

APPENDIX L COVERED PREVENTIVE SERVICES FOR ADULTS AND CHILDREN

The following is a listing of preventive services for which payments will be made by the health plans.

For Adults:

The following are services for which payment will be made by health plans as separate medical services, as components of separate medical services, or as components of the "evaluation and management" services rendered by the health plans' providers. The services and periodicity are adapted from the 1996 U.S. Preventive Services Task Force.

Screening:

1. Blood Pressure Measurement:

Minimum: single measurement; all ages and sex

Periodicity: every 2 years if normal
(on basis of expert opinion) every 1 year or more frequently if abnormal

2. Weight/Height Measurement:

Minimum: all ages and sex; single measurement

Periodicity: (on basis of expert opinion) every 2 years

3. Total Cholesterol Measurement:

Minimum: females age 45-65; single measurement
males 35-65; single measurement

Periodicity: every 5 years
(there is insufficient evidence to recommend cholesterol measurement in younger adults with high cardiovascular disease risk factors or in older adults, however recommendation for screening may be made on other grounds. See U.S. Preventive Services Task Force. Guide to Clinical Preventive Services, 2nd ed. Baltimore: Williams & Wilkins, 1996)

4. Breast Cancer Screening:

age 50-69 Minimum: mammography alone or mammography and clinical breast exam (CBE)

Periodicity: annual

age 40-49: Although there is insufficient evidence to recommend either mammography alone or mammography and CBE, the American Cancer Society, the American College of OB/Gyn, and the American Academy of Family Physicians recommend mammography every 1-2 years and CBE every year and if done at this frequency, these screenings will be reimbursed by health plans.

age 70-74: Although there is insufficient evidence to recommend mammography screening, it will be reimbursed by health plans at the frequency of every 1 to 2 years.

5. Cervical Cancer Screening:

Minimum: pap test and pelvic exam; all sexually active women or age 18-65
Periodicity: annual, decreasing to every 3 years after 3 successive normal annual tests

Since it may be difficult to assess accurately if there have been 3 successive normal annual tests, annual pap tests will be reimbursed by Health plans.

6. Colorectal Cancer Screening:

Minimum: single sigmoidoscopy or annual fecal occult blood test (FOBT); age 50 or older
Periodicity: annual FOBT, sigmoidoscopy at age 50 and then every 10 years.

7. Prostate Cancer Screening:

Not recommended for routine screening.

If screening is to be performed, digital rectal exam and prostate specific antigen (PSA) for age 50-70 is best evaluated approach but should be preceded by objective information about the potential benefits and harms of early detection

8. Rubella serology or vaccination history:

Minimum: women of child bearing age

9. Tuberculin Skin Testing using the current methodology, schedule, and priority (immigrants, TB contacts, food handlers, health care and school workers, etc.) established by the DOH

10. Health Education and Counseling

1. substance use, including alcohol
2. diet and exercise
3. injury prevention
4. sexual behavior
5. dental health
6. family violence
7. depression: There is insufficient evidence to recommend for or against the routine use of standardized questionnaires to screen for depression in asymptomatic patients.
8. results and implications of screening listed above

Immunizations:

1. Tetanus-diphtheria (Td) booster
2. Rubella (or evidence of immunity) for women of child-bearing age
3. Hepatitis B in high risk groups--household and sexual contacts of HBsAg positive persons

Chemoprophylaxis:

1. Multivitamin with folic acid - pregnant women; women actively trying to become pregnancy
2. Counsel all peri and post menopausal women about the potential benefits and risks of hormone prophylaxis.

For the high risk population the required preventive interventions are an Adult Health Regimen which includes the prior listed preventive interventions in addition to the following:

<u>Risk Factor</u>	<u>Intervention</u>
1) low income; immigrants, alcoholics TB contacts	1) PPD
2) certain chronic medical conditions, institutionalized persons	2) PPD; pneumococcal vaccine influenza vaccine
3) health care/lab workers	3) PPD; hepatitis B and hepatitis A influenza vaccine
4) family h/o skin cancer; fair skin	4) avoid sun exposure
5) blood product recipients	5) HIV screen; hepatitis B vaccine
6) susceptible to measles, mumps, or varicella	6) MMR; varicella vaccine
7) previous pregnancy with neural tube defect	7) folic acid 4.0 mg
8) injection or street drug use	8) RPR/VDRL; PPD; HIV screen hepatitis B & A vaccine
9) high risk sexual behavior vaccines	9) STD screens; hepatitis B&A

For Pregnant Women:

The following are services for which payments will be made by the health plans as separate medical services, components of separate medical services or as components of the maternity (vaginal/Cesarean Section delivery; prenatal care, postpartum care) benefit.

1. **Prenatal laboratory screening tests**, including voluntary HIV testing and counseling and tests for alpha-fetoprotein alone or in combination with other tests to screen for neural tube anomalies and chromosomal anomalies such as Down's syndrome. Prenatal laboratory screening tests covered include testing for gestational diabetes, rubella, GC, syphilis, chlamydia, pap smear, Hepatitis B, Blood typing and RH, urinalysis, complete blood count, etc. as currently recommended by the American College of Obstetrics and Gynecology (ACOG).
2. **Prenatal visits** meeting the periodicity and standards currently recommended by the ACOG.
3. **Health education and Screening** for conditions which could make a pregnancy "high risk"--such as smoking, alcohol and other substance use, depression, inadequate diet, psychosocial problems, early signs of premature labor, other medical conditions, etc. and appropriate referrals including WIC and mental health providers. Other health education such as fetal development, breastfeeding, labor and delivery.
3. **Diagnosis of premature labor**
4. **Diagnostic amniocentesis, diagnostic ultrasound, fetal stress and non-stress testing.**
5. **Prenatal vitamins including folic acid.**
6. **Hospital stays** for up to 48 hours after vaginal delivery or 96 hours after cesarean section delivery for healthy women with uncomplicated deliveries and postpartum stays following current guidelines of the American Academy of Pediatrics (AAP) or ACOG.

For Children:

The following are services for which payments will be made by health plans as separate medical services, as components of separate medical services, or as components of the EPSDT comprehensive evaluation.

1. **Newborn Screening**--newborn hearing assessment, newborn laboratory screening--phenylketonuria, hypothyroidism, and other metabolic diseases as specified by the Department of Health (DOH) and currently in effect.
2. **Hospital stays for normal, term, healthy newborns** up to 48 hours after normal vaginal delivery or up to 96 hours after cesarean section delivery following current guidelines of the American Academy of Pediatrics (AAP) and American College of Obstetrics and Gynecology (ACOG).
3. **Other age appropriate laboratory screening tests** currently in effect as recommended by the American Academy of Pediatrics (AAP), the Centers for Disease Control (CDC), and/or required by Health Care Financing Administration (HCFA) for Medicaid recipients (examples, hemoglobin/hematocrit, blood lead level). Refer to HCFA State Medicaid Manual 5123.2, October 1993 for HCFA minimum standard for Lead screening (12 and 24 months).
4. **Screening to assess health status** to include age appropriate general physical and mental health, growth, development, and nutritional status. The periodicity schedule follows the AAP's Guidelines for Health Supervision currently in effect. Included but not limited to the following:
 - a. Initial/interval health history
 - b. Height/Weight/Head Circumference
 - c. Blood Pressure
 - d. Developmental Assessment using the Denver Developmental Screening Test or Development Inventory (MCDI), or any other acceptable method for developmental screening.
 - e. Behavioral Assessment (including screening for substance abuse for age 12+)
 - f. Vision Testing
 - g. Hearing/Language Testing; Audiometry
 - h. Physical Examination
5. **Tuberculin Skin Testing** using the methodology recommended by the DOH following a schedule recommended by the Hawaii Chapter, American Academy of Pediatrics.
6. **Immunizations** following the standards and schedule of the Advisory Committee on Immunization Practices (ACIP) and the DOH currently in effect.

7. **Age appropriate Dental referral and oral fluoride**
8. **Age appropriate Health Education** of child and/or parent including dietary counseling, injury prevention, child maturation/development, behavior management, dental care, sexuality, family violence, STD, HIV, pregnancy, and depression. Provisions for children aged 12 years and older to be able to discuss sensitive issues alone with the provider or designated staff.

**APPENDIX M
DENTAL PROCEDURES WHICH ARE THE
RESPONSIBILITY OF THE MEDICAL PLANS**

HCPCS or CDT-5 PROCEDURE CODE*	DESCRIPTION
D/07340	Vestibuloplasty - ridge extension
D/07350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
	Excision of Tumors:
D/07440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D/07441	Excision of malignant tumor - lesion diameter over 1.25 cm
	Removal of Cysts and Neoplasms:
D/07450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25 cm
D/07451	Removal of benign odontogenic cyst or tumor lesion diameter over 1.25 cm
D/07460	Removal of benign non-odontogenic cyst or tumor lesion diameter up to 1.25 cm
D/07461	Removal of benign non-odontogenic cyst or tumor lesion diameter over 1.25 cm
D/07465	Destruction of lesions by physical methods: electrosurgery, chemotherapy, cryotherapy or laser
	Excision of Bone Tissue:
D/07471	Removal of lateral exostosis – mandible or maxilla
D/07472	Removal of torus palatinus
D/07473	Removal of torus mandibularis
D/07490	Radical resection of mandible or maxilla
	Surgical Incision:
D/07511	Incision and drainage of abscess-intra oral soft tissue-complicated
D/07520	Incision and drainage of abscess - extraoral soft tissue
D/07530	Removal of foreign body, skin, or subcutaneous areolar tissue
D/07540	Removal of reaction - producing foreign bodies, musculoskeletal system
D/07550	Sequestrectomy for osteomyelitis
D/07560	Maxillary sinusotomy for removal of tooth fragment or foreign body

* HCPCS Codes will be billed with the "zero" as the first character. CDT-5 codes will be billed with the "D" as the first character.

HCPCS or CDT-5 PROCEDURE CODE*	DESCRIPTION
	Treatment of Fractures - Simple:
D/07610	Maxilla - open reduction (teeth immobilized if present)
D/07620	Maxilla - closed reduction (teeth immobilized if present)
D/07630	Mandible - open reduction (teeth immobilized if present)
D/07640	Mandible - closed reduction (teeth immobilized if present)
D/07650	Malar and/or zygomatic arch-open reduction
D/07660	Malar and/or zygomatic arch-closed reduction
D/07670	Alveolus - stabilization of teeth, open reduction, splinting
D/07680	Facial bones - complicated reduction with fixation and multiple surgical approaches
	Treatment of Fractures - Compound:
D/07710	Maxilla - open reduction
D/07720	Maxilla - closed reduction
D/07730	Mandible - open reduction
D/07740	Mandible - closed reduction
D/07750	Malar and/or zygomatic arch-open reduction
D/07760	Malar and/or zygomatic arch-closed reduction
D/07770	Alveolus - stabilization of teeth open reduction, splinting
D/07780	Facial bones - complicated reduction with fixation and multiple surgical approaches
	Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions:
D/07810	Open reduction of dislocation
D/07820	Closed reduction of dislocation
D/07830	Manipulation under anesthesia
D/07840	Condylectomy
D/07850	Surgical discectomy, with/without implant
D/07852	Disc repair
D/07854	Synovectomy
D/07856	Myotomy
D/07858	Joint reconstruction
D/07860	Arthrotomy
D/07870	Arthrocentesis
D/07872	Arthroscopy - diagnosis, with our without biopsy

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HCPCS or CDT-5 PROCEDURE CODE*	DESCRIPTION
D/07873	Arthroscopy - surgical: lavage and lysis of adhesions
D/07874	Arthroscopy - surgical: disc repositioning and stabilization
D/07875	Arthroscopy - surgical: synovectomy
D/07876	Arthroscopy - surgical: discectomy
D/07877	Arthroscopy - surgical: debridement
D/07880	Occlusal - orthotic device, by report
	Other Oral Surgery - Repair of Traumatic Wounds:
D/07910	Suture of recent small wounds up to 5 cm
D/07911	Complicated suture up to 5 cm
D/07912	Complicated suture over 5 cm
D/07920	Skin grafts (identify defect covered, location and type of graft)
	Other Repair Procedures:
D/07940	Osteoplasty for orthognathic deformities
D/07941	Osteotomy – mandibular rami
D/07943	Osteotomy mandibular rami with bone graft; includes obtaining the graft
D/07944	Osteotomy, segmented or subapical, per sextant or quadrant
D/07945	Osteotomy, body of mandible
D/07946	Le Fort I (Maxilla - total)
D/07947	Le Fort I (Maxilla - segmented)
D/07948	Le Fort II or Le Fort III – (osteoplasty of facial bones for midface hypoplasia retrusion) without bone graft
D/07949	Le Fort II or Le Fort III - with bone graft
D/07950	Osseous, osteoperiosteal, periosteal, or cartilage graft of the mandible - autogenous or nonautogenous
D/07955	Repair of maxillofacial soft and hard tissue defects
D/07980	Sialolithotomy
D/07981	Excision of salivary gland, by report
D/07982	Sialodochoplasty
D/07983	Closure of salivary fistula
D/07990	Emergency tracheotomy
D/07991	Coronoidectomy
D/07995	Synthetic graft - mandible or facial bones, by report

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HCPCS or CDT-5 PROCEDURE CODE*	DESCRIPTION
D/07996	Implant - mandible for augmentation purposes (excluding alveolar ridge), by report
D/07997	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D/07999	Unspecified oral surgery procedure, by report
Adjunctive General Services:	
D/09220	General anesthesia - first 30 minutes (limitation: nitrous oxide for unruly children or highly apprehensive adults; attach report or a note)
D/09221	General anesthesia - each additional 15 minutes
D/09420	Hospital calls (limitation: confinement must be approved; only under physician's request, no routine or follow-up visits)

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APPENDIX N GUIDELINES FOR ONE MONTH WAITING PERIOD

The health plan may subject a new adult member to a one-month waiting period for services which are not covered by the Medicaid State Plan. Health plans shall not apply the waiting period to adult members who have a break in coverage of 60 days or less. The waiting period may be reapplied to the member if the break in coverage is more than 60 days. The waiting period cannot be applied to children below the age of 21. The plan also cannot impose the waiting period for a member who is changing plans due to the Annual Plan Change Period or other reasons as the recipient was continuously enrolled in the program. The DHS will provide the plan with plan change information for persons electing to change plans during the Annual Plan Change period.

Urgent care for medical and behavioral health problems including office visits and related services such as laboratory and x-ray services for diagnostic purposes, prescription drugs (includes new and renewals of prescription drugs) shall not be subject to the waiting period. Follow-up visits related to the urgent or emergent conditions should also not be subject to the waiting period.

Pre-natal care is considered to be urgent care and therefore, not subject to a waiting period. Termination of a pregnancy is also not subject to the waiting period.