

April 2, 2010

## **Alcohol and/or Substance Abuse Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

Perhaps you know that in all age categories, Alaska has one of the highest alcohol consumption AND illicit drug use rates in the nation.

**What if you could help your patients stop drinking and using harmful substances before these problems become serious enough to destroy their lives?** Alaskans need your help and the State of Alaska's Department of Health & Social Services is sending this information to remind you that the Medicaid program is supportive of your efforts to provide such help to affected Medicaid recipients.

**Did you know that the Alaska Medicaid program (including Denali KidCare) pays for the services for Alcohol and/or Substance Abuse Screening, Brief Intervention, and Referral to Treatment (SBIRT)?** These services have been covered by the Alaska Medicaid and Denali KidCare since November 1, 2008 when performed by enrolled primary health care providers.

Through the provision of SBIRT services, patients undergo a quick screening to assess their alcohol and drug use. Patients who are at risk of developing a serious problem receive a brief intervention that focuses on raising their awareness of substance abuse and motivating them to change their behaviors. Patients who need more extensive treatment receive a referral to specialty care for assessment, diagnosis, and appropriate treatment.

A number of screening instruments have been developed for use in various primary health care settings. You may investigate which instrument is the right fit for your practice by visiting the SBIRT Website provided through the Substance Abuse and Mental Health Services Association (SAMHSA) at [www.samhsa.gov](http://www.samhsa.gov) and selecting "SBIRT" under the heading "Programs & Campaigns" on the homepage. Complete information about SBIRT is available at this location, including training manuals, on-line resources, publications and other tools.

To bill the SBIRT services provided to Alaska Medicaid recipients, use one of the following procedure codes (complete information is published in the American Medical Association's Current Procedural Terminology (CPT) book):

- |              |   |
|--------------|---|
| <b>99408</b> | Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes |
| <b>99409</b> | greater than 30 minutes   |

In addition to SBIRT information that can be obtained from the SAMHSA website, please feel free to contact the Division of Health Care Services (907-334-2400) or the Division of Behavioral Health (907-269-3600) about SBIRT or the Alaska Medicaid fiscal agent, Affiliated Computer Services, Inc (907-644-6800 or 800-770-5650) about claims billing and payment for SBIRT services.

**With your help, we can all make a difference in reducing the rates of alcohol and drug use in Alaska.**



## COVERAGE FOR DENTAL FLOURIDE VARNISH PROVIDED BY PHYSICIANS, NURSE PRACTITIONERS, AND PHYSICIAN ASSISTANTS

Effective July 1, 2010, Alaska Medical Assistance will allow reimbursement for dental fluoride varnish applications and oral evaluations performed by physicians, nurse practitioners and physician assistants who have successfully completed an Oral Health or Caries Risk Assessment training program.

### Credentials

Each medical provider will be responsible for successfully completing an Oral Health or Caries Risk Assessment training that includes oral evaluation and topical fluoride varnish applications.

Accepted trainings include online and in-person training courses and workshops that provide a certificate of completion. A certificate of completion from the training program is required and must be presented to Alaska Medical Assistance upon request.

Numerous acceptable training courses are available online, including the American Academy of Pediatrics Oral Health Risk Assessment training at <http://www.aap.org/oralhealth/cme/>. To find additional information on acceptable training courses, please contact Brad Whistler at (907) 465-8628.

### Limitations of Coverage

Alaska Medical Assistance will cover a maximum of 4 fluoride varnish applications (D1206) per calendar year.

Coverage of oral evaluations (D0145) is limited to 2 exams per calendar year and is limited to patients under 3 years of age.

Only those services performed on/after July 1, 2010 are reimbursable.

### Billing

Topical fluoride varnish and oral evaluations performed by physicians, nurse practitioners, and physician assistants must be billed on the CMS-1500 or 837P using the following dental procedure codes:

- D1206 - topical fluoride varnish
- D0145 - oral evaluation for a patient under three years of age and counseling with primary caregiver

Reimbursement	100% of Dental Fee Schedule	85% of Dental Fee Schedule
D1206	\$28.00	\$23.80
D0145	\$56.70	\$48.20

If you have questions or require additional assistance, please contact the ACS Provider Inquiry Unit at (907) 644-6800, option 1, or (800) 770-5650, option 1, 1 (toll-free in Alaska).

April 2, 2010

## **Guidance for Diagnosis Coding For Mental Health and Developmental Disorders in Infants and Toddlers**

The Alaska Medicaid program supports the use of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R)* as tool by health care providers to aid in their efforts to report the mental health and developmental disorder diagnoses for young children from birth through age five. The *DC: 0-3R* was developed by consensus of a multidisciplinary group of experts in early childhood development and mental health drawing on more than 15 years of empirical research and worldwide clinical practice.

Use of the *DC: 0-3R* will help both primary health care practitioners and mental health clinicians to more accurately report diagnoses for infants and toddlers experiencing mental health and/or developmental disorders. Although providers are not required to use the *DC: 0-3R*, the Alaska Medicaid program encourages providers to make use of this tool when diagnosing young children.

Providers are reminded that clinical records must support the given diagnosis through assessment processes and that claims to bill for services rendered require diagnosis codes using exclusively the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* code set. Because the *DC: 0-3R* codes do not align precisely with the *ICD-9-CM* codes, the table below is a "cross-walk" between these two coding systems. Also, in some cases, the *ICD-9-CM* codes listed below may require additional 4<sup>th</sup> or 5<sup>th</sup> digits to ensure code validity.

Please contact Shirley Pittz at 907-269-8923 with the Office of Children's Services Infant Learning Program with questions about the use of *DC: 0-3R*.

<b>DC: 03R – Diagnosis</b>		<b>ICD-9-CM Diagnosis</b>	
<b>Axis 1</b>			
100.	Posttraumatic Stress Disorder	308.3	Other acute reactions to stress
		309.81	Prolonged post-traumatic stress disorder
150.	Deprivation/Maltreatment Disorder	308.4	Mixed disorders as reaction to stress
		308.9	Unspecified acute reaction to stress
		313.89	Other or mixed emotional disturbances of childhood or adolescence, Other – (Reactive Attachment Disorder)
<b>200.</b>	<b>Disorders of Affect</b>	313.9	Unspecified emotional disturbance of childhood of adolescence
<b>210.</b>	<b>Prolonged Bereavement/Grief Reaction</b>	309.0	Brief depressive reaction
		309.1	Prolonged depressive reaction
<b>220.</b>	<b>Anxiety Disorders of Infancy and Early Childhood</b>	300.00	Anxiety state, unspecified
	221 Separation Anxiety Disorder	313.0	Overanxious disorder
	222 Specific Phobia	309.21	Separation Anxiety Disorder
		300.29	Other isolated or specific phobias
	223 Social Anxiety Disorder (Social Phobia)	300.23	Social Phobia
	224 Generalized Anxiety Disorder	300.02	Generalized Anxiety Disorder
	225 Anxiety Disorder NOS	300.0	Anxiety state, unspecified
<b>230.</b>	<b>Depression of Infancy and Early Childhood</b>	311	Depressive disorder, NOS
		300.4	Dysthymic disorder
		313.1	Misery and unhappiness Disorder
231.	Type I: Major Depression	296.2	Major Depressive Disorder, single episode
		296.3	Major depressive disorder, recurrent episode
		301.1	Prolonged depressive disorder
232.	Type: II: Depressive Disorder NOS	311	Depressive disorder, NOS
<b>240.</b>	<b>Mixed Disorder of Emotional Expressiveness</b>	313.8	Other or mixed emotional disturbances of childhood or Adolescence
		313.9	Unspecified emotional disturbance of childhood or adolescence



<b>300. Adjustment Disorder</b>	309. Adjustment Reaction
	309.0 Adj. Dis. w/depressed mood
	309.2 w/predominant disturbance of other emotions (range from 309.21-309.29)
	309.3 Adjustment disorder w/disturbance of conduct
	309.4 Adjustment disorder w/mixed disturbance of emotions and conduct
	309.8 Other specified adjustment reactions (range from 309.81- 309.89)
	309.9 Unspecified adjustment reaction
<b>400. Regulation Disorders of Sensory</b>	313.9 Unspecified emotional disturbance of childhood
410. Hypersensitive	
411. Type A: Fearful/Cautious	313.22 Sensitivity/shyness disorder of childhood
	313.22 Introverted disorder of childhood
412. Type B: Negative Defiant	313.81 Oppositional defiant disorder
	313.9 Unspecified emotional disturbance of childhood or adolescence
420. Hyposensitive/Underresponsive	313.2 Sensitivity, shyness, and social withdrawal disorder
	313.9 Unspecified emotional disturbance of childhood
430. Sensory Stimulation-Seeking/	314 Hyperkinetic syndrome of Impulsive Childhood (range of diagnosis from 314.0– 314.9)
	313.9 Unspecified emotional disturbance of childhood
<b>500. Sleep Behavior Disorder</b>	307.40 Non-organic sleep disorder, unspecified
	307.47 Other dysfunctions of sleep stages or arousal from sleep
	307.49 Other
<b>510. Sleep-Onset Disorder (Protodyssomnia)</b>	307.41 Transient disorder of initiating or maintaining sleep
	307.42 Persistent disorder of initiating or maintaining sleep



<p><b>520. Night-Waking Disorder (Protodyssomnia)</b></p>	<p>307.41 Transient disorder of initiating or maintaining sleep  307.42 Persistent disorder of initiating or maintaining sleep  307.46 Sleep arousal disorder  307.47 Other dysfunction of sleep stages or arousal from sleep</p>
<p><b>600. Feeding Behavior Disorder</b></p> <p>601. Feeding Disorder of State Regulation  602. Feeding Disorder of Caregiver-Infant Reciprocity  603. Infantile Anorexia  604. Sensory Food Aversions  605. Feeding Disorder Associated w/Concurrent Medical Condition  606. Feeding Disorder Associated w/Insults to Gastro-Intestinal Tract</p>	<p>307.5 Other and unspecified disorders of eating  307.49 Eating disorder, unspecified  307.59 Other (Feeding disorder of infancy or early childhood of non-organic origin)</p>
<p><b>700. Disorder of Relating and Communicating</b></p>	<p>299 Pervasive developmental disorders (range from 299.0 – 299.9)  315.9 Developmental disorder NOS</p>
<p><b>710. Multisystem Developmental Disorder (MSDD)</b></p>	<p>299 Pervasive developmental disorders (range from 299.0 – 299.9)  315.9 Developmental disorder NOS</p>
<div style="border: 1px solid black; padding: 5px;"> <p>The use of V-codes are subject to additional medical necessity reviews.</p> </div>	<p><b>V61.20 Parent-Child Relational Problem</b>  <b>V61.21 Child Neglect/Physical/Sexual Abuse</b>  <b>V61.8 Sibling Relational Problem</b>  <b>V61.9 Relational Problem Related to a Mental Disorder or General Medical Condition</b>  <b>V62.82 Bereavement</b>  <b>V71.02 Child or Adolescent Antisocial Behavior</b></p>

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R) may be ordered from: Zero to Three, 2000 M St., NW, Ste. 200, Washington, DC 20036-3307. [www.zerotothree.org/estore](http://www.zerotothree.org/estore)



# Affiliated Computer Services, Inc. Certificate of Medical Necessity, Page 1 of 2

ACS is now a Xerox company

Submitted by: \_\_\_\_\_

Date: \_\_\_\_\_

Recipient Name: \_\_\_\_\_

Ordering Provider's Name: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

Medicaid ID# or AK License #: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex: \_\_\_ (M or F)

Telephone #: (\_\_\_) \_\_\_-\_\_\_ Ext. \_\_\_

HT: \_\_\_ (inches) WT: \_\_\_ (pounds)

Retrospective Review? \_\_\_ (Y/N)

Date of last visit: \_\_\_\_\_

### SECTION A: CLINICAL INFORMATION

(THIS SECTION **MUST** BE COMPLETED BY THE ATTENDING PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT OR AUDIOLOGIST.)

**DIAGNOSIS**

**ICD-9-CM**

Estimated Length of Need (# of Months): \_\_\_\_\_ 1 – 99 (99 = Lifetime)

**SECTION B: CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEM(S) AND PLAN:** Record information indicating the medical necessity of the requested services or items. Attach any additional information pertinent to the necessity of the requested equipment. (THIS SECTION MAY BE COMPLETED BY THE ATTENDING SPECIALIST, INCLUDING THE PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, SPEECH LANGUAGE PATHOLOGY THERAPIST, REGISTERED DIETITIAN, AUDIOLOGIST, OR OTHER ATTENDING SPECIALIST WITHIN THE SCOPE OF HIS OR HER SPECIALTY.)

**PLAN:** The plan should list each service or item specifically needed for the treatment of the recipient. Additional information may be attached to this form.

### ATTESTATION, SIGNATURE AND DATE OF AUDIOLOGIST/PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT AND SPECIALIST (Note: Specialist = PT, OT, SLP, RD, MD, NP, PhD, LSW, etc.)

*A physician, nurse practitioner, physician assistant, audiologist or specialist who attests to the medical necessity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.*

\_\_\_\_\_  
Signature of Specialist – Title

\_\_\_\_\_  
Date

*This must be signed by the specialist if Section B is completed by someone other than the provider in Section A.*

\_\_\_\_\_  
Signature of Audiologist / Physician / Nurse Practitioner / Physician Assistant

\_\_\_\_\_  
Date

*I hereby certify that I am the ordering audiologist/physician/nurse practitioner/physician assistant identified in this form.*



A xerox Company

**Affiliated Computer Services, Inc.  
Certificate of Medical Necessity, Page 2 of 2**

ACS is now a Xerox company

Submitted by: \_\_\_\_\_

Date: \_\_\_\_\_

Recipient Name: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex: \_\_\_ (M or F)

Ordering Provider's Name: \_\_\_\_\_

Medicaid ID# or AK License #: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

**SECTION C: REQUESTED SERVICES OR ITEMS**  
*(To Be Completed by DME, P&O, Audiology, or Hearing Aid Providers)*

Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

Provider Medicaid No.: \_\_\_\_\_

Requester Name: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Fax #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Dates of Need – Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**ACS Use Only**

Your request is:

Approved as requested

Approved as modified  
(Items marked as authorized may be claimed.)

Prior Authorization Number:  
\_\_\_\_\_

From Date: \_\_\_\_\_ Thru Date:  
\_\_\_\_\_

Denied

Authorizing Agent Signature & Date:

Comments:

	Procedure Code	Mod.	Description	QTY (#)	Charges	Authorized		Approved Quantity	Approved Amount
						Yes	No		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									

**SECTION D: SUPPLIER ATTESTATION, SIGNATURE AND DATE**

*I certify that those services or items listed in this form are those exact services or items ordered and certified as medically necessary by the ordering audiologist/physician/nurse practitioner/physician assistant specified in this form, and that these exact services or items listed in this form will be supplied to the specified recipient. A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.*

\_\_\_\_\_  
Signature of Supplier

\_\_\_\_\_  
Date

**Appendix A**  
**Select Diagnoses and Procedures Pre–certification List**  
Effective January 1, 2010\*

**DIAGNOSES/SYMPTOMS REQUIRING PRE–CERTIFICATION**  
**FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS**

Diagnosis	ICD–9 CM Diagnosis Code	LOCATION		REVIEW METHOD	
		Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Gastroenteritis	001.1, 002.0, 002.9, 003.0, 004.9, 005.0, 005.1, 005.9, 006.0 through 006.2, 006.9, 007.1, 007.2, 007.8, 007.9 008.00 through 008.04, 008.09, 008.1, 008.2, 008.3, 008.5, 008.8, 008.41 through 008.47, 008.49, 008.61 through 008.69, 008.8, 009.0, through 009.3, 014.80-014.86, 112.85, 487.8, 536.8, 556.0 through 556.9, 557.0, 557.1, 557.9, 558.1, 558.2, 558.3, 558.41, 558.9, 564.9, 569.9	✓		✓	
Cellulitis	682.0 through 682.9	✓		✓	
Respiratory Illness Bronchitis	466.0 through 466.19 (Children under the age of five ( <i>1825 days</i> ) are excluded from pre–certification. Continued Stay Review is required after day 3, as are all hospital stays.)	✓		✓	
Pneumonia	480.9 through 486 (Children under the age of five ( <i>1825 days</i> ) are excluded from pre–certification. Continued Stay Review is required after day 3, as are all hospital stays.)	✓		✓	
Physical Rehabilitation	V57.0, V57.1, V57.21, V57.22, V57.3, V57.4, V57.81, V57.89, V57.9	✓		✓	
<b>All Admissions to Long Term Acute Care Facilities (LTAC)</b>		✓		✓	

All categories on this page require the facility’s Utilization Review Department to notify Qualis Health of urgent/emergent admits within 24 hours or the next business day. The attending physician is responsible for pre-certifying any non-urgent/emergent admissions for the above diagnoses/symptoms.

PROCEDURES REQUIRING PRE-CERTIFICATION  
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

Procedure	ICD-9 CM Procedure Code	CPT® Code	LOCATION		REVIEW METHOD	
			Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Alcohol Detoxification	94.62	90899	✓		✓	
Drug Detoxification	94.65	90899	✓		✓	
Combined Alcohol & Drug Detoxification	94.68	90899	✓		✓	
Cochlear device implantation	20.95, 20.96, 20.97, 20.98, 20.99	69930	✓	✓	✓	
Cholecystectomy	51.21 through 51.24	47562, 47563, 47564, 47600, 47605, 47610, 47612, 47620	✓	✓	✓	
Gastric Bypass for Obesity	44.31	43644, 43645, <b>43775</b> , 43845, 43846, 43847, 43848, 43850, 43886, 43887, 43888, 47740, 47741				
Laparoscopic Gastroplasty/Gastric Bypass	44.68	43645, 43843	✓	✓		✓
Gastric Adjustable Band	44.95	43845, 43770, 43771, 43772, 43773, 43774, 43842				
Duodenal Switch	43.89, 45.91	43845				
Hysterectomy ( <b>All Hysterectomies must have informed consent and meet the following criteria:</b> <ul style="list-style-type: none"> <li>• Patient must be over 21 years of age</li> <li>• Patient must be mentally competent)</li> </ul>						
Abdominal	68.39, 68.49, 68.69	58150, 58152, 58180, 58200, 58951, 58953, 58954, 58956, 59135, 59525	✓	✓	✓	
Vaginal	68.51, 68.59, 68.71, 68.79	58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294	✓	✓	✓	
Laparoscopic	68.31, 68.41, 68.51, 68.61, 68.71	58550, 58552, 58553, 58554, S2078, 58541, 58542, 58543, 58544, 58548, 58570, 58571, 58572, 58573, 58578	✓	✓	✓	
Radical	68.8	58210, 58240, 58548	✓	✓	✓	
Laminectomy/Diskectomy	03.02, 03.09, 80.50, 80.51	63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200, 63250, 63251, 63252, 63265, 63266, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63295	✓	✓	✓	

PROCEDURES REQUIRING PRE-CERTIFICATION  
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

Procedure	ICD-9 CM Procedure Code	CPT® Code	LOCATION		REVIEW METHOD	
			Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Division of intra-spinal nerve root-Rhizotomy	03.1	63185, 63190, 0090T, 0091T, 0092T, 0093T, 0095T, 0096T, 0098T	✓	✓	✓	
Internal fixation of bone without fracture reduction	78.59	22841	✓		✓	
Spinal Fusion (arthrodesis)	81.00 through 81.08, 81.30 through 81.39, 84.51, 84.52, 81.62, 81.63, 81.64	22585, 22614, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22851, 27280	✓		✓	
Cervical including revision	81.01, 81.02, 81.03, 81.31, 81.32, 81.33	22548, 22554, 22590, 22595, 22600	✓	✓	✓	
Dorsal/Thoracic including revision	81.04, 81.05, 81.34, 81.35	22532, 22556, 22610	✓	✓	✓	
Lumbar/Lumbosacral including revision	81.06, 81.07, 81.08, 81.36, 81.37, 81.38	22533, 22534, 22558, 22612, 22630	✓	✓	✓	
Insertion of Spinal disc prosthesis	84.60	22851, 22852, 22855, 22857, 22862, 22864, 22865, 0090T, 0092T, 0163T				
Revision or Replacement	84.69					
Cervical						
Insertion of partial spinal disc prosthesis	84.61					
Insertion of total spinal disc prosthesis	84.62					
Revision, Replacement or Removal	84.66					
Dorsal/Thoracic						
Insertion of partial spinal disc prosthesis	84.63					
Revision or Replacement	84.67					
Lumbar/Lumbosacral						
Insertion of partial spinal disc prosthesis	84.64					
Insertion of total spinal disc prosthesis	84.65					
Revision or Replacement	84.68					
Mastopexy	85.6, 85.70, 85.71, 85.72, 85.73, 85.74, 85.75, 85.76, 85.79					
Mastectomy	85.4, 85.41	19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307				
Mammoplasty (reduction)	85.31 (unilateral) 85.32 (bilateral)	19318				
Mammoplasty	85.5, 85.50	19324				
Unilateral injection to breast for augmentation	85.51	19324				

PROCEDURES REQUIRING PRE-CERTIFICATION  
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

Procedure	ICD-9 CM Procedure Code	CPT® Code	LOCATION		REVIEW METHOD	
			Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Bilateral injection to breast for augmentation	85.52	19324				
Unilateral prosthetic implant	85.53	11970, 19325, 19340, 19342				
Bilateral prosthetic implant	85.54	19325, 19340, 19342				
Removal of prosthetic implant	85.94	19328, 19330				
Revision of implant of breast	85.93	19342				
Breast reconstruction with insertion of breast tissue expander	85.95	19357				
Removal of breast tissue expander	85.96	19357				
Other	85.99, 85.85, 85.87	19350, 19355, 19361, 19364, 19366, 19367, 19368, 19369, 19396				
Revision of reconstructed breast	85.53, 85.89	19342, 19380				
Unlisted procedure, breast	85.99	19499				
Unilateral Subcutaneous mastectomy with implant	85.33	19304				
Unilateral Subcutaneous mastectomy NEC	85.34	19304				
Bilateral Subcutaneous mastectomy with implant	85.35	19304				
Other bilateral subcutaneous mastectomy	85.36	19304				
Breast DIEP Flap Reconstruction	85.85	S2068				
Panniculectomy/Abdominoplasty	86.83	15830, 15847	✓	✓		✓
Total Knee Replacement	81.54	27440, 27441, 27442, 27443, 27445, 27446, 27447				
Revision of Knee Replacement	81.55, 81.59, 00.80, 00.81, 00.82, 00.83, 00.84	27486, 27487	✓		✓	
Meniscectomy, Knee ( <i>Inpatient only</i> )	80.6	27332, 27333, 29880, 29881	✓		✓	
Total Hip Replacement	81.51	27130	✓		✓	
Revision-Total or Partial	81.53, 81.59, 00.70, 00.71, 00.72, 00.73, 00.74, 00.75, 00.76, 00.77, 00.85, 00.86, 00.87	27132, 27134, 27137, 27138	✓		✓	
Partial Hip Replacement	81.52	27125	✓		✓	
Total Ankle Replacement including revision	81.56, 81.59	27700, 27702, 27703	✓		✓	
Video/telemetric EEG Monitoring	89.19	95950, 95951, 95953, 95956	✓		✓	

PROCEDURES REQUIRING PRE-CERTIFICATION  
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

**IMPORTANT COVERAGE INFORMATION ABOUT TRANSPLANTS**

• **Alaska Medicaid Regulations provide for limited coverage of transplants.**

- All transplants must be medically necessary.
- Kidney/cornea/skin/bone transplants do not require preauthorization from Qualis Health
- All other covered transplants listed below require preauthorization from Qualis Health.
- Multiple organ transplants including any of the procedures below require preauthorization.

**TRANSPLANTS NOT LISTED BELOW ARE NOT COVERED BY ALASKA MEDICAID.**

**Transplant Procedures Requiring Special Review**

Procedure	ICD-9 CM Procedure Code	CPT® Code	LOCATION		REVIEW METHOD	
			Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Bone Marrow Transplant (includes stem cell transplant) Autologous	41.00, 41.01, 41.04, 41.07, 41.09	38241	} Commonly performed for many leukemia's, however some cases require special review, depending on clinical circumstances.	✓	✓	
Allogenic	41.02, 41.03, 41.05, 41.06, 41.08	38240 38242				
Liver Transplant (Cadaver)	50.51, 50.59	47135, 47136				
Liver Transplant (Living Donor)	50.59	47135, 47136	✓			✓
Heart Transplant, including <b>Artificial Heart</b> (All ages covered, effective 8/26/08)	37.51, 37.52, 37.53, 37.54	33945	✓			✓
Lung Transplant (All ages covered, effective 8/26/08)	33.50, 33.51, 33.52	32851, 32852, 32853, 32854	✓			✓
Heart/Lung Transplant (All ages covered, effective 8/26/08)	33.6	33935	✓			✓

**Other Surgical Procedures Requiring Special Review**

Gastric Neurostimulator	<b>04.92, 86.94</b>	43647, 43648, 43881, 43882, 64590, 64595	✓	✓		✓
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