microdilution or agar dilution, each plate
87188	Evaluation of antimicrobial drug (antibiotic, antifungal, antiviral), macrobroth dilution method
87190	Antimicrobial study, mycobacteria (TB organism family)
87197	Evaluation of antibiotic therapy
87205	Special Gram or Giemsa stain for microorganism
87206	Special fluorescent and/or acid fast stain for microorganism
87207	Special stain for inclusion bodies or parasites
87209	Special stain for parasites
87210	Smear for infectious agents
87220	Tissue fungi or parasites
87230	Microbial toxin or antitoxin assay
87250	Inoculation of embryonated eggs, or small animal for virus isolation
87252	Tissue culture inoculation for virus isolation
87253	Tissue culture for virus isolation
87254	Virus isolation, centrifuge enhanced
87255	Virus isolation

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
87260	Detection test for adenovirus (virus)
87265	Detection test for bordetella pertussis or parapertussis (respiratory bacteria)
87269	Detection test by immunofluorescent technique for giardia (intestinal parasite)
87270	Detection test by immunofluorescent technique for chlamydia
87271	Detection test by immunofluorescent technique for cytomegalovirus (CMV)
87272	Detection test by immunofluorescent technique for cryptosporidium (parasite)
87273	Detection test by immunofluorescent technique for herpes simplex virus type 2
87274	Detection test by immunofluorescent technique for herpes simplex virus type 1
87275	Detection test by immunofluorescent technique for influenza B virus
87276	Detection test by immunofluorescent technique for influenza A virus
87278	Detection test by immunofluorescent technique for legionella pneumophila (water borne bacteria)
87279	Detection test by immunofluorescent technique for parainfluenza virus
87280	Detection test by immunofluorescent technique for respiratory syncytial virus (RSV)
87281	Detection test by immunofluorescent technique for pneumocystis carinii (respiratory parasite)
87283	Detection test by immunofluorescent technique for rubeola (measles virus)
87285	Detection test by immunofluorescent technique for treponema pallidum (syphilis organism)
87290	Detection test by immunofluorescent technique for varicella (chicken pox) zoster virus
87299	Detection test by immunofluorescent technique for organism
87300	Detection test by immunofluorescent technique for multiple organisms
87301	Detection test by immunoassay technique for adenovirus enteric types 40/41
87305	Detection test by immunoassay technique for aspergillus (fungus)
87320	Detection test by immunoassay technique for Chlamydia trachomatis
87324	Detection test by immunoassay technique for clostridium difficile toxins (stool pathogen)
87327	Detection test by immunoassay technique, multistep method, for Cryptococcus neoformans (yeast)
87328	Detection test by immunoassay technique for cryptosporidium (parasite)
87329	Detection test by immunoassay technique for giardia (intestinal parasite)
87332	Detection test by immunoassay technique for cytomegalovirus
87335	Detection test by immunoassay technique for Escherichia coli 0157 (E. coli)
87336	Detection test by immunoassay technique for entamoeba histolytica dispar group (parasite)
87337	Detection test by immunoassay technique for entamoeba histolytica group (parasite)
87338	Detection test by immunoassay technique for Helicobacter pylori (GI tract bacteria) in stool
87339	Detection test by immunoassay technique for helicobacter pylori (GI tract bacteria)
87340	Detection test by immunoassay technique for Hepatitis B surface antigen
87341	Detection test by immunoassay technique for Hepatitis B surface antigen neutralization

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
87350	Detection test by immunoassay technique for Hepatitis Be surface antigen
87380	Detection test by immunoassay technique for Hepatitis D
87385	Detection test by immunoassay technique for histoplasma capsulatum (parasite)
87389	Detection test by immunoassay technique for HIV-1 antigen and HIV-1 and HIV-2 antibodies
87390	Detection test by immunoassay technique for HIV-1 antigen
87391	Detection test by immunoassay technique for HIV-2 antigen
87400	Detection test by immunoassay technique for influenza virus
87420	Detection test by immunoassay technique for respiratory syncytial virus (RSV)
87425	Detection test by immunoassay technique for Rotavirus
87427	Detection test by immunoassay technique for Shiga-like toxin (bacterial toxin)
87430	Detection test by immunoassay technique for Streptococcus, group A (strep)
87449	Detection test by immunoassay technique for other organism
87451	Detection test by immunoassay technique for multiple organisms, each polyvalent antiserum
87467	Detection of Hepatitis B surface antigen (HBsAg)
87468	Detection of Anaplasma phagocytophilum by amplified nucleic acid probe technique
87469	Detection of Babesia microtim by amplified nucleic acid probe technique
87471	Detection by nucleic acid Bartonella henselae and Bartonella quintana (bacteria), amplified probe technique
87472	Detection by nucleic acid Bartonella henselae and Bartonella quintana (bacteria), quantification
87475	Detection by nucleic acid for borrelia burgdorferi (bacteria), direct probe technique
87476	Detection by nucleic acid for borrelia burgdorferi (bacteria), amplified probe technique
87478	Detection of Babesia Borrelia miyamotoi by amplified nucleic acid probe technique
87480	Detection test for candida species (yeast), direct probe technique
87481	Detection test for candida species (yeast), amplified probe technique
87482	Detection test for candida species (yeast), quantification
87483	Test for detecting nucleic acid of organism causing infection of central nervous system
87484	Detection of Ehrlichia chaffeensis by amplified nucleic acid probe technique
87485	Detection test by nucleic acid for chlamydia pneumoniae, direct probe technique
87486	Detection test by nucleic acid for Chlamydia pneumoniae, amplified probe technique
87487	Detection test by nucleic acid for chlamydia pneumoniae, quantification
87490	Detection test by nucleic acid for chlamydia, direct probe technique
87491	Detection test by nucleic acid for chlamydia trachomatis, amplified probe technique
87492	Detection test by nucleic acid for chlamydia trachomatis, quantification
87493	Detection test by nucleic acid for clostridium difficile, amplified probe technique
87495	Detection test by nucleic acid for cytomegalovirus (CMV), direct probe technique
87496	Detection test by nucleic acid for Cytomegalovirus (CMV), amplified probe technique
87497	Detection test by nucleic acid for cytomegalovirus, quantification

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
87498	Detection test by nucleic acid for enterovirus (intestinal virus), amplified probe technique
87501	Detection test by nucleic acid for influenza virus, each type or subtype
87502	Detection test by nucleic acid for multiple types influenza virus
87503	Detection test by nucleic acid for multiple types influenza virus, each additional influenza virus type or sub-type
87505	Detection test by nucleic acid for digestive tract pathogen, multiple types or subtypes, 3-5 targets
87506	Detection test by nucleic acid for digestive tract pathogen, multiple types or subtypes, 6-11 targets
87507	Detection test by nucleic acid for digestive tract pathogen, multiple types or subtypes, 12-25 targets
87510	Detection test for gardnerella vaginalis (bacteria), direct probe technique
87511	Detection test for gardnerella vaginalis (bacteria), amplified probe technique
87512	Detection test for gardnerella vaginalis (bacteria), quantification
87513	Detection test by nucleic acid for helicobacter pylori clarithromycin resistance, amplified probe technique
87516	Detection test by nucleic acid for Hepatitis B virus, amplified probe technique
87517	Detection test by nucleic acid for Hepatitis B virus, quantification
87520	Detection test by nucleic acid for Hepatitis C virus, direct probe technique
87521	Detection test by nucleic acid for Hepatitis C virus, amplified probe technique
87522	Detection test by nucleic acid for Hepatitis C virus, quantification
87523	Detection of Hepatitis D (delta)
87525	Detection test by nucleic acid for Hepatitis G virus, direct probe technique
87526	Detection test by nucleic acid for Hepatitis G virus, amplified probe technique
87527	Detection test by nucleic acid for Hepatitis G virus, quantification
87528	Detection test by nucleic acid for herpes simplex virus, direct probe technique
87529	Detection test by nucleic acid for herpes simplex virus, amplified probe technique
87530	Detection test by nucleic acid for herpes simplex virus, quantification
87531	Detection test by nucleic acid for herpes virus-6, direct probe technique
87532	Detection test by nucleic acid for herpes virus-6, amplified probe technique
87533	Detection test by nucleic acid for herpes virus-6, quantification
87534	Detection test by nucleic acid for HIV-1 virus, direct probe technique
87535	Detection test by nucleic acid for HIV-1 virus, amplified probe technique
87536	Detection test by nucleic acid for HIV-1 virus, quantification
87537	Detection test by nucleic acid for HIV-2 virus, direct probe technique
87538	Detection test by nucleic acid for HIV-2 virus, amplified probe technique
87539	Detection test by nucleic acid for HIV-2 virus, quantification
87540	Detection test by nucleic acid for legionella pneumophila (water borne bacteria), direct probe technique
87541	Detection test by nucleic acid for legionella pneumophila (water borne bacteria), amplified probe technique
87542	Detection test by nucleic acid for legionella pneumophila (water borne bacteria), quantification

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
87550	Detection test by nucleic acid for Mycobacteria species (bacteria), direct probe technique
87551	Detection test by nucleic acid for Mycobacteria species (bacteria), amplified probe technique
87552	Detection test by nucleic acid for Mycobacteria species (bacteria), quantification
87555	Detection test by nucleic acid for Mycobacteria tuberculosis (TB bacteria), direct probe technique
87556	Detection test by nucleic acid for Mycobacteria tuberculosis (TB bacteria), amplified probe technique
87557	Detection test by nucleic acid for Mycobacteria tuberculosis (TB bacteria), quantification
87560	Detection test by nucleic acid for Mycobacteria avium-intracellulare (bacteria), direct probe technique
87561	Detection test by nucleic acid for Mycobacteria avium-intracellulare (bacteria), amplified probe technique
87562	Detection test by nucleic acid for Mycobacteria avium-intracellulare (bacteria), quantification
87563	Detection of Mycoplasma genitalium by DNA or RNA probe
87564	Detection test by nucleic acid for mycobacterium tuberculosis rifampin resistance
87580	Detection test by nucleic acid for Mycoplasma pneumoniae (bacteria), direct probe technique
87581	Detection test by nucleic acid for Mycoplasma pneumoniae (bacteria), amplified probe technique
87582	Detection test by nucleic acid for Mycoplasma pneumoniae (bacteria), quantification
87590	Detection test by nucleic acid for Neisseria gonorrhoeae (gonorrhoeae bacteria), direct probe technique
87591	Detection test by nucleic acid for Neisseria gonorrhoeae (gonorrhoeae bacteria), amplified probe technique
87592	Detection test by nucleic acid for Neisseria gonorrhoeae (gonorrhoeae bacteria), quantification
87593	Detection of orthopoxvirus
87594	Detection test by nucleic acid for pneumocystis jirovecii
87623	Detection test by nucleic acid for human papillomavirus (hpv), low-risk types
87624	Detection test by nucleic acid for human papillomavirus (hpv), high-risk types
87625	Detection test by nucleic acid for human papillomavirus (hpv), types 16 and 18 only
87626	Detection test by nucleic acid for Human Papillomavirus (HPV), separately reported high-risk types
87631	Detection test by nucleic acid for multiple types of respiratory virus, multiple types or subtypes, 3-5 targets
87632	Detection test by nucleic acid for multiple types of respiratory virus, multiple types or subtypes, 6-11 targets
87633	Detection test by nucleic acid for multiple types of respiratory virus, multiple types or subtypes, 12-25 targets
87634	Detection test by nucleic acid for respiratory syncytial virus, amplified probe technique
87640	Detection test by nucleic acid for Staphylococcus aureus (bacteria), amplified probe technique

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
87641	Detection test by nucleic acid for Staphylococcus aureus, methicillin resistant (MRSA bacteria), amplified probe technique
87650	Detection test by nucleic acid for Strep (Streptococcus, group A), direct probe technique
87651	Detection test by nucleic acid for Strep (Streptococcus, group A), amplified probe technique
87652	Detection test by nucleic acid for Strep (Streptococcus, group A), quantification
87653	Detection test by nucleic acid for Strep (Streptococcus, group B), amplified probe technique
87660	Detection test by nucleic acid for Trichomonas vaginalis (genital parasite), direct probe technique
87661	Infectious agent detection by nucleic acid (dna or rna); trichomonas vaginalis, amplified probe technique
87797	Detection test by nucleic acid for organism, direct probe technique
87798	Detection test by nucleic acid for organism, amplified probe technique
87799	Detection test by nucleic acid for organism, quantification
87800	Detection test by nucleic acid for multiple organisms, direct probe(s) technique
87801	Detection test by nucleic acid for multiple organisms, amplified probe(s) technique
87802	Detection test by immunoassay with direct visual observation for Streptococcus, group B (bacteria)
87803	Detection test by immunoassay with direct visual observation for Clostridium difficile toxin A
87804	Detection test by immunoassay with direct visual observation for influenza virus
87806	Detection test by immunoassay with direct visual observation for HIV-1 antigen, with HIV-1 and HIV-2 antibodies
87807	Detection test by immunoassay with direct visual observation for respiratory syncytial virus
87808	Detection test by immunoassay with direct visual observation for Trichomonas vaginal (genital parasite)
87810	Detection test by immunoassay with direct visual observation for Chlamydia trachomatis
87850	Detection test by immunoassay with direct visual observation for Neisseria gonorrhoeae (gonorrhea)
87880	Detection test by immunoassay with direct visual observation for Streptococcus, group A (strep)
87899	Detection test by immunoassay with direct visual observation for other organism
87900	Infectious agent drug susceptibility analysis
87901	Analysis test by nucleic acid for HIV-1 virus
87902	Analysis test by nucleic acid for Hepatitis C virus
87905	Infectious agent enzymatic activity to detect organism
87906	Analysis test by nucleic acid for HIV-1 virus, other region
87910	Analysis test by nucleic acid for cytomegalovirus, cytomegalovirus
87912	Analysis test by nucleic acid for hepatitis b virus
88104	Cell examination of body fluid, smears
88106	Cell examination of body fluid, simple filter method
88108	Cell examination of specimen, concentration technique
88112	Cell examination of specimen, selective cellular enhancement technique

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
88120	Cell examination of urine, manual
88121	Cell examination of urine, computer-assisted
88125	Forensic (investigation) examination of specimen
88130	Sex identification, Barr bodies
88140	Sex identification, peripheral blood smear
88141	Pap test
88142	Pap test, manual screening
88143	Pap test, manual screening and rescreening
88147	Pap test (Pap smear), automated system
88148	Pap test (Pap smear), automated system with manual rescreening
88150	Pap test, slides, manual screening
88152	Pap test, slides, automated system with computer-assisted rescreening
88153	Pap test, slides, manual screening and rescreening
88155	Pap test, slides, definitive hormonal evaluation
88160	Screening examination of specimen cells, screening and interpretation
88161	Screening examination of specimen cells, preparation, screening and interpretation
88162	Screening examination of specimen cells, extended study
88164	Pap test, slides, manual screening (the Bethesda System)
88165	Pap test, slides, manual screening and rescreening (the Bethesda System)
88166	Pap test, slides, manual screening and computer-assisted rescreening (the Bethesda System)
88167	Pap test, slides, manual screening and computer-assisted rescreening using cell selection (the Bethesda System)
88172	Evaluation of fine needle aspirate
88173	Evaluation of fine needle aspirate with interpretation and report
88174	Pap test, automated thin layer preparation; automated system
88175	Pap test, automated thin layer preparation; automated system and manual rescreening
88177	Pap test, evaluation of fine needle aspirate, immediate, each additional evaluation episode
88182	Flow cytometry technique for DNA or cell analysis
88184	Flow cytometry technique for DNA or cell analysis, first marker
88185	Flow cytometry technique for DNA or cell analysis, each additional marker
88187	Flow cytometry technique for DNA or cell analysis, 2 to 8 markers
88188	Flow cytometry technique for DNA or cell analysis, 9 to 15 markers
88189	Flow cytometry technique for DNA or cell analysis, 16 or more markers
88230	Tissue culture to identify white blood cell disorders
88233	Tissue culture to identify skin disorders
88235	Tissue culture for disorders of amniotic fluid or placenta cells
88237	Tissue culture for tumor disorders of bone marrow and blood cells
88239	Tissue culture for tumor disorders

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
88240	Cryopreservation, freezing and storage of cells
88241	Thawing and expansion of frozen cells
88263	Chromosome analysis for genetic defects, count 45 cells for mosaicism
88272	Chromosome analysis for genetic defects, analyze 3-5 cells
88280	Chromosome analysis for genetic defects, additional karyotypes, each study
88283	Chromosome analysis for genetic defects, additional specialized banding technique
88285	Chromosome analysis for genetic defects, additional cells counted, each study
88289	Chromosome analysis for genetic defects, additional high resolution study
88300	Pathology examination of tissue using a microscope, limited examination
88302	Pathology examination of tissue using a microscope
88304	Pathology examination of tissue using a microscope, moderately low complexity
88305	Pathology examination of tissue using a microscope, intermediate complexity
88307	Pathology examination of tissue using a microscope, moderately high complexity
88309	Pathology examination of tissue using a microscope, high complexity
88311	Preparation of tissue for examination by removing any calcium present
88312	Special stained specimen slides to identify organisms including interpretation and report
88313	Special stained specimen slides to examine tissue including interpretation and report
88314	Special stained specimen slides to examine tissue and frozen preparation of specimen including interpretation and report
88319	Evaluation of specimen enzymes
88321	Surgical pathology consultation and report on referred slides prepared elsewhere
88323	Surgical pathology consultation and report on referred material requiring preparation of slides
88325	Surgical pathology consultation and report, comprehensive
88329	Pathology examination of specimen during surgery
88331	Pathology examination of specimen during surgery, first tissue block
88332	Pathology examination of specimen during surgery, each additional tissue block
88333	Pathology cytologic examination of specimen during surgery, initial site
88334	Pathology cytologic examination of specimen during surgery, each additional site
88341	Special stained specimen slides to examine tissue, each additional procedure
88342	Special stained specimen slides to examine tissue, initial procedure
88344	Special stained specimen slides to examine tissue, each multiplex procedure
88346	Antibody evaluation, initial single antibody stain procedure
88348	Electron microscopy for diagnosis
88350	Antibody evaluation, each additional single antibody stain procedure
88355	Microscopic genetic analysis of muscle
88356	Microscopic genetic analysis of nerve tissue
88358	Microscopic genetic analysis of tumor
88360	Microscopic genetic analysis of tumor, manual

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
88361	Microscopic genetic analysis of tumor, using computer-assisted technology
88362	Nerve teasing preparation
88364	Genetic sequencing localization, each additional procedure
88365	Genetic sequencing localization, initial procedure
88366	Genetic sequencing localization, each multiplex procedure
88367	Microscopic genetic analysis of tissue, computer-assisted technology, initial procedure
88368	Microscopic genetic analysis of tissue, manual, initial procedure
88369	Microscopic genetic analysis of tissue, manual, each additional procedure
88371	Protein analysis of tissue with interpretation and report
88372	Protein analysis of tissue by western blot, with interpretation and report
88373	Microscopic genetic analysis of tissue, computer-assisted technology, each additional procedure
88374	Microscopic genetic analysis of tissue, computer-assisted technology, initial procedure, each multiplex procedure
88377	Microscopic genetic analysis of tissue, manual, each additional multiplex stain procedure
88381	Preparation of specimen, manual
88387	Pathologist examination, dissection, and preparation of tissue
88720	Measurement of bilirubin
89049	Test for malignant hyperthermia susceptibility (genetic disorder)
89050	Body fluid cell count
89051	Body fluid cell count with cell identification
89055	White blood cell measure, stool specimen
89060	Crystal identification from tissue or body fluid
89125	Fat stain of stool, urine, or respiratory secretions
89160	Examination of stool for meat fibers
89190	Nasal smear for eosinophils (allergy related white blood cells)
89220	Sputum specimen collection
89230	Sweat collection
89321	Semen analysis for sperm presence
91200	Measurement of liver stiffness
92650	Screening evaluation of brain response to sound with automated analysis
92651	Evaluation of brain response to sound for determination of hearing status with interpretation and report
92652	Evaluation of brain response to sound for determination of hearing threshold with interpretation and report
92653	Evaluation of brain response to sound for diagnosis of nervous system disorders with interpretation and report
93976	Ultrasound of abdomen and pelvis artery and vein blood flow
99202	New patient office or other outpatient visit with straightforward medical decision making, if using time, 15 minutes or more
99203	New patient office or other outpatient visit with low level of medical decision making, if using time, 30 minutes or more

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
99204	New patient office or other outpatient visit with moderate level of medical decision making, if using time, 45 minutes or more
99205	New patient office or other outpatient visit with a high level of medical decision making, if using time, 60 minutes or more
99211	Office or other outpatient visit for the evaluation and management of established patient that may not require presence of healthcare professional
99212	Established patient office or other outpatient visit with straightforward medical decision making, if using time, 10 minutes or more
99213	Established patient office or other outpatient visit with low level of decision making, if using time, 20 minutes or more
99214	Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more
99215	Established patient office or other outpatient visit with high level of medical decision making, if using time, 40 minutes or more
99221	Initial hospital care with straightforward or low level of medical decision making, per day, if using time, at least 40 minutes
99222	Initial hospital inpatient or observation care with moderate level of medical decision making. If using time, 55 minutes or more
99223	Initial hospital inpatient or observation care with high level of medical decision making, if using time, 75 minutes or more
99231	Subsequent hospital care with straightforward or low level of medical decision making, per day, if using time, at least 25 minutes
99232	Subsequent hospital care with moderate level of medical decision making, if using time, at least 35 minutes
99233	Subsequent hospital inpatient or observation care with high level of medical decision making, if using time, 50 minutes or more
99234	Hospital inpatient or observation care with admission and discharge on the same date with straightforward or low level of medical decision making, if using time, 45 minutes or more
99235	Hospital inpatient or observation care with admission and discharge on the same date with moderate level of medical decision making, if using time, 70 minutes or more
99236	Hospital inpatient or observation care with admission and discharge on the same date with high level of medical decision making, if using time, 85 minutes or more
99238	Hospital inpatient or observation discharge day management, 30 minutes or less
99239	Hospital inpatient or observation discharge day management, more than 30 minutes
99281	Emergency department visit for problem that may not require health care professional
99282	Emergency department visit with straightforward medical decision making
99283	Emergency department visit with low level of medical decision making
99284	Emergency department visit with moderate level of medical decision making
99285	Emergency department visit with high level of medical decision making
99288	Physician direction of emergency advanced life support paramedic services
99291	Critical care, first 30-74 minutes
99292	Critical care, each additional 30 minutes
99418	Prolonged inpatient or observation service, each 15 minutes of total time beyond required time of primary service
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
	a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to cpt codes 99205, 99215, 99483 for office or other outpatient evaluation and management services) (do not report g2212 on the same date of service as 99358, 99359, 99415, 99416). (do not report g2212 for any time unit less than 15 minutes)
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional
G9978	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved bundled payments for care improvement advanced (bpci advanced) model episode of care, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are self limited or minor. typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology
G9979	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved bundled payments for care improvement advanced (bpci advanced) model episode of care, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of low to moderate severity. typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology
G9980	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved bundled payments for care improvement advanced (bpci advanced) model episode of care, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate severity. typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology
G9981	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved bundled payments for care improvement advanced (bpci advanced) model episode of care, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the

Abortion Procedures Requiring Documentation	
CPT®/HCPCS	Description
	nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate to high severity. typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology
G9982	Remote in-home visit for the evaluation and management of a new patient for use only in a medicare-approved bundled payments for care improvement advanced (bpci advanced) model episode of care, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate to high severity. typically, 60 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology
G9983	Remote in-home visit for the evaluation and management of an established patient for use only in a medicare-approved bundled payments for care improvement advanced (bpci advanced) model episode of care, which requires at least 2 of the following 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are self limited or minor. typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology
G9984	Remote in-home visit for the evaluation and management of an established patient for use only in a medicare-approved bundled payments for care improvement advanced (bpci advanced) model episode of care, which requires at least 2 of the following 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of low to moderate severity. typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology
G9985	Remote in-home visit for the evaluation and management of an established patient for use only in a medicare-approved bundled payments for care improvement advanced (bpci advanced) model episode of care, which requires at least 2 of the following 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate to high severity. typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology

Appendix C. Hysterectomy Procedures

The following CPT®/HCPCS codes have been identified as requiring documentation attached to the claim when billed, per the [Hysterectomy](#) section.

Hysterectomy Procedures Requiring Documentation	
CPT®/HCPCS	Description
01963	Anesthesia for cesarean and removal of uterus
01969	Anesthesia for cesarean removal of uterus following labor
01962	Anesthesia for procedure to remove uterus following delivery
00944	Anesthesia for vaginal removal of uterus
00846	Anesthesia for removal of uterus including use of an endoscope
51597	Removal of bladder and ureters and/or removal of rectum and partial removal of large bowel with creation of opening in large bowel through abdominal wall to skin
51925	Repair of abnormal drainage tract from bladder into vagina and removal of uterus
58150	Removal of uterus and cervix through abdomen
58152	Removal of uterus and cervix through abdomen with repair of vagina
58180	Removal of uterus through abdomen
58200	Removal of uterus through abdomen with partial removal of vagina
58210	Removal of uterus, cervix, and lymph nodes of pelvis with biopsy of lymph nodes of aorta
58240	Removal of malignant uterus, cervix, lymph nodes, and bladder with transplant of ureters and bowel
58260	Removal of uterus through vagina, 250.0 g or less
58262	Removal of uterus, tubes, and/or ovaries through vagina, 250.0 g or less
58263	Removal of uterus, tubes, and/or ovaries with repair of herniated bowel through vagina, 250.0 g or less
58267	Removal of uterus with repair for incontinence, 250.0 g or less
58270	Removal of uterus with repair of herniated bowel through vagina, 250.0 g or less
58275	Removal of uterus and vagina
58280	Removal of uterus and vagina with repair of herniated bowel into rectum or vagina through vagina
58285	Removal of uterus, vagina, and pelvic lymph nodes through vagina
58290	Removal of uterus through vagina, more than 250.0 g
58291	Removal of uterus, tubes, and/or ovaries through vagina, more than 250.0 g
58292	Removal of uterus, tubes, and/or ovaries with repair of herniated bowel through vagina, more than 250.0 g
58294	Removal of uterus with repair of herniated bowel through vagina. 250.0 g or more
58541	Partial removal of uterus with retention of cervix using an endoscope, 250.0 g or less
58542	Partial removal of uterus, tubes, and/or ovaries with retention of cervix using an endoscope, 250.0 g or less

Hysterectomy Procedures Requiring Documentation	
CPT®/HCPCS	Description
58543	Partial removal of uterus with retention of cervix using an endoscope, more than 250.0 g
58544	Partial removal of uterus, tubes, and/or ovaries with retention of cervix using an endoscope, more than 250.0 g
58548	Removal of uterus, cervix, and lymph nodes of pelvis with biopsy of aortic lymph node using an endoscope
58550	Removal of uterus through vagina using an endoscope, 250.0 g or less
58552	Removal of uterus, tubes, and/or ovaries through vagina using an endoscope, 250.0 g or less
58553	Removal of uterus through vagina using an endoscope, more than 250.0
58554	Removal of uterus, tubes, and/or ovaries through vagina using an endoscope, more than 250.0 g
58570	Removal of uterus through abdomen using an endoscope, 250.0 g or less
58571	Removal of uterus, tubes, and/or ovaries through abdomen using an endoscope, 250.0 g or less
58572	Removal of uterus through abdomen using an endoscope, more than 250.0 g
58573	Removal of uterus, tubes, and/or ovaries through abdomen using an endoscope, more than 250.0 g
58575	Removal of uterus for removal of growth using an endoscope
58951	Removal of lining of abdomen, uterus, ovaries, fallopian tubes, and lymph nodes of pelvis and aorta
58953	Removal of lining of abdomen, uterus, ovaries, and fallopian tubes with extensive reduction of growth
58954	Removal of lining of abdomen, uterus, ovaries, fallopian tubes, and lymph nodes of pelvis and aorta for reduction of growth
58956	Removal of lining of abdomen, uterus, ovaries, and fallopian tubes
59525	Cesarean delivery with removal of uterus

Appendix D. Sterilization Procedures

The following CPT®/HCPCS codes have been identified as requiring documentation attached to the claim when billed, per the [Sterilization Procedures](#) section.

Sterilization Procedures Requiring Documentation	
CPT®/HCPCS	Description
00840	Anesthesia for other procedure on lower abdomen
00851	Anesthesia for tying or incision of fallopian tubes using an endoscope
00921	Anesthesia for vasectomy
00952	Anesthesia for exam of uterus using an endoscope
55250	Removal of sperm duct
58565	Placement of implants to block fallopian tubes using an endoscope
58600	Tying or incision of fallopian tubes
58605	Tying or incision of fallopian tubes during same hospitalization
58611	Tying or incision of fallopian tubes during cesarean delivery or other abdominal surgery
58615	Tying of fallopian tubes by device through vagina
58661	Removal of ovaries and/or tubes using an endoscope
58662	Destruction or removal of ovary or growth of pelvis using an endoscope
58670	Destruction of fallopian tubes using an endoscope
58671	Blockage of uterine tubes by device using an endoscope
58673	Repair of uterine tube using an endoscope
58679	Other procedure on fallopian tube or ovary using an endoscope
58700	Removal of uterine tubes
58720	Removal of uterine tubes and ovaries
58740	Removal of scar tissue of ovaries or fallopian tubes
58940	Removal of ovaries
58943	Removal of ovaries for ovarian cancer
58950	Removal of lining of abdomen, ovaries, and fallopian tubes
58952	Removal of lining of abdomen, ovaries, and fallopian tubes with reduction of growth
81225	Gene analysis (cytochrome P450, family 2, subfamily C, polypeptide 19) common variants
81226	Gene analysis (cytochrome P450, family 2, subfamily D, polypeptide 6) common variants
81227	Gene analysis (cytochrome P450, family 2, subfamily C, polypeptide 9) common variants
81355	Gene analysis (vitamin K epoxide reductase complex subunit 1) common variants
86386	Protein test for diagnosis and monitoring of bladder cancer

Appendix E. Medical Services, Provider Handbook Modifications

This table lists the last three years of changes to this handbook as of the publication date. Changes to references or of a non-substantive technical nature are not captured.

Medical Services, Provider Handbook Modifications				
Version	Section/ Column	Modification Description	Date	SME
65.0	All	Published version	12/24/2025	TQD
64.3	4.16. Family Planning	Healthy Connections removed.	12/23/2025	A Welch W Deseron
64.2	3.2. Referrals	Removed Healthy Connections information.	12/23/2025	A Welch W Deseron
64.1	2. Provider Qualifications	Renamed section Provider Qualifications: General.	12/23/2025	A Welch W Deseron
64.0	All	Published version	11/19/2025	TQD
63.22	5.2. Provider- Preventable Conditions	Updated policy to reflect requirements included elsewhere.	11/13/2025	W Deseron K Lolofie
63.21	4.35.2. Technical Component	Added info about radiology technicians.	11/13/2025	W Deseron K Lolofie
63.20	4.35. Radiology	Integrated content from Technologist handbook.	11/13/2025	W Deseron K Lolofie
63.19	4.31.7. Lactation Counseling	Policy rewritten.	11/13/2025	W Deseron K Lolofie
63.18	4.30. Nutritional Services	Integrated policy from Nutritional Services handbook.	11/13/2025	W Deseron K Lolofie
63.17	4.9. Clinic Services	Updated section with current operations.	11/13/2025	W Deseron K Lolofie
63.16	2.6. Radiologic Technologist (Diagnostic)	New section.	11/13/2025	W Deseron K Lolofie
63.15	1.11. Physician Assistants	Section deleted. Content moved to general requirements.	11/13/2025	W Deseron K Lolofie
63.14	2.5. Pharmacists	General content removed.	11/13/2025	W Deseron K Lolofie
63.13	1.9. Nurse Practitioners	Section deleted. Content moved to general requirements.	11/13/2025	W Deseron K Lolofie
63.12	2.4. Operating Room Technician	New section.	11/13/2025	W Deseron K Lolofie
63.11	2.3. Mobile Clinics	Renamed Mobile Clinics and Imaging Units. Added info on imaging units.	11/13/2025	W Deseron K Lolofie
63.10	1.8. Clinical Nurse Specialists	Section deleted. Content in general section.	11/13/2025	W Deseron K Lolofie
63.9	1.7. Certified Registered Nurse Anesthetists	Section deleted. Content in general section.	11/13/2025	W Deseron K Lolofie
63.8	1.6. Certified Nurse Midwives	Section deleted. Content in general section.	11/13/2025	W Deseron K Lolofie
63.7	1.5.4. Residents	Section deleted. Moved to physicians.	11/13/2025	W Deseron K Lolofie
63.6	1.5.3. International Medical Graduate	Section deleted. Moved to physicians.	11/13/2025	W Deseron K Lolofie
63.5	1.5.2. Bridge Year Physician	Section deleted. Moved to physicians.	11/13/2025	W Deseron K Lolofie
63.4	2.2. Physicians	Combined bridge year, international medical graduates and residents into physician section.	11/13/2025	W Deseron K Lolofie

Medical Services, Provider Handbook Modifications				
Version	Section/ Column	Modification Description	Date	SME
63.3	2. Provider Qualifications	Updated language to include general requirements from other sections.	11/13/2025	W Deseron K Lolofie
63.2	1.4. Telligen, Inc.	Clarified when a PA would be provided by Telligen.	11/13/2025	W Deseron K Lolofie
63.1	1.1. Gainwell Technologies	Clarified Gainwell doesn't handle managed care.	11/13/2025	W Deseron K Lolofie
63.0	All	Published version	07/01/2025	TQD
62.18	Appendix D. Sterilization Procedures	New section	07/01/2025	W Deseron K Lolofie
62.17	Appendix C. Hysterectomy Procedures	New section	07/01/2025	W Deseron K Lolofie
62.16	Appendix B. Abortion Procedures	New section	07/01/2025	W Deseron K Lolofie
62.15	9.2. Modifiers	Clarified % for modifier 51.	07/01/2025	W Deseron K Lolofie
62.14	9. Reimbursement	Clarified lactation consultants and RNLC are paid 85%.	07/01/2025	W Deseron K Lolofie
62.13	5.10. Sterilization Procedures	Added list of codes that require documentation.	07/01/2025	W Deseron K Lolofie
62.12	5.7. Hysterectomy	Added list of codes that require documentation. Allow guardian to sign.	07/01/2025	W Deseron K Lolofie
62.11	4.42.4. Child Wellness Exam: Maternal Postpartum Depression Screening	Coverage changed to 4 visits.	07/01/2025	W Deseron K Lolofie
62.10	4.36. Skin Substitute Products	Updated policy.	07/01/2025	W Deseron K Lolofie
62.9	4.33.1. Reporting National Drug Code (NDC) for Drugs Billed with HCPCS Codes	Renamed Reporting National Drug Codes	07/01/2025	W Deseron K Lolofie
62.8	4.31.7. Lactation Counseling	Added RN certified lactation consultants.	07/01/2025	W Deseron K Lolofie
62.7	4.18. Fluoride Treatments	Changed age for treatments.	07/01/2025	W Deseron K Lolofie
62.6	4.17. Family Planning	Update contraceptive coverage to six months.	07/01/2025	W Deseron K Lolofie
62.5	4.12.2. Provider Qualifications: Diabetes Education and Training	Add dietitian and pharmacist as acceptable providers.	07/01/2025	W Deseron K Lolofie
62.4	4.3. Advance Directives	Revised section to point to General Information and Requirements for Providers.	07/01/2025	W Deseron K Lolofie
62.3	4.1. Abortions	Added dx list for claim documentation.	07/01/2025	W Deseron K Lolofie
62.2	2.7. Pharmacists	Clarified reimbursement amounts.	07/01/2025	W Deseron K Lolofie
62.1	2.5. Mobile Clinics	New section.	07/01/2025	W Deseron K Lolofie
62.0	All	Published version	01/21/2025	TQD
61.5	Appendix C. Pharmacist Services	Updated with new codes.	01/13/2025	W Deseron S Fox
61.4	Appendix B. Anesthesia Base Units	Section deleted. Information moved to fee schedule.	01/13/2025	W Deseron S Fox
61.3	6. Inpatient Stay Reviews	Clarified procedure and applicability for reviews.	01/13/2025	W Deseron S Fox
61.2	5.5. Anesthesiology	Clarify prior authorization number requirement on claims.	01/13/2025	W Deseron S Fox

Medical Services, Provider Handbook Modifications				
Version	Section/ Column	Modification Description	Date	SME
61.1	4.44.3. Child Wellness Exams	Clarify when an interperiodic exam may be conducted.	01/13/2025	W Deseron S Fox
61.0	All	Published version	12/04/2024	TQD
60.9	Appendix C. Pharmacist Services	Added covered codes.	11/25/2024	W Deseron E Garibovic
60.8	9.3. Physician Employees	Renamed section Employees. Added applicability to non-physician practitioners.	11/25/2024	W Deseron E Garibovic
60.7	9.2. Site of Service Differential	Remove telehealth POS.	11/25/2024	W Deseron E Garibovic
60.6	5.7. Hysterectomy	Clarified that Sterilization form have to be signed before the procedure.	11/25/2024	W Deseron E Garibovic
60.5	4.16. Gender Transition Services	Incorporated policy.	11/25/2024	W Deseron E Garibovic
60.4	4.15. Evaluation and Management	Update to current standards.	11/25/2024	W Deseron E Garibovic
60.3	4.12. Diabetes Education and Training	Allow for telehealth.	11/25/2024	W Deseron E Garibovic
60.2	4.6. Behavioral Health Services	Updated providers exempt from billing Magellan.	11/25/2024	W Deseron E Garibovic
60.1	2.6. Pharmacists	Clarified reimbursement for MTM.	11/25/2024	W Deseron E Garibovic
60.0	All	Published version	08/18/2024	TQD
59.2	2.6. Pharmacists	Removed billing exceptions.	08/16/2024	W Deseron E Garibovic
59.1	Physician and Non-Physician Practitioner	Added pharmacist to the definition of non-physician practitioner.	08/16/2024	W Deseron E Garibovic
59.0	All	Published version	07/01/2024	TQD
58.13	Appendix C. Pharmacist Services	New section.	06/27/2024	W Deseron M Hanifen
58.12	8. Documentation	Updated section to standard language.	06/27/2024	W Deseron M Hanifen
58.11	5.7. Hysterectomy	Added form requirements from Medicaid article.	06/27/2024	W Deseron M Hanifen
58.10	4.43.4. Child Wellness Exam: Maternal Postpartum Depression Screening	Changed Optum to Magellan.	06/27/2024	W Deseron M Hanifen
58.9	4.43. Wellness Examinations	Added clarification on billing problem-focused encounters.	06/27/2024	W Deseron M Hanifen
58.8	4.36. Skin Substitute Products	Reiterated medical necessity requirement.	06/27/2024	W Deseron M Hanifen
58.7	4.34. Psychiatric Care	Section and subsections deleted. Replaced with Behavioral Health Services.	06/27/2024	W Deseron M Hanifen
58.6	4.31.12. Risk Reduction Follow-up	New section.	06/27/2024	W Deseron M Hanifen
58.5	4.31. Obstetric Care	Added reference to pregnancy-related services.	06/27/2024	W Deseron M Hanifen
58.4	4.21.4.22. Immunization and Vaccines	Updated Magellan to Prime.	06/27/2024	W Deseron M Hanifen
58.3	4.6. Behavioral Health Services	New section.	06/27/2024	W Deseron M Hanifen
58.2	2.6. Pharmacists	Moved allowed codes to an appendix.	06/27/2024	W Deseron M Hanifen

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Version	Section/ Column	Modification Description	Date	SME
58.1	Physician and Non-Physician Practitioner	Added standard language regarding rules and requesting records.	06/27/2024	W Deseron M Hanifen
58.0	All	Published version	05/01/2024	TQD
57.6	5.7. Hysterectomy	Incorporated form requirements.	05/01/2024	W Deseron S Fox
57.5	5.5.3. Obstetrical Anesthesia	Removed requirement to bill all anesthesia on the date of delivery.	05/01/2024	W Deseron S Fox
57.4	4.43. Wellness Examinations	Added information about depression screenings.	05/01/2024	W Deseron S Fox
57.3	4.30.7. Lactation Counseling	Added lactation classes and additional codes.	05/01/2024	W Deseron S Fox
57.2	4.26. Mammography Services	Added language for procedure in other states.	05/01/2024	W Deseron S Fox
57.1	2.6. Pharmacists	Updated codes.	05/01/2024	W Deseron S Fox
57.0	All	Published version	02/02/2024	TQD
56.23	Appendix B. Anesthesia Base Units	Added codes and units.	02/02/2024	W Deseron E Garibovic
56.22	Appendix B. Periodicity Schedule	Deleted section.	02/02/2024	W Deseron E Garibovic
56.21	8. Documentation Requirements	Renamed section Documentation. Clarified policy.	02/02/2024	W Deseron E Garibovic
56.20	5.10.2. Informed Participant Consent	Updated preferred form to most recent version. Removed requirement for details of premature delivery.	02/02/2024	W Deseron E Garibovic
56.19	5.7. Hysterectomy	Clarified date of signature can be electronically populated.	02/02/2024	W Deseron E Garibovic
56.18	5.5.6. Office-Based Pediatric Dental Anesthesia	Section deleted. MCNA handles service now.	02/02/2024	W Deseron E Garibovic
56.17	4.43.3. Child Wellness Exams	Updated policy.	02/02/2024	W Deseron E Garibovic
56.16	4.43.2. Adult Wellness Exams	Updated limitation and added co-pay exclusions.	02/02/2024	W Deseron E Garibovic
56.15	4.43. Wellness Examinations	Updated policy.	02/02/2024	W Deseron E Garibovic
56.14	4.41. Virtual Care Services	New section.	02/02/2024	W Deseron E Garibovic
56.13	4.38 Telehealth	Section deleted. Replaced with Virtual Care Services section.	02/02/2024	W Deseron E Garibovic
56.12	4.34.3. Psychiatric Crisis via Telehealth	Renamed section Psychiatric Crisis via Virtual Care. Updated terminology.	02/02/2024	W Deseron E Garibovic
56.11	4.27. National Diabetes Prevention Program	Changed verbiage for virtual care services.	02/02/2024	W Deseron E Garibovic
56.10	4.26. Mammography Services	Corrected biannual to biennial.	02/02/2024	W Deseron E Garibovic
56.9	4.25. Lung Cancer Screening	Updated preapproved diagnoses.	02/02/2024	W Deseron E Garibovic
56.8	4.21.2. Stand-Alone Vaccine Counseling	New section.	02/02/2024	W Deseron E Garibovic
56.7	4.21. Immunization and Vaccines	Clarified policy.	02/02/2024	W Deseron E Garibovic
56.6	4.14. Evaluation and Management	Added pharmacists to eligible providers.	02/02/2024	W Deseron E Garibovic

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56.5	2.6. Pharmacists	Clarified billing for services and services that can be provided.	02/02/2024	W Deseron E Garibovic
56.4	2.1.2. Residents	New section.	02/02/2024	W Deseron E Garibovic
56.3	2.1.1. International Medical Graduate	New section.	02/02/2024	W Deseron E Garibovic
56.2	2.1.2. Bridge Year Physician	New section.	02/02/2024	W Deseron E Garibovic
56.1	2.1. Physicians	Relocated residents, bridge physicians and international medical graduates to their own sections.	02/02/2024	W Deseron E Garibovic
56.0	All	Published version	08/16/2023	TQD
55.33	7.8. Transferring a Prior Authorization	New section.	08/08/2023	W Deseron A Welch
55.32	7.7.1. References: Prior Authorization Appeals	New section.	08/08/2023	W Deseron A Welch
55.31	7.7. Prior Authorization Appeals	New section.	08/08/2023	W Deseron A Welch
55.30	7.6. Prior Authorization Reconsiderations	New section.	08/08/2023	W Deseron A Welch
55.29	7.5. Status of a Prior Authorization	New section.	08/08/2023	W Deseron A Welch
55.28	7.4. Modifying a Prior Authorization	New section.	08/08/2023	W Deseron A Welch
55.27	7.3.1. References: Telligen, Inc.	New section.	08/08/2023	W Deseron A Welch
55.26	7.3. Telligen, Inc.	Update process.	08/08/2023	W Deseron A Welch
55.25	7.2. The Medical Care Unit	Update process.	08/08/2023	W Deseron A Welch
55.24	7. Prior Authorizations	Update process.	08/08/2023	W Deseron A Welch
55.23	5.10.2. Informed Participant Consent	Clarify when corrections can be made on form.	08/08/2023	W Deseron A Welch
55.22	5.5.4.(C)(v) State Regulations	Update references.	08/08/2023	W Deseron A Welch
55.21	4.30.12. Surrogates	New section.	08/08/2023	W Deseron A Welch
55.20	4.29.4.30. Obstetric Care	Added reference to Surrogates section.	08/08/2023	W Deseron A Welch
55.19	4.27.4.(a) References: Reimbursement - NDPP	New section.	08/08/2023	W Deseron A Welch
55.18	4.27.4. Reimbursement: NDPP	New section.	08/08/2023	W Deseron A Welch
55.17	4.27.3.(a) References: Eligible Participants - NDPP	New section.	08/08/2023	W Deseron A Welch
55.16	4.27.3. Participant Eligibility: NDPP	New section.	08/08/2023	W Deseron A Welch
55.15	4.27.2.(a) References: Provider Qualifications – NDPP	New section.	08/08/2023	W Deseron A Welch
55.14	4.27.1. References: National Diabetes Prevention Program 4.27.2. Provider Qualifications: NDPP	New section.	08/08/2023	W Deseron A Welch
55.13	4.27. National Diabetes Prevention Program	New section.	08/08/2023	W Deseron A Welch

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55.12	4.26. Mammography Services	Update coverage to bi-annual screening.	08/08/2023	W Deseron A Welch
55.11	4.11.4.(a) References: Reimbursement – Diabetes Education and Training	New section.	08/08/2023	W Deseron A Welch
55.10	4.11.3.(a)(i) State Regulations	Update references.	08/08/2023	W Deseron A Welch
55.9	4.11.2.(a)(ii) State Regulations	Update references.	08/08/2023	W Deseron A Welch
55.8	4.11.2. Provider Qualifications: Diabetes Education and Training	Add ADCES programs.	08/08/2023	W Deseron A Welch
55.7	4.11.1. (b) State Regulations	Update references.	08/08/2023	W Deseron A Welch
55.6	4.11. Diabetes Education and Training	Updated language to correct grammar.	08/08/2023	W Deseron A Welch
55.5	4.1.3. Spontaneous Abortion	Clarify that dilation and curettage is included.	08/08/2023	W Deseron A Welch
55.4	4.1.1. Induced Abortion	Included allowance for reporting to child protective services.	08/08/2023	W Deseron A Welch
55.3	2.1.1.(a) Idaho Medicaid Publications	Update references.	08/08/2023	W Deseron A Welch
55.2	2.1. Physicians	Updated to include additional physician types.	08/08/2023	W Deseron A Welch
55.1	1.4. Telligen, Inc.	Removed fax number.	08/08/2023	W Deseron A Welch
55.0	All	Published version	06/02/2023	TQD
54.13	5.10.1. References: Sterilization Procedures	Updated.	05/26/2023	W Deseron K Duke
54.12	5.10. Sterilization Procedures	Clarify coverage and documentation.	05/26/2023	W Deseron K Duke
54.11	5.7.1. References: Hysterectomy	Updated.	05/26/2023	W Deseron K Duke
54.10	5.7. Hysterectomy	Clarification of form requirements.	05/26/2023	W Deseron K Duke
54.9	4.42.3. Child Wellness Exams	Removed codes for cesarean section.	05/26/2023	W Deseron K Duke
54.8	4.35.1. EpiCord® and EpiFix®	Clarify Telligen is reviewer for prior auths.	05/26/2023	W Deseron K Duke
54.7	(a) References: Multiple Deliveries	New section.	05/26/2023	W Deseron K Duke
54.6	4.29.8. Multiple Deliveries	Clarification of billing multiple deliveries.	05/26/2023	W Deseron K Duke
54.5	4.29.7. Lactation Counseling	Clarification of billing.	05/26/2023	W Deseron K Duke
54.4	4.26.1. References: Mammography Services	New section.	05/26/2023	W Deseron K Duke
54.3	4.26. Mammography Services	New section. Incorporate policy.	05/26/2023	W Deseron K Duke
54.2	4.21.1. References: Immunization and Vaccines	Updated.	05/26/2023	W Deseron K Duke
54.1	4.21. Immunization and Vaccines	Clarifications on \$0 vaccines, co- pays and COVID-19 vaccinations.	05/26/2023	W Deseron K Duke