

AmeriChoice a UnitedHealth Group Company  
County of San Diego  
County Medical Services Program

# CMS Medical Policies

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This document is periodically updated. Please visit the County Medical Services website for the most up-to-date issue"

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## ALLERGIC RHINITIS AND SINUSITIS

The CMS program does not cover treatment or referral for common allergic rhinitis. Treatment or referral is covered only for disease which interferes with the ability to function and work.

### Criteria for Authorization

#### Patient History (two of three)

- chronic symptoms, at least 3 days per week
- facial pain
- chronic purulent discharge

#### Physical Exam (two of three)

- facial tenderness
- green/yellow discharge
- swelling and polypoid changes in the nose

#### Medication failure (all three)

- decongestants and/or antihistamines
- antibiotics for 6 weeks
- nasal steroids and/or nasal Cromolyn Sodium

#### X-Rays

- sinus imaging (plain films or CT scan) showing evidence of infection

## ARTHRITIS – OSTEOARTHRITIS

### Criteria for Authorization

Referral to Orthopedic Surgery is only allowable if the patient requires surgery to function at work or with daily activities. Joint replacement for Osteoarthritis is not a CMS benefit. Physical therapy is approved only if rehabilitation is necessary. Joint replacement is not a covered benefit [special circumstances may be considered for approval replacement, considering work history, age of patient, etc.]

#### Patient History (three of four)

- restriction of daily activities
- interferes with current work
- failure to respond to medications - 3 month trial
- failure to respond to physical therapy (Orthopedic referral)

AND

#### Physical Exam (two of four)

- tenderness with movement
- decrease range of motion
- muscle wasting
- deformity

AND

#### Imaging

- evidence of moderate to severe joint changes

## ASTHMA

Mild intermittent, mild persistent and moderate persistent asthma are managed at the primary care level. Severe asthma, defined as requiring continuous systemic steroid therapy and a history of hospitalization, should be referred to an allergy or pulmonary specialist. Desensitization is covered by CMS only for asthma which interferes with function or work.

### Criteria for Authorization

#### Patient History (one of three)

- life threatening
- asthma not responding to maximum medical therapy
- multiple ER visits, > 2 per year, or hospitalization

#### Treatment failure (two of four)

- b-agonists, including long acting
- theophylline
- cromolyn sodium
- inhalation corticosteroids for 3 or more months

#### Tests

- pulmonary function testing which shows severe reversible disease

## BEE STING

The CMS program covers Bee Sting Allergy kits for a history of definite systemic allergic reaction to bee stings. Referral for consultation and desensitization is based on the following criteria.

### Criteria for Authorization

#### Patient History (three)

- respiratory distress, acute urticaria or hypotension after a bee sting (history of anaphylaxis)
- reaction of bee sting is remote from the local reaction, at least 6 inches from sting
- personal risk at work or at home for bee sting exposure

Physical Exam (not required if history is clear or reaction documented by past medical records).

Evidence of allergic reaction remote from the site of the sting, including hives (urticaria), respiratory distress or hypotension.

## BONE MINERAL DENSITY (BMD) TESTING

The CMS program covers only diagnostic evaluation to confirm the presence of suspected disease and provide critical treatment. Screening BMD is not covered. There must be evidence of likely or present osteoporosis or other metabolic bone disease.

### Criteria for Authorization

- Patient has vertebral abnormalities as demonstrated by X-ray to be indicative of osteoporosis, low bone mass (osteopenia), or vertebral fracture.
- Glucocorticoid therapy equivalent of 7.5 mg of prednisone or greater per day for 3 months or longer, or the equivalent of 5 mg of prednisone or greater for 6 months or longer.
- Patient has hyperparathyroidism.
- Patient is being monitored to assess the response to or efficacy of an FDA approved osteoporosis drug therapy.



## BONE GROWTH STIMULATOR

### Criteria for Authorization

Although bone stimulators have been used in a variety of clinical settings, the following requirements, adapted from the MediCal program (2/07 criteria), limit their utilization to the following situations:

- Nonunion of long bone fracture - approve bone stimulator purchase or rental when nonunion (absence of healing) has been established for 6 months or more. Serial radiographs must include a minimum of 2 sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days.
- As an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site or for those undergoing a multiple level fusion. A multiple level fusion involves 3 or more vertebrae.
- Failed fusion, where a minimum of 9 months has elapsed since the last surgery.
- Congenital pseudoarthrosis is an indication for bone stimulation, requiring only confirmation the patient possesses this condition.
- If surgery has been performed in an attempt to induce healing of the bone fracture or nonunion via bone graft or internal fixation, the six or twelve month duration begins from the date of the surgery. The surgery date and procedure performed should be included with the TAR. CMS will cover the bone stimulation only to promote healing which has ceased or never began, not to facilitate an ongoing healing present at the site of defect. This also applies to surgery for congenital pseudoarthrosis.
- Although the pulse generator is returned to the manufacturer, the device is billed as a purchase

**BONE GROWTH STIMULATOR (Continued)**

because the manufacturer does not provide the generator separately from the coils. Whenever possible, attempt to rent the device for one fee which will cover any periods up to one year. Use HCPCS Code E1399 (Miscellaneous – By Report) for rental, along with modifier – Y6, indicating a taxable rental.

- If the device is approved as a rental, authorize for a one year period. Any reauthorization request should be denied, because if the OBS has failed to produce complete union within one year’s time, the device is not effective in that case.
- Use modifier 0Y7 with HCPCS Code E0747, indicating a taxable DME purchase, or modifier - HCPCS Code E1399, indicating a taxable DME rental. The following procedure code facilitates the identification and reimbursement of the use of electrical stimulation to aid bone healing:

<u>DPT-4 Code</u>	<u>Description</u>
20974	Electrical stimulation to aid bone healing; noninvasive. Cast applications may be billed in addition to CPT-4 code 20974

## BREAST CANCER – DIAGNOSIS AND TREATMENT

The CMS program follows California law for the diagnosis and treatment of breast cancer.

The people of the State of California do enact as follows:

SEC. 1. Section 1367.6 of the Health and Safety Code is repealed.

SEC. 2. Section 1367.6 is added to the Health and Safety Code, to read:

1367.6. (a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, shall provide coverage for screening for, diagnosis of, and treatment for, breast cancer.

(b) No health care service plan contract shall deny enrollment or coverage to an individual solely due to a family history of breast cancer, or who has had one or more diagnostic procedures for breast disease but has not developed or been diagnosed with breast cancer.

(c) Every health care service plan contract shall cover screening and diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the referral of the enrollee's participating physician.

(d) Treatment for breast cancer under this section shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the co-payment, or deductible and coinsurance conditions, that are applicable to the mastectomy and all other terms and conditions applicable to other benefits.

(e) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

**BREAST CANCER (Continued)**

(f) As used in the section, "prosthetic devices" means the provision of initial and subsequent devices pursuant to an order of the patient's physician and surgeon.

SEC. 3. Section 1367.65 of the Health and Safety Code is amended read:

1367.65 (a) On or after January 1, 2000, every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed shall be deemed to provide coverage for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse midwife, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.

(b) Nothing in this section shall be construed to prevent application of co-payment or deductible provisions in a plan, nor shall this section be construed to require that a plan be extended to cover any other procedures under an individual or a group health care service plan contract. Nothing in this section shall be construed to authorize a plan enrollee to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, unless the plan enrollee is referred to that provider by a participating physician, nurse practitioner, or certified nurse midwife providing care.

SEC. 4. Section 10123.8 of the Insurance Code is repealed.

SEC. 5. Section 10123.8 is added to the Insurance Code, to read:

10123.8 (a) Every policy of disability insurance that provides coverage for hospital, medical, or surgical expenses, that is issued, amended, delivered, or renewed on or after January 1, 2000, shall provide coverage for screening for, diagnosis of, and treatment for, breast cancer.

(b) No policy of disability insurance that provides coverage for hospital, medical, or surgical expenses shall deny enrollment or coverage to an individual solely due to a family history of

**BREAST CANCER (Continued)**

breast cancer, or who has had one or more diagnostic procedures for breast disease but has not developed or been diagnosed with breast cancer.

(c) Every policy of disability insurance shall cover screening and diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the referral of the insured's participation physician.

(d) Treatment for breast cancer under this section shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits.

(e) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

As used in this section, "prosthetic devices" means the provision of initial and subsequent devices pursuant to an order of the patient's physician and surgeon.

(f) For the purposes of this section, disability insurance does not include accident only, credit, disability income, specified disease and hospital confinement indemnity, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

**BREAST CANCER (Continued)**

SEC. 6. Section 10123.81 of the Insurance Code is amended to read:

10123.81 On or after January 1, 2000, every individual or group policy of disability insurance of self-insured employee welfare benefit plan that is issued, amended, or renewed, shall be deemed to provide coverage for at least the following, upon the referral of a nurse practitioner, certified nurse midwife, or physician, providing care to the patient and operating within the scope of practice provided under existing law for breast cancer screening or diagnostic purposes:

- a) A baseline mammogram for women age 35 to 39, inclusive.
- b) A mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the women's physician's recommendation.
- c) A mammogram every year for women age 50 and over.

Nothing in this section shall be construed to require an individual or group policy to cover the surgical procedure known as mastectomy or to prevent application of deductible or co-payment provisions contained in the policy or plan, nor shall this section be construed to require that coverage under an individual or group policy be extended to any other procedures.

Nothing in this section shall be construed to authorize an insured or plan member to receive the coverage required by this section if that coverage is furnished by a nonparticipating provider, unless the insured or plan member is referred to that provider by a participating physician, nurse practitioner, or certified nurse midwife providing care.

**BREAST CANCER (Continued)**

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

## BREAST RECONSTRUCTION

The CMS program covers breast reconstruction only in relation to breast cancer treatment and following or concordant with breast cancer surgery. In rare instances, breast reconstruction may be approved for removal of prosthesis if it is extruding and interferes with the ability to work.

### Criteria for Authorization

- following or concordant with breast cancer surgery
- treatment associated abnormalities or deformities
- removal of prosthesis for fibrosis or extrusion (work history required)
- replacement of prosthesis if mastectomy due to breast cancer
- nipple reconstruction (for breast cancer)
- breast prosthesis and bras (2), with replacements covered every two years



## BUNIONS

### Criteria for Authorization

#### Patient History

- symptomatic bunions which interfere with daily function or work.

AND

#### Physical Exam

- marked deformity is present

AND

#### Radiology

- x-ray confirmation of severe deformity
- hallux valgus angle greater than 40 degrees
- marked lateral deviation
- some overlapping of second toe
- subluxation of lateral sesamoid bone

AND

#### Work History

## BURNS – BURN CENTER POLICIES FOR MAJOR BURNS

The CMS Program covers up to 5 days of UCSD Burn Center level of treatment and reimbursement. Any extension of this coverage requires Medical Director review and approval.

### Criteria for Authorization

- patient has 30% or more 3<sup>rd</sup> degree burns, or
- patient has inhalation burns requiring intubation, or
- level of care required is intensive for both medical and burn care

### Rule of Nines

Wallace's Rule of Nines provides an approximation of the area of skin burned. It divides the body into units of surface area divisible by nine, with the exception of the perineum. Charts are available in most burn units.

The following are the respective percentages of an adult body surface area:

- head and neck front and back – 9%
- each upper limb total front and back – 9%
- chest and Abdomen front – 18%
- back side, thorax and low back – 18%
- perineum – 1 %
- each lower limb total for front and back – 18%

## CARDIAC STRESS TESTING (Medicated Non-Nuclear)

Exercise Cardiac Stress Testing is done on all patients except those unable to exercise on the treadmill. Referral for Cardiac Stress Testing is based on a clear risk for coronary artery disease. Screening Cardiac Stress Testing is not approved by the CMS program. The patient must have two or more cardiac risk factors (age over 40, positive family history, smoking, hypertension, hyperlipidemia, diabetes, and obesity) to qualify for medicated non-nuclear cardiac stress testing.

Medicated Cardiac Stress Testing (Adenosine, Dipyridamole) is approved based on the following:

### Criteria for Authorization

History (one of three)

- incapable of exercising on a treadmill
  - difficulty maintaining balance
  - excessive obesity
- reactive airway disease – risk of bronchospasm
- frail and elderly

AND

Conjunction Testing

- echocardiography
- nuclear scan

## CARDIAC NUCLEAR STRESS TESTING

### Criteria for Authorization

A cardiac thallium scan is done to evaluate the chambers and structure of the heart while exercising. It is used to evaluate circulation to the heart muscle. A cardiac thallium is more accurate in evaluation evidence of coronary heart disease than a regular exercise stress test.

#### Patient History Required:

- prior treadmill testing
- abnormal EKG – 1mm or greater deviation from normal baseline
- bundle branch block
- unstable angina
- female > 45 or surgical menopause with chest pain or anginal equivalent

## CARDIOLOGY

Referral for Cardiology is for critical need only, not for screening. Patients with active heart disease, such as coronary artery disease, heart failure, cardiomyopathy or cardiac arrhythmia may be followed by a cardiologist. Cardiac consultation is approved with clear evidence of a cardiac condition, and for an acutely ill or unstable patient. The initial evaluation for cardiac disease is done by the primary care physician (PCP). The PCP may order without a TAR, on a supplemental form, the following studies: EKG, Exercise EKG (stress test), Echocardiogram, Stress Echocardiogram and Holter monitor.

### Criteria for Authorization

#### History (two of four)

- chest pain on exertion
- shortness of breath on exertion
- major risk factors for heart disease, including diabetes mellitus, hypertension, dyslipidemia, smoking, family history, obesity, age over 40 (male) and over 50 (female)
- new onset of weakness and fatigue

#### Physical Exam (one of four)

- cardiac murmur
- abnormal heart sounds
- peripheral edema
- jugular venous distention

AND

#### Testing (one of five)

- abnormal EKG
- abnormal echocardiography
- abnormal exercise EKG
- cardiomegaly by chest x-ray or echocardiogram
- abnormal holter monitor

## CARPAL TUNNEL SYNDROME

Most patients with carpal tunnel syndrome improve and recover in the primary care setting. For many patients, carpal tunnel syndrome is an overuse injury and a change in work position and rest resolve the problem. For patients with persistent carpal tunnel syndrome despite rest and wrist splinting, referral to an orthopedic surgeon for injection or surgery may be necessary. Referral to Neurology for nerve conduction study is unnecessary unless the diagnosis is uncertain.

### Criteria for Authorization

Patient History (one of two required)

- failed three months of conservative management
  - regular use of NSAIDs and night splints
  - trial of changed work positioning
- interferes with A.D.L

AND

Physical Exam (one of three required)

- positive tinell's and/or phalen's test
- atrophy or weakness of the thenar muscles
- documented nerve impairment on nerve conduction velocity testing (done only if the physical exam is uncertain)

AND

Work History (a procedure will help the patient continue or return to work)

## CHOLECYSTITIS AND CHOLELITHIASIS

### Criteria for Authorization

The CMS program covers cholecystectomy only for the removable of symptomatic gallstones causing clinical obstruction or infection. The CMS program does not cover surgery for asymptomatic gallstones

#### History (one of four)

- the diagnostic tests verify the presence of gallstones
- history of jaundice
- two documented episodes of abdominal colic or RUQ pain
- the presence of nausea/vomiting, chills and fever, leukocytosis

AND

#### Physical (one of two)

- the patient has abdominal guarding/tenderness
- a mass in the RUQ

AND

#### Diagnostic Tests

- ultrasound or CT scan documents presence of gallstones

## CHRONIC FATIGUE SYNDROME

### Criteria for Authorization

#### History (four of four)

- severe unexplained fatigue for > 6 months
- functionally impaired
- identifiable date of onset
- unrelated to psychological stress

AND

#### Symptoms (three of eight)

- memory or concentration complaints
- sore throat
- tender lymph nodes
- muscle pain
- multi-joint pain
- new pattern of headaches
- unrefreshing sleep
- postexertional malaise lasting more than 24 hours

AND

#### Treatment (five of five)

- judicious use of medication to ameliorate symptoms
- graded exercise or rehabilitation measures
- hypothyroidism has been ruled out
- depression has been ruled out or treated
- family history of colon cancer
  - three 1° relatives - q 3-5 years from age 20
  - one or two 1° relatives - q 3-5 years from age 40



## COLONOSCOPY

### Criteria for Authorization

CMS does not cover screening colonoscopy. Any one of the following indications must be met.

History (at least one present)

- positive stool culture or O&P study
- unexplained iron deficiency anemia
- acute diarrhea - following recent antibiotic therapy
- melena - normal UGI endoscopy
- rectal bleeding unexplained
- abnormal x-ray findings, mass, lesion or ulceration
- chronic diarrhea
- ulcerative colitis
- crohn's disease

OR

Therapeutic (at least one present)

- excision of polyps
- removal of foreign body
- dilatation of stricture
- control active bleeding

OR

Surveillance (at least one present)

- with colon polyps – every 3-5 years, if large (greater than 2 cm), may repeat in 3-6 months, if multiple adenomas, repeat at 1 and 4 years.
- following polypectomy - 1 year, then 1-3 year intervals
- following removal of colon cancer, 6 months, 1 year, q 2-3 years
- ulcerative colitis - q 1-2 years after 8th year when stable
- left sided colitis - q 1-2 years after 15th year when stable

## COLONOSCOPY (Continued)

- family history of colon cancer
  - three 1° relatives - q 3-5 years from age 20
  - one or two 1° relatives - q 3-5 years from age 40

## COLPOSCOPY - CERVICAL

### Criteria for Authorization

Colposcopy is performed to evaluate abnormal Pap Smears and to allow for guided cervical biopsies. Not all atypical Pap smears require Colposcopy, and Colposcopy should not be routinely repeated if the cervical abnormalities are minor. Repeat Pap smears are an acceptable way to monitor mild cervical pathology, especially if HPV testing is negative.

Colposcopy is indicated for cervical cytology demonstrating:

- ASCUS (Atypical Squamous Cells of Undetermined Significance)
  - 2 or more Pap reports are abnormal
  - Positive HPV testing
  - Suspicious cervical lesion
  - ASCUS persists in repeat pap 3-6 months after infections are treated
- SIL (Moderate Dysplasia, CIN I)
  - visible abnormality
- HSIL (Moderate and Severe Dysplasia, CIN II, CIN III)
- Other suspicious lesion

## COMPRESSION STOCKINGS

### Criteria for Authorization

Compression stockings are used for a variety of conditions: dependent edema, chronic venous insufficiency, recurrent leg ulcers and for wound management. CMS will approve compression stockings only when critically necessary to restore or maintain function in the patient, such as allowing the patient to work. When approved, two pair of stockings are allowable with a renewal no sooner than six months.

## CT OR MRI OF SPINE

### Criteria for Authorization

Advanced imaging of the spine should be performed for specific indications and not simply because of pain. In the presence of chronic pain, advanced imaging is done only if there are symptoms of neurologic impairment or suspicion of a lesion in the bone. CT is done to evaluate the bone tissue, and MRI is preferred for looking at the spinal cord and nerves. Indications include:

- suspected fractures and dislocations (not clear by plain x-rays) (CT)
- disk herniations causing neurologic signs or symptoms (MRI)
- previously documented spinal stenosis (MRI)
- previous spinal surgery and demonstration of non-union on x-ray or positive Bone Scan (CT)
- significant trial of conservative therapy including anti-inflammatory medications and physician supervised home exercise/physical therapy (MRI)
- chronic pain in a patient at risk for cancer (CT)
- localized tenderness of a vertebral body suggesting osteomyelitis (CT)

## DENTAL

### Criteria for Authorization

The County Medical Services Dental Program is designed to provide EMERGENCY dental treatment to alleviate a patient's IMMEDIATE source of dental pain and does not provide comprehensive preventive or restorative dental care. Dental clinics will provide emergency dental care based on the CMS basic dental service list; all other procedures/treatments must be medically indicated and require prior approval.

#### Emergency Care Only (for acute pain)

- site specific x-rays
- urgent extractions
- palliative Restoration fillings
- 2 visits allowed, then submit Rx plan

#### Endodontics (Root canal treatment): TAR Required

- Anterior teeth (6-11 and 22-27) are covered. Other teeth may be approved under circumstances of persistent symptoms and need to maintain nutrition. The final composite restoration is covered under the basic encounter fee. The composite restoration only is covered (Patient may pay for a crown).

#### Dental prosthesis:

CMS covers these only for critical function purposes and not for cosmetics. In most circumstances, only the anterior teeth are covered.

- To replace recently extracted teeth only after adequate healing to allow pursuit of employment (documentation required).
- Necessary to ensure adequate medical treatment (documentation of health condition required).

**DENTAL (Continued)**

- Repair or replacement of an existing appliance – one time in 12 months (once a year) is covered.

**Not Covered:**

- routine dental examinations, x-rays, cleaning, or prophylaxis
- restoration of asymptomatic teeth
- comprehensive periodontal treatment
- permanent crowns and bridges
- dental prosthesis not meeting the above criteria
- orthodontia
- elective services and/or medications not required to treat a potentially disabling or life-threatening illness or condition
- immediate dentures and immediate partial dentures

**The Following should be submitted with Dental TARS:**

- illustration of mouth with teeth numbered
- x-rays of the affected teeth will be sent upon request of CMS/AmeriChoice (not routinely required)

**Specific Dental Prostheses:**

Upper or lower stayplate: Dental clinics will frequently have CMS pay for a stayplate with allowable teeth (anterior only) and the patient will pay for those not covered.

- recently extracted teeth (within 6 months)
- evaluation of the remaining teeth (must be good dentition)
- anterior only (6-11, 22-27)
- repair or replace if necessary once every 12 months
- work history (denture form attached) Apply standard criteria

**DENTAL (Continued)**

Upper or lower denture:

- work history (new form attached) Apply standard criteria (anterior teeth only)

Aveleoplasty:

- if patient does not already have dentures, need a work history. Approve for re-fit when patient has existing dentures

Stainless steel:

- crowns are only covered if a posterior tooth has no integrity, but the remaining teeth are in good shape.

Oral Surgery: CMS only covers Oral Surgery for critically necessary services (TAR required):

- Wisdom teeth (#1, 16, 17, 32) – only symptomatic 3<sup>rd</sup> molars are covered. Soft tissue impaction can be extracted in the dental clinic. Authorization is not needed.
- oral lesions to remove or biopsy for cancer



## DERMATOLOGY

### Criteria for Authorization

Referral and Office biopsy is allowed for the following:

- possible Melanoma
- basal Cell Cancer (BCC)
- squamous Cell Cancer
- other Malignant neoplasm
- dysplastic nevi

Referral for Certain Conditions:

**Pruritis: (Itching):** Most itching in primary care is due either to excessive use of soap (dry skin) or neurodermatitis. The primary care physician is able to evaluate and treat most causes of pruritis, including primary and secondary conditions. Referral is approved to Dermatology only after a thorough primary care evaluation is done and the cause is uncertain or the treatment is ineffective. The patient history, physical findings and previous treatments must be well documented.

**Rash:** Most skin rashes are diagnosed and treated in primary care. Referral to Dermatology is approved when the diagnosis and treatment remain uncertain. The patient history, physical findings and previous treatments must be well documented.

**Acne:** The CMS program does not cover the treatment of mild or moderate acne. Referral to Dermatology would only be allowed for severe, cystic, inflammatory acne. The patient history, physical findings and previous treatments must be well documented.

**Psoriasis:** Referral to Dermatology is approved only for psoriasis in multiple areas which is actively inflammatory and unstable. The patient history, physical findings and previous treatments must be well documented. Treatments for psoriasis which are not on formulary,

## DERMATOLOGY (Continued)

or procedures such as PUVA, require prior authorization.

Actinic Keratosis: Most actinic keratosis is managed by primary care. Referral to Dermatology is allowed for extensive disease on exposed areas. The patient history, physical findings and previous treatments must be well documented. Treatments which are not on formulary require prior authorization.

**DIABETIC SHOES**

Diabetic shoes are frequently recommended to protect the feet of patients with diabetic neuropathy. The CMS program does not cover customized diabetic shoes for patients with diabetes or any other medical condition unless a specialist is able to indicate that such treatment is critically necessary for work or life function. Indications for diabetic shoes include patients with an amputation, with a chronic wound or ulcer, or in someone with an extensive history of such.

## DILATATION & CURETTAGE OF THE UTERUS (D&C)

### Criteria for Authorization

D & C is performed less commonly today with better procedures for evaluating the tissue in the uterus. For diagnostic purposes, endometrial biopsy, hysteroscopy and ultrasound are often used when D & C had been done in the past.

Patient History (either one of these present)

- excessive bleeding with a suspicion of tissue present
- post-menopausal bleeding to evaluate for endometrial cancer
- recurrent post-menopausal bleeding (for treatment, other tests are performed for diagnosis)

Addendum:

- there is no indication for performing a D&C in an adolescent
- heavy bleeding is usually better treated with hormones
- office endometrial biopsy is the first step to evaluate for endometrial cancer, and hysteroscopy is preferable to a D & C as the second test
- bleeding associated with pregnancy is not a covered CMS benefit

## DUPUYTREN'S CONTRACTURE

### Criteria for Authorization

Referral for this condition is only approved in cases in which the disease interferes with work or activities of daily living.

Patient History (both must be present)

- involvement of the palmar and digital fascia
- flexion deformity of the fingers

AND

Physical Exam (both must be present)

- characteristic nodule or cord in the palmar fascia
- metacarpophalangeal joint contracture >30 degrees

AND

Work History

## ESOPHOGASTRODUODENOSCOPY (EGD)

### Criteria for Authorization

EGD is also known as Upper GI Endoscopy and is performed when direct visualization of the upper GI tract is necessary. Biopsy of the esophagus, stomach and duodenum can also be done by EGD.

#### Patient History

- persistent symptoms of heartburn or GERD despite 2 months of PPI therapy.
- age of onset of GERD age 50 or later.
- extra esophageal symptoms, e.g., hoarseness, chest pain, wheezing
- complicated GERD, e.g. dysphagia or iron deficiency anemia
- symptoms of five years duration in patient > 50 years of age
- failure of lifestyle modifications such as no smoking, caffeine, aspirin, alcohol and spices

#### Repeat EGD (may be done in 8–12 weeks)

- erosive or transitional cells present on initial biopsy

## ENDOMETRIAL ABLATION

### Criteria for Authorization

Endometrial ablation is an alternative to hysterectomy for women with persistent excessive vaginal bleeding. It is also used for women with hypertrophy or polyps of the endometrial tissue. It has the advantage over hysterectomy in that it does not require major surgery and preserves the uterus.

Patient History (all should be present)

- excessive vaginal bleeding in a woman who has completed childbearing
  - profuse bleeding or repetitive periods
  - anemia due to acute or chronic blood loss
- no uterine or cervical pathology that would require hysterectomy
- no finding of remedial cause by hysteroscopy
- failure of hormone treatment

## EPIDURAL STEROID INJECTION

### Criteria for Authorization

Epidural steroid injection is indicated for chronic neck or back pain with radiculopathy. It is an alternative to surgery, and may reduce the need for pain medications. Approval is given for only one injection at a time.

#### Patient History

- chronic neck or back pain with radicular symptoms present for at least 3 months.
- conservative pain management has been used for at least 6 weeks without benefit

#### Physical Exam

- evidence of neurologic signs (numbness, weakness or reflex changes)

Addendum: Injections limited to three in a given year, with at least 3 months separation between injections.



**EPILEPSY (SEIZURE DISORDER) Vagus Nerve Stimulation (VNS)**Criteria for Authorization

All patients with a current active seizure disorder should be seen by a neurologist at least once a year, even if seizure free. The number and types of seizure medications is changing frequently. Only a neurologist should remove seizure medication therapy. In those patients where medications are not effective for control, VNS or epilepsy surgery may be indicated.

## Patient History (for VNS)

- failure of at least three drugs as therapy to control seizures
  - exclude discontinuance due to side effects and non-compliance.
- patient has the ability to manage a VNS magnet

**ERYTHROPOIETIN (RECOMBINANT GROWTH FACTOR), EPOGEN, PROCRIT**Criteria for Authorization

The use of these medications has recently come under criticism for their failure to improve patient outcomes and their great expense. Medicare and other health insurance plans are increasing their restrictions on these medications. Erythropoietin is covered only for patients with severe anemia due to chronic kidney disease or cancer therapy to avoid blood transfusions.

Patient History (anemia criteria must be met for either condition)

- recurring chemotherapy expected to cause bone marrow suppression
- chronic kidney disease
- anemia with hemoglobin (Hgb) less than 10 gm/dl or hematocrit (Hct) less than 30%

Addendum:

- Dosages are approved for one month at a time, and are continued only if Anemia criteria are still present.
- Continuation of therapy for more than 6-8 weeks is not beneficial in the absence of response (e.g.<1 to 2 gm/dl rise in Hgb). Longer term use of the medications will not be approved in the absence of a response.

## GANGLION CYST

### Criteria for Authorization

Most ganglion cysts are painless and do not interfere with work or living activities. Approval for referral for surgery is limited to those patients who have a critical medical indication for surgery.

#### Patient History

- pain which causes interference with work or essential activities
- weakness or altered range of motion

#### Physical Exam

- cyst or mass of dorsal or volar wrist
- cyst or mass in other location causing a limitation of function

#### Addendum:

- 50% of ganglion cysts disappear without therapy
- regardless of therapy, reoccurrence is common

## GYNECOMASTIA

Abnormal enlargement of the breast in a male is usually due to hormonal imbalance or medications, especially anabolic steroids. The management of Gynecomastia is usually medical and a referral to endocrinology is indicated if the cause is unclear in the primary care setting. The basic work-up should be done in primary care, such as a careful medication history and hormone levels. CMS does not cover surgery for Gynecomastia unless there is a malignancy.

Patient History (must be documented)

- duration of gynecomastia
- medication history
- use of alcohol
- mammogram report (if done)
- significant weight gain
- history of liver disease
- onset of puberty

AND

Physical Exam

- unilateral or bilateral
- increased adipose vs. breast tissue

## HEADACHE

Most patients with headache, including migraine, are managed by primary care. The following are criteria which may lead to a referral to a neurologist or other headache specialist. Advanced imaging (CT or MRI) is only indicated for headache when there are neurologic signs or an abnormal neurologic exam. CT is generally done in the emergency setting to rule out hemorrhage or mass lesion. MRI is preferred to evaluate for brain tumors and other intracranial lesions.

Note: A separate medical policy follows for Migraine.

### Patient History

- sudden onset of new severe headache
- progressively worsening headaches
- onset with exertion, coughing, straining, and/or sexual activity
- associated symptoms such as:
  - drowsiness, confusion, memory loss
  - chronic malaise, myalgia, arthralgia
  - fever
  - progressive visual disturbances
  - weakness, clumsiness, loss of balance
  - onset of first headache after the age of 50 years

### Physical Exam

- abnormal vital signs, especially fever or high blood pressure
- altered consciousness or cognition
- meningeal irritation ('stiff neck')
- papilloedema or fundal hemorrhage
- pupils unequal and/or poorly reactive
- weakness or sensory loss in face or limbs
- reflex asymmetry or abnormal plantar response
- clumsiness or loss of balance
- tender temporal arteries with diminished pulse

## HEADACHE - MIGRAINES

### Criteria for Authorization

The PCP is able to evaluate and manage most patients with migraines. Referral to a neurologist is only approved for a failure to respond to treatment or positive neurologic findings.

#### Patient History

- dissimilar headache (One item)
  - decreased alertness
  - first headache after age 50
  - "worst headache ever"
  - headache with exertion
- failure of adequate trial of management (Two of five)
  - nonsteroidal anti-inflammatories
  - isometheptine
  - ergotamine
  - butalbital
  - triptans (see below)

#### Physical Exam

- neurologic exam performed, any focal abnormality
- nuchal rigidity
- abnormal vital signs

#### Criteria for the approval of a triptin medication (e.g. Imitrex)

- requested by a Neurologist
- requested by PCP:
  - failed a non-steroidal medication
  - failed other generic anti-migraine medications

## HEARING LOSS

The CMS program covers referral, testing and treatment for hearing loss which impairs a person's ability to work and handle activities of daily living. A work history is usually required for any treatment.

### Criteria for Authorization

Patient History (At least one of these is required)

- infection or trauma suggesting a Conductive hearing loss. With infection (otitis media), the hearing loss must be present for at least 2 months
- otosclerosis
- sensorineural hearing loss with:
  - lesion of cochlea
  - tinnitus
  - gait imbalance
  - unilateral hearing loss
- a family history of a genetic hearing loss
- sudden onset of a major hearing loss
- recurrent dizziness with hearing loss
- poor speech discrimination

Physical Exam (At least one of these is present)

- otoscope Exam
  - no presence of blood, pus, cerumen plug, or foreign objects (all of which are treated in primary care)
  - abnormal findings of the tympanic membrane or middle ear which suggest a permanent or chronic problem

Tests

- audiogram shows evidence of more than a 30 decibel deficit
- replacement or repair-1x per 12 month period
- bi-aural hearing aids require visual acuity justification

## HEMORRHOIDECTOMY

### Criteria for Authorization

Most thrombosed external hemorrhoids resolve with warm baths, topical creams and fiber in the diet. CMS does not cover referral for treatment of external hemorrhoids unless the following criteria are met. Internal hemorrhoids which demonstrate recurrent bleeding and/or prolapse may warrant a procedure if they interfere with work or daily activities.

#### Patient History (any one of these present)

- repeated or persistent prolapse or thrombosis with severe pain (internal hemorrhoids)
- recurrent bleeding unresponsive to conservative treatment (either external or internal hemorrhoids)
- thrombosis with severe pain not responsive to warm baths or medications over 3 days

#### Physical Exam

- acute irreducible prolapse of internal hemorrhoids



## HEPATITIS B & C

### Criteria for Authorization

A large number of CMS patients are Hepatitis B or C antibody positive. Of these patients, 55-85% will be chronically infected. 80-95% of patients with a positive Hepatitis C antibody will not develop serious liver disease such as cirrhosis or liver failure. The CMS program will only approve for referral and treatment those patients who are candidates for treatment.

In order to use limited CMS funds wisely for this population, only patients with some evidence of active liver disease from Hepatitis B or C will be referred for treatment. Referral requests should include: Hepatitis B or C antibody test, liver function tests (especially ALT) and information about other possible causes of liver disease such as active alcoholism, hyperlipidemia, weight and whether there is ongoing IV drug use.

For those patients who are Hepatitis B or C antibody positive, who have elevated liver function tests, and do not have another apparent cause for liver disease, HBV or HCV RNA testing should be done to evaluate for chronic infection. If the HCV RNA testing is positive, and the ALT is at least 50% above normal due to no other cause, a referral to GI for consideration for treatment will be approved. Also, if the HCV RNA testing is positive, HCV Genotype testing may be done by your clinic (if required by the GI referral specialist) or by the specialty clinic.

Patients who are Hepatitis B or C antibody positive and have normal liver function tests should be followed clinically at the primary care level. Also, patients with ongoing alcoholism, IV drug use, fatty liver or other causes of liver disease should have these conditions managed before consideration for hepatitis C referral for treatment.

## HEPATITIS-B&C (Continued)

This link to the CDC website office recommended Clinical Guidelines for the Diagnosis and Treatment of Hepatitis:

<http://www.cdc.gov>

<https://www.aasld.org>

## HERNIAS – SURGICAL CORRECTION

### Criteria for Authorization

The CMS program does not cover elective surgery for hernia repair. Current clinical guidelines support “watchful waiting” for hernias in patients who are not at high risk for incarceration. The near-elderly and those persons doing heavy manual labor are at risk. The CMS program will only cover for referral and treatment of hernias that are symptomatic and interfere with work or activities of daily living.

Inguinal, Incisional, Ventral or Peri-umbilical Hernias:

#### Patient History (one of two)

- pain of significant duration
- affects employability

AND

#### Physical Exam (one of two)

- difficulty reducing hernia
- incarcerated hernia

AND

#### Work History

## HIRSUTISM

### Criteria for Authorization

Hirsutism is the excessive growth of hair in women. A family and cultural history are important to be sure that the hair growth is not normal. People from Mediterranean countries often have excessive hair growth including some masculinization of women. Hirsutism is triggered by androgen production, and the work-up focuses on hormonal causes. The work-up can usually be done in primary care, but based on the criteria below, a referral to an endocrinologist, or an gynecologist may be appropriate.

Patient History (all are present)

- symptoms suggestive of polycystic ovarian disease or adrenal hyperplasia, Hyperandrogenic, insulin-resistant, acanthosis nigricans syndrome and androgen secreting tumors
- absent familial predilection for hirsutism
- evaluation of patient's medications

AND

Physical Exam (both are done)

- confirmation of hirsutism
- pelvic ultrasound

## HORMONE THERAPY

### Criteria for Authorization

Oral Contraceptives Pills (OCPs): The CMS program does not cover contraceptive care. OCPs are only approved for specific medical indications:

#### Patient History

- dysfunctional bleeding
- polycystic ovary syndrome
- hypothalamic amenorrhea
- endometriosis
- recurrent functional ovarian cysts

#### Progesterone Challenge (usually 10-14 days)

As an alternative to surgery or prevention of surgery

- dysfunctional bleeding
- secondary amenorrhea
- Hemoglobin < 10 mg/dl

#### Lupron

Prescribed only as recommended by a gynecologist

- fibroids
- endometriosis
- limited to 3 mg (1x per month)

Hormone Replacement Therapy (HRT): CMS does not cover HRT for normal menopause

May be prescribed for:

- surgical menopause < 40 years of age (include date of surgery), and approve only to age 50
- osteoporosis, documented by Dexa Scan
- progesterone used with estrogen if uterus present
- other congenital estrogen deficiency

## HYDROCELE

### Criteria for Authorization

Hydrocele is rarely a significant health problem and CMS does not cover routine referral or correction.

#### Patient History

- painless mass
- vague, gradual symptoms may occur with enlargement

#### Physical Exam

- mass or focal swelling
- cystic
- freely movable
- non-tender
- transluminates with light
- there may be testicular atrophy
- usually left-sided

#### Diagnosis

- based on transillumination with a lack of any mass or solid tissue. Ultrasound may be performed if exam is uncertain

#### Management

- observe for spontaneous resolution or if any change
- no treatment necessary if stable
- aspiration may be performed if enlarging, causing discomfort or interfering with work
- criteria for surgical removal
  - persistent pain
  - interferes with work

## HYPERPARATHYROIDISM (CAUSING HYPOCALCAEMIA)

### Criteria for Authorization

#### Patient History and Laboratory Findings:

- occurrence of renal stones
- progressive bone loss (by Dexa Scan)
- serum CA > 11.5 mg/d or simultaneous elevation of serum PTH and Calcium indicating hyperparathyroidism

## HYSTERECTOMY

### Criteria for Authorization

The CMS program does not cover elective hysterectomy. The procedure is only approved when critically necessary for the woman's health. Abdominal, vaginal or laparoscopic hysterectomy is only approved when clinically necessary. Less invasive procedures, such as uterine ablation therapy should always be considered.

#### Patient History

- cancer or pre-cancer of the uterus, cervix or ovary
- recurrent endometrial hyperplasia after adequate treatment with curettage and progestin therapy
- rapid growth of fibroids which are causing health problems such as persistent heavy vaginal bleeding
- progressive dysmenorrhea or menorrhagia unresponsive to D&C, hysteroscopy and hormone therapy
- refractory menorrhagia for 3-6 months despite adequate hormone therapy. There must be a clinically significant drop in Hb or Hct.

OR

#### Physical Exam

- the presence of uterine fibroids > 16 wks gestational size

AND

Hysterectomy worksheet required



**REQUEST FOR AUTHORIZATION  
HYSTERECTOMY WORKSHEET**

History  
 Age \_\_\_\_\_ Gravida \_\_\_\_\_ Parity \_\_\_\_\_  
 Symptoms:

- Recurrent Bleeding  
 Duration \_\_\_\_\_  
 Lowest Hb/Hct \_\_\_\_\_  
 (with documentation)  
 Current Hb/Hct\* \_\_\_\_\_
- Treatment  
 Oral Contraceptives (3 cycles) \_\_\_\_\_  
 Depo-Provera (3 cycles) \_\_\_\_\_  
 D&C or Hysteroscopy\* \_\_\_\_\_
- Intractable Pelvic Pain  
 Duration \_\_\_\_\_  
 Cyclic \_\_\_\_\_  
 Constant \_\_\_\_\_
- Treatment  
 Medications \_\_\_\_\_  
 Duration \_\_\_\_\_
- Presence of Fibroids  
 Size >16 weeks\* \_\_\_\_\_

Physical Exam

- Pelvic Relaxation - Severity  
 - Uterine Prolapse \_\_\_\_\_  
 - Cystocele \_\_\_\_\_  
 - Rectocele \_\_\_\_\_
- Pelvic Tenderness \_\_\_\_\_
- Abnormal Findings \_\_\_\_\_

\*provide documentation

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date completed \_\_\_\_\_ Completed By: \_\_\_\_\_

## HYSTEROSCOPY

### Criteria for Authorization

Hysteroscopy is an outpatient procedure allowing the physician to visualize the inside of the uterus. Hysteroscopy is superior to D&C for diagnosis of intrauterine pathology. Endometrial biopsies and endometrial ablation may be done as part of Hysteroscopy.

#### Patient History

- postmenopausal bleeding
- failure to find cervical or uterine pathology that would cause abnormal bleeding
- history of excessive uterine bleeding evidenced by profuse bleeding, repetitive periods lasting more than 8 days or frequent periods at less than 21-day intervals
- failure of appropriate medical therapy

AND

#### Physical exam and Diagnostics

- pelvic exam
- obtain cervical cytology
- obtain endometrial sampling

## INCONTINENCE

### Criteria for Authorization

Most urinary incontinence in women is managed by primary care with pelvic exercises and medication. Referral for surgical correction is only approved if critically necessary for employment or daily activities.

#### Patient History

- duration of symptoms
- thoroughly evaluated and treated with behavioral techniques and medication
- patient has previously followed a mandatory voiding schedule with specific fluid intake, i.e. no caffeinated beverages
- compliance with a pelvic exercise program (Kegels)
- trial of medications for incontinence
- alternative use of pessary offered to patient

AND

#### Physical Exam

- assessment of estrogen status (evidence of atrophy)
- adequate pelvic exam, R/O diverticula and fistulas, description of prolapse
- urine culture

## **INFLUENZA (INCLUDING SWINE FLU)**

The CMS formulary does not cover anti-viral agents for influenza (the only anti-viral agent covered is acyclovir for herpes).

The generic anti-viral agent (amantadine) and Flumadine are not effective against the swine flu.

Tamiflu and Relenza are expensive and only recommended in highly suspect patients that are either seriously ill or if being treated in the first 48 hours.

Use of the anti-viral drugs should be a code 1 authorization request.

The most current recommendation of the CDC and the San Diego County Public Health Department will be followed.

**INSULIN PUMP**Criteria for Authorization

- request from Endocrinologist
- patient must have frequent and severe glycemic events requiring visits to Physician, ER or Hospital.
- significant ketosis
- insulin reactions and/or ketoacidosis
- blood glucose levels greater than 140 mg/dL preprandially and/or greater than 200 mg/dL fasting (“Dawn phenomenon”)
- glycosylated hemoglobin (HbA1c) greater than 8 percent
- chronic renal failure or ongoing dialysis
- intermittent insulin injection not a practical option for the patient

Note: If insulin pump in place and patient is doing well, CMS will provide supplies to maintain it.

## LAMINECTOMY (SPINE SURGERY)

### Criteria for Authorization

Surgery to the spine, cervical, thoracic or lumbar, is done for nerve impingement not responsive to conservative measures. Physical therapy and epidural steroid injections should be tried first in most cases.

#### Patient History

- radiating pain from lumbar spine down leg
- numbness of leg or foot
- low back pain
- bowel or bladder dysfunction

AND

#### Physical Exam

- ↓ sensation
- + contra lateral straight leg raising
- ↓ DTR (deep tendon reflexes)
- ↓ muscle strength
- change in gait
- unequal deep tendon reflexes

AND

#### Diagnostics

MRI is the imaging of choice. A CT scan may be adequate if already done

- demonstrates positive disc protrusion
- spinal stenosis
- cord compression with neurological sign

## LAPAROSCOPY (GYNECOLOGY)

### Criteria for Authorization

- chronic pelvic pain with no cause identified
- abnormal ovarian findings
- failure of conservative management (OCs, progesterone)
- failure of GnRH Agonist (endometriosis)

## MAMMOGRAPHY

### Criteria for Authorization

The CMS program does not cover routine screening mammography. A diagnostic mammogram is only approved when critically necessary to evaluate an abnormality suggesting possible breast cancer.

- If the woman is eligible, refer to the Breast and Cervical Cancer Early Detection Program (BCCEDP).



## MRI

### Criteria for Authorization

An MRI should only be performed if the diagnosis or extent of the disease is unknown. Written progress notes and an order must be submitted in order to document the need for the imaging. The MRI is used most commonly to image soft tissue to look for disease not visible on regular x-rays. In most cases, plain x-rays are done first and if common osteoarthritis is found an MRI is not necessary. An MRI of the spine requires a history of persistent radicular symptoms and findings on a neurologic exam that confirm nerve entrapment. An MRI of the brain requires positive neurologic findings on physical exam. For other areas of the body, suspected malignancy, suspect osteomyelitis and significant interference with work or activities of daily living are important criteria for approval. An MRI should only be done when its findings will have a direct result on the diagnosis and treatment of the patient.

Milliman Ambulatory Care Guidelines should be consulted if there is any question about the use of MRI to various areas of the body.

## MRI OF KNEE

### Criteria for Authorization

A MRI of the knee should only be performed if the diagnosis or extent of the disease is unknown. Plain x-rays of the knees are done first and if common osteoarthritis is found, a MRI is not necessary. A careful knee exam should also be performed before consideration is given for an MRI. A MRI of the knee should be performed before an Orthopedic consultation for most knee problems.

### Patient History

- aid in the diagnosis of meniscal tear
- aid in the diagnosis of an internal ligament tear
- detection, staging, post-treatment evaluation of tumor of the knee
- suspected osteochondritis dessicans if the clinical picture and plain x-rays are not confirmatory
- suspected osteonecrosis if the clinical picture and plain x-rays are not confirmatory
- persistent knee pain/swelling and/or instability after an injury which has not responded to conservative management (ice, rest, elevation, medication, non-weight bearing, physical therapy), if plain x-rays have failed to demonstrate a fracture or loose body, and if the clinical picture is unclear
- persistent knee/pain swelling and/or instability (gives way) not associated with an injury after a 3-6 week trial of conservative treatment
- if specifically requested by a consulting physician (orthopedist or rheumatologist)

Addendum: An MRI is not indicated for:

- Diagnosis of osteoarthritis or rheumatoid arthritis.
- Diagnosis of torn meniscus, loose body, or osteochondritis dessicans when the clinical examination and x-rays are diagnostic. If there is a true "locking" of the knee in flexion rather than

## MRI OF KNEE (Continued)

“catching” in extension, this is indicative of loose body or torn meniscus.

- When the MRI results will not alter the treatment plan of an anticipated surgical procedure.

## NEPHROLOGY

### Criteria for Authorization

Referral to Nephrology is most often considered for patients with renal failure. Other indications include chronic renal stones and other renal disease. In patients with hypertension and diabetes, monitoring renal function is vitally important, since these diseases are the most common causes of renal failure.

Mild renal insufficiency is managed at the primary care level. Counseling and appropriate adjustment of medications with declining renal function are important management considerations. Referral to Nephrology and follow-up is approved for patients with a serum creatinine of 2.0 or higher or if the estimated GFR is 30 or lower.

**OCULAR DISEASE – REFERRAL FOR VISION LOSS OR EYE PAIN**Criteria for Authorization

The CMS program does not cover routine eye care, including refractions. The program will cover critical eye services necessary to allow a patient to work and to relieve pain. Treatment Authorizations Requests for refraction are covered only for patients experiencing vision loss to the extent that it interferes with work and basic life functions. All conjunctivitis is treated by primary care.

## Patient History (one of three)

- decreased visual acuity (provide visual acuity)
- ocular pain
- photophobia

## Physical Exam (one of three must be present unless vision loss is documented)

- injection of vessels around the cornea
- corneal opacification
- pupil abnormalities
- suspicious for corneal ulceration

## OPHTHALMOLOGY - CATARACTS

Cataract: An opacity that develops in the crystalline lens of the eye or in its envelope.

### Criteria for Authorization

#### Patient History

- blurred vision (provide visual acuity)

#### Physical Exam

- cornea is clouded and cataract is seen on fundus exam

### Criteria for Surgical Removal

#### History (both required)

- functional impairment - employment and/or ADL's affected
- failure of vision to improve with prescription changes and/or other corrective measures

AND

#### Physical Exam

- Visual acuity in best eye must be worse than 20/50 with corrective lenses. (Surgery is covered for both eyes.)

Addendum: A cataract may be removed at any level of acuity if it precludes diagnosis or treatment of another ocular disease, such as diabetes or natural disease.

## OPHTHALMOLOGY - GLAUCOMA

### Criteria for Authorization

#### Patient History

- loss of the mid-peripheral visual field
- elevated intraocular pressure
- advanced age
- African-American ethnicity
- family history of glaucoma
- other risk factors
  - myopia
  - diabetes mellitus
  - migraine
  - hypertension
  - long-term corticosteroid use
  - previous eye injury

#### Physical Exam

- suspicious looking optic nerve head

Addendum: According to A.A.O. (American Academy of Ophthalmology).

- > 60 years exam every 2 years
- > 40 years in Blacks
- 20-39 years in Blacks – exam every 3-5 years

## OPHTHALMOLOGY - PTERYGIUM

### Criteria for Authorization

Pterygium is fibrous material that forms in the eye and covers part of the cornea. This benign condition often occurs in persons chronically exposed to dust and outdoor conditions. Referral for surgery is only necessary when vision is impaired.

#### Patient History

- visual interference (provide documentation)

AND

#### Physical Exam

- extension onto or over cornea to the extent that vision is impaired



## OPHTHALMOLOGY

Chalazion (is a cyst in the eyelid that is caused by inflammation of the meibomian gland).

The primary treatment is application of warm compresses for 10 - 20 minutes at least 4 times a day. This may soften the hardened oils blocking the duct and promote drainage and healing.

Topical antibiotic drops or ointment are sometimes used for the initial acute infection, but are otherwise of little value in treating a chalazion. Chalazia will often disappear without further treatment within a few months and virtually all will reabsorb within two years.

If they continue to enlarge or fail to settle within a few months, then a referral to an ophthalmologist is appropriate. Smaller lesions may be injected with a corticosteroid or larger ones may be surgically removed using local anesthesia.

### Criteria for Authorization

#### Patient History

- persistent lesion (3 months or longer)

#### Failure of Treatment

- conservative therapy with antibiotic and warm compresses for two months and/or local injection of a corticosteroid

### Blepharitis (inflammation of the eyelids)

Many forms of treatment will improve blepharitis, including both antibiotic or steroid eye drops, and certain oral antibiotics. Unfortunately it may recur when any treatment is ceased. Recommend a regime of daily eyelid cleaning which is both effective and can be continued safely long-term. Simply cleaning the eyelids with a face cloth during every bath or shower may be a good system for a patient.

## OPHTHALMOLOGY (Continued)

### Patient History

- failure of improvement despite treatment

### Physical Exam

- Persistent Inflammation of the lid margins

Iritis (or Uveitis) Iritis is inflammation predominantly located in the iris of the eye. Inflammation in the iris is more correctly classified as anterior uveitis. The ciliary body can also be inflamed and this would then be called iridocyclitis.

### Criteria for Authorization

Patient History (all three required if no physical findings present)

- photophobia
- moderate pain
- vision is blurred

Physical Exam (any one item)

- redness of the sclera
- red halo around the cornea
- a clear discharge may be present

**OPHTHALMOLOGY – FOLLOW-UP EXAMINATION GUIDELINES**

- DIAGNOSIS:        **ANTERIOR ISCHEMIC OPTIC NEUROPATHY** – every 2 weeks for 2 visits, then every 3-6 months
- DIAGNOSIS:        **BLEPHARITIS** – up to 2 visits annually
- DIAGNOSIS:        **CATARACT** - If immature cataract, every 12 months. If post-operative – covered in global, every 3 months. If post capsule thickening, every 6 months. If best corrected visual acuity is 20/40 or worse in the best eye, every 6 months. If following surgery in eye #1, when best corrected visual acuity is 20/40 in the remaining eye, every 6 months.
- DIAGNOSIS:        **CHLOROQUINE RETINOPATHY** – every 6-12 months
- DIAGNOSIS:        **CORNEAL ABRASION** – every 1-2 days until healed
- DIAGNOSIS:        **CORNEAL ULCER** – every 24 hours until healed
- DIAGNOSIS:        **CYSTOID MACULAR EDEMA (CME)** – every 6 weeks to 3 months, depending on medication used.
- DIAGNOSIS:        **DIABETES MELLITUS (DM)**, - annually for retina exam  
With retinopathy – every 3-6 months
- DIAGNOSIS:        **DIABETIC MACULAR EDEMA** – every 3 months
- DIAGNOSIS:        **EPIRETINAL MEMBRANE (ERM)** – every 3 months
- DIAGNOSIS:        **GIANT CELL ARTERITIS (VASCULITIS)** – as often as needed based on the stability of the patient and nature of steroid therapy
- DIAGNOSIS:        **GLAUCOMA (chronic)** – Every 3 months
- DIAGNOSIS:        **GLAUCOMA SUSPECT** – every 3-6 months depending on the pressure
- DIAGNOSIS:        **HYPERTENSIVE RETINOPATHY** – every 6-12 months

<u>DIAGNOSIS:</u>	<b>HYPERTENSIVE RETINOPATHY</b> – every 6-12 months
<u>DIAGNOSIS:</u>	<b>IRITIS, UVEITIS, IRIDOCYCLITIS</b> – every 1-2 weeks if acute, every 1-3 months if chronic depending on medication used and severity of the inflammation
<u>DIAGNOSIS:</u>	<b>MACULAR DEGENERATION</b> – every 1-12 months depending on severity and progression of the disease
<u>DIAGNOSIS:</u>	<b>MACULAR HOLE</b> – every 1-3 months
<u>DIAGNOSIS:</u>	<b>OPACIFICATION OF POSTERIOR CAPSULE</b> – once a year
<u>DIAGNOSIS:</u>	<b>OPTIC NEURITIS</b> – as often as needed
<u>DIAGNOSIS:</u>	<b>PSEUDOPHAKIA</b> – once a year
<u>DIAGNOSIS:</u>	<b>RETINAL DETACHMENT</b> – as often as needed before or after surgery
<u>DIAGNOSIS:</u>	<b>RETINAL VEIN OCCLUSION (Central or Branch)</b> - Every month for 3 months, then every 3 months until stable, then every 6 months as needed
<u>DIAGNOSIS:</u>	<b>RETINITIS PIGMENTOSA</b> – once a year
<u>DIAGNOSIS:</u>	<b>STEROID EYE DROP USE</b> – once a year
<u>DIAGNOSIS:</u>	<b>STEROID SYSTEMIC MEDICATION</b> – once a year
<u>DIAGNOSIS:</u>	<b>TAMOXIFEN RETINOPATHY</b> – every 12 months, including Visual Field
<u>DIAGNOSIS:</u>	<b>VISUAL FIELD DEFECT</b> – once a year
<u>DIAGNOSIS:</u>	<b>VITREOUS DETACHMENT OR FLOATER</b> – with symptoms such as flashes of light, every 3-6 months, otherwise once a year
<u>DIAGNOSIS:</u>	<b>VITREOUS HEMORRAGE</b> – every 1-3 weeks, ultrasound as needed

## OPTOMETRY- COVERAGE FOR GLASSES

### Criteria for Authorization

- vision defect by Snellen testing of equal to or > 20/50 or change in any meridian by at least 1.0 Diopter from the previous prescription
- correction required for employment

### Changes in Prescription:

- any meridian change by at least 1.0 diopter
- astigmatic correction of .5 diopters or more

### Replacement:

- replacement of glasses - 1x in 12 months if broken, lost or stolen

### Not a Benefit:

- reading glasses
- routine refractions without any noticeable change in vision

## **ORGAN TRANSPLANTATION**

CMS never covers organ and bone transplant services or services related to getting an organ transplant. CMS may cover services related to avoiding rejection and/or medical complications that arise from an organ transplant received when a patient was not on the CMS program. Any such coverage would be based on a review by medical management.

## OTITIS MEDIA

### Criteria for Authorization

Acute otitis media resolves most of the time in 2-8 weeks. Treatment is performed in primary care. Chronic serous otitis media refers to a persistent collection of fluid in the middle ear. This usually resolves spontaneously or is accompanied by allergic rhinitis. The following criteria are used for referrals to ENT:

#### Patient History (one present)

- 3 or more episodes of acute otitis media in 6 months
- persistent pain and pressure in the middle ear longer than 3 months

#### Physical exam (one present)

- visualization of the tympanic membrane shows bulging, retraction or fluid layer
- inflammation of the tympanic membrane
- reduced mobility testing of the tympanic membrane by:
  - tympanometry
  - acoustic reflectometry

#### Decreased hearing by audiometry

## PAIN MANAGEMENT

### Criteria for Authorization

Most patients with chronic pain are managed by primary care. Referral to a Pain Specialist is appropriate if the diagnosis of chronic pain is uncertain despite a work-up by primary care, if a procedure such as an epidural injection is indicated, or if specialist help is needed with pain management.

Patient History (at least 7 must be present in the clinical record)

- failure of adequate medication treatment, NSAIDS, opiates
  - failure of an individualized proactive pain control plan
  - failure of relaxation exercises
  - failure of a home exercise program
  - patient has knowledge of and expectation of his or her pain management
  - measurement of pain on a scale of 1-10
  - failure of therapeutic modalities, heat, cold, physical therapy
  - no evidence of drug addiction or drug-seeking behavior
  - narcotic contract in place with clear boundaries and limitations
  - documentation of previous surgeries
- AND

Physical Exam (at least 1 present)

- restriction of movement
  - sites of tenderness
  - neurologic signs with neck or back pain, especially radiculopathy
- AND

Tests done in primary care (Imaging and other studies) are required.



## PEPTIC ULCER DISEASE

### Criteria for Authorization

Peptic ulcer refers to gastric and duodenal ulcers. The most common causes are chronic *h. pylori* infection and the use of NSAIDs. Gastric ulcers carry an increased risk of cancer. Medical management by primary care is usually sufficient to treat peptic ulcers. Referral to GI is done for endoscopy (EGD). Because of the effectiveness of modern medical management, surgery for peptic ulcer disease is rarely necessary.

#### Patient History

- intractable and recurrent epigastric pain
  - adequate trial of a PPI medication (at least 2 months therapy)
  - treatment for *h. pylori* not successful
- AND

#### Physical Exam

- epigastric tenderness is present.
- AND

#### Labs

- *h. pylori* testing
- fecal occult blood

## PET SCAN (POSITRON – EMISSION TOMOGRAPHY)

### Criteria for Authorization

A PET scan differs from a CT or MRI by imaging cellular function of tissue. It is most useful in cancer diagnosis and follow-up. PET scanning is now being applied to other organ systems such as the heart. The CMS only covers PET scanning when it is critically necessary and no other modality will give the information.

- Diagnosis, staging and restaging or the following clinical conditions:
  - lung cancer (non-small-cell)
  - esophageal cancer
  - colorectal cancer
  - lymphoma
  - melanoma
  - head and neck malignancy
  - brain malignancy
  - thyroid cancer
  - breast cancer
  - cervical cancer
- To determine appropriate treatment, surgery v. chemotherapy.
- To determine if a tumor has been completely eradicated, post treatment.

**PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY**

Criteria for Authorization

PT, OT and ST are approved only for clinical conditions which require them for return to function. In general, an evaluation and 2 follow-up treatments are approved initially, unless the condition dictates longer therapy (such PT in a long bone fracture or OT/ST post stroke).

- ordered by the PCP when office education is not sufficient
- ordered by specialist
- post-op surgery
- must include aggressive patient education and home exercises
- greater than 12 patient visits require case management
- document action of progress and modalities used
- chronic low back pain – unresponsive to medication management

Patient History must include a description of limitations

Physical Exam must include deficits or impairment

Patient Responsibility

- motivation to follow exercise program
- “No shows” and non-compliance will lose approval for further treatment

Addendum: Extension of therapy requests must be accompanied by original evaluation and comparative documentation to allow assessment of improvement in function.

## PLANTAR FASCIITIS

### Criteria for Authorization

Most patients with plantar fasciitis are managed by primary care. All patients should have their feet and shoes evaluated. Initial treatment includes heel lifts or shoe inserts. Decreased activity, stretching and weight loss are part of conservative treatment. Only persistent and severe cases are approved for referral.

#### Patient History

- Heel Pain:
  - increased upon awaking
  - located just anterior to the heel

AND

- Failure to respond to conservative management
  - modify activity
  - limit weight bearing (running)
  - oral anti-inflammatory medications
  - heel pads (OTC products)
  - hot soaks with no symptomatic relief
  - exercises to strengthen lower leg muscles and to increase flexibility of the achilles tendon and hamstrings

AND

#### Physical Exam

- pain to palpitation at plantar aspect of the calcaneus
- may have positive heel squeeze test
- often associated with pes cavus or pes planus

## PODIATRY

Referral to Podiatry or an Orthopedist for foot problems is covered by CMS for conditions which are critically necessary for work and/or activities of daily living.

Most common foot problems such as plantar fasciitis and skin conditions are managed by primary care.

Proper shoes and the use of inserts treat most foot problems, along with weight loss and stretching.

Routine foot examinations, including the annual diabetic foot exam, are done by primary care.

CMS does not cover referral or treatment of toenail fungus infestation (tinea unguum).

### Criteria for Referral to a Podiatrist or an Orthopedist

- major foot deformity, including a bunion which is causing pain and inability to work or perform ADLs
- failure of conservative care provided by PCP
- heel spurs – failure to respond to conservative care and requiring an injection

## PROSTATECTOMY

### Criteria for Authorization

There are now multiple options for treating prostate disease other than surgery. Medications are very effective for benign prostatic hypertrophy (BPH). Surgery is only one of many options for treating prostate cancer. The decision to remove the prostate requires a specialist in Urology or Urologic Oncology.

#### Patient History (one of four)

- history of urinary retention despite treatment with medications
- presence of incontinence
- recurrent urinary infections
- nocturia – more than twice/night despite treatment with medications

AND

#### Physical Exam (one of three)

- enlarged prostate or with malignant nodules
- > 20 c.c. post-voiding residual despite medications
- persistent hematuria

AND

#### Diagnostic (one of four)

- IVP - obstructing prostate
- U/S - hydronephrosis
- positive needle biopsy for cancer
- abnormal creatinine level, or decreased creatinine clearance

## RHEUMATOLOGY - INCLUDING RHEUMATOID ARTHRITIS

### Criteria for Authorization

Referral to Rheumatology must have evidence of active collagen vascular (autoimmune) disease. A thorough history, musculoskeletal exam and laboratory studies below must be done. The treatment of Rheumatoid Arthritis has changed to the early use of disease modifying medications to prevent further disability. Early referral to Rheumatology is now the standard of care. An accurate diagnosis of the condition should occur at the primary care level.

#### Patient History (three of six)

- chronic pain
- loss of joint function
- limitation of self-care (Noticeable joint inflammation, stiffness, deformity)
- morning stiffness, warmth, redness, swelling, and deformity
- any loss of finger function
- generalized illness

#### ACR – Diagnostic Criteria (three of seven)

- morning stiffness of at least 60 minutes duration
- arthritis of three or more joints
- arthritis of hand joints
- symmetric arthritis - Present for six weeks
- rheumatoid nodules
- serum Rheumatoid Factor
- radiographic changes

#### Physical Exam

- fusiform swelling of small joints, especially the hands

#### Laboratory (the first four must be provided)

- ANA (Antinuclear antibodies)
- Rheumatoid Factor
- ESR (Erythrocyte Sedimentation Rate)
- CBC, electrolytes, creatinine, liver function tests, UA
- synovial fluid analysis

## SECOND OPINION

### Criteria for Authorization

CMS may authorize a request for a second opinion from the patient or practitioner or CMS may suggest a second opinion when any one of the following circumstances are present:

- A more cost-effective treatment option is available.
- Conservative therapy has not been attempted or has not had sufficient time to show results.
- Practitioner or patient disagrees with the diagnosis and/or plan of treatment recommended by the specialist.
- Practitioner or patient is seeking an alternate treatment option that may improve the outcome.
- Patient/practitioner relationship is hindered.
- Geographic and/or other obstacles prohibit patient from accessing care.



**SEPTOPLASTY**Criteria for Authorization

The CMS program does not cover surgery on the nose for any cosmetic purpose. Approval for referral and surgery would be approved only if the abnormality markedly interferes with work or daily function.

## Patient History (one of two)

- documented nasal trauma of recent origin which causes significant nasal obstruction
- persistent serous otitis media secondary to nasal obstruction and Eustachian tube dysfunction

AND

## Physical Exam

- dislocation of septal cartilage causing complete or near complete obstruction of the nasal cavity

## SINUSITIS – Acute and Chronic

### Criteria for Authorization

Most acute and chronic sinusitis is managed by primary care. Underlying causes such as allergy and infection are determined and treated by primary care. Referral is only necessary for persistent disease that markedly interferes with work or daily function.

#### Patient History (one of two)

- persistent obstruction beyond two months which interferes with function
- failure to respond to 2-3 courses of antibiotic therapy

#### Physical Exam (one of two)

- nasal exam - documenting purulent discharge
- palpable sinus tenderness

#### Treatment (three of three)

- first and second line antibiotics used for up to 6 weeks
- decongestant therapy for up to 6 weeks
- nasal corticosteroids used for up to 6 weeks without benefit

#### Diagnostic

- sinus x-rays or CT scan confirm obstruction

## SLEEP APNEA

### Criteria for Authorization

Sleep Apnea is common among obese people and people with upper airway obstruction. The sleep apnea form must be completed to help determine level of need. CPAP is the treatment of choice for documented clinically significant sleep apnea unless there is a removable obstructive lesion. Heat and humidification may be included with CPAP as standard therapy.

Patient History: (two of first four)

- chronic loud snoring
- gasping or choking episodes
- excessive daytime sleepiness
- cognitive difficulties
- stable home situation. (required)
- willingness to use C-PAP machine if recommended with electricity available in patient's bedroom (required)

Physical Exam:

- obesity, including nuchal obesity
- hypertension
- nasopharyngeal narrowing
- BMI > 35

Treatment:

- Oral Surgery only if there is an obstructive lesion that will relieve the problem.
- CPAP – CPAP equipment is purchased from an approved DME provider. The usual life span for the equipment is 3-5 years. Replacement is on an as needed basis with a recommendation of the DME provider after an evaluation of the equipment.

**COUNTY MEDICAL SERVICES  
STATEMENT OF MEDICAL NECESSITY  
REQUEST FOR SLEEP APNEA STUDY**

Patient Name \_\_\_\_\_ SSN \_\_\_\_\_  
Date \_\_\_\_\_ CMS Eligible From: \_\_\_\_\_ To: \_\_\_\_\_  
Clinic \_\_\_\_\_ Requesting Practitioner \_\_\_\_\_ Contact # \_\_\_\_\_

Please complete the information below to determine the medical necessity of a Sleep Apnea Study.

Patient History of Sleep Disturbance

Average number of hours of sleep each night \_\_\_\_\_  
Does patient nap during the day?  Occasionally  Daily  
Snoring:  Soft  Loud  
 Falls asleep while driving  Excessive daytime somnolence  
 Wakens with a sensation of choking or gasping

Medical Conditions

Hypertension  Controlled  Malignant  Allergic Rhinitis  
 Asthma  Depression  Nocturia  Diabetes  Type I  Type II  
Controlled  Yes  No  
 Obesity  Heart Disease

Life Style Behaviors

Number of caffeinated beverages per day \_\_\_\_\_  
Amount of alcohol consumed  Daily \_\_\_\_\_  Occasionally \_\_\_\_\_  
Smokes more than 1 pack of tobacco per day  Yes  No  
Does the patient have a stable home environment?  Yes  No

Medical Exam (all required)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Neck circumference \_\_\_\_\_  
Adeno-tonsillar enlargement  Yes  No  
Maxillo-mandibular malformation  Yes  No

Medications (list all)

The practitioner has discussed the treatment options with the patient.  Yes  No  
If a CPAP is indicated, the patient is willing to tolerate the inconvenience of the treatment (equipment, noise, dryness).  Yes  No  
If a CPAP is indicated, the patient has a working electrical outlet by their bed.  Yes  No

## TENS UNIT

### Criteria for Authorization

May be indicated for patients with chronic pain disorders who are refractory to other treatment and who have demonstrable relief from a TENS trial. TENS units will only be provided on a rental basis. No TENS rental will be authorized without a trial.

A completed referral must fully document indications for a TENS unit.

- refer patient to PT for TENS trial with two visits.
- PT to report results to Medical Director

Addendum: TENS rental may be approved for 3 months at a time, providing the patient remains eligible.

## THYROID DISEASE

### Criteria for Authorization

Hypothyroidism is evaluated and treated at the primary care level. Referral to Endocrinology is approved for severe cases or when the primary care physician is unable to control the disease .

Most patients with hyperthyroidism should be referred to endocrinology to be evaluated and to explore treatment options. Hyperthyroidism secondary to taking excessive thyroid medication is managed by primary care.

Thyroid nodules or other thyroid masses are referred to endocrinology and to either interventional radiology or general surgery for biopsy or other surgery. Occasionally, referral to endocrinology is needed to evaluate and recommend treatment for severely ill or cardiac patients.

### Patient History (Indications for Referral)

- for fine needle aspiration of solitary nodules
- for treatment of thyroid cancer
- to confirm the diagnosis and treatment plan for hyperthyroid patients
- for radioactive iodine therapy
- when lab values are ambiguous, especially in sick or elderly patients
- uncontrolled hypothyroidism

## THYROIDECTOMY

### Criteria for Authorization

#### Patient History (one of two)

- family history of thyroid cancer
- recurrent cystic lesions

AND

#### Physical (one of three)

- presence of a thyroid nodule or mass
- lymphadenopathy or metastasis
- cystic lesion > 4cm

AND

#### Diagnostic (one of four)

- fine needle aspiration, positive for cancer
- I<sub>131</sub>, scan-positive
- chronic thyroiditis by microsomal antibodies
- ↑ calcitonin levels

## TEMPOROMANDIBULAR JOINT DISORDER-TMJ

### Criteria for Authorization

TMJ refers to persistent pain and other symptoms such as clicking in the temporomandibular joint of the jaw. This common problem has many causes: arthritis, dental problems, and stress causing grinding or clenching the teeth (bruxism). TMJ is initially evaluated by primary care to determine the most likely cause. Dental referral should be done before a medical specialist if there is evidence of malocclusion or other dental problems. Other possible referrals include counseling, physical therapy and ENT which are approved based on these criteria:

#### Patient History (two of four)

- pain or difficulty opening mouth
- jaw locking
- clicking, popping or crepitus sound
- past history of rheumatoid arthritis or osteoarthritis

AND

#### Physical Exam (one of three)

- presence of facial asymmetry
- limited movement of the jaw
- tenderness and/or crepitation over TMJ joint on palpation

Dental evaluation should be done on most patients.

#### Failure of Past Treatment (two of three)

- muscle relaxants
- anti-inflammatory agents
- splint/oral appliance



**TONSILLECTOMY AND ADENOIDECTOMY (T & A)**Criteria for Authorization

Chronic persistent infection unresponsive to antibiotics and chronic obstruction are the most common reasons for referral to ENT and removal of these glands.

## Patient History (one of three)

- repeated episodes of acute tonsillitis (four or more) in past year with failure of resolution despite antibiotic therapy
- persistent obstruction of breathing and swallowing
- recurrent otitis media with persistence of fluid pressure secondary to enlarged adenoids causing obstruction to the eustachian tubes

## Physical Exam (one of three)

- markedly enlarged and chronically infected tonsils
- tonsils causing oral obstruction
- peritonsillar abscess
- adenoid obstruction of the eustachian tubes (by imaging)

## Adenoidectomy alone (one of three)

- nasal obstruction resulting in sleep apnea
- chronic otitis media with effusion secondary to adenoids

## TRIGGER FINGER

### Criteria for Authorization

Trigger finger or stenosing tenosynovitis is a condition in which one or more fingers (including the thumb) is/are caught in a bent position. This finger may straighten with a snap like a trigger being pulled and released. The finger remains in a bent and locked position in more severe cases. Referral and surgery is approved when correction of the trigger finger is critically necessary for work or daily function.

#### Patient History (one of first two)

- pain at the interphalangeal joint of forefinger or thumb
- failure of injectable steroids
- affecting work (obtain work history) - required

AND

#### Physical Exam (one of two)

- nodular thickening at the M.C.P. joint
- catching or locking of the P.I.P. joint with extension of finger

## TYMPANOPLASTY

### Criteria for Authorization

Tympanoplasty is repair of the tympanic membrane, or eardrum. The procedure is done for persistent perforations of the eardrum.

#### Patient History (two of three)

- recurrent infection of the middle ear
- chronic hearing loss interfering with work or daily function
- failure of previous antibiotic therapy and observation to result in healing of the perforation
- trauma resulting in perforation of the eardrum

AND

#### Physical Exam and Testing (two of two)

- perforation of tympanic membrane
- hearing loss of > 40 db by audiometry

## TYMPANOTOMY

### Criteria for Authorization

Tympanotomy, also known as myringotomy, is a surgical incision of the tympanic membrane, or eardrum. The procedure is done to perform surgery in the middle ear, or more commonly to insert drainage tubes because of persistent fluid in the middle ear.

Patient History or medical records documenting one of the following:

- cholesteotoma (collection of tissue in the middle ear)
- for insertion of typanostomy tubes (documented need by consult)
- to explore the middle ear for hearing loss (> 40 db) or other pathology

## VARICOSE VEINS

### Criteria for Authorization

Varicose veins are veins that become enlarged or twisted. Usually these occur in superficial veins of the leg, especially in women during and after pregnancy. Most varicose veins cause no significant medical problems and treatment is not necessary. CMS approves referral and surgery for varicose veins that cause major problems with work or daily function, and never for cosmetic purposes.

#### Patient History (both present)

- associated with severe, constant pain and/or stasis ulceration
- prescription compression stockings have failed after at least a six- month trial

Note: Patient unlikely to require coronary artery bypass grafting in the future.

#### Physical Exam (one of these present)

- recurrent superficial phlebitis (two or more occasions)
- stasis ulcer that is recurrent (three or more occasions) or not responding to conservative therapy after six weeks

Contraindication: Occlusive arterial disease (moderate to severe)

- recent deep vein thrombophlebitis
- pregnancy
- congenital abnormalities of deep veins

## VERTIGO

### Criteria for Authorization

Vertigo is dizziness associated with a feeling of movement, such as the room spinning. Vertigo is usually caused by a problem with the inner ear balance mechanism (vestibular system), or in the brain. The most common cause of vertigo is benign positional vertigo (BPV), a temporary condition common in middle age and the elderly. Temporary vertigo is also caused by inner ear infections, usually a virus, called labyrinthitis. Other more serious causes include toxicity with medications, ischemia to the brain (TIA or stroke) or brain tumors. If the vertigo is caused by an inner ear problem, it is referred to as peripheral vertigo. If the cause is in the brain, it is referred to as central vertigo. The initial assessment of vertigo, including maneuvers to determine if it is peripheral or central, is done by primary care. Referrals for peripheral vertigo usually go to ENT, while central vertigo is referred to Neurology.

### Patient History

- True rotatory vertigo elicited by a rapid head movement in a non-axial plane, e.g. rolling over in bed.
- If other neurologic symptoms are present, such as weakness, severe headache or hearing loss, early referral is indicated.
- Failure of treatment for BPV including:
  - medications
  - epley Maneuvers
- Assume position of Dix-Hallpike with the affected ear down then slowly rotate head in the opposite direction. Then, rotate head and whole body another 90 degrees, resume sitting.

AND

## VERTIGO (Continued)

### Physical Exam

- Dix-Hallpike maneuver
  - Patient moves from a sitting to a supine position with the head hanging over the edge of the bed or table and rotated 45 degrees; ear down. Bi-lateral testing.
  - Affected ear facing ground → vertigo and rotating movement of eyes or nystagmus indicated peripheral vertigo and most likely BPV.
  - If this is negative, a central cause of vertigo is considered and neurologic testing is indicated.

### Diagnostic Testing

- Audiometry should be done to document hearing loss.
- A CT scan (for acoustic neuroma) or MRI (for brain tumor or mass) may be requested by primary care.

## WOUND MANAGEMENT

### Criteria for Authorization

Patients with diminished circulation or low oxygen in the blood may have chronic wounds that if not treated aggressively become more complicated. Most wound management is done by primary care, but complicated wounds may require the evaluation and management recommendations of a wound care specialist or clinic. CMS authorizes such a referral and treatment procedures if critically necessary for wound healing.

#### Patient History (all must be present)

- chronic ulcers-not healed within 30 days of occurrence
- failure of standard wound therapy
- no measurable signs of healing

#### Physical Exam

- chronic stage 3 & 4 pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis