

Chapter 6

Medical Management

Overview

This chapter provides information on South Country Health Alliance (SCHA) requirements for prior authorization, notification and medical necessity criteria for services.

This Chapter Includes:

- Services Requiring Prior Authorization or Notification
- Authorization Requests and Decision Making
- Inpatient Hospital and Skilled Nursing Facility Admission and Notification Requirements
- Concurrent and Retrospective Reviews
- Prior Authorization, Notification and Authorization Documentation Submission
- Medical Necessity Criteria
- Continuity of Care
- Access to Specialty Care
- Disease Management
- Tobacco Cessation Services

Definition of Terms

Approval Authority – Mayo Clinic Health Solutions is a third-party administrator to whom SCHA has delegated the ability to make decisions to approve or deny prior authorizations and/or out-of-network authorizations.

Notification – Process of provider notifying Mayo Clinic Health Solutions about a service or treatment being provided within a specific period.

Prior Authorization – Process of review of a service or treatment prior to service or the treatment being rendered. Prior authorization requests are completed in writing by the provider of service. The prior authorization request is reviewed by medical professionals to determine if the service or treatment requested is medically necessary and appropriate, and that less expensive alternatives have been considered. Emergency services do not require prior authorization.

Standing Referral – A member's request to see an out-of-network specialist for a specified period of time.

Services Requiring Prior Authorization or Notification

SCHA focuses on removing barriers for members to see in-network providers for obtaining necessary care. SCHA's model is that every member is assigned to a primary care clinic. Members can access other in-network providers without an authorization from their primary care clinic. Some services and treatments do require prior authorization or notification. These services include:

- Services or treatments that have limited requirements
- Services or treatments that are listed as non-covered services, but the provider considers the service medically necessary
- Services where there are lower cost options that have similar safety and effectiveness

Refer to the prior authorization or notification grid for detailed requirements. If the service or treatment is not listed, call SCHA/ Mayo Clinic Health Solutions Provider Service Center at 1-800-995-4543 to determine if an authorization is needed.

Medical Services - Authorization Requests and Decision Making

Prior Authorization and Notification list can be found on the South Country website at https://mnscha.org/?page_id=304

Note: authorization for surgical procedures does not include/infer authorization for follow-up care. Refer to member's benefit plan for coverage information.

South Country contracts with Mayo Clinic Health Solutions for utilization review for medical benefits and services. Mayo Clinic Health Solutions uses evidence-based standards of care, medical necessity criteria and the member's benefit coverage to make the authorization decisions. SCHA/Mayo Clinic Health Solutions does not reward providers or other individuals for denying services to members, nor does SCHA/Mayo Clinic Health Solutions reward decisions that result in under-utilization of services. Decisions made by SCHA/Mayo Clinic Health Solutions do not constitute the practice of medicine. South Country encourages open access to covered services at appropriate levels of care.

Prior authorization confirms medical necessity only and does not guarantee payment.

Payment is determined at the time the claim is received and is subject to health plan exclusions and out-of-network benefit limitations. Plan coverage must be in effect for the member at the time service(s) is rendered.

Medical Services - Prior Authorization and Notification Documentation Submission

Requests that require prior authorization for non-urgent conditions must be received at SCHA/Mayo Clinic Health Solutions at least 14 calendar days prior to the first date of service. SCHA/Mayo Clinic Health Solutions will respond to your request in writing within 10 working days. If a request is marked urgent, the reason for the urgency must be included. Urgent requests will be processed within 72 hours.

Prior Authorization requests and notifications for medical/surgical and mental health/chemical health should be faxed:

Medical, Surgical, Mental Health and Chemical Dependency Services

Mayo Clinic Health Solutions

Attention: Health Services

- Fax 1-888-889-7822
- Phone 1-800-995-4543

Authorizations requests and reviews

Authorization for out-of-network providers

Authorization request forms found on the South Country website

Mental Health – Targeted Case Management

South Country Health Alliance

Attention: Behavioral Health Program Manager

- Fax: 1-507 431-6329
- Phone 1-866 567-7242

Authorization for out-of-network providers

Notification form found on the South Country website

Chiropractic Services

Chiropractic-Related Questions – Dates of Service Through 12/31/2017

Clinical Resource Group, Inc

- Phone 1-866-281-1997

Chiropractic-Related Questions –
Date of Service 01/01/2018 and after

Mayo Clinic Health Solutions

- Phone 1-800-995-4543

Chiropractic network questions

Claims questions for chiropractic services

Dental Services

Dental Related Questions –
Dates of Service Through 12/31/17

DentaQuest Provider Services

- Phone 1-800-341-8478

Dental Related Questions –
Dates of Service 01/01/2018 and after

Delta Dental

- Phone 1-866-567-7242

Authorization requests and reviews

Claim questions for dental services

Pharmacy Services

PerformRx, LLC

Customer Care Center

Medicaid

- Standard Authorization fax 1-855-446-7894
- Expedited Authorization fax 1-855-446-7899
- Phone 1-866-935-8874

Medicare

- Standard Authorization fax 1-855-446-7895
- Expedited Authorization fax 1-855-446-7896
- Phone 1-866-935-6681

Authorization requests and reviews

Coverage determinations and redeterminations

Formulary exceptions, prior authorizations, step therapy and quantity limits

Inpatient Hospital and Nursing Facility Admission and Notification Requirements

South Country is responsible to cover nursing facility care for members enrolled in MSC+, SeniorCare Complete (MSHO) and Special Needs Basic Care (SNBC) including AbilityCare, SingleCare and Shared Care.

MSC+ and SeniorCare Complete members

South Country is responsible to pay for 180 days of nursing home care. Members become eligible for the benefit at the time of admission to the Skilled Nursing Facility (SNF) or Nursing Facility (NF) on or after the first effective date of enrollment.

- For MSC+ members with Original Medicare, the 180 days begin at the time when the member's Medicare Part A Skilled Nursing Facility (SNF) benefit ends.
- For SeniorCare Complete (MSHO) and MSC+ with no Medicare, the 180 days begin at the time of the member's date of admission to a Skilled Nursing Facility (SNF) or Nursing Facility (NF) on or after the first effective date of enrollment.

Both Medicaid and Medicare covered days shall be counted toward the 180-day benefit.

For SeniorCare Complete (MSHO) members, South Country is responsible for services covered under the Medicare Advantage Skilled Nursing Facility (SNF) benefit.

Special Needs Basic Care (SNBC) members including AbilityCare, SingleCare, and SharedCare

South Country is responsible to pay for 100 days of nursing home care. Members become eligible for the benefit at the time of admission to the Skilled Nursing Facility (SNF) or Nursing Facility (NF) on or after the first effective date of enrollment.

- For SharedCare (SNBC) members, the 100 days begin at the time when the member's Medicare Part A Skilled Nursing Facility (SNF) benefit ends.
- For AbilityCare (SNBC) and SingleCare (SNBC) members, the 100 days begin at the time of the member's date of admission to a Skilled Nursing Facility (SNF) or Nursing Facility (NF) on or after the first effective date of enrollment.

Both Medicaid and Medicare covered days shall be counted toward the 100-day benefit.

For AbilityCare (SNBC) members, South Country is responsible for services covered under the Medicare Advantage Skilled Nursing Facility (SNF) benefit.

Hospital and Nursing Facility Responsibility

1. Prior to providing service, verify member eligibility
2. Notification of an inpatient hospital admission and/or nursing facility admission is requested within 24 hours of admission.
3. The admission and discharge information from an inpatient and/or nursing facility stay can be faxed to Mayo Clinic Health Solutions at (1-888-889-7822). All required forms are found on SCHA web site www.mnscha.org.
 - A. Hospital admissions – complete the 2291 Inpatient Notification Worksheet and fax to Mayo Clinic Health Solutions. Be sure to include the following information on the form:
 - a. member name
 - b. SCHA ID number
 - c. date of birth
 - d. diagnosis
 - e. admission date,
 - f. admission facility
 - g. Utilization Review contact and phone number
 - h. return fax number
 - B. Nursing home admissions including skilled and custodial – complete the 2297 Nursing Home Communication Form and Instructions and include the RUG code and fax to Mayo Clinic Health Solutions at 1-888-889-7822. If the stay qualifies for Medicare Part A skilled care include information that supports the need for the skilled care.
4. Retrospective admissions – complete the (form) and include pertinent clinical information. Fax the form and clinical information to Mayo Clinic Health Solutions at 1-888-889-7822.

Mental Health and Chemical Dependency Admissions

1. Notification of hospital admission is required within 24 hours of admission.
2. The first two days of the hospital stay are approved. The third (3rd) day requires utilization review for continued inpatient stay.
3. Complete the Mental Health Admission Worksheet (SCHA #2324) and fax to Mayo Clinic Health Solutions.
4. A retrospective admission requires that clinical documentation supporting the need for admission be faxed to Mayo Clinic Health Solutions, Attn: Behavioral Health staff.

Concurrent and Retrospective Reviews

SCHA performs concurrent or retrospective reviews dependent on utilization triggers. A medical director is consulted if review of clinical documentation does not clearly demonstrate medical necessity of the admission or services provided. SCHA's intent is to be actively involved in hospital discharge planning and member's case management needs. Review information may include:

1. Clinical information upon request for any inpatient stays;
2. Clinical information for all medical and surgical inpatient stays greater than 2 days faxed to Mayo Clinic Health Solutions (888-889-7822);
3. Access to hospital utilization review staff and additional information and clarification of information as requested;
4. Notification to Mayo Clinic Health Solutions of members with complex discharge needs or those who may benefit from case management.

Medical Necessity Criteria

Medical necessity criteria are based on DHS and CMS criteria. Please refer to the DHS the DHS Provider Manual or CMS Benefit Manual. You may also call SCHA/Mayo Clinic Health Solutions at: 800-995-4543 to verify criteria for a procedure. Refer to the Prior Authorization Grid for detail procedures that require prior authorization.

Continuity of Care

In accordance with Minnesota Statutes 62Q.56 SCHA enrollees are required to access services through selected primary care provider for coverage. However, if a provider has had their contract terminated, SCHA will:

- Inform affected members about termination at least 30 days before the termination is effective providing SCHA has had at least 120 days' prior notice.
- SCHA/Mayo Clinic Health Solutions will inform the affected enrollees about what other participating providers are available to assume care and how it facilitates a transfer either by telephone or in writing.
- If a member that will be transferring to another participating provider has special medical needs, special risks or other special circumstances, such as cultural or language barriers, SCHA/Mayo Clinic Health Solutions will work closely with the member and allow, if needed a longer transition period.

- Members with special needs will be identified by SCHA/Mayo Clinic Health Solutions staff, County Care Coordinators or complex case managers. Criteria will be based on medical, physical, mental and cultural needs.

Members with special medical needs or at special risk, continuity of care will be provided for the enrollee up to 120 days for the following conditions:

- an acute condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;
- a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last of at least one year, or can be expected to result in death; or
- a disabling or chronic condition that is in an acute phase; or
- for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

The request for authorization may come from the enrollee or the enrollee's current provider. SCHA/Mayo Clinic Health Solutions will grant the requests for authorization to receive services unless the enrollee does not meet the criteria provided above

For new members who are subject to a change in a health plan, upon request, SCHA/Mayo Clinic Health Solutions may do an authorization to receive services that are otherwise covered under the terms of the new health plan through the member's current provider if:

- an acute condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;
- a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last of at least one year, or can be expected to result in death; or
- a disabling or chronic condition that is in an acute phase; or
- for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

SCHA may require medical records and other supporting documentation be submitted with the requests for authorization.

Access to Specialty Care

In accordance with Minnesota Statutes 62Q.58 SCHA will approve standing authorizations for a health care provider who is a specialist and SCHA does not have an appropriate participating specialist who is reasonably available and accessible to treat the member's condition or disease.

The member must meet one of the following conditions:

- a chronic health condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;
- a degenerative disease or disability; or
- any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist.

Disease Management

SCHA conducts a Disease Management Programs for members with heart failure, diabetes and adult and child asthma. Members who may benefit from participation in one of these programs are identified in a variety of ways, such as new member assessments, claims screening, UM process, referrals from a caregiver, county staff, case managers, care coordinators, providers, and by self-referral.

The program addresses condition monitoring, member's adherence to the program's treatment plans, considers other health conditions and lifestyle.

Members who are in the program are stratified into severity level. This stratification determines the interventions a member may receive.

To assure good care coordination with members, the members who are enrolled or contacted regarding a disease management program are charted in the Client Contact Manager (CCM) program. Members are encouraged to discuss any of the materials they receive with their Providers and to always follow their Provider's advice and treatment plan.

Additional documents on each program can be found on the www.mnscha.org web page under Provider Resources.

Tobacco Cessation Program

South Country covers tobacco cessation education, counseling and products when they are ordered by a primary care provider and provided by an eligible provider.

Eligible providers for education and counseling services, including tobacco cessation:

- Physicians
- Enrolled Physician Assistants and Advanced Practice Registered Nurses (Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives)
- Physician extenders: non-enrolled Advanced Practice Nurses, Registered Nurses, genetic counselors, licensed acupuncturists, tobacco cessation counselors (those with their tobacco treatment specialist certification) and pharmacists
(HCPCS Codes 99401-99409 and 99411-99412)

Prescriptions for smoking cessation products are subject to quantity limits. Prescriptions may not be dispensed for quantities in excess of the FDA-approved dose for any smoking cessation product.

Nutritional Products and Related Supplies

A nutritional product is a commercially formulated substance that provides nourishment and affects the nutritive and metabolic processes of the body. Enteral nutritional products are a covered service for eligible South Country Health Alliance recipients who meet criteria for medical necessity.

Parenteral nutritional products are considered drugs; only a pharmacy may dispense these solutions.

Nasogastric tubes, gastrostomy, or jejunostomy tubes (feeding tubes), enteral supply kits and enteral nutrition infusion pumps are supplies used to administer enteral nutritional products to individuals who are unable to take enteral nutritional products orally.

Eligible Providers

The following providers may provide enteral nutrition products and related supplies:

- Federally qualified health center
- Home health agencies
- Indian Health Services

- Medical suppliers
- Pharmacies
- Rural Health Clinic

TPL and Medicare

Providers must meet any provider criteria, including accreditation, for third party liability (TPL) insurance or for Medicare in order to assist recipients for whom South Country is not the primary payer. South Country will not reimburse providers who do not meet provider criteria for the primary payer.

Eligible Recipients

Enteral nutrition is covered for eligible South Country recipients who need nutritional supplementation because solid food or the nutrients in the food cannot be properly absorbed by the body, for treatment of phenylketonuria (PKU), hyperlysinemia, maple syrup urine disease (MSUD) or a combined allergy to human milk, cow's milk and soy formula. Enteral nutrition may be covered for recipients with other specific medical conditions that are discussed in the Covered Services section.

Covered Services

Enteral Nutritional Products

Codes: B4149-B4162 (For these codes 100 calories = one unit), S9435

Only products classified by Medicare's Pricing, Data Analysis and Coding (PDAC) contractor are covered. If you are unsure of what HCPCS code to use, refer to the DMECS Product Classification List. Up to 1,050 units per month of enteral nutrition are covered for recipients who meet criteria. Documentation must support the need for the number of units requested. Up to 400 units of enteral nutrition products may be dispensed to be taken orally by recipients over age one before authorization is required. Oral enteral nutrition for treatment of PKU, hyperlysinemia or MSUD do not require authorization unless the recipient is under age one.

Nutrition for Recipients under Age One

Children under age one may be able to get infant formula through the Women, Infants and Children (WIC) program. Instruct families to contact their county human services or county public health office.

All enteral nutrition products for children under age one requires authorization. Document that the specific formula that is required is not available to the child through

WIC or that WIC does not provide the formula in quantities sufficient to meet the child's medical need. The child must meet one of the medical necessity criteria below.

Nutrition for Recipients with Feeding Tubes

Enteral nutritional products are medically necessary for recipients with feeding tubes. Authorization will be approved for recipients under age one with documentation that WIC cannot meet the child's medical needs. Authorization is not required for recipients over age one.

Oral Nutrition for Recipients with Inborn Errors of Metabolism

Enteral nutritional products are medically necessary for recipients with many inborn errors of metabolism. Oral enteral nutritional products manufactured for the treatment of PKU, hyperlysinemia or MSUD are covered with authorization for recipients under age one and without authorization for recipients over age one if the recipient has the associated diagnosis. Oral enteral nutritional products manufactured for the treatment of other inborn errors of metabolism are covered with authorization if the recipient has the associated diagnosis.

Solid food products specially manufactured for treatment of amino-acid transport and metabolism including PKU and MSUD are covered up to \$525 per calendar month when obtained from an enrolled medical food supplier.

Oral Nutrition for Recipients with Allergies

Enteral nutritional products may be medically necessary for recipients with a combined allergy to cow's milk, human milk and soy milk. Oral enteral nutritional products are covered with authorization if the recipient has a combined allergy to cow's milk, human milk, and soy, which is supported by appropriate medical testing and documentation. It is expected that the need for oral enteral nutritional products will decrease as the recipient ages and additional foods are added to the diet. If the recipient gets less than 75 percent of daily nutrition from a nutritionally complete enteral nutrition product, a nutritionist, a speech-language pathologist, or a physician must write a detailed plan to decrease dependence on the supplement.

Oral Nutrition for Recipients Who Cannot Properly Absorb Solid Food or Nutrients

Enteral nutritional products are medically necessary if the recipient has a medical condition that causes an inability to absorb adequate nutrients, and that has led to weight loss. Oral enteral nutritional products are covered with authorization if the recipient meets criteria. Documentation must establish all of the following:

- The recipient has a diagnosed medical condition such as, but not limited to:

- A mechanical inability to chew or swallow solid or pureed or blenderized foods
- A malabsorption problem due to disease or infection
- An oral aversion which significantly limits the ability to get adequate nutrition through solid or pureed or blenderized foods
- Weaning from TPN or feeding tube
- The medical condition leads to inability to consume or absorb adequate nutrients
- The recipient has experienced significant weight loss over the past six months or, for children under aged 21, has experienced significantly less than expected weight gain
- If the recipient gets less than 75 percent of daily nutrition from a nutritionally complete enteral nutrition product, a nutritionist, speech-language pathologist, or a physician must write a detailed plan to decrease dependence on the supplement.

Oral Nutrition for Recipients with Non-Healing Wounds

High protein enteral nutritional products are covered for up to six months with authorization if the recipient has one or more wounds that have not responded to treatment for at least 30 days, and a dietary assessment has determined that the recipient has a nutritional deficit which may be impeding healing. Documentation must include a nutritional plan written by a nutritionist, physician or other health care provider.

Supplies for Enteral or Parenteral Nutrition

Food thickeners

Code: B4100 (For this code, one ounce = one unit)

Food thickeners (Simply Thick, Thicken-It) may be medically necessary for individuals at risk of choking or aspirating liquids.

Noncovered Services

South Country does not cover the following:

- Nutritional products for healthy newborns
- Nutritional products for people living in LTC facilities (included in the per diem)
- Nutritional products for which the need is nutritional rather than medical or is related to an unwillingness to consume solid or pureed foods
- Nutritional products that are requested as a convenient alternative to preparing or consuming regular foods

- Nutritional products for which coverage is requested because of an inability to afford regular foods or supplements (refer recipient to county human services)
- Food thickeners for people living in LTC facilities (included in the per diem)
- Food thickeners for infants under age one who were born at less than 37 weeks gestation due to FDA caution
- SimplyThick brand thickener for infants under age one regardless of gestational age at birth is not covered due to FDA caution
- Energy drinks
- Sport shakes

Authorization Requirements

Submit authorizations and required documentation to South Country/Mayo Clinic Health Solutions for review.

For all requests for authorization of enteral nutritional products, documentation must include **all** of the following:

- The specific enteral nutritional product requested
- The average number of calories to be obtained per day from the enteral nutritional product
- The average number of calories to be obtained per day from other sources
- The medical condition that requires an enteral nutritional product
- A list of all foods the recipient is able to consume and a list of all foods the recipient has tried but cannot consume
- The types of food preparation that have been tried (mechanically chopped, blenderized)
- Any specific information required by the policy above under which coverage is requested (for example, allergy testing, the plan to decrease dependence on the supplement, a nutritional plan to increase protein)

For requests for thickeners for recipients under age one, documentation must include gestational age at birth. Documentation must include a swallowing study or swallowing evaluation by a speech and language pathologist and a history of any aspiration. Documentation must also include a plan of care and a plan for follow-up at least annually.

Billing

- Use MN–ITS 837P Professional.
- Report the ordering provider in the Other Provider Types section of the claim

Enteral Nutrition Products When Authorization is not Required

A valid diagnosis of phenylketonuria, hyperlysinemia, maple syrup urine disease or tube-feeding must be on the claim or the claim will deny for needing authorization.

Enteral Nutrition Products When Authorization is Required

HCPCS codes and modifiers on submitted claims must be identical to the approved authorization to prevent a denial.

All Claims for Enteral Nutritional Products

Enter the following information on all claims for enteral nutritional products:

- Modifier BO for recipients taking their enteral nutrition orally
- A valid diagnosis code to the greatest specificity indicating the medical condition that requires the product
- The date of service is the date the product was dispensed to the recipient. Do not use a date span
- The appropriate HCPCS code for the product dispensed
- The appropriate number of units dispensed (one unit = 100 calories)
- The product name in the service line level notes field when product-specific pricing is requested

Pricing for enteral nutritional products

- B4149–B4155 with modifier NU, with or without modifier BO: Medicare fee schedule rate. Effective for date of service July 1, 2015, and after: by report or product specific pricing
- B4157–B4162 with modifier NU, with or without modifier BO: product-specific pricing

Gastrostomy or Jejunostomy Tubes and Supplies Not Otherwise Classified

- Bill B4087-B4088 only for the feeding tubes. Use B9998 for all related supplies including extension sets.

- Include a valid diagnosis code to the greatest specificity indicating the medical condition that requires the tube feeding
- The date of service is the date the item was dispensed to the recipient. Do not use a date span
- Enter the item name in the comments/description field.
- Do not use B9998 for feeding supply kits or for syringes smaller than 35 ml.

Enteral Feeding Kits

- Use the HCPCS code that is appropriate to the ordered method of feeding.
- The date of service is the date the item was dispensed to the recipient. Do not use a date span

Acupuncture Services

This section provides policy and billing information for acupuncture service provided by eligible providers.

The Practice of Acupuncture

The practice of acupuncture means a comprehensive system of health care using Oriental medical therapy, including the insertion of acupuncture needles through the skin, and its unique methods of diagnosis and treatment.

Eligible Providers

The following licensed practitioners may provide acupuncture:

- Acupuncturists
- Chiropractors who have complied with the Minnesota Board of Chiropractic Examiners acupuncture registration requirements
- Osteopaths
- Physicians

Enrollment Requirements

Effective January 1, 2012, the following enrollment requirements apply for acupuncturists and chiropractors:

Acupuncturists

- A person is eligible to enroll as an acupuncturist if he or she holds a license to engage in the practice of acupuncture from the Minnesota Department of Health.
- Acupuncturists practicing outside Minnesota must comply with the licensure requirements of the state in which they practice.

Chiropractors

- Chiropractors must have complied with the Minnesota Board of Chiropractic Examiners (MBCE) acupuncture registration requirements.
- Current South Country enrolled chiropractors must provide a copy of the MBCE acupuncture registration to Provider Enrollment
- Claims submitted for acupuncture services will deny if Provider Enrollment has not received the MBCE registration.
- Chiropractors practicing chiropractic medicine outside Minnesota must comply with the acupuncture licensure and registration requirements in the state in which they practice.

Eligible Recipients

Recipients of the following may receive acupuncture services:

- Medical Assistance (MA)
- MinnesotaCare

Covered Services

Acupuncture is covered only when provided by a licensed acupuncturist or by another Minnesota licensed practitioner for whom acupuncture is within the practitioner's scope of practice and who has specific acupuncture training or credentialing.

Acupuncture is covered for the following conditions:

- Acute pain
- Chronic pain
- Depression
- Anxiety
- Schizophrenia
- Post-traumatic stress disorder
- Insomnia

- Smoking cessation
- Restless legs syndrome
- Menstrual disorders
- Xerostomia (dry mouth) associated with:
 - Sjogren's syndrome
 - Radiation therapy
- Nausea and vomiting associated with:
 - Post-operative procedures
 - Pregnancy
- Cancer care

Items that fall within an acupuncturist scope of practice such as, breathing techniques, dietary guidelines and exercise based on Oriental principles are considered part of an acupuncturist's visit and are not reimbursed separately.

South Country allows up to 20 units of acupuncture services annually without authorization. Request authorization if additional units are needed.

Prior to the start of acupuncture treatment, a comprehensive history and physical evaluation of the patient is required to document the cause or origin of the condition being treated. The provider must document this comprehensive history in the patient's record.

South Country does not cover maintenance treatment where symptoms are not regressing or not showing improvement. Acupuncture treatment is not considered medically necessary if the recipient does not show improvement in symptoms.

Non-covered Services

Acupuncture is not covered for the following conditions: (This is not an all-inclusive list of conditions for which acupuncture is not covered.)

- Weight loss
- Drug or alcohol dependence
- Infertility
- Fatigue
- Allergies or asthma
- Acne
- Nausea due to conditions other than surgery, pregnancy or cancer care
- High blood pressure

- Cold or influenza
- Sexual dysfunction
- Other types of Oriental medicine are not covered. South Country does not cover the following: (This is not an all-inclusive list of non-covered Oriental medicine services.)
- Acupressure
- Massage
- Herbal supplements

Authorization Requirements

To request an authorization, submit the form Authorization Request Medical Surgical Services Form (SCHA #2293)

Authorization Criteria

Documentation must include the following:

- The diagnosis for the cause/origin of the symptom being treated
- Evidence that the patient is responding favorably to the acupuncture treatment and that further improvement is expected with additional treatment
- The acupuncture technique being requested
- A comprehensive history and physical evaluation of the patient
- Plan of care for the acupuncture treatment
- Other treatments the patient is receiving for the diagnosis, regardless of where or by whom they are being treated. Examples of other treatment may include opioids, physical therapy and medical cannabis.
- When applicable, provide documentation that favorable outcomes from acupuncture treatments have reduced the patient's need for opioids or led to improved utilization of other treatment modalities.

Billing

Use 837P Professional.

Diagnosis Codes

Providers are required to indicate the most applicable ICD diagnosis codes when billing acupuncture services.

Acupuncture Codes

Codes	Description
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-to-one contact with patient
97811	Without electrical stimulation, each additional 15 minutes of personal one-to-one contact with patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
97813	With electrical stimulation, initial 15 minutes of personal one-to-one contact with the patient
97814	With electrical stimulation, each additional 15 minutes of personal one-to-one contact with the patient, with re-insertion of needles(s) (List separately in addition to code for primary procedure)

Definitions

Acupuncture Practice

"Acupuncture practice" means a comprehensive system of health care using Oriental medical theory and its unique methods of diagnosis and treatment. Treatment techniques include the insertion of acupuncture needles through the skin and use of other biophysical methods of acupuncture point stimulation, including the use of heat, Oriental massage techniques, electrical stimulation, herbal supplemental therapies, dietary guidelines, breathing techniques, and exercise based on Oriental medical principles.