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United States Virgin Islands Department of Human Services

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1.0 General Information

This policy chapter applies to the following licensed physicians and non-physician practitioners acting within the scope of their practice: physicians (MD, DO); doctors of podiatric medicine (DPM); physician assistants (PAs); advance practice registered nurses (APRNs), including certified nurse practitioners (NPs), certified nurse midwives (CNMs), and certified registered nurse anesthetists (CRNAs).

Information in this policy chapter is included to assist the practitioner in determining how the VI Medicaid Program covers specific services. This information should be used in conjunction with all other applicable policies and provisions of the VI Medicaid Program's provider manuals.

The policy and all its subchapters will be reviewed periodically to incorporate updates in federal and territory regulations, medical coverage determinations, or organizational changes.

1.1 Medical Necessity

The VI Medicaid Program covers medically necessary professional services provided by enrolled, licensed practitioners acting within the scope of their license provided to eligible Medicaid members. This includes, but is not limited to, medically necessary healthcare services that are evidence-based and provided within generally accepted clinical standards of medical practice to help prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms.

The VI Medicaid Program may deny or recoup payment if a service fails to meet VI Medicaid Program medical necessity requirements.

1.2 Administrative Services

Services of physicians, medical staff, or other licensed or certified health professionals functioning in an administrative or teaching capacity for a hospital or nursing facility (including physician-owners or other staff paid by the physician) are not covered separately as physician services.

Pathology services or interpretive studies done for a hospital or nursing facility quality improvement purpose or other reasons which do not directly assist with the specific care and treatment of a specific member are considered administrative services and are not separately covered as physician services. These services are included in the facility's allowable costs and are paid to the facility.

1.3 Component Services

Many physician services are covered as global services. A global service includes all resources necessary to perform the procedure (e.g., office overhead, equipment, supplies, and staff) and the services provided by the physician, such as interpretation of results and preparation of a report of findings.



Some services are divided into a professional component and a technical component for coverage purposes. The professional component includes the services provided by the physician while the technical component includes equipment supplies and technical staff.

Coverage for the professional component or the technical component generally depends on where the service is provided and who provides that portion of the service. Services for which the components are covered for the physician are identified in the Medicare Physician Fee Schedule Relative Value Unit (RVU) file. Refer to the Centers for Medicare & Medicaid Services (CMS) Medicare website for additional information.

Global services are covered for the physician in non-facility settings. The professional component is covered for the physician in any setting. The technical component is only covered when the service is provided in an appropriate non-facility setting. The global service and its professional component services cannot both be covered by the same service because the professional component is included in the global service.

1.4 Hospital-Based Providers

The VI Medicaid Program covers services by hospital-based providers (HBPs). An HBP is employed by the hospital. Each HBP has their own assigned National Provider Identifier (NPI) number. The VI Medicaid Program follows Medicare guidelines for the coverage of HBP services provided by physicians. Generally, professional services provided by non-physician providers employed by a hospital are included in the hospital cost report and reimbursed to the hospital.

1.5 Physician Supervision and Delegation

Physician services covered by the VI Medicaid Program must be performed by the enrolled physician personally, the physician's employee, or an employee of the same legal entity that employs the physician, under the physician's delegation and supervision in accordance with USVI Territory law, professional scope of practice, and program and organizational policy.

Physicians and non-physician practitioners must enroll in the VI Medicaid Program to be eligible to receive Medicaid payments. Billing for services provided by a non-enrolled practitioner under another practitioner's name and NPI is not permitted.

1.6 Physician Services in Teaching Settings

Administrative costs associated with teaching physician services, as well as payment for direct patient care services provided by a resident (including interns or fellows) in a teaching setting and supervised by a teaching physician, are subject to guidelines and conditions developed and published by CMS. Teaching institutions and teaching physicians within those institutions must abide by the CMS teaching physician guidelines which explain when services provided in teaching settings can be covered by the VI Medicaid Program or must be included as allowable medical education costs in the hospital's cost report. Services covered by the VI Medicaid



Program under these guidelines must be identified with the appropriate reporting modifier on claims for reimbursement.

1.7 Physician Responsibility

The physician is responsible for verifying a member's Medicaid eligibility and obtaining appropriate authorization before services are provided.

Determination of medical necessity and appropriateness of services is the physician's responsibility within the scope of currently accepted medical practice and the VI Medicaid Program limitations. The physician is held responsible if they order excessive or unnecessary services (e.g., diagnostic tests, prescriptions) regardless of who renders or who receives payment for the service. The physician may also be subject to any corrective action related to these services, including recovery of funds.

Services generally must be ordered by a VI Medicaid Program enrolled physician to be covered by Medicaid. Some services provided by other providers, such as medical suppliers, laboratory services, and prescriptions, may require the physician to provide written documentation to support the need for the service.

1.8 Prior Authorization

The VI Medicaid Program requires prior authorization (PA) to cover certain services before those services are rendered to the member. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or member Medicaid eligibility.

For additional information on prior authorization requirements, refer to the VI Medicaid Program Provider Manual, General Information chapter applicable to all providers.

1.9 Physician-Administered Drugs

A physician-administered drug is an oral, injectable, intravenous, or inhaled drug administered by a physician or a medical professional within their scope of practice.

The VI Medicaid Program covers injectable drugs and biological products administered by a physician in the office, clinic setting, and in the member's home. The drug or biological product must be Food and Drug Administration (FDA) approved and reasonable and necessary according to acceptable standards of medical practice for the diagnosis or treatment of the illness or injury of the member. There must be sufficient clinical evidence demonstrating the effectiveness and safety of the drug or biological product.

To help ensure the content and integrity of the drugs administered to members, prescribers are required to obtain all drugs that will be administered in their offices. Prescribers may obtain a physician-administered drug from a pharmacy provider if the drug is delivered directly from the pharmacy to the prescriber's office. Prescribers may also obtain a drug to be administered in the prescriber's office from a drug wholesaler or direct purchase. Pharmacy providers should not



dispense a drug to a member if the drug is administered in the prescriber's office or other outpatient visit.

Pharmacies, including mail order pharmacies, who are providing the drugs for a clinic visit must bill the clinic and not the VI Medicaid Program for the drugs dispensed. The VI Medicaid Program will make an exception only if a member has third-party liability and the third-party payer requires that the drugs be billed through the pharmacy benefit.

The VI Medicaid Program generally does not reimburse physicians and practitioners for the administration of drugs or biological products that can be self-administered, such as those in pill form or used for self-injection.

1.9.1 Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excluding Chemotherapy)

A therapeutic, prophylactic, or diagnostic intravenous (IV) infusion or injection, other than hydration, is for the administration of substances/drugs. The fluid used to administer the drug(s) is incidental hydration and is not separately payable. If performed to facilitate the infusion or injection or hydration, the following services and items are included and are not separately billable:

1. Use of local anesthesia
2. IV start
3. Access to indwelling IV, subcutaneous catheter, or port
4. Flush at conclusion of infusion
5. Standard tubing, syringes and supplies.

Payment for the above is included in the payment for the medication administration or nonchemotherapy injection and infusion service

If a significant separately identifiable evaluation and management service is performed, the appropriate evaluation and management (E/M) code should be reported utilizing Modifier 25 in addition to the chemotherapy administration or nonchemotherapy injection and infusion service. For an evaluation and management service provided on the same day, a different diagnosis is not required.

1.9.2 Chemotherapy Administration

Chemotherapy administration is considered highly complex and requires physician or qualified health professional work and monitoring beyond the level of the therapeutic, prophylactic, and diagnostic injections and infusions, due to the high incidence of potentially adverse reactions for the patient. This service typically requires direct supervision from qualified health professionals and/or clinical staff with advanced practice training in the special considerations of preparation,



dosage, and disposal and often involves frequent monitoring of the patient and conferring with a physician.

Chemotherapy administration services and reporting codes apply to parenteral administration of non-radionuclide anti-neoplastic drugs, to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for autoimmune conditions), and to substances such as monoclonal antibody agents, and other biologic response modifiers.

The administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients is not considered chemotherapy administration.

If performed to facilitate the chemotherapy infusion or injection, the following services and items are included and are not separately billable:

1. Use of local anesthesia
2. IV access
3. Access to indwelling IV, subcutaneous catheter, or port
4. Flush at the conclusion of infusion
5. Standard tubing, syringes, and supplies
6. Preparation of chemotherapy agent(s)

Payment for the above is included in the payment for the chemotherapy administration service. If a significant, separately identifiable evaluation and management service is performed, the appropriate E/M code should be reported utilizing Modifier 25 in addition to the chemotherapy code. For an evaluation and management service provided on the same day, a different diagnosis is not required.

1.9.3 Outpatient Physician-Administered Drugs NDC Reporting

Medicaid programs are required to collect information about covered outpatient drugs administered by physicians. To comply, Medicaid programs must gather utilization data including the National Drug Code (NDC), quantity, and unit of measure from claims submitted for physician-administered drugs.

Providers must include the correct NDC information on all claims, including Medicare and other third-party claims, when billing non-vaccine drugs using Healthcare Common Procedure Coding System (HCPCS) codes. Participants in the 340B Drug Pricing Program are included in the NDC reporting requirements.

1.9.4 Reporting the Discarded Portion of Administered Drugs

When a provider must discard the remainder of a single-use vial or other single-use package after administering a dose or quantity of the drug or biological, report the amount of the unused and discarded drug on a separate claim line using the JW modifier. Providers are expected to



use the package size that minimizes the amount of waste billed to Medicaid. For example, if a member needs 50 mg of drug and the product comes in 50 mg and 100 mg vials, use the 50 mg vial.

The JW modifier is not permitted when the actual dose of the drug or biological administered is less than the billing unit. The JW modifier is not appropriate for drugs from multiple-dose vials or packages.

1.10 Laboratory Services in Office Settings

The VI Medicaid Program covers laboratory services provided in a physician's office laboratory when they are appropriate to be performed in the office, and the laboratory is certified to perform the specialties or subspecialties of tests billed. The laboratory must hold a Clinical Laboratory Improvement Amendments Act of 1988 (CLIA) certificate of registration, certificate of waiver, or certificate of Physician Performed Microscopy Procedures (PPMP) from CMS. The physician's office laboratory's CLIA number must be present on the claim for laboratory services to be considered for reimbursement.

Laboratory testing performed in a profile, panel, or battery is covered only when all the included tests are reasonable and necessary for the member. If all tests of a CPT-defined laboratory panel are performed, the provider is to bill the panel code and not bill the individual component codes separately. Unbundling panel codes and billing individual tests when the panel code is applicable will result in claim rejections or denials.

1.11 Supplies in the Office Setting

Payments to physicians include payment for the office overhead expenses associated with the service. In most cases, the overhead includes the supplies used or provided by the physician in connection with the service, and the supplies are not separately reimbursed.

Providers must not require members to purchase an item in advance from a pharmacy or medical supplier that is an integral component of this service. Surgical dressings applied by a physician in the office or other non-facility setting are not covered separately.

The VI Medicaid Program does not cover take home supplies dispensed from the office setting. If a member requires in-home supplies, a written prescription must be presented to the pharmacy or medical supplier, and supplies dispensed accordingly. In keeping with the RVU based fee schedule, The VI Medicaid Program separately covers a limited number of supplies used in the office setting (such as intrauterine devices and casting supplies) because an allowance for these supplies is not typically included in the respective RVU procedure code reimbursement.

1.12 Uniform Reporting of Services

The VI Medicaid Program follows the American Medical Association's (AMA's) manual and coding guidelines for Current Procedural Terminology (CPT) numeric codes, and the Level II



Healthcare Common Procedure Coding System (HCPCS). In conjunction with the CPT/HCPCS coding systems to describe services rendered, the VI Medicaid Program utilizes the Medicaid National Correct Coding Initiative (NCCI) coding policies and edits as developed by CMS to promote national correct coding methods.

Providers shall report the HCPCS/CPT code describing the procedure performed to the greatest specificity possible. A HCPCS/CPT code shall be reported only if all services described by the code are performed. A provider shall not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services performed. This type of unbundling is incorrect coding.



2.0 Anesthesia Services

This policy outlines the VI Medicaid Program coverage and conditions under which anesthesia services are covered under the program. It provides information regarding eligibility, benefits, limitations, and exclusions related to anesthesia administration and management.

2.1 Definitions

- **Anesthesia Services:** Refers to the administration of medications to induce a state of controlled unconsciousness or sedation to undergo surgery or other medical procedures
- **General Anesthesia:** A medically induced coma to prevent pain during surgery or procedures
- **Regional Anesthesia:** Anesthesia that numbs a specific region of the body (e.g., epidural or spinal block)
- **Monitored Anesthesia Care (MAC):** A type of anesthesia that includes sedation and monitoring of vital signs without inducing full unconsciousness
- **Sedation:** A lesser form of anesthesia, typically involving light or moderate sedation, to help a patient relax during a procedure
- **Anesthesiologist:** A physician specially trained in anesthesia and its administration
- **Certified Registered Nurse Anesthetist (CRNA):** A licensed professional nurse with advanced education and training in anesthesia
- **Base Units:** A fixed value assigned to anesthesia procedures under Medicare's fee schedule
- **Time Units:** Calculated based on the duration of anesthesia services, generally in 15-minute increments
- **Conversion Factor:** A territory regional value applied to determine reimbursement for anesthesia services

2.2 Coverage Criteria

Anesthesia services are covered when they are medically necessary for the performance of an eligible medical procedure. Coverage is provided for anesthesia services when the following conditions are met:

1. **Medically Necessary:** The anesthesia service must be deemed medically necessary for the procedure, as determined by the attending physician or surgeon. Medical necessity includes situations where anesthesia is required to perform diagnostic procedures, surgery, or other medically indicated interventions.



2. **Covered Procedures:** Anesthesia services are covered for a wide range of surgical and non-surgical procedures, including, but not limited to:
 - Major and minor surgeries
 - Obstetric procedures (e.g., labor, delivery)
 - Diagnostic procedures (e.g., endoscopies, biopsies)
 - Pain management procedures (e.g., epidural injections, nerve blocks)
3. **Anesthesia Provider:** Coverage is provided when anesthesia is administered by qualified enrolled VI Medicaid Program providers such as:
 - Anesthesiologists (MD/DO)
 - Certified registered nurse anesthetists (CRNA), under the supervision of an anesthesiologist, where required
 - Anesthesia assistants (in accordance with applicable regulations).

There is no separate coverage for anesthesia services performed by physicians who are also performing the medical or surgical service requiring anesthesia. Any anesthesia service provided personally by the surgeon is included in the reimbursement for the surgical procedure itself.

4. **Types of Anesthesia:**
 - **General Anesthesia:** Coverage for general anesthesia services, including medications, monitoring, and all associated costs
 - **Regional Anesthesia:** Coverage for spinal, epidural, and nerve blocks, if they are medically necessary
 - **Monitored Anesthesia Care (MAC):** Coverage for MAC when necessary for patient safety and comfort. MAC involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician of the patient's physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure
 - **Moderate Conscious Sedation:** Coverage of moderate conscious sedation when the service is not bundled into the procedure being provided. Moderate sedation is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands. It does not include minimal sedation, deep sedation, or monitored anesthesia care
5. **Prior Authorization Requirements:** Certain specialized anesthesia services may require prior authorization from the VI Medicaid Program. For example, certain types of



anesthesia for outpatient or elective procedures may require review before approval. For additional information on prior authorization requirements, refer to the VI Medicaid Program Provider Manual, General Information chapter applicable to all providers.

6. **Settings for Coverage:** Anesthesia coverage is applicable in a variety of settings, including, but not limited to:
 - Hospitals
 - Ambulatory Surgical Centers (ASCs)
 - Physician offices for certain procedures
 - Outpatient surgical centers
 - Dental offices
7. **Emergency Situations:** Anesthesia services provided in emergencies are covered, regardless of prior authorization, when medically necessary to manage the patient's condition.
8. **Medically Directed Anesthesia Services:** The VI Medicaid Program reimburses for anesthesiologist medical direction consistent with anesthesia team practice only when the physician fulfills specific requirements, as documented in the patient's record:
 - Performs the pre-anesthetic examination and evaluation
 - Prescribes the anesthesia plan
 - Personally participates in the most demanding services in the anesthesia plan including, if applicable, induction and emergence
 - Ensures that a qualified individual performs any services in the anesthesia plan that the physician does not personally perform
 - Monitors the course of anesthesia administration at frequent intervals
 - Remains physically present and available for immediate diagnosis and treatment of emergencies; and
 - Provides indicated post-anesthesia care

Physicians who provide medical direction of anesthesia care generally cannot provide additional services to other patients.
9. **Pain Management:** The VI Medicaid Program covers post-operative pain management, including the use of anesthetic techniques such as nerve blocks, epidural injections, or continuous analgesia.
10. **Other Anesthesia Services:** The VI Medicaid Program separately covers certain medical or surgical services rendered by a provider while furnishing anesthesia services



to a patient. These services include the insertion of a Swan Ganz catheter, insertion of a central venous pressure line, emergency intubations, and critical care. Payment for these specific services is not based on time unit reporting but is based on the VI Medicaid Program fee schedule for the procedure code.

2.3 Exclusions

The following services are excluded from the VI Medicaid Program anesthesia coverage:

1. **Cosmetic Procedures:** Anesthesia for elective cosmetic or non-medically necessary procedures (e.g., liposuction, breast augmentation) is not covered unless it is medically necessary.
2. **No Prior Authorization:** Certain non-urgent or elective procedures requiring anesthesia may not be covered if prior authorization was not obtained (where required).
3. **Administrative Services:** Administrative services provided by anesthesia providers, such as non-essential consultations or pre-operative evaluations not directly related to anesthesia management, are not covered.

2.4 Billing and Reimbursement

- **Anesthesia Billing Codes:**

Anesthesia providers must submit claims using the appropriate CPT codes and anesthesia billing codes (e.g., for time-based billing or flat-fee billing). Anesthesia CPT codes include all services integral to the anesthesia procedure, such as preparation, monitoring, intra-operative care, and post-operative care until the patient is released by the anesthesia practitioner to the care of another physician or other qualified healthcare professional.

Only one primary anesthesia service should be reported for a surgical session. Providers should use the anesthesia code related to major surgery.

- **Anesthesia Base Units:**

Anesthesia base units represent the value assigned by CMS to each anesthesia CPT code. Anesthesia base units account for all other activities other than anesthesia time, which include usual pre-operative, intra-operative, and post-operative visits, administration of fluids and/or blood products incident to anesthesia care, and monitoring services. The anesthesia base units for each surgical procedure are specified in the anesthesia fee schedule.

For certain anesthesia services, reimbursement is based on the time spent administering anesthesia, including preparation and recovery time.



- **Time Reporting:**

- Anesthesia time is defined as the period during which an anesthesia practitioner is furnishing continuous anesthesia care to the patient. Anesthesia starts when the provider begins preparing the patient for the induction of anesthesia and ends when the patient is safely placed under post-anesthesia supervision.
- Anesthesia start and stop times must be documented in the medical record.
- Time is to be reported in actual minutes, converted into units for billing.
- The evaluation and examination of the patient prior to surgery is considered part of the anesthesia service and is included in the base unit value of the anesthesia code and is not to be reported in the anesthesia time.

- **Modifiers:**

- Providers are to report specific **HPCPS modifiers** to clarify the role of the anesthesia provider. Reimbursement adjustments may be made for medically directed anesthesia services. Every anesthesia service must have an appropriate anesthesia modifier reported on the claim service line:
 - **AA:** Anesthesiologist performing the service
 - **AD:** Supervision, more than four procedures
 - **QK:** Medical direction of two – four concurrent cases
 - **QX:** CRNA service with medical direction
 - **QY:** Medical direction of one CRNA by anesthesiologist
 - **QZ:** CRNA service without medical direction

- **Payment Calculation:**

Reimbursement is based on the following formula:

- Total Anesthesia Payment = (Base Units + Time Units + Modifier Adjustments) × Conversion Factor

- **Separate Billing for Pain Blocks:**

- Pain blocks or epidurals performed separately from the primary anesthesia procedure must be billed with distinct documentation and codes.



3.0 Antigen and Allergy Services

This policy outlines the VI Medicaid Program coverage and conditions for allergy testing and immunotherapy. Allergen immunotherapy is defined as the repeated administration of specific allergens to individuals with IgE-mediated conditions to protect against allergic symptoms and inflammatory reactions associated with natural exposure to these allergens. The VI Medicaid Program covers allergen immunotherapy in accordance with the Centers for Medicare & Medicaid (CMS) Medicare policies.

3.1 Coverage

Testing. Allergy testing is covered under the appropriate CPT/HCPCS code with the appropriate quantity as indicated by the code description. An evaluation and management (E/M) visit is covered in addition to the testing. Coverage of the testing includes the interpretation of the test results in relation to the history and physical examination of the member.

Immunotherapy. Immunotherapy services are covered under the appropriate CPT/HCPCS component codes. The services of the provider who prepares and provides the antigens/venoms are covered on a per dose basis. Services of the provider who parenterally administers the antigen/venom are covered under the appropriate injection codes. The injection and the antigen/venom preparation services are covered separately.

Allergen immunotherapy must be administered under the supervision of a physician who can recognize early signs and symptoms of anaphylaxis and administer emergency medications when necessary.

Allergy injection services are not covered in addition to the visit unless the visit represents another significant, separately identifiable service above and beyond the antigen/venom immunotherapy and the appropriate modifier is reported.

The VI Medicaid Program expects antigens to be prepared for administration over a period of increasing doses. Antigens are covered at the same rate per dose regardless of whether multiple or single dose vials are used. The VI Medicaid Program covers the dose administered and the preparation of the dose administered.

Any allergy testing and treatments that have not been proven to be effective are not covered.

3.2 Criteria and Indications

For allergen immunotherapy to be considered medically reasonable and necessary, **both** of the following criteria must be met:

1. The allergen(s) to which the patient is allergic must be clinically relevant
2. Trial of avoidance measures has failed or there is unavoidable exposure to allergy triggers identified in allergy testing



Covered Indications. Conditions for which immunotherapy will be considered medically reasonable and necessary include:

1. Allergic rhinitis
2. Allergic conjunctivitis
3. Allergic asthma
4. Dust mite atopic dermatitis
5. Stinging insect hypersensitivity (e.g., bees, hornets, wasps, fire ants)

Immunotherapy may have severe, unpredictable systemic and local reactions within the first 30 minutes following the injection. It is recommended that immunotherapy be administered in a setting that permits the prompt recognition and management of adverse reactions, particularly anaphylaxis. It is recommended that patients wait at the physician's office/medical clinic for at least 30 minutes after the immunotherapy injection.

Services performed for any given diagnosis must meet all the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.



4.0 Bariatric Services

This policy outlines the VI Medicaid Program coverage and conditions for bariatric surgery services. Bariatric services refer to the range of medical care and support provided to individuals considering or undergoing bariatric surgery, also known as weight loss surgery. The goal of these operations is to modify the stomach and intestines to treat obesity and related diseases.

4.1 Coverage

Bariatric surgery is a covered service for the treatment of obesity when medically indicated and when the procedure is performed within professional standards of medical practice. The VI Medicaid Program coverage aligns with the Medicare program. Covered surgical procedures may include, but are not limited to:

- Roux-en-Y Gastric Bypass
- Biliopancreatic Diversion with Duodenal Switch or Gastric Reduction Duodenal Switch
- Adjustable Gastric Banding
- Sleeve Gastrectomy
- Vertical Gastric Banding

Procedures considered investigational/experimental are not covered services.

Certain medically necessary reconstructive procedures to alleviate complications attributable to weight loss surgery may be covered. In cases where there has been substantial weight loss with significant skin redundancy with complicating factors, such as chronic pain or ulceration created by the abdominal skin folds, procedures such as panniculectomy surgeries may be medically indicated. Reconstructive surgical procedures will be considered on a case-by-case basis through the prior authorization (PA) process. The medical record must contain the following information for the consideration of reconstructive procedures:

- Description of the pannus and underlying skin
- Documentation that the panniculus causes chronic intertrigo (dermatitis occurring on the opposed surfaces of the skin, skin irritation, infection, or chafing)
- Description of functional impairments (e.g., difficulty walking, exercising, or impairment in activities of daily living)
- Description of conservative treatment the beneficiary has received and the results of treatment
- Preoperative photographs of the pannus and underlying skin are required

4.2 Criteria



Surgical management for the treatment of morbid obesity is considered reasonable and necessary for bariatric surgical procedures and laparoscopic sleeve gastrectomy when ALL the following conditions are met and recorded in the medical record:

- The patient meets the definition of morbid obesity, which is defined as a body mass index (BMI) ≥ 35 kg/m² and comorbid conditions exist (e.g., hypertensive cardiovascular disease, pulmonary/respiratory disease, diabetes, sleep apnea, or degenerative arthritis of weight-bearing joints). Documentation of the level of severity of the existing comorbid condition must be included in the patient's medical record
- The patient has been previously unsuccessful with medical treatment for obesity
- Treatable metabolic causes of obesity (e.g., adrenal or thyroid disorders) have been ruled out or have been clinically treated if present

4.3 Comorbid Conditions

Severe obesity is known to exacerbate numerous medical conditions. Comorbid conditions for which bariatric surgery is covered include the following:

- Type II diabetes mellitus
- Resistant hypertension
- Refractory hyperlipidemia
- Obesity-induced cardiomyopathy
- Clinically significant obstructive sleep apnea
- Obesity-related hypoventilation
- Pseudotumor cerebri (documented idiopathic intracerebral hypertension)
- Severe arthropathy of spine and/or weight-bearing joints
- Nonalcoholic fatty liver disease (NAFLD) as confirmed by a physician with expertise in liver disease. Consideration of the risk-benefit for each individual patient must be used to determine that surgery for obesity is the best option for treatment for that patient and no contraindications to bariatric surgery may exist

4.4 Unsuccessful Medical Treatment for Obesity

Successful obesity management requires adoption and lifelong practice of healthy eating and physical exercise (i.e., lifestyle modification). Without adequate patient motivation and/or skills needed to make such lifestyle modifications, the benefit of bariatric surgical procedures is severely jeopardized and not medically reasonable or necessary. Patients considering bariatric surgical options must have been provided with knowledge and tools needed to achieve such lifelong lifestyle changes and must be capable and willing to undergo the changes.



For this criterion, a patient will be deemed to have been unsuccessful with medical treatment of obesity if all the following minimal requirements are met per documentation in the medical record:

- The patient has BMI ≥ 35 at the time of surgery.
- The patient has been provided with the knowledge and tools needed to achieve such lifelong lifestyle changes, exhibits understanding of the needed changes, and has demonstrated to clinicians involved in their care to be capable and willing to undergo the changes.
- The patient has made a diligent effort to achieve a healthy body weight, with such efforts described in the medical record and certified by the operating surgeon.
- The patient has failed to maintain a healthy weight despite adequate participation in a structured dietary program overseen by one of the following:
 - Physician (MD or DO).
 - Registered dietician (RD).
 - Board certified specialist in pediatric nutrition (CSP).
 - Board certified specialist in renal nutrition (CSR).
 - Fellow of the American Dietetic Association (FADA).

4.5 Pre-Operative Psychological/Psychiatric Evaluation

Patients who have a history of psychiatric or psychological disorder or are currently under the care of a psychologist/psychiatrist, or are on psychotropic medications, **must** undergo pre-operative psychological evaluation and clearance, and the patient's record must include documentation of the evaluation and assessment.

An objective examination by a licensed mental health professional (psychiatrist or psychologist) experienced in the evaluation and management of **bariatric** surgery candidates to exclude patients who are unable to personally provide informed consent, who are unable to comply with a reasonable pre- and post-operative regimen, or who have a significant risk of post-operative decompensation is recommended. Such evaluation is a covered service.

A diagnostic session is appropriate, and treatment sessions are appropriate if the patient has a diagnosable disorder that is likely to adversely impact the surgical outcome, including post-operative compliance. The mental health professional, the surgeon, and the patient should agree that the patient is an appropriate candidate for the surgery.

4.6 Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available upon request.



2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected International Classification of Diseases (ICD)-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
4. Medical record documentation must include the following: history and physical containing evidence of comorbid conditions, operative report containing a detailed procedure note, and office/progress notes documenting unsuccessful medical treatment for obesity.
 - The medical record must substantiate the presence and severity of associated organic diseases requiring the treatment of obesity, documented through appropriate physiologic testing and/or imaging.
 - The patient's medical record must include documentation of all required pre-operative and post-operative evaluations and interventions, and all other applicable coverage provisions required as outlined in this LCD.
 - Patients who have a history of psychiatric or psychological disorder must undergo pre-operative psychological evaluation and clearance, and the patient's record must include documentation of the evaluation and assessment.
 - Documentation of smoking history, and that the patient has received counseling on the effects of smoking on surgical outcomes and treatment for smoking cessation, if applicable.

4.7 Prior Authorization

Prior authorization is required for bariatric surgeries. Requests must include the medical history, past and current treatment and results, complications encountered, results of the health behavior/ psychosocial assessment (when indicated), and expected benefits or prognosis for the method requested. For additional information on prior authorization requirements, refer to the VI Medicaid Program Provider Manual, General Information chapter applicable to all providers.

4.8 Provider Qualifications

Bariatric surgery procedures must be performed by a surgeon trained and substantially experienced with surgery of the digestive tract, working in a clinical setting with adequate support for all aspects of management, assessment, and follow-up. The American College of Surgeons (ACS) and American Society for Bariatric Surgery (ASBS) certification requirements for physician credentialing satisfy this requirement. Physicians who do not meet ACS or ASBS



certification criteria for performing bariatric procedures do not qualify for payment for bariatric surgery procedures.



5.0 Cardiac and Pulmonary Rehabilitation Programs

This policy outlines the VI Medicaid Program coverage and conditions for cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR) and pulmonary rehabilitation (PR) programs if specific criteria are met. The VI Medicaid Program coverage aligns with the Medicare program for cardiac and pulmonary rehabilitation services.

5.1 Rehabilitation Programs

Cardiac Rehabilitation (CR) Programs

CR programs are defined as physician supervised, comprehensive, long-term programs involving medical evaluation, physician-prescribed exercise, cardiac risk factor modification, including education and counseling. It also includes behavioral intervention and psychological and outcomes assessment.

Intensive Cardiac Rehabilitation (ICR) Programs

ICR programs are physician supervised programs that furnish CR and have shown, in peer-reviewed published research, that it accomplished one or more of the following for its patients:

- Positively affected the progression of coronary heart disease
- Reduced the need for coronary bypass surgery
- Reduced the need for percutaneous coronary interventions

An ICR program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before CR services to after CR services:

- Low density lipoprotein
- Triglycerides
- Body mass index
- Systolic blood pressure
- Diastolic blood pressure
- The need for cholesterol, blood pressure, and diabetes medications

Pulmonary Rehabilitation (PR) Programs

PR programs are multidisciplinary programs of care for patients with chronic respiratory impairment that are individually tailored and designed to optimize physical and social performance and autonomy. Programs are evidence-based, multidisciplinary, and comprehensive interventions for patients with chronic respiratory diseases who are symptomatic and often have decreased daily life activities.



5.2 Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Criteria and Coverage

5.2.1 Criteria

The VI Medicaid Program covers CR and ICR for members who have experienced one or more of the following:

- An acute myocardial infarction (MI) within the preceding 12 months
- A coronary artery bypass surgery
- Current stable angina pectoris
- Heart valve repair or replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- A heart or heart-lung transplant
- Stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) Class II to IV symptoms despite being on optimal heart failure therapy for at least six weeks

5.2.2 Components

CR and ICR programs must include:

- Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished
- Cardiac risk factor modification, including education, counseling, and behavioral intervention at least once during the program, tailored to patients' individual needs
- Psychosocial assessment
- Outcomes assessment
- An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

5.2.3 Limitations

CR sessions:

- Limited to a maximum of two one-hour sessions per day, up to 36 sessions over a period of up to 36 weeks



- Duration of treatment must be at least 31 minutes for one session or at least 91 minutes for two sessions on the same day

ICR sessions:

- Limited to 72 one-hour sessions, up to six sessions per day over a period of up to 18 weeks
- Duration of the treatment must be at least 31 minutes
- Additional sessions beyond the first session may only be reported on the same day if the duration of treatment is 31 minutes or greater beyond the hour increment

5.3 Pulmonary Rehabilitation (PR) Criteria and Coverage

5.3.1 Criteria

PR services are covered for members with moderate to very severe chronic obstructive pulmonary disease (COPD), which is defined as Global Initiative for Obstructive Lung Disease (GOLD) classification II, III, and IV, when referred by the physician treating the chronic respiratory disease.

5.3.2 Components

PR programs must include the following components:

- Physician-prescribed exercise. Note: Some aerobic exercise must be included in each pulmonary rehabilitation session.
- Education or training closely and clearly related to the individual's care and treatment, which is tailored to the individual's needs, including information on respiratory problem management and, if appropriate, brief smoking cessation counseling.
- Psychosocial assessment.
- Outcomes assessment.
- An individualized treatment plan detailing how components are utilized for each patient.

5.3.3 Limitations

Limited to two one-hour sessions per day, for up to 36 lifetime sessions (in some instances, up to 72 lifetime sessions).

5.4 Prior Authorization

Prior authorization is required for CR, ICR, and PR services. For additional information on prior authorization requirements, refer to the VI Medicaid Program Provider Manual, General Information chapter applicable to all providers.



5.5 Provider Qualifications

Physician-directed clinics and outpatient hospitals with a Medicare-approved rehabilitation programs may provide rehabilitation services to Medicaid members.

All provider settings must have a physician or non-physician practitioner immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program.

The necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic cardiac and respiratory diseases is required.



6.0 Clinical Trial Services

This policy outlines the VI Medicaid Program coverage and conditions related to routine patient costs for items and services furnished in connection with participation in qualifying clinical trials.

Clinical trials are research studies that evaluate the safety and effectiveness of medical care.

6.1 Covered Routine Patient Costs

Routine patient costs for a member participating in a qualifying clinical trial include any item or service provided to help prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial to the extent that the provision of such items or services to the member would otherwise be covered outside the course of participation in the qualifying clinical trial under the state plan or waiver.

Routine services and costs also include any item or service required solely for the provision of the investigational item or service that is the subject of the qualifying clinical trial, including the administration of the investigational item or service. Some examples of routine costs in a clinical trial could include otherwise covered physician services or laboratory or medical imaging services that assist with prevention, diagnosis, monitoring or treatment of complications arising from clinical trial participation.

Prior authorization for services is required. For additional information on prior authorization requirements, refer to the VI Medicaid Program Provider Manual, General Information chapter applicable to all providers.

6.2. Items and Services Not Covered

Routine patient costs **do not** include any investigational item or service that is the subject of the qualifying clinical trial and is not otherwise covered outside of the clinical trial under the VI Medicaid Program.

Routine patient costs **do not** include any item or service provided to the member solely to satisfy data collection and analysis for the qualifying clinical trial that is not used in the direct clinical management of the member and is not otherwise covered under the Medicaid state plan, waiver, or demonstration project. For example, if a member has a condition that typically requires monitoring through an annual medical imaging scan and the member is participating in a clinical trial with a protocol that requires monthly medical imaging scans only to collect data on the effects of the investigational item or service, the additional monthly scans for purposes of clinical trial data collection would not be included in the member's routine patient costs to the extent they are not used for the direct clinical management of the member or are not otherwise covered under the state plan, waiver, or demonstration project.



6.3. Qualifying Clinical Trial

A “qualifying clinical trial” is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition. A qualifying clinical trial must be one or more of the following:

- A study or investigation that is approved, conducted, or supported (including by funding through in-kind contributions) by one or more of the following:
 - The National Institutes of Health (NIH)
 - The Centers for Disease Control and Prevention (CDC)
 - The Agency for Health Care Research and Quality (AHRQ)
 - The Centers for Medicare & Medicaid Services (CMS)
 - A cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
 - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants
- A clinical trial, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review that the secretary determines comparable to the system of peer review of studies and investigations used by the NIH, and that works to assure unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:
 - The Department of Energy
 - The Department of Veterans Affairs
 - The Department of Defense
- A clinical trial that is one conducted pursuant to an investigation into new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act
- A clinical trial that is a drug trial exempt from being required to have one of the exemptions in the prior bullet

6.4 Provider Attestation Documentation

Coverage of services requires an attestation regarding the appropriateness of the qualifying clinical trial by the healthcare provider and principal investigator.

A completed and signed Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial must be submitted with all claims and prior authorization requests for routine



patient costs for items and services furnished in connection with a member's participation in a qualified clinical trial. The form represents the attestation by the principal investigator of the clinical trial and the member's healthcare provider to the appropriateness of the clinical trial. The form is available on the VI Medicaid Program provider website, vimmis.com. Providers are to ensure submission complies with program-specific guidelines.

Coverage determinations will be made within 72 hours and do not require submission of the protocols of the qualifying clinical trial or any other documentation that may be proprietary.



7.0 Evaluation and Management Services

This policy outlines the VI Medicaid Program coverage and conditions for medically necessary evaluation and management (E/M) services performed by licensed physicians and non-physician practitioners, such as physician assistants and nurse practitioners. E/M services represent visits and services that involve evaluating and managing patient health.

7.1 General Information

The VI Medicaid Program generally adopts the coding, introductory language, and interpretive guidance framework that has been issued by the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel for payment of office and outpatient E/M services.

For most E/M visit services, practitioners will select and report a visit level based on the level of medical decision-making (MDM) or the amount of time spent by the physician or non-physician practitioner. For some types of visits (such as emergency department visits and critical care), in accordance with their CPT codes, practitioners do not have this choice and will use only MDM or only time to bill. The CPT E/M Guidelines for MDM apply.

For all E/M visits, history and physical exam must be performed in accordance with code descriptors. When practitioner time is used to select the visit level, the full time must be completed and recorded in the medical record.

For purposes of reporting office and outpatient E/M services, patients are identified as either new or established, depending on previous encounters with the provider. When billing certain other visit types, such as inpatient or nursing facility (NF), the patient type is initial or subsequent.

- **New Patient:** A person who did not receive any professional services from the physician, non-physician practitioner (NPP), or another physician of the same specialty who belongs to the same group practice within the previous three years.
- **Established Patient:** A person who receives professional services from the physician, NPP, or another physician of the same specialty who belongs to the same group practice within the previous three years.

Only one E/M service is covered on the same date of service per member per practitioner. Only one E/M service may be billed when more than one practitioner in the same specialty and same group provides a service to the same member on the same date of service, unless the E/M services are for unrelated reasons.

An office visit associated with a covered procedure or minor surgery performed in a practitioner's office is considered part of the procedure and is not separately payable by the VI Medicaid Program. The visit may be billed separately with the appropriate modifier if the visit is for a distinctly unrelated reason.



7.2 Preventive Care Services Visits

The VI Medicaid Program covers annual physical examinations for adults and other preventive and diagnostic services in alignment with Medicare guidelines

For members under 21 years of age, preventive care visits and screening services are covered at recommended intervals as part of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.

7.3 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The EPSDT benefit covers screenings and other preventive health services at regularly scheduled intervals to members up to 21 years of age, based on the recommended periodicity schedule established by the American Academy of Pediatrics (AAP) and Bright Futures. These services target early detection of disease and illness to correct or ameliorate a physical or mental condition and provide referral of members for necessary diagnostic and treatment services.

EPSDT is made up of the following screening, diagnostic, and treatment services:

- Comprehensive health and developmental history
- Comprehensive physical exam
- Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
- Laboratory tests including lead toxicity screening
- Health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

Schedules for EPSDT periodic screening services must be provided at intervals that meet reasonable standards of medical practice. The Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, also known as the "Periodicity Schedule," is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. The most recent version of the periodicity schedule can be located on the AAP website.

Each child and family are unique; therefore, the AAP recommendations are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Additional visits also may become necessary if circumstances suggest concerns. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.



All children enrolled in the VI Medicaid Program are required to receive blood lead screening tests at 12 and 24 months of age. In addition, any child between the ages of 24 and 72 months with no record of a previous blood lead screening test must receive one. Additional information on Medicaid's universal blood lead screening requirement can be found on the [Medicaid.gov](https://www.Medicaid.gov) > Medicaid Benefits > Early and Periodic Screening, Diagnostic, and Treatment > Lead Screening.

When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to help ensure the member receives a complete diagnostic evaluation.

Necessary healthcare services are available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

7.4 E/M Visits and Global Surgery Packages

An E/M service that results in the decision for surgery is covered separately when provided by the surgeon on the day before or the day of a procedure with a 90-day global period and the decision for surgery modifier is reported. This same E/M service provided the day before or the day of a procedure with a 0-day or 10-day global period is not covered separately.

An E/M service is not covered separately on the same day as a procedure with any global surgery period unless the member's condition requires a significant, separately identifiable E/M service that is above and beyond the pre- and post-operative care associated with the procedure or service performed.

If the surgeon performs E/M services during the post-operative global surgery period for a reason unrelated to the surgical procedure, report the appropriate modifier with the E/M service. All care provided during the inpatient stay in which the surgery is performed is compensated through the global surgery package and is not covered separately.

7.5 Consultations

The VI Medicaid Program covers consultations rendered by a physician whose opinion or advice is requested by another appropriate practitioner (e.g., physician, CNM, dentist) for the further evaluation and management of the patient. A consultation includes preparation of a report of findings that is provided to the referring provider for the referring provider's use in the treatment of the member. A consultant may initiate diagnostic and/or therapeutic services.

7.6 Observation Care

The VI Medicaid Program covers physician E/M services related to hospital observation care. Observation care services are a well-defined set of specific, clinically appropriate hospital outpatient services. Professional services include the ongoing short-term treatment, assessment, and reassessment necessary to determine whether a member will require further treatment as a hospital inpatient or if they are able to be discharged from the hospital. In most



cases, the decision whether to discharge a member from the hospital or to admit the member as an inpatient can be made in less than 24 – 48 hours.

Reimbursement for the initial observation care codes and subsequent observation care code codes encompass the full scope of care provided by the physician who ordered the hospital observation services. The applicable code can only be reported once per day. Initial observation care codes and codes that include the initial observation care are only reimbursable on the first day of treatment and are not intended to be billed on subsequent days of the observation care. Likewise, subsequent observation care codes will be reimbursable on each additional day of the observation stay and only by the admitting/ordering provider.

7.7 Inpatient Acute Care Hospital Services

The VI Medicaid Program covers practitioner services to hospital inpatients that are medically necessary. As with other E/M services, only one hospital visit per date of service is covered regardless of how many times a practitioner sees the member on that date.

The VI Medicaid Program does not cover the services of a standby surgeon, anesthesiologist, or surgical team. Only direct member care is covered. Physician standby services are covered as a part of the hospital services.

7.8 Nursing Facility Services

Visits necessary to perform Medicare and Medicaid required assessments are covered under the appropriate E/M services involving comprehensive resident assessments.

The VI Medicaid Program covers nursing facility practitioner visits when made by the member's primary care provider. Visits for the diagnosis or treatment of illness or injury, are covered when documentation of the medical necessity for the visit is included in the member's clinical records. Documentation must include diagnoses describing the acute illness or injury.

7.9 Medicaid Eligibility Examinations

The USVI Department of Human Services may request physical examinations and reports on pending applications for the purpose of determining Medicaid eligibility. One eligibility examination E/M procedure code may be reimbursed per provider. Diagnostic services may be ordered by the examining physician if medically necessary to complete the examination. The documentation of the authorization, examination, medical necessity for diagnostic procedures, and diagnostic findings must be maintained in the member's record

7.10 Documentation

Clear and concise medical record documentation is critical to giving patients quality care and getting correct and prompt payment for services. Medical records chronologically report a patient's care and records related facts, findings, and observations about the patient's health history. A provider must follow the CPT coding guidelines, and their documentation must



support the E/M level billed. For additional information on documentation requirements, refer to the VI Medicaid Program General Information Manual applicable to all providers.

Principles of medical record documentation of E/M Services include:

- The medical record must be:
 - Complete and legible
 - Support the level of service billed
 - Support medical necessity for the service billed, and
 - Authenticated as signed by the provider performing the service with date and time
- Documentation of each patient encounter should include:
 - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
 - Assessment, clinical impression, or diagnosis
 - Medical plan of care
 - Time spent with the member for medical decision-making
- Rationale for ordering diagnostic and other services (it should be easily inferred)
- Past and present diagnoses should be accessible
- Identification of appropriate health risk factors
- Documentation of the patient's progress, response to and changes in treatment, and revision of diagnosis
- Documentation in the medical record should report the diagnosis and treatment codes reported on the health insurance claim form or billing statement



8.0 Hyperbaric Oxygen Therapy (HBOT) Services

This policy outlines the VI Medicaid Program coverage and conditions for hyperbaric oxygen therapy (HBOT) services. HBOT is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

8.1 Coverage

Program reimbursement for HBOT services requires prior authorization. Program coverage aligns with the Medicare program and will be limited to therapy that is administered in a chamber and for the following conditions:

1. Acute carbon monoxide intoxication
2. Decompression illness
3. Gas embolism
4. Gas gangrene
5. Acute traumatic peripheral ischemia (as adjunctive treatment in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened)
6. Crush injuries and suturing of severed limbs. As in the previous conditions, HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened
7. Progressive necrotizing infections (necrotizing fasciitis)
8. Acute peripheral arterial insufficiency
9. Preparation and preservation of compromised skin grafts (not for primary management of wounds)
10. Chronic refractory osteomyelitis unresponsive to conventional medical and surgical management
11. Osteoradionecrosis as an adjunct to conventional treatment
12. Soft tissue radionecrosis as an adjunct to conventional treatment
13. Cyanide poisoning
14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment
15. Diabetic wounds of the lower extremities in patients who meet the following three criteria:



- a. Patient has Type 1 or Type 2 diabetes and has a lower extremity wound that is due to diabetes
- b. Patient has a wound classified as Wagner Grade III or higher
- c. Patient has failed an adequate course of standard wound therapy

The use of HBOT is covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care.

Standard wound care in patients with diabetic wounds includes: assessment of a patient's vascular status and correction of any vascular problems in the affected limb if possible; optimization of nutritional status; optimization of glucose control; debridement by any means to remove devitalized tissue; maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings; appropriate off-loading; and necessary treatment to resolve any infection that might be present.

Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBOT. Continued treatment with HBOT is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

For additional information on prior authorization requirements, refer to the VI Medicaid Program Provider Manual, General Information chapter applicable to all providers.

8.2 Limitations

HBOT is not covered by the VI Medicaid Program for treatment of the following conditions:

1. Cutaneous, decubitus, and stasis ulcers
2. Chronic peripheral vascular insufficiency
3. Anaerobic septicemia and infection other than clostridial
4. Skin burns (thermal)
5. Senility
6. Myocardial infarction
7. Cardiogenic shock
8. Sickle cell anemia
9. Acute thermal and chemical pulmonary damage (i.e., smoke inhalation with pulmonary insufficiency)
10. Acute or chronic cerebral vascular insufficiency



11. Hepatic necrosis
12. Aerobic septicemia
13. Nonvascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, Korsakoff's disease)
14. Tetanus
15. Systemic aerobic infection
16. Organ transplantation
17. Organ storage
18. Pulmonary emphysema
19. Exceptional blood loss anemia
20. Multiple Sclerosis
21. Arthritic diseases
22. Acute cerebral edema

8.3 Provider Qualifications

Physicians providing HBOT are required to meet one of the following educational certification requirements:

- Have board certification in Undersea and Hyperbaric Medicine by one of the following entities:
 - American Board of Emergency Medicine (ABEM)
 - American Board of Preventive Medicine (ABPM)
 - American Osteopathic Association (AOA)
- Have successfully completed a minimum 40-hour in-person accredited training program such as one approved by the American College of Hyperbaric Medicine or the Undersea and Hyperbaric Medical Society and have supervised at least 300 HBOTs



9.0 Maternity Care and Delivery Services

This policy outlines the VI Medicaid Program coverage and conditions for maternity care and delivery services. The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care. These services are included in the global obstetrical package. The global obstetrical package is covered when one physician or physician group practice provides the obstetric care to a member. The global obstetrical package is covered as long as the provider or group has provided seven or more antepartum visits, the delivery, and the postpartum care. If less than seven antepartum visits are provided, report the global package with the modifier for reduced services and indicate the number of antepartum visits on the claim.

9.1 Antepartum Care

Antepartum care includes the initial and any subsequent history, physical examinations, recording of weight, blood pressure, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks of gestation, biweekly visits to 36 weeks of gestation, and weekly visits until delivery. Typically, if a member enrolls in the first trimester and delivers at term, they have about 13 antepartum visits. This varies depending on the actual start of antepartum care and the delivery date. If the total number of antepartum visits exceeds 13 due to a high-risk condition, the additional visits are covered when using the appropriate E/M codes with the diagnosis for the high-risk condition.

9.2 Delivery

Delivery includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, and delivery. All hospital visits within 24 hours of delivery are generally considered part of the global package. If the member is admitted more than 24 hours before delivery and stays more than 24 hours, hospital care rendered prior to the day of delivery is covered separately as an E/M code. Medical problems complicating labor and delivery management that require additional resources are also covered separately.

9.3 Postpartum

Postpartum includes all the visits following delivery, both in the hospital and in the office. Services provided by physicians within the same group practice are considered as provided by the primary physician responsible for the member's overall obstetrical care.

9.4 Obstetrical Package vs. Components

If the same physician or group practice does not provide all obstetric care, the VI Medicaid Program covers the portion of the care provided by each provider. Postpartum care or antepartum care is covered separately if provided by a different physician or group than the physician providing the delivery services. To be consistent with some commercial payers and Medicare, the physician or group providing the entire global obstetrical package may choose to



report either the entire global package or may report the antepartum care, delivery, and postpartum care separately as each of these services is provided. Components such as antepartum care or postpartum care cannot be unbundled into individual visits.

Services that are **not** included in the global package include:

- Maternal or fetal echography or fetal echography procedures
- Fetal biophysical profile
- Chorionic villus sampling, any method
- Fetal contraction stress test
- Fetal non-stress test
- Hospital and observation care visits for premature labor (prior to 36 weeks gestation)

9.5 Non-Covered Services

The VI Medicaid Program does not cover services related to surrogate pregnancies.

9.6 Billing and Reimbursement Considerations

- When billing the global bundle code as defined in the CPT coding guidelines, bill any services above and beyond a routine pregnancy separately from the bundle
- Do not bill the CPT obstetric panel laboratory code unless all components of the laboratory panel are performed. If all components of the panel are not performed, bill the individual laboratory procedure codes
- Miscellaneous services (for example, amniocentesis, ultrasound, fetal non-stress test, fetal Fibronectin, oxytocin challenge, estriol) must be billed with the appropriate codes
- Bill newborn services using the newborn's Medicaid ID number and date of birth. This includes routine newborn care and any inpatient services to the newborn, whether before or after the mother's discharge



10.0 Pain Management

This policy outlines The VI Medicaid Program coverage and conditions under which certain pain management services are covered by the program.

10.1 Covered Services

The VI Medicaid Program covers an array of medically necessary, evidence-based pain management interventions and treatments including physician consultations, diagnostic tests, medications, physical therapy, and interventional procedures.

Prior authorization is required for services performed in provider settings with place of service code 11 (office) for members for whom Medicaid is the primary payer. For additional information on prior authorization requirements, refer to the VI Medicaid Program Provider Manual, General Information chapter applicable to all providers.

10.2 Facet Joint Interventions

Facet joint interventions may be used in pain management for chronic cervical/thoracic and back pain arising from the paravertebral facet joints. The facet block procedure is an injection of a local anesthetic, with or without a steroid medication, either into the facet joint (intra-articular) or outside the joint space around the nerve supply to the joint. Paravertebral facet joint denervation is a therapeutic intervention used to provide both long-term pain relief and reduce the likelihood of recurrence of chronic cervical/thoracic or back pain confirmed as originating in the facet joint's medial branch nerve. The VI Medicaid Program aligns its coverage and limitations with the CMS Medicare program.

Facet joint interventions generally consist of four types of procedures: intra-articular (IA) facet joint injections, medial branch blocks (MBB), radiofrequency ablations (RFA), and facet cyst rupture/aspiration.

Facet joint interventions are considered medically reasonable and necessary for the diagnosis and treatment of chronic pain in patients who meet **ALL** the following criteria:

1. Moderate to severe chronic neck or low back pain, predominantly axial, that causes functional deficit measured on pain or disability scale, **AND**
2. Pain that has been present for a minimum of three months with documented failure to respond to non-invasive conservative care management (as tolerated), **AND**
3. Absence of untreated radiculopathy or neurogenic claudication (except for radiculopathy caused by facet joint synovial cyst), **AND**
4. There is no non-facet pathology per clinical assessment or radiology studies that could explain the source of the patient's pain, including, but not limited to fracture, tumor, infection, or significant deformity



A pain assessment must be performed and documented at baseline after each diagnostic procedure using the **same** pain scale for each assessment. A disability scale must also be obtained at baseline to be used for functional assessment (if patient qualifies for treatment).

10.2.1 Diagnostic Facet Joint Injection Procedures

The primary indication of a diagnostic facet joint procedure is to diagnose whether the patient has facet syndrome.

1. For the first diagnostic facet joint injection to be considered medically reasonable and necessary, the patient must meet the criteria outlined under indications for facet joint interventions.
2. A second confirmatory diagnostic facet joint injection is considered medically reasonable and necessary in patients who meet **ALL** the following criteria:
 - The patient meets the criteria for the first diagnostic injection; **AND**
 - After the first diagnostic facet joint injection, there must be a consistent positive response of at least 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used)

Frequency limitation: For each covered spinal region, no more than four diagnostic joint sessions will be considered medically reasonable and necessary per rolling 12 months, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure.

10.2.2 Therapeutic Facet Joint Injection Procedures

Therapeutic facet joint injections are considered medically reasonable and necessary for patients who meet **ALL** the following criteria:

1. The patient has had two medically reasonable and necessary diagnostic facet joint procedures, with each one providing a consistent minimum of 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used); **AND**
2. Subsequent therapeutic facet joint procedures at the same anatomic site results in at least consistent 50% pain relief for at least three months from the prior therapeutic procedure **or** at least 50% consistent improvement in the ability to perform previously painful movements and activities of daily living (ADLs) as compared to baseline measurement using the same scale; **AND**
3. Documentation of why the patient is not a candidate for radiofrequency ablation (such as established spinal pseudarthrosis, implanted electrical device)

Frequency limitation: For each covered spinal region, no more than four therapeutic facet joint injection sessions will be reimbursed per rolling 12 months.



10.2.3 Facet Joint Denervation

The thermal radiofrequency destruction of cervical, thoracic, or lumbar paravertebral facet joint (medial branch) nerves is considered medically reasonable and necessary for patients who meet the following criteria:

1. Initial RFA: After the patient has had at least two medically reasonable and necessary diagnostic MBBs, with each one providing a consistent minimum of 80% sustained relief of primary (index) pain (with the duration of relief being consistent with the agent used).
2. Repeat facet joint RFA at the same anatomic site is considered medically reasonable and necessary, provided the patient had a minimum of consistent 50% improvement in pain for at least 6 months **and** at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale.

Frequency limitation: For each covered spinal region, no more than two radiofrequency sessions will be reimbursed per rolling 12 months.

10.2.4 Facet Cyst Aspiration/Rupture

Intra-articular facet joint injection performed with synovial cyst aspiration is considered medically reasonable and necessary when **BOTH** of the following criteria are met:

1. Advanced diagnostic imaging study (e.g., magnetic resonance imaging [MRI]/ computed tomography [CT]/myelogram) confirm compression or displacement of the corresponding nerve root by a facet joint synovial cyst; **AND**
2. Clinical and physical symptoms related to synovial facet cyst are documented in the medical record

Frequency limitation: Cyst aspiration/rupture may be repeated **once** per individual cyst and only if there is 50% or more consistent improvement in pain for at least three months.

10.2.5 Limitations

The following facet joint interventions for pain management are considered not medically reasonable and necessary:

1. Intra-articular and extra-articular facet joint prolotherapy
2. Non-thermal modalities for facet joint denervation, including chemical, low-grade thermal energy (less than 80 degrees Celsius), laser neurolysis, and cryoablation
3. Intra-facet implants
4. Facet joint procedure performed after anterior lumbar interbody fusion
5. Definitive clinical and/or imaging findings pointing to a specific diagnosis other than facet joint syndrome



10.3 Peripheral Nerve Blocks

Peripheral nerves can be the cause of pain in a variety of medical conditions. Peripheral nerve blocks may be used for both diagnostic and therapeutic purposes. Diagnostically, a peripheral nerve block allows the clinician to isolate the specific cause of pain in an individual patient. The injection of local anesthetic, with or without steroid, may also provide an extended therapeutic benefit. The VI Medicaid Program coverage aligns with the Medicare program.

Peripheral nerve blocks will be considered medically reasonable and necessary for conditions such as the following diagnostic and therapeutic purposes:

1. When the patient's pain appears to be due to a classic mononeuritis, but the neuro-diagnostic studies have failed to provide a structural explanation, selective peripheral nerve blockade can usually clarify the situation
2. When peripheral nerve injuries/entrapment or other extremity trauma leads to complex regional pain syndrome
3. When selective peripheral nerve blockade is used diagnostically in those cases in which the clinical picture is unclear
4. When an occipital nerve block is used to confirm the clinical impression of the presence of occipital neuralgia. Chronic headache/occipital neuralgia can result from chronic spasm of the neck muscles as the result of either myofascial syndrome or underlying cervical spinal disease
5. When the suprascapular nerve block is used to confirm the diagnosis of suspected entrapment of the nerve
6. When the trigeminal nerve is blocked centrally at the trigeminal ganglion, along one of the three divisions or at one of the many peripheral terminal branches (i.e., supraorbital nerve)
7. Nerve blocks as preemptive analgesia
 - A. When a single injection peripheral nerve block provides post-surgical pain control
 1. During the transition to oral analgesics
 2. In those procedures that cause severe pain normally uncontrolled by oral analgesics
 3. In cases otherwise requiring control with intravenous or parenteral narcotics
 4. In cases where the patient cannot tolerate treatment with narcotics due to allergy or side effects, etc.



- B. When a continuous peripheral nerve block provides the same as above, and furthermore may provide extended (i.e., one to five or more days) relief as a result of chronic administration of an anesthetic

Limitations on the coverage of peripheral nerve blocks include:

1. The signs and symptoms that justify peripheral nerve blocks should be resolved after one – three injections at a specific site. More than three injections per anatomic site (e.g., specific nerve, plexus, or branch as defined by the CPT code description) in a six-month period will be denied
2. More than two anatomic sites (e.g., specific nerve, plexus, or branch as defined by the CPT code description) injected at any one session will be denied. If the patient does not achieve progressively sustained relief after receiving two – three repeat peripheral nerve block injections on the same anatomical site, alternative therapeutic options should be explored
3. There is insufficient evidence to support the use of peripheral nerve blocks in the treatment of diabetic peripheral neuropathy
4. The use of nerve blocks with or without the use of electrostimulation, and the use of electrostimulation alone for the treatment of multiple neuropathies or peripheral neuropathies caused by underlying systemic diseases, is not considered medically reasonable and necessary. Medical management using systemic medications is clinically indicated for the treatment of these conditions
5. At present, the literature and scientific evidence supporting the use of peripheral nerve blocks with or without the use of electrostimulation, and the use of electrostimulation alone for neuropathies or peripheral neuropathies caused by underlying systemic diseases, is insufficient to warrant coverage. These procedures are considered investigational and are not eligible for coverage for the treatment of neuropathies or peripheral neuropathies caused by underlying systemic diseases
6. More than three injections per anatomic site (specific nerve, plexus, or branch as defined by the CPT code description) in a six-month period will be denied
7. More than two anatomic sites (specific nerve, plexus, or branch as defined by the CPT code description) injected at any one session will be denied

Medical documentation requirements include:

- Whether the block was a diagnostic or therapeutic injection
- Pre- and post-procedure evaluation of the patient
- Patient education

When preemptive analgesia is performed by a provider other than the surgeon or the anesthesia professional who provides anesthesia/analgesia for the procedure, there must be a



compelling patient care reason for the involvement of the additional provider. The rationale for this approach must be clearly documented in the medical record.

10.4 Injection of Trigger Points

Trigger point injections are a covered pain management therapeutic modality to treat myofascial pain. Injection of a tendon sheath, ligament, or trigger point consists of an anesthetic agent and/or steroid agent injected into an area for the management of pain. The VI Medicaid Program coverage aligns with the CMS Medicare program.

Trigger points are areas of taut muscle bands or palpable knots of the muscle that are painful on compression and can produce referred pain, referred tenderness, and/or motor dysfunction. A trigger point may occur in any skeletal muscle/fascia in response to strain produced by acute or chronic overload. Pain from trigger points can be mild to severe. When trigger point pain is severe and unresponsive to non-invasive treatments (e.g., anti-inflammatory medications, physical therapy, etc.), trigger point injections with local anesthetic and/or a steroid agent may be helpful.

The injection of trigger point(s) will be considered to be medically reasonable and necessary for the treatment of trigger points that are unresponsive to non-invasive treatments or when non-invasive methods of treatment are contraindicated. The medical record should clearly reflect all methods attempted and the results. If treatments are contraindicated, the medical record should indicate why the trigger point(s) is not amenable to other therapeutic modalities.

Non-invasive treatments may include, but are not limited to:

- Medications (non-steroidal anti-inflammatory drugs, muscle relaxants, etc.)
- Physical therapy (massage, heat or ice, stretching, etc.)
- Activity modification
- Home exercise instruction

The medical record must clearly indicate the number of injections given per session and the site(s) injected. Furthermore, the medical record must clearly document the medical necessity for repeated injections of trigger point(s). When frequent injections are required, the medical record must reflect the reason for repeated injections.

The frequency at which trigger point injection(s) are performed is dependent on the clinical presentation of the patient. However, it is generally expected that the patient's response to the previous injection is important in deciding whether to proceed with additional injections. If the patient has achieved significant benefit after the first injection, an additional injection would be appropriate for recurring symptoms. (Repeated injections may be justified by evidence of improvement, such as reduction in pain, muscle tenderness, or spasm; or improvement in the range of motion.)



Multiple trigger points may be injected during any one session. Some trigger points may need to be reinjected weekly or monthly for brief intervals consisting of a few months, depending on the results of the injections and the relief of pain that the injection provides. If therapeutic effect is achieved, medical literature supports that no more than three sets (or sessions) of injections should be performed during one year.

If the patient experiences no symptom relief or functional improvement after two – three injections into a muscle, repeated injections into that muscle are not recommended.

10.5 Post-Operative Pain Management

Per CMS Medicare global surgery reimbursement policy, post-operative pain management is a component of the global surgical package and is the responsibility of the physician performing the global surgical procedure. If the physician performing the global surgical procedure does not have the skills and experience to manage the post-operative pain and requests that an anesthesia practitioner assume the post-operative pain management, the anesthesia practitioner may report the additional services performed once this responsibility is transferred to the anesthesia practitioner.

Pain management services after the date of insertion of a catheter for continuous infusion may be reported with the appropriate CPT code for epidural/subarachnoid infusions (e.g., CPT 01996) and with E/M codes for nerve block continuous infusions.

10.6 Additional Limitations

The VI Medicaid Program does not cover hypnosis, prolotherapy, any treatment not approved by the FDA, or therapy not generally accepted as effective by the medical practice community for pain management.

Local anesthetics administered in conjunction with certain interventional procedures, such as peripheral nerve blocks and trigger point injections, are included in the procedure and are not reimbursed separately.



11.0 Podiatry Services

This policy outlines the VI Medicaid Program coverage and conditions for podiatry services.

11.1 Covered Services

The VI Medicaid Program covers medically necessary and appropriate foot care services provided by enrolled licensed podiatrists. In accordance with V.I. CODE ANN. tit. 27 § 168, podiatrists can diagnose, treat, operate, and prescribe for any disease, injury, deformity, or other condition of the foot, including surgery. Podiatric services are inclusive of the treatment of warts, leg ulcers, ingrown nails, corns, calluses, heel pain, fractures, skin lesions, and amputations or other surgeries limited to the foot.

Foot care services are also covered when rendered by enrolled, licensed physicians and other qualified licensed practitioners who are provided within the scope of their clinical practice, as defined by the appropriate licensing entity.

11.2 Foot Care

11.2.1 Covered Indications

In certain circumstances, the VI Medicaid Program may cover services ordinarily considered routine if they are necessary and integral to otherwise covered services (e.g., diagnosing and treating ulcers, wounds, or infections).

The presence of a systemic condition, like metabolic, neurologic, or peripheral vascular disease, may require diligent foot care by a provider that, absent such conditions, the VI Medicaid Program considers routine (and excluded from coverage). So, the VI Medicaid Program may cover foot care it considers routine when systemic conditions result in severe circulatory discomfort or areas of reduced sensation in the patient's legs or feet. In these instances, certain foot care procedures considered routine (e.g., cutting or removing corns and calluses or trimming, cutting, clipping, or debriding nails) may pose a hazard when done by a non-professional person on patients with such systemic conditions.

The VI Medicaid Program may also cover treatment of mycotic nails without a systemic condition. The VI Medicaid Program covers treatment for an ambulatory patient with mycotic nails when the physician attending the patient's mycotic condition documents that:

- Clinical evidence shows toenail mycosis
- The patient has marked ambulation limitation, pain, or secondary infection because of the infected toenail plate's thickening and dystrophy

The VI Medicaid Program covers treatment for a non-ambulatory patient with mycotic nails when the physician attending the patient's mycotic condition documents that:

- Clinical evidence shows toenail mycosis



- The patient suffers from pain or secondary infection because of the infected toenail plate's thickening and dystrophy

For these requirements, documentation of medical necessity must be supported by clinical evidence in the patient's medical record.

11.2.2 Limitations

The following foot care services are considered not medically reasonable and necessary:

1. Routine foot care
 - Foot hygiene (cleaning and soaking the feet to maintain a clean condition)
 - Cutting or removal of corns and calluses (except as noted above)
 - Trimming, cutting, clipping, or debriding of nails (except as noted above)
 - Use of skin creams to maintain skin tone
 - Any other service performed in the absence of localized illness, injury, or symptoms involving the foot
2. Services not covered by Medicare, or services denied by Medicare:
 - Subluxations of the foot (partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot)
 - Treatment of flat feet
 - Routine foot care
3. Routine supplies provided in the office

11.3 Surgical Treatment of Nails

The VI Medicaid Program covers medically necessary surgical treatment of nails consistent with CMS Medicare coverage and limitations.

11.3.1 Covered Indications

Avulsion of the nail plate, excision of the nail and nail matrix, and wedge excision of the skin of the nail fold are considered medically reasonable and necessary for the following indications:

1. Symptomatic onychocryptosis (ingrown nails)
2. Subungual abscess and/or hematoma
3. Subungual and periungual tumors
4. Injury of the toes involving the nail component to evaluate the stability of the nail bed or to release a subungual hematoma after a failed puncture aspiration



5. Severe or recurrent fungal nail infection that has failed to respond to usual, less invasive treatment (for example, pharmacological treatment, debridement)
6. For diagnosis of suspected lichen planus or psoriasis of the nail
7. Onychogryphosis or onychauxis
8. Congenital or acquired nail dystrophies that jeopardize the integrity of the toe

11.3.2 Limitations

The following are considered not medically reasonable and necessary:

1. Nail debridement or removing small chips or wedges of the nail and/or skin that does not require local anesthesia does not constitute surgical treatment of a nail
2. Trimming, cutting, or clipping of the distal unattached nail margins does not constitute surgical treatment of a nail
3. Surgical treatment of asymptomatic conditions
4. Repeat nail avulsion on the same toe following a complete nail avulsion performed more frequently than every eight months (32 weeks) for toenails
5. Repeat nail excision on the same toe following a complete nail excision for permanent removal



12.0 Radiology Services

This policy outlines the VI Medicaid Program coverage and conditions for radiology services. Radiology services include diagnostic imaging services and therapeutic radiology services such as x-rays, computed tomography (CT) procedures, magnetic resonance imaging (MRI) services, diagnostic ultrasound, nuclear medicine, radiation therapy, proton beam therapy, and other diagnostic and therapeutic services.

12.1 General Information

Services must be performed by an enrolled, licensed physician or under the supervision of an enrolled, licensed physician or other authorized, licensed provider within the scope of their licensure and must be medically necessary. Generally accepted professional standards of care must be followed by all personnel.

Prior authorization of radiology services is required for most outpatient procedures. Radiology procedures performed by hospitals and Federally Qualified Health Centers (FQHC) providers do not require prior authorization. For additional information on prior authorization requirements, refer to the VI Medicaid Program Provider Manual, General Information chapter applicable to all providers.

Radiology services require a written or electronic order that includes the original signature of the member's treating provider, date test was ordered, member's diagnosis, and the specific test or procedure requested. Use of a non-specific diagnosis code does not satisfy this requirement. The radiology order and the results of the test must be kept on file with the member's medical record.

A written report regarding the analysis and interpretation of the radiological test results is required for Medicaid reimbursement of the professional component.

12.1.1 Global and Component Services

A physician or physician clinic may be reimbursed for the "complete" (global) procedure when performing both the professional component (Modifier 26) and technical component (Modifier TC) in the office, clinic, or other non-hospital setting.

12.1.2 Professional Component

The professional component of a radiology procedure includes the professional services of the physician and includes the following:

- Examination of the member when indicated
- Performance or supervision of the procedure
- Interpretation
- Written report of the examination



The professional component is applicable in an encounter when the physician submits a charge for professional services only. It does not include the cost of personnel, materials, space, equipment, or other facilities.

12.1.3 Technical Component

The technical component of a radiology procedure code includes the personnel and materials, including:

- Contrast media and drugs
- Film or xerography
- Space
- Equipment
- Other facilities

If the place of service is a hospital setting (inpatient, POS Code 21, or on campus — outpatient, POS Code 22) or if the technical portion is performed by a portable x-ray provider, a physician may be reimbursed only for the professional component, not for the complete procedure. The technical component is reimbursed to the hospital or provider of portable x-ray services.

Physician clinics that perform only the technical component of radiological services are reimbursed by the VI Medicaid Program only for the technical component. The outside physician performing the professional component of the service is reimbursed only for the professional component.

12.2 Coverage

Radiology services eligible for coverage include, but are not limited to:

- Diagnostic x-ray tests and therapeutic procedures
- Computed tomography (CT), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), and Positron Emission Tomography (PET) Scans
- Radiation oncology/Interventional Radiology
- Bone Density Studies
- Nuclear medicine services
- Proton Beam Radiotherapy
- Ultrasound services provided by radiologists and certain medical specialists qualified by advanced training and experience in the use of diagnostic ultrasound procedures
- Radiopharmaceutical and contrast materials



- One interpretation/report per radiology procedure

12.2.1 CT and MRI Services

Radiographic images, including CT and MRI studies of the same anatomical area, are covered on the same day only when medically indicated. Physicians are responsible for using the most appropriate, least invasive diagnostic tests according to current standards of clinical practice.

12.2.2 Mammography Services

The VI Medicaid Program covers diagnostic and therapeutic radiology and screening mammography services. A referring/treating Medicaid enrolled provider must order all covered services except for screening mammography.

The VI Medicaid Program provides coverage of diagnostic mammogram procedures furnished to members with signs or symptoms of breast disease, a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease.

The VI Medicaid Program provides coverage for screening mammography to facilitate the early detection of breast cancer for members with no signs or symptoms of disease. A screening mammography is limited to one per rolling year. Organizations differ on their recommendations for the appropriate interval for mammography. Providers must follow generally accepted clinical guidelines with respect to initiation and frequency of mammography services based on the member's age, risk factors, and symptoms.

The VI Medicaid Program will cover digital breast tomosynthesis (3D tomosynthesis) for both screening and diagnostic mammography. Screening mammograms do not require a physician referral/order for coverage; however, the name of a physician must be documented in the record to receive the results and provide follow-up for the member, if necessary.

All facilities (hospital, outpatient department, clinic, radiology practice, mobile unit, physician's office, or other facility) providing diagnostic and screening mammography services are required to have U.S. Food and Drug Administration (FDA) certification under the Mammography Quality Standards Act (MQSA).

12.2.3 Bone Density Studies

Bone density studies involve a radiologic, radioisotopic, or other procedure that is performed to identify bone mass, detect bone loss, or determine bone quality. The VI Medicaid Program follows CMS Medicare coverage guidelines and limits for bone density studies. Bone density studies are limited to once every two years. To be covered, a member must meet at least one of the following conditions:

- A woman who has been determined by the physician or qualified non-physician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings



- An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture
- An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to an average of 5.0 mg of prednisone, or greater, per day for more than three months
- An individual with primary hyperparathyroidism
- An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy

12.2.4 Proton Beam Radiotherapy

Proton beam radiotherapy is a type of particle beam radiation therapy that delivers high dose radiation to a localized site.

Proton beam therapy will be considered medically reasonable and necessary for the following conditions, consistent with the CMS Medicare coverage guidelines:

- Benign or malignant conditions otherwise not suitable for intensity modulated radiation therapy (IMRT) or 3D conformal therapy involving the base of the skull or axial skeleton, including, but not limited to, chordomas and chondrosarcomas
- Solid tumors in children up to age 18
- Benign or malignant central nervous system tumors to include primary and variant forms of medulloblastoma, astrocytoma, glioblastoma, arteriovenous malformations, acoustic neuroma craniopharyngioma, benign and atypical meningiomas, and pineal gland tumors
- Intraocular melanomas

If certain condition criteria are met, consistent with Medicare coverage requirements, proton beam treatment may be considered medically reasonable and necessary for the following conditions:

- Malignant lesions of the head and neck when the intent of treatment is to be curative
- Malignant lesions of the paranasal sinus and other accessory sinuses
- Malignant lesions of the prostate
- Malignant advanced stage, non-metastatic tumors of the bladder
- Advanced pelvic tumors including malignant lesions of the cervix
- Left breast tumors
- Pancreatic and adrenal tumors



- Skin cancer with perineural/cranial nerve invasion
- Unresectable retroperitoneal sarcoma and extremity sarcoma
- Cancers of the lung and upper abdominal/peri-diaphragmatic cancers
- Malignant lesions of the liver, biliary tract, anal canal, and rectum

12.3 Multiple Procedure Payment Reduction

The VI Medicaid Program applies the multiple procedure payment reduction (MPPR) model outlined by CMS for multiple diagnostic radiology procedures. The MPPR applies to the technical component (TC) of certain diagnostic imaging procedures when billed for the same client, on the same day and session, by the same billing provider.

12.4 Non-Covered Services

Non-covered services include, but are not limited to:

- Experimental and investigational services for research purposes
- Radiology services for which a required prior authorization has been denied or not obtained
- Radiology services rendered by providers and facilities not properly licensed, certified, or enrolled with the VI Medicaid Program
- Mass screenings or examinations of members at nursing facilities, schools, or other institutional or public settings
- Mammograms that are not in compliance with the Mammography Quality Standards Act (MQSA)
- Diagnostic services ordered by a provider who is not the member's VI Medicaid Program enrolled, attending/treating provider.
- Interpretation of x-rays for quality assurance/confirmation
- Review of x-ray or other radiology service without providing a written report
- Set up of portable x-ray/EKG equipment is considered included in the procedure itself
- A second interpretation/report of a radiology procedure. Payment for initial report is considered payment in full and includes any additional reports that may be submitted



13.0 Reproductive Health Services

This policy outlines The VI Medicaid Program coverage and conditions for reproductive health services.

13.1 Family Planning Services

The VI Medicaid Program's coverage of family planning services is limited to services provided in Department of Health facilities or Federally Qualified Health Centers except that, with prior authorization from the VI Medicaid Program, the member may receive services from other providers that have a signed provider agreement with the VI Medicaid Program.

All medically necessary family planning services will be provided to both women and men to allow them to determine the number and spacing of children. The range of services provided includes all medically indicated procedures, devices, and prescriptions, including, but not limited to, birth control pills, implants, injections, vasectomy procedures, condoms, etc.

The VI Medicaid Program does not cover fertility treatments.

13.2 Emergency Contraceptives

Emergency contraceptive devices, such as intrauterine devices (IUDs), are covered. Oral emergency contraceptives, which contain the hormone levonorgestrel, a progestin, (Plan B One-Step[®], Next Choice[®]) or ulipristal acetate, a progesterone agonist-antagonist, (Ella[®]), are covered by the VI Medicaid Program as a pharmacy benefit. The VI Medicaid Program requires a prescription for coverage of over the counter (OTC) emergency contraception.

13.3 Sterilization Procedures

Sterilization is any medical procedure, treatment, or operation to render a person permanently incapable of reproducing.

Consistent with federal Medicaid regulations at 42 CFR 441.253, sterilization procedures are covered only if the following is met:

- (a) The individual is at least 21 years old at the time consent is obtained
- (b) The individual is not a mentally incompetent individual
- (c) The individual has voluntarily given informed consent in accordance with all the requirements prescribed in §§ 441.257 and 441.258
- (d) At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of



premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery

Informed Consent Requirements

The Code of Federal Regulations (CFR) outlines requirements, including the use of the Consent for Sterilization form, for obtaining informed consent. It is the physician provider's responsibility to meet all requirements for the VI Medicaid Program to reimburse for performing sterilization procedures. These requirements apply to all Medicaid members. Requirements can be accessed at 42 CFR §§ [441.257](#) and [441.258](#).

The Medicaid Consent for Sterilization Form must be completed by the physician for Medicaid reimbursement for sterilization procedure services. The form is available on the VI Medicaid Program provider website, vimmis.com, and must be submitted with claims for reimbursement. Providers are to ensure submission complies with program-specific guidelines. Documentation must be kept in accordance with the record keeping requirements of the VI Medicaid Program and may be subject to review and post-payment audit.

13.4 Hysterectomy Procedures

Hysterectomy procedures or operations to remove the uterus are covered when medically necessary.

A hysterectomy is **not** covered when either of the following applies:

- Is performed solely to make a member sterile
- More than one purpose exists for the procedure, and the hysterectomy would not have been performed but to render the individual permanently incapable of reproducing

The Code of Federal Regulations (42 CFR 441.250 – 441.259) outlines requirements, including member acknowledgment of information, that must be complied with for the VI Medicaid Program to reimburse providers for performing hysterectomy procedures.

The member must sign the Medicaid Hysterectomy Information Acknowledgment Form except under the following conditions:

- The member was already sterile when the hysterectomy was to be performed
- The member requires a hysterectomy because of a life-threatening emergency (e.g., the member is in imminent danger of loss of life) for which the physician determines prior acknowledgment is not possible, or
- The member has a hysterectomy during the time of retroactive eligibility

The Medicaid Hysterectomy Information Acknowledgment Form must be completed by the physician for Medicaid reimbursement for hysterectomy services. The form is available on the VI Medicaid Program provider website, vimmis.com, and must be submitted with claims for reimbursement. Providers are to ensure submission complies with program-specific guidelines.



Documentation must be kept in accordance with the record keeping requirements of the VI Medicaid Program and may be subject to review and post-payment audit.

13.5 Elective Abortion Procedures

The VI Medicaid Program is prohibited from paying for elective abortion procedures except when the continuation of the pregnancy would endanger the mother's life.

Reimbursement for an elective abortion is permissible only when a physician (MD or DO) has found, and certified in writing to the VI Medicaid Program, that based on their professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the member.

The Medicaid Physician Certification for Abortion Services Form must be completed by the physician for Medicaid reimbursement for elective abortion services. The form is available on the VI Medicaid Program provider website, vimmis.com, and must be submitted with claims for reimbursement. Providers are to ensure submission complies with program-specific guidelines noted in this chapter and applicable forms. Documentation must be kept in accordance with the record keeping requirements of the VI Medicaid Program and may be subject to review and post-payment audit.

Copies of the form are not required to be submitted with claims for services related to ectopic pregnancies or spontaneous, incomplete, or threatened abortions.



14.0 Surgical Services

This policy outlines the VI Medicaid Program coverage and conditions for surgical and surgery-related services under the program. The policy is designed to help ensure equitable access to medically necessary surgical procedures while adhering to federal and territory regulations and policies.

14.1 Prior Authorization Requirements

Prior authorization is required for all elective and non-emergency surgical procedures. Emergency surgeries are exempt from prior authorization but are subject to post-procedure medical necessity review. For additional information on prior authorization requirements, refer to the VI Medicaid Program Provider Manual, General Information chapter applicable to all providers.

14.2 Global Surgery

Coverage for the global surgery package includes related services that are furnished by the physician who performs the surgery or by members of the same group with the same specialty. The VI Medicaid Program policy is based on CMS guidelines for Medicare services for the global surgery package.

Under Medicare's resource-based relative value units (RVUs) payment rules, physicians are paid a single global fee for surgical services. Payments are not made for individual components of a complete or bundled procedure.

14.2.1 Services Included in the Global Surgery Package

- Pre-operative visits beginning with the day before the surgery for major surgeries and the day of the surgery for minor surgeries
- Intra-operative services that are a usual and necessary part of a surgical procedure
- Complications following surgery. This includes all additional medical or surgical services required of the surgeon during the post-operative period due to complications that do not require return to the operating room. The surgeon's visits to a patient in an intensive care or critical care unit are also included
- Follow-up visits within the post-operative period related to recovery from the surgery
- Post-surgical pain management by the surgeon
- Supplies for certain services furnished in a physician's office
- Miscellaneous services and items such as dressing changes, local incisional care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters,



routine peripheral intravenous lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes

14.2.2 Services Not Included in the Global Surgery Package

- The surgeon's initial consultation or evaluation of the problem to determine the need for surgery
- The office or hospital visit to decide upon surgery, if it occurs on the day before or the day of a major surgery
- Other physicians' services, except when the surgeon and the other physician(s) agree on the transfer of care. (The transfer of care agreement may be in the form of a letter or an annotation in the discharge summary, hospital records, or ambulatory surgical center records.)
- Visits unrelated to the diagnosis for which the surgical procedure was performed
- Treatment of the underlying condition or an added course of treatment that is not part of the normal recovery from surgery
- Diagnostic tests and procedures, including diagnostic radiology procedures
- Clearly distinct surgical procedures that are not repeat procedures or treatment for complications during the post-operative period. A new post-operative period begins with the subsequent procedure
- Staged procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples include procedures to diagnose and treat epilepsy in succession within 90 days of each other
- Chemotherapy and/or radiation therapy following cancer surgery
- Treatment for post-operative complications that requires a return to the operating room. For this purpose, an operating room is a place of service specially equipped and staffed for the sole purpose of performing surgical procedures, including a cardiac catheterization suite, a laser suite, and an endoscopy suite. Not included is a patient's room, a minor treatment room, a recovery room, or intensive care unit unless the patient's condition is so critical that there is insufficient time for transportation to an operating room
- A second, more extensive procedure when a less extensive procedure fails
- Immunosuppressive therapy for organ transplants
- Critical care services unrelated to the surgery when a seriously injured or burned patient is critically ill and requires constant attendance of the physician



- When a patient is returned to the operating room for treatment of complications, only the intra-operative portion of the service is covered

14.2.3 Partial Global Surgery Package

Services of physicians furnishing less than the full global surgery package are covered. Modifiers are used to identify the portion of the global surgery package that is covered separately when performed by different physicians under certain circumstances. Only procedures with 10- or 90-day global periods are eligible for partial global surgery package coverage.

Surgeons should use the modifier for surgical care only when another physician provides all or part of the outpatient post-operative care. The VI Medicaid Program assumes that the surgeon is responsible for pre-operative, intra-operative, and inpatient hospital post-operative care at a minimum. The modifier for post-operative management only is used when a second physician provides all or part of the post-operative care after hospital discharge in the global package. Surgeons must transfer care to the second physician, and both must keep a copy of the written transfer agreement in the member's medical record.

14.3 Bilateral Surgery

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The descriptions for some procedure codes include the terms "bilateral" or "unilateral or bilateral." The reimbursement for these codes reflects the work involved if done bilaterally, as the description states. Other procedure code descriptions do not include bilateral but may be performed bilaterally. The bilateral procedure modifier is used with these procedure codes.

14.4 Multiple Surgical Procedures

Multiple surgeries are separate procedures performed by a physician on the same patient during the same operative session or on the same day, for which separate coverage may be allowed. Co-surgeons, surgical teams, or assistants at surgery may participate in performing multiple surgeries on the same patient on the same day.

When the same physician performs multiple surgical procedures during one operative session, all services are covered separately. The VI Medicaid Program follows Medicare's multiple surgery guidelines for coverage of the procedures. If an integral procedure (one that is part of a larger surgery and is necessary to perform the larger surgery) is performed, it is covered as part of the larger procedure. If two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases), the procedures are covered separately.



Multiple surgery reimbursement policy applies to procedures performed during the same operative session or on the same day by the same physician or physicians of the same specialty in the same group practice. The VI Medicaid Program reimburses up to 100% of the Medicare fee schedule for the most complex surgical procedure and up to 50% of the fee screens for the second through the fifth surgical procedures. If more than five multiple procedures are performed, an operative report must be provided with the claim.

14.5 Multiple Surgeons

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required due to the complex nature of the procedures or the patient's condition. The VI Medicaid Program reimbursement policy is based on CMS guidelines for Medicare services for multiple surgeons. The appropriate modifier must be included on the claim with the appropriate service code for payment consideration.

- **Co-Surgeons**

Two surgeons who work together as primary surgeons performing distinct parts of a total service are considered co-surgeons. The medical record must contain sufficient documentation supporting the medical necessity for co-surgeons. Report the modifier indicating two surgeons for the services furnished by each co-surgeon. The primary procedure is reimbursed at the full screen times 62.5%. Second and subsequent services are paid at 50% of the full-allowed amount times 62.5%.

- **Team Surgeons**

Three or more surgeons who work together as primary surgeons to perform a specific procedure are considered team surgeons. Sufficient documentation must be submitted with the claim to establish that a team was medically necessary. If two or more surgeons are of the same specialty, the reason each was needed must be documented also. Report the surgical team modifier when billing for services rendered by each team surgeon. Each surgeon's dictated operative report must be included with the claims. Reimbursement is based on individual consideration.

- **Assistant at Surgery/Assistant Surgeon**

The VI Medicaid Program covers assistant at surgery services for designated surgical procedures. Assistant at surgery services must be considered reasonable and necessary for the surgery performed. An assistant at surgery actively assists the primary surgeon during the surgical procedure. Coverage for assistant at surgery services is not allowed when co-surgeons or team surgeons are utilized. When providers do assistant at surgery services, the fee schedule payment equals 16% of the applicable surgical payment.

14.6 Second Medical Opinions



The VI Medicaid program will cover second medical opinions on medically necessary, non-emergency, surgical procedures.



15.0 Tobacco Cessation Services

This policy outlines the VI Medicaid Program coverage and conditions for tobacco cessation counseling.

15.1 Coverage

The VI Medicaid Program covers tobacco cessation services to assist members to discontinue use of tobacco products. Through the VI Medicaid Program, participants have access to tobacco cessation counseling and medications.

Medicaid members must obtain services in the primary care provider site, such as the USVI Department of Health clinics or Federally Qualified Health Centers, located in the USVI. Prior authorization for services outside of those facilities is required. For additional information on prior authorization requirements, refer to the VI Medicaid Program Provider Manual, General Information chapter applicable to all providers.

This service can be billed on the same day as evaluation and management services if the evaluation and management service is significant and separately identifiable from the tobacco cessation counseling. The evaluation and management service must be billed with the appropriate modifier to indicate the additional service.

15.2 Limitations

The benefit package consists of four counseling sessions per quit attempt, with a maximum of two quit attempts per 12-month period.

The VI Medicaid Program does not cover group sessions or telephone conversations between the provider and member under the evaluation and management (E/M) procedure codes.

15.3 Documentation

Tobacco cessation counseling sessions are face-to-face, time-sensitive, and must be documented in the member's medical record. The documentation must include:

- Time: the amount of time spent counseling the member face-to-face
- Type of tobacco: the type of use, cigarettes, chewing tobacco, or vaping
- Amount: the amount of tobacco the member uses
- Cessation methods: the methods and skills the member will use to quit smoking, such as behavior change interventions
- Willingness: the member's willingness to quit smoking
- Plan: the plan of action agreed upon with the member



- Follow-Up: the method of follow-up agreed upon with the member



16.0 Wound Care

This policy outlines the VI Medicaid Program coverage and conditions under which certain wound care services are covered by the program.

For policy information on the coverage of hyperbaric oxygen therapy (HBOT) services, please refer to the specific sub-chapter of this manual.

16.1 Covered Services

The VI Medicaid Program covers medically necessary, evidence-based wound care interventions and treatments. The VI Medicaid Program coverage aligns with the CMS Medicare program.

For this policy, wound care is defined as care of wounds that are refractory to healing or have complicated healing cycles, either because of the nature of the wound itself or because of complicating metabolic and/or physiological factors. This definition **excludes** the following:

- Management of acute wounds
- The care of wounds that normally heal by primary intention, such as clean, incised traumatic wounds
- Surgical wounds that are closed primarily and other post-operative wound care are not separately covered during the surgical global period

Wound care must be performed in accordance with accepted standards for medical and surgical treatment of wounds. The goal of most chronic wound care should be eventual wound closure with or without grafts, skin replacements, or other surgery (such as amputation, wound excision, etc.). Adjunctive measures include, but are not limited to, appropriate control of complicating factors such as pressure (e.g., off-loading, padding, appropriate footwear), infection, vascular insufficiency, metabolic derangement, and/or nutritional deficiency.

Prior authorization is required for services performed in provider settings with place of service code 11 (office) for members for whom Medicaid is the primary payer. For additional information on prior authorization requirements, refer to the VI Medicaid Program Provider Manual, General Information chapter applicable to all providers.

16.2 Covered Indications

Wound care is medically necessary for the following types of wounds:

- Surgical wounds that must be left open to heal by secondary intention
- Infected open wounds induced by trauma or surgery
- Wounds with biofilm



- Wounds associated with complicating autoimmune, metabolic, and vascular or pressure factors
- Open or closed wounds complicated by necrotic tissue and/or eschar

16.3 Wound Care Management

Active wound care procedures involve selective and non-selective debridement techniques and are performed to remove devitalized tissue and promote healing. The provider is required to have direct (one-on-one) patient contact when performing active wound care management.

The appropriate interval and frequency of debridement depends on the individual clinical characteristics of the patient and the extent of the wound.

A treatment plan for a patient who requires frequent, repeated debridement shall be documented in the patient record. The treatment plan should be regularly reevaluated to help ensure that issues including, but not limited to, pressure reduction, nutritional status, vascular insufficiency, and infection control, have been adequately addressed. Overall, evaluation of the wound should be performed at a regular frequency to determine whether the individualized treatment goals are being met for the patient.

16.4 Negative Pressure Wound Care

Negative pressure wound therapy (NPWT), utilizing either durable or disposable medical equipment, is a method of wound care to manage wound exudates and promote wound closure. The vacuum-assisted drainage collection (i.e., NPWT) may be applied to cleanse the wound by removing fluids and stimulate the wound bed in order to reduce localized edema and improve local oxygen supply.

NPWT involves the application of controlled or intermittent negative pressure to a properly dressed wound cavity. Suction (negative pressure) is applied under airtight wound dressings to promote the healing of open wounds resistant to prior treatments.

NPWT for non-healing wounds is medically necessary when at least one of the following conditions is met:

- There are complications of a surgically created wound (e.g., dehiscence, post sternotomy disunion with exposed sternal bone, post sternotomy mediastinitis, or post-operative disunion of the abdominal wall)
- There is a traumatic wound (e.g., pre-operative flap or graft, exposed bones, tendons, or vessels) and a need for accelerated formation of granulation tissue not achievable by other topical wound treatments (e.g., the individual has comorbidities that will not allow for healing times usually achievable with other available topical wound treatments)
- There is a chronic, non-healing ulcer with lack of improvement despite standard wound therapy, including the application of dressings, debridement of necrotic tissue (if



present), maintenance of an adequate nutritional status, and weekly evaluations with documentation of wound measurements (i.e., length, width, and depth) in **ONE** of the following clinical situations:

- Acute wounds
- Subacute and dehisced wounds
- Traumatic wounds
- Ulcers (such as diabetic or pressure)
- Chronic Stage III or Stage IV pressure ulcer
- Chronic diabetic neuropathic ulcer
- Chronic venous ulcer
- Flaps and grafts

16.5 Low-Frequency, Non-Contact, Non-Thermal Ultrasound

Low-frequency, non-contact, non-thermal (MIST) ultrasound describes a system that uses continuous low-frequency ultrasonic energy to produce and propel a mist of liquid and deliver continuous low-frequency ultrasound to the wound bed. This modality is often referred to as “MIST Therapy.”

MIST therapy is considered reasonable and necessary wound therapy and therefore eligible for coverage by Medicare when provided for any of the following clinical conditions:

- Wounds and ulcers that are too painful for sharp or excisional debridement and have failed conventional debridement with documentation supporting the same
- Wounds and ulcers meeting Medicare coverage for debridement but with documented contraindications to sharp or excisional debridement
- Wounds and ulcers meeting Medicare coverage for debridement but with documented evidence of no signs of improvement after 30 days of standard wound care

MIST therapy may be provided two – three times per week to be considered reasonable and necessary. The length of individual treatments will vary per wound size.

Observable, documented improvements in the wound(s) should be evident after six treatments. Improvements include documented reduction in pain, necrotic tissue, or wound size or improved granulation tissue.

Continuing MIST treatments for wounds demonstrating no improvement after six treatments is considered not reasonable and necessary.



16.6 Documentation Requirements

1. The patient's medical record must contain clearly documented evidence of the progress of the wound's response to treatment at each physician visit. This documentation must include, at a minimum:
 - Current wound volume (surface dimensions and depth)
 - Presence (and extent of) or absence of obvious signs of infection
 - Presence (and extent of) or absence of necrotic, devitalized or non-viable tissue
 - Other material in the wound that is expected to inhibit healing or promote adjacent tissue breakdown
2. Identification of the wound location, size, depth, and stage by description and may be supported by a drawing or photograph. Photographic documentation of wounds immediately before and after debridement is recommended for prolonged or repetitive debridement services (especially those that exceed five debridements per wound). Photographic documentation is required for payment of more than five extensive debridements (beyond skin and subcutaneous tissue) per wound.
3. Medical record documentation for debridement services must include the type of tissue removed during the procedure, as well as the depth, size, or other characteristics of the wound and must correspond to the debridement service submitted. A pathology report substantiating the depth of debridement is encouraged when billing for the debridement procedures involving deep tissue or bone.
4. In addition, except for patients with compromised healing due to severe underlying debility or other factors, documentation in the medical record must show:
 - There is an expectation that the treatment will substantially affect tissue healing and viability, reduce or control tissue infection, remove necrotic tissue, or prepare the tissue for surgical management.
 - The extent and duration of wound care treatment must correlate with the patient's expected restoration potential. If wound closure is not a reasonable goal, the expectation is to optimize recovery and establish an appropriate non-skilled maintenance program. Alternatively, palliative care of the patient and wound may be provided to diminish the probability of prolonged hospitalization, etc. If it is determined that the goal of care is not wound closure, the patient should be managed following appropriate covered palliative care standards.
5. Service(s) must include an operative note or procedure note for the debridement service(s). This note should include the following:
 - Medical diagnosis



- Indication(s) and medical necessity for the debridement
 - Type of anesthesia used, if and when used
 - Wound characteristics such as diameter, depth, undermining or tunneling, color, presence of exudates, or necrotic tissue
 - Level/depth of tissue debrided and a description of the types(s) of tissue involved, and the tissue(s) removed
 - Vascular status, infection, or evidence of reduced circulation
 - Narrative of the procedure to include the instruments used. When debridements are reported, the debridement procedure notes must demonstrate tissue removal (i.e., skin, full or partial thickness; subcutaneous tissue; muscle and/or bone), the method used to debride (e.g., hydrostatic, sharp, abrasion, etc.) and the character of the wound (including dimensions, description of necrotic material present, description of tissue removed, degree of epithelialization, etc.) before and after debridement
 - Patient specific goals and/or response to treatment
 - Immediate post-op care and follow-up instructions
 - The presence or absence of necrotic, devitalized, fibrotic, or other tissue or foreign matter must be documented in the medical record when wound debridement is performed
6. The medical record must include a plan of care containing treatment goals and physician follow-up. The record must document complicating factors for wound healing as well as measures taken to control complicating factors when debridement is part of the plan. Appropriate modification of treatment plans, when necessitated by failure of wounds to heal, must be demonstrated. A wound that shows no improvement after 30 days may require a new approach. Documentation of such cases may include a physician reassessment of underlying infection, metabolic, nutritional, or vascular problems inhibiting wound healing, or a new treatment approach.
7. Documentation for low-frequency, non-contact, non-thermal ultrasound (MIST Therapy) services should include documented improvements of pain reduction, reduction in wound size, improved and increased granulation tissue, or reduction in necrotic tissue. The services should be medically necessary based on the provider's documentation of a medical evaluation of the patient's condition, diagnosis, and plan.



Revision History

The revision history identifies the document version number, date, changes made to the document, and a brief description of revisions applied.

Table 1: Version History

Document Version #	Date	Revisions Applied
1.0	January 2026	Initial Publication