HOSPITAL SERVICES MANUAL

MEDICAID PROGRAM

Department of Health and Hospitals
Bureau of Health Services Financing



Issued September 15, 1994

STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Department of HEALTH and HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

July 25, 2005

Dear Health Care Provider:

Louisiana Medicaid's Pharmacy Benefits Management staff (LMPBM) and Louisiana Medicaid's Drug Utilization Review Board are charged with assuring that prescriptions billed to Medicaid are appropriate and medically necessary. In 2005, our Drug Utilization Review program is focusing on behavioral health issues and pain disorders. The purpose of this correspondence is to notify prescribers of upcoming edits and limitations the LMPBM is implementing regarding antipsychotic agents and anti-anxiety drugs. The goal is to assure appropriate use of antipsychotic agents and anti-anxiety agents based on established clinical practice guidelines and available diagnostic information.

Procedures in the pharmacy audit program have been established to verify the provider's documentation and compliance associated with program policy. Therefore, prescribers are asked to assist pharmacists in obtaining required documentation and notations.

If you have concerns or comments regarding this correspondence, you may contact Melwyn B. Wendt at 225-342-9768 or send a fax to 225-342-1980. We appreciate your continued cooperation and support of our Drug Utilization Review (DUR) efforts to assure prescriptions paid by Medicaid are appropriate for the individual patient.

Sincerely,

Ben A. Bearden
Medicaid Director

BAB/MJT/mbw

Attachment

OFFICE OF MANAGEMENT AND FINANCE • BUREAU OF HEALTH SERVICES FINANCING
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"AN EQUAL OPPORTUNITY EMPLOYER"

ANTIPSYCHOTIC AGENTS

Medicaid's Drug Utilization Review Board joined the Department of Health and Hospitals Office of Mental Health to establish parameters for reviewing antipsychotic agents. To help ensure the safety and well being of Medicaid patients, and to avoid duplication of benefits, **effective August 10, 2005,** prescriptions for antipsychotic agents:

- **will require an appropriate ICD-9 diagnosis code on all new prescriptions. The accepted diagnosis codes fall in the range from 290.0 through 319.9. The numeric code must be documented on the hardcopy prescription by either the prescriber or the pharmacist. The ICD-9 code may be transmitted to the pharmacist electronically or via telephone or facsimile;**

- **will be screened per recipient to search for two active prescriptions for antipsychotic agents. Any incoming pharmacy claim for an antipsychotic agent will deny when the recipient has two active antipsychotic prescriptions on their file. An active prescription is a prescription in which the days supply has not expired;**

- **that are classified as atypical agents, will be screened for doses exceeding the maximum recommended dose.**

(1) Pharmacy claims for **new** prescriptions for antipsychotic agents shall be submitted with an ICD-9 diagnosis code. Claims submitted without an appropriate diagnosis code or without any diagnosis code will deny. If the prescriber does not indicate a diagnosis code, and the pharmacist determines the patient cannot wait to receive the medication, the pharmacy provider may override the denial.

(2) Incoming pharmacy claims for antipsychotic agents billed for recipients who have **two** (2) active prescriptions for any antipsychotic medications (either typical or atypical agents) on file will deny with a therapeutic duplication. The pharmacist may override the denial upon consultation with the prescriber. The pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive a third antipsychotic agent. Listed below are the current antipsychotic agents reviewed in the screening process. As new antipsychotic agents are made available, they will be included in the screening process.

Typical Antipsychotic Agents

Chlorpromazine	Thiothixene	Haloperidol
Perphenazine	Fluphenazine	Mesoridazine
Trifluoperazine	Prochlorperazine	Thioridazine
Loxapine	Pimozide	Molindone

Atypical Antipsychotic Agents

Generic Name	Brand Name	Maximum Dose Per Day
Aripiprazole	Abilify	30mg/day
Clozapine	Clozaril	900mg/day
Olanzapine	Zyprexa	40mg/day
Quetiapine	Seroquel	1200mg/day
Risperidone	Risperdal	16mg/day
Ziprasidone	Geodon	200mg/day

(3) Pharmacy claims for doses for **atypical antipsychotic agents** (listed above) which exceed the maximum recommended doses will deny. After consultation with the prescriber, the pharmacist may override the claim. The pharmacist must note on the hardcopy prescription, the reason the prescriber requires a dose above the maximum recommended dose.

ANTIANXIETY AGENTS

Effective **August 10, 2005** an incoming pharmacy claim for a recipient who has an **active** prescription for an anti-anxiety agent on file will deny as a therapeutic duplication. The pharmacist may override the denial upon consultation with the prescriber. The pharmacist must document on the hardcopy prescription the reason an additional anti-anxiety agent was requested by the prescriber.

Alprazolam	Halazepam
Buspirone	Hydroxyzine
Chlordiazepoxide	Lorazepam
Chlorazepate	Meprobamate
Diazepam	Oxazepam

TABLE OF CONTENTS

Page

LIST OF FIGURES xi

PREFACE xiii

GENERAL MEDICAID INFORMATION 1-1
Chapter Contents 1-1
Introduction 1-2
What Is Medicaid? 1-2
How Does Medicaid Work? 1-3
General Standards for Provider Participation 1-4
Indication of Agreement 1-4
Medicaid Eligibility 1-5
Aged 1-5
Blind 1-5
Aid to Families with Dependent Children (AFDC) 1-5
Child Health and Maternity Program (CHAMP) 1-5
Disabled 1-6
Foster Care 1-6
Qualified Medicare Beneficiary (QMB) 1-6
Medically Needy 1-7
Identification of Recipients 1-9
152-N—Eligibility Inquiry for Newborns 1-15
Processing at BHSF 1-16
Lock-In Program 1-18
CommunityCARE Program 1-20
Out-of-State Medical Care 1-22

ABBREVIATIONS/ACRONYMS/DEFINITIONS 2-1
Chapter Contents 2-1

PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS 3-1
Chapter Contents 3-1
Hospital Provider Enrollment Requirements 3-2
Licensure 3-2
Distinct Part Psychiatric Units 3-2
Provider Enrollment Procedures 3-3
Change of Address/Enrollment Status 3-4

INPATIENT HOSPITAL SERVICES 4-1
Chapter Contents 4-1
Introduction 4-2
Inpatient Care Service 4-2
Distinct Part Psychiatric Units 4-3
Outpatient Surgery 4-4
Services Requiring Special Procedures 4-5
Sterilizations 4-5
Informed Consent 4-5
Correcting the BHSF Form 96 4-10
Hysterectomies 4-11
Other Inpatient Services 4-14
Blood 4-14
Hospital-Based Ambulance Services 4-14
Nursery Charges 4-14
Pregnancy-Related Services 4-15
Abortions 4-15
Ectopic Pregnancies 4-17
Molar Pregnancies 4-17
Deliveries With Non-Payable Sterilizations 4-18
Inpatient Hospital Policy/Procedures 4-19
Discharge and Readmit on the Same Day 4-19
Direct Transfers of Patients 4-19
Date of Discharge or Death 4-19
Split-Billing 4-19
Split-Billing Procedures 4-20
Therapeutic Passes 4-20
Swing Beds 4-21

OUTPATIENT HOSPITAL SERVICES 5-1
Chapter Contents 5-1
Introduction 5-2
Clinic Services 5-3
Emergency Room Services 5-3
Hospital-Based Ambulances (Air or Ground) 5-4
Hospital Laboratory Services 5-4
Hyperbaric Oxygen Therapy 5-5
Norplant Insertions 5-6
Outpatient Rehabilitation Services 5-6
Outpatient Surgery Program 5-8
Intraocular Lens Implants 5-9
Observation Room Charges 5-10
Therapeutic and Diagnostic Services 5-10

HOSPITAL-BASED PHYSICIANS 6-1
Chapter Contents 6-1
Introduction 6-2
Enrollment of Hospital-Based Physicians 6-2

PRE-ADMISSION CERTIFICATION/LENGTH OF STAY 7-1
Chapter Contents 7-1
Introduction 7-2
Pre-Admission Certification 7-2
Length of Stay 7-3
Extensions 7-3
Medicaid Hospital Pre-Admission/Length of Stay Review Program Information 7-4
Functional Operations 7-5
Admission Review with LOS Assignment for Distinct Part Psychiatric and Long Term Hospitals 7-5
Acute Care (Medical-Surgical) and Rehabilitation Hospitals—Registration of Admission and Prospective LOS Review Only 7-7
Maximum Turnaround Times 7-11
Instructions for Completing P.C.F01 Form 7-13
Long Term Hospital Pre-Admission 7-16
Certification Guidelines 7-16
Psychiatric 7-16
Acute Care (Medical-Surgical) 7-16

Rehabilitation 7-16
All Other Long Term Hospitals 7-16
Long Term Hospital Exclusionary Criteria 7-17
Definition of Terms 7-17
Long Term Hospital 7-17
Severity of Illness 7-18
Intensity of Service 7-19
Long Term Hospital Criteria 7-19
Level I 7-19
Level II 7-22
Level III 7-25
Long Term Hospital Discharge Criteria 7-28
Distinct Part Psychiatric Unit 7-37
Admission Criteria for Adults 7-37
Severity of Illness 7-37
Intensity of Service 7-38
Exclusionary Criteria 7-39
Extension Criteria for Adults 7-39
Severity of Illness 7-39
Intensity of Service 7-41
Discharge Criteria 7-42
Admission Criteria for Children 7-46
Severity of Illness 7-46
Intensity of Service 7-48
Exclusionary Criteria 7-48
Extension Criteria for Children 7-49
Severity of Illness 7-49
Intensity of Service 7-51
Exclusionary Criteria 7-52
Discharge Criteria for Children 7-52
Community Based Psychiatric Service Definitions 7-56
Alcoholism and Drug Treatment Units 7-59
Admission Criteria 7-59
Severity of Illness 7-59
Intensity of Service 7-62
Extension Criteria 7-62
Severity of Illness 7-62
Intensity of Service 7-63
Discharge Criteria 7-63
Rehabilitation Hospitals 7-68
Length of Stay Criteria 7-68

Severity of Illness 7-68
Intensity of Service 7-69
Appropriate Diagnoses for Inpatient Admission 7-70
Discharge Criteria 7-70
Outpatient Surgery Performed as Inpatient 7-73

PRIOR AUTHORIZATION 8-1
Chapter Contents 8-1
Introduction 8-2
Outpatient Rehabilitation Services 8-3
Instructions for Completing PA01 Form 8-6
Instructions for Completing PA02 Form 8-9
Organ Transplants 8-11
Transplants and Other Extensive Surgical Procedures Requiring Prior Authorization 8-13
Out-of-State Non-Emergency Hospitalizations 8-15
Reconsideration 8-16
Instructions for Submitting a Reconsideration 8-16

REIMBURSEMENT 9-1
Chapter Contents 9-1
Introduction 9-3
Inpatient Reimbursement 9-3
Neonatal Care Units 9-6
Level I Unit 9-6
Level II Unit 9-7
Level III Unit 9-8
Level III Regional Unit 9-10
Pediatric Intensive Care Units 9-13
Organizational Structure 9-13
Staffing 9-13
Hospital Facilities and Services 9-14
Equipment and Drugs 9-15
Miscellaneous Requirements 9-16
Burn Care Units 9-17
Organizational Structure 9-17
Staffing 9-18
Burn Center Referral Criteria 9-21
Equipment and Facilities 9-22

Other Programs 9-23
Education Program 9-23
Rehabilitation Program 9-24
Burn Prevention/Research 9-24
Transplants 9-25
Level of Care/Specialty Service Determination 9-28
Rate Determination/Peer Group Designation 9-29
Appeals Procedure 9-31
Request for Administrative Review 9-31
Administrative Appeal 9-36
Judicial Review 9-36
Medicaid Disproportionate Share Payment Adjustment for Inpatient Hospital Reimbursement 9-37
Qualifications 9-37
Staffing Requirements 9-38
Utilization Rates 9-38
DSH Payment Adjustment Methodologies 9-39
Disproportionate Share Payments—Medicaid Days Pool Payments 9-39
Disproportionate Share Payments—Indigent Care (Free Care) 9-42
Inpatient Reimbursement 9-45
Request for Adjustment of Cost Per Discharge Limits 9-46
Examples and Illustrated Calculations 9-50
Example 2-A: Adjustment Calculation for Increase in Average Length of Stay 9-51
Example 3-A: Adjustment Calculation for Increased Routine (Adults and Pediatrics) Service Intensity with Increased ALOS and No Additional Staffing 9-53
Example 3-B: Adjustment Calculation for Increased Routine Service Intensity with Additional Staffing 9-55
Example 3-C: Increased Ancillary Service Intensity with Increased ALOS and No Additional Staffing 9-57
Example 3-D: Increased Ancillary Service Intensity with Increased ALOS and Additional Staffing 9-59
Example 3-E: Adjustment Calculation for Addition/Deletion of Services . . . 9-61
Free-Standing Psychiatric Hospitals and Distinct Part Psychiatric Units 9-63
Outpatient Reimbursement 9-63
Out-of-State Hospital Reimbursement 9-64
Lump Sum Adjustments 9-64

CLAIMS FILING 10-1
Chapter Contents 10-1
Introduction 10-3
UB-92 Billing Instructions 10-3
UB-92 Form Instructions 10-5
Medicaid Revenue Codes 10-19
Third Party Liability (TPL) 10-29
TPL Codes 10-29
Medicare/Medicaid Coverage 10-30
Crossover Process 10-30
Medicare Part A Only Claims 10-31
Medicare Part B Only Claims 10-31
Exhausted Medicare Part A Claims 10-32
The Remittance Advice 10-33
The Purpose of the Remittance Advice 10-33
What Happens to the Provider's Claim? 10-33
Returned Claims 10-33
What Happens to a Processed Claim? 10-34
Approved Claims 10-34
Denied Claims 10-34
Pended Claims 10-35
Remittance Advice Copy Requests 10-35
Timely Filing Guidelines 10-36
Claims for Dates of Service Over Two Years Old 10-37
UB-92 Adjusting/Voiding Claims 10-38
Locator 84 10-38
Locator 4 10-38
Retroactive Payment for Inpatient Hospital Services 10-40
Retroactive Payments for Medicare-Eligible Persons 65 or Older 10-40
Refund/Return Checks 10-41
Refund Checks 10-41
Return Checks 10-42
Provider Relations 10-43
Recipient Eligibility Verification System (REVS) 10-44

FRAUD AND ABUSE 11-1
Chapter Contents 11-1
Introduction 11-2
Fraud 11-3
Provider Fraud 11-3
Recipient Fraud 11-4
Abuse 11-5
Provider Abuse 11-5
Recipient Abuse 11-5
Fraud and Abuse Detection 11-6
Referrals 11-6
Recipient Verification Notices (REOMBs) 11-6
Computer Profiling 11-7
Administrative Sanctions 11-9
Levels of Administrative Sanctions 11-9
Grounds for Sanctioning Providers 11-10
Provider Appeals 11-13

APPENDIX A: OUTPATIENT SURGERY LIST A-1
Chapter Contents A-1
Outpatient Surgical Procedures Requiring Pre-Admission Approval if Performed on an Inpatient Basis A-2

APPENDIX B: ORDERING INFORMATION B-1
Chapter Contents B-1
CPT-4 and ICD-9-CM Code Book B-2
Form HCFA-1500 . . . . . B-3
BHSF Form 96 and BHSF Form 96-A B-4
BHSF Form 152-N B-4
Forms PA01 and PA02 . . . . . B-5
HCIA (LOS) B-5
InterQual ISD B-5

APPENDIX C: BLANK MASTER FORMS C-1
Chapter Contents C-1
P.C.F01 Form—Request for Hospital Pre-Admission Certification and LOS Assignment C-2
Long Term Hospital Length of Stay Criteria C-3

Distinct Part Psychiatric Unit Admission/Extension Criteria for Adults C-10
Distinct Part Psychiatric Unit Admission/Extension Criteria for Children C-13
Hospital-Based Alcoholism and Drug Treatment Units C-16
Rehabilitation Hospital Length of Stay Criteria C-19
Summary of Pre-Certification/Length of Stay Policy C-21
PA01 Form Request for Prior Authorization C-22
PA02 Form Rehabilitation Services Request C-23

LIST OF FIGURES

Figure		Page
1-1	Spend-Down Medically Needy Notice	1-8
1-2	Sample Medicaid Card Issued by WIS	1-10
1-3	Sample Medicaid Presumptive Eligibility Card Issued by WIS	1-10
1-4	Sample Spend-Down Medically Needy Medicaid Card Issued by WIS	1-11
1-5	Sample Front Side of Medicaid Card Issued by OFS and BHSF	1-12
1-6	Sample Back Side of Medicaid Card Issued by OFS and BHSF	1-12
1-7	Sample Medicaid Card Issued by the Fiscal Intermediary	1-13
1-8	Sample Pure QMB Medicaid Card Issued by the Fiscal Intermediary	1-13
1-9	Sample Dual QMB Medicaid Card Issued by the Fiscal Intermediary	1-14
1-10	Form 152-N Notice of Newborn Eligibility	1-17
1-11	Sample Front Side of a Lock-In Medicaid Card Issued by BHSF	1-19
1-12	Sample Back Side of a Lock-In Medicaid Card Issued by BHSF	1-19
1-13	Sample CommunityCARE Medicaid Card Issued by the Fiscal Intermediary	1-21
4-1	BHSF Form 96 Consent Form	4-8
4-2	Checklist for Form 96	4-9
4-3	BHSF Form 96-A Acknowledgement of Receipt of Hysterectomy Information	4-13
7-1	P.C.F01 Form—Request for Hospital Pre-Admission Certification and LOS Assignment	7-12
7-2	Long Term Hospital Length of Stay Criteria Form	7-30
7-3	Distinct Part Psychiatric Unit Admission Criteria for Adults	7-43
7-4	Distinct Part Psychiatric Unit Admission Criteria for Children	7-53
7-5	Hospital-Based Alcoholism and Drug Treatment Units	7-65
7-6	Rehabilitation Hospital Length of Stay Criteria Form	7-71
7-7	Summary of Pre-Certification/LOS Policy	7-75
8-1	PA01 Form Request for Prior Authorization	8-5
8-2	PA02 Form Rehabilitation Services Request	8-8
9-1	Example 2-A: Adjustment Calculation for Increase in Average Length of Stay	9-52
9-2	Example 3-A: Adjustment Calculation for Increased Routine (Adults and Pediatrics) Service Intensity with Increased ALOS and No Additional Staffing	9-54
9-3	Example 3-B: Adjustment Calculation for Increased Routine Service Intensity with Additional Staffing	9-56
9-4	Example 3-C: Increased Ancillary Service Intensity with Increased ALOS and No Additional Staffing	9-58

9-5 Example 3-D: Increased Ancillary Service Intensity with Increased ALOS and Additional Staffing 9-60
9-6 Example 3-E: Adjustment Calculation for Addition/Deletion of Services 9-62

10-1 Sample UB-92 10-4

PREFACE

The Medicaid Program (Title XIX), formerly known as the Louisiana Medical Assistance Program, is designed to assist eligible Medicaid recipients in obtaining medical care within the applicable federal and state rules and regulations. The Medicaid Program is administered by the Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF). Reimbursement may be made for hospital services when these services are provided to eligible Medicaid recipients by qualified, enrolled providers.

This manual is one of a series published for the use of medical services providers enrolled in the Medicaid Program. It is not a legal description of all aspects of the Medicaid Program or Title XIX rules and regulations, but it does set forth conditions and requirements hospital providers must meet to qualify for reimbursement. In addition, the manual provides the procedural information hospital providers will need to file claims for services promptly and accurately.

This manual is divided into easily accessible sections, so providers may find information quickly. This manual is applicable to providers who file claims with the fiscal intermediary, Unisys, for recipients of Medicaid services. We suggest that you study the material and maintain it in a special file for future reference.

From time to time, policies governing hospital services may change. Providers will be notified via written memoranda, remittance advices, provider updates and revised manual pages regarding revisions and updates to policies in this manual. All revisions received should be placed in the appropriate section of the manual. Should there be a conflict between manual material and pertinent laws or regulations governing the Medicaid Program, the latter take precedence.

Providers may obtain copies of this manual by contacting the Provider Relations Unit at Unisys at **(504) 924-5040.**

CHAPTER 1
GENERAL MEDICAID INFORMATION

CHAPTER CONTENTS

Page

INTRODUCTION 1-2
What Is Medicaid? 1-2
HOW Does Medicaid Work? 1-3

GENERAL STANDARDS FOR PROVIDER PARTICIPATION 1-4
Indication of Agreement 1-4

MEDICAID ELIGIBILITY 1-5
Aged 1-5
Blind 1-5
Aid to Families with Dependent Children (AFDC) 1-5
Child Health and Maternity Program (CHAMP) 1-5
Disabled 1-6
Foster Care 1-6
Qualified Medicare Beneficiary (QMB) 1-6
Medically Needy 1-7
Identification of Recipients 1-9
152-N—Eligibility Inquiry for Newborns 1-15

LOCK-IN PROGRAM 1-18

COMMUNITYCARE PROGRAM 1-20

OUT-OF-STATE MEDICAL CARE 1-22

INTRODUCTION

The Louisiana Medical Assistance Program, now referred to as the Medicaid Program, became effective on July 1, 1966, under provisions of Title XIX of the 1965 Amendments to the ***Federal Social Security Act*** and Article 18, Section 7, Subsection 1, of the ***Louisiana Constitution***, as amended. The Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), is the designated single state agency responsible for administering the program. The Medicaid Program is designed to provide certain health care benefits for those ***categorically needy*** and ***medically needy recipients*** who are in need of medical services.

The BHSF is responsible for the overall management of the Medicaid Program, including the following functions:

- Determining all necessary regulations and guidelines for the Medicaid Program policy
- Administering the program
- Determining the services covered by the program and setting the reimbursement rates within federal guidelines
- Determining eligibility of recipients, maintaining the recipient eligibility file, and issuing medical cards to eligible recipients
- Enrolling providers who wish to participate in the program
- Operating a Medicaid Management Information System (MMIS) and processing claims from providers through its Fiscal Intermediary.

WHAT IS MEDICAID?

Medicaid is a means of delivering medical care to eligible needy individuals. The term ***Medicaid*** is derived from the words ***medical*** and ***aid***, and it indicates the financial, as well as the medical assistance, that many patients require.

The state's Medicaid plan is formally included within the Medicaid Program. The legal basis for the plan is contained in Title XIX of the ***Social Security Act***; and, therefore, the term ***Title XIX*** is also used to refer to the program. Thus, the Medicaid Program may be referred to as The Medical Assistance Program or Title XIX.

The Medicaid system provides state and federal funds for health professionals who perform and/or deliver medically necessary services and/or supplies for eligible Medicaid recipients. The administration of the Medicaid Program is a cooperative effort on the part of the federal and state government.

Health Care Financing Administration (HCFA) sets the guidelines for the states' participation in Medicaid and monitors the different state programs. The Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), determines policies for complying with state laws and federal guidelines. It is directly responsible for the administration and monitoring of the Medicaid Program and for distributing information to providers.

HOW DOES MEDICAID WORK?

The Provider: The provider's role is to render health care services within a specialized field to eligible Medicaid recipients. To receive reimbursement for these services, the provider must agree to abide by the rules and regulations set forth by the program.

Medicaid Recipients: The purpose of Medicaid is to make health services available to the needy. Determining eligibility for Medicaid is the responsibility of DHH-BHSF. Medicaid recipients are classified as ***Categorically Needy*** or ***Medically Needy***. The recipients, in either classification, will be issued a Medicaid card on a monthly basis. The purpose of this card is to serve not only as a notice to recipients of their eligibility for Medicaid, but also to identify eligible recipients to providers of medical care services. A detailed explanation of the Medicaid card can be found in the **Eligibility** section of this manual.

GENERAL STANDARDS FOR PROVIDER PARTICIPATION

Provider participation in the Medicaid Program is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. These standards are listed as follows:

- Provider agreement and enrollment with BHSF
- Agreement to charge Medicaid no more for services furnished eligible recipients than is charged on the average for similar services to others
- Agreement to accept as payment in full the amounts established by the BHSF and not to seek additional payment from the recipient for any unpaid portion of a bill, except in cases of Spend-Down Medically Needy recipients
- Agreement to maintain medical records and any information regarding payments claimed by the provider for furnishing services

  Note: ***Records must be retained for a period of three years and be furnished, as requested, to the BHSF, its authorized representative, representatives of the DHHS, or the state Attorney General's Medicaid Fraud Control Unit.***

- Compliance with local, state, and federal laws and regulations
- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the *1964 Civil Rights Act*, Section 504 of the *Rehabilitation Act of 1973*, the Americans With Disabilities Act of 1990, and, where applicable, Title VII of the *1964 Civil Rights Act*.

INDICATION OF AGREEMENT

Although Medicaid is a voluntary program, providers should note that their signature on a claim form will serve as their agreement to abide by all policies and regulations of the Medicaid Program. This agreement also certifies that, to the best of the provider's knowledge, information contained on the claim form is true, accurate, and complete.

MEDICAID ELIGIBILITY

Eligibility for the Medicaid Program is determined by the BHSF office in the parish or region where the recipient resides. Eligibility for each Medicaid program is based on categorical requirements. Recipients who meet all requirements, **including the income requirement,** of a specific Medicaid program are classified as **categorically eligible** for the Medicaid Program. Categorically eligible recipients cannot be billed, nor can payment be accepted by the provider, for any portion of their medical expense which is billed to the Medicaid Program.

The following are the categories and definitions of Medicaid eligibility.

AGED

Individuals who are aged (age 65 or older) as defined and established by the Social Security Administration (SSA). Recipients are identified by "01" in the third and fourth digits of their Medicaid identification number.

BLIND

Individuals who are blind as defined and established by SSA. Recipients are identified by "02" in the third and fourth digits of their Medicaid identification number.

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

Families with minor or unborn children who meet the categorical requirement of deprivation. Recipients are identified by "03" in the third and fourth digits of their Medicaid identification number.

CHILD HEALTH AND MATERNITY PROGRAM (CHAMP)

- Children born on or after October 1, 1983, **age 6 or older,** whose family income is below the 100% Federal Poverty Income Guidelines, and

- Children **under age 6** and **pregnant women** whose family income is below the 133% Federal Poverty Income Guidelines.

The **CHAMP child** and **CHAMP pregnant women** are identified by "03" in the third and fourth digit of their Medicaid identification numbers. The eligibility of the CHAMP Pregnant Woman ends sixty (60) days after the date of delivery unless she is eligible in another category of assistance.

Pregnant women who are determined **Presumptively Eligible** are identified by "16" in the third and fourth digits of their Medicaid identification number. **These recipients are not eligible to receive inpatient hospitalization services.**

DISABLED

Individuals who are disabled as defined by SSA or receive SSI assistance based on disability. Recipients are identified by "04" in the third and fourth digits of their Medicaid identification number.

FOSTER CARE

Children who are in the custody of the Office of Community Services (OCS) or the Office of Youth Development (OYD) are eligible for Medicaid covered services. Recipients are identified by "06", "08", "15",or "22" in the third and fourth digits of their Medicaid identification number.

QUALIFIED MEDICARE BENEFICIARY (QMB)

Individuals who are enrolled or conditionally enrolled in Medicare Part A (Medicare Hospital Insurance) and who meet the income and resource requirement for QMB. QMB eligibles are divided into two categories.

- **Pure QMB** recipients are eligible for Medicaid payment only for QMB services which includes: (1) Medicare Part A and B premiums, (2) Medicare deductibles for Medicare covered services, and (3) Medicare co-insurance for Medicare covered services. **If the services are not covered by Medicare, Medicaid will not provide reimbursement.** These recipients are identified by "17 in the third and fourth digits of their Medicaid identification number.

- **Dual QMB** recipients are eligible for the same benefits as the Pure QMB **as well as** the full range of Medicaid covered services in any other category of assistance. These recipients are identified by indicator on their Medicaid card "*MEDICARE/Medicaid SERVICES."

MEDICALLY NEEDY

Recipients who meet all of the requirements of a specific Medicaid program **except the income requirement,** are classified as **Medically Needy**. There are two groups of Medically Needy recipients:

- Regular Medically Needy
- Spend-Down Medically Needy.

Regular Medically Needy recipients are not financially responsible for any medical services which are reimbursed by Medicaid.

Spend-down medically needy recipients may, in certain instances, be financially liable for a portion of their medical expenses. Eligibility for Spend-down Medically Needy begins on the exact date that medical expenses incurred by these recipients allow them to "spend-down" to the level of income (MNIES) which will qualify them for Medicaid.

Any provider who has provided services to a Medicaid recipient on the recipient's spend-down date will receive a **Spend-down Medically Needy Notice (Form 110- MNP)** from BHSF (Figure 1-1). This form will notify the provider of the amount due by the recipient (spend-down portion) and of the amount to be billed to the Medicaid Program. The provider should attach Form 110-MNP to the claim and submit it to the Fiscal Intermediary for processing.

Note: The provider cannot bill the beneficiary for any amount over the amount specified on the 110-MNP Form under "Beneficiary Liability."

BHSF 110 MNP
Revised 09/93
Prior Issue Usable
IV

MEDICAID PROGRAM
SPEND-DOWN MEDICALLY NEEDY NOTICE

Anna M. Doar
Case Name

3601012345601
Identification Number

Beneficiaries listed on the medical eligibility card are eligible for Medicaid health care coverage **from** 10 / 08 / 93 (spend-down date) **through** 10 / 08 / 93 .

PROVIDER NOTICE: The services listed below occurred on the spend-down date (beginning date of Medicaid coverage) according to information available to us. Bill our Fiscal Intermediary (FI) for the services rendered on this date **only** if Medicaid Liability for the service is indicated by a ☑ in the Yes block of the last column below. Medicaid payment for services rendered on the spend-down date will be made **only** for the services listed below and **only** if a copy of this form is attached to your claim. Payment will be made in accordance with the limits established as **usual, reasonable,** and **customary** charges. Enter the Beneficiary Liability Amount shown below in the Recipient Liability column of the billing document

Patient Name and Identification No. (13 digits)	Provider Name and Vendor No.	Service or Rx Received on Spend-Down Date	Total Unpaid Charges for Services Received	Beneficiary Liability Amount	Medicaid Liability? Yes	Medicaid Liability? No
Anna M. Doar 3601012345601	Dr. George Burns 1312345	Hospital Care	$250.00	$20.00	☒	☐
Anna M. Doar 3601012345601	ABC Hospital 1732345	Inpatient Services	500.00	0.00	☒	☐
Anna M. Doar 3601012345601	Critical Care Ambulance 1181234	Ambulance	85.00	0.00	☒	☐
					☐	☐
					☐	☐
					☐	☐

Signature/Title
Agency Representative Signature/Title

11-01-93
Date

Figure 1-1. Spend-Down Medically Needy Notice

IDENTIFICATION OF RECIPIENTS

A **Louisiana Medicaid card** is issued to each recipient and/or family when Medicaid eligibility is determined. These cards are issued monthly with the exception of "spend-down Medicaid recipients". Spend-down Medicaid cards are issued only once (at initial certification) indicating the period of Medicaid eligibility. The Louisiana Medicaid cards are issued by either the Department of Social Services (DSS) state office, the recipient's parish Office of Family Support (DSS-OFS), Department of Health and Hospitals - Bureau of Health Services Financing (DHH-BHSF), or the Fiscal Intermediary depending on the circumstances as listed below.

1. DSS-OFS state office issues computer generated Medicaid cards **at initial certification only.**

2. The local DSS-OFS parish office can **only issue replacement** Medicaid cards (these cards are manually issued).

3. The local DHH-BHSF offices manually issue Medicaid cards for

   A. Emergency situations (initial certifications and adding a recipient to the Medicaid file)
   B. Prior period certifications
   C. Replacement Medicaid cards
   D. Lock-in Medicaid cards (cards restricting recipients to a specific physician and/or pharmacy to ensure appropriate use of Medicaid benefits).

4. The Fiscal Intermediary issues computer generated Medicaid cards monthly for ongoing certifications.

Figures 1-2 through 1-9 are reproductions of sample cards for both the categorically needy and the medically needy recipients. Providers may want to refer to these samples to assist in understanding the information appearing on the recipient monthly Medicaid card. These examples are only facsimiles of the cards; they do not represent the actual size of the cards.

JUN 90-MAR 92 LOUISIANA MEDICAID CARD SSW805B

OFFICE OF FAMILY SECURITY
604 SECOND STREET
FRANKLIN, LA 70538

BOB D. JONES
P O BOX 2222
SOMEWHERE, LA 70381
*ELIG FOR KIDMED/EPSDT

ID. NUMBER	ELIGIBLE BENEFICIARIES	BIRTHDATE	TPL
5101018291901	JONES BOB D	01 24 78	*

A=MEDICARE A B=MEDICARE B C=MEDICARE A & B
D=OTHER INSURANCE E=AMBULANCE COVERAGE

Figure 1-2. Sample Medicaid Card Issued by WIS

9PE LOUISIANA MEDICAID CARD PRESUMPTIVE ELIGIBILITY PAD163

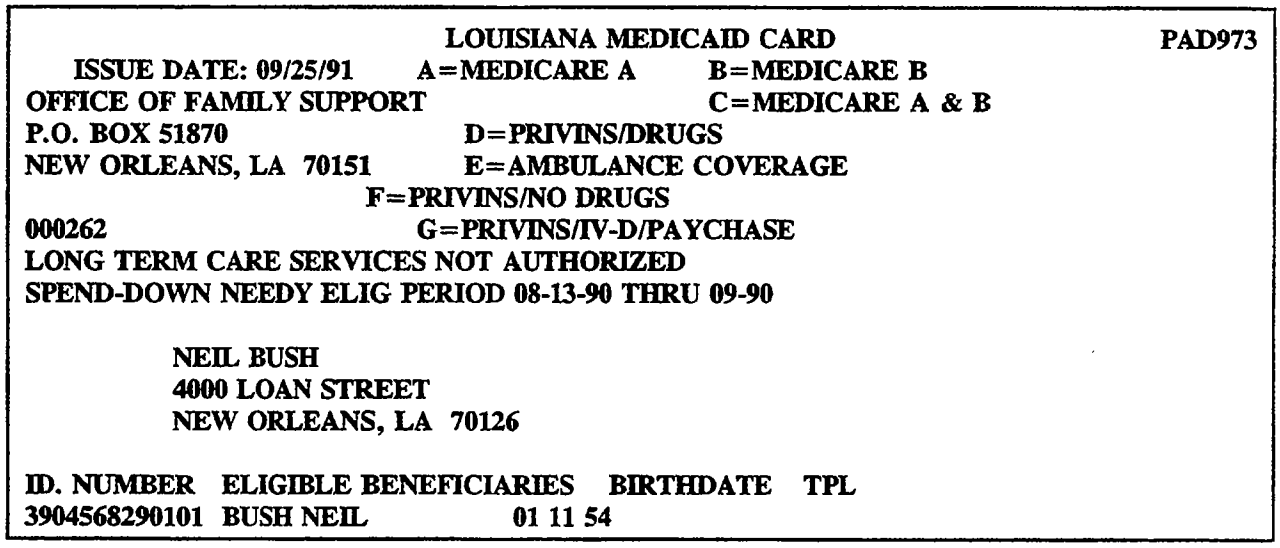
P.O. BOX 2343
BATON ROUGE LA 70896
ERMA SMITH
555 BROWN STREET
ANYTOWN, LA 70000

ID NUMBER	NAME	BIRTHDATE
17-16-0-012350-20	ERMA SMITH	10-30-73

PRESUMPTIVE ELIGIBILITY PERIOD BEGINS ***01-02-89***
SERVICES LIMITED TO AMBULATORY PRENATAL CARE ONLY
HOSPITALIZATION, LONG TERM CARE SERVICES NOT AUTHORIZED
**MAY NOT EXCEED 45 DAYS AND MAY BE SHORTENED IF BENEFICIARY IS INELIGIBLE OR FAILS TO COMPLY WITH ELIGIBILITY REQUIREMENTS H

Figure 1-3. Sample Medicaid Presumptive Eligibility Card Issued by WIS

(NOTE: Authorized for outpatient services only. Card has a 45 day limit maximum.)



LOUISIANA MEDICAID CARD PAD973

ISSUE DATE: 09/25/91 A=MEDICARE A B=MEDICARE B
OFFICE OF FAMILY SUPPORT C=MEDICARE A & B
P.O. BOX 51870 D=PRIVINS/DRUGS
NEW ORLEANS, LA 70151 E=AMBULANCE COVERAGE
F=PRIVINS/NO DRUGS
000262 G=PRIVINS/IV-D/PAYCHASE
LONG TERM CARE SERVICES NOT AUTHORIZED
SPEND-DOWN NEEDY ELIG PERIOD 08-13-90 THRU 09-90

NEIL BUSH
4000 LOAN STREET
NEW ORLEANS, LA 70126

ID. NUMBER	ELIGIBLE BENEFICIARIES	BIRTHDATE	TPL
3904568290101	BUSH NEIL	01 11 54	

Figure 1-4. Sample Spend-Down Medically Needy Medicaid Card Issued by WIS

BHSF Form 9 **REV. 03/92** **Eligible From** **Prior Issue Usable** **Through** **LOUISIANA MEDICAID CARD**				
ID NUMBER	ELIGIBLE BENEFICIARY(IES)	BIRTHDATE	T.P.L.*	
Agency Representative Signature			Date of Issue	
IMPORTANT: Show this card to each provider who has provided or will provide service(s) to you during the dates shown above. *SEE CODES ON REVERSE				

Figure 1-5. Sample Front Side of Medicaid Card Issued by OFS and BHSF

***THIRD PARTY LIABILITY (T.P.L.) CODES**

COLUMN 1

D=Private Health Insurance - Drug Coverage; E=Ambulance Insurance; F=Private Health Insurance - No Drug Coverage; G=Private Health Insurance (IV-D) - Pay & Chase

COLUMN 2

A=Medicare, Part A; B=Medicare, Part B; C=Medicare, Parts A & B

IMPORTANT: PATIENT MUST SHOW THIS CARD WHEN APPLYING FOR MEDICAL SERVICES

The person(s) shown on the reverse side is (are) eligible for the payment of certain medical services authorized by the Louisiana Medicaid Program. Benefits under other insurance coverage, including Medicare, must be used first. Eligibility for medical services is effective only for the dates shown on the reverse side.

Use of this card to obtain medical services to which a person is not entitled will subject that person to arrest and trial under state and federal laws and regulations.

Figure 1-6. Sample Back Side of Medicaid Card Issued by OFS and BHSF

LOUISIANA MEDICAID CARD 1 ELIG. FOR-SEPT.92

OFFICE OF FAMILY SUPPORT 26
ST. CHARLES *KIDMED/EPSDT
P.O. BOX 453
HAHNVILLE LA 70057

TYPE CASE: 01 ID. NUMBER	ELIGIBLE RECIP. NAME	BIRTH DATE	TPL	CARRIER CODE
4503495788301 *	FRAN SUE	09/28/89	F	126100
4509839202802 *	FRAN JANE	11/07/91	F	126100
4567284920020	FRAN DORA	01/26/60	F	126100

****

DORA FRAN
200 WEST ST.
DESTREHAN LA 70047

Figure 1-7. Sample Medicaid Card Issued by the Fiscal Intermediary

LOUISIANA MEDICAID CARD 1 ELIG. FOR-APRIL 92

OFFICE OF FAMILY SUPPORT 533
EAST JEFFERSON #MEDICARE COVERED SERVICES ONLY
P.O. BOX 97
METAIRIE LA 70004

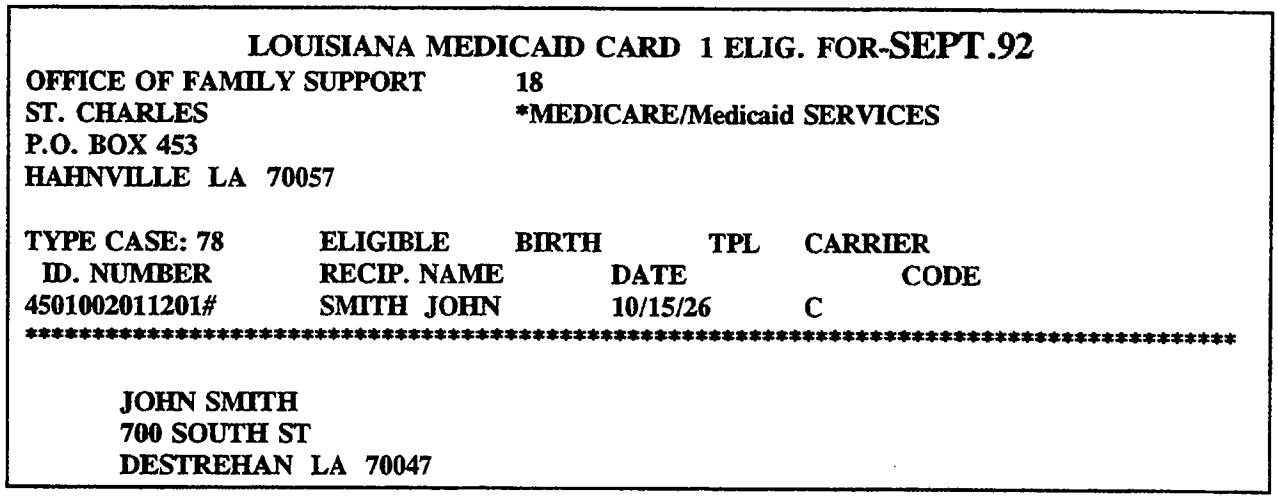
TYPE CASE: 95 ID. NUMBER	ELIGIBLE RECIP. NAME	BIRTH DATE	TPL	CARRIER CODE	
6717018169801#	BROWN DANA	10/15/20	CF	010400	

****

DANA BROWN
300 SOUTH ST
METAIRIE LA 70001

Figure 1-8. Sample Pure QMB Medicaid Card Issued by the Fiscal Intermediary

(NOTE: Medicaid pays only the Medicare co-insurance and deductible.)



LOUISIANA MEDICAID CARD 1 ELIG. FOR-SEPT.92

OFFICE OF FAMILY SUPPORT 18
ST. CHARLES *MEDICARE/Medicaid SERVICES
P.O. BOX 453
HAHNVILLE LA 70057

TYPE CASE: 78 ID. NUMBER	ELIGIBLE RECIP. NAME	BIRTH DATE	TPL	CARRIER CODE
4501002011201#	SMITH JOHN	10/15/26		C

****

JOHN SMITH
700 SOUTH ST
DESTREHAN LA 70047

Figure 1-9. Sample Dual QMB Medicaid Card Issued by the Fiscal Intermediary

(NOTE: Medicaid pays the Medicare co-insurance and deductible and pays for Medicaid covered services as well.)

152-N - ELIGIBILITY INQUIRY FOR NEWBORNS

Effective October 1, 1991 BHSF implemented procedures to facilitate the process of acquiring a Medicaid identification number for infants born to mothers who are Medicaid eligible when the infant is born. BHSF Form 152-N (Title XIX Medicaid Eligibility Inquiry for Newborns) is the form used to verify the child's name, date of birth, race, sex and enumeration and to report the child's eligibility status for Medicaid (Figure 1-10).

Providers should **type** or **print** all information on the form, completing all items in Parts I and II. Incomplete, illegible or unsigned forms will be returned to the provider.

Providers should not attach proof of birth or acknowledgement of paternity to the form. The Form 152-N serves as proof of birth and of relationship to the mother.

Part I of the Form 152-N is completed by the hospital or medical provider in the mother's presence, preferably at admission. The revised Form 152-N documents enumeration and the mother's intent regarding her child's residence and will be signed by the mother or qualified relative.

> *Note: **Unsigned forms will not be processed. They will be returned to the provider to secure the signature.***

Part II is completed by the hospital or medical provider at the time of the baby's birth. Providers are instructed to complete the child's name exactly as it was completed on the Certificate of Live Birth form submitted to Vital Statistics. The name and address, including zip code, of the hospital, baby's examining physician, pediatrician and any other medical provider, i.e., home health service, specialist, medical appliance provider should be entered on the Form 152-N. Stamps may be used for addresses.

A copy of the completed Form 152-N will be sent to each provider listed on the form. It is not necessary for each provider to complete a separate form.

The hospital or medical provider completing Form 152-N initiates enumeration for the newborn when completing the Certificate of Live Birth form. This is documented on the Form 152-N.

> *Note: **If the mother is pursuing adoption proceedings, Form 152-N will be sent to the BHSF office in the parish in which the mother resides. The child will receive Medicaid as a deemed child only through the month in which the mother signs relinquishment papers.***

Following birth of the baby private hospital providers should route the Forms 152-N to the state BHSF Eligibility Operations Section, P. O. Box 91030, Baton Rouge, LA 70821-9030, only when the mother is already Medicaid eligible on the date of the child's birth.

Forms 152-N for babies born in public hospitals to Medicaid mothers are to be submitted to their respective MAP Units.

Public hospitals for purposes of Form 152-N procedures are Earl K. Long, Huey P. Long, Lallie Kemp, Washington-St. Tammany, University Medical Center, Leonard J. Chabert Medical Center, W. O. Moss Regional, E. A. Conway, LSUMC-Shreveport, Medical Center of LA at New Orleans, Tulane, LSUMC-NO and University Hospital.

If the mother has an application pending for Medicaid, the Form 152-N should be sent to the BHSF office in the parish/region in which the mother is a resident or to the public hospital's respective MAP Unit.

If the mother has not applied for Medicaid prior to the birth, an application should be taken or she should be provided with proof of the baby's birth and referred to the parish/region BHSF office in her parish of residence.

Processing at BHSF

The BHSF staff will process the Forms 152-N (Figure 1-10) within 10 working days in the date order of receipt.

Part III of the Form 152-N will be completed by BHSF staff documenting certification or denial of Medicaid eligibility for the newborn.

The original Form 152-N will be returned to the initiating medical provider, with photocopies provided to all other medical providers named on the form, the BHSF and/or OFS Parish Office, the mother and KIDMED.

Form MAP-1 should be sent to the mother or responsible party to verify the child's Medicaid eligibility and serve as documentation of the child's eligibility until receipt of the monthly Medicaid card.

If a Medicaid recipient reports the birth of a newborn to the BHSF, an eligibility determination will be made if the child has not already been deemed eligible.

BHSF 152-N
Rev 10/91
Prior Issues Obsolete

MEDICAID OF LOUISIANA
NOTICE OF NEWBORN ELIGIBILITY

PART I (To Be Completed At Admission) MOTHER'S MEDICAID I.D. NUMBER_____
(13 digits)
Patient Mother's Name_____ Date of Admission_____
Address_____ Parish of Residence_____
Mother's Telephone_____ Mother's DOB_____ Mother's SSN_____ Mother's Race_____
Medical Record No._____/_____ Patient Account No._____/_____
Mother Baby Mother Baby

TO BE COMPLETED IN PATIENT'S PRESENCE AND REQUIRES HER SIGNATURE

I, _____, consent to the release of the information requested below from the Medical Records of _____ Hospital and the below-named medical provider(s) to the Department of Health and Hospitals, Bureau of Health Services Financing in order to determine Medicaid eligibility for my newborn. I further agree and give permisstion to the DHH/BHSF to release to _____
(Name of Hospital)
and the medical provider(s) listed below the information below in order that they may submit a bill for services rendered. It is my intent that upon release my child(ren) will reside with me.

_____ _____
Date Signature of Mother (Patient) or Authonzed Representative

PART II (To Be Completed After Child's Birth)

This is to certify that _____ was born on _____
(Full Name of Newborn(s) Submitted on Birth Certificate) (Date of Birth)
to _____ and _____. The baby, a _____
(Name of Mother) (Name of Father) (Sex)
was delivered by _____ at _____
(Name of Delivering Physician) (Address) (Name of Hospital) (Address)
The baby's examining physician was: _____
(Name) (Address)
The baby's Pediatrician is. _____
(Name) (Address)
Other Provider: _____
(Name) (Address)
Has an application been made for a Social Security Number? ☐ Yes ☐ No

Signed by:_____ Date:_____
(Hospital Representative)

PART III
TO BE COMPLETED BY BHSF AND SENT TO HOSPITAL, OTHER MEDICAL PROVIDERS AND THE MOTHER.

_____ _____
Name of Newborn Date of Birth

☐ Newborn Eligible for Medicaid ☐ Newborn NOT Eligible for Medicaid

_____ _____
Newborn's Medicaid I D. No. (13 digits) BHSF Representative Signature

_____ _____
Newborn's Effective Date of Medicaid Eligibility Phone

_____
Date

Figure 1-10. Form 152-N Notice of Newborn Eligibility

LOCK-IN PROGRAM

The BHSF has developed a program to educate recipients who may be unintentionally misusing program benefits and to ensure that program funds are used to provide optimum health services for recipients. Recipients who misuse pharmacy and physician benefits may be restricted to the use of one pharmacy, one physician, and one specialist.

A Lock-In recipient is asked to choose one physician provider and one pharmacy provider to be his Lock-In providers. Under most circumstances the recipients named on the Lock-In Medicaid card are restricted to receiving physician and pharmacy services from the providers named on their Lock-In Medicaid cards.

The Lock-In Medicaid card (Figure 1-11) is larger than the regular card and is printed on green paper. Recipients who present this card to providers not named on the Lock-In Medicaid card should be reminded that only those providers named on the front of the card can offer those recipients services. No payment will be made to a physician or pharmacist whose name does not appear on the card for services provided under usual circumstances.

The Lock-In system affects recipients only in the areas of physician and pharmacy services. Providers other than physicians or pharmacists may provide the services which they normally do for any eligible recipient.

BHSF Form 9LI
Rev 09/92
Prior Issue Obsolete

LOCK-IN
LOUISIANA MEDICAID CARD

Month/Year __|__

ID NUMBER BENEFICIARY NAME & ADDRESS BIRTHDATE T.P.L.*

Physician Name Physician Vendor Number

LOCK-IN

Specialist Name Specialist Vendor Number

Pharmacist Name Pharmacist Vendor Number

Agency Representative Signature Date of Issue

PROVIDER: READ REVERSE SIDE OF THIS CARD CAREFULLY BEFORE PROVIDING A SERVICE
***SEE CODES ON REVERSE**

Figure 1-11. Sample Front Side of a Lock-In Medicaid Card Issued by BHSF

IMPORTANT: PATIENT MUST SHOW THIS CARD WHEN RECEIVING MEDICAL SERVICES

The person shown on the reverse side is eligible for the payment of certain medical services authorized by **the Louisiana Medicaid Program**. Benefits under other insurance coverage, including Medicare, must, with certain exceptions, be used first.

Eligibility for medical services will terminate at the end of the month shown. This beneficiary is participating in a special program to educate him/her as to the most efficient use of medical benefits so as to assure maximum health benefits. **This beneficiary IS NOT eligible to receive routine physician or pharmacy services from providers other than those listed on this card.** Other physicians who provide emergency services to this beneficiary MUST certify that an emergency existed by writing "Emergency" in the remarks section of the claim form. He/she shall write "Emergency RX" on any prescription resulting from such a situation. Pharmacists filling a prescription from physicians who are not listed shall verify that the term "Emergency RX" is shown on the prescription by writing "Emergency" on the service claim. Pharmacists other than the one listed may fill prescriptions ONLY for life sustaining medication or upon receipt of a prescription containing the term "Emergency RX" and shall certify that the prescription was for an emergency on the service claim. Medical providers other that physicians or pharmacists are not restricted to these limitations. **Use of this card to obtain medical services to which a person is not entitled will subject that person to arrest and trial under state and federal laws and regulations.**

*THIRD PARTY LIABILITY (T.P.L.) CODES

COLUMN 1

D=Private Health Insurance - Drug Coverage; E=Ambulance Insurance; F=Private Health Insurance - No Drug Coverage; G=Private Health Insurance (IV-D) - Pay & Chase

COLUMN 2

A=Medicare, Part A; B=Medicare, Part B; C=Medicare, Parts A & B

Figure 1-12. Sample Back Side of a Lock-In Medicaid Card Issued by BHSF

COMMUNITYCARE PROGRAM

CommunityCARE is a managed care program administered by the Medicaid Program. A primary care case management (PCCM) system of comprehensive health care has been adopted because of its advantages in rural communities. The program provides Medicaid recipients under age 65 in designated parishes with a primary care physician (PCP) who serves as the recipient's doctor. The PCP provides basic primary care, referral, and after hours coverage of medical services for each recipient. The PCP receives a small monthly care management fee for recipients assigned to him/her in addition to fee-for-service reimbursement for medical services rendered. The PCP must authorize and refer recipients assigned to him/her for any medical care not available from the PCP.

The goal of CommunityCARE is to improve the accessibility, the continuity and quality of care as well as to reduce inappropriate utilization of medical services and the overall cost of care to Medicaid recipients. Medicaid recipients in designated parishes have the opportunity to select a participating physician in their parish or an adjoining parish to be their doctor. If they do not select a PCP, one is assigned.

CommunityCARE recipients are identified by the name and telephone number of their PCP being printed in the bottom right-hand corner of their monthly Medicaid card. See the sample of a CommunityCARE Medicaid card presented as Figure 1-13. Written referrals from the appropriate PCP should be obtained from admitting physicians prior to hospital admissions (except emergencies). It is the hospital's responsibility to share that referral with providers of ancillary services related to an admission, i.e., lab, x-ray, anesthesiology, etc. Failure to obtain the appropriate referral/authorization for services provided to CommunityCARE recipients may result in claims being denied.

For more information on the CommunityCARE program, please call (504) 342-1304.

LOUISIANA MEDICAID CARD 1 ELIG. FOR - MARCH 92

OFFICE OF FAMILY SUPPORT 640
CLAIBORNE *KIDMED/EPSDT
P.O. DRAWER 210
HOMER LA 71040

TYPE CASE 10

ID. NUMBER	ELIGIBLE RECIP.	NAME	BIRTH DATE	TPL	CARRIER CODE
90333112457891	*1JONES	GARY	03/14/79		
z9003321456890	*1JONES	TOM	03/22/86		
9003456789123	*1SMITH	JACK	10/16/89		
9002534567892	*1JONES	BOB	12/22/90		
9002345678196	*2JONES	SUE	05/03/63		

****

******* CAR-RT SORT ** B001
JONES SUE
PO BOX 280
LISBON LA 71048-0215

COMMUNITY CARE PATIENT

PROVIDER	NAME	TEL.#
1 ABC CLAIBORNE CLINIC		3183453255
2 XYZ CLINIC		3185679876

Figure 1-13. Sample CommunityCARE Medicaid Card Issued by the Fiscal Intermediary

OUT-OF-STATE MEDICAL CARE

The Medicaid Program will reimburse claims for medical services provided to eligible recipients who are temporarily absent from the state if any of the following conditions exists:

- When an emergency is caused by accident or illness
- When the health of the recipient would be endangered if the recipient undertook travel to return to Louisiana
- When the health of the recipient would be endangered if medical care were postponed until the recipient returns to Louisiana
- When it is the general practice of recipients in a particular locale to use medical facilities in areas outside of Louisiana
- When medical care or needed supplemental resources are not available in Louisiana. **Prior authorization must be obtained from the Fiscal Intermediary in these non-emergency circumstances.**

CHAPTER 2
ABBREVIATIONS/ACRONYMS/DEFINITIONS

CHAPTER CONTENTS

Page

ABBREVIATIONS/ACRONYMS/DEFINITIONS 2-2

This chapter contains a comprehensive list of abbreviations, acronyms, and definitions used in the Hospital Services Manual.

Abuse

For purposes of this manual refers to abuse of the Medicaid Program by either provider or beneficiaries, including practices which are not criminal acts and which may even be technically legal, but which still represent the inappropriate use of public funds.

Accident

An event which is unforeseen and unintended.

Acute Care

Inpatient general routine care provided to patients who are in an acute phase of illness, but not to the degree which requires the concentrated and continuous observation and care provided in the intensive care unit of an institution.

Acute Care Facility

An institution or facility which provides concentrated and continuous professional medical care.

Adjudicate

The steps through which a claim is processed by a third-party payer, to verify coverage eligibility, to determine appropriateness of care and services rendered, and to establish the amount of reimbursement.

Applicant

An individual whose written application for Medicaid has been submitted to the Medicaid agency but whose financial or medical eligibility has not yet been determined.

BCA/BSA

Blue Cross and Blue Shield Association.

Benefit Eligibility Period (Primary Payer)

The inclusive dates during which CHAMPUS medical benefits are available to a sponsor's recipient as shown on the recipient's identification card.

Beneficiary

Another term for recipient.

Benefit Period
The period of time during which benefits are available to the patient.

Benefits
The reimbursable items provided by an insurance program or contract.

Bureau of Health Services Financing (BHSF)
The Division within the Office of the Secretary of Department of Health and Hospitals responsible for the administration of the Medicaid Program.

CHAMP
Acronym for Child Health and Maternal Program.

CHAMPUS
See ***Civilian Health and Medical Program of the Uniformed Services.***

CHAMPUS/CHAMPVA Beneficiary
The eligible dependent of a CHAMPUS OR CHAMPVA sponsor.

CHAMPVA
See ***Civilian Health and Medical Program of the Veterans Administration.***

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)
A program administered by the Department of Defense that provides benefits for healthcare services to spouses and children of active duty, retired, and deceased members that are furnished by civilian providers and physicians.

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)
A program administered by both the Department of Defense and the Veterans Administration that provides benefits for healthcare services furnished by civilian providers and physicians and supplies to spouses and children of veterans who are entitled to VA permanent and total disability benefits and to widows and children of veterans who died of service connected disabilities.

CommunityCARE
Medicaid Managed Care Program in Louisiana authorized under a federal waiver utilizing primary care physicians.

Cost Avoidance
Term referring to avoiding the payment of Medicaid claims when other insurance resources are available to the Medicaid recipient.

Coordination of Benefits (COB)
A method of integrating benefits payable under more than one group health insurance plan so that the insured's benefits from all sources do not exceed 100% of his allowable medical expenses.

Crossover
The process by which the primary payer transfers billing and payment data for a particular claim to a secondary payer for further adjudication of the claim.

Crossover Claim
A claim which is billed to two or more payers who have agreed to transfer billing and payment data from the primary payer to a secondary or tertiary payer.

Deductible Certificate
A statement issued to a sponsor by a fiscal intermediary, certifying to deductible amounts satisfied by a CHAMPUS beneficiary for any applicable fiscal year. Information may also appear as a printed statement on the CHAMPUS ***Explanation of Benefits***.

Delimiter
A symbol that is used to separate and organize items of data or a character that is used to group or separate words or values within printed material.

Dependent
An insured's spouse, not legally separated from the insured, and unmarried children who meet certain eligibility requirements who are not otherwise insured under the same group policy. The precise definition of ***dependent*** varies by insurer.

Department of Health and Hospitals (DHH)
The state agency responsible for the Medicaid Program in Louisiana.

Department of Health and Human Services (DHHS)
The federal agency responsible for administering the Medicaid Program.

Department of Social Services (DSS)
The state agency responsible for financial eligibility determination for a number of entitlement programs under the Social Security Act.

DSM-IIIR
Diagnostic and Statistical Manual of Mental Disorders: Third Edition, Revised.

Fiscal Intermediary
The private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. It processes Medicaid claims for services provided under the Medicaid Program and issues appropriate payment.

Fraud
Fraud, in all aspects, is a matter of law rather than of ethics or abuse of privilege. The definition of fraud that governs between citizens and government agencies is found in Louisiana R.S. 14:67 and Louisiana R.S. 14:70.01. Legal action may also be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142 (HR-30).

Grace Days
Days billable to the patient occurring after the denial of extension of stay notification which permits the patient's physician or family to make arrangements for discharge.

HCPCS
HCFA Common Procedure Coding System based on CPT-4 procedure codes.

Health Care Financing Administration (HCFA)
The Federal organization within DHHS responsible for administering the Medicaid Program and overseeing and monitoring the State's Medicaid Program.

Health Insurance Card (HI Card)
Also known as the Medicare card. A card issued by the Social Security Administration central office or Railroad Retirement Board to individuals or beneficiaries who have established entitlement to health insurance (Medicare). The health insurance card serves as a source of essential information necessary in the processing of claims under the Medicare program. It shows the beneficiary's name and sex, health insurance claim number, and effective date of entitlement to hospital insurance and/or medical insurance.

Health Maintenance Organization (HMO)
A private health organization providing medical care to enrolled individuals on a fixed, periodic prepayment basis.

Health Standards Section (HSS)
The section in BHSF whose responsibilities include medical approval of applicants for admission to long term care facilities or alternative programs.

Insurer

The party to the insurance contract who promises to pay losses or benefits. Also any corporation primarily engaged in the business of furnishing insurance protection to the public. Sometimes referred to as the payer.

Intermediary

An organization which processes hospital bills for an insurance carrier or government program.

KIDMED

Screening for the EPSDT Program.

Licensed Mental Health Professional (LMHP)

A person who meets one of the following criteria:

A **physician** who is licensed to practice medicine in the State of Louisiana and has completed and accredited training program in psychiatry.

A **psychologist** who is licensed as a practicing psychologist under the provisions of State Law and has a declared specialty in clinical psychology or clinical neuropsychology or counseling psychology.

A **social worker** who holds a master's degree in social work from an accredited school of social work and is a board certified social worker under the provisions of R.S. 37:2701-2718.

A **nurse** who is licensed to act as a registered nurse in the State of Louisiana by the Board of Nursing and

- Has two years post master's, supervised experience in the delivery of mental health services; **OR**
- Has four years post baccalaureate, supervised experience in the delivery of mental health services.

A **licensed professional counselor** who is licensed as such under the provision of State Law and has two years post master's, supervised experience in the delivery of services to persons who are seriously mentally ill as defined by the Office of Mental Health.

Lock-In

A mechanism for restricting Medicaid beneficiaries to a specific physician and/or a specific pharmacy to ensure appropriate use of Medicaid benefits by recipients and/or providers. Lock-In also serves as an educational device in instructing recipients in the most efficient method of using Medicaid services to ensure maximum health benefits.

Medicaid Program

The Medicaid Program in Louisiana formerly known as Louisiana's Medical Assistance Program administered by the Department of Health and Hospitals, Bureau of Health Services Financing provided under the State Plan approved under Title XIX of the Social Security Act. Medicaid is financed jointly by the federal and state governments.

Medicaid (Title XIX of the Social Security Act)

A federally aided, but state operated and administered, program which provides medical benefits for medically indigent persons in need of health and medical care.

Medicare (Title XVIII of the Social Security Act)

A federally funded program which provides federal health insurance to the aged and disabled.

Medicaid

A federal-state medical assistance entitlement program provided under a State plan approved under Title XIX of the Social Security Act.

Medicaid Card

A medical eligibility card issued to each eligible recipient and/or family each month. These cards may be issued by the Department of Social Services - Office of Family Support, Department of Health and Hospitals - Bureau of Health Services Financing, or the fiscal intermediary - Unisys.

Medically Needy

A medical program designed to provide Medicaid coverage when an individual's or family's income and/or resources are sufficient to meet basic needs in a categorical assistance program but not sufficient to meet medical needs according to Medically Needy Program standards.

Medicare

The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

Medicaid Management Information System (MMIS)
The computerized claims processing and information retrieval system which includes all providers eligible for participation in the Medicaid Program. This system is an organized method of payment for claims for all Medicaid services. It includes all Medicaid providers and recipients.

Newborn Admission
A baby born within a facility. Use of this code necessitates the use of special source of admission codes (form locator 18).

Non-Covered Days
Days of care not covered by the primary payer.

Nursing Facility (NF)
Nursing facility that participates in the Medicaid Program.

OFS
Abbreviation for the Office of Family Support of DSS.

OMH SPOE
Office of Mental Health (OMH) Single Point of Entry (SPOE) process into OMH operated psychiatric beds.

Other Donor Bank Charges
Charges for the acquisition, storage, and preservation of all human organs, except kidneys.

Packed Red Blood Cells
Derivatives of whole blood which frequently can be used in its place when primary need in replacement of red cells.

Part A (Medicare) or Hospital Insurance
A basic part of the health insurance program that provides benefits for inpatient hospital care and post hospital extended care furnished by skilled nursing facilities and home health agencies.

Part B (Medicare) or Supplementary Medical Insurance
A basic part of the health insurance program designed to supplement the basic hospital insurance coverage. Part B covers home health services; physician services; diagnostic services furnished on an outpatient basis by a hospital or other facility; X-ray, radium, and radioactive isotope therapy; surgical dressings; splints and other fracture devices; rental or

purchase of durable medical equipment for use in the patient's home; ambulance services; prosthetic devices (leg, arm, etc.); outpatient physical therapy; and services furnished by hospitals to inpatients who have exhausted their Part A inpatient benefits or who are otherwise not eligible for Part A benefits.

Presumptive Eligibility (PE)

A medical program which provides limited Medicaid coverage for pregnant women. Presumptive Eligibility covers ambulatory (outpatient) prenatal services and cannot exceed 45 days per Presumptive Eligibility certification.

Primary Payer

The insurance carrier or program that takes precedence in the payment of a hospital bill when two or more third-party payers have potential responsibility for the reimbursement.

Professional Component

The charges associated with the professional services provided to a patient by a hospital-based physician.

Professional Standards Review Organization (PSRO)

A program which provides peer review of the medical necessity for healthcare services under federally reimbursed programs.

Provider

A person, organization, or institution licensed to provide healthcare services.

Provider

Any individual or entity furnishing Medical services under a provider agreement with the Medicaid Agency.

Provider Agreement

A contract between the provider of services and the Louisiana Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing. The agreement specifies responsibilities with respect to the provision of services and payment under the Title XIX Medicaid Program.

Provider Enrollment

Refers to the act of registering a licensed provider into the computerized system for payment of eligible services under the Medical Assistance Program. Enrollment includes the execution of the provider agreement and assignment of the provider number used for payment.

QMB
Abbreviation for Qualified Medicare Beneficiary.

Recipient
An individual who has been certified for medical benefits by the Medicaid Program. If the individual has been interdicted in a court of law, the term "recipient" refers to the curator of record.

Remittance Advice
A list of all claims paid, pending, or denied during a particular payment period.

Secretary
The Secretary of Health and Human Services or any official to whom (s)he has delegated the pertinent authority.

Skilled Nursing Facility (SNF)
Skilled Nursing Facility that participates in the Medicare Program.

Spend-Down
A term used to describe a group of the Medically Needy Program. The income of these Medicaid applicants/recipients is above the Medically Needy Income Eligibility Standards but they may qualify for the Medically Needy Program on the basis that countable income has been spent or is obligated to pay unpaid medical expenses.

Third Party Liability (TPL)
Refers to the responsibility of another payor (Medicare, insurance, etc.) to pay benefits for services before Medicaid pays. Medicaid is always the payor of last resort.

Welfare Information System (WIS)
The management information system within DSS which carries the information used to update the Louisiana MMIS eligibility file.

Whole Blood
Blood that has been drawn for a selected donor under rigid aseptic precautions and from which none of the liquid or cellular components have been removed.

CHAPTER 3
PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

CHAPTER CONTENTS

Page

HOSPITAL PROVIDER ENROLLMENT REQUIREMENTS 3-2
Licensure 3-2
Distinct Part Psychiatric Units 3-2

PROVIDER ENROLLMENT PROCEDURES 3-3

CHANGE OF ADDRESS/ENROLLMENT STATUS 3-4

HOSPITAL PROVIDER ENROLLMENT REQUIREMENTS

In addition to completing the Provider Enrollment Form, Medicaid PE-50, hospital service providers must meet the enrollment requirements listed below.

- Disclosure of ownership
- Verification of licensing and/or Medicare/Medicaid participation for out-of-state.

LICENSURE

All hospitals must be licensed and in compliance with the Rules, Regulations, and Minimum Standards governing hospitals and the Hospital Licensing Law.

The applicant must complete the Application for Hospital Licensure and submit it along with a per annum license fee of $400.00, plus $3.00 per bed to the Health Standards Section of BHSF. This fee is non-refundable subsequent to the on-site licensure survey performed by the Health Standards Section of BHSF.

If the applicant is in substantial compliance with the Minimum Standards based upon the licensure survey, a license will be issued which will not exceed one year in duration.

DISTINCT PART PSYCHIATRIC UNITS

If an acute care general hospital has a Distinct Part Psychiatric Unit, the Health Standards Section must verify the units compliance with Medicare's Prospective Payment System (PPS) criteria and identify the number and location of beds in the psychiatric unit. A unit which qualifies for distinct part status must complete a separate provider enrollment packet and must be assigned a separate provider number from the rest of the hospital.

PROVIDER ENROLLMENT PROCEDURES

Providers who wish to participate in the Medicaid Program should contact Unisys, Provider Relations, to request an enrollment packet. They must then complete the packet and submit it to the Provider Enrollment Unit at the Bureau of Health Services Financing (BHSF). Enrollment will be approved if the provider meets all qualifications and licensure requirements, as well as the standards for participation in the Medicaid Program described on the Provider Enrollment form, PE-50.

Each enrolling provider must enter into an agreement with the Medicaid Program. The agreement requires that providers adhere to regulations, including the requirements contained in this provider manual. To participate in Medicaid of Louisiana, providers must complete a Medicaid PE-50 enrollment form and meet other additional requirements outlined below.

Copies of enrollment packets may be obtained from the following address:

Unisys Provider Relations
P.O. Box 91024
Baton Rouge, LA 70821
(504) 924-5040
1-800-473-2783

Completed forms should be submitted to the following address:

Provider Enrollment Unit
Bureau of Health Services Financing
P.O. Box 91030
Baton Rouge, LA 70821-9030

If additional information is required, the applicant will be notified. A notification letter from the Provider Enrollment Unit is sent to the provider confirming enrollment in the Medicaid Program. This letter advises the provider of their effective date of enrollment in the Medicaid Program and of their provider number. This number is a unique identification number which must be utilized by the provider in correspondence with the BHSF, the fiscal intermediary, and for billing.

CHANGE OF ADDRESS/ENROLLMENT STATUS

Providers who have address changes will notify the Provider Enrollment Unit of the Medicaid Program and Health Standards Section **in writing**. Giving notification of address changes will allow correspondence, checks, and rejected claims to be delivered to the appropriate providers in a timely manner.

Providers who change their group affiliation should notify Provider Enrollment to eliminate the possibility of payments being delivered to the wrong provider/group.

Hospitals with a change in ownership or fiscal year-end must notify Provider Enrollment Unit and Health Standards Section prior to the change or as soon as possible. A lease is considered a change of ownership. A new provider number must be assigned when a change of ownership occurs. A new provider enrollment form must be completed and submitted by the new owners.

Send information to the following address:

Provider Enrollment Unit
Bureau of Health Services Financing
P.O. Box 91030
Baton Rouge, LA 70821-9030

Department of Health and Hospitals
Health Standards Section
P. O. Box 3767
Baton Rouge, LA 70821-3767

CHAPTER 4
INPATIENT HOSPITAL SERVICES

CHAPTER CONTENTS

Page

INTRODUCTION 4-2

INPATIENT CARE SERVICE 4-2

DISTINCT PART PSYCHIATRIC UNITS 4-3

OUTPATIENT SURGERY (Performed on an Inpatient Basis) 4-4

SERVICES REQUIRING SPECIAL PROCEDURES 4-5
- Sterilizations 4-5
- Hysterectomies 4-11

OTHER INPATIENT SERVICES 4-14
- Blood 4-14
- Hospital-Based Ambulance Services 4-14
- Nursery Charges 4-14
- Pregnancy-Related Services 4-15

INPATIENT HOSPITAL POLICY/PROCEDURES 4-19
- Disscharge and Readmit on the Same Day 4-19
- Direct Transfers of Patients 4-19
- Date of Discharge or Death 4-19
- Split-Billing 4-19
- Therapeutic Passes 4-20
- Swing Beds 4-21

INTRODUCTION

Inpatient hospital services must be ordered by the attending physician, an emergency room physician, or a dentist (if the patient has an existing condition which must be monitored during the performance of the authorized dental procedure).

Inpatient hospital care may be defined as follows:

> ***...care needed for the treatment of an illness or injury which can only be provided safely and adequately in a hospital setting and includes those basic services that a hospital is expected to provide. Payment shall not be made for care which can be provided in the home or for which the primary purpose is of a convalescent or cosmetic nature.***

INPATIENT CARE SERVICE

DHH/BHSF requires registration and length of stay assignment for all admissions to acute care and rehabilitation hospitals. Pre-Admission certification and length of stay assignment is required for long term hospitals and inpatient psychiatric/substance abuse services hospitals. Additional information regarding pre-admission certification and length of stay procedures can be found in the chapter 7 of this manual, "Pre-Admission Certification/Length of Stay."

> *Note:* ***Inpatient admissions for Medicare/Medicaid recipients are not subject to these requirements except when Medicare Part A benefits have been exhausted or recipient has Medicare Part B only.***
>
> ***Because of certain TEFRA restrictions, state operated hospitals are not subject to these requirements.***

There is no limit on the number of inpatient care service days effective July 1, 1994.

DISTINCT PART PSYCHIATRIC UNITS

Effective with date of service January 1, 1989, Medicaid began recognizing distinct part psychiatric units within an acute care general hospital differently for reimbursement purposes if the unit met the Medicare criteria for exclusion from Medicare's Prospective Payment System (PPS excluded unit). More information regarding this criteria may be obtained from the Bureau of Health Services Financing's Health Standards Section. Review of the hospital by the Health Standards Section for adherence to these guidelines is necessary prior to enrollment as a distinct part psychiatric unit.

A unit which qualifies for distinct part status must complete a separate provider enrollment packet and must be assigned a separate provider number from the rest of the hospital. Reimbursement for services provided in such a unit is a prospective per diem rate that is adjusted annually. This per diem includes all services provided to an inpatient of such a unit, except for physician services, which should be billed separately. **All therapies (individual/group counseling or occupational therapy) should be included in this per diem.**

Providers must bill on the hospital claim form (HCFA 1450/UB-92) for these services. The primary diagnosis must be indicated with an ICD-9-CM psychiatric diagnosis code within the range of 290 through 316.

> *Note: All admissions require pre-admission certification and length of stay assignment from the fiscal intermediary.*

The hospital must set up the distinct part psychiatric unit as a separate cost center and be identified as a sub-provider on the hospital's cost report. The costs for this unit are not subject to cost settlement. Additional information regarding Distinct Part Psychiatric Units can be found in the section entitled Pre-Admission Certification/Length of Stay.

OUTPATIENT SURGERY
(Performed on an Inpatient Basis)

Certain surgical procedures usually are covered by the Medicaid Program if they are performed as **outpatient**. Reimbursement to hospitals for the performance of these outpatient surgical procedures is made on a flat-fee per service basis, not to exceed the Medicare payment rate.

These same surgical procedures may be provided on an **inpatient** basis when medically necessary. Pre-admission certification/length of stay for these procedures must be obtained.

A list of the outpatient procedures requiring approval for inpatient performance is provided in Appendix A. The procedures for obtaining prior authorization and a list of the circumstances under which these procedures may be performed on an inpatient basis are provided in chapter 7 of this manual, "Pre-Admission Certification/Length of Stay."

SERVICES REQUIRING SPECIAL PROCEDURES

STERILIZATIONS

Sterilization is any medical procedure, treatment, or operation which is performed for the purpose of rendering an individual permanently incapable of reproducing. In accordance with federal regulations, the following conditions must be met before Medicaid reimbursement can be made for sterilizations.

1. The patient must be at least 21 years of age.

2. The patient is mentally competent. According to federal regulations an individual can be considered legally incompetent only if found to be so by a court of competent jurisdiction or so identified by virtue of a provision of state law. The Medicaid Program will not make reimbursement on behalf of an individual who is mentally incompetent or institutionalized in a mental facility.

3. The patient must have voluntarily given his or her informed consent by signing BHSF Form 96. This form must be signed at least 30 days, but no more than 180 days, before the sterilization is performed.

   Exception:

   If the patient has a premature delivery or requires emergency abdominal surgery within the 30 days of consent, and at least 72 or more hours have passed since the consent form was signed, sterilization can be performed at the time of the delivery or emergency abdominal surgery.

   - In the case of premature delivery, the expected date of delivery must be given.
   - In the case of emergency abdominal surgery, the emergency must be described.

Informed Consent

An eligible recipient will be considered informed only if the following conditions are met:

1. The person who obtains the consent for the sterilization procedure must offer to answer any questions the individual may have concerning the procedure, provide a copy of the consent

form, i.e., BHSF Form 96, and orally give all of the following information or advice to the individual being sterilized:

A. Advise the individual that he/she is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federal benefits to which he/she might be otherwise entitled.

B. Give the individual a description of available alternative methods of family planning and birth control.

C. Advise the individual that the sterilization procedure is considered to be irreversible.

D. Give the individual a thorough explanation of the specific sterilization procedure to be performed.

E. Give the individual a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used.

F. Advise the individual that the sterilization will not be performed for at least 30 days, except under the circumstances specified on the preceding page.

2. Suitable arrangements were made to ensure that the information specified above was effectively communicated to any individual who is blind, deaf, or otherwise handicapped.

3. An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent.

4. The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained.

*Note: **Informed consent <u>shall not be obtained</u> while the individual to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the individual's state of awareness.***

The patient must be given BHSF Form 96, written consent document, by the physician or clinic. No other form will be accepted. The consent form must contain a signature from **each** of the following individuals:

- The individual to be sterilized
- The interpreter, if one was provided
- The person who obtained the consent
- The physician who performed the sterilization procedure. (If the physician who performs the sterilization procedure is the one who obtained the consent, he/she must sign **both** statements.)

The BHSF Form 96 (Consent Form) is supplied as a 3-part NCR form. The original (white) is the patient's copy, the second (blue) is the physician's copy, and the third (pink) is State Office copy which is to be attached to the claim form. All blanks on the form must be completed and the form must be signed by all required persons.

A copy of the consent form must be attached to all claims for sterilization, including attending physician, assistant surgeon, anesthesiologist, and hospital claims. The physician's who signs the Form 96 (Consent Form) must be the physician listed in Items 82 and/or 83 of the UB-92.

*Note: **A facsimile of BHSF Form 96 is provided on the following page. Sections of the form have been assigned Roman numerals, so the instructions for correcting the Form 96 that follow the facsimile may be more easily understood. In addition, a checklist for Form 96 has also been provided. Refer to Appendix B for ordering information of these forms.***

BHSF Form 96
Rev 01/92
Prior Issue Usable

CONSENT FORM

NOTICE YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS

I **CONSENT TO STERILIZATION**

I have asked for and received information about sterilization from _____1_____. When I first asked for
(doctor or clinic)
the information, I was told that the decision to be sterilized is com-pletely up to me. I was told that I could decide not to be sterilized. If I decide no to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DE-CIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN, OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future I have rejected these alternatives and chosen to be sterilized

I understand that I will be sterilized by an operation known as a _____2_____. The discomforts, risks, and benefits associated with the operation have been explained to me All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs

I am at least 21 years of age and was born on _____3_____
Month Day Year

I, _____4_____, hereby consent of my own free will to be sterilized by _____5_____
doctor

by a method called _____6_____. My consent expires 180 days from the date of the signature below

I also consent to the release of this form and other medical records about the operation to·

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form

_____7_____ Date: _____8_____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required

Race and ethnicity designation (please check)

☐American Indian or Alaska Native ☐Black (not of Hispanic origin) ☐Hispanic ☐Asian or Pacific Islander ☐White (not of Hispanic origin)

II **INTERPRETER'S STATEMENT**

If an interpreter is provided to assist the individual to be sterilized·

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent I have also read him/her the consent form in _____9_____ language and explained its contents to him/her To the best of my knowledge and belief he/she understood this explanation

_____10_____ _____11_____
Interpreter *Date*

III **STATEMENT OF PERSON OBTAINING CONSENT**

Before _____12_____ signed the consent form, I explained to him/her the nature of the sterilization operation _____13_____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____14_____ _____15_____
Signature of person obtaining consent *Date*

_____16_____
Facility

_____17_____
Address

IV **PHYSICIAN'S STATEMENT**

Shortly before I performed a sterilization operation upon _____18_____ on _____19_____,
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation _____20_____, the fact that it is
specify type of operation
intended to be a final and irreversible procedure and the discomforts, risk, and benefits associated with it

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure

(Instructions for use of alternative final paragraphs Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the signature on this consent form because of (Check applicable box and fill in information needed):

21 ☐Premature Delivery (give expected date of delivery)
☐Emergency abdominal surgery (describe circumstances)

_____22_____ _____23_____
Physician *Date*

Figure 4-1. BHSF Form 96 Consent Form

CHECKLIST FOR FORM 96

Y	N	Are all blanks filled in and legible?
Y	N	Is the recipient's signature present?
Y	N	Is the date of the signature present?
Y	N	Was the patient at least 21 years old on the date the consent form was signed?
Y	N	Is race and ethnicity section filled out? (Not mandatory)

INTERPRETER'S STATEMENT (if applicable)

Y	N	Are all blanks filled in and legible?
Y	N	Is the interpreter's signature present?
Y	N	Is the date of the signature the same as the date of the patient's signature?

STATE OF PERSON OBTAINING CONSENT

Y	N	Are all blanks filled in and legible?
Y	N	Is the signature of the person obtaining consent and date of signature present?
Y	N	Is the date of the signature the same as the date of the patient's signature?

PHYSICIAN'S STATEMENT

Y	N	Are all blanks filled in and legible?
Y	N	Is the physician's signature and date present?
Y	N	Have at least 30 days, but no more than 180 days, passed between the date of the patient's signature and the date the surgery was performed?

"When counting, do not count the date of the patient's signature as one day." (Ex., if the patient signed on Jan. 1, 30 days will have passed after Jan. 31)

Y	N	If 30 days have not passed, was the surgery performed in response to either premature delivery (or early delivery) or emergency abdominal surgery?
Y	N	If premature delivery, is the EDC at least 30 days after the date of informed consent?
Y	N	Is the EDC documented and shown on Form 96?
Y	N	Have at least 72 hours (3 days) passed since the date of the patient's surgery?
Y	N	If emergency abdominal surgery, have 72 hours (3 days) passed since the date of the patient's surgery?
Y	N	Are the circumstances described on the physician's statement on the consent form?
Y	N	Was the physician statement signed on or after the sterilization operation date?

Figure 4-2. Checklist for Form 96

Correcting the BHSF Form 96

Errors made in certain items of sections I, II, III, and IV of Form 96 can be corrected, but **only by the person over whose signature they appear.** The following items on the form **cannot be changed** after the form has been signed.

Section I	Items 7 & 8	Signature and date of person (recipient) giving consent for sterilization
Section II	Items 10 & 11	Signature and date of the interpreter (if applicable)
Section III	Items 14 & 15	Signature and date of person obtaining consent

If either the recipient, the interpreter, or the person obtaining consent returns to the office to make a correction to his/her portion of the consent form, the medical record must reflect his/her presence in the office on the day of the correction.

The individual making the corrections on the form should line through the mistake once, write the corrected information above or to the side of the mistake, and initial and date the correction.

The corrections of the recipient, the interpreter, and the person obtaining consent must be made **before** the claim is submitted.

The date of the sterilization (Section IV, item 19) may be corrected by the doctor over whose signature it appears either **before or after** submission by the doctor. However, the operative report must support the corrected date.

Providers must remember that ***informed consent*** must be obtained and documented **prior to** the performance of the sterilization, not afterward. Therefore, corrections to blanks 7, 8, 10, 11, 14, and 15 may not be made subsequent to the performance of the procedure.

HYSTERECTOMIES

Federal regulations governing payment of hysterectomies prohibit Medicaid payment for a hysterectomy under either of the following circumstances:

- If the hysterectomy is performed solely for the purpose of terminating reproductive capability

- If there was more than one purpose for performing the hysterectomy, but the procedure would not have been performed except for the purpose of rendering the individual permanently incapable of reproducing.

According to the Medicaid Program guidelines, if a hysterectomy is performed, payment can be made only if the patient is informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing and only if she has signed a written acknowledgement of receipt of this information. The acknowledgement statement that must be used by providers performing hysterectomies is **BHSF Form 96-A**. The Form 96-A must be signed and dated by the recipient on or before the date of the hysterectomy.

> *Note: **This regulation applies to all hysterectomy procedures (with exception to special circumstances listed on the following page), regardless of the woman's age, fertility, or reason for the surgery.***

The BHSF Form 96-A (Acknowledgement Statement) is supplied as a 3-part NCR form. The original (blue) is the physician's copy, the second (pink) is the Fiscal Intermediary's copy, and the third (green) is the recipient's copy. A copy of the Form 96-A must be attached to all claims that are submitted to the Fiscal Intermediary for processing, including those of the attending physician, the hospital, the assistant surgeon, and the anesthesiologist.

A facsimile of Form 96-A is provided on the following page for review. Refer to Appendix B for ordering information. **A Form 96-A is not necessary only in the following special circumstances.**

1. The recipient was already sterile before the hysterectomy. The physician who performs the hysterectomy must certify in his own writing that the recipient was already sterile at the time of the hysterectomy and state the cause of sterility.

2. The recipient required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible. The physician must certify in his own writing that the hysterectomy was performed under these conditions and include in his narrative a description of the nature of the emergency.

3. The recipient was certified retroactively for Medicaid benefits, and the physician who performed the hysterectomy certifies in his own writing that one of the following conditions were met.

   A. The recipient was informed by the physician before the operation that the hysterectomy would make her permanently incapable of reproducing.

   B. The recipient met one of the two other exceptions listed above. In this case the statement must describe the cause of the sterility or the nature of the emergency.

BHSF Form 96-A
Revised 08/93
08/91 Issue Usable

Medicaid of Louisiana
Acknowledgement of Receipt of Hysterectomy Information

Beneficiary Name: _____
ID No.: _____
Physician Name: _____
Provider No.: _____

Payment by *Medicaid of Louisiana* cannot be authorized for the performance of any hysterecomy committed solely for the purpose of rendering an individual permanently incapable of reproducing or where, if there is more than one purpose for the procedure, the hysterectomy would not be performed but for the purpose of rendering the individual permanently incapable of reproducting.

Medicaid payment for a medically indicated hysterectomy can be authorized **only if:** (1) the individual and her representative*, if any, are informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing, **and,** (2) the individual and her representative*, if any, have signed a written acknowledgement of receipt of that information. The written acknowledgement **must** be signed and dated prior to the opertion and **must** be attached to the claim form which is submitted for payment.

*A representative is that person who has the legal authority to act for an individual. For purposes of this acknowledgement, a representative shall be defined as either the curator of an interdicted woman or the tutor or parent of an unmarried minor. A minor emancipated by marriage is deemed capable of acting for herself in the matter.

I hereby acknowledge that I have been informed orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom the procedure is performed permanently incapable of bearing children.

_____ _____
Signature of Beneficiary Date

_____ _____
Signature of Representative, if any Date

Physician's Copy

Figure 4-3. BHSF Form 96-A Acknowledgement of Receipt of Hysterectomy Information

OTHER INPATIENT SERVICES

BLOOD

The Medicaid Program will pay for all necessary blood while the recipient is hospitalized if other provisions to obtain blood cannot be made. However, every effort must be made to have the blood replaced. To bill for blood on the UB-92, form locator blocks 39 through 41 must be completed, and the total number of units billed must be entered in the ***Description of Services*** block.

HOSPITAL-BASED AMBULANCE SERVICES

If a patient is transported to a hospital by a hospital-based ambulance (ground or air) and is admitted, the ambulance charges must be billed on the UB-92 as part of the inpatient services using revenue code 540.

> ***Note: Air ambulance services are not covered unless the patient is transported to the facility which owns the ambulance.***

Hospital-based ambulances must meet equipment and personnel standards set by the Bureau of Emergency Medical Services (EMS). Hospitals must submit a copy of EMS certification to Provider Enrollment for recognition to bill ambulance charges.

NURSERY CHARGES

Medicaid policy requires that the baby's charges be included in the mother's bill while the mother and child are both hospitalized. This policy includes those children born in hospital emergency rooms, even when those facilities are not equipped with nurseries. Billing for a newborn cannot be billed on the child's Medicaid number until after the mother is discharged or the baby is transferred to another hospital.

If the baby is ill and must be moved into a neonatal intensive care unit (NICU) which is recognized as a specialty unit by the Bureau, then bill for these services using revenue code 175 using baby's name and number on the claim form.

When providers bill for nursery charges after the mother's discharge or baby's transfer, the admit date for the baby is the mother's discharge date, and special billing instructions apply. Form locators 19 and 20 on Form UB-92 must be completed as follows.

- Form locator 19 (Type of Admission) codes include the following:

  1 Emergency

  2 Urgent

  3 Elective

  4 Newborn

  Note: Providers should enter a 4 to indicate newborn status.

- Providers should enter one of the codes below in form locator 20 (Source of Admission) for newborn admissions:

  2 Premature Delivery

  3 Sick Baby

  4 Extramural Birth

PREGNANCY-RELATED SERVICES

Abortions

Medicaid payment for abortions is restricted to those abortions which meet the following criterion:

1. A physician has found, and so certifies in writing, that on the basis of his/her professional judgement, the life of the pregnant woman would be endangered if the fetus were carried to term. The certification statement either must be on the claim form sent to Paramax or attached to the claim. If attached, the certification must contain the name and address of the patient. The diagnosis or medical condition which makes the pregnancy life-endangering must be specified on the claim.

OR

2. In the case of terminating a pregnancy due to rape or incest all of the following requirements must be met:

   A. The Medicaid recipient shall report the act of rape or incest to a law enforcement official unless the treating physician certifies in writing that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the rape or incest.

   B. The Medicaid recipient shall certify that the pregnancy is the result of rape or incest and this certification shall be witnessed by the treating physician.

   C. The report of the act of rape or incest to a law enforcement official or the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest must be submitted to the Bureau of Health Services Financing along with the treating physician's claim for reimbursement for performing an abortion.

In review, when submitting a claim for reimbursement of an abortion due to rape or incest, the claim form must have attached a law enforcement report **or** the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest **AND** a signed statement from the Medicaid recipient certifying that the pregnancy is the result of rape or incest. This certification **shall** be witnessed by the treating physician.

> *Note: **Providers should note that 69.01, 69.51, 74.91, and 75.0 indicate a termination of the pregnancy. These codes are used for therapeutic abortions.***

Claims associated with the abortion, including those of the attending physician, hospital, assistant surgeon, and anesthesiologist, which are submitted to the Fiscal Intermediary for processing must be accompanied by a copy of the attending physician's written statement of medical necessity. Therefore, only hard-copy claims will be processed. No EMC claims for abortions will be accepted for processing.

> *Note: **All abortion claims will be reviewed by the Fiscal Intermediary physician consultants.***

Threatened abortions will be reimbursed, except when surgery is performed. If surgery is performed, the claim will be denied with an error code message requesting a statement of medical necessity (as stated above) by the performing physician.

Spontaneous and missed abortions must be coded with the appropriate ICD-9 code, and the operative report must be submitted with the claim.

Note: Appropriate ICD-9 codes for spontaneous and missed abortions are as follows: 69.0, 69.02, 69.5, 69.52, or 69.59.

Ectopic Pregnancies

To receive Medicaid reimbursement for the termination of an ectopic pregnancy, commonly known as a tubal pregnancy, hospitals must submit billing on hardcopy with a copy of the operative report attached.

Providers must use an appropriate ICD-9 surgical procedure code that denotes the termination of an ectopic pregnancy rather than a sterilization procedure. Use of an improper ICD-9 surgical procedure may cause the claim to deny.

Note: An example of a correct code is "66.62, Salpingectomy with removal of tubal pregnancy". An example of an incorrect code would be procedure code "66.4, Total unilateral salpingectomy".

Molar Pregnancies

A molar pregnancy results from a missed abortion; i.e., the uterus retains the dead and organized products of conception. The Medicaid Program covers the termination of molar pregnancies. To bill for the termination of a molar pregnancy, providers should use one of the following procedure codes with a diagnosis of ***molar pregnancy***.

68.0 Hysterectomy with removal of hydatidiform mole
69.0 Dilation and curettage of uterus
69.02 D & C following delivery or abortion
69.52 Aspiration curettage following delivery or abortion
69.59 Other aspiration of uterus

Deliveries With Non-Payable Sterilizations

The Bureau of Health Services Financing allows payment of an inpatient hospital claim for a delivery/C-section when a non-payable sterilization is performed during the same hospital stay.

A sterilization procedure is considered non-payable if the sterilization consent form (BHSF Form 96) is either missing or invalid. Occurrence code 50 and the date of the performance of the sterilization procedure must be entered in form locator 32 to denote such an instance.

All charges for ancillary services related to the sterilization must be shown as non-covered charges on the UB-92 claim form. Sterilization must be indicated as the secondary diagnosis and procedure for these claims.

Claims for these services will not require any prior or post-authorization and may be billed to Unisys on paper or EMC.

Note: All claims for abortions, ectopic pregnancies, molar pregnancies, or deliveries with non-payable sterilizations should be submitted to the following address:

Unisys Corporation
P. O. Box 91021
Baton Rouge, LA 70821

INPATIENT HOSPITAL POLICY/PROCEDURES

DISCHARGE AND READMIT ON THE SAME DAY

When a patient is discharged and readmitted to the same hospital on the same day, the pre-administration certification/length of stay process as described in Section VII is applicable.

If the patient is readmitted to a different hospital than the discharging hospital, the readmitting hospital should enter the name of the discharging hospital, as well as the discharge date, in form locator 84 of the UB-92 claim form.

DIRECT TRANSFERS OF PATIENTS

When patients must be transferred from one hospital to another for additional medical care, pre-admission certification and length of stay assignment is applicable as stated below.

- Registration and length of stay assignment is required when transferring to acute care and rehabilitation hospitals.

- Pre-admission certification and length of stay assignment is required when transferring to long term hospitals and distinct part psychiatric/substance abuse units in acute care hospitals.

  Note: The above procedures also apply when a patient transfers from the acute care section to the Distinct Part Psychiatric Unit within the same hospital.

DATE OF DISCHARGE OR DEATH

The Medicaid Program does not pay the date of discharge or the date of death for an inpatient hospital stay, unless the date of discharge/death is the same date as the date of admission.

SPLIT-BILLING

Split-billing is permitted/required by the Medicaid Program only in the following circumstances.

- Hospitals must split-bill claims at the state's fiscal year end of June 30.
- Psychiatric hospitals must split-bill at the calendar year end of December 31.
- Hospitals may split-bill long stays, such as neonatal, rehabilitation, cardiac, and long term claims, every 30 days.

Split-Billing Procedures

Specific instructions for split-billing on the UB-92 claim form are provided below.

1. In the ***Type of Bill*** block (form locator 4), the hospital must enter code 112, 113, or 114 to indicate the specific type of facility, the bill classification, and the frequency for both the first part or the split-billing interim and any subsequent part of the split-billing interim.
2. In the ***Patient Status*** block (form locator 22), the hospital must enter a 30 to show that the recipient is "still a patient."

   Note: When split-billing, the hospital should never code the first claim as a discharge.
3. In the ***Remarks*** section of the claim form (form locator 84), the hospital must write in the part of stay for which it is split-billing. For example, the hospital should write in "Split-billing for Part 1," if it is billing for Part 1.

Providers submitting a hospital claim which crosses the date for the fiscal year end, should complete the claim in two parts: (1) through the date of the fiscal year end and (2) for the first day of the new fiscal year.

THERAPEUTIC PASSES

Although therapeutic passes are often beneficial in the treatment of patients hospitalized for extended periods, Medicaid policy prohibits reimbursement to the hospital for a day of service when the patient was not in the facility to receive any services.

If the patient is absent from the facility/unit for more than 24 hours, the absence shall be considered a non-covered day and must be reflected as such in form locator 36 on the UB-92 claim form.

The medical necessity for the therapeutic pass must be documented in the patient's chart by the attending physician, and any pass exceeding 72 hours must be considered a discharge.

*Note: **The therapeutic pass policy applies to all hospital stays: psychiatric, rehabilitation, long term, and acute care. Only one leave of absence may be entered on the claim form.***

SWING BEDS

"Swing bed" is a concept developed to provide Skilled Nursing Facility (SNF) services in small rural hospitals by allowing hospital beds to be used as either Long Term Care (LTC) beds or as acute care beds. Medicaid participation is based on the facility meeting nursing home licensure requirements and approved facility need review. Enrollment in the Medicaid Program as a swing bed facility is contingent on being certified by the Health Standards Section as both a Medicare and Medicaid provider. The swing bed facility is enrolled under a separate provider number from the acute care hospital, and claims for services rendered in the swing bed facility must be billed under that number.

SNF services in a swing bed facility are considered the same as those services in a free-standing SNF facility. The hospital must be in substantial compliance with: Resident rights; admission, transfer and discharge rights; resident behavior and facility practices; patient activities; social services; discharge planning; specialized rehabilitative services; and dental services.

The reimbursement rate for swing beds is the same as the reimbursement rate for a SNF facility, and claims must be submitted on the long term care billing form. Ancillary services are billed on the UB-92 claim form and are reimbursed in accordance with the rate in effect for those services under the ***Hospital Program***. Pharmacy, durable medical equipment (DME), supplies, and any other services not reimbursable under the ***Hospital Program***, but which are covered for long term care recipients, must be billed on the appropriate claim form for the service provided.

*Note: **Reimbursement will not be made to a swing bed hospital for patients requiring Intermediate Care Facility (ICF) services.***

Consult the *Long Term Care Standards of Payment Manual* for information on admission reviews, eligibility determination, utilization reviews, professional medical reviews, and other requirements for SNF services that are applicable to hospital swing beds.

CHAPTER 5
OUTPATIENT HOSPITAL SERVICES

CHAPTER CONTENTS

Page

INTRODUCTION 5-2

CLINIC SERVICES 5-3

EMERGENCY ROOM SERVICES 5-3

HOSPITAL-BASED AMBULANCES (AIR OR GROUND) 5-4

HOSPITAL LABORATORY SERVICES 5-4

HYPERBARIC OXYGEN THERAPY 5-5

NORPLANT INSERTIONS 5-6

OUTPATIENT REHABILITATION SERVICES 5-6

OUTPATIENT SURGERY PROGRAM 5-8

INTRAOCULAR LENS IMPLANTS 5-9

OBSERVATION ROOM CHARGES 5-10

THERAPEUTIC AND DIAGNOSTIC SERVICES 5-10

INTRODUCTION

Diagnostic and therapeutic services provided on an outpatient basis are covered by the Medicaid Program. The following is a list of the general guidelines pertaining to Medicaid coverage of outpatient services.

- Inpatient services shall not be billed as outpatient, even if the stay is less than 24 hours. Federal regulations are specific in regard to the definition of both inpatient and outpatient services. Billing outpatient services for a patient who is admitted as an inpatient within **24 hours of the performance of the outpatient service is not allowed and the facility may be subjected to financial sanctions.**

  - All outpatient services performed within 24 hours of an inpatient admission shall be included on the inpatient claim.

  - All outpatient services performed within 24 hours before an inpatient admission and 24 hours after the discharge shall be included on the inpatient claim.

  - If an inpatient in one hospital has outpatient services performed at another hospital, the inpatient hospital is responsible for reimbursing the hospital providing the outpatient services. The inpatient hospital may reflect the outpatient charges on its claim.

- Outpatient surgery shall be billed as outpatient, provided that the duration of the treatment from beginning to end is less than 24 hours and that the patient is not admitted as inpatient.

- If a patient is treated in the emergency room and requires surgery which cannot be performed for several hours because arrangements need to be made, the services may be billed as outpatient provided that the patient is not admitted as an inpatient and that the duration of the services from entry into the emergency room until release does not exceed 24 hours.

- Outpatient services exceeding 24 hours in duration are "deemed" inpatient, even if the patient is admitted as outpatient. Such services must be billed as inpatient services.

This section contains a description of covered outpatient services as well as information regarding the applicable service limits.

CLINIC SERVICES

Physician services provided in a clinic setting on an outpatient basis are covered as outpatient physician visits and should be billed as physician services on the physicians claim form (HCFA-1500), not as outpatient services. The facility fee for clinic services may not be billed as a separate charge by the hospital. Hospital clinic visits are counted as part of the 12 annual physician office visits allowed.

> *Note: **Exceptions of clinic visits may be requested in the same manner as physician outpatient visits.***

Refer to Physician's Services Provider Manual for further information.

EMERGENCY ROOM SERVICES

The Medicaid Program will cover up to three emergency room visits per calendar year for a recipient who is 21 years of age or older or who is a state foster care (category 15) child. Recipients under the age of 21 have unlimited emergency room visits.

Providers should use revenue codes 450 and 459 to bill for outpatient emergency room services, except when the patient is admitted as inpatient. In instances where patients are admitted from the emergency room, the provider should bill the emergency room charges with revenue code 500 on the inpatient claim form.

HOSPITAL-BASED AMBULANCES (AIR OR GROUND)

Hospital-based emergency ambulance services for Medicaid recipients may be reimbursed if circumstances exist that make the use of any conveyance other than an ambulance medically inadvisable for transport of the patient. Such circumstances must be documented in the patient's medical record.

Hospital-based ambulances can be used only to transport patients to the hospital in an emergency so they may be stabilized. Any transfers to another hospital must occur only because the transporting hospital cannot provide appropriate services.

Non-emergency transport by a hospital-based ambulance is not covered. Claims for hospital-based ambulance services must be filed on the UB-92 as outpatient services using revenue code 540 under the hospital provider number. However, if the patient is admitted to the hospital, the services must be billed on the UB-92 as part of the inpatient services, as the reimbursement for the services will be included in the per diem rate.

Note: Air ambulance charges are not covered as an outpatient service.

Hospital-based ambulances must meet equipment and personnel standards set by the Bureau of Emergency Medical Services (EMS). Hospitals must submit a copy of EMS certification to Provider Enrollment for recognition to bill ambulance charges.

HOSPITAL LABORATORY SERVICES

Hospitals are allowed by Medicaid to contract with an independent laboratory for performance of outpatient laboratory services. However, it is the responsibility of the hospital to ensure that both the physician who performs the professional service and the laboratory that performs the technical service meet all state and federal requirements. One such requirement is that both the physician and laboratory have a valid CLIA number.

When a hospital contracts with a freestanding laboratory for the performance of the technical service only, it is the responsibility of the hospital to pay the laboratory. **The laboratory cannot bill Medicaid** because there is no mechanism in the system to pay a technical component only to a freestanding laboratory.

HYPERBARIC OXYGEN THERAPY

Hyperbaric oxygen therapy may be performed as an outpatient service and is covered by the Medicaid Program. No authorization for these rehabilitative services is required if the procedures are performed for the diagnoses specified below:

- Acute carbon monoxide intoxication
- Decompression illness
- Gas embolism
- Gas gangrene
- Acute traumatic peripheral ischemia
- Crush injuries and suturing of severed limbs
- Meleney ulcers (no other type of cutaneous ulcer is covered)
- Acute peripheral arterial insufficiency
- Preparation and preservation of compromised skin grafts
- Chronic refractory osteomyelitis, unresponsive to conventional treatment
- Osteoradionecrosis, adjunctive to conventional treatment
- Soft tissue radionecrosis, adjunctive to conventional treatment
- Cyanide poisoning
- Actinomycosis, adjunctive to conventional treatment, when process is refractory to antibiotics and surgical treatment
- Diabetic wounds, marginal
- Venous status ulcers (recommended only if venous surgery, local wound care, leg elevation, counter pressure support, and skin grafting fail)
- Decubitus ulcers which persist after reconstructive surgery has restored large vessel function
- Arterial insufficiency ulcers which persist after reconstructive surgery has restored large vessel function
- Necrotic wounds secondary to brown recluse spider bite.

Note: ***The covered diagnosis should be entered as the primary diagnosis for hyperbaric oxygen therapy claims. These claims will be reviewed by the Medical Director and/or the other physicians in the Unisys Medical Review Unit.***

Requests for approval for hyperbaric oxygen therapy for other diagnoses must be submitted to the following address:

Unisys
Medical Review Unit
P. O. Box 14919
Baton Rouge, LA 70898-4919

NORPLANT INSERTIONS

Billing for the Norplant contraceptive implant kit by use of a pharmacy revenue code is prohibited by the Medicaid Program in Louisiana. Only physicians may bill Medicaid for this service.

OUTPATIENT REHABILITATION SERVICES

The Medicaid Program provides coverage for outpatient rehabilitation services with prior approval. Outpatient rehabilitation services include

- Physical therapy
- Occupational therapy
- Speech therapy
- Hearing therapy.

The Prior Authorization Unit will recommend approval only for therapy plans for individuals who are likely to realize substantial gains in rehabilitation, self-care, or self-help.

"**Rehabilitation**" is defined as a program to prevent further impairment or physical deformity and malfunction, enabling a significant increase in the capacity of the individual, so the individual will require less care by others.

"**Self-care**" and "**self-help**" are defined as the ability of the individual to take care of personal needs (eating; dressing; and the ability to walk, talk, or use devices unassisted).

"**Less individual care by others**" is defined as the ability of the client to use a minimum of assistance to take care of personal needs. Optimum utilization of the device will be an additional criteria when prosthesis training is involved.

Medicaid will not pay for vocational or developmental evaluations, voice evaluations, voice therapy, instruction in the use hygiene of the voice as treatment for vocal cord nodules, or hoarseness and related conditions, unless the problem is serious enough to interfere with normal speech.

Medicaid does not have a program for long term therapy or maintenance therapy. Other resources, such as Handicapped Children's Services, school therapy programs, and community resources, should be considered.

The referrals for services must be made by a licensed physician. The referral must include the diagnosis, the date of the accident (or onset of illness), the address of the referring physician, his/her specialty (if known), and the date of the referral. The hospital must retain a copy of the physician's recommendation on file.

When providers request approval for outpatient rehabilitation services, they must specify the number of rehabilitation services/visits being requested in a rehabilitation plan, and the plan must be prior authorized by the Unisys Prior Authorization Unit.

The hospital rehabilitation services department must evaluate the recipient and complete a copy of the proposed plan of services, including PA01 and PA02 forms. The evaluation does not require prior authorization. Medicaid will only pay for one evaluation every six months. Initial therapy and extended therapy plans must be submitted to the Unisys Prior Authorization Unit at the address below for approval prior to treatment of eligible Medicaid recipients.

Unisys
P.O. Box 14919
Baton Rouge, LA 70809-4919
Attention: Prior Authorization

PA01 and PA02 forms must be completed fully when they are submitted for review. All initial requests for approval must have attached a copy of the physician's referral and the results of the evaluation of the patient which necessitates therapy. Refer to Prior Authorization section for samples of PA01 and PA02 and the instructions for completing these forms.

In those cases where delay of therapy would result in deterioration of the medical condition; e.g., burn cases, accidents, or surgery; the treatment may be instituted subject to later approval. The request for therapy should be submitted within the first week of therapy, with an explanation and a request for approval from the start of therapy. Reimbursement for rehabilitation services provided without an approved plan for therapy will be dependent on the approval of the treatment plan.

Note: All outpatient hospital claims for therapy must have a PA number in form locator 63.

OUTPATIENT SURGERY PROGRAM

Certain surgical procedures usually are covered by the Medicaid Program if they are performed as outpatient services. Reimbursement to hospitals for the performance of these outpatient surgical procedures is made on a flat-fee per service basis, not to exceed the Medicare payment rate.

Hospitals must bill all outpatient surgery charges for the specified surgeries using Revenue Code "490" - Ambulatory Surgical Care. This includes observation room charges, as well as related laboratory and radiology services.

The current payment rate for these procedures is in accordance with the following four groupings.

- Group 1 $220.39
- Group 2 $262.36
- Group 3 $282.40
- Group 4 $320.56

A list of the surgical procedures and the four payment groups are provided in ***Appendix A*** of this provider manual. These same surgical procedures may be performed on an inpatient basis when medically necessary. Refer to Pre-Admission Certification/Length of Stay section for further information.

Certain surgical procedures usually are covered by the Medicaid Program if they are performed as outpatient services. Reimbursement to hospitals for the performance of these outpatient surgical procedures is made on a flat-fee per service basis, not to exceed billed charges.

Hospitals must bill all outpatient surgery charges for the specified surgeries using Revenue Code "490" - Ambulatory Surgical Care. This includes observation room charges, as well as related laboratory, radiology, and all other services performed in conjunction services.

The current payment rate for these procedures is in accordance with the following nine groupings.

- Group 1 $349.65
- Group 2 $468.30
- Group 3 $535.50
- Group 4 $661.50
- Group 5 $752.85
- Group 6 $709.80
- Group 7 $1,044.75
- Group 8 $864.15
- Group 9 $1,405.95

The most appropriate CPT/HCPCS code for the surgical procedure must be entered in Form Locator 44 on the UB-92 claim form. Only one CPT/HCPCS code may be entered in the field.

A list of the surgical procedures and the nine payment groups are provided in ***Appendix A*** of this provider manual. These same surgical procedures may be performed on an inpatient basis and must be pre-certified if performed on the first or second day of the inpatient stay when medically necessary. Refer to Pre-Admission Certification/Length of Stay section for further information.

Note: Providers who are performing these procedures as an inpatient should continue to use ICD-9 procedure codes on pre-certification request and billing.

OBSERVATION ROOM CHARGES

When applicable, hospitals should bill for treatment or observation room charges with revenue codes 760–769. The entire outpatient visit, including observation, may not exceed 24 hours duration.

When billing for these services, hospitals must include the A*dmission Hour* and *Discharge Hour* (items 18 and 21) in addition to the other required items on the outpatient hospital claim.

Hospitals billing for any of the outpatient surgical procedures listed in Appendix A may not bill separately for treatment and observation room charges provided on the same day. Charges for these services have been included in the flat fee reimbursement for the outpatient surgical procedures.

THERAPEUTIC AND DIAGNOSTIC SERVICES

All other outpatient services, including, but not limited to, therapeutic and diagnostic radiology services, chemotherapy, hemodialysis, and laboratory services, have no services limits. However, these services must be medically necessary as substantiated by the patient's medical records.

CHAPTER 6
HOSPITAL-BASED PHYSICIANS

CHAPTER CONTENTS

Page

INTRODUCTION 6-2

ENROLLMENT OF HOSPITAL-BASED PHYSICIANS 6-2

INTRODUCTION

Hospital-based physicians (HBP) are those individuals who are either under contract to or are paid a salary by a hospital to perform professional services. These individuals may include emergency room physicians, pathologists, radiologists, certified registered nurse anesthetists (CRNAs), and other physician specialties. The hospital bills for the professional services provided by the HBP group on the HCFA 1500 claim form using the HBP group provider number.

Provided in this chapter is an explanation of the enrollment procedures for HBPs. A description of the services HBPs may render is provided in the *Physician Services Provider Manual.*

ENROLLMENT OF HOSPITAL-BASED PHYSICIANS

The Medicaid Program enrolls hospital-based physicians as providers separate from the hospital. Hospitals are required to obtain a group physician number to bill for services provided by all physicians currently under contract with the hospital who do not have agreement to bill Medicaid directly.

Enrollment procedures are as follows.

1. The hospital must complete a provider enrollment form to obtain the hospital's group physician number.

2. Each physician employed or under contract without an agreement to bill Medicaid directly must submit a completed enrollment form with a copy of the contract to receive a Medicaid individual provider number and to show affiliation with the hospital.

3. Hospitals contracting with such organizations as National Emergency Room Physicians should not complete an enrollment for the organization. The organization is responsible for completing enrollment for each physician who provides services in the hospital under this contract.

CHAPTER 7
PRE-ADMISSION CERTIFICATION/LENGTH OF STAY

CHAPTER CONTENTS

Page

INTRODUCTION 7-2
Pre-Admission Certification 7-2
Length of Stay 7-3
Extensions 7-3

MEDICAID HOSPITAL PRE-ADMISSION/LENGTH OF STAY
REVIEW PROGRAM INFORMATION 7-4
Functional Operations 7-5
Maximum Turnaround Times 7-11
Instructions for Completing P.C.F01 Form 7-13

LONG TERM HOSPITAL PRE-ADMISSION 7-16
Certification Guidelines 7-16
Definition of Terms 7-17
Long Term Hospital Criteria 7-19

DISTINCT PART PSYCHIATRIC UNIT 7-37
Admission Criteria for Adults 7-37
Extension Criteria for Adults 7-39
Admission Criteria for Children 7-46
Extension Criteria for Children 7-49
Community Based Psychiatric Service Definitions 7-56

ALCOHOLISM AND DRUG TREATMENT UNITS 7-59
Admission Criteria 7-59
Extension Criteria 7-62

REHABILITATION HOSPITALS 7-68
Length of Stay Criteria 7-68

OUTPATIENT SURGERY PERFORMED AS INPATIENT 7-73

INTRODUCTION

The Department of Health and Hospitals, Bureau of Health Services Financing, has the following requirements for inpatient hospital services:

- **Registration** and **length of stay** (LOS) assignment for all admissions to acute care and rehabilitation hospital

- **Pre-admission certification** and **length of stay** assignment for long term hospitals and distinct part psychiatric/substance abuse units in acute care general hospitals.

  *Note: **Request for hospital pre-admission certification and length of stay assignment is made on P.C.F01 form. A sample P.C.F01 form and the instructions for completing this form is provided as Figure 7-1.***

None of the following are subject to these requirements:

- Inpatient admissions for dual Medicare/Medicaid recipients

  *Note: **Pre-Admission certification/length of stay requirements are applicable to recipients with Medicare Part B only or exhausted Medicare Part A benefits.***

- State operated hospitals (because of certain TEFRA restrictions)

- Free-standing psychiatric hospitals (because of the existing pre-admission screening process mandated by DHH).

PRE-ADMISSION CERTIFICATION

The pre-admission certification requirement applies only to long term hospitals and distinct part psychiatric/substance abuse units in acute care general hospitals. Pre-admission certifications must be obtained before admission or on a concurrent basis, with provision for retrospective review only in exceptional circumstances. Medicaid reimbursement will not be authorized without completion of the pre-admission certification requirement. Certification for emergency admissions will be requested upon admission. Medical necessity of admissions will be determined using customized criteria and clinical data provided by the hospital.

LENGTH OF STAY

Acute care and rehabilitation hospitals must register each Medicaid admission no later than one business day after admission. ***Length of stay*** for each acute care/rehabilitation case will be determined by the fiscal intermediary using Interqual ISD, HCIA LOS Southern Region grand totals, customized criteria, and clinical information for the case provided by the hospital.

Late submissions of an initial Pre-Cert case due to an incorrect response from a MEVS inquiry will be given consideration if a good faith effort is verified with the actual printout from the MEVS system that was accessed within the one business day of the admission. (Submit to Unisys Pre-Certification Unit)

EXTENSIONS

Extensions may be requested by the hospital when appropriate care of the patient indicates the need for hospital days in excess of the originally approved number.

The Department of Health and Hospitals will now allow hospitals to submit an extension request on the expected discharge date instead of the day before the expected discharge date.

When a hospital is denied an extension based on timely submission of the medical information requested by Unisys and the patient remains hospitalized, the hospitals can request to re-open the Pre-Certification case under a new Pre-Certification number. However, the hospital must submit current documentation to be reviewed as long as the patient continues to be hospitalized.

A new Pre-Certification number will be issued with the admit date being the date that the hospital submitted the current documentation to the Unisys Pre-Certification Department.

The days that were denied my be appealed through the DHH appeal process using the Pre-Certification number under which the days were denied.

PROCESS:

Hospitals must submit an initial PCF-O1 with no Pre-Certification number. On the bottom of the PCF-O1, write "Attention Pre-Certification Unit". Also note the Pre-Certification number under which the extension request was denied. Hospitals will be assigned a new Pre-Certification number with the admit date being the date that Unisys receives the re-submitted PCF-O1. This re-submitted request must have current documentation which supports the continued length of stay.

Extensions will be granted on a case-by-case basis and will be based on clinical information provided by the hospital.

Note: ***Medical registration and length of stay assignment for the surgical procedure does not replace or in any way affect other policy requirements that may apply to surgical claims (e.g., timely filing limits, sterilization consent requirements, or recipient's eligibility for inpatient services).***

(Any questions can be directed to Unisys Pre-Certification at (800) 877-0666)

MEDICAID HOSPITAL PRE-ADMISSION/LENGTH OF STAY REVIEW PROGRAM INFORMATION

To control and monitor admissions, length of stay (LOS), and program expenditures, hospital pre-admission certification is an important adjunct to the new hospital prospective payment methodology. Under the present payment methodology (cost-settlement at year-end), controls for applicable admits and LOS are embedded in the rate-setting and cost audit process. As the private hospitals convert to the new prospective payment methodology, these controls are compromised. Therefore, implementing a hospital pre-admission certification program is necessary to establish the proper prospective control procedures. However, DHH has opted to minimize the program's effect by limiting pre-admission certification to only distinct-part psychiatric facilities and long term hospitals. All hospitals (excluding state-operated and free-standing psychiatric hospitals) will participate in a prospective LOS review of admissions. The state-operated hospitals are exempt from the program by DHH because they have been excluded from the new prospective reimbursement methodology. The state-operated hospitals will remain under the current payment methodology with its TEFRA restrictions. Free-standing psychiatric facilities are exempt from this program because these facilities currently undergo a pre-admission screening process mandated by DHH.

Medicaid hospital admission/LOS reviews will use the InterQual Adult and Pediatric ISD criteria sets (edition currently used by the Louisiana Medicaid program), HCIA LOS (grand total percentages based upon the admitting diagnosis) Southern Region criteria, and customized criteria. Initial review processes will use the 1993 version of InterQual and HCIA LOS, subject to change with notification. Reviews will be conducted by Unisys nurses and physicians based in Baton Rouge under the Unisys contract with DHH. Unisys review staff will be divided into specialty groups representing those services requiring pre-admission certification and LOS assignment.

An advisory council with broad representation from hospitals, provider associations, DHH, and Unisys will be established to recommend and review criteria, procedures, and performance standards. The committee will also survey the provider community on an ongoing basis to obtain usage information and to provide feedback.

For the purpose of this document, a ***working day*** is defined as one observed by the Unisys Corporation occurring on Monday through Friday from 8 a.m. to 5 p.m. and excluding the following holidays: New Year's Day (observed), Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and the day after, Christmas holidays. ***Working hours*** are defined as those from 8 a.m. to 5 p.m. on a working day.

FUNCTIONAL OPERATIONS

Admission Review with LOS Assignment for Distinct Part Psychiatric and Long Term Hospitals

Admission Process

1. Complete form P.C.F01 (Figure 7-1) and fax it to Unisys. When a fax is unavailable, hospitals may call Unisys during established working hours and a Unisys review nurse (or licensed mental health professional for psychiatric cases) will accept the information by phone and handle the case. After hours the information may be left on voice mail. Admission certification will occur prior to or concurrent with the admission. Medicaid reimbursement will not be made without admission certification.

2. Case review nurse or licensed mental health professional (LMHP) obtains all pertinent case information (hospital Medicaid ID, recipient Medicaid ID, diagnosis codes, procedure codes, admit date, etc.—as per attached form), and enters this data into the database where validation and eligibility verification is performed.

3. Nurse (or LMHP) uses established criteria and procedures to determine medical necessity of admission and length of stay. Medical necessity of admission for distinct-part psychiatric services will be determined using customized admission criteria and clinical data provided on the case by the hospital. Medical necessity of admission to a long term hospital will be determined using customized admission criteria. InterQual intensity of service/severity of illness criteria are the standard for the pre-certification/LOS program. LOS assignment for distinct-part psychiatric admissions will be determined by the HCIA LOS (grand total percentages) Southern Region criteria. Initial LOS for distinct-part psychiatric admissions will be set at the 50th percentile based on the admitting diagnosis. For acute care, psychiatric, and rehabilitation admissions to long term hospitals, procedures for pre-admission certification and LOS assignment as described elsewhere in this chapter will be used. Initial LOS assignment for all other long term hospital admissions will be 14 days.

4. Case review nurse (or LMHP) determines admission certification status (approved, denied, or rejected due to lack of information). Single Point of Entry (SPOE) approved requests for admission are automatically certified by Unisys when no state-operated beds are available. LOS is assigned for approved admits.

5. Approved cases are assigned an authorization number that is communicated to the hospital (along with the LOS days) for reference on the claim. This information will be given by phone or fax, and then officially in the mail.

6. Cases rejected due to insufficient information are remanded to the hospital for more information (ED record [if any], physician's admit note, physician's orders, and applicable progress notes) or corrections needed for admission and LOS determination.

7. All cases rejected by the review nurse (or LMHP) are referred to the Unisys physician for review and resolution. If the admission is denied by the physician and the facility still feels the need for the admission, a reconsideration for independent review may be requested by the hospital. The reconsideration process involves a physician-to-physician conference; that is, the hospital's admitting physician (or designee) consults with the Unisys physician on the clinical aspects of the case within one working day of denial notification. If the outcome of the reconsideration is a denial of admission, then the hospital and/or patient may initiate a formal appeal through the DHH.

Extension Request

1. Complete form P.C.F01 (Figure 7-1) and fax it to Unisys. When a fax is unavailable, hospitals may call Unisys during established working hours and a Unisys review nurse (or licensed mental health professional for psychiatric cases) will accept the information by phone and handle the case. After hours the information may be left on voice mail. Extension of days can be requested any time during the approved stay; however, the extension must be requested no later than the last authorized day or the last business day before the last authorized day. Clinical exceptions will be handled on a case-by-case basis.

2. Case review nurse (or LMHP) obtains all information needed for LOS extension.

3. Case review nurse (or LMHP) determines LOS extension request status (approved, denied, or rejected due to lack of information). For acute care, psychiatric, and rehabilitation admissions to long term hospitals, procedures for pre-admission certification and LOS assignment as described elsewhere in this chapter will be used. Initial psychiatric extension requests may be submitted for consideration up to the 75th percentile; subsequent extension requests may be submitted for consideration of up to three additional days. Initial long term hospital extension requests may be submitted for consideration up to 14 days; subsequent extension requests may be submitted for consideration of up to seven additional days.

4. Approved cases are assigned additional LOS days under the same authorization number as that of the initial pre-admit request. The extension days information is communicated by phone or fax, and then officially in the mail.

5. Cases rejected due to insufficient information are remanded to the hospital for more information (ED record [if any], physician's admit note, physician's orders, and applicable progress notes) or corrections needed for LOS extension determination.

6. All cases denied or approved in part (i.e., where assignment of LOS days is less than the requested days and when the requested days are less than or equal to the maximum allowable number of extension days as defined by Medicaid policy) by the review nurse (or LMHP) are referred to the Unisys physician for review and resolution. If the extension is denied by the physician and the facility still feels the need for the extension, a reconsideration for independent review may be requested by the hospital. The reconsideration process involves a physician-to-physician conference; that is, the hospital's admitting physician (or designee) consults with the Unisys physician on the clinical aspects of the case within one working day of denial notification. If the outcome of the reconsideration is a denial of extension, then the hospital and/or patient may initiate a formal appeal through the DHH.

Acute Care (Medical-Surgical) and Rehabilitation Hospitals—Registration of Admission and Prospective LOS Review Only

Initial LOS Review Process

1. Complete form P.C.F01 (Figure 7-1) and fax it to Unisys. When a fax is unavailable, hospitals may call Unisys during established working hours and a Unisys review nurse (or licensed mental health professional for psychiatric cases) will accept the information by phone and handle the case. After hours the information may be left on voice mail. An outpatient stay that results in an inpatient admission will require LOS review, and the LOS assigned by Unisys will include the outpatient day. LOS review and assignment can be requested prior to or concurrent with the admission, but no later than one working day after admission.

2. Case review nurse obtains all pertinent information to the case (hospital Medicaid ID, recipient Medicaid ID, diagnosis codes, procedure codes, admit date—as per attached form) and enters this data into the database for validation and eligibility verification. Inpatient stays for surgical procedures normally done on an outpatient basis will not be assigned a length-of-stay without documentation justifying the need for these procedures to be performed on an inpatient basis. Outpatient surgery list located in Appendix A of this manual will be used in lieu of the ambulatory surgery list in InterQual.

3. Length of stay assignment for each acute care case will be determined by the Unisys review nurse using the HCIA LOS (grand total percentages based upon the admitting diagnosis) Southern Region criteria and clinical information for the case provided by the hospital. Lengths-of-stay for each rehabilitation case will be assigned 14 days based on the lowest average length-of-stay from the American Hospital Association Average Stay Study for Rehabilitation Conditions.

4. Case review nurse assigns the LOS days to each registered case. The initial LOS assignment for acute care hospitals will be based on the 50th percentile unless Unisys determines medical necessity is not met. In these cases, Unisys will assign a one-day LOS. If there is insufficient information to assign a LOS, the case is rejected until the information is provided.

5. Registered cases are assigned an authorization number that is communicated to the hospital (along with the LOS days) for reference on the claim. This information will be given by phone or fax, and then officially in the mail.

Extension Request

1. Complete form P.C.F01 (Figure 7-1) and fax it to Unisys. When a fax is unavailable, hospitals may call Unisys during established working hours and a Unisys review nurse (or licensed mental health professional for psychiatric cases) will accept the information by phone and handle the case. After hours the information may be left on voice mail. Extension of days can be requested any time during the approved stay; however, the extension must be requested no later than the last authorized day or the last business day before the last authorized day. Clinical exceptions will be handled on a case by case basis.

2. Case review nurse obtains all information needed for LOS extension.

3. Case review nurse determines LOS extension request status (approved, denied, or rejected due to lack of information).

4. Approved cases are assigned additional LOS days under the same authorization number as that of the initial LOS request. The extension days information is communicated by phone or fax, and then officially in the mail. The Unisys case review nurse will use the InterQual intensity of service (IS) and discharge screens to assess the appropriateness of continued stay in the hospital. If the intensity of service criteria are still met and discharge screens are not met, the Unisys case review nurse will extend the LOS for the initial extension request at the 75th percentile. Patient clinical data will be taken into

consideration for those cases where the intensity of service criteria are still met, and the discharge screens are also met. Using the same process, subsequent extension requests for acute care cases may be submitted for consideration of up to three additional days. Approved extension requests for rehabilitation cases will be assigned up to seven days.

5. Cases rejected due to insufficient information are remanded to the hospital or admitting physician for more information (ED record [if any], physician's admit note, physician's orders, and applicable progress notes) or corrections needed for LOS extension determination.

6. All cases denied or approved in part (i.e., where assignment of LOS days is less than the requested days and when the requested days are less than or equal to the maximum allowable number of extension days as defined by Medicaid policy) by the review nurse are referred to the Unisys physician for review and resolution. If the extension is denied by the physician, and the facility still feels the need for the extension, a reconsideration for independent review may be requested by the hospital. The reconsideration process involves a physician-to-physician conference; that is, the hospital's admitting physician (or designee) consults with the Unisys physician on the clinical aspects of the case within one working day of denial notification. If the outcome of the reconsideration is a denial of extension, then the hospital may initiate a formal appeal through the DHH.

Retrospective Review Based on Patient Retroactive Eligibility

1. A request for admission certification and/or LOS assignment cannot be made until the patient's Medicaid eligibility has been loaded on Unisys files. Unisys recognizes only one situation for retrospective review: positive determination cannot be made during the admission period. If a patient's Medicaid eligibility is verified by the hospital during the stay, then the case would not be considered a retrospective review; instead, it should be reported to Unisys through the normal prospective procedures described above. If the patient's stay has exceeded the LOS determined by Unisys, the facility may request an extension concurrently with the LOS review.

   In case of an ill newborn whose mother is **Medicaid eligible**, a request for LOS assignment can be made even though Medicaid eligibility is not yet loaded on the Unisys file. The case review nurse will examine all pertinent information receiving on the case and assign an authorization number and LOS. There will be no Medicaid identification number on the approval letter. Hospitals must submit the 13-digit ID number whenever it is assigned so that this information can then be entered onto the Unisys file.

2. Hospital retains patient information and claim data until Medicaid coverage is established.

3. Hospital submits admission information to Unisys via mail along with verification of retroactive eligibility (such as a copy of the Medicaid identification card or correspondence from the parish office).

4. Unisys case review nurse obtains all pertinent information to the case (hospital Medicaid ID, recipient Medicaid ID, diagnosis codes, procedure codes, admit date, etc.—as per attached form) and relevant hospital records such as the typed admission and discharge notes. The case review nurse then enters this data into the database where validation and eligibility verification is performed.

5. The case review nurse uses established criteria and procedures to determine admit need (in the cases of distinct-part psychiatric and long term hospital) and length of stay.

6. Approved cases are assigned an authorization number and LOS days, and a notification indicating approval and assigned LOS days is mailed to the hospital for reference on the claim. If the approved LOS days are less than the days of the actual stay, only the number of approved LOS days will appear on the notification and be paid on the claim.

7. Cases rejected due to insufficient information are remanded to the hospital for more (ED record [if any], physician's admit note, physician's orders, and applicable progress notes) or corrections needed for admission and LOS determination.

8. In the case of a partial stay approval or a denial for lack of medical necessity, a reconsideration may be requested if the hospital does not concur with the decision. If the hospital is not satisfied with the reconsideration decision, then they may appeal that decision utilizing the established appeal process through the DHH.

MAXIMUM TURNAROUND TIMES

	Acute Care (Med-Surg)/Rehab	Long Term Hospital	Psychiatric
Initial LOS	24 hrs.	24 hrs.	4 hrs.
LOS Extension	4 hrs.	24 hrs.	24 hrs.
Pre-Cert Review	N/A	24 hrs.	4 hrs.
Retrospective Review	21 days	21 days	21 days

- Turnaround times indicate the maximum time that Unisys will reply on a case, from receipt of the request to final decision, including Unisys physician review when necessary. These times do not represent turnaround times for appeal.
- Hours for turnaround refer to same or next business day.
- Extensions can be requested any time during the approved LOS.

Mail to: Jnisys Louisiana Medicaid
Hospital Pre-Certification Program
Post Office Box 14849
Baton Rouge, LA 70898-4849

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM

REQUEST FOR HOSPITAL PRE-ADMISSION CERTIFICATION AND LOS ASSIGNMENT

Phone 1-800-877-0666 Fax 1-800-717-4329 CASE NUMBER (1)

TYPE (2)
01 DISTINCT PART PSYCH (PRE-ADMISSION / LOS REVIEW)
02 LONG TERM HOSPITAL (PRE-ADMISSION / LOS REVIEW)
03 ACUTE CARE (MED-SURG) / REHAB (LOS REVIEW ONLY)

(3) INITIAL REQUEST
LOS EXTENSION REQUEST
RECONSIDERATION REQUEST

LEVEL OF CARE / UNIT OF CARE (4)

RECIPIENT MEDICAID ID (5) AGE (6) SEX (7)

DATE OF BIRTH / / (8) MEDICARE PART-A BENEFITS EXHAUSTED (9)

RECIP LAST NAME (10) FIRST MI

HOSPITAL MEDICAID ID (11)

HOSPITAL CONTACT PERSON (12)

PHONE (13) FAX (14)

ATTENDING PHYSICIAN MEDICAID ID (if Medicaid enrolled) (15)

ADMISSION DATE (actual or anticipated) / / (16)

DISCHARGE DATE (FOR RETROSPECTIVE REVIEWS ONLY) / / (17)

IF THIS IS A TRANSFER FROM ANOTHER FACILITY, ENTER THE TRANSFERRING FACILITY MEDICAID ID OR FACILITY NAME BELOW (18)

DIAGNOSIS (ICD-9-CM) (19) DESCRIPTION

ADMITTING
PRIMARY
OTHER
EXTENSION

SURGERY DATE / / (20)

PROCEDURE CODE(S) (ICD-9-CM) (21)

I certify that all information given is accurate and complete, and that any incomplete or inaccurate data may result in certification denial

AUTHORIZED SIGNATURE _____ (22)

REQUEST DATE AND TIME / / (23) (MILITARY TIME) : (24)

THIS AREA FOR OFFICE USE ONLY

REVIEWER INITIALS (25) DATE / / (26)

STATUS (27) DAYS APPROVED (28)

02 = APPROVED
03 = DENIED
05 = RETURNED DUE TO INSUFFICIENT INFORMATION (See Attached Notes)

P.C.F01
ISSUED 8/94

Figure 7-1. P.C.F01 Form–Request for Hospital Pre-Admission Certification and LOS Assignment

INSTRUCTIONS FOR COMPLETING P.C.F01 FORM

Block	Description	Instructions
1.*	Case Number	Enter the case number when requesting extension of days or reconsideration.
2.*	Type	Enter the type of facility requesting admission approval and LOS assignment.
3.*	Type of Request	Check the appropriate box.
4.*	Level of Care/ Unit of Care	Enter one of the following **Level-of-Care** or **Unit-of-Care** codes.

BURN	Burn Unit
CCU	Coronary Care Unit
GEN	General Unit
ICU	Intensive Care Unit
NICU	Neonatal Intensive Care Unit
OU	Observation Unit
PICU	Pediatric Intensive Care Unit
PSYCH	Psychiatric Unit
REHAB	Rehabilitation Unit
SAU	Substance Abuse Unit
TU	Telemetry Unit

5.*	Recipient Medicaid ID	Enter the recipient's 13-digit Medicaid number.
6.*	Age	Enter the recipient's age on date of admit. If recipient is less than 1 year old, enter zeros in this field.
7.*	Sex	Enter the recipient's sex, M=male; F=female.
8.*	Date of Birth	Enter the recipient's date of birth MM/DD/YY.
9.	Medicare Part A Benefits Exhausted	Enter a "Y" in this field if the recipient is eligible for Medicare Part A and benefits have expired. Medicare EOMB or other appropriate documentation must be attached to this form.

10.*	Recipient last name, first, MI	Enter the recipient's last name, first, middle initial.
11.*	Hospital Medicaid ID.	Enter the seven-digit hospital Medicaid number.
12.	Hospital Contact Person	Enter the contact person for information pertaining to this case.
13.	Phone	Enter the phone number for the contact on this case.
14.	FAX	Enter the fax number where data should be faxed.
15.	Attending Physician Medicaid ID (if Medicaid enrolled)	Enter the admitting/attending physician Medicaid number of the primary care physician. If the physician is not enrolled in the Medicaid program, leave blank.
16.*	Admission Date (actual or anticipated)	Enter the admission date MM/DD/YY. If the actual date is unknown, enter the anticipated admit date.
17.	Discharge Date (for retrospective reviews)	Enter the date of discharge for retrospective review cases only, where the recipient has already been discharged.
18.	Transfer	If the recipient is being transferred from another facility, or a separate unit in the same facility, enter the transferring facility's Medicaid ID number (if Medicaid enrolled). If not enrolled in Medicaid, enter that facility's name. If not a transfer, leave blank.
19.	Diagnosis (ICD-9-CM)	For an initial admission, enter the ADMITTING, (most likely the initial diagnosis), PRIMARY (more specific or final disposition based on hospital diagnostic testing), and OTHER ICD-9-CM diagnosis code(s) that pertain to the recipient's condition. You must enter at least the admitting and/or primary diagnosis. For extension requests, must enter an EXTENSION diagnosis. At least one diagnosis is required. Please note that you must include the ICD-9-CM code here and the description is helpful, but optional.

20.	Surgery Date	Enter the date of surgery, if applicable to this case (Required for organ transplants and outpatient surgery performed on an inpatient basis).
21.	Procedure Code(s) (ICD-9-CM)	Enter the ICD-9-CM procedure code(s) associated with this case. (Required for organ transplants and outpatient surgery performed on an inpatient basis).
22.*	Authorized Signature	Authorized signature is required. Requests will not be accepted if not signed.
23.*	Request Date and Time	Enter the date this request is submitted to Unisys.
24.	Military Time	Enter the time of day (military time format) this request is submitted to Unisys.

* Required Items

LONG TERM HOSPITAL PRE-ADMISSION

CERTIFICATION GUIDELINES

Pre-admission and initial and subsequent length-of-stay assignment for all admissions to long term hospitals must meet the following guidelines.

Psychiatric

Follows the established Medicaid Admission Review and Continued Stay Criteria for Distinct Part Psychiatric Units with lengths of stay determined by HCIA and Medicaid.

Acute Care (Medical-Surgical)

Follows Interqual Admission Review/Continued Stay Criteria with LOS determined by HCIA.

Rehabilitation

Follows the established Medicaid Admission Review and Continued Stay Criteria for Rehabilitation with lengths of stay determined by Medicaid.

All Other Long Term Hospital Admissions

Follows the established Medicaid Admission Review and Continued Stay Criteria for Long Term Hospitals with lengths of stay determined by Medicaid.

> *Note: During the pre-admission certification, the facility must identify the potential patient under one of the above classifications. Certification and determination of LOS will be based upon the patient classification.*

Long Term Hospital Exclusionary Criteria

If patient meets one or more of the following criteria, admission is denied.

1. Patient does not require 24-hour physician coverage (can include physical medicine and rehabilitation specialist).

2. Patient requires custodial services.

3. Patient could be treated on an out-patient basis or lower level of care (rehab services three times per week or less to achieve optimal level of functioning).

4. Patient is unstable for transfer, in which transfer could result in further deterioration or death.

5. Patient is terminally ill with less than six-month survival rate and has requested no medical intervention for the disease process.

6. Patient has severe neurobehavioral disorder requiring a locked ward or specialized treatment team (i.e., Alzheimer's Disease, s/p head injury, or toxin exposure).

DEFINITION OF TERMS

Long Term Hospital

A facility must meet all of the following elements to be considered a long term hospital.

1. Long Term Hospital Program must include medical management by a physician and a registered nurse plus the provision of an interdisciplinary team consisting of the following services as required by the patient's clinical condition:

   A. Respiratory care
   B. Nutritional services
   C. Physical therapy
   D. Social services
   E. Occupational therapy
   F. Speech pathology
   G. Recreational/activity therapy
   H. Psychological services.

2. There must be evidence of periodic multi-disciplinary review at least every two weeks with documentation and recommendations for continuation of the Long Term Acute Care Program.

3. Projected length of stay exceeds 25 days.

4. There is evidence that an alternative level of care is either inadequate or is not available. Alternative levels of care may include Home Health Services, Intermediate Care Facilities, Skilled Nursing Facilities, Hospice, Acute Rehabilitation Unit/Hospital (when projected LOS is less than 25 days), Outpatient Services, or Psychiatric Unit/Hospital (when projected LOS is less than 25 days).

The following definitions 1) describe aspects of assessment, monitoring, and treatment protocols found throughout the criteria set, and 2) facilitate understanding of some of the complex medical conditions characteristic of long term acute patients and the accompanying complex services required to adequately treat those patients.

Severity of Illness

1. "Unstable medical condition" includes, but is not limited to

   A. Unstable cardiovascular conditions
   B. Uncontrolled hypertension
   C. Uncontrolled acid-base, fluid, electrolyte, or other metabolic disorders
   D. Systemic infection or other complicated infectious process
   E. Acute renal failure
   F. Acute bleeding or clotting disorders (i.e., DVT,PE)
   G. Exacerbation of congestive heart failure
   H. Exacerbation of chronic obstructive pulmonary disease
   I. Uncontrolled diabetes
   J. Acute Respiratory Distress Syndrome
   K. Complicated neuromuscular disorders (i.e., Myasthenia gravis, SLE, Guillain-Barre', pulmonary fibrosis)
   L. Seizure disorders.

2. "Observation and monitoring" includes, but is not limited to physical assessment of the patient, monitoring of lab values and drug levels to initiate interventions, and monitoring patient response to medications.

3. "Complex medical problems" refers to multisystem diseases (see number 1 above).

4. "Clinical complications" (see numbers 1 and 3 above).

5. "Cognition" is the mental operation of recognizing, knowing, comprehending, and understanding information.

Intensity of Service

1. "Respiratory therapy/treatment" includes, but is not limited to nebulizer with medication, chest physiotherapy with or without postural drainage, oxygen therapy.

2. "Continuous monitoring devices" includes, but is not limited to telemetry, pulse oximetry, pulmonary artery/wedge pressure (Swan Ganz), central venous pressure, arterial lines.

3. "IV therapy" (other than "keep open") requires at least 30 ML/Kg of body weight in 24 hours (i.e., TPN).

4. "Specialized studies" examples include, but are not limited to the Block Design and Picture Arrangement subtests of the Thechsler Adult Intelligence Scale, the Halstead Reitan Battery, the Rey Auditory-Verbal learning test, TOVA, and the Peabody Individual Achievement test.

LONG TERM HOSPITAL CRITERIA

Level I

*Must meet **one or more** Severities of Illness with the corresponding Intensities of Service.*

Severity of Illness

1. Respiratory dysfunction associated with inability to maintain physiological ventilation or functional level without need for mechanical support requiring **at least four** of the following Intensities of Service.

Intensity of Service

1a. Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress

1b. Respiratory therapy requiring licensed respiratory therapist for observation, monitoring, and maintenance of mechanical ventilatory support
1c. Use of continuous monitoring devices
1d. Suctioning at least every two hours
1e. Pulmonary hygiene with bronchodilators at least every six hours

Severity of Illness

2. Impaired integument (i.e., infected and/or necrotic skin conditions, Stage III or IV decubiti, multiple decubiti, surgical wounds, burns) requiring any **two or more** of the following Intensities of Service.

Intensity of Service

2a. Complex dressing changes using aseptic technique with the application of topical medications at least every eight hours
2b. IV or IM medications administered at least every eight hours or per therapeutic regime
2c. IM or IV antibiotics or antifungals per therapeutic regime
2d. Daily whirlpool therapy
2e. Wound management requiring 24-hour observation/monitoring and positioning every two hours by a licensed nurse
2f. Wound debridement/dressing changes requiring IM or IV analgesic
2g. Patient/family education related to initial phases of patient care
2h. Hyperbaric oxygen or magnetic resonance therapy treatment at least daily

Severity of Illness

3. Unstable medical condition requiring **at least three** of following Intensities of Service.

Intensity of Service

3a. Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress, clinical complications, and/or cardiac signs and symptoms
3b. IV or IM medication administered at least every eight hours or therapeutic regime
3c. IM or IV antibiotics or antifungals per therapeutic regime
3d. Use of continuous monitoring devices
3e. Licensed respiratory therapist providing respiratory treatment at least every eight hours

3f. Surgical and/or invasive procedure
3g. Post-operative care with or without associated complications
3h. IV fluids (other than "keep open") and/or blood/blood component administration
3i. Monitoring of two of the following every four hours:

a. VS - temperature, pulse, respirations, BP
b. Lab values/drug levels
c. Neurovital signs
d. Neurovascular checks - skin color, motor and sensory functions
e. Central pressure monitoring
f. Intake and output

Severity of Illness

4. Mobility/neurological/cognitive impairment or rehabilitation condition (i.e., seizure, toxin exposure, head injury-trauma) not due to psychiatric disorder with documented potential for improvement which no longer would qualify for an acute rehabilitation program requiring **at least three** of the following Intensities of Service.

Intensity of Service

4a. One hour of physical therapy per day at least five days per week
4b. One hour of occupational therapy per day at least five days per week
4c. One hour of speech pathology per day at least five days per week
4d. Observation and monitoring by a licensed nurse
4e. Specialized studies related to assessment and treatment of cognitive dysfunction

Severity of Illness

5. Infectious process with the inability to perform ADLs requiring **at least two** of the following Intensities of Service.

Intensity of Service

5a. IV or IM medications administered at least every eight hours or per therapeutic regime
5b. IM or IV antibiotics or antifungals per therapeutic regime
5c. Category-specific isolation
5d. Initiation of specialized treatment modalities, observation and monitoring by licensed nurse

Level II

*Must meet **two or more** Severities of Illness with the corresponding Intensities of Service*

Severity of Illness

1. Respiratory dysfunction associated with the inability to maintain physiological ventilation or functional level and/or the inability to perform ADLs without the need for mechanical support requiring **at least three** of the following Intensities of Service.

   Intensity of Service

   1a. Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress
   1b. Respiratory therapy requiring licensed respiratory therapist for observation, monitoring, and maintenance of mechanical ventilatory support
   1c. Use of continuous monitoring devices
   1d. Suctioning at least every two hours
   1e. Pulmonary hygiene with bronchodilators at least every six hours

Severity of Illness

2. Mobility dysfunction necessitating the initial phase of training in stump care requiring **all** of the following Intensities of Service.

   Intensity of Service

   2a. One hour of rehabilitation therapy, at least five days per week, with established goals
   2b. 24-hour observation and monitoring by a licensed nurse
   2c. Patient/family education related to initial phases of patient care

Severity of Illness

3. Elimination dysfunction secondary to neurological or surgical changes requiring **at least two** of the following Intensities of Service.

   Intensity of Service

   3a. Intermittent catheterizations at least twice per day
   3b. Implementation and monitoring of specified medication regimens

3c. 24-hour observation and monitoring by a licensed nurse
3d. Initial stages of extensive bowel and bladder retraining
3e. Initial instruction in self-care of ostomy or suprapubic catheter, or patient/family education related to initial phases of patient care

Severity of Illness

4. Impaired Integument (infected and/or necrotic skin conditions Stage III or IV decubiti, multiple decubiti, surgical wounds, burns) requiring **one or more** of the following Intensities of Service.

Intensity of Service

4a. Complex dressing changes using aseptic technique with the application of topical medications at least every eight hours
4b. IV or IM medications administered at least every eight hours or per therapeutic regime
4c. IM or IV antibiotics or antifungals per therapeutic regime
4d. Daily whirlpool therapy
4e. Wound management requiring 24-hour observation/monitoring and positioning every two hours by a licensed nurse
4f. Wound debridement/dressing changes requiring IM or IV analgesic
4g. Hyperbaric oxygen or magnetic resonance therapy treatment at least daily
4h. Patient/family education related to initial phases of patient care

Severity of Illness

5. Mobility/neurological/cognitive impairment or rehabilitation condition (i.e., seizure, toxin exposure, head injury-trauma) not due to psychiatric disorder associated with the inability to perform ADLs requiring the following Intensity of Service.

Intensity of Service

5a. At least two hours of rehabilitation therapy per day at least five days per week with established goals

Severity of Illness

6. Inadequate maintenance of nutritional status with potential for improvement or stabilization requiring **at least one** of the following Intensities of Service.

Intensity of Service

6a. Parenteral hyperalimentation
6b. Dysphagia studies and treatment

Severity of Illness

7. Unstable medical condition requiring **at least two** of the following Intensities of Service.

Intensity of Service

7a. Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress, clinical complications, and/or cardiac signs and symptoms
7b. IM or IV medications administration at least every eight hours or per therapeutic regime
7c. IM or IV antibiotics or antifungals per therapeutic regime
7d. Licensed respiratory therapist providing respiratory treatment at least every eight hours
7e. Use of intermittent monitoring devices
7f. IV fluids (other than "keep open") and/or blood/blood component administration
7g. Monitoring of two of the following every four hours:

a. VS - temperature, pulse, respirations, BP
b. Lab values/drug levels
c. Neurovital signs
d. Neurovascular checks - skin color, motor and sensory functions
e. Central pressure monitoring
f. Intake and output

7h. Surgical and/or invasive procedure or post-operative care with or without associated complications.

Severity of Illness

8. Infectious process requiring **at least one** of the following Intensities of Service.

Intensity of Service

8a. IV or IM medications administered at least every eight hours or per therapeutic regime
8b. IM or IV antibiotics or antifungals per therapeutic regime
8c. Specialized treatment modalities, observation and monitoring by licensed nurse
8d. Category specific isolation

Level III
*Must meet **three or more** of the following Severities of Illness with corresponding Intensities of Service*

Severity of Illness

1. Respiratory dysfunction associated with the inability to perform ADLs requiring **at least two** of the following Intensities of Service.

Intensity of Service

1a. Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress
1b. Pulmonary hygiene with bronchodilators at least every six hours
1c. Use of continuous monitoring devices
1d. Suctioning at least every two hours
1e. Licensed nursing and respiratory care education in self-care of a tracheostomy or other pulmonary related procedures, equipment, and treatments

Severity of Illness

2. Mobility dysfunction necessitating the initial phase of training in stump care requiring **all** of the following Intensities of Service.

Intensity of Service

2a. Two hours of rehabilitation therapy at least five days per week with established goals
2b. 24-hour observation and monitoring by a licensed nurse
2c. Patient/family education related to initial phases of patient care

Severity of Illness

3. Mobility dysfunction necessitating training in the maintenance and use of prosthesis requiring **all** of the following Intensities of Service.

Intensity of Service

3a. Two hours of rehabilitation therapy at least five days per week with established goals
3b. 24-hour observation and monitoring by a licensed nurse
3c. Patient/family education related to initial phases of patient care

Severity of Illness

4. Elimination dysfunction secondary to neurological or surgical changes requiring **at least two** of the following Intensities of Service.

Intensity of Service

4a. Intermittent catheterizations at least twice per day
4b. Implementation and monitoring of specified medication regimens
4c. 24-hour observation and monitoring by a licensed nurse
4d. Initial stages of extensive bowel and bladder retraining
4e. Continued observation and education in self-care of an ostomy or suprapubic catheters, or patient/family education related to initial phases of patient care by a licensed nurse

Severity of Illness

5. Impaired integument (infected and/or necrotic skin conditions Stage III or IV decubiti, multiple decubiti, surgical wounds, burns) requiring **at least two** of the following Intensities of Service.

Intensity of Service

5a. Complex dressing changes using aseptic technique with the application of topical medications at least every eight hours
5b. IV or IM medications administered at least every eight hours or per therapeutic regime
5c. IM or IV antibiotics or antifungals per therapeutic regime

5d. Daily whirlpool therapy
5e. Wound management requiring 24-hour observation/monitoring and positioning every two hours by a licensed nurse
5f. Patient/family education related to initial phases of patient care
5g. Hyperbaric oxygen or magnetic resonance therapy treatment at least daily

Severity of Illness

6. Unstable medical condition requiring **at least two** of the following Intensities of Service.

Intensity of Service

6a. Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress, clinical complications, and/or cardiac signs and symptoms
6b. IM or IV medications at least every eight hours or per therapeutic regime
6c. IM or IV antibiotics or antifungals per therapeutic regime
6d. Licensed respiratory therapist providing respiratory treatment at least every eight hours
6e. Instruction in the use of medications and treatment with licensed nursing observation and monitoring
6f. IV fluids (other than "keep open") and/or blood/blood component administration
6g. Monitoring of two of the following every four hours:

a. VS - temperature, pulse, respirations, BP
b. Lab values/drug levels
c. Neurovital signs
d. Neurovascular checks - skin color, motor and sensory functions
e. Central pressure monitoring
f. Intake and output

6h. Surgical and/or invasive procedure or post-operative care with or without associated complications.

Severity of Illness

7. Mobility/neurological/cognitive impairment or rehabilitation condition (i.e., seizure, toxin exposure, head injury-trauma) not due to psychiatric disorder associated with the inability to perform ADLs requiring the following Intensity of Service.

Intensity of Service

7a. One hour of rehabilitation therapy per day at least five days per week with established goals to include at least one hour of physical therapy

Severity of Illness

8. Inadequate maintenance of nutritional status with the potential for improvement or stabilization requiring **at least one** of the following Intensities of Service.

Intensity of Service

8a. IV fluids other than a "keep open" rate
8b. Initiation and/or stabilization of enteral feedings
8c. Assessment of nutritional status, initiation and/or stabilization of a special diet by a multi-disciplinary team of licensed professionals

Severity of Illness

9. Infectious process requiring **one** of the following Intensities of Service.

Intensity of Service

9a. IM or IV medications at least every eight hours or per therapeutic regime
9b. IM or IV antibiotics or antifungals per therapeutic regime
9c. Specialized treatment modalities

Long Term Hospital Discharge Criteria

1. Patient refuses further treatment.

2. Patient's clinical condition remains stable and functional status is unchanged for 21 days.

3. Patient and/or family members demonstrate ability to care for patient's physical/ medical home care regime.

4. Documented evidence by physical therapy, speech therapy, and occupational therapy that the patient has reached maximum hospital benefit with no potential for further improvement.

5. Documented evidence that the patient has achieved stated goals.

6. Documented evidence of no change in pulmonary condition, mechanical ventilator parameters stabilized within a safe and appropriate range, and no potential for further improvement.

   A. Fi02 of 28% or less for 14 days
   B. Absence of pressure support of greater than 5cm for 30 days
   C. No changes in ventilator parameters for 30 days
   D. No incidence of mucus plugging or other untoward complications for 30 days
   E. No introduction of respiratory depressant medications within 14 days.

7. Documented evidence that an adequate, less intense level of care is available.

LONG TERM HOSPITAL LENGTH OF STAY CRITERIA

It is the hospital's responsibility to provide Unisys with the specific information necessary for the case review nurse to determine that the patient meets length of stay criteria as specified on this form. Include the following items from the medical record: 1) ED record (if any), 2) admit note, 3) physician's orders, and 4) applicable progress notes.

NAME:	CASE #:
MEDICAID ID#:	CUSTODY:
ICD CODE #	

ADMISSION/EXTENSION REQUIREMENT: Level I: Patients must meet **ONE** Severity of Illness with **ALL** corresponding Intensities of Service. Level II: Patients must meet **TWO** Severities of Illness with **ALL** corresponding Intensities of Service. Level III: Patients must meet **THREE** Severities of Illness with **ALL** corresponding Intensities of Service.

LEVEL I

(Must meet **one or more** Severities of Illness with the corresponding Intensities of Service)

Severity of Illness

☐ 1. **Respiratory dysfunction** associated with the inability to maintain physiological ventilation or functional level without the need for mechanical support requiring at least **four** of the following Intensities of Service.

Intensity of Service

- ☐ **1a.** Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress
- ☐ **1b.** Respiratory therapy requiring licensed respiratory therapist for observation, monitoring, and maintenance of mechanical ventilatory support
- ☐ **1c.** Use of continuous monitoring devices
- ☐ **1d.** Suctioning at least every two hours
- ☐ **1e.** Pulmonary hygiene with bronchodilators at least every six hours

Specifics:_____

_____

Severity of Illness

☐ 2. **Impaired integument** (i.e., infected and/or necrotic skin conditions, Stage III or IV decubiti, multiple decubiti, surgical wounds, burns) requiring any **two or more** of the following Intensities of Service.

Intensity of Service

- ☐ **2a.** Complex dressing changes using aseptic technique with the application of topical medications every eight hours
- ☐ **2b.** IV or IM medications administered at least every eight hours or per therapeutic regime
- ☐ **2c.** IM or IV antibiotics or antifungals per therapeutic regime
- ☐ **2d.** Daily whirlpool therapy
- ☐ **2e.** Wound management requiring 24-hour observation/monitoring and positioning every two hours by a licensed nurse
- ☐ **2f.** Wound debridement/dressing changes requiring IM or IV analgesic
- ☐ **2g.** Patient/family education related to initial phases of patient care
- ☐ **2h.** Hyperbaric oxygen or magnetic resonance therapy treatment at least daily

Specifics:_____

_____

Figure 7-2. Long Term Hospital Length of Stay Criteria Form (Page 1 of 7)

LONG TERM HOSPITAL LENGTH OF STAY CRITERIA page 2

Severity of Illness

☐ 3. **Unstable medical** condition requiring at least at least three of the following Intensities of Service.

Intensity of Service

- ☐ 3a. Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress, clinical complications, and/or cardiac signs and symptoms
- ☐ 3b. IV or IM medications administered at least every eight hours or per therapeutic regime
- ☐ 3c. IM or IV antibiotics or antifungals per therapeutic regime
- ☐ 3d. Use of continuous monitoring devices
- ☐ 3e. Licensed respiratory therapist providing respiratory treatment at least every eight hours
- ☐ 3f. Surgical and/or invasive procedure
- ☐ 3g. Post-operative care with or without associated complications
- ☐ 3h. IV fluids (other than "keep open") and/or blood/blood component administration
- ☐ 3i. Monitoring of **TWO** of the following every four hours:
  - ☐ a. VS - temperature, pulse, respirations, BP
  - ☐ b. Lab values/drug levels
  - ☐ c. Neurovital signs
  - ☐ d. Neurovascular checks - skin color, motor and sensory functions
  - ☐ e. Central pressure monitoring
  - ☐ f. Intake and output

Specifics:_____

Severity of Illness

☐ 4. **Mobility/neurological/cognitive** impairment or rehabilitation condition (i.e., seizure, toxin exposure, head injury-trauma) not due to psychiatric disorder with documented potential for improvement which no longer would quality for an acute rehabilitation program requiring at least three of the following Intensities of Service.

Intensity of Service

- ☐ 4a. One hour of physical therapy per day at least five days per week
- ☐ 4b. One hour of occupational therapy per day at least five days per week
- ☐ 4c. One hour of speech pathology per day at least five days per week
- ☐ 4d. Observation and monitoring by a licensed nurse
- ☐ 4e. Specialized studies related to assessment and treatment of cognitive dysfunction

Specifics:_____

Severity of Illness

☐ 5. **Infectious process** with the inability to perform ADLs requiring at least two of the following Intensities of Service.

Intensity of Service

- ☐ 5a. IV or IM medications administered at least every eight hours or per therapeutic regime
- ☐ 5b. IM or IV antibiotics or antifungals per therapeutic regime
- ☐ 5c. Category-specific isolation
- ☐ 5d. Initiation of specialized treatment modalities, observation, and monitoring by licensed nurse

Figure 7-2. Long Term Hospital Length of Stay Criteria Form (Page 2 of 7)

LONG TERM HOSPITAL LENGTH OF STAY CRITERIA page 3

LEVEL II

(Must meet two or more criteria from Severity of Illness with the corresponding Intensities of Service)

Severity of Illness

☐ 1. **Respiratory dysfunction** associated with the inability to maintain physiological ventilation or functional level and/or the inability to perform ADLs without the need for mechanical support requiring at least three of the following Intensities of Service.

Intensity of Service

- ☐ 1a. Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress
- ☐ 1b. Respiratory therapy requiring licensed respiratory therapist for observation, monitoring, and maintenance of mechanical ventilatory support
- ☐ 1c. Use of continuous monitoring devices
- ☐ 1d. Suctioning at least every two hours
- ☐ 1e. Pulmonary hygiene with bronchodilators at least every six hours

Specifics:_____

Severity of Illness

☐ 2. **Mobility dysfunction** necessitating the initial phase of training in stump care requiring all of the following Intensities of Service.

Intensity of Service

- ☐ 2a. One hour of rehabilitation therapy at least five days per week with established goals
- ☐ 2b. 24-hour observation and monitoring by a licensed nurse
- ☐ 2c. Patient/family education related to initial phases of patient care

Specifics:_____

Severity of Illness

☐ 3. **Elimination dysfunction** secondary to neurological or surgical changes requiring at least two of the following Intensities of Service.

Intensity of Service

- ☐ 3a. Intermittent catheterizations at least twice per day
- ☐ 3b. Implementation and monitoring of specified medication regimens
- ☐ 3c. 24-hour observation and monitoring by a licensed nurse
- ☐ 3d. Initial stages of extensive bowel and bladder retraining
- ☐ 3e. Initial instruction in self-care of an ostomy or suprapubic catheter, or patient/family education related to initial phases of patient care

Specifics:_____

Severity of Illness

☐ 4. **Impaired Integument** (infected and/or necrotic skin conditions Stage III or IV decubiti, multiple decubiti, surgical wounds, burns) requiring one or more of the following Intensities of Service.

Intensity of Service

- ☐ 4a. Complex dressing changes using aseptic technique with application of topical medications every eight hours
- ☐ 4b. IV or IM medications administered at least every eight hours or per therapeutic regime
- ☐ 4c. IM or IV antibiotics or antifungals per therapeutic regime
- ☐ 4d. Daily whirlpool therapy
- ☐ 4e. Wound management requiring 24-hour observation/monitoring and positioning every two hours by a licensed nurse
- ☐ 4f. Wound debridement/dressing changes requiring IM or IV analgesic
- ☐ 4g. Hyperbaric oxygen or magnetic resonance therapy treatment at least daily
- ☐ 4h. Patient/family education related to initial phases of patient care

Specifics:_____

Figure 7-2. Long Term Hospital Length of Stay Criteria Form (Page 3 of 7)

LONG TERM HOSPITAL LENGTH OF STAY CRITERIA page 4

Severity of Illness

☐ 5. **Mobility/neurological/cognitive** impairment or rehabilitation condition (i.e., seizure, toxin exposure, head injury-trauma) not due to psychiatric disorder associated with the inability to perform ADLs requiring the following Intensity of Service.

Intensity of Service

☐ 5a. At least two hours of rehabilitation therapy per day at least five days per week with established goals

Specifics:_____

Severity of Illness

☐ 6. **Inadequate maintenance of nutritional status** with potential for improvement or stabilization requiring at least one of the following Intensities of Service.

Intensity of Service

☐ 6a. Parenteral hyperalimentation
☐ 6b. Dysphagia studies and treatment

Specifics:_____

Severity of Illness

☐ 7. **Unstable medical condition** requiring **at least two** of the following Intensities of Service.

Intensity of Service

☐ 7a. Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress, clinical complications, and/or cardiac signs and symptoms
☐ 7b. IM or IV medications administration at least every eight hours or per therapeutic regime
☐ 7c. IM or IV antibiotics or antifungals per therapeutic regime
☐ 7d. Licensed respiratory therapist providing respiratory treatment at least every eight hours
☐ 7e. Use of intermittent monitoring devices
☐ 7f. IV fluids (other than "keep open") and/or blood/blood component administration
☐ 7g. Monitoring of TWO of the following every four hours:
  ☐ a. VS - temperature, pulse, respirations, BP
  ☐ b. Lab values/drug levels
  ☐ c. Neurovital signs
  ☐ d. Neurovascular checks - skin color, motor and sensory functions
  ☐ e. Central pressure monitoring
  ☐ f. Intake and output
☐ 7h. Surgical and/or invasive procedure or post-operative care with or without associated complications

Specifics:_____

Severity of Illness

☐ 8. **Infectious process** requiring **at least one** of the following Intensities of Service.

Intensity of Service

☐ 8a. IV or IM medications administered at least every eight hours or per therapeutic regime
☐ 8b. IM or IV antibiotics or antifungals per therapeutic regime
☐ 8c. Specialized treatment modalities, observation and monitoring by licensed nurse
☐ 8d. Category-specific isolation

Specifics:_____

Figure 7-2. Long Term Hospital Length of Stay Criteria Form (Page 4 of 7)

LONG TERM HOSPITAL LENGTH OF STAY CRITERIA page 5

LEVEL III

(Must meet three or more criteria from Severity of Illness with the corresponding Intensity of Service)

Severity of Illness

☐ 1. Respiratory dysfunction associated with the inability to perform ADLs requiring at least two of the following Intensities of Service.

Intensity of Service

- ☐ 1a. Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress
- ☐ 1b. Pulmonary hygiene with bronchodilators at least every six hours
- ☐ 1c. Use of continuous monitoring devices
- ☐ 1d. Suctioning at least every two hours
- ☐ 1e. Licensed nursing and respiratory care education in self-care of a tracheostomy or other pulmonary related procedures, equipment, and treatments

Specifics: _____

Severity of Illness

☐ 2. Mobility dysfunction necessitating the initial phase of training in stump care requiring all of the following Intensities of Service.

Intensity of Service

- ☐ 2a. Two hours of rehabilitation therapy at least five days per week with established goals
- ☐ 2b. 24-hour observation and monitoring by a licensed nurse
- ☐ 2c. Patient/family education related to initial phases of patient care

Specifics: _____

Severity of Illness

☐ 3. Mobility dysfunction necessitating training in the maintenance and use of prosthesis requiring all of the following Intensities of Service.

Intensity of Service

- ☐ 3a. Two hours of rehabilitation therapy at least five days per week with established goals
- ☐ 3b. 24-hour observation and monitoring by a licensed nurse
- ☐ 3c. Patient/family education related to initial phases of patient care

Specifics: _____

Severity of Illness

☐ 4. Elimination dysfunction secondary to neurological or surgical changes requiring at least two of the following Intensities of Service.

Intensity of Service

- ☐ 4a. Intermittent catheterizations at least twice per day
- ☐ 4b. Implementation and monitoring of specified medication regimens
- ☐ 4c. 24-hour observation and monitoring by a licensed nurse
- ☐ 4d. Initial stages of extensive bowel and bladder retraining
- ☐ 4e. Continued observation and education in self-care of an ostomy or suprapubic catheters, or patient/family education related to initial phases of patient care by a licensed nurse

Specifics: _____

Figure 7-2. Long Term Hospital Length of Stay Criteria Form (Page 5 of 7)

LONG TERM HOSPITAL LENGTH OF STAY CRITERIA page 6

Severity of Illness

☐ 5. **Impaired Integument** (infected and/or necrotic skin conditions Stage III or IV decubiti, multiple decubiti, surgical wounds, burns) requiring **at least two** or more of the following Intensities of Service.

Intensity of Service

- ☐ 5a. Complex dressing changes using aseptic technique with the application of topical medications every eight hours
- ☐ 5b. IV or IM medications administered at least every eight hours or per therapeutic regime
- ☐ 5c. IM or IV antibiotics or antifungals per therapeutic regime
- ☐ 5d. Daily whirlpool therapy
- ☐ 5e. Wound management requiring 24-hour observation/monitoring and positioning every two hours by a licensed nurse
- ☐ 5f. Patient/family education related to initial phases of patient care
- ☐ 5g. Hyperbaric oxygen or magnetic resonance therapy treatment at least daily

Specifics:_____

Severity of Illness

☐ 6. **Unstable medical** condition requiring **at least two** of the following Intensities of Service.

Intensity of Service

- ☐ 6a. Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress, clinical complications, and/or cardiac signs and symptoms
- ☐ 6b. IM or IV medications at least every eight hours or per therapeutic regime
- ☐ 6c. IM or IV antibiotics or antifungals per therapeutic regime
- ☐ 6d. Licensed respiratory therapist providing respiratory treatment at least every eight hours
- ☐ 6e. Instruction in the use of medications and treatment with licensed nursing observation and monitoring
- ☐ 6f. IV fluids (other than "keep open") and/or blood/blood component administration
- ☐ 6g. Monitoring of **TWO** of the following every four hours:
  - ☐ a. VS - temperature, pulse, respirations, BP
  - ☐ b. Lab values/drug levels
  - ☐ c. Neurovital signs
  - ☐ d. Neurovascular checks - skin color, motor and sensory functions
  - ☐ e. Central pressure monitoring
  - ☐ f. Intake and output
- ☐ 6h. Surgical and/or invasive procedure or post-operative care with or without associated complications

Specifics:_____

Severity of Illness

☐ 7. **Mobility/neurological/cognitive** impairment or rehabilitation condition (i.e., seizure, toxin exposure, head injury-trauma) not due to psychiatric disorder associated with the inability to perform ADLs requiring the following intensity of service.

Intensity of Service

- ☐ 7a. One hour of rehabilitation therapy per day at least five days per week with established goals to include at least one hour of physical therapy

Specifics:_____

Figure 7-2. Long Term Hospital Length of Stay Criteria Form (Page 6 of 7)

LONG TERM HOSPITAL LENGTH OF STAY CRITERIA page 7

Severity of Illness

☐ 8. **Inadequate maintenance of nutritional status** with the potential for improvement or stabilization requiring **at least one** of the following Intensities of Service.

Intensity of Service

- ☐ **8a.** IV fluids other than a "keep open" rate
- ☐ **8b.** Initiation and/or stabilization of enteral feedings
- ☐ **8c.** Assessment of nutritional status, initiation and/or stabilization of a special diet by a multidisciplinary team of licensed professionals

Specifics:_____

_____

Severity of Illness

☐ 9. **Infectious process** requiring **one** of the following Intensities of Service.

Intensity of Service

- ☐ **9a.** IM or IV medications at least every eight hours or per therapeutic regime
- ☐ **9b.** IM or IV antibiotics or antifungals per therapeutic regime
- ☐ **9c.** Specialized treatment modalities

Specifics:_____

_____

EXCLUSIONARY CRITERIA

If patient meets **one or more** of the following criteria, continued stay of care is denied.

- ☐ 1. Patient does not require 24-hour physician coverage (can include physical medicine and rehabilitation specialist)
- ☐ 2. Patient requires custodial services
- ☐ 3. Patient could be treated on an outpatient basis or lower level of care (rehab services three times per week or less to achieve optimal level of functioning)
- ☐ 4. Patient is unstable for transfer, in which transfer could result in further deterioration or death
- ☐ 5. Patient is terminally ill with less than six-month survival rate and has requested no medical intervention for the disease process
- ☐ 6. Patient has severe neurobehavioral disorder requiring a locked ward or specialized treatment team (i.e., Alzheimer's Disease, s/p head injury or toxin exposure).

DISCHARGE CRITERIA

Patient must meet **at least one** to be released.

- ☐ 1. Patient refuses further treatment
- ☐ 2. Patient's clinical condition remains stable and functional status remains unchanged for 21 days
- ☐ 3. Patient and/or family members demonstrate ability to care for patient's physical/medical home care regime
- ☐ 4. Documented evidence by physical therapy, speech therapy, and occupational therapy that the patient has reached maximum hospital benefit with no potential for further improvement
- ☐ 5. Documented evidence that the patient has achieved stated goals
- ☐ 6. Documented evidence of no change in pulmonary condition, mechanical ventilator parameters stabilized within a safe and appropriate range, and there is no potential for further improvement
  - ☐ **A.** Fi02 of 28% or less for 14 days
  - ☐ **B.** Absence of pressure support of greater than 5 cm for 30 days
  - ☐ **C.** No changes in ventilator parameters for 30 days
  - ☐ **D.** No incidence of mucus plugging or other untoward complications for 30 days
  - ☐ **E.** No introduction of respiratory depressant medications within 14 days
- ☐ 7. Documented evidence that an adequate less intense level of care is available

Figure 7-2. Long Term Hospital Length of Stay Criteria Form (Page 7 of 7)

DISTINCT PART PSYCHIATRIC UNIT

A DSM-III-R diagnosis is a mental disorder diagnosis as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders: Third Edition, Revised*, as published by the American Psychiatric Association. (Note: Upon the publication of any future editions of the DSM, the most current version will be used for admission/continued stay determination.)

ADMISSION CRITERIA FOR ADULTS

Severity of Illness
*Must meet **one or more** of 1, 2, or 3*

1. Patient presents as a danger to self as evidenced by **one or more** of the following:

   A. Recent (within the past 72 hours) suicide attempt
   B. Documentation that the patient has a current suicide plan, specific suicide intent, or recurring suicidal ideation
   C. Documentation of self-mutilative behavior (occurring within the past 72 hours).

OR

2. Patient presents a danger to others due to a DSM-III-R Axis I diagnosis as evidenced by **one or more** of the following:

   A. Dangerously aggressive behavior during the past seven days due to a DSM-III-R Axis I diagnosis
   B. Threats to kill or seriously injure another person with the means to carry out the threat AND the threatening behavior is due to a DSM-III-R Axis I diagnosis
   C. Documentation that the patient has a current homicide plan, specific homicidal intent, or recurrent homicidal ideation, AND this is due to a DSM-III-R Axis I diagnosis.

OR

3. Patient is gravely disabled and unable to care for self due to DSM-III-R Axis I diagnosis as evidenced by the following **(a selection of indicator A must be accompanied by B or C)**:

   A. Documentation of a serious impairment in function (as compared to others of the same age) in one or more major life roles (school, job, family, interpersonal relations, self-care) due to a DSM-III-R Axis I diagnosis

AND (Indicator A must be accompanied by B **OR** C)

B. Inability of patient to comply with prescribed psychiatric and/or medical health regimens as evidenced by the following:

1) Patient has a history of decompensation without psychotropic medications and patient refuses to use these medications as an outpatient
2) Patient is at risk of health or life due to non-compliance with medical regimens (e.g., insulin-dependent diabetes, etc.) and refuses medical regimens as an outpatient.

OR

C. Patient presents with acute onset or acute exacerbation of hallucinations, delusions, or illusions of such magnitude that the patient's well being is threatened.

Intensity of Service
Must meet all

1. Ambulatory (outpatient) care resources in the community do not meet and/or do not exist to meet the treatment needs of the patient, or the patient has been unresponsive to treatment at a less intensive level of care.

AND

2. Services provided in the hospital can reasonably be expected to improve the patient's condition or prevent further regression so that patient will no longer need the services.

AND

3. Treatment of the patient's psychiatric condition requires services on an inpatient hospital basis requiring 24-hour nursing observation under the direction of a psychiatrist, such as, but not limited to

A. Suicide precautions, unit restrictions, and continuous observation and limiting of behavior to protect self or others **(Patients requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or responsible other.)**

B. Active intervention by a psychiatric team to prevent assaultive behavior **(Patients requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or responsible other.)**
C. Patient exhibits behaviors that indicate that a therapeutic level of medication has not been reached and this necessitates 24-hour observation and medication stabilization **(Patients requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or responsible other.)**

Exclusionary Criteria

The following categories of patients are not appropriate for admission to a distinct part psychiatric unit.

1. Patients with a major medical or surgical illness or injury that would prevent active participation in a psychiatric treatment program (patients must be medically stable)

2. Patients with criminal charges who do not have a DSM-III-R Axis I diagnosis

3. Patients whose anti-social behaviors are a danger to others and those anti-social behaviors are characterological rather than due to a DSM-III-R Axis I diagnosis

4. Patients who have a DSM-III-R Axis II diagnosis of mental retardation without an accompanying DSM-III-R Axis I diagnosis.

EXTENSION CRITERIA FOR ADULTS

Severity of Illness
*Must continue to meet **one or more** of 1, 2 or 3*

1. Patient presents as a danger to self as evidenced by **one or more** of the following:

   A. Documentation that the patient continues to have a current suicide plan, specific suicide intent, recurring suicidal ideation, or suicide attempts
   B. Documentation of continuing self-mutilative behavior as a result of a psychiatric disorder.

OR

2. Patient presents as a danger to others due to a DSM-III-R Axis I diagnosis as evidenced by **one or more** of the following:

   A. Documentation that patient continues to display dangerously aggressive behavior due to a DSM-III-R Axis I diagnosis
   B. Documentation that patient continues to threaten to kill or seriously injure another person with the means to carry out the threat AND the threatening behavior is due to a DSM-III-R Axis I diagnosis
   C. Documentation that the patient continues to have a current homicide plan, specific homicidal intent, or recurrent homicidal ideation AND this is due to a DSM-III-R Axis I diagnosis.

OR

3. Patient is gravely disabled and unable to care for self due to a DSM-III-R Axis I diagnosis as evidenced by the following **(selection of indicator A must be accompanied by B or C)**:

   A. Documentation of a continuing serious impairment in function (as compared to others of the same age) in one or more major life roles (school, job, family, interpersonal relations, self-care, etc.) due to a DSM-III-R Axis I diagnosis

   AND (A must be accompanied by B **OR** C)

   B. Documentation of the continuing inability of the patient to comply with prescribed psychiatric and/or medical health regimens as evidenced by each of the following:

      1) Patient has a history of decompensation without psychotropic medications and continues to refuse these medications
      2) Patient is at risk of health or life due to non-compliance with medical regimens (e.g., insulin-dependent diabetes, etc.) and continues to refuse these regimens.

   OR

   C. Documentation that patient continues to present with exacerbation of hallucinations, delusions, or illusions of such magnitude that the patient's well being is threatened.

Intensity of Service

Patient continues to require an intensity of service requiring services on an inpatient hospital basis under the direction of a psychiatrist such as, but not limited to

1. Suicide precautions, unit restrictions, and continual observation and limiting of behavior to protect self or others **(Patients requiring the above treatments must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or responsible other.)**

2. Active intervention by a psychiatric team to prevent assaultive behavior **(Patients requiring the above treatments must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or responsible other.)**

3. The patient continues to exhibit behaviors that indicate that a therapeutic level of medication has not been reached and this necessitates continued 24-hour observation and medication stabilization. **(Patients requiring the above treatments must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or a responsible other.)**

4. Services in the community do not exist or do not meet the patient's treatment needs, or the patient has been unresponsive to treatment at a less intensive level of care. (Services considered tried, and/or needed must be documented.)

5. Services provided in the hospital can reasonably be expected to improve the patient's condition or prevent further regression so that the patient will no longer need the services.

6. Treatment of the patient's psychiatric condition requires services on an inpatient basis, including 24-hour nursing observation, under the direction of a psychiatrist. **(Patients requiring the above treatments must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or a responsible other.)** These services include, but are not limited to

   A. Suicide precautions, unit restrictions, and continuous observation and limiting of behavior to protect self or others or property.
   B. Active intervention by a psychiatric team to prevent assaultive behavior.
   C. 24-hour observation and medication stabilization because the patient exhibits behaviors that indicate a therapeutic level of medication has not been reached.

Discharge Criteria
*Must meet **at least one***

1. Non-compliance with treatment program within three days of admission
2. No improvement within seven days of admission
3. Type/dosage of psychotropics unchanged in last two days
4. Documented by physician that maximum hospital benefit attained
5. Ability to appropriately control behavior
6. Alternative placement/follow-up care arranged
7. Ability to function cooperatively in hospital environment/community.

DISTINCT PART PSYCHIATRIC UNIT ADMISSION/EXTENSION CRITERIA FOR ADULTS

It is the hospital's responsibility to provide Unisys with the specific information necessary for the case review nurse/LMHP to determine that the patient meets admission criteria as specified on this form. Include the following from the medical record: 1) ED record (if any), 2) admit note, 3) physician's orders, and 4) applicable progress notes.

NAME:	CASE #:
MEDICAID ID:	
ICD CODE # (MUST correspond to a DSM-III-R Diagnosis):	

ADMISSION/EXTENSION REFERRAL CRITERIA: At least ONE Severity of Illness Criteria must be met. **ALL** Intensity of Service Criteria must be met. No Exclusionary Criteria will be met.

SEVERITY OF ILLNESS CRITERIA

(Must meet **one or more** of 1, 2, or 3)

☐ 1. Patient presents as a **danger to self** as evidenced by **one or more** of the following:

- ☐ A. Recent (within the past 72 hours) suicide attempt
- ☐ B. Documentation that the patient has a current suicide plan, specific suicide intent, or recurring suicidal ideation
- ☐ C. Documentation of self-mutilative behavior (occurring within the past 72 hours).

Specifics: _____

☐ 2. Patient presents as a **danger to others** due to a DSM-III-R Axis I diagnosis as evidenced by **one or more** of the following:

- ☐ A. Dangerously aggressive behavior during the past seven days due to a DSM-III-R Axis I diagnosis
- ☐ B. Threats to kill or seriously injure another person with the means to carry out the threat AND the threatening behavior is due to a DSM-III-R Axis I diagnosis
- ☐ C. Documentation that the patient has a current homicide plan, specific homicidal intent, or recurrent homicidal ideation AND this is due to a DSM-III-R Axis I diagnosis.

Specifics: _____

☐ 3. Patient is **gravely disabled and unable to care for self** due to a DSM-III-R Axis I diagnosis as evidenced by the following (**a selection of indicator A must be accompanied by B or C**):

- ☐ A. Documentation of a serious impairment in function (as compared to others of the same age) in one or more major life role (school, job, family, interpersonal relations, self-care, etc.) due to a DSM-III-R Axis I diagnosis

AND (Indicator A must be accompanied by B OR C)

- ☐ B. Inability of patient to comply with prescribed psychiatric and/or medical health regimens as evidenced by the following:
  1) Patient has a history of decompensation without psychotropic medications and patient refuses to use these medications as an outpatient
  2) Patient is at risk of health or life due to non-compliance with medical regimens (e.g., insulin-dependent diabetes, etc.) and patient refuses these medical regimens as an outpatient.

OR

- ☐ C. Patient presents with acute onset or acute exacerbation of hallucinations, delusions, or illusions of such magnitude that the patient's well being is threatened.

Specifics: _____

Figure 7-3. Distinct Part Psychiatric Unit Admission Criteria for Adults (Page 1 of 3)

DISTINCT PART PSYCHIATRIC UNIT ADMISSION/EXTENSION CRITERIA FOR ADULTS

INTENSITY OF SERVICE CRITERIA

(Must meet all)

☐ 1. Ambulatory (outpatient) care resources in the community do not meet, and/or do not exist to meet the treatment needs of the patient, or the patient has been unresponsive to treatment at a less intensive level of care; For each service listed below, check the appropriate box to indicate the following codes:
Service Alternative ***Tried*** and patient unresponsive,
Service Alternative ***Needed*** (If service was available and/or adequate, it would have been tried),
Service Alternative does ***Not*** provide ***Sufficient*** level of restrictiveness.

SERVICE	TRIED	NEEDED	NOT SUFFICIENT
CRISIS MANAGEMENT			
IN-HOME CRISIS SERVICE			
RESIDENTIAL SERVICES			
PARTIAL HOSPITALIZATION			
DAY PROGRAMS			
MEDICATION MANAGEMENT			
FAMILY SUPPORT SERVICES			
COUNSELING AND THERAPY			
PSYCHOSOCIAL SKILLS TRAINING			
TREATMENT INTEGRATION			
TARGETED CASE MANAGEMENT			
OTHER (SPECIFY)			

AND

☐ 2. Services provided in the hospital can reasonably be expected to improve the patient's condition or prevent further regression so that patient will no longer need the services.

AND

☐ 3. Treatment of the patient's psychiatric condition requires services on an inpatient hospital basis requiring 24-hour nursing observation under the direction of a psychiatrist. **(The patient requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or a responsible other.)** These services include, but are not limited to

A. Suicide precautions, unit restrictions, and continuous observation and limiting of behavior to protect self or others
B. Active intervention by a psychiatric team to prevent assaultive behavior
C. The patient exhibits behaviors that indicate that a therapeutic level of medication has not been reached and this necessitates 24-hour observation and medication stabilization.

Specifics: _____

_____

Figure 7-3. Distinct Part Psychiatric Unit Admission Criteria for Adults (Page 2 of 3)

DISTINCT PART PSYCHIATRIC UNIT ADMISSION/EXTENSION CRITERIA FOR ADULTS page 3

EXCLUSIONARY CRITERIA

The following categories of patients are not appropriate for admission to a distinct part psychiatric unit.

☐ 1. Patients with a major medical or surgical illness or injury that would prevent active participation in a psychiatric treatment program (patients must be medically stable)
☐ 2. Patients with criminal charges and who do not have a DSM-III-R Axis I diagnosis
☐ 3. Patients whose anti-social behaviors that are a danger to others and those anti-social behaviors are characterological rather than due to a DSM-III-R Axis I diagnosis
☐ 4. Patients who have a DSM-III-R Axis II diagnosis of mental retardation without an accompanying DSM-III-R Axis I diagnosis.

Specifics:_____

DISCHARGE CRITERIA

(Must meet **at least one**)

☐ 1. Non-compliance with treatment program within three days of admission
☐ 2. No improvement within seven days of admission
☐ 3. Type/dosage of psychotropics unchanged in last two days
☐ 4. Documented by physician that maximum hospital benefit attained
☐ 5. Ability to appropriately control behavior
☐ 6. Alternative placement/follow-up care arranged
☐ 7. Ability to function cooperatively in hospital environment/community.

DATE ADMISSION CERTIFIED:_____ LOS ASSIGNED:_____

DATE EXTENSION APPROVED:_____ LOS EXTENSION:_____

Figure 7-3. Distinct Part Psychiatric Unit Admission Criteria for Adults (Page 3 of 3)

ADMISSION CRITERIA FOR CHILDREN

Severity of Illness
*Child must meet **one** of the following three criteria.*

1. Child is a danger to self due to a DSM III-R Axis I diagnosis as indicated by the following: *Indicator A, B, or C and D must exist to meet criteria 1.*

   A. Documented suicide attempt within the last 24 hours.

   OR

   B. Documented presence of self-mutilative behavior within the past 24 hours.

   OR

   C. Documented information from the child or a reliable source that the child has a current suicide plan, specific suicidal intent, or recurrent suicide thoughts, and lethal means available to follow the plan.

   AND *(Indicators A, B, or C must be accompanied by D below.)*

   D. It is the judgement of a mental health professional that the child is at significant risk of making a suicide attempt without immediate inpatient intervention.

2. Child is a danger to others or property due to a DSM III-R Axis I diagnosis as indicated by the following. (*Indicator A, B, or C and D must exist to meet criteria 2. The criteria must arise from a DSM III-R Axis I Diagnosis and include the specific criteria that were met in order to justify that diagnosis.*)

   A. Documented dangerously aggressive behavior that was harmful or potentially harmful to others or property within the last 72 hours.

   OR

   B. Documented threats to kill or seriously injure another person or seriously damage property, and the means to carry out the threats.

   OR

C. Documented information from the child or a reliable source that the child has a current plan, specific intent, or recurrent thoughts to seriously harm others or property.

AND *(Indicators A, B, or C must be accompanied by D below.)*

D. It is the judgement of a mental health professional that the child is at significant risk of making a homicide attempt or engaging in other seriously aggressive behavior without immediate inpatient intervention.

3. Child presents as gravely disabled due to a DSM III-R Axis I diagnosis as indicated by the following. (*Indicator A and either B, C, or D must exist to meet criteria 3. The criteria must arise from a DSM III-R Axis I Diagnosis and include the specific criteria that were met in order to justify that diagnosis.*)

A. The child has serious impairment of functioning compared to others of the same age in one or more major life roles (school, family, interpersonal relations, self-care, etc.) Specific description of the following must be documented:

1) Deficits in control, cognition, or judgement
2) Circumstances resulting from those deficits in self-care, personal safety, social/family functioning, academic, or occupational performance
3) Prognostic indicators which predict the effectiveness of acute treatment.

AND *(Indicator A must be accompanied by B, C, or D below.)*

B. The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child unmanageable and unable to cooperate in non-hospital treatment.

OR

C. There is a need for medication therapy or complex diagnostic testing where the child's level of functioning precludes cooperation with treatment in an outpatient or non-hospital based regimen, and may involve forced administration of medication.

OR

D. A medical condition co-exists with a DSM III-R Axis I diagnosis which, if not monitored/treated appropriately, places the child's life or well-being at serious risk.

Intensity of Service
Child must meet criteria 1, 2, and 3.

1. Services in the community do not exist or do not meet the treatment needs of the child, or the child has been unresponsive to treatment at a less intensive level of care. (Services considered tried, and/or needed must be documented.)

AND

2. Services provided in the hospital can reasonably be expected to improve the child's condition or prevent further regression so that the services will no longer be needed by the child.

AND

3. Treatment of the child's psychiatric condition requires services on an inpatient basis, including 24-hour nursing observation, under the direction of a psychiatrist. **(The child requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or a responsible other.)** These services include but are not limited to

   A. Suicide precautions, unit restrictions, and continual observation and limiting of behavior to protect self or others or property
   B. Active intervention by a psychiatric team to prevent assaultive behavior
   C. 24-hour observation and medication stabilization because the child exhibits behaviors that indicate that a therapeutic level of medication has not been reached.

Exclusionary Criteria
*If child meets **one or more** of the following criteria, admission is denied.*

1. The child has a major medical or surgical illness or injury that prevents active participation in a psychiatric treatment program.

2. The child has criminal charges and does not meet severity of illness and intensity of service criteria.

3. The child has anti-social behaviors that are a danger to others and the anti-social behaviors are characterological rather than due to a DSM III-R Axis I diagnosis.

4. The child has a DSM III-R Axis II diagnosis of mental retardation and does not meet severity of illness and intensity of service criteria.

5. The child lacks a place to live and/or family supports and does not meet severity of illness and intensity of service criteria.

6. The child has been suspended or expelled from school and does not meet severity of illness and intensity of service criteria.

EXTENSION CRITERIA FOR CHILDREN

Severity of Illness
Child must continue to meet criteria 1, 2, or 3.

1. Child is a danger to self due to a DSM III-R Axis I diagnosis as indicated by the following: *(Indicator A, B, or C and D must exist to meet criteria 1.)*

   A. The child continues to have a documented current suicide plan, specific suicide intent, recurring suicidal ideation, or suicide attempts.

   OR

   B. Continued documented presence of self-mutilative behavior.

   OR

   C. Continued documented information from the child or a reliable source that the child has a current suicide plan, specific suicidal intent, or recurrent suicide thoughts.

   AND *(Indicators A, B, or C must be accompanied by D below.)*

   D. It is the judgement of a mental health professional that the child is still at significant risk of making a suicide attempt without immediate inpatient intervention.

2. Child is a danger to others or property due to a DSM III-R Axis I diagnosis as indicated by the following. *(Indicator A, B, or C and D must exist to meet criteria 2. The criteria must arise from a DSM III-R Axis I Diagnosis and include the specific criteria that were met in order to justify that diagnosis.)*

   A. Continued documented dangerously aggressive behavior that was harmful or potentially harmful to others or property.

OR

B. Continued documented threats to kill or seriously injure another person or seriously damage property.

OR

C. Documented information from the child still has a current plan, specific intent, or recurrent thoughts to seriously harm others or property.

AND *(Indicators A, B, or C must be accompanied by D below.)*

D. It is the judgement of a mental health professional that the child is still at significant risk of making a homicide attempt or engaging in other seriously aggressive behavior without immediate inpatient intervention.

3. Child presents as gravely disabled due to a DSM III-R Axis I diagnosis as indicated by the following. (*Indicator A and either B, C, or D must exist to meet criteria 3. The criteria must arise from a DSM III-R Axis I Diagnosis and include the specific criteria that were met in order to justify that diagnosis.*)

   A. The child continues to have serious impairment of functioning compared to others of the same age in one or more major life roles (school, family, interpersonal relations, self-care, etc.) Specific description of the following must be documented:

      1) Deficits in control, cognition, or judgement
      2) Circumstances resulting from those deficits in self-care, personal safety, social/family functioning, academic, or occupational performance
      3) Prognostic indicators which predict the effectiveness of acute treatment.

   AND *(Indicator A must be accompanied by B, C, or D below.)*

   B. The child continues to have a psychiatric disorder complicated by a acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child unmanageable and unable to cooperate in non-hospital treatment.

   OR

C. There is a continued need for medication therapy or complex diagnostic testing where the child's level of functioning precludes cooperation with treatment in an outpatient or non-hospital based regimen, and may involve forced administration of medication.

OR

D. A medical condition continues to co-exists with a DSM III-R Axis I diagnosis which, if not monitored/treated appropriately, places the child's life or well-being at serious risk.

Intensity of Service

Child must continue to require an intensity of service requiring inpatient hospitalization under the direction of a psychiatrist. (*Criteria 1, 2, **and** 3 must be met.*)

1. Services in the community do not exist and/or cannot meet the treatment needs of the child. (Services considered and rationale must be documented.)

AND

2. Services provided in the hospital can reasonably be expected to improve the child's condition or prevent further regression so that the services will no longer be needed by the child.

AND

3. Treatment of the child's psychiatric condition requires services on an inpatient basis, including 24-hour nursing observation, under the direction of a psychiatrist. **(The child requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or a responsible other.)** These services include but are not limited to

   A. Suicide precautions, unit restrictions, and continual observation and limiting of behavior to protect self or others or property
   B. Active intervention by a psychiatric team to prevent assaultive behavior
   C. 24-hour observation and medication stabilization because the child exhibits behaviors that indicate that a therapeutic level of medication has not been reached.

Exclusionary Criteria

The child continues to meet none of the following criteria.

1. The child has a major medical or surgical illness or injury that prevents active participation in a psychiatric treatment program.

2. The child has criminal charges and does not meet severity of illness and intensity of service criteria.

3. The child has anti-social behaviors that are a danger to others and the anti-social behaviors are characterological rather than due to a DSM III-R Axis I diagnosis.

4. The child has a DSM III-R Axis II diagnosis of mental retardation and does not meet severity of illness and intensity of service criteria.

5. The child lacks a place to live and/or family supports and does not meet severity of illness and intensity of service criteria.

6. The child has been suspended or expelled from school and does not meet severity of illness and intensity of service criteria.

Discharge Criteria
Must meet at least one

1. Failure to comply with treatment program within three days of admission.
2. Failure to improve within seven days of admission.
3. Type/dosage of psychotropics unchanged in last two days.
4. Documented by physician that maximum hospital benefit attained.
5. Ability to appropriately control behavior.
6. Alternative placement/follow-up care arranged.
7. Ability to function cooperatively in hospital environment.

DISTINCT PART PSYCHIATRIC UNIT ADMISSION/EXTENSION CRITERIA FOR CHILDREN

It is the hospital's responsibility to provide Unisys with the specific information necessary for the case review nurse/LMHP to determine that the patient meets admission criteria as specified on this form. Include the following from the medical record: 1) ED record (if any), 2) admit note, 3) physician's orders, and 4) applicable progress notes.

NAME:	CASE #:
MEDICAID ID#:	CUSTODY:
ICD CODE # (Must correspond to DSM III-R Diagnosis):	

ADMISSION/EXTENSION CRITERIA REQUIREMENTS: At least ONE Severity of Illness Criteria must be met. ALL Intensity of Service Criteria must be met. No Exclusionary Criteria will be met.

SEVERITY OF ILLNESS CRITERIA

(Child must meet one of the following three criteria)

☐ 1. Child presents as a **danger to self** due to a DSM III-R Axis I diagnosis as indicated by the following: (Indicator A, B, or C, and D must exist to meet criteria 1)

☐ A. Documented suicide attempt within the last 24 hours

OR

☐ B. Documented presence of self-mutilative behavior within the last 24 hours

OR

☐ C. Documented information from the child or a reliable source that the child has a current suicide plan, specific suicidal intent, or recurrent suicide thoughts, and lethal means available to follow the plan

AND (Indicators A, B, or C must be accompanied by D below)

☐ D. It is the judgement of a mental health professional that the child is at significant risk of making a suicide attempt without immediate inpatient intervention.

Specifics: _____

_____

☐ 2. Child presents as a **danger to others/property** due to a DSM III-R Axis I diagnosis as indicated by the following: (Indicator A, B, or C and D must exist to meet criteria 2. The criteria must arise from a DSM III-R Axis I diagnosis and include the specific criteria that were met to justify that diagnosis)

☐ A. Documented dangerously aggressive behavior that was harmful or potentially harmful to others or property within the last 72 hours

OR

☐ B. Documented threats to kill or seriously injure another person or seriously damage property, and the means to carry out the threats

OR

☐ C. Documented information from the child or a reliable source that the child has a current plan, specific intent, or recurrent thoughts to seriously harm others or property

AND (Indicators A, B, or C must be accompanied by D below)

☐ D. It is the judgement of a mental health professional that the child is at significant risk of making a homicide attempt or engaging in other seriously aggressive behavior without immediate inpatient intervention.

Specifics: _____

_____

Figure 7-4. Distinct Part Psychiatric Unit Admission Criteria for Children (Page 1 of 3)

DISTINCT PART PSYCHIATRIC UNIT ADMISSION/EXTENSION CRITERIA FOR CHILDREN page 2

☐ 3. Child presents as **gravely disabled** due to a DSM III-R Axis I diagnosis as indicated by the following (Indicator A and either B, C, or D must exist to meet criteria 3. The criteria must arise from a DSM III-R Axis I diagnosis and include the specific criteria that were met to justify that diagnosis)

☐ A. The child has serious impairment of functioning compared to others of the same age in one or more major life roles (school, family, interpersonal relations, self-care, etc.) Specific description of the following must be documented:

☐ 1) Deficits in control, cognition, or judgement

☐ 2) Circumstances resulting from those deficits in self-care, personal safety, social/family functioning, academic, or occupational performance

☐ 3) Prognostic indicators which predict the effectiveness of acute treatment.

AND (Indicator A must be accompanied by B, C, or D below)

☐ B. The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child unmanageable and unable to cooperate in non-hospital treatment

OR

☐ C. There is a need for medication therapy or complex diagnostic testing where the child's level of functioning precludes cooperation with treatment in an outpatient or non-hospital based regimen, and may involve forced administration of medication

OR

☐ D. A medical condition co-exists with a DSM III-R Axis I diagnosis which, if not monitored/treated appropriately, places the child's life or well-being at serious risk.

Specifics:_____

INTENSITY OF SERVICE CRITERIA

(Child must meet criteria 1, 2, and 3)

☐ 1. Services in the community do not meet, and/or do not exist to meet the treatment needs of the child, or the child has been unresponsive to treatment at a less intensive level of care. For each service listed below, check the appropriate box using the following codes:

Service Alternative ***Tried*** and child unresponsive,
Service Alternative ***Needed*** (Service exists but no available slots or service does not exist; if service had been available it would have been tried),
Service Alternative does ***Not*** provide ***Sufficient*** level of restrictiveness.

SERVICE	TRIED	NEEDED	NOT SUFFICIENT
CRISIS MANAGEMENT			
IN-HOME CRISIS SERVICE			
RESIDENTIAL SERVICES			
PARTIAL HOSPITALIZATION			
DAY PROGRAMS			
MEDICATION MANAGEMENT			
FAMILY SUPPORT SERVICES			
COUNSELING AND THERAPY			
PSYCHOSOCIAL SKILLS TRAINING			
TREATMENT INTEGRATION			
TARGETED CASE MANAGEMENT			
OTHER (SPECIFY)			

AND

☐ 2. Services provided in the hospital can reasonably be expected to improve the child's condition or prevent further regression so that the services will no longer be needed by the child.

AND

☐ 3. Treatment of the child's psychiatric condition requires services on an inpatient basis including 24-hour nursing observation, under the direction of a psychiatrist. **(The child requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or a responsible other.)** These services include, but are not limited to

A. Suicide precautions, unit restrictions, and continual observation and limiting of behavior to protect self or others or property

B. Active intervention by a psychiatric team to prevent assaultive behavior

C. 24-hour observation and medication stabilization because the child exhibits behaviors that indicate that a therapeutic level of medication has not been reached.

Specifics:_____

Figure 7-4. Distinct Part Psychiatric Unit Admission Criteria for Children (Page 2 of 3)

DISTINCT PART PSYCHIATRIC UNIT ADMISSION/EXTENSION CRITERIA FOR CHILDREN page 3

EXCLUSIONARY CRITERIA

If child meets **one or more** of the following criteria, admission is denied.

- ☐ 1. The child has a major medical or surgical illness or injury that prevents active participation in a psychiatric treatment program.
- ☐ 2. The child has criminal charges and does not meet severity and intensity criteria.
- ☐ 3. The child has anti-social behaviors that are a danger to others and the anti-social behaviors are characterological rather than due to a DSM III-R Axis I diagnosis.
- ☐ 4. The child has a DSM III-R Axis II diagnosis of mental retardation and does not meet severity and intensity criteria.
- ☐ 5. The child lacks a place to live and/or family supports and does not meet severity and intensity criteria.
- ☐ 6. The child has been suspended or expelled from school and does not meet severity and intensity criteria.

Specifics:_____

_____

DISCHARGE CRITERIA

(Must meet at least one)

- ☐ 1. Failure to comply with treatment program within three days of admission
- ☐ 2. Failure to improve within seven days of admission
- ☐ 3. Type/dosage of psychotropics unchanged in last two days
- ☐ 4. Documented by physician that maximum hospital benefit attained
- ☐ 5. Ability to appropriately control behavior
- ☐ 6. Alternative placement/follow-up care arranged
- ☐ 7. Ability to function cooperatively in hospital environment.

DATE ADMISSION CERTIFIED:_____ LOS ASSIGNED:_____

DATE EXTENSION APPROVED:_____ LOS EXTENSION:_____

Figure 7-4. Distinct Part Psychiatric Unit Admission Criteria for Children (Page 3 of 3)

COMMUNITY BASED PSYCHIATRIC SERVICE DEFINITIONS

The following is a list of alternatives to inpatient psychiatric treatment as listing in figures 7-3 and 7-4.

Crisis Management Services

Crisis management services are provided on a 24-hour basis. These services are designed to provide a quick and appropriate response to persons who are experiencing acute distress. Specific crisis management services include face-to-face screening, assessment, and crisis counseling; community housing for crisis stabilization; crisis respite; and crisis support as defined by the mental health rehabilitation services (MHRS) program. Crisis management services may be delivered in a community facility, the home, school, or other community locations.

In-Home Crisis Services

In-home crisis service is an intensive, family-focused intervention provided in the home for the purpose of preventing out-of-home placement. The service is characterized by flexible staff hours (including 24-hour on-call capacity); very small caseloads (two to four families); a brief intervention period (several weeks to several months); and a multi-faceted approach including helping the family obtain resources, instruction in behavior management techniques, problem-solving skill development, and counseling. In-home crisis service is primarily for children with serious emotional disturbance and their families.

Residential Services

Residential services include non-medical, live-in facilities that provide treatment and care to persons who require supervision and a structured living environment without 24-hour medical or nursing care. Specific residential services for children include therapeutic foster homes, group homes, therapeutic camps, and supervised apartments for older adolescents. Residential services for adults include supervised apartments, group homes, board and care facilities, and support within the person's own private residence.

Partial Hospitalization

Partial hospitalization provides daytime treatment and medical supervision for persons who are at substantial risk of hospitalization. It is most typically provided in a hospital. Partial hospitalization is the most intensive program available that still allows the person to live in his/her home.

Day Programs: Children

Day treatment is an intensive, structured, non-residential program of several hours duration (usually five or more) providing an integrated set of counseling, behavioral, education, and family interventions that enable children to reside at home and maintain community, school, and family ties. Day treatment programs may be located in schools or other community facilities.

Day Programs: Adults

Psychosocial rehabilitation and day treatment programs provide opportunities for teaching new rehabilitative skills related to community living and work activities, build networks or peer support, teach self-help community activities, and provide a place where individuals can learn how to successfully relate to persons and communicate their needs and desires. In addition, these programs provide secure, structured environments where individuals experiencing disruption in routine behaviors brought on by their illness can receive treatment and support.

Medication Management

Medication management services include monitoring a person's status in relation to treatment with medication; instructing the client, family, significant others, or caregivers of the expected effects of therapeutic doses of medications; and administering prescribed medication when ordered by a supervising physician.

Family Support Services: Children

Family support services assure that families of children with serious emotional disturbance have the necessary personal support, information, and skill to cope and maintain family integrity and to enhance the likelihood that the child can successfully remain at home. Service elements include planned respite care, wraparound funding, parent education, parent support groups, parent case manager training, cash subsidy, home aide services, transportation, and advocacy services.

Counseling and Therapy

Counseling and therapy is the least intensive treatment intervention. It may be provided on an individual, group, or family basis. The primary counseling and therapy approaches are behavioral, family systems, psychodynamic, and chemotherapy.

Psychosocial Skills Training

Psychosocial skills training is provided by paraprofessionals to help integrate therapeutic principles into the daily activities of the child or adult. The purpose is to restore, reinforce, and enhance the skills and/or knowledge necessary for the person to achieve the maximum reduction of psychiatric symptoms, to increase the level of his/her age appropriate and/or

independent functioning, and to successfully assimilate into the community. The services may be provided on an individual or group basis and may be part of a partial hospitalization or day treatment.

Treatment Integration

Treatment integration is a support service provided by a training paraprofessional which complements and assists in implementing other mental health services including beginning a person's behavior management plan; assisting in transferring psychosocial skills from one setting to another; and/or physically managing a person who is, or potentially is, engaged in violent or other disruptive behavior.

Targeted Case Management

Targeted case management is an intensive brokering and advocacy service with a primary focus on individual/family strengths. Caseload size is usually 10-15 children with serious emotional disturbance and their families or 20-25 adults with serious mental illness. Targeted case management involves locating and accessing services, finding advocacy with the multiple systems that offer services, overseeing the development and implementation of an adequate service plan, reviewing the person's progress, and coordinating services across agencies.

ALCOHOLISM AND DRUG TREATMENT UNITS

Hospital-based alcoholism and drug treatment units must be capable of 1) providing medically directed acute detoxification and related treatment aimed at alleviating acute emotional, behavioral, and/or biomedical distress resulting from patient's use of alcohol and other drugs; 2) providing life-support care and treatment directly; and 3) providing a level of care calling for an active addiction treatment in addition to the focus on psychiatric and/or biomedical problem.

ADMISSION CRITERIA

Severity of Illness

Hospital-based alcoholism and drug treatment units shall comply with both of the following criteria and their accompanying specifications.

1. Admit only patients assessed as meeting the criteria for substance use disorder and principle diagnosis of substance abuse as defined by the current revision of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* or the chapter entitled "Mental Disorders" in the current revision of *International Classification of Diseases.*

AND

2. Certify that the patient meets the specifications in one of the dimensions of A, B, or C.

   A. Acute alcohol and/or other drug intoxication and/or potential withdrawal—one of the following:

      1) The patient is assessed as at risk for severe withdrawal syndrome as evidenced by

         a) CIWA-A (Clinical Institute Withdrawal Assessment-Alcohol) score (or other comparable standardized scoring system) greater than or equal to 20
         b) Blood alcohol greater than 0.1gm% with withdrawal symptoms present, or blood alcohol greater than 0.3gm%
         c) Pulse greater than 110 or blood pressure higher than 160/110 and CIWA-A or comparable score greater than 10
         d) History of seizures, hallucinations, myoclonic contractions, or delirium tremens when withdrawing from similar amounts of alcohol
         e) Seizure, delirium tremens, hallucinations, myoclonic contractions, or hyperpyrexia

f) Daily ingestion of sedative hypnotics for over six months plus daily alcohol use, or regular use of another mind-altering drug known to have its own withdrawal syndrome, and the patient has an accompanying chronic mental/physical disorder
g) Daily ingestion of sedative hypnotics above the recommended therapeutic dosage level for at least four weeks and the patient has an accompanying chronic mental/physical disorder
h) Antagonist medication used in the withdrawal (e.g., pharmacological induction of opiate withdrawal and subsequent management)
i) Recent (within 24 hours) head trauma or loss of consciousness with resultant need to observe the intoxicated patient closely
j) A patient with a history of opioid use who exhibits grade two or above opioid withdrawal (e.g., muscle twitching, myalgia, arthralgia, anorexia, nausea, vomiting, diarrhea, extremes of vital signs, dehydration, or "curled up position") requiring acute nursing care for management
k) Drug overdose compromising mental status, cardiac functioning or other vital signs
l) Patient with a history of daily opioid use for at least two weeks before admission and past attempts to stop at similar doses have resulted in one or more of the following withdrawal symptom: muscle twitching, myalgia, arthralgia, abdominal pain, rapid breathing, fever, anorexia, nausea, vomiting, diarrhea

2) There is a strong likelihood the patient will not complete detoxification or enter into continuing addiction treatment as evidenced by

a) A past history of detoxification at a less intense level of care without completion of detoxification or entry into a continuing addictions treatment program
b) Current use of medications or medical conditions known to interfere with ability to complete detoxification (MAO inhibitors with alprazolam).

3) This is the only available level of care that can provide the needed medical support and comfort for the patient as evidenced by

a) Detoxification regimen or patient's response to the regimen requires monitoring at least every two hours (e.g., clonidine detoxification with opiates or high dose benzodiazepine withdrawal)
b) The patient requires detoxification while pregnant.

OR

B. Biomedical conditions and complications due to a primary diagnosis of a substance use disorder (one of the following):

1) Biomedical complications of addiction requiring medical management and skilled nursing care
2) Concurrent biomedical illness or pregnancy needing stabilization and daily medical management with daily primary nursing interventions
3) Presence of biomedical problems requiring inpatient diagnosis and treatment, such as

   a) Liver disease or problems with impending hepatic decompensation
   b) Acute pancreatitis requiring parenteral treatment
   c) Active gastrointestinal bleeding
   d) Cardiovascular disorders requiring monitoring
   e) Multiple current medical problems

4) Recurrent or multiple seizures
5) Disulfiram-alcohol reaction
6) Life-threatening symptomatology related to excessive use of alcohol or other drugs (stupor, convulsions, etc.)
7) Chemical use gravely complicating previously diagnosed medical conditions
8) Changes in the patient's medical status such as severe worsening of a medical condition making abstinence imperative, or significant improvement in an unstable medical condition allowing response to chemical dependency treatment
9) Demonstrating biomedical problems requiring 24-hour observation and evaluation.

OR

C. Emotional/behavioral conditions and complications due to a primary diagnosis of a substance use disorder (one of the following):

1) Emotional/behavioral complications of addiction requiring medical management and skilled nursing care
2) Concurrent emotional/behavior illness needing stabilization and daily medical management and primary nursing interventions
3) Uncontrolled behavior endangering self or others
4) Co-existing serious emotional/behavioral disorder which complicates the treatment of chemical dependency and requires differential diagnosis and treatment

5) Extreme depression presenting in a patient resulting in the patient being a danger to self or others
6) Thought process impairment, impairment in abstract thinking, limitation in ability to conceptualize to the degree that the patient's major life areas are severely impaired
7) Alcohol and other drug use gravely complicates or exacerbates previously diagnosed psychiatric or emotional/behavioral condition
8) Altered mental status with or without delirium as manifested by

   a) Disorientation to self
   b) Alcoholic hallucinations
   c) Toxic psychosis.

Intensity of Services
One or more must be met

1. Intensive treatment with medications for delirium tremens
2. IV medications or total parenteral nutrition (T.P.N.)
3. Documented detoxification regime of decreasing drug dosage
4. Neurological checks and vital signs every two hours and "visual checks" every 15 minutes
5. Environmental control such that the patient is prevented from harming self or others.

EXTENSION CRITERIA

Severity of Illness
Length of stay will vary with the severity of the illness and the response to treatment ***(criteria 1 and 2 must be met).***

1. The patient continues to meet the diagnostic criteria required for admission.

AND

2. To comply with criteria 2, one of the following must be met.

   A. Acute alcohol and/or other drug intoxication and/or potential withdrawal, persistence of acute withdrawal symptomology or detoxification protocol requires continued medical and/or nursing management on a 24-hour basis
   B. Biomedical conditions and complications

1) A continued biomedical problem or intervening medical event which was serious enough to interrupt treatment, but the patient is again progressing in treatment
2) A biomedical condition that was initially interfering with treatment is improving, yet the patient still requires 24-hour continued medical management for this condition along with the treatment for the addiction

C. Emotional/behavioral conditions and complications

1) The patient is making progress toward resolution of a concomitant emotional/behavioral problem, but continued medically managed and nursing interventions are needed before transfer can be made to a less intensive level of care.
2) The patient is assessed as having an Axis I psychiatric condition or disorder according to the current revision of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, or its equivalent, which in combination with alcohol and/or other drug use, continues to present a major health risk and is actively being treated (e.g., medication stabilization).

Intensity of Services
One or more must be met

1. Intensive treatment with medications for delirium tremens
2. IV medications or total parenteral nutrition (T.P.N.)
3. Documented detoxification regime of decreasing drug dosage
4. Neurological checks and vital signs every two hours and "visual checks" every 15 minutes
5. Environmental control such that the patient is prevented from harming self or others.

Discharge Criteria
Must meet criteria 1 or 2

1. The patient is assessed post-admission as not having met the diagnostic criteria for Psychoactive Substance Use Disorder as defined by the current revision of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* or the current revision of the *International Classification of Diseases.*

2. Must meet one of the following:

A. Acute alcohol and/or other drug intoxication and/or potential withdrawal. The patient is assessed as not being intoxicated or in withdrawals or the symptoms have diminished

sufficiently to be managed in a less intensive level of care, and the patient does not meet any continued stay criteria that indicate the need for further treatment.

B. Biomedical conditions or complications

1) The patient's biomedical problems have diminished or stabilized so that daily medical and nursing management is no longer necessary, and the patient does not meet any of the continued stay criteria that indicate the need for further treatment.
2) A biomedical condition has arisen or an identified biomedical problem which is being addressed is not responding to treatment and needs treatment in another setting.

C. Emotional/behavior conditions and complications

1) The patient's emotional/behavioral problems have diminished in acuity so that the daily medical and nursing management is no longer necessary, and the patient does not meet any of the continued stay criteria that indicate the need for further treatment
2) An emotional/behavioral condition has arisen or an identified emotional/behavioral problem being addressed is not responding and needs treatment in another setting.

D. Treatment resistance

1) The patient consistently refuses continued treatment despite motivating interventions, and the patient does not meet any of the continued stay criteria that indicate the need for further treatment.

HOSPITAL-BASED ALCOHOLISM AND DRUG TREATMENT UNITS

It is the hospital's responsibility to provide Unisys with the specific information necessary for the case review nurse to determine if the patient meets all admission criteria as specified on these forms. Include the following from the medical record: 1) ED record (if any), 2) admit note, 3) physician's orders, and 4) applicable progress notes.

NAME:	CASE #:
MEDICAID ID:	
ICD CODE #:	

ADMISSION CRITERIA REQUIREMENTS: From the Severity of Illness, the patient must meet criteria 1 **AND** criteria 2 (by meeting indicator A, B, **OR** C), **AND** all Intensity of Service criteria.

SEVERITY OF ILLNESS CRITERIA

(Must meet 1 **AND** one or more indicators from 2)

☐ 1. Admit only patients assessed as meeting the criteria for substance use disorder and principle diagnosis of substance abuse as defined by the current revision of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* or "Mental Disorders" in the current revision of *International Classification of Diseases*.

Specifics: _____

AND

☐ 2. Certify that the patient meets the specifications in one of the dimensions of A, B, or C as listed below.

- ☐ A. Acute alcohol and/or other drug intoxication and/or potential withdrawal (one of the following)
  - ☐ 1) Patient assessed as being at risk for severe withdrawal syndrome as evidenced by
    - ☐ a) CIWA-A (Clinical Institute Withdrawal Assessment-Alcohol) score (or other comparable standardized scoring system) greater than or equal to 20
    - ☐ b) Blood alcohol greater than 0.1 gm% with withdrawal symptoms present, or blood alcohol greater than 0.3 gm%
    - ☐ c) Pulse greater that 110 or blood pressure higher than 160/100 and CIWA-A or comparable score greater than 10
    - ☐ d) History of seizures, hallucinations, myoclonic contractions, or delirium tremens when withdrawing from similiar amounts of alcohol
    - ☐ e) Seizure, delirium tremens, hallucinations, myoclonic contractions, or hyperpyrexia
    - ☐ f) Daily ingestion of sedative hypnotics for over six months plus daily alcohol use, or regular use of another mind-altering drug known to have its own withdrawal syndrome, and the patient has an accompanying chronic mental/physical disorder
    - ☐ g) Daily ingestion of sedative hypnotics above the recommended therapeutic dosage level for at least four weeks and the patient has an accompanying chronic mental/physical disorder
    - ☐ h) Antagonist medication used in the withdrawal (e.g., pharmacological induction of opiate withdrawal and subsequent management)
    - ☐ i) Recent (within 24 hours) head trauma or loss of consciousness with resultant need to observe intoxicated patient closely
    - ☐ j) History of opioid use exhibiting grade two or above opioid withdrawal (e.g., muscle twitching, myalgia, arthralgia, anorexia, nausea, vomiting, diarrhea, extremes of vital signs, dehydration, or "curled up position") requiring acute nursing care for management
    - ☐ k) Drug overdose compromising mental status, cardiac functioning, or other vital signs
    - ☐ l) History of daily opioid use for at least two weeks prior to admission and past attempts to stop at similar doses have resulted in one or more of the following signs and symptoms of withdrawal: muscle twitching, myalgia, arthralgia, abdominal pain, rapid breathing, fever, anorexia, nausea, vomiting, diarrhea.
  - ☐ 2) There is a strong likelihood patient will not complete detoxification or enter into continuing addiction treatment as evidenced by
    - ☐ a) Past history of detoxification at a less intense level of care without completion of detoxification or entry into a continuing addictions treatment program
    - ☐ b) Current use of medications or presence of medical conditions known to interfere with ability to complete detoxification (MAO inhibitors in association with alprazolam)

Figure 7-5. Hospital-Based Alcoholism and Drug Treatment Units (Page 1 of 3)

HOSPITAL-BASED ALCOHOLISM AND DRUG TREATMENT UNITS page 2

☐ 3) This is the only available level of care that can provide the needed medical support and comfort for the patient as evidenced by
- ☐ a) Detoxification regimen or patient's response to the regimen requires monitoring at least every two hours (e.g., clonidine detoxification with opiates or high dose benzodiazepine withdrawal)
- ☐ b) Detoxification required while pregnant.

Specifics: _____

OR

☐ B. Biomedical conditions and complications due to a primary diagnosis of a substance use disorder (one of the following)
- ☐ 1) Biomedical complications of addiction requiring medical management and skilled nursing care
- ☐ 2) Concurrent biomedical illness or pregnancy needing stabilization and daily medical management with daily primary nursing interventions
- ☐ 3) Presence of biomedical problems requiring inpatient diagnosis and treatment such as
  - ☐ a) Liver disease or problems with impending hepatic decompensation
  - ☐ b) Acute pancreatitis requiring parenteral treatment
  - ☐ c) Active gastrointestinal bleeding
  - ☐ d) Cardiovascular disorders requiring monitoring
  - ☐ e) Multiple current medical problems
- ☐ 4) Recurrent or multiple seizures
- ☐ 5) Disulfiram-alcohol reaction
- ☐ 6) Life-threatening symptomatology related to excessive use of alcohol or other drugs (stupor, convulsions, etc.)
- ☐ 7) Chemical use gravely complicating or exacerbating previously diagnosed medical conditions
- ☐ 8) Changes in medical status such as a severe worsening of a medical condition making abstinence imperative, or significant improvement in a previously unstable medical condition allowing the patient to respond to chemical dependency treatment
- ☐ 9) The patient demonstrates other biomedical problems requiring 24-hour observation and evaluation.

Specifics: _____

OR

☐ C. Emotional/behavioral conditions and complications due to a primary diagnosis of a substance use disorder (one of the following)
- ☐ 1) Emotional/behavioral complications of addiction requiring medical management and skilled nursing care
- ☐ 2) Concurrent emotional/behavioral illness needing stabilization and daily medical management and primary nursing interventions
- ☐ 3) Uncontrolled behavior endangering self or others
- ☐ 4) Co-existing serious emotional/behavioral disorder which complicates the treatment of chemical dependency and requires differential diagnosis and treatment
- ☐ 5) Extreme depression presenting in patient resulting in the patient being a a danger to self or others
- ☐ 6) Thought process impairment, impairment in abstract thinking, limitation in ability to conceptualize to the degree that major life areas are severely impaired
- ☐ 7) Alcohol and other drug use gravely complicates or exacerbates previously diagnosed psychiatric or emotional/behavioral condition
- ☐ 8) Altered medtal status with or without delirium as manifested by
  - ☐ a) Disorientation to self
  - ☐ b) Alcoholic hallucinations
  - ☐ c) Toxic psychosis.

Specifics: _____

INTENSITY OF SERVICE

(One or more must be met)
- ☐ 1. Intensive treatment with medications for delirium tremens
- ☐ 2. IV medications or total parenteral nutrition (T.P.N.)
- ☐ 3. Documented detoxification regime of decreasing drug dosage
- ☐ 4. Neurological checks and vital signs every two hours and "visual checks" every 15 minutes
- ☐ 5. Environmental control such that the patient is prevented from harming self or others.

Specifics: _____

Figure 7-5. Hospital-Based Alcoholism and Drug Treatment Units (Page 2 of 3)

HOSPITAL-BASED ALCOHOLISM AND DRUG TREATMENT UNITS page 3

DATE ADMISSION CERTIFIED:_____ LOS ASSIGNED:_____

EXTENSION CRITERIA - SEVERITY OF ILLNESS

Length of stay will vary with the severity of the illness and the response to treatment (criteria 1 and 2 must be met)
☐ 1. Patient continues to meet the diagnostic criteria required for admission.
☐ 2. To comply with criteria 2, one of the following must be met.
- ☐ A. Acute alcohol and/or drug intoxication and/or potential withdrawal, persistence of acute withdrawal symptomatology or detoxification protocol requires continued medical and/or nursing management on a 24-hour basis
- ☐ B. Biomedical conditions and complications
  - ☐ 1) Continued biomedical problem or intervening medical event which was serious enough to interrupt treatment, but the patient is again progressing in treatment
  - ☐ 2) Biomedical condition initially interfering with treatment is improving, yet the 24-hour continued medical management for this condition along with the treatment for the addiction is required
- ☐ C. Emotional/behavioral conditions and complications
  - ☐ 1) Noted progress toward resolution of a concomitant emotional/behavioral problem, but continued medically managed and nursing interventions are needed before transfer to a less intensive level of care
  - ☐ 2) Assessed as having an Axis I psychiatric condition or disorder according to the current revision of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, or its equivalent, which in combination with alcohol and/or other drug use, continues to present a major health risk and is actively being treated (e.g., medication stabilization).

Specifics:_____

INTENSITY OF SERVICE

(One or more must be met)
☐ 1. Intensive treatment with medications for delirium tremens
☐ 2. IV medications or total parenteral nutrition (T.P.N.)
☐ 3. Documented detoxification regime of decreasing drug dosage
☐ 4. Neurological checks and vital signs every two hours and "visual checks" every 15 minutes
☐ 5. Environmental control such that the patient is prevented from harming self or others.

Specifics:_____

DISCHARGE CRITERIA

(Must meet criteria 1 or 2)
☐ 1. The patient is assessed post-admission as not having met the diagnostic criteria for psychoactive substance use disorder as defined by the current revision of American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* or the current revision of the *International Classification of Diseases*.

OR

☐ 2. Must meet one of the following:
- ☐ A. Acute alcohol and/or other drug intoxification and/or potential withdrawal. Assessed as not being intoxicated or in alcohol or other drug withdrawal or the symptoms have diminished sufficiently to be managed in a less intensive level of care, and does not meet any extension criteria that indicate the need for further treatment
- ☐ B. Biomedical conditions or complications
  - ☐ 1) Biomedical problems, if any, have diminished or stabilized to the extent that daily medical and nursing management for the condition is no longer necessary, and the patient does not meet any of the extension criteria that indicate the need for further treatment
  - ☐ 2) Biomedical condition has arisen or an identified biomedical problem which is being addressed is not responding to treatment and needs treatment in another setting
- ☐ C. Emotional/behavior conditions and complications
  - ☐ 1) Emotional/behavioral problems have diminished in acuity and no longer necessitate daily medical and nursing management, and do not meet any of the extension criteria that indicate the need for further treatment
  - ☐ 2) An emotional/behavioral condition has arisen or an identified emotional/behavioral problem which is being addressed is not responding to treatment and needs treatment in another setting
- ☐ D. Treatment resistance
  - ☐ 1) Consistently refuses continued treatment despite motivating interventions, and does not meet any of the extension criteria that indicate the need for further treatment.

DATE EXTENSION APPROVED:_____ LOS EXTENSION:_____

Figure 7-5. Hospital-Based Alcoholism and Drug Treatment Units (Page 3 of 3)

REHABILITATION HOSPITALS

LENGTH OF STAY CRITERIA

Severity of Illness
Must meet either criteria 1 or 2 **and** *from criteria 3 any one of the elements A through E,* **and** *elements F* **and** *G.*

1. Physical—Inability to function independently as demonstrated by meeting one element from A, B, or C with the potential for significant practical improvement as measured against his/her condition prior to rehabilitation.

   A. Activities of daily living (any one of)

      1) Feeding
      2) Personal hygiene
      3) Dressing

   B. Mobility (any one of)

      1) Transfers
      2) Wheelchair
      3) Ambulation
      4) Stair climbing

   C. Communicative/cognitive (must be accompanied by either element A or B)

      1) Aphasia with major receptive and/or expressive components
      2) Cognitive dysfunction (e.g. attention span, confusion, memory, intelligence)
      3) Perceptual motor dysfunction area (e.g., spatial orientation, visual-motor, depth and distance perception).

OR

2. Somatic dysfunction

   A. Somatic dysfunction which significantly impairs the individual's efficiency of performance (e.g., spasticity, incoordination, paresis, bowel and bladder dysfunction, gait disturbance, dysarthria, dyskinesia)

AND

3. Comprehensive rehabilitative status (any one of A through E **and** F **and** G)

   A. Has had no previous comprehensive rehabilitative effort or previous rehabilitative efforts for the same condition showed little or no improvement, but because of an intervening circumstance rehabilitation is now considered reasonable
   B. Previously has been unable to attain rehabilitation goals which are currently considered attainable because of techniques or technology not previously available to patient. This may include previous trial of outpatient therapy with unsatisfactory response
   C. Has lost previous level of attained functional independence due to complication(s) or intercurrent illness, and reattainment of functional independence currently is feasible
   D. The patient is medically stable, but has complications which require special care during rehabilitation goals or attainment of goals
   E. Documented objective evidence of a significant change in the patient's function requiring a planned evaluation or re-evaluation of rehabilitation goals or attainment of goals

   AND

   F. Significant practical improvement expected in a reasonable time period. An expectation of complete independence in the activities of daily living is not necessary, but there must be a reasonable expectation of improvement that will be of practical value to the patient, measured against his/her condition at the start of rehabilitation

   AND

   G. The patient has sufficient mental alertness to participate in the program.

Intensity of Service
Must meet 1, 2, and 3

1. Medical management by a physician and a registered nurse

2. The provision of at least one of the following services for a minimum of three hours per day and no less than five days a week:

   A. Occupational therapy
   B. Physical therapy

C. Speech/language pathology services and/or prosthetic/orthotic services (must be a combination of these two services or one in conjunction with OT or PT).

AND

3. Evidence of periodic multi-disciplinary rehabilitation team review at least every two weeks with documentation of progress and recommendations for continuing rehabilitation program.

Appropriate Diagnoses for Inpatient Admission
This list is not all inclusive.

1. Amputees
2. Cerebrovascular accident/stroke
3. Spinal cord injury
4. Head trauma
5. Major multiple trauma
6. Neurological disorders
7. Burns
8. Orthopedic disabilities
9. Rheumatoid arthritis.

Discharge Criteria
Must meet at least one

1. Evidence is in record that patient has achieved stated goals.
2. Medical complications preclude intensive rehabilitative effort.
3. Multi-disciplinary therapy is no longer needed.
4. No additional functional improvement is anticipated.
5. Patient's functional status has remained unchanged for 14 days.

REHABILITATION HOSPITAL LENGTH OF STAY CRITERIA

It is the hospital's responsibility to provide Unisys with the specific information necessary for the case review nurse/LMHP to determine if the patient meets admission criteria as specified on this form. Include the following from the medical record: 1) ED record, if any, 2) admit date, 3) physician's orders, and 4) applicable progress notes.

NAME:	CASE #:
MEDICAID ID:	
ICD CODE #:	

EXTENSION REQUIREMENT: From the Severity of Illness, the patient must meet at least one element from criteria 1 **OR** 2, **AND**, from criteria 3, the patient must meet one element from A through E **AND** F **AND** G. All Intensity of Service criteria must be met.

SEVERITY OF ILLNESS

(Must meet either criteria 1 or 2, and from criteria 3 any one of the elements A through E and elements F and G)

☐ 1. Physical—Inability to function independently as demonstrated by meeting one element from A, B, or C, with the potential for significant practical improvement as measured against his/her condition prior to rehabilitation

- ☐ A. Activities of daily living (any one of)
  - ☐ 1) Feeding
  - ☐ 2) Personal hygiene
  - ☐ 3) Dressing

  OR
- ☐ B. Mobility (any one of)
  - ☐ 1) Transfers
  - ☐ 2) Wheelchair
  - ☐ 3) Ambulation
  - ☐ 4) Stair climbing

  OR
- ☐ C. Communicative/Cognitive (must be accompanied by either element A or B)
  - ☐ 1) Aphasia and major receptive and/or expressive components
  - ☐ 2) Cognitive dysfunction (e.g., attention span, confusion, memory, intelligence)
  - ☐ 3) Perceptual motor dysfunction area (e.g., spatial orientation, visual-motor, depth and distance perception).

Specifics: _____

_____

OR

☐ 2. Somatic Dysfunction

- ☐ A. Somatic dysfunction which significantly impairs the individual's efficiency of performance (e.g., spasticity, incoordination, paresis, bowel and bladder dysfunction, gait disturbance, dysarthria, dyskinesia).

Specifics: _____

_____

AND

Figure 7-6. Rehabilitation Hospital Length of Stay Criteria Form (Page 1 of 2)

REHABILITATION HOSPITAL LENGTH OF STAY CRITERIA page 2

☐ 3. Comprehensive Rehabilitative Status (any one of A through E and F and G)
- ☐ A. Has had no previous comprehensive rehabilitative effort or previous rehabilitative efforts for the same condition showed little or no improvement, but because of an intervening circumstance, rehabilitation is now considered reasonable
- ☐ B. Previously has been unable to attain rehabilitation goals which are currently considered attainable because of techniques or technology not previously available to the patient. This may include previous trials of outpatient therapy with unsatisfactory response
- ☐ C. Has lost previous level of attained functional independence due to complicating intercurrent illness, and reattainment of functional independence currently is feasible
- ☐ D. The patient is medically stable, but has complications which require special care during rehabilitation goals or attainment of goals
- ☐ E. Documented objective evidence of a significant change in a the patient's function requiring a planning evaluation or re-evaluation of rehabilitation goals or attainment of goals

AND
- ☐ F. Significant practical improvement expected in a reasonable period of time. It is not necessary that there be an expectation of complete independence in the activities of daily living, but there must be a reasonable expectation of improvement that will be of practical value to the patient, measured against his/her condition at the start of the rehabilitation program

AND
- ☐ G. The patient has sufficient mental alertness to participate in the program.

Specifics:_____

_____

INTENSITY OF SERVICE

(Must meet 1, 2, and 3)

☐ 1. Medical management by a physician and a registered nurse

Specifics:_____

_____

AND

☐ 2. The provision of at least one of the following services for a minimum of three hours per day and no less than five days a week:
- ☐ A. Occupational therapy
- ☐ B. Physical therapy
- ☐ C. Speech/language pathology services and/or prosthetic/orthotic services (must be a combination of these two services or one in conjunction with OT or PT)

Specifics:_____

_____

AND

☐ 3. Evidence of periodic multi-disciplinary rehabilitation team review at least every two weeks with documentation of progress and recommendations for continuing rehabilitation program.

Specifics:_____

_____

DISCHARGE CRITERIA

(Must meet at least ONE)
- ☐ 1. Evidence is in record that the patient has achieved stated goals
- ☐ 2. Medical complications preclude intensive rehabilitative effort
- ☐ 3. Multi-disciplinary therapy is no longer needed
- ☐ 4. No additional function improvement is anticipated
- ☐ 5. Patient's functional status has remained unchanged for 14 days.

DATE EXTENSION APPROVED:_____ **LOS EXTENSION**_____

Figure 7-6. Rehabilitation Hospital Length of Stay Criteria Form (Page 2 of 2)

OUTPATIENT SURGERY PERFORMED AS INPATIENT

Certain surgical procedures are covered by the Medicaid Program only when performed outpatient unless otherwise authorized. A list of these procedures are provided in Appendix A of this manual. If these procedures are performed on an inpatient basis, the provider must register the patient and request length of stay for the procedure from the fiscal intermediary before the procedure is performed.

Providers requesting length of stay for outpatient surgery performed as inpatient must use the P.C.F01 form (Figure 7-1). To expedite the review process, providers should continue to attach the appropriate medical data to substantiate the need for the service being provided in an inpatient setting.

Approval for inpatient performance of these procedures will be granted only when **one or more** of the following exception criteria exists.

- Documented medical conditions exist that make prolonged pre- and/or postoperative observation by a nurse or skilled medical personnel a necessity.
- The procedure is likely to be time consuming or followed by complication.
- An unrelated procedure is being performed simultaneously that requires hospitalization.
- There is a lack of availability of proper post-operative care.
- Another major surgical procedure could likely follow the initial procedure (e.g, mastectomy).
- Technical difficulties as documented by admission or operative notes could exist.
- The procedure carries high patient risk.

*Note: **Authorization is not required if the procedure is performed in a hospital based ambulatory surgery center.***

Reimbursement to hospitals for the performance of these specified surgical procedures on an outpatient basis will be made on a flat fee-for-service basis, not to exceed the Medicare payment rate. Reimbursement to hospitals for surgical procedures approved for inpatient performance will be made in accordance with prospective reimbursement methodology for acute care inpatient hospital services.

When both the primary and secondary procedures require length of stay assignment, all procedure codes must be listed on the P.C.F01 form. The P.C.F01 form should be submitted prior to the performance of the surgery. However, post authorization may be requested in emergency situations. Completed P.C.F01 forms with the supporting documentation attached should be mailed to the following address:

Unisys
P. O. Box 14919
Baton Rouge, LA 70898-4919
Attn: Hospital Pre-Cert. Dept.

Figure 7-7 is a summary sheet of the rules of the pre-certification/LOS policy. Each element of the table was fully explained earlier in this chapter. The figure is intended as a quick reference tool for your convenience.

SUMMARY OF PRE-CERTIFICATION/LENGTH OF STAY POLICY

LENGTH OF STAY

PRE-CERT TYPE/LOC		INITIAL	1ST EXT.	SUBSEQUENT
Distinct part psych	(type 01)	50th percentile	75th percentile	3 days
Long-term hosp.	(type 02)	14 days	14 days	7 days
Acute hosp.	(type 03)	50th percentile	75th percentile	3 days
Rehab	(type 03)	14 days	7 days	7 days

ISD REVIEW RULES SUMMARY FOR ADULTS/CHILDREN

PRE-ADMISSION
- Planned *IS* must be met for scheduled admission/procedure

ADMISSION
- At time of admission *SI* and/or *IS* must be met

EXTENSION
- On renewal date, *IS* must be met. If *IS* met, *SI* must be met.

DISCHARGE
- When *IS* no longer met:
  - Clinical/functional DS met, schedule for discharge today
  - Clinical/functional DS not met, review next day
- When *IS* met and *IS* no longer met:
  - Clinical/functional DS met, explore options

MAXIMUM RESPONSE TIMES
(Begins When All Necessary Information Received)

	ACUTE CARE/REHAB	LONG-TERM HOSP.	PSYCH.
Initial LOS	24 hours	24 hours	4 hours
LOS Extension	4 hours	24 hours	24 hours
Pre-Cert Review	N/A	24 hours	4 hours
Retrospective Review	21 days	21 days	21 days

CONTACT PHONE NUMBERS

PRE-CERTIFICATION/LOS	1-800-877-0666
PRE-CERTIFICATION FAX	1-800-717-4329
PROVIDER RELATIONS	1-800-473-2783

(Billing, Inquiries, General Information, and Questions)

Figure 7-7. Summary of Pre-Certification/LOS Policy

CHAPTER 8
PRIOR AUTHORIZATION

CHAPTER CONTENTS

Page

INTRODUCTION 8-2

OUTPATIENT REHABILITATION SERVICES 8-3
Instructions for Completing PA01 Form 8-6
Instructions for Completing PA02 Form 8-9

ORGAN TRANSPLANTS 8-11
Transplants and Other Extensive Surgical Procedures Requiring Prior Authorization 8-13

OUT-OF-STATE NON-EMERGENCY HOSPITALIZATIONS 8-15

RECONSIDERATION 8-16
Instructions for Submitting a Reconsideration 8-16

INTRODUCTION

Certain Medicaid services/procedures require prior authorization from the Fiscal Intermediary Prior Authorization Unit (PAU) before they can be rendered or performed. Refer to Appendix A for listing of services/procedures. To obtain authorization for these procedures, providers must submit a completed PA01 form with the supporting medical documentation attached to the Fiscal Intermediary PAU. Provided in this section is a sample of the PA01 form. Instructions for completion of the PA01 follow the sample form. **All of the following services require prior authorization:**

- Outpatient rehabilitation services
- Transplant procedures (state operated hospitals only)
- Out-of-state non-emergency hospitalizations.

Once a request for prior authorization is received by the fiscal intermediary, it will be assigned a unique nine-digit prior authorization number. After the request is assigned a number, it will be entered into the prior authorization file at the fiscal intermediary. Upon entry, the system will perform a series of front-end edits. It will check for a valid seven-digit Medicaid provider identification number, a valid 13-digit recipient identification number, recipient eligibility, a valid diagnosis code and a valid procedure code (ICD-9-CM or CPT), age restrictions, etc. If any of the above do not clear the editing process, the system will deny the request automatically, and a letter of denial will be generated and sent to the provider and the recipient.

If the request clears the above editing process, it will pend to a "review status". The medical consultants will then review the request to determine medical necessity and adherence to Medicaid policy.

If the request is denied by the consultant(s), a letter of denial will be generated with the appropriate denial message(s) and sent to the provider and the recipient.

If a request is approved on the first submission or after a reconsideration is submitted, the medical consultant(s) will denote payment if authorized, and that information will be entered into the prior authorization file. In addition, a letter of approval will be generated and sent to the provider and the recipient. Once the provider receives notification of approval, he/she may render the service.

When submitting a claim for the service, the provider must enter the nine-digit prior authorization number in the appropriate block on the claim form (Form Locator 63). Providers may also bill these claims electronically to expedite payments.

These procedures are described in more detail in the following subsections.

OUTPATIENT REHABILITATION SERVICES

All rehabilitation services provided to Medicaid recipients, including physical, occupational, or speech and hearing therapy performed on an outpatient basis, must be prior authorized by the Prior Authorization Unit at the fiscal intermediary.

To obtain rehabilitation services, patients must be referred by a licensed physician to a rehabilitation center. Referrals must include the patient's diagnosis, the date of the accident or the onset of the illness, the address of the referring physician and his specialty (if known), and the date of the referral.

Note: The rehabilitation center must retain a copy of the physician's recommendation on file. The recommendation must include the results of the evaluation which necessitates therapy.

After the rehabilitation center receives the referral, the center must evaluate the patient and submit a proposed plan of service, including PA01 and PA02 forms (Initial Therapy and Extended Therapy Plan) to the Prior Authorization unit at the following address:

Unisys
P. O. Box 14919
Baton Rouge, LA 70898-4919
Attn: Prior Authorization Unit

Note: Providers may begin rendering treatment before the plan is approved. However, if the plan is not approved, the provider will not be reimbursed for the treatment services.

Note: In those cases when a delay in therapy would result in a deterioration of the patient's medical condition, (e.g., burn cases, accidents, or surgery) the center may begin treatment without obtaining prior authorization, but the treatment will be subject to approval at a later date. In such instances, the request for therapy must be submitted for approval within the first week of treatment.

The Medical Review Team will recommend approval for therapy plans for individuals who are likely to realize substantial gains in self-care, self-help, or rehabilitation as defined in chapter 5 of this manual, "Outpatient Hospital Services." More information regarding the coverage for rehabilitation services is provided in chapter 5.

> *Note: **A sample PA01 form and the instructions for completing PA01 form for Outpatient Rehabilitation Services is provided as Figure 8-1. A sample PA02 form and the instructions for completing PA02 form for Outpatient Rehabilitation Services is provided as Figure 8-2. Refer to Appendix B for ordering information of these forms.***

Providers should ensure that they attach an evaluation and doctor's orders (signed by an M. D.) to substantiate the need for the service(s) being provided.

MAIL TO:
UNISYS / LA MEDICAID
P.O. BOX 14919
Baton Rouge, LA 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

ICN

PRIOR AUTHORIZATION TYPE
☐ 01 INPATIENT
☐ 05 REHABILITATION
☐ 07 AIR AMBULANCE
☐ 09 DME
☐ 99 OTHER

RECIPIENT ID NUMBER

RECIP LAST NAME FIRST MI

SOCIAL SECURITY NUMBER

DATE OF BIRTH

PROVIDER NUMBER

DATES OF SERVICE
FROM THRU

INPATIENT EXT ☐ YES ☐ NO

TOTAL DAYS

DIAGNOSIS
PRIMARY CODE AND DESCRIPTION

SECONDARY CODE AND DESCRIPTION

P.A. REVIEWER SIGNATURE

STATUS CODES:
2 • APPROVED
3 • DENY
4 • PEND

PRESCRIBING PHYSICIANS NAME \ NUMBER

PRESCRIPTION DATE

PRIOR AUTHORIZATION NUMBER

DESCRIPTION OF SERVICES

SHADED FOR OFFICE USE ONLY

PROCEDURE CODE	DESCRIPTION	BILLED UNITS	BILLED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT	DATE	STATUS

PROVIDER NAME, ADDRESS, TELEPHONE

DATE OF REQUEST

PLACE OF RESIDENCE \ TREATMENT
HOME ☐ LTC ☐ INPATIENT ☐ OUTPATIENT ☐

COMMENTS

PROVIDER SIGNATURE: _____

P A 01
ISSUED 1/91

Figure 8-1. PA01 Form–Request for Prior Authorization

INSTRUCTIONS FOR COMPLETING PA01 FORM

Block	Descripti	Instructions
1.	PA Type	Check the second square entitled **05 Rehabilitation.**
2.	Recipient ID Number	Enter the recipient's Medicaid identification number exactly as it appears on the Medicaid identification card.
3.	SSN	Enter the recipient's social security number.
4.	Recipient Last Name First MI	Enter the recipient's last name, first name, and middle initial exactly as they appear on the recipient's Medicaid identification card.
5.	Date of Birth	Enter the recipient's date of birth (MM/DD/YY).
6.	Provider Number	Enter the 7-digit Medicaid provider number.
7.	Dates of Service	Enter the anticipated **From** and **Thru** dates of the rehabilitation services.
8.	Inpatient Ext.	Leave this block blank.
9.	Diagnosis	Enter the ICD-9-CM diagnosis code for the primary diagnosis in the square entitled **Primary Code and Description.** If applicable, enter the ICD-9-CM diagnosis code for the secondary diagnosis in the square entitled **Secondary Code and Description.** In addition, be sure to include a narrative description of each code listed.
10.	Prescribing Physician's Name/Number	N/A
11.	Prescription Date	N/A

12.	Description of Services (Procedure Code)	Enter the current ICD-9-CM procedure revenue code for the procedure that is to be performed, and in the space provided under the block entitled **Description**, enter the appropriate narrative description of the procedure revenue code you entered. The **Units** block should also be completed.
13.	Provider Name, Address, Telephone	Enter the provider's name, address, and telephone telephone number.
14.	Date of Request	Enter the date the request is being made.
15.	Provider Signature	Ensure that the request is signed by the provider of service or another authorized representative. Stamped or computer-generated signatures will be accepted but only if they are initialed.

MAIL TO:
UNISYS / LA MEDICAID
P.O. BOX 14919
Baton Rouge, LA 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
Medical Assistance Program
REHABILITATION SERVICES REQUEST

PATIENT NAME _____ AGE ____ PROVIDER NAME _____

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY _____

LIMITATIONS ☐ AMBULATORY ☐ NON-AMBULATORY TRANSPORTATION AVAILABLE ☐ YES ☐ NO

AIDS NEEDED ☐ WALKER ☐ CANE ☐ WHEELCHAIR ☐ LIMBS OR BRACE ☐ OTHER: _____

REHABILITATION PLAN

PLAN OF SERVICE ☐ INITIAL ☐ EXTENSION
IF INITIAL, INITIAL EVALUATION DATA AND MD REFERRAL MUST BE ATTACHED.
IF EXTENSION, PRIOR ATTENDANCE: ☐ REGULAR ☐ NON-REGULAR

REQUESTED SERVICES:	PROCEDURE CODE	DESCRIPTION	FREQUENCY	TIME/ VISIT	TOTAL UNITS
PHYSICAL THERAPY:					
SPEECH THERAPY:					
OCCUPATIONAL THERAPY					

LENGTH OF PLAN SERVICE FROM _____ TO _____
MONTH DAY YEAR MONTH DAY YEAR

DATE OF RE-EVALUATION _____
MONTH DAY YEAR

PROPOSED GOALS/COMMENTS _____

REQUESTED BY _____ DATE: _____

P A 02
ISSUED 1/91

Figure 8-2. PA02–Form Rehabilitation Services Request

INSTRUCTIONS FOR COMPLETING PA02 FORM

Providers should follow the instructions listed below when completing the PA02 form. The PA02 form must be attached to the PA01 form when submitting a request for outpatient rehabilitation services.

Block	Description	Instructions
1.	Patient Name	Enter the patient's name exactly as it appears on the Medicaid identification card.
2.	Patient Age	Enter the patient's age.
3.	Provider Name	Enter the providers name.
4.	Date of Accident or Surgery	Enter the appropriate date.
5.	Limitations	Check the appropriate boxes.
6.	Aids Needed	Check the appropriate boxes.
7.	Plan of Service	Check either **Initial** or **Extension**.
8.	Requested Services	Enter the appropriate procedure code, the narrative description of the procedure code, the frequency, the time, and the total units.
9.	Length of Plan of Service	Enter the **From** and **To** dates, including the initial evaluation date.
10.	Date of Re-Evaluation	Enter the appropriate date.
11.	Proposed Goals/ Comments	Enter any additional information not included in the evaluation section that will assist the Prior Authorization Unit in reviewing for authorization for the services requested. For instances where treatment was already initiated, an explanation of the reason for not delaying treatment to prevent deterioration of patient's condition should be included here.

12.	Requested By and Date	Ensure that the provider or the authorized representative signs and dates the form.

Note: ***When requesting an extension for rehabilitation services, providers must submit a PA01 form, PA02 form, progress notes, and a copy of the re-evaluation if after six months of therapy. Providers can only request extensions for six-month time periods. The only exception to this rule is for children under 21 years of age with long-term disabilities, e.g., cerebral palsy or muscular dystrophy. In these instances, extensions will be approved for one-year time periods.***

Once the review process has been completed and the request has been approved or denied, the provider of services and the recipient will receive written notification informing them of the results.

If the request is approved providers should bill the Medicaid Program for the services on the appropriate claim form and enter the nine-digit prior authorization number that was assigned by the fiscal intermediary in Form Locator 63 of the claim form.

Completed requests should be mailed to the following address:

Unisys
P. O. Box 14919
Baton Rouge, LA 70898-4919
Attn: Prior Authorization Unit

ORGAN TRANSPLANTS

The following organ transplant surgeries are covered by the Medicaid Program:

- Heart
- Lung
- Heart/Lung
- Liver
- Kidney
- Pancreas
- Kidney/Pancreas
- Bone Marrow.

*Note: **These services must always be prior authorized for out-of-state hospitals and state operated facilities. Refer to Chapter 7 of this manual, "Pre-Admission Certification/Length of Stay" for transplants performed in all other hospitals.***

These services must always be authorized by the Prior Authorization Unit prior to the performance of the surgery. The only exception to this rule is transplants for recipients with retroactive eligibility.

The hospital or physician may request authorization by submitting a written request with supporting medical documentation to the Prior Authorization Unit (PAU) for consideration. If the transplant is approved, the authorization letter must be attached to every transplant related claim submitted to the fiscal intermediary for processing (i.e., hospital, physician, assistant surgeon, anesthesiologist, etc.). The transplant authorization request should be submitted to the following address:

Unisys
P. O. Box 14919
Baton Rouge, LA 70898-4919
Attn: Prior Authorization Unit

If the transplant request is approved the Prior Authorization Unit will issue an authorization letter to the provider who initiated the request, and a copy of the letter may be used by any other provider who participates in the transplant procedure. If a computer-generated notice has already been issued, any transplant related claim submitted with the authorization notice attached will be processed despite the difference in provider numbers on the notice and the claim.

Note: A list of Organ Transplant and Other Extensive Surgical Procedures that require prior authorization are listed on the following pages.

TRANSPLANTS AND OTHER EXTENSIVE SURGICAL PROCEDURES REQUIRING PRIOR AUTHORIZATION

Organ Transplant Procedures	ICD-9-CM Code
Insertion of tissue expander(s) for other than breast, including	86.93
Replace expander-permanent prosthesis	86.89
Removal of tissue expander(s) without insertion of prosthesis	86.05
Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty)	86.83
Reduction mammaplasty	85.31
Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	85.53
Nipple/areola reconstruction	85.87
Bone graft with microvascular anastomosis, fibula	77.77
Rib graft with microvascular anastomosis, fibula	77.71
Other bone graft (specify) with microvascular anastomosis, fibula	77.70
Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, rib, metatarsal, or great toe	77.70
Free osteocutaneous flap with microvascular anastomosis; iliac crest	77.79
Free osteocutaneous flap with microvascular anastomosis; rib	77.71
Free osteocutaneous flap with microvascular anastomosis; metatarsal	77.78
Free osteocutaneous flap with metatarsal, great toe/web	77.79
Osteoplasty, facial bones, augmentation (autograft, allograft, or prosthetic implant)	76.91
Osteoplasty, facial bones, reduction	76.69
Heart-lung transplant with recipient cardiectomy-pneumonectomy	33.6
Heart transplant, with or without recipient cardiectomy	37.5
Bone marrow harvesting for transplant	41.91
Bone marrow transplantation; allogenic	41.03

Organ Transplant Procedures	ICD-9-CM Code
Sphincteroplasty, anal; artificial sphincter	49.79
Liver transplant, with or without recipient hepatectomy	50.4
Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islets	52.6
Donor nephrectomy, with preparation and maintenance of homograft; from living donor, unilateral	55.51
Recipient nephrectomy (separate procedure)	55.51
Renal homotransplantation, implantation of graft; excluding donor and recipient nephrectomy	55.69
Renal homotransplantation, implantation of graft; excluding donor and with recipient nephrectomy	55.69 55.51*
Renal autotransplantation, re-implantation of kidney	55.61

Other Extensive Surgical Procedures	ICD-9-CM Code
Removal, repair or replacement of inflatable sphincter including pump	58.99
Intersex surgery; male to female	64.5
Intersex surgery; female to male	64.5
Construct of artificial vagina; without graft	70.61
Construct of artificial vagina; with graft	70.61
Reconstruction of external auditory canal (metoplasty) (eg, for stenosis due to trauma, infection) (separate procedure)	18.6

* Additional code required

OUT-OF-STATE NON-EMERGENCY HOSPITALIZATIONS

Out-of-state non-emergency hospitalizations require authorization, unless the request for hospitalization is for a recipient who is both Medicare and Medicaid eligible. Authorization is required for dual Medicare/Medicaid recipients only if transportation services are being requested in addition to the hospitalization.

To obtain authorization for out-of-state non-emergency hospitalizations, providers should send a facsimile of a "Letter of Referral" to the attention of the Prior Authorization Unit at (504) 924-6179. The "Letter of Referral" should be signed by the referring physician and it should answer the following questions.

- What is the recipient's name and Medicaid identification number?
- What is the name and telephone number of the contact person representing the recipient?
- Is the recipient both Medicare and Medicaid eligible?
- Does the recipient require transportation services as well?
- Is the facility where the recipient will be hospitalized a Louisiana Medicaid provider with a valid seven-digit provider number?
- Why is the situation so unique that it cannot be provided in Louisiana or in one of the Louisiana trade areas?
- What referrals were made in Louisiana before a referral was made to an out-of-state provider/hospital?

RECONSIDERATION

If a request for prior authorization is denied, a provider may submit a reconsideration.

> ***Note: Emergency out-of-state hospitalizations do not require prior authorizations.***

To submit a reconsideration, providers should follow the instructions outlined below.

INSTRUCTIONS FOR SUBMITTING A RECONSIDERATION

1. Write the word "Reconsideration" across the top of the denial letter, and write the reason the request for reconsideration is being made at the bottom of the letter.

2. Attach all of the original documentation, as well as any additional documentation or information which supports medical necessity, to the letter.

3. Mail the letter and all documentation to the following address:

Unisys
P. O. Box 14919
Baton Rouge, LA 70898-4919
Attn: Prior Authorization Unit

CHAPTER 9
REIMBURSEMENT

CHAPTER CONTENTS

Page

INTRODUCTION 9-3

INPATIENT REIMBURSEMENT 9-3

NEONATAL CARE UNITS 9-6
Level I Unit 9-6
Level II Unit 9-7
Level III Unit 9-8
Level III Regional Unit 9-10

PEDIATRIC INTENSIVE CARE UNITS 9-13
Organizational Structure 9-13

BURN CARE UNITS 9-17
Organizational Structure 9-17
Other Programs 9-23

TRANSPLANTS 9-25

LEVEL OF CARE/SPECIALTY SERVICE DETERMINATION 9-28

RATE DETERMINATION/PEER GROUP DESIGNATION 9-29

APPEALS PROCEDURE 9-31
Request for Administrative Review 9-31
Administrative Appeal 9-36
Judicial Review 9-36

MEDICAID DISPROPORTIONATE SHARE PAYMENT ADJUSTMENT FOR INPATIENT HOSPITAL REIMBURSEMENT 9-37
Qualifications 9-37
DSH Payment Adjustment Methodologies 9-39

INPATIENT REIMBURSEMENT 9-45

REQUEST FOR ADJUSTMENT OF COST PER DISCHARGE LIMITS 9-46
Examples and Illustrated Calculations 9-50

FREE-STANDING PSYCHIATRIC HOSPITALS AND DISTINCT PART PSYCHIATRIC UNITS 9-63

OUTPATIENT REIMBURSEMENT 9-63

OUT-OF-STATE REIMBURSEMENT 9-64

LUMP SUM ADJUSTMENTS 9-64

INTRODUCTION

An overview of the reimbursement methodology as well as an explanation of the Medicaid qualifying criteria for hospital providers is presented in this chapter.

INPATIENT REIMBURSEMENT

Reimbursement for acute care inpatient hospital services (instate) provided in a non-state operated hospital setting is based on prospective reimbursement methodology. This prospective methodology will not apply to distinct part psychiatric/substance abuse units, including hospital-based alcohol and drug treatment units. This methodology is designed to meet or exceed the requirements of federal law, including the requirement that reimbursement for inpatient hospital services provided to eligible recipients be made through the use of rates that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide access, care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

The acute care hospital reimbursement rates are prospective per diem rates based on peer groups for the payment of inpatient hospital services provided to Medicaid recipients with further differentiation for certain intensive care services such as NICU, PICU, Burn, and Transplant services. The Bureau has determined that the revised Medicaid reimbursement methodology for inpatient hospital services will meet or exceed adequate levels of payment for inpatient hospital services, reduce the Medical Assistance Program's administrative costs and encourage providers of these services to operate efficiently.

Effective for dates of service July 1, 1994, Medicaid reimbursement for inpatient hospital services in a non-state operated hospital will be made according to prospective per diem rates for various peer groups of hospitals/units. Each peer group's per diem rate will be composed of the applicable following components:

- Operating costs
- Movable equipment costs
- Fixed capital costs
- Medical education costs.

Payment rates for operating costs and movable equipment expenses are established according to peer groups. Facilities were classified for operating costs into **one of five peer groups and three specialty peer groups.** Certain specialty units are also treated separately as noted below. Initially, all facilities within each peer group will be reimbursed at a blended rate for operating

costs and movable equipment expenses. The purpose of the blended rate is to provide a phase-in period (three years) culminating in a statewide flat peer group rate.

The five general peer groups are as follows:

1. Major teaching hospitals—Facilities enrolled with full membership in the Council of Teaching Hospitals (COTH) as of December 31, 1992. They must also be recognized by Medicare as teaching hospitals.

2. Minor teaching hospitals—Facilities which are recognized by Medicare as teaching hospitals, but do not meet the COTH requirements.

3. Non-teaching hospitals—Less than 58 beds.

4. Non-teaching hospitals—58 to 138 beds

5. Non-teaching hospitals—More than 138 beds.

> ***Note: Non-teaching hospitals are grouped according to the number of staffed beds as reported on the Medicaid cost report for 1991, the base year.***

Separate peer group payment rates are established for certain specialty hospital services and certain services of high intensity provided in the general acute care setting. These facilities restrict their scope of services such that they are not able to be grouped with general medical and surgical acute care hospitals. Specialty hospitals must be recognized by Medicare as PPS exempt hospitals and are categorized as follows:

- Rehabilitation hospitals
- Long-term hospitals
- Children's hospitals

Hospitals wishing to change their status as defined above must submit a request to Provider Enrollment within 90 days before effective date. If the department approves the requested change, the effective date will be the beginning of the next state fiscal year. The payment rate will be established in accordance with the applicable peer group blending methodology.

Payment rates for operating costs are determined for each peer group according to the weighted median of all non-state operated facilities' within the group. Per diem operating costs are based on the 1991 Medicaid filed cost report. The weighted median is equal to the median of all Medicaid days of care provided by all facilities within each peer group, arrayed according to allowable cost for each component.

Movable equipment costs are determined for each peer group according to the median of all non-state operated facilities within the group. Medical education costs will be reimbursed as a facility-specific, per diem amount. Per diem rates for medical education were established according to allowable costs reported in the fiscal year 1991 cost reports.

Fixed capital payment rates will be reimbursed on a statewide rate established at the median for all five general peer group hospitals. Specialty hospitals/units will each have a separate peer group fixed capital per diem rate established at the statewide median for all such hospitals/units.

These rates are established based on the facilities' reported 1991 base year costs and trended to the midpoint of the first payment year by the DRI type hospital market basket index.

Certain resource intensive inpatient services have historically been recognized through a separate reimbursement methodology by Louisiana Medicaid. This policy will continue under the proposed prospective reimbursement methodology. Peer groups have been formed to reimburse these high intensity services which include

- Neonatal Intensive Care (NICU)
- Pediatric Intensive Care (PICU)
- Burn Care
- Transplant.

Reimbursement methodology recognizes four categories of neonatal units based on severity of illness and intensity of service. Guidelines developed by the Louisiana Perinatal Commission were used to group neonatal units according to levels of care. In devising criteria for certification of medical facilities for delivery of neonatal services, it is acknowledged that the level of professional expertise and the type of physical facilities available in hospitals vary considerably. The availability of appropriate facilities, equipment and personnel is essential for effective management of the neonatal population with the highest risk. In order to define which institutions are capable of rendering care to the high risk neonate, the following levels of care are established to describe the characteristics of hospitals to render specific neonatal services.

In addition, the compliance to staffing requirements for Level III and Level III Regional facilities will be determined by reviewing historical averages, not on a daily basis. The only differences in a Level III and Level III Regional facility is the availability of all subspecialties required in the *Guidelines for Perinatal Care*, Third Edition by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists and recognition as a medical center of excellence. A Level III facility is not expected or required to transport any baby to a Level III Regional center unless the baby requires the care of a sub-specialist not available at the Level III facility. The criteria established for neonatal units is as follows.

NEONATAL CARE UNITS

LEVEL I UNIT

This level of NICU is reimbursed at the same rate as regular nursery. Use revenue codes 170, 171, 172, or 179. DO NOT use code 175.

1. Unit Mission

   A. To evaluate the condition of healthy neonates and provide continuing care of these neonates until their discharge in compliance with state regulations regarding eye care, hearing screening, and metabolic screening.
   B. To stabilize unexpectedly small or sick neonates before transfer to a Level II, Level III, or Level III Regional NICU unit.
   C. To maintain consultation and transfer agreements with Level II, Level III, and Level III Regional NICU units, emphasizing maternal transport when possible.

2. Minimum Levels of Care

   A. Resuscitation and stabilization of all inborn neonates.
   B. Nursery defined area with limited access and security or rooming-in facilities,
   C. Parent-neonate visitation/interaction must be provided.
   D. Data collection and retrieval.

3. Medical Staff

   A. A Level I NICU unit medical director and/or department chief must be a board-eligible or board-certified pediatrician, or a board-eligible or board-certified family practitioner on staff.

4. Nursing Staff

A. A nurse manager dedicated for the neonatal care area will be available to all units. The nurse manager will have specific training and experience in neonatal intensive care. The nurse manager will help develop written policies and procedures for the neonatal care areas, coordinate staff education, and prepare budgets with the medical director. The nurse manager will name qualified substitutes to fulfill his or her duties during absences. Nurse to patient ratios will vary with patient needs; however, the range for Level I will be 1:8.

LEVEL II UNIT

1. Unit Mission
   A Level II NICU unit must be capable of the following:

   A. Must meet all requirements of all Level I NICU unit services at a superior level.
   B. Must manage small, sick neonates with a moderate degree of illness that are admitted or transferred.

2. Minimum Levels of Care

   A. Performance of all Level I NICU unit services at a superior level.
   B. Neonatal ventilatory support, vital signs monitoring, and fluid infusion in defined area of the nursery.
   C. Neonates born in a Level II NICU unit with a birth weight of less than 1000 grams must be transferred to a Level III or Level III Regional NICU unit once they have been stabilized if they require prolonged ventilatory support or have life threatening diseases or surgical complications requiring a higher level of care.
   D. Neonates with a birth weight in excess of 1000 grams who require prolonged ventilation therapy may be cared for in a Level II NICU unit, provided such unit performs a minimum of 72 days of ventilator care annually. A day of ventilator care is defined as any period of time during a 24-hour period.
   E. If a Level II NICU unit performs less than 72 ventilator days per year, it must transfer any neonate requiring prolonged (greater than 24 consecutive hours) ventilator therapy to a Level III or Level III Regional NICU unit. Neonates requiring transfer to a Level III or Level III Regional NICU unit may be returned to a Level II NICU unit for convalescence.

3. Medical Staff

   A. A board-certified pediatrician of a Level II NICU unit with subspecialty certification in neonatal medicine must be the medical director and/or department chief. In existing units, consideration will be given to waiving this requirement for board-certified pediatricians with a minimum of five years experience in neonatal care who are currently serving as medical directors of Level II units. The request for waiver must be made in writing to the Office of the Secretary.

4. Nursing Staff

   A. A nurse manager dedicated for the neonatal care area will be available to all units. The nurse manager will have specific training and experience in development of written

policies and procedures for the neonatal care areas, coordinate staff education and budget preparation with the medical director. The nurse manager will name qualified substitutes to fulfill his or her duties during their absences. Nurse to patient ratios will vary with patient needs; however, the range for Level II will be 1:3-4.

5. Support Personnel

The following support personnel should be available to the perinatal care service of Level II and Level III NICU units:

A. At least one full-time medical social worker who has experience with the socioeconomic and psychosocial problems of high-risk mothers and fetuses, sick neonates, and their families (additional medical social workers may be required if the patient load is heavy).
B. At least one occupational or physical therapist with neonatal expertise.
C. At least one registered dietitian/nutritionist who has special training in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates.
D. Qualified personnel for support services such as laboratory studies, radiologic studies, and ultrasound examinations (these personnel should be readily available 24-hours a day).
E. Respiratory therapists or nurses with special training who can supervise the assisted ventilation of neonates with cardiopulmonary disease (optimally, one therapist is needed for each four neonates who are receiving assisted ventilation).

LEVEL III UNIT

1. Unit Mission
A Level III NICU unit must be capable of the following:

A. Must meet all requirements of all Level I and II NICU unit services at a superior level.
B. Provision of comprehensive care of high-risk neonates of all categories admitted and transferred.
C. A Level III NICU unit will have a neonatal transport agreement with Level III Regional unit and will be involved in organized outreach educational programs.

2. Minimum Levels of Care

A. There must be one neonatologist for every 10 patients in intensive care (Level III NICU unit) area. If the neonatologist is not in-house, there must be one licensed physician who has successfully completed the Neonatal Resuscitation Program (NRP), or one neonatal nurse practitioner in-house for Level III NICU unit patients who require intensive care.

A five-year phase-in period will be allowed for the hospital to recruit adequate staff to meet these requirements.

B. Obstetrics and neonatal diagnostic imaging, provided by obstetricians or radiologists who have special interest and competence in maternal and neonatal disease must be available 24-hours a day.

C. A Level III NICU unit will have a neonatologist or a licensed physician (who has successfully completed the Neonatal Resuscitation Program (NRP), or a neonatal nurse practitioner in-house at all times.

3. Medical Staff

A. The medical director and/or department chief of a Level III NICU unit must be a board-certified pediatrician with subspecialty certification in neonatal medicine. The following exceptions are recognized:

1) Board-eligible neonatologists must achieve board certification within five years of completion of fellowship training.

2) In existing units, consideration will be given to waiving this requirement for neonatologists who are currently medical directors and/or department chiefs of Level III NICU's. The request for waiver must be made in writing to the Office of the Secretary/Bureau of Health Services Financing. This exception applies only to the individual at the hospital where the medical director and/or department chief position is held. The physician can not relocate to another hospital nor can the hospital replace the medical director and/or department chief for whom the exception was granted and retain the exception.

3) There must be one neonatologist for every 10 patients in the intensive care Level III NICU unit area. If the neonatologist is not in-house, there must be one licensed physician (who has successfully completed the neonatal resuscitation program (NRP), or one neonatal nurse practitioner in-house for Level III NICU unit patients who require intensive care. A five-year phase-in period will be allowed for the hospital to recruit adequate staff to meet these requirements. A Level III NICU unit will have a neonatologist, or a licensed physician (who has successfully completed the neonatal resuscitation program (NRP), or a neonatal nurse practitioner in-house at all times.

B. Medical and surgical consultation must be readily available and pediatric subspecialists may be used in with a transfer agreement with a Level III Regional NICU unit.

4. Nursing Staff

   A. A nurse manager dedicated for the neonatal care area will be available to all units. The nurse manager will have specific training and experience in the development of written policies and procedures for the neonatal care areas, coordinate staff education and budget preparation with the medical director. The nurse manager will name qualified substitutes to fulfill his or her duties during their absences. Nurse to patient ratios will vary with patient needs; however, the range for Level III NICU unit will be 1:2-3.

5. Support Personnel

   The following support personnel will be available to the perinatal care service of Level II and Level III, and Level III Regional NICU units:

   A. At least one full-time medical social worker who has experience with the socioeconomic and psychosocial problems of high-risk mothers and fetuses, sick neonates, and their families (additional medical social workers may be required if the patient load is heavy).
   B. At least one occupational or physical therapist with neonatal expertise.
   C. At least one registered dietitian/nutritionist who has special training in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates.
   D. Qualified personnel for support services such as laboratory studies, radiologic studies, and ultrasound examinations (these personnel will be readily available 24-hours a day).
   E. Respiratory therapists or nurses with special training who can supervise the assisted ventilation of neonates with cardiopulmonary disease (optimally, one therapist is needed for each four neonates who are receiving assisted ventilation).

LEVEL III REGIONAL UNIT

1. Unit Mission
   A Level III Regional NICU unit must be capable of the following:

   A. Must meet all requirements of Level I, II and III NICU unit services at a superior level.
   B. A Level III Regional NICU unit must have a transport team and provide for and coordinate a maternal and neonatal transport with Level I, Level II, and Level III NICUs throughout the state.
   C. A Level III Regional unit will be recognized as a medical center of excellence, and a center of research, educational and consultative support to the medical community.

2. Medical Staff

A. The medical director and/or department chief must be a board-certified neonatologist.

B. In addition to the medical staff requirements for a Level III NICU unit, a Level III Regional NICU unit will have the following subspecialties on staff and clinical services available to provide consultation and care in a timely manner.

1) Pediatric surgery
2) Pediatric cardiology
3) Pediatric neurology
4) Pediatric hematology
5) Genetics
6) Pediatric nephrology
7) Endocrinology
8) Pediatric gastroenterology
9) Pediatric infectious disease
10) Pediatric pulmonary medicine
11) Cardiovascular surgery
12) Neurosurgery
13) Orthopedic surgery
14) Pediatric urologic surgery
15) Pediatric ophthalmology
16) Pediatric ENT surgery
17) Pediatric nutritionist
18) Pediatric PT/OT
19) Neonatal Social Services
20) Bioethics Committee.

3. Nursing Staff

A. A nurse manager dedicated for the neonatal care area will be available to all units. The nurse manager will have specific training and experience in neonatal intensive care. The nurse manager will participate in the development of written policies and procedures for the neonatal care areas, coordinate staff education and budget preparation with the medical director. The nurse manager will name qualified substitutes to fulfill his or her duties during their absences. Nurse to patient ratios will vary with patient needs; however, the range for Level III Regional unit will be 1:1-2.

4. Support Personnel

The following support personnel will be available to the perinatal care service of Level I, II, III, and III Regional NICU units:

A. At least one full-time medical social worker who has experience with the socioeconomic and psychosocial problems of high-risk mothers and fetuses, sick neonates, and their families (additional medical social workers may be required if the patient load is heavy).
B. At least one occupational or physical therapist with neonatal expertise.
C. At least one registered dietitian/nutritionist who has special training in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates.
D. Qualified personnel for support services such as laboratory studies, radiologic studies, and ultrasound examinations (these personnel will be readily available 24-hours a day).
E. Respiratory therapists or nurses with special training who can supervise the assisted ventilation of neonates with cardiopulmonary disease (optimally, one therapist is needed for each four neonates who are receiving assisted ventilation).

PEDIATRIC INTENSIVE CARE UNITS

Reimbursement methodology recognizes two categories of Pediatric Intensive Care Units (PICU). Although pediatric critical care is provided primarily at one level, there is a need for an additional level of care in geographic regions with small population base to allow stabilization of critically ill children and to avoid long-distance transfers for disorders of less complexity or of low acuity. The criteria established for recognition as a PICU for Medicaid reimbursement purposes are listed below.

ORGANIZATIONAL STRUCTURE

There shall be a PICU Committee established as a standing committee of the hospital. It shall be composed of at least physicians, nurses, respiratory therapists and other disciplines as appropriate to the specific hospital unit. The committee shall participate in delineation of privileges for all personnel (both MD and Non-MD) within the unit. Policies and procedures shall be established by the medical director and the nurse manager in collaboration with the committee and with approval of the medical staff and governing body. These written policies and procedures shall be maintained in the unit and shall include but not be limited to safety procedures, infection control, visitation, admission and discharge criteria, patient monitoring and record keeping, and equipment preventive maintenance and repair.

Staffing

The Medical Director in Level I units shall meet **at least one** of the following criteria:

1. Board-certified in pediatrics and board-certified or in the process of board certification in Pediatric Critical Care Medicine (must be completed within five years)

2. Board-certified in anesthesiology with practice limited to infants and children and with special qualifications (as defined by the American Board of Anesthesiology) in critical care medicine

3. Board-certified in pediatric surgery with added qualifications in surgical critical care medicine (as defined by the American Board of Surgery).

The Level II medical director must meet the same criteria of Level I except the board certification in Pediatric Critical Medicine is not required. The medical director will name a qualified alternate to serve in his/her absence.

In existing units, consideration will be given to waiving this requirement for board-certified pediatricians with a minimum of five years experience in pediatric care who are currently serving as medical directors of Level I and II units. The request for waiver must be made in writing to the Office of the Secretary.

Level I and II units must have at least one physician of at least the post-graduate year two assigned to the PICU in house 24 hours per day. Other physicians including the attending physician or designee shall be available within 30 minutes. Level I units shall have on staff a pediatric anesthesiologist, surgeon, cardiothoracic surgeon, neurosurgeon, intensivist, cardiologist, neurologist, pulmonologist, hematologist/oncologist, endocrinologist, gastroenterologist, allergist or immunologist, as well as a radiologist, pathologist and a psychiatrist or psychologist. Level II units shall meet the above medical staff except the cardiothoracic surgeon and the pediatric sub-specialties.

Level I and II shall have a unit manager dedicated to the unit who is a Registered Nurse with specific training and experience in pediatric critical care. The Level I manager shall be certified in Critical-Care Nursing. The nurse manager shall name a qualified alternate to act in his/her absence. The staff to patient ratio shall vary with the acuity of the patients; however, the minimum shall be 1:3. There shall be an organized written orientation program as well as an ongoing in-service/continued education program. (There shall be a three-year phase-in period with regard to staffing requirements.)

For Level I Units, the respiratory therapy staff assigned to unit shall be in-house 24 hours per day. Biomedical technicians shall be available within one hour, 24 hours a day. A unit clerk shall be readily available to the unit 24 hours a day. A pharmacist and radiologist must be in-house 24 hours a day. A social worker, physical therapist, and nutritionist are assigned to the unit as applicable.

For Level II Units, the respiratory therapist shall be in-house 24 hours a day; biomedical technician available within one hour, 24 hours a day; pharmacist and radiologist on call 24 hours a day; unit clerks, social worker, physical therapist and nutritionist available as applicable.

Hospital Facilities and Services

The Level I and II units shall be distinct, separate units within the hospital. There shall be clean and soiled utility rooms, isolation room capabilities, medication and nourishment storage areas, and a conference area available on the units.

The head of each bed and/or crib shall be rapidly accessible for emergency airway management. Electrical power, oxygen, medical compressed air, and vacuum outlets shall be available at each

bed/crib. There shall be walls or curtains available at each bedside to provide for full visual privacy.

Level I units shall be located in Category 1 facility as defined in the 1989 American Medical Association's *Guidelines for Categorization of Hospital Emergency Capability,* Chapter 7, "Pediatric Emergencies."

The Emergency Department (ED) shall have a separate covered entrance. Two or more areas within the ED shall have the capacity and equipment to resuscitate any pediatric patient with any medical, surgical, or traumatic illness in facilities within Level I units. Hospitals with Level II units only need one such area. The emergency room shall be staffed 24 hours a day in facilities with either Level I or II units.

There shall be an operating suite with one room available within 30 minutes and a second room within 45 minutes 24 hours a day. Hospitals with Level I units must have the capability of providing cardiopulmonary bypass, pediatric bronchoscopy, and radiography.

Clinical laboratories shall have micro-specimen capability and clotting studies with one-hour turn around capability. There must also be the capability to perform complete blood cell count, differential count, platelet count, urinalysis, electrolytes, blood urea nitrogen, creatine, glucose calcium, prothrombin time, partial prothrombin time, and cerebrospinal fluid cell counts. Preparation of gram stains and bacteriologic cultures shall be available 24 hours per day. Blood gas values must be available within 15 minutes. Results of drug screening and levels of serum ammonia, serum and urine osmolarity, phosphorus and magnesium shall be available within three hours for Level I units. There must be a blood bank able to provide all blood components 24 hours a day in both Level I and II. Cross-matching shall allow for transfusions within one hour unless some unusual antibody is encountered.

Hospitals with Level I units must have radiology services capable of portable radiography, fluoroscopy, computerized tomography scanning, ultrasonography, and nuclear scanning angiography. Diagnostic cardiac and neurologic studies shall be available to both Level I and II unit facilities. A catheterization laboratory or angiography suite must be present in facilities with Level I units. Level I units shall have the capability to provide hemodialysis 24 hours a day.

Equipment/Drugs

There shall be lifesaving therapeutic and monitoring equipment present in Level I and II units. There shall be a complete "code" or "crash" cart available on both Level I and II units. The cart contents should include but not be limited to approved medications, a defibrillator/cardioverter,

and automated blood pressure apparatus devices available on Level I and II units. All equipment shall be of proper size for infants and children. Oxygen tanks are needed for transport and backup for both Level I and II units. There will be additional equipment available to meet the needs of the patient population. Level I units shall have the capability of ventilator support. There must be bedside monitoring in all PICUs with the capability for continuously monitoring heart rate and rhythm, respiratory rate, temperature, and one hemodynamic pressure. Level I units must also have the ability to monitor systemic arterial, central venous, pulmonary arterial, and intracranial pressures. The monitors must have alarms with both high and low settings and they must also have both audible and visible capability. There shall be a maintenance and calibration schedule maintained for all monitoring devices.

Miscellaneous Requirements

PICUs shall be integrated with the Regional EMS system as available. Rapid access to a Poison Control Center is essential. Each PICU shall have or be affiliated with a transport system and team to assist other hospitals in arranging safe patient transport.

There shall be a quality assurance program in place to review quality of care and compare observed and predicted mortality rates for the severity of illness in the PICU population. Each Level I PICU shall offer pediatric critical care education for EMS providers, emergency department, and transport personnel as well as for the general public. The staff nurses and respiratory therapists must also have Basic Life Support Certification.

Level I PICUs will possess sufficient patient volume, teaching expertise, and research capability to support a fellowship program in Pediatric Critical Care. Programs providing sub-specialty training in critical care must possess approval by the Residency Review Committee of the Accreditation Council on Graduate Medical Education. Research is essential for improving our understanding of the pathophysiology affecting vital organ systems. Such knowledge is vital to improve patient care techniques and therapies and thereby decrease morbidity and mortality.

BURN CARE UNITS

An organized burn service should be formally established by the medical staff of the institution. The burn unit is a specialized nursing unit that is dedicated to providing optimal care for patients with burn injuries (both adults and children) from the time of injury through rehabilitation. The Bureau is adopting the American Burn Association's guidelines.

ORGANIZATIONAL STRUCTURE

The commitment of the institution's medical and administrative leadership should be documented in a burn center manual with policies specifying the commitment. Policies included should address the institutional relationships, administrative operation, staffing, and programs of the burn center.

The burn center manual will include protocols and policies that support systematic and comprehensive approaches to the care of the burn patient. These should include triage and resuscitation/stabilization protocols that should be disseminated to health care providers within the burn center service area. A coordinated multidisciplinary plan should be developed for each patient on admission and revised as appropriate during hospitalization with respect to both treatment objectives during hospitalization and post-discharge plans.

Conferences should be held at least weekly to review and evaluate the status of each burn center inpatient with representation by each clinical discipline regularly involved in burn center care. The conference should include a review of each patient's progress in recovery, need for surgery, and rehabilitation needs, both physical and psychosocial. A documented morbidity/mortality conference should be held at regular intervals consistent with education program requirements. Other conferences of a problem-solving nature should be scheduled with minutes taken to document the responsibility for problem-solving and to record the results of actions taken.

The use of beds in the burn unit by other medical/surgical services should be governed by a protocol specifying priorities and assuring the availability of specialized burn beds for patients with acute burns when needed.

The care of the burn center patients accommodated in areas other than the specialized nursing unit should be guided by policies and protocols consistent with those of the burn unit. Similarly, annual statistical reports should encompass care provided both in the burn nursing unit and in other units accommodating burn center patients.

Protocols governing the involvement of other hospital departments in support of the burn center should be included in the burn center manual. Such departments will include but not limited to

central supply, emergency, housekeeping, laboratory, pharmacy, public relations, security, and volunteers.

The burn center will have an internal registry for all inpatients and should participate in an externally based registry. The burn center will provide an audit of the previous year's patient care covering at least severity of burn, deaths, incidence of complications, length of hospitalization, and cost of care. Additional audits of any of these or other elements of care will be carried out as a given situation requires. The burn center will cooperate with the appropriate audit committees of the regional or state EMS system where they exist by providing patient care data for system management, quality assessment, and operations research, both routinely and in response to special requests, and by participating in local audits of the EMS system.

Staffing

Medical care to burn center patients should be provided by the burn center medical director or other appropriately certified physicians operating with the director's approval and using standard burn center patient care protocols. The members of the burn service should be properly certified by the institution.

There should be at least one full-time equivalent surgeon involved in the management of patients with burns for each 200 annual inpatient admissions to the burn center. This coverage requirement may be met in part by residents.

The availability and accessibility of consultation by physicians and surgeons in all specialties relevant to the care of the patient with burns should be documented. An on-call schedule should be established for the most important specialty areas.

The majority of pediatric burn patients are treated in burn centers with adults. Burn centers that treat pediatric patients should have personnel with special interest and expertise in the care and management of children with burns.

Burn Center Medical Director

The medical director should be a licensed, board-certified general or plastic surgeon on the active medical staff of the institution with at least two years of experience in the management of patients in a burn center. The chief of the burn service should also serve as the medical director of the burn center.

The medical director will be provided by the institution with the appropriate authority and responsibility to direct and coordinate all medical services to patients admitted to the burn center. The medical director will be responsible for regular communications with physicians and other authorities regarding referred patients, and for appropriate burn center management functions including quality assurance, liaison with adjacent burn centers, internal and external education programs, and coordination with regional and state EMS programs. The burn center director will designate one or more appropriately certified physicians with at least six months of experience in management of the burn patient to be accessible for administrative and clinical decisions when the director is not available. The burn service director should participate actively in at least 50 cases a year.

Specialty Support

Staff specialists are to be on call and available promptly for consultation in the specialties listed below. The initial response may be provided by residents who are capable of assessing emergency situations in their respective specialties and who can provide any immediately indicated treatment.

The surgical specialties for which staff members are to be on call are General, Cardiothoracic, Neurologic, Obstetrics/Gynecologic, Ophthalmic, Oral, Orthopedic, Otorhinolaryngologic, Pediatric, Plastic, and Urologic.

The following non-surgical specialties should also be available: Anesthesiology, Cardiology, Gastroenterology, Hematology, Infectious Disease, Internal Medicine, Nephrology, Neurology, Nutrition, Pathology, Pediatrics, Physiatry, Psychiatry, Pulmonary, and Radiology.

Nursing Personnel

One registered nurse (RN) should be administratively responsible for the burn unit. This individual should be a full-time employee with two years of intensive care or equivalent experience and a minimum of 12 months of experience in a burn unit. Education qualifications will be a baccalaureate degree (minimum) and at least six months of management experience. The assigned number of nursing staff hours should be based on a documented patient classification system.

Burn Rehabilitation Therapy

Both physical and occupational therapy should be represented in the burn center staff. The respective roles of physical and occupational therapy should be representative of and consistent with their respective professional training and with licensing laws.

Burn rehabilitation therapists may be physical therapists or occupational therapists. They should be licensed or registered in their specific disciplines and should be assigned on a full-time basis to the burn center. Staffing should be based on the combined inpatient and outpatient work load of the burn service. There should be at least one full-time equivalent burn therapist for an average of seven patients, which may represent a combination of both inpatients and outpatients.

Where either therapy service is provided to the burn center on a rotational basis, rotations must be for at least three months and must be filled by therapists who meet the continuing education requirements in burn care as related to their specialty. During their initial rotation, therapists in either discipline should receive regular supervision from individuals who have a minimum of one year of experience in burn treatment.

Other Personnel

A **social worker** should be assigned permanently to inpatient and outpatient burn care facilities. If assignment is by rotation, such rotations should be at least one year in duration.

A **dietitian** should be available on a daily basis for consultation to burn center medical and nursing staff and patients.

A **pharmacist** should be available on a daily basis for consultation to burn center medical and nursing staff and patients. This pharmacist should have had a minimum of six months of critical care experience and should be knowledgeable in pharmacokinetics and the special kinetics of patients with burn injuries.

Respiratory therapists should be available to participate in the assessment and treatment of all burn center patients as needed.

Clinical psychologists and clergy should be assigned permanently to inpatient and outpatient burn care facilities. If assignment is by rotation, such rotations should be at least one year in duration.

Burn Center Referral Criteria

Burn injuries usually requiring referral to a burn center include the following. (Questions concerning specific patients can be resolved by consultation with the burn center physician.)

- Second and third degree burns greater than 10% total body surface area (TBSA) in patients under 10 or over 50 years of age.
- Second and third degree burns greater than 20% TBSA in other age groups.
- Second and third degree burns that involve the face, hands, feet, genitalia, perineum, and major joints.
- Third degree burns greater than 5% TBSA in any age group.
- Electrical burns including lightning injury.
- Chemical burns.
- Burn injury with inhalation injury.
- Burn injury in patients with pre-existing medical disorders that could complicate management, prolong recovery, or affect mortality.
- Any patients with burns and concomitant trauma (e.g., fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient may be treated initially in a trauma center until stable before being transferred to a burn center. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.
- Hospitals without qualified personnel or equipment for the care of children should transfer children with burns to a burn center with these capabilities.
- Burn injury in patients who will require special social/emotional and/or long-term rehabilitative support, including cases involving suspected child abuse, substance abuse, etc.

There should be a direct communication link between the pre-hospital system and the burn center. The contact point may be either in the burn unit or in the emergency department.

Admission of Census Levels for the Burn Center

The following numbers of patients are deemed appropriate to maintain skill levels and provide reasonable access to specialized burn care. The average daily census of the burn center, including the burn unit and any other areas accommodating patients with acute injuries in the burn service, should be at least four patients with acute burns. The number of acute burn admissions to the burn center, including the burn unit and any other areas accommodating burn center patients, should exceed 75 annually. Burns identified as usually requiring referral to a burn center (as detailed in the above paragraph) should make up at least 80% of the admissions required to meet this standard.

Equipment and Facilities

The burn unit should contain beds that should be used predominantly for the care of patients with burn injuries or those suffering form other injuries or skin disorders whose treatment requirements are similar to those of patients with burns. Intensive care capability, providing full cardiopulmonary monitoring and respiratory support, should be available for at least four beds in the burn unit. Because of the known susceptibility of burn wounds to infection, an effective means of isolation should be provided for all patients.

The following equipment should be available to all patients in the burn unit: weight measurement devices, a system of temperature control in areas where patients' wounds are exposed, oxygen sources with concentration controls, cardiac emergency cart, and backup electrical supply.

The following equipment and supplies should be available in both the hospital emergency department and the burn unit and should be available in sizes and doses appropriate for adult and pediatric patients: airway control and ventilation equipment, including laryngoscope and endotracheal tubes of appropriate sizes; bag mask resuscitator and source of oxygen; bronchoscopes; suction devices; sterile surgical sets; gastric lavage equipment; drugs and related supplies; roentgenographic equipment; Foley catheters; electrocardiograph/ oscilloscope/defibrillator; apparatus to establish central venous pressure; and intravenous fluids and administration devises, including intravenous catheters.

There should be provision for renal dialysis on a 24-hour basis or a written transfer agreement with an available and accessible dialysis facility in another hospital.

The hospital's radiologic capability should be provided on a 24-hour basis and should include angiography, sonography, nuclear scanning, and computed axial tomography.

The hospital's clinical laboratory service should be available 24 hours a day and should include the following capabilities: routine studies for blood, urine, and other body fluids; blood gases; pH determinations and carboxyhemoglobin; coagulation studies; serum and urine osmolality; microbiologic culture and sensitivity; comprehensive blood bank or access to a community central blood bank; adequate hospital storage facilities; and toxicology screening.

Operating suites used in burn surgery should contain or have access to the following equipment: operating microscope, thermal control equipment for patients, roentgenographic equipment, dermatomes including mesh dermatones, electrocardiograph/oscilloscope/defibrillator, direct blood pressure arterial line equipment, blood flow rate monitor, in-line blood and intravenous fluid warmers, and anesthetic breathing circuit heating humidifiers.

If a skin bank exists, the physical configuration must conform to the standard of the American Association of Tissue Banks or equivalent. If there is no skin bank, a protocol for procurement and handling of banked skin should exist, if banked skin is used.

A conference room/meeting room, a family room, and an adequate exercise area must be available.

OTHER PROGRAMS

Education Program

Medical, nursing, and ancillary staff of the burn center will participate in educational programs or activities pertaining to burn care, both at initial orientation and on a planned, organized and coordinated inservice basis. Educational programs should be designed to incorporate the results of problem-solving audits and conferences.

Participants in the hospital's general surgery and other residency programs should have the opportunity to experience a rotation to the burn service. A formal educational program in burn care shall be required for all nurses, physical therapists, and occupational therapists employed in the burn center with burn care content equivalent to approximately four continuing education units. This educational program will be related to the individual nurse's or therapist's background and level of responsibility in the burn center. Nurse education will be planned and coordinated by the burn unit head nurse or by a member of the hospital nursing staff with equivalent critical care and burn nursing experience.

All professional personnel employed in the burn center will have access to continuing education programs in burn care conducted inside or outside the institution on at least an annual basis. All

educational programs should meet the standard of some external organization that provides or approves curriculum or continuing education programs, when such an organization is available.

Rehabilitation Program

The burn center should provide the following rehabilitation services:

- Recreational and educational services during hospitalization for those patients able to utilize them
- Evaluation of needs and support capabilities of patient's family or other significant persons and cooperative planning with family or other significant persons for patient discharge
- Documentation of need for and availability and accessibility of community resources to assist in meeting the patient's physical, psychosocial, educational, and vocational needs following discharge. The social worker assigned to the burn unit should coordinate these activities. A clinical psychologist or psychiatrist should be available for consultation as needed.
- Evaluation of each patient's physical, psychological, and vocational status should be done at appropriate intervals after discharge from the hospital
- Plans for readmission for medical/surgical treatment for late problems or rehabilitation and reconstruction.

Burn Prevention/Research

A member of the burn center or hospital staff should be assigned to maintain data and develop statistics regarding the causes of injuries sustained by burn center patients. Each burn center system should participate in a public burn awareness program covering prevention and immediate treatment of burn injuries.

Burn center staff should be involved in research related to burn injury that may include but is not limited to basic research, clinical research, or health services research.

TRANSPLANTS

Transplant services are reimbursed on a per discharge basis for the admission in which the transplant surgery occurs. Transplant services covered under the Medical Assistance Program include but are not limited to heart, liver, kidney and bone marrow transplants for which rates have been established. Rates for other types of transplants will be established as necessary. Transplants must be pre-approved by the department and performed in hospitals that meet the federal criteria required to qualify as a Medicare-designated transplant center including volume requirements for related procedures when applicable. The Bureau's Health Standards Section may grant an exception to the qualifying criteria for a hospital whose transplant program was recognized by Medicaid of Louisiana prior to July 1, 1994. These hospitals must operate or participate in a recognized organ procurement program.

The prospective per discharge rates will not apply to organ procurement costs except for bone marrow transplants. Heart, liver, and kidney procurement costs will be reimbursed outside the prospective payment system based on allowable costs in accordance with Medicare principles of cost reimbursement.

As transplants become recognized as non-experimental and covered by Medicare, the department will develop rates and criteria accordingly.

In addition to the above criteria, transplant units must meet the following criteria for recognition by Medicaid for specialty unit reimbursement:

1. Be a member of the (OPTN) Organ Procurement & Transplant Network.

2. Have organ receiving and tissue typing facility (HCFA approved for histocompatability) or an agreement for such services.

3. Maintain written records tracking mechanism for all grafts and patients including:

   A. Patient and/or graft loss with reason specified for failure
   B. Date of procedure
   C. Source of graft
   D. If infections agent involved must have written policy for contacting patients and appropriate governmental officials.

4. Have written criteria for acceptable donors for each type of organ for which transplants are performed.

5. Have adequate ancillary departments and qualified staff necessary for pre-, intra-, and post-operative care including but not limited to

   A. Assessment Team
   B. Surgical Suite
   C. Intensive Care
   D. Radiology
   E. Laboratory Pathology
   F. Infectious Disease
   G. Dialysis
   H. Therapy (rehab).

6. Minimum Designated Transplant Staff (continuing education is required for continued licensure and certification as applicable)

   A. Transplant Surgeon - adopt standards as delineated and updated by the Organ Procurement and Transplant Network.
   B. Transplant Physician - same as above
   C. Clinical Transplant Coordinator

      1) RN Licensed in Louisiana
      2) Certified by NATCO or in training and certified within 18 months of hire date.

   D. Transplant Social Worker
   E. Transplant Dietician
   F Transplant Data Coordinator
   G Transplant Financial Coordinator.

7. Written patient selection criteria and an implementation plan for application of criteria.

8. Facility plan, commitment and resources for a program capable of performing the following number of transplants per year/per organ a minimum of

   A. Heart - 12
   B. Liver - 12
   C. Kidney - 15.

Other organs as established per Medicare and/or OPTN. If level falls below the required volume, hospital will be evaluated by Health Standards for continued recognition as a transplant center.

9. Facility must demonstrate survival rates per organ type per year which meet or exceed the mean survival rates as published annually by the OPTN. (If rates fall below this level, the hospital must supply adequate written documentation for evaluation and justification to Health Standards.)

LEVEL OF CARE/SPECIALTY SERVICE DETERMINATION

Hospitals seeking Medicaid reimbursement for high intensity services such as NICU, PICU, Burn Care and/or Transplant must submit an application to Provider Enrollment of the Bureau of Health Services Financing of the Department of Health and Hospitals specifying the service and level of care they are/will be providing. Each applicant must also attest to their compliance with the specified service criteria for each type of service.

Upon receipt applications, Provider Enrollment will notify the Health Standards Section of BHSF to schedule an on-site survey to verify the applicant's compliance with such standards. Hospitals with currently recognized high intensity service units will be surveyed for compliance prior to 7/1/94. All other applicants will be scheduled within 30 days after receipt of their applications.

Annual resurveys will be performed on a 15% sample basis throughout the calendar year.

A hospital wishing to change a level of care must submit an application to Provider Enrollment and an attestation to their compliance with the new levels's requirements. A change in level of care will only be recognized at the beginning of the hospital's subsequent cost reporting period after Health Standards has verified the applicant's compliance via an on-site survey. Therefore, requests should be filed 90 days prior to the beginning of the new cost reporting period.

A separate prospective rate is established for infants that remain in the hospital's nursery department after the mother is discharged. The principal cost of the birth is included with the payment for the mother's stay at the general peer group per diem rate. This separate rate for nursery is intended to cover incidental costs associated with an infant's short-term stay in the nursery following the mother's discharge.

RATE DETERMINATION/PEER GROUP DESIGNATION

A per diem rate for each grouping and/or specialty service is established based on the facilities' allowable unaudited costs for each hospital's fiscal year 1991, and trended forward to the midpoint of fiscal year 1994, using the Data Resources Incorporated, published hospital market basket index (DRI) for non-PPS hospitals.

The Bureau will review rates annually to determine the need for rebasing rates. New hospitals beginning operations subsequent to FY 1991, the base year, will be placed into a peer group based on bed size or specialty. New hospitals not having completed six months or more of operations and not having filed such a cost report by June 30, 1994 will receive the applicable peer group rates in the first prospective rate year for operations and movable equipment and the statewide median for fixed capital. In establishing the prospective rates for new hospitals that did not file a Title XIX 1991 cost report, the department will utilize cost data contained in their initial Title XIX cost report in the event that cost reporting period includes a minimum of six months and is filed by June 30, 1994. The methodology for establishing these blended rates will be in accordance with the methodology outlined below.

Blended rates will be established to phase in over a three year transition period to minimize the impact from changing the reimbursement methodology. Throughout this phase-in period, all hospitals will receive a blended rate of the established peer group rate and a portion of the trended base period hospital-specific cost per diem for operating, capital (movable and fixed), education and specialty units per diem costs.

The blend for hospitals with costs per day above the group's weighted median for operations will be 70% of the peer group rate and 30% hospital or unit-specific allowable costs per day in the first year of the phase-in period. Payment for movable equipment will be calculated as 70% of the peer group median plus 30% of the hospital/unit-specific allowable cost per day.

The blend for hospitals with costs per day for operations above the group's weighted median (inflated using the DRI type hospital market basket index) will be 80% of the peer group rate and 20% hospital or unit-specific allowable cost per day (inflated using the DRI type hospital market basket index) in the second year of the phase-in period. Payment for movable equipment will be calculated as 80% of the median plus 20% of the hospital/unit-specific allowable cost per day.

The blend in the third year will become 90% of the peer group rates and 10% of the hospital or unit-specific allowable operating cost and movable equipment cost per day. DRI type hospital market basket index will be applied to peer group rates and cost per day amounts.

Fixed capital statewide median rates will be established for acute care hospitals, specialty hospitals and high-intensity special care units. These medians will be blended with hospital/unit-specific fixed capital allowable costs to calculate the fixed capital payment rates. The blend during the phase-in is as explained earlier. (70/30, 80/20, and 90/10 - median/hospital or unit-specific rate.)

Hospitals whose allowable operating cost per day is below the peer group rates will receive their cost plus 25% of the difference between their costs and the peer group rate during the phase in period of three years.

Specialty hospitals and high intensity units without peers are treated separately with prospective payment rates based on their allowable operating, movable equipment, fixed capital, and education costs. These payment rates are established according to the facilities' base year operating, movable equipment, fixed capital, and education costs as reported in fiscal year 1991 trended forward as previously explained.

Rates will be trended from 1991 until rebasing occurs. All rates will be adjusted effective July 1 of each year. The new rates will be inflated to the mid-point of the State's fiscal year using Data Resources Incorporated published hospital market basket index for non-PPS hospitals.

An outlier policy is established which addresses catastrophic cost associated with services to children under six years of age received in a disproportionate share hospital and for services to infants one year or under in all acute care general hospitals. On an individual case basis, if covered charges exceed 200% of the prospective payment, payment will be made at cost. Cost is defined as the hospital specific ratio of cost to charges from the base period applied to covered charges. New hospitals not having submitted a cost report of at least 6 months on or before June 30, 1994, will use the ratio of cost to charges from their respective peer group weighted median hospital.

APPEALS PROCEDURE

REQUEST FOR ADMINISTRATIVE REVIEW

Any hospital seeking an adjustment to the operations, movable, fixed capital, or education component of its rate, will submit a written request for administrative review to the Director of Institutional Reimbursement (hereafter referred to as director) in the Department of Health and Hospitals (hereafter referred to as department), within 30 days after receipt of the letter notifying the hospital of its rates. The receipt of the letter notifying the hospital of its rates will be deemed to be 5 days from the date of the letter. The time period for requesting an administrative review may be extended upon written agreement between the department and the hospital.

1. Written Request

   The written request for administrative review must contain the information specified below. The department will acknowledge receipt of the written request within 30 days after actual receipt. The department may request additional documentation from the hospital as may be necessary for the director to render a decision. The director will make a decision upon the hospital's request for an adjustment to the operations, movable equipment, fixed capital, or education component of its rate within 90 days after receipt of all additional documentation or information requested. The decision of the director will be written, and if adverse to the hospital, the hospital may appeal the director's decision to the Office of the Secretary, Bureau of Appeals for the Department of Health and Hospitals, P.O. Box 4183, Baton Rouge, Louisiana 70821-4183. The appeal must be lodged with the Bureau of Appeals within thirty days of receipt of the written decision of the director. The receipt of the decision of the director will be deemed to be 5 days from the date of the decision.

2. Requirements

   Any hospital seeking an adjustment to the operating, movable equipment, fixed capital, or education component of its rate, must specify all the following:

   - The nature of the adjustment sought
   - The amount of the adjustment sought
   - The reasons or factors that the hospital believes justify an adjustment.

Any request for an adjustment must include an analysis demonstrating the extent to which the hospital is incurring or expects to incur a qualifying loss (defined below) in providing covered services to Title XIX Medicaid clients.

The hospital will not be required to present an analysis of its qualifying loss where the basis for its appeal is limited to a claim that

- The rate-setting methodology or criteria for classifying hospitals or hospital claims under the State Plan were incorrectly applied
- That incorrect or incomplete data or erroneous calculations were used in establishment of the hospital rates
- That the hospital has incurred additional costs because of a catastrophe that meets the conditions specified below.

3. Qualifying Loss

"Qualifying loss" as used in these rules means that amount by which the hospital's operating costs, movable equipment costs, fixed capital costs, or education costs (excluding disproportionate share payment adjustments) exceeds the Title XIX Medicaid reimbursement implemented pursuant to this rule for each relevant component thereof (i.e., operating costs, movable equipment costs, fixed capital costs, or education costs.

"Costs" when used in the context of operating costs, movable equipment costs, fixed capital costs, and education costs means a hospital's costs for providing covered inpatient services to Title XIX Medicaid clients as calculated in relevant definitions governing cost reporting.

Except in cases where the basis for the hospital's appeal is limited to a claim that rate-setting methodologies or principles of reimbursement established under the reimbursement plan were incorrectly applied, or that the incorrect or incomplete data or erroneous calculations were in the establishment of the hospital's rate, the department will not award additional reimbursement to a hospital, unless the hospital demonstrates that the reimbursement it receives based on its prospective rate is 70% or less of the operating costs, movable equipment costs, fixed capital costs and /or education costs it incurs in providing Title XIX Medicaid patients care and services that conform to the applicable state and federal laws of quality and safety standards. The department will not increase a provider's rate to more than 150% of the peer group rate.

4. Unresolved Disputes

In cases where the rate appeal relates to an unresolved dispute between the hospital and its Medicare fiscal intermediary as to any cost reported in the hospital's base year cost report, the director will resolve such disputes for purposes of deciding the request for administrative review.

5. Exclusions

The following matters will not be subject to appeal:

- The use of peer grouped weighted medians to establish operations prospective per diems
- The use of peer grouped medians to establish movable capital prospective per diems
- The use of statewide median to establish fixed capital prospective per diems
- The percentages used to blend peer group and statewide rates and hospital-specific costs during the three year phase-in period
- The use of teaching, non-teaching, and bed-size as criteria for hospital peer groups
- The use of Council of Teaching Hospitals membership as criteria for major teaching status
- The use of fiscal year 1991 medical education costs to establish a hospital-specific medical education component of each teaching hospital's prospective rate
- The use of the DATA Resources, Inc. DRI Type Hospital market Basket Index as the prospective escalator for operating and movable equipment costs
- The decision not to escalate fixed capital during the three year phase-in period
- The use of the Marshal Swift construction index as the prospective escalator for fixed-capital statewide median costs following the three year phase-in period
- The criteria used to establish the levels of neonatal intensive care
- The criteria used to establish the levels of pediatric intensive care

- The methodology used to calculate the boarder baby rates for nursery
- The use of per case prospective rates for transplants
- The criteria used to identify specialty hospital peer groups
- The criteria used to establish the level of burn care.

6. Burden of Proof and Factors for Consideration in Determining Whether to Grant a Rate Adjustment

The hospital will bear the burden of proof in establishing facts and circumstances necessary to support a rate adjustment. Any costs the provider cites as a basis for relief must be calculable and auditable. The department will award additional reimbursement to a hospital that clearly demonstrates **all of the following:**

- The hospital demonstrated a qualifying loss
- The hospital's current prospective rate jeopardized the its long-term financial viability
- The Medicaid population served by the hospital has no reasonable access to other inpatient hospitals for the services that the hospital provides and that the hospital contends are under reimbursed.

In determining the award of additional reimbursement to a hospital that has met the requirements, the director will consider one or more of the factors and may take any of the actions described below.

- The director shall consider whether the hospital has demonstrated that its unreimbursed costs are generated by factors generally not shared by other hospitals in its peer group. Such factors may include but are not limited to extraordinary circumstances beyond the hospital's control and improvements required to comply with licensing or accrediting standards. Where it appears from the evidence presented that the hospital's costs are controllable through good management practices or cost containment measures, the director may deny the request for rate adjustment.
- The director may consider and may require the hospital to provide financial data including but not limited to financial ratio data indicative of the hospital's performance quality in particular areas of hospital operation.

- The director shall consider whether the hospital has taken every reasonable action to contain costs on a hospital-wide basis. In making such a determination, the director may require the hospital to provide audited cost data or other quantitative data including but not limited to occupancy statistics, average hourly wages paid, nursing salaries per adjusted patient day, average length of stay, cost per ancillary procedure, average cost per meal served, average cost per pound of laundry, average cost per pharmacy prescription, housekeeping costs per square foot, medical records costs per admission, full-time equivalent employees per occupied bed, age of receivables, bad debt percentage, inventory turnover rate and information about actions that the hospital has taken to contain costs.

The director may also require that an on-site operational review/audit of the hospital be conducted by the department or its designee.

7. Awarding Relief

In awarding relief under this provision, the director shall

- Make any necessary adjustments so as to correctly apply the rate-setting methodology to the hospital submitting the appeal or to correct calculations, data errors or omissions

- Increase one or more of the hospital's rates or rate components by an amount that can reasonably be expected to ensure continuing access to sufficient inpatient hospital services of adequate quality for Title XIX Medicaid clients served by the hospital.

Decisions by the director to recognize omitted, additional or increased costs incurred by any hospital; to adjust the hospital rates; or to otherwise award additional reimbursement to any hospital will not result in any change in the peer group weighted median for operation or median for movable capital or statewide median for fixed capital until rebasing of the reimbursement system.

Rate adjustments granted under this provision shall be effective from the first day of the rate period to which the hospital's appeal relates, shall continue in effect during subsequent rate periods until re-basing of the payment system, and shall be inflated by the applicable prospective escalator. However, no retroactive adjustments will be made to the rate or rates that were paid during any prior rate period.

ADMINISTRATIVE APPEAL

If the director's decision is adverse to the hospital, the hospital may appeal the decision to the Office of the Secretary, Bureau of Appeals for the Department of Health and Hospitals, P.O. Box 4183, Baton Rouge, Louisiana 70821-4183. The appeal must be lodged with the Bureau of Appeals within 30 days of receipt of the written decision of the director. The receipt of the decision of the director shall be deemed to be five days from the date of the decision. The administrative appeal shall be conducted in accordance with the Louisiana Administrative Procedures Act (La.R.S. 49:951 et seq). The Bureau of Appeals shall submit a recommended decision to the Secretary of the Department (hereafter referred to as the secretary). The secretary will issue the final decision of the department.

JUDICIAL REVIEW

Judicial review of the administrative appeal decision shall be in accordance with the Louisiana Administrative Procedures Act (La.R.S. 49:951 et seq) and shall be filed in the nineteenth Judicial District Court.

MEDICAID DISPROPORTIONATE SHARE PAYMENT ADJUSTMENT FOR INPATIENT HOSPITAL REIMBURSEMENT

Disproportionate share adjustment payments are an additional Medicaid payment to hospitals which serve a disproportionate number of low income patients with special needs. Congress enacted this provision in 1981 as an option, but when most states failed to implement such additional payments, implementation of a provision for disproportionate share adjustment payments to Medicaid payment methodologies for inpatient hospital services provided on or after July 1, 1988 via Section 4112 of the Omnibus Reconciliation Act of 1987 (OBRA-87), was subsequently mandated.

Section 411(k) of the Medicare Catastrophic Coverage Act of 1988 required inclusion of state subsidies into the low-income utilization formula for qualification as a disproportionate share hospital (DSH). Sections 4702 and 4703 of the Omnibus Reconciliation Act of 1990 (OBRA-90) further modified the original statute to define an "inpatient day" as each day an individual (including a newborn) is an inpatient in the hospital; and added provisions which tied the disproportionate share adjustment to the low income utilization percentage as well as provided an alternative payment adjustment that may vary by type of hospital.

Medicaid Voluntary Contributions and Provider Specific Taxes Act of 1991 (P. L. 102-234) placed a cap on DSH payments effective for services 10/1/92 and after, not to exceed DSH payments in federal fiscal year 1992 (10/1/91 - 9/30/92) or 12% of total Medicaid expenditures for all services, whichever is higher. The Omnibus Reconciliation Act of 1993 placed further restrictions on disproportionate share payments to public hospitals for services effective July 1, 1994 which limits DSH payments to either 100% or 200% of uncompensated costs for Medicaid and indigent patients. It also provides, effective for services July 1, 1995, that all hospitals (public and private) will have DSH payments limited to 100% of uncompensated costs for Medicaid and indigent patients beginning in fiscal year 1995. A transition period for services furnished from 7/1/94 through 6/30/95 is provided for high disproportionate share public hospitals. Public "high disproportionate share hospitals" will receive disproportionate share payments not to exceed 200% of costs incurred during the year for furnishing hospital services to individuals who are either Medicaid eligible or who have no health insurance or other source of third party coverage for services provided, not of any payments received from Medicaid (other than disproportionate share payments) or from uninsured parties.

QUALIFICATIONS

To qualify as a hospital serving a disproportionate share of indigent patients, specific criteria must be met. The hospital must provide documentation that the following criteria are met prior to being recognized as a DSH hospital. A form letter is sent out by DHH to verify the staffing

requirement, while utilization criteria is based on the latest filed cost report. The DSH qualifying criteria are as follows.

Staffing Requirements

1. Hospital has at least two obstetricians who have staff privileges at the hospital and who agree to provide obstetric services to individuals who are Medicaid eligible. In rural areas (area outside of a Metropolitan Statistical Area) the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures; or

2. The hospital did not offer non-emergency obstetric services to the general public as of December 22, 1987; or

3. The hospital treats inpatients predominantly under 18 years of age.

*Note: **New hospitals must meet the obstetric requirement unless the hospital can document that it treats inpatients predominantly under 18 years of age.***

Utilization Rates

1. **Medicaid Utilization Rate:** The qualifying disproportionate share hospital must have a Medicaid inpatient utilization rate of at least one per cent. The hospital's ratio of Medicaid inpatient days to total inpatient days (both are exclusive of Skilled Nursing (SNF) beds, swing beds and observation beds) is greater than the mean plus one standard deviation of the Medicaid utilization rates for all hospitals in the state receiving payments; the qualifying percentages are noted below for the specified cost reporting periods.

   A. Cost reporting periods beginning 7/1/88 = 21.42%
   B. Cost reporting periods beginning 10/1/88 = 24.3%
   C. Cost reporting periods beginning 10/1/89 = 26.86%
   D. Cost reporting periods beginning 10/1/90 = 30.78%
   E. Cost reporting periods beginning 10/1/91 = 33.32%
   F. Cost reporting periods beginning 10/1/92 = 38.86%

OR

2. **Low-Income Utilization Rate (LIUR):** The hospital qualifies as DSH if the sum of the below two fractions exceeds 25%.

A. **Revenue Fraction:** A fraction the numerator of which equals the sum of net Medicaid patient revenues plus state subsidies attributed to patient care; and the denominator of which equals the total amount of net patient revenues for the hospital (including state/local subsidy). Net revenues are defined as gross revenues less contractual adjustments and discounts for inpatient and outpatient hospital services and excludes disproportionate share payments.

B. **Free Care Fraction:** A fraction the numerator of which equals the inpatient charges for inpatient services provided to indigent patients in accordance with a free care plan approved by the department; the denominator of which is equal to total inpatient charges.

DSH PAYMENT ADJUSTMENT METHODOLOGIES

Disproportionate Share Payments—Medicaid Days Pool Payments

Qualification and payment adjustment for disproportionate share will be based on the hospital's year end cost report for the year ending during April 1 through March 31 of the previous year.

> **Example:** Hospital fiscal year ends November 30. Any disproportionate payment made after April 1, 1994 would be based on the November 30, 1993 cost report. Effective April 1995, payment would be made on the hospital's November 30, 1994 cost report.

Hospitals which have not filed a cost report by March 31, 1994 will not participate in the disproportionate share payment pools from April 1, 1994 through March 31, 1995. Hospitals which meet the qualification criteria outlined in the State Plan, based on the latest filed fiscal year end cost report as of March 31st of each year will be included in not more than two of following six pools for calculation of disproportionate share payments.

For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization, but for purposes of disproportionate share hospital payment adjustments, the distinct part psychiatric units will be placed in the psychiatric pools while the acute medical/surgical will be included in the appropriate teaching or non-teaching pool. Hospitals must meet the criteria for the pool classification based on their latest filed fiscal year-end cost report as of March 31st of each year. These six pools are as follows.

1. **Private Rural Acute Hospitals:** Privately owned acute care general hospitals that are designated as a rural hospital under criteria specified below.

2. **Private Rural Distinct Part Psychiatric Units/Freestanding Psychiatric Hospitals:** Privately-owned distinct part psychiatric units/freestanding psychiatric hospitals that are located in a rural area under criteria specified below.

3. **Private Teaching Hospitals:** Privately owned acute care general hospitals (exclusive of distinct part psychiatric units) that are recognized as approved teaching hospitals under criteria specified below.

4. **Private Urban Non-Teaching Hospitals:** Privately owned acute care general hospitals (exclusive of distinct part psychiatric units) that are designated as urban hospitals and not recognized as approved teaching hospitals under criteria specified below.

5. **Private Teaching Distinct Part Psychiatric Units/Freestanding Psychiatric Hospitals:** Privately owned distinct part psychiatric units/freestanding psychiatric hospitals that meet the criteria for recognition as approved teaching hospitals under criteria specified below.

6. **Private Urban Non-Teaching Distinct Part Psychiatric Units/Freestanding Psychiatric Hospitals:** Privately-owned distinct part psychiatric units/freestanding psychiatric hospitals that are located in an urban area and do not meet the criteria for recognition as approved teaching hospitals under criteria specified below.

The definitions for hospital classifications applicable to the Medicaid days pools are given below.

Teaching Facility

A teaching hospital is defined as a licensed acute care hospital in compliance with the Medicare regulations regarding such facilities, or a specialty hospital that is excluded from the prospective payment system as defined by Medicare. A teaching hospital must have a written affiliation agreement with an accredited medical school to provide post graduate medical resident training in the hospital for the specialty services provided in the specialty hospital. The affiliation agreement must contain an outline of its program in regard to staffing, residents at the facility, etc. A distinct part or carve-out unit of a hospital will not be considered a teaching hospital separate from the hospital as a whole. Teaching hospitals that are not recognized by Medicare as an approved teaching hospital must furnish copies of graduate medical education program assignment schedules and rotation schedules to the department.

Urban Hospital

A hospital located in a Metropolitan Statistical Area as defined per the 1990 census. This excludes any reclassification under Medicare.

Rural Hospital

A hospital that is not located in a Metropolitan Statistical Area as defined per the 1990 census. This excludes any reclassification for Medicare.

Distinct Part Psychiatric Unit/Free-Standing Psychiatric Hospital

Distinct part psychiatric units of acute care general hospitals or psychiatric units in long term care hospitals meeting the Medicare criteria for PPS exempt units and enrolled under a separate Medicaid provider number and freestanding psychiatric hospitals enrolled as such.

Hospitals qualifying by March 31st each year under the provisions in the approved state plan with fiscal year-end cost reports which do not reflect 12 months of cost report data shall have Medicaid days annualized by the Bureau for the above pools. This includes hospitals which have partial year fiscal year-end cost reports as well as hospitals which added beds during the year to ensure that these are equally represented in the pool for the period of time to which the DSH payments will apply. Hospitals which request annualization of Medicaid days for purposes of the above pools must submit sufficient documentation to the Bureau. All days included in the pool will be weighted by a factor of 1.0. This includes days for hospitals that were previously recognized as "Medicaid dependent hospitals" and a factor of 1.25 was used.

Disproportionate share payments for each pool shall be calculated based on the product of the ratio determined by dividing each qualifying hospital's total Medicaid inpatient days for the applicable cost report as adjusted for annualization by the total Medicaid inpatient days provided by all such hospitals in the state qualifying as disproportionate share hospitals in their respective pools and then multiplied by an amount of funds for each respective pool to be determined by the Director of the Bureau of Health Services Financing. Total Medicaid inpatient hospital days include Medicaid nursery days, but do not include SNF or swing-bed days.

Partial payments based on the above Medicaid pools may be made in February and March of 1994. Subsequent payments shall be made on dates as determined by the Secretary of the Department of Health and Hospitals.

If at audit or final settlement of the cost reports on which the pools are based, the above qualifying criteria are not met, or the number of Medicaid inpatient days are reduced from those originally reported, appropriate action shall be taken to recover any over payments resulting from the use of erroneous data. No additional payments shall be made if an increase in days is determined after audit.

Hospitals/units which close or withdraw from the Medicaid Program shall become ineligible for further DSH pool payments.

Disproportionate Share Payments—Indigent Care (Free Care)

In addition to the six pools based on Medicaid days described above, the Bureau will continue to reimburse qualifying hospitals an additional disproportionate share adjustment payment based on the hospital's number of indigent care days provided under a indigent care plan approved by the Bureau. Payment(s) shall be made during the federal fiscal year to qualifying disproportionate share hospitals for indigent care days based on the following criteria.

1. The indigent disproportionate share adjustment per diem payment will be limited to each hospital's total Medicaid per diem equivalent amount. Medicaid per diem equivalence will no longer be paid for indigent days for public hospitals. The Medicaid per diem equivalent amount is the sum of the provider's base Medicaid per diem (cost based or prospective, as applicable) plus the provider's Medicaid disproportionate share per diem as established according to the Medicaid DSH pool in which the facility participates. For Federal Fiscal Year 1994, the Medicaid per diem amount will be each hospital's Medicaid per diem amount in effect as of March 1, 1994 and the Medicaid DSH pool per diem amount paid in accordance with the revised February 1994 pool amounts. For subsequent federal fiscal years, the per diem will be the Medicaid per diem amount in effect the previous July 1st and the Medicaid DSH pool per diem amount as established for the federal fiscal year.

2. The indigent care payments will be determined based on each DSH hospital's (which qualified for DSH per the latest filed March 31st fiscal year-end cost report) indigent care days provided within the state fiscal year. Qualifying disproportionate share hospitals will submit documentation of indigent care days provided during a state fiscal year within 120 days of the end of the state fiscal year in a format specified by the state and will maintain documentation for all indigent care determinations for the same period Medicaid records for qualification for disproportionate share adjustment are maintained.

3. The department's Indigent Care Plan Criteria for recognition of indigent days in the Indigent Pool for additional disproportionate share payments are delineated below.

   A. The annual family income for patients qualifying for indigent care may not exceed 200% of the Federal Poverty Income Guidelines for the period of time in which the services were provided.

   B. The facility must advise the public of the availability of indigent care services and of its policies for qualifying patients for indigent care. The facility must post a written copy of its policy conspicuously in all patient treatment areas, admissions and provide individual written notices to patients and/or their family members upon admission.

C. The facility must provide a form for individuals to apply for indigent care services upon admission to the facility. These forms must be maintained on file and be available for audit in accordance with all state and federal rules and regulations. The application must be signed by the applicant except for patients deemed mentally unstable by the physician and for which access for interview has been restricted by physician's orders. The facility must supply auditors with facility's procedures for verification of available payment sources for such patients. Medicaid eligibility resources must be demonstrated to have been exhausted (i.e. application denied) for recognition as an indigent care patient.

D. The facility must make a determination of the patient's eligibility for indigent care services within two working days after application, notify the patient properly of the decision, and keep a copy on file for audit in accordance with state and federal rules and regulations. Income verification should be attempted via review of pay stubs, W-2 records, unemployment compensation book, or collateral contact with employer etc. If income verification has not been completed within two working days, the facility may condition the determination of eligibility on income verification. The facility may also condition the determination of indigent care eligibility on application for Medicaid eligibility. The conditional determination must be completed within two working days of the request for indigent care. The facility must supply documentation that Medicaid eligibility was denied.

E. The facility must maintain a log of indigent care services provided each fiscal year for audit purposes in compliance with state and federal rules and regulations. Patient identifying information such as patient name, social security number, date of birth, dates of service, medical record number, patient account number, number of free care days, and amount of indigent care charges must be included on the log.

F. An indigent day may be included in the indigent care days count only to the extent that the entire day is deemed to be an indigent care day. If indigence is determined on a sliding scale which is based on total charges, any day for which the patient is liable for more than 50% of the charges may **not** be considered as an indigent care day. Inpatient days denied for Medicaid recipients who had exhausted their Medicaid inpatient days may be recognized as indigent days provided that documentation of the reasons for denial demonstrates that the recipient is over the limit of days. Medicaid days denied for other reasons resulting from failure to comply with Medicaid policies and procedures will not be recognized as indigent days. Prisoners receiving services in state hospitals are deemed indigent in accordance with state law. Inpatient days paid by Medicaid are <u>not</u> recognized as indigent days. Hill-Burton days used to meet an obligation under this program are <u>not</u> recognized as free care days. Medicare bad debt days are not allowable as indigent days. Days for accounts written off as bad debt are not allowable as indigent days.

G. For state-operated facilities an indigent care plan promulgated and implemented in accordance with state law and regulations will be recognized in lieu of the above criteria for determining indigent care days eligible for disproportionate share payments.

If audit of the data submitted for indigent care days results in the hospital not meeting the disproportionate share qualification provisions in the approved state plan or the number of indigent inpatient days are reduced from those originally reported, appropriate action will be taken to recover such overpayments. No additional payments shall be made if an increase in indigent days is determined.

Hospitals/units which close or withdraw from the Medicaid Program will become ineligible for further DSH indigent care payments.

Disproportionate share payments/pool amounts shall be allocated based on consideration of the volume of days in each pool and allowable indigent days or the average cost per day for hospitals in each pool. Disproportionate share payments cumulative for all DSH payments under the pools or any other DSH payment methodology will not exceed the federal disproportionate share state payment cap for each federal fiscal year.

INPATIENT REIMBURSEMENT
(Only State-Operated Hospitals)

An interim reimbursement for inpatient hospital services is made in the form of a per diem rate. These rates are determined after each fiscal year or after cost settlement or as requested by provider, and they become effective when advised by BHSF. This per diem is paid throughout the year and is determined by dividing the allowable Medicaid inpatient service costs by Medicaid (Title XIX) days. At the year-end cost settlement, a payment adjustment is made to balance out per diem payments in accordance with the hospital's allowable costs subject to limits. A cost report must be submitted within 90 days after the fiscal year-end to Blue Cross of Louisiana or to the Medicaid Program if Medicare Intermediary is other than Blue Cross. The cost report is reviewed for payment adjustments that will be put into effect.

Final reimbursement is determined at the time of the hospital's cost settlement and is based on the hospital's actual cost per discharge, as compared to the hospital's target amount (cost per discharge limit multiplied by number of Medicaid discharges) for services to Medicaid recipients.

The hospital's target rate is determined based on Medicaid allowable operating costs divided by the number of Medicaid discharges for the cost reporting period between September 30, 1981, and September 29, 1982. The following costs are excluded from the calculation of this cost per discharge:

- Capital-related expenses
- Medical education-related expenses
- Malpractice insurance costs
- Return on equity.

The Medicaid share of these costs is included in the total Medicaid reimbursement at the time of the hospital's cost settlement at fiscal year end.

The target rate for subsequent years is determined by increasing the previous year's target rate by the target rate percentage (the market basket index of hospital wages and prices plus 1% as adjusted by the Health Care Financing Administration) for the applicable cost reporting period(s).

REQUEST FOR ADJUSTMENT OF COST PER DISCHARGE LIMITS
(Only State-Operated Hospitals)

A hospital may request an exception to have its operating cost adjusted upward or downward, as appropriate, under any of the following circumstances:

- Extraordinary Circumstances
- Change in Case Mix/Increase in Intensity of Services
- Length of Stay Changes.

An adjustment will be made only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified, separately identified by the hospital, and verified by audit. An exception or adjustment will be granted only when the hospital's operating costs exceed the rate of increase ceiling applicable for that cost reporting period. An exception/adjustment will not be granted when increased costs are attributable solely to decreases in utilization. Requests for adjustments or exceptions must be submitted no later than 60 days from the ***Medicaid Notice of Provider Reimbursement (NPR)***. Detailed documentation supporting the provider's request must be submitted within 120 days from the Medicaid NPR date.

The specific methodology used by Medicaid to review requests for adjustments or exceptions for hospital providers who are subject to the TEFRA cost per discharge limitations are further delineated below. Such adjustments are intended to take into account factors which could result in significant distortions in the operating costs of inpatient hospital services. Such adjustments may be necessary to ensure comparability of cost reporting periods. The hospital must provide sufficient documentation in the format specified below and as otherwise requested by the Medicaid Program.

Requests for adjustments or target rates must be submitted in writing to the Director of the Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, Louisiana 70821-9030, with the basis for the adjustment specifically stated in the documentation submitted for review. Additional information may be requested by the state to ensure that adjustments are related to actual costs and not to the redistribution of costs.

1. Extraordinary Circumstances

   The hospital must demonstrate that it incurred unusual costs (in either a cost reporting period subject to the ceiling or in the hospital's base period) due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquakes, floods, or similar unusual occurrences with substantial cost effects. Generally,

these adjustments are applicable only to that specific cost reporting period and are not a "permanent" adjustment which would trend forward to subsequent cost reporting periods.

2. Length of Stay Changes

When the average length of stay has increased from the base period to the current period, a one-time adjustment (not permanent) may be granted for that specific cost reporting period in which the change in length of stay occurred. The adjustment is calculated using the following steps.

- Identify the total inpatient operating cost, excluding pass-through costs for the reporting period for which adjustment is requested (Worksheet D-1, part II, Line 54).
- Identify the number of Medicaid days in the cost reporting period for base period and the requested adjustment period (Worksheet D-1, Part I, Line 9).
- Convert the target amount for the current period to a per diem amount by multiplying the target rate for the cost reporting period by the number of discharges and dividing by the number of Medicaid days.
- Multiply the per diem amount for the current period by the base period discharges and divide by the base period days to determine a revised target amount.
- Ensure that the allowable program inpatient costs for the requested adjustment period is the lesser of the revised target amount times the current number of discharges or the actual inpatient operating costs plus excluded program costs.

If the addition of a new unit also increases the average length of stay, the length of stay adjustment must be completed first. An additional adjustment may be requested if the length of stay adjustment is not sufficient to permit reimbursement of reasonably allowable costs related to the reason for the adjustment. If the length of stay adjustment results in all allowable costs being reimbursed in the initial year, it is anticipated to do so in subsequent fiscal years as well. If the increase in length of stay adjustment does not cover all costs in subsequent years, it is supposed that the basis for any further adjustments would have to be different from the original length of stay adjustment. These procedures and calculations are based on the methodology used by Medicare for the purpose of reviewing and calculating adjustments to the cost per discharge limitations in accordance with 42 CFR 413.40.

3. Change in Case Mix/Increase in Intensity of Services

Such circumstances include all of the following.

- The hospital has added or discontinued services in a cost reporting period after its base period.
- The hospital has experienced a change in case mix as a result of the increased severity of illness in patients treated that results in a distortion in the rate of cost increase.
- The hospital has submitted data/documentation summarizing the case-mix changes and the resulting changes in costs.

If increased costs are attributed to the addition of a new unit or service, the costs and discharges for this unit/service should be isolated, and these costs should be added to the current period target amount for the applicable cost reporting period for which the adjustment is requested. The direct operating costs related to this unit/service may be limited to only routine operating costs or may include related ancillary costs, if these differ significantly from those applicable to discharges in the base period. Then, the revised total inpatient operating cost should be divided by the revised number of discharges (the number of discharges attributable to the new unit/service plus the current period number of discharges without the new unit/service discharges).

The figure derived will be the adjusted target rate. This rate will be a "permanent" adjustment which would then flow forward to subsequent cost reporting periods if the new unit/service is in operation for the full 12 months of the cost reporting period.

If the new unit/service has been operating less than 12 months, a one-time adjustment for that cost reporting period may be granted, but a "permanent" adjustment will need to be calculated, using the subsequent cost reporting period which includes a full 12 months of operation. In addition, the provider must do the following.

- Identify the new inpatient unit or service responsible for the increase in inpatient operating costs.
- Identify the date on which a new unit/service became operational.
- Specify the direct costs of the new unit/service and the portion of those costs included in the Total Program Inpatient Operating cost.

- Identify indirect costs incurred specifically as a result of the addition of the new unit/service.

The request must identify actual increases in indirect cost specifically attributable to the new unit or service. An adjustment is only available for actual increases in the indirect costs, not redistribution of existing indirect costs that result from the cost finding process.

Documentation submitted must be as complete and detailed as possible. In addressing the amount of the distortion that occurs, hospitals should specify the basis for such a distortion. Costs must be categorized as capital costs, staffing costs, supplies, etc. Additional information, such as the number of new personnel employed, special training of personnel, hours of operation, and hourly salary levels of staff, should be submitted as well. The impact of the new unit/service on the historical cost structure of the hospital should be documented as well. A cost report for the period impacted by the new unit/service which identifies costs associated with this unit/service by reporting these as a sub-provider would be acceptable as documentation, but the impact on the inpatient utilization levels of the hospital and a summary of the patient logs related to the new unit/service must be submitted as well. Such summaries should include the patient name, Medicaid identification number, dates of service, date of payment, and total charges by revenue code (routine and ancillary).

If increased costs are attributed to an increase in intensity or utilization of a particular ancillary service/cost center for Medicaid recipients, the cost for this service/cost center for the base period should be componentized by determining the average Medicaid cost per discharge in the base period and then inflating up to the current period for which the adjustment has been requested. Hospitals should compare the current period cost per discharge for this service/cost center to the inflated base period cost/discharge. If the current year cost is greater than the inflated base period cost, hospitals should incorporate the current period cost into the base period ancillary cost to adjust the base period target rate, and then inflate up to the current period to calculate the revised cost per discharge limitation. Documentation regarding the utilization in both periods must be submitted, i.e., number of procedures/units.

The addition of a new service does not necessarily warrant rebasing under Section 6105(a) of Public Law 101-239. In order to justify rebasing, a permanent, substantial, and significant change in the nature of services provided by the hospital must have occurred. For example, the addition of a substance abuse unit would not warrant rebasing.

EXAMPLES AND ILLUSTRATED CALCULATIONS

The examples and calculations illustrated on the following pages demonstrate the methodology Medicaid uses to calculate the adjustments indicated. Without the information reflected in a particular calculation, Medicaid is unable to process the respective adjustment. The following are examples of situations most commonly found as the factors causing a hospital to exceed its rate of increase ceiling. A hospital is not precluded, however, from submitting and documenting other factors related to patient care services that contributed to its costs exceeding the rate of increase ceiling as long as these factors are substantiated with documentation that quantifies the financial effect relative to its Medicaid inpatient operating costs per discharge in the current cost reporting period compared to its base year.

1. Adjustment for Extraordinary Circumstances

   These circumstances include, but are not limited to, fire, earthquakes, floods, or similar unusual occurrences causing substantial cost increases in a cost reporting period. A provider may request an adjustment to the rate of increase ceiling for the cost reporting period(s) affected by such circumstances that are beyond the provider's control.

   There is no example or illustrated calculation given for this type of adjustment.

2. Increase in the Average Length of Stay of Medicaid Patients

   If an increase in the average length of stay of Medicaid patients over that of the base year is the cause of the excess costs, the reasons contributing to length of stay increase must be established and documented. Common causes for increases in length of stay are

   - Increased medical acuity
   - Changes in admission practices or criteria
   - Changes in types of patients served
   - Changes in practice patterns

   The reasons for a length of stay increase must be substantiated with supporting documentation, such as differences in the number of cases per diagnosis and their length of stay in the base year as compared to the applicable cost reporting period upon verification of documentation.

Example 2-A: Adjustment Calculation for Increase in Average Length of Stay

Since the rate of increase ceiling is based on an average cost per discharge, the impact of the increase in the average length of stay of Medicaid patients is measured by converting the target amount from a per discharge limit to a limit based on a per diem rate. The amount of the adjustment is limited to the lesser of the difference between the ceiling based on the per discharge target amount and one based on the per diem target amount or the operating costs that exceed the ceiling based on the per discharge target amount.

The following example illustrates the methodology for determining an adjustment for a hospital's FY 1992 cost reporting period.

Example 2-A:	Medicaid TEFRA Target Rate Adjustment For Increase in Average Length of Stay FYE 6/30/92	
A.	**Data Input:**	
1.	Base TEFRA FYE	6/30/82
2.	Base Year Medicaid discharges	1,228
3.	Base year Medicaid days	6,632
4.	Base year Medicaid target amount per discharge	$2,247.34
5.	FYE adjustment requested	6/30/92
6.	FYE 6/30/92 Medicaid discharges	2,500
7.	FYE 6/30/92 Medicaid days	14,100
8.	FYE 6/30/92 inflated Medicaid target amount per discharge	$3,113.12
9.	FYE 6/30/92 disallowance based on per discharge ceiling	$280,056
10.	FYE 6/30/92 Medicaid excludable cost	$540,888
B.	**Determination of Increase in Medicaid ALOS:**	
1.	Base year Medicaid ALOS	5.40
3.	Current year Medicaid ALOS	5.64
4.	Difference in average Medicaid LOS (line 2 - line 1)	**0.24**
C.	**Calculation of Medicaid ALOS Adjustment:**	
1.	Target rate converted into a per diem limitation – a) Current target rate multiplied by Medicaid base year discharges b) Target amount divided by base year Medicaid days	 $3,822,911 $576.43
2.	Revised ceiling (Current year Medicaid days x per diem limitation)	$8,127,722
3.	Ceiling based on a per discharge rate (from Supplemental Worksheet D-1)	$7,782,800
4.	Difference between per diem and per discharge ceilings (line 2 - line 3)	$344,922
5.	Disallowance based on per discharge ceiling (from Supplemental Worksheet D-1)	$280,056
6.	ALOS adjustment (lesser of line 4 or line 5)	**$280,056**
D.	**Adjusted Medicaid Inpatient Allowable Cost:**	
1.	Current ceiling based on per discharge amount (excl. DSH)	$7,782,800
2.	ALOS adjustment	$280,056
3.	Excludable cost	$540,888
4.	Total Medicaid inpatient allowable cost (sum of lines 1, 2, & 3)	**$8,603,744**
	NOTE: Adjusted Target Rate Amount = $3,225.14	

Figure 9-1. Example 2-A: Adjustment Calculation for Increase in Average Length of Stay

3. Increase in Costs of Direct Patient Care Services

A variety of factors can cause an increase in the cost per patient day of direct patient care services as compared to the base year. Serving a different patient population than in the base year may require the delivery of more services per patient, the hiring of additional staff or an upgrading of staff skill level, or the addition of new services. The change in patient population must be documented and its affect on the hospital's inpatient operating costs must be quantified.

Adjustment calculations will differ slightly depending on whether or not there has been an ALOS increase. If the ALOS has increased, the ALOS calculation is done first to determine the increased costs that are accounted for in the ALOS adjustment.

Example 3-A: Adjustment Calculation for Increased Routine (Adults and Pediatrics) Service Intensity with Increased ALOS and No Additional Staffing

Changes in the type of patients served may result in an increase in the amount of nursing services provided to patients. In addition, there are situations where regulatory of coverage changes result in an increase in service intensity. The following methodology applies to situations involving increased service intensity when additional staffing is not required. When no additional staff are involved, the hospital's per diem costs for all patients are held to the base year costs per diem updated by the applicable update factors as demonstrated in steps 4 through 9. The lesser of the hospital's updated base year costs or actual current year costs are then apportioned to the Medicaid program for determining the amount of an adjustment, if warranted.

Refer to the following page for an illustrated calculation.

Example 3-A: Methodology for Adjustment for Increased Routine Services (Adults & Pediatrics) with No Additional Staffing Note: Lines 4 & 5 must be completed only when Medicaid ALOS increases Routine (8/31/88) Sub-provider	
1. Base year inpatient costs excluding pass-through costs	$224,222
2. Base year Medicaid discharges	23
3. Base year Medicaid average cost per discharge updated [(line 1 ÷ line 2) x (appropriate update factors)]	$13,267.53
4. ALOS increase adjustment factor (Medicaid current ALOS - base year Medicaid ALOS) ÷ (base year Medicaid ALOS) + 1) [(28.68 - 26.16) ÷ 26.16] + 1	1.096330
5. Base year Medicaid average cost per discharge adjusted for ALOS increase (line 3 x line 4)	$14,545.59
6. Base year total sub-provider routine costs excluding pass-through costs	$2,037,929
7. Base year sub-provider inpatient days	149,768
8. Current year total sub-provider inpatient days	150,485
9. Base year total costs adjusted for utilization [(line 6 ÷ line 7) x line 8	$2,047.685
10. Base year adjusted total costs updated (line 7 x appropriate update factors)	$2,230,424
11. Current year total costs excluding pass-through costs	$2,263,181
12. Current year total sub-provider inpatient days	6,000
13. Average cost per day [(lesser of line 10 or line 11) ÷ (line 12)]	$371.74
14. Current year Medicaid sub-provider inpatient days	3,000
15. Adjusted Medicaid inpatient costs (line 13 x line 14)	$1,115,220
16. Adjusted average cost per discharge [(line 15 ÷ current year Medicaid discharges) (105)]	$10,621.14
17. Adjustment [(line 16 - line 5) x (current year Medicaid discharges) (0 if negative)]	- 0 -

Figure 9-2. Example 3-A: Adjustment Calculations for Increased Routine (Adults and Pediatrics) Service Intensity with Increased ALOS and No Additional Staffing

Example 3-B: Adjustment Calculation for Increased Routine Service Intensity with Additional Staffing

To calculate an adjustment for increased staffing, determine Medicaid's share of general routine costs in the base year target amount. Compute a total average cost per FTE (salaries and fringe benefits) in the base year. The total average cost per FTE in the base year is then multiplied by the number of FTEs in the cost reporting period in question to impute an adjusted general routine service salary cost. This methodology limits salary increases to the target rate of increase percentage. The adjustment is based on the lesser of Medicaid's share of the actual general routine service costs in the year under appeal and the imputed general routine service costs.

> ***Note: Should a hospital experience a change from the base year in the skill level and/or mix of skill level of its nursing staff, it could also be grounds for an adjustment if documented and justified. The hospital must submit data indicating nursing hours or FTE levels and nursing salaries by job classification in the base year as well as the year under appeal in order to determine the effect of the change of skill mix on average salary cost per FTE and whether an adjustment is warranted.***

A facility experiences a significant increase in the medical acuity of its patient population and exceeds the rate of increase ceiling applicable to its FY 1987 cost reporting period because of an increase in the intensity of nursing services. The hospital hired additional nursing staff at higher skill levels to meet the increased demands of its patients.

A listing of the number of cases per diagnosis in the base year compared to FY 1987 indicated that the facility was serving a patient population with greater patient needs than in the base year. A comparison of patients' Global Assessment Scores from the base year and FY 1987 also indicated that an increased number of patients were admitted in FY 1987 with a higher dysfunctional status.

Having sustained that the facility was serving a patient population requiring more patient care and that additional nursing staff was necessary, the provider must demonstrate the impact that hiring the additional nursing staff had on its inpatient operating costs.

Refer to the following page for an illustrated calculation.

Example 3-B: Methodology for Adjustment for Increased Staffing with Increased Medicare ALOS
Note: Lines 4 & 5 must be completed only when Medicaid ALOS increases.
(FYE 8/30/88) Routine

1.	Base year inpatient costs excluding pass-through costs	$741,306
2.	Base year Medicaid discharges	156
3.	Base year Medicaid average cost per discharge updated [(line 1 ÷ line 2) x (appropriate update factors)]	$5,176.03
4.	ALOS increase adjustment factor (Medicaid current ALOS - base year Medicaid ALOS) ÷ (base year Medicaid ALOS) + 1)	1.146047
5.	Base year Medicaid average cost per discharge adjusted for ALOS increase (line 3 x line 4)	$5,931.97
6.	Base year salaries plus fringe benefits (A & B) per FTE (total must tie to base year cost report)	

A Salaries	x	B Worksheet B-1 EH&W Multiplier	=	C Salaries + EH&W	÷	D FTE Empl.	=	
$ 73,043	x	1.15000	=	$ 84,000	÷	4	=	$21,000
109,565	x	1.15000	=	126,000	÷	7	=	18,000
208.696	x	1.15000	=	240,000	÷	15	=	16,000
32,609	x	1.15000	=	37,500	÷	3	=	12,500

7.	Base year salaries cost at current year FTE levels			$651,000
	a) RNs	7	x	$21,000
	b) LPNs	11	x	$18,000
	c) Aides	16	x	$16,000
	d) Clerical	4	x	$12,500
8.	Base year other than salaries and fringe benefit costs (Wkst B, Part I - pass-through - line 6, col. C)			$295,374
9.	Base Year other than costs adjusted for utilization [(line 8 + base year total days) x (current year total days)]			$367,336
10.	Base year total costs updated [(line 7 + line 9) x appropriate update factor]			$1,200,000
11.	Current year total costs excluding pass-through costs (Wkst B, Part I - pass-through costs)			$1,508,943
12.	Current year total inpatient days			5,000
13.	Average cost per day [(lesser of line 10 or line 11) ÷ (line 12)]			$240
14.	Current year Medicaid inpatient days			3,960
15.	Adjusted Medicaid costs (line 13 x line 14)			$950,400
16.	Adjusted Medicaid average cost per discharge (line 15 ÷ current year Medicaid discharges) (208)			$4,569.23
17.	Adjustment [(line 16 - line 5) x (current year Medicaid discharges)] (0 if negative)			- 0 -

Figure 9-3. Example 3-B: Adjustment Calculation for Increased Routine Service Intensity with Additional Staffing

Example 3-C: Increased Ancillary Service Intensity with Increased ALOS and No Additional Staffing

A facility experiences an increase in patients with severe illnesses which require close monitoring. As a result, utilization of laboratory services increases. The hospital demonstrates that the increased laboratory cost is attributable to increased patient medical acuity.

Refer to the following page for an illustrated calculation.

Example 3-C: Methodology for Adjustment Without an Increase in Staffing Note: Lines 4 & 5 must be completed only when Medicaid ALOS increases (FYE 06/30/88) Laboratory	
1. Base year Medicaid inpatient costs excluding pass-through costs	$39,534
2. Base year Medicaid discharges	133
3. Base year Medicaid average cost per discharge updated [(line 1 ÷ line 2) x (appropriate update factors)]	$323.47
4. ALOS increase adjustment factor [(Medicaid current ALOS - base year Medicaid ALOS) ÷ (base year Medicaid ALOS)] [(24.26 - 22.58) ÷ 22.58] + 1	1.074402
5. Base year Medicaid average cost per discharge adjusted for ALOS increase (line 3 x line 4)	$347.54
6. Base year total costs excluding pass-through costs (From Wkst B, page I - pass-through costs)	$2,345,636
7. Base year total inpatient days (hospital routine days + sub-provider days)	73,306
8. Current year total inpatient days	71,546
9. Base year total costs adjusted for utilization (line 6 ÷ line 7) x (line 8)	$2,289,320
10. Base year adjusted total costs updated (line 9 x appropriate update factors)	$2,491,295
11. Current year total costs excluding pass-through costs (from Wkst B, Part I - pass-through costs)	$2,723,302
12. Current year total inpatient charges	$3,603,173
13. Cost to charge ratio [(lesser of line 10 or line 11) ÷ (line 12)]	.691417
14. Current Medicaid inpatient charges	$113,472
15. Adjusted Medicaid inpatient costs (line 13 x line 14)	$78,456
16. Adjusted average cost per discharge (line 15 ÷ current year Medicaid discharges) (150)	$523.04
17. Adjustment [(line 16 - line 5) x (current year Medicaid discharges) (0 if negative)]	$26,325

Figure 9-4: Example 3-C: Increased Ancillary Service Intensity with Increased ALOS and No Additional Staffing

Example 3-D: Increased Ancillary Service Intensity with Increased ALOS and Additional Staffing

The facility in example 3-C also experienced an increase in utilization of medically necessary physical therapy services. The increase in demand was such that the hospital had to increase employment in the physical therapy department. While the ratio of therapists to aides to clerks did not change, total employment increased from 23 to 26 FTE employees.

Refer to the following page for an illustrated calculation.

Example 3-D: Methodology for Adjustment for Increased Staffing Note: Lines 4 & 5 must be completed only when Medicaid ALOS increases (FYE 06/30/88) Physical Therapy	
1. Base year Medicaid inpatient costs excluding pass-through costs	$247,395
2. Base year Medicaid discharges	133
3. Base year Medicaid average cost per discharge updated [(line 1 ÷ line 2) x (appropriate update factors)]	$2,026.11
4. ALOS increase adjustment factor (Medicaid current ALOS - base year Medicaid ALOS) ÷ (base year Medicaid ALOS) + 1	1.074402
5. Base year Medicaid average cost per discharge adjusted for ALOS increase (line 3 x line 4)	$2,176.86
6. Base year P. T. salaries plus fringe benefits per FTE A x B = C ÷ D = $652,174 x 1.150000 = $750,000 ÷ 23 =	$32,608.70
7. Base year payroll cost at current year FTE levels x 26	$847,826
8. Base year other than salaries and fringe benefit costs (Wkst B, Part I - pass-through - line 6-C)	$425,000
9. Base year other costs adjusted for utilization [(line 8 ÷ base year total days) x (current year total days)]	$414,796
10. Base year total costs updated (line 7 + line 9) x appropriate update factors	$1,375,300
11. Current year total costs excluding pass-through costs (from Wkst B, Part I - pass-through costs)	$1,398,506
12. Current year total inpatient charges	$1,834,682
13. Cost to charge ratio [(lesser of line 10 or line 11) ÷ (line 12)]	.749612
14. Current Medicaid inpatient charges	$516,084
15. Adjusted Medicaid inpatient costs (line 13 x line 14)	$386,863
16. Adjusted average cost per discharge (line 15 ÷ current year Medicaid discharges) (150)	$2,579.09
17. Adjustment [(line 16 - line 5) x (current year Medicaid discharges) (0 if negative)]	$60,335

Figure 9-5. Example 3-D: Increased Ancillary Service Intensity with Increased ALOS and Additional Staffing

Example 3-E: Adjustment Calculation for Addition/Deletion of Services

A provider adding a new service could incur increased costs due to a variety of factors such as increased staff or upgrading of staff skill level. If the hospital's costs exceed its ceiling, the addition of a new service could warrant a permanent adjustment to the TEFRA target amount for the first 12 month cost reporting period in which the service was provided in all 12 months and those subsequent to it. Similarly, any deletion of services would warrant a permanent change to the TEFRA target amount.

Example:

A hospital requested an adjustment to its rate of increase ceiling for 1990 because in 1990, the facility exceeded its ceiling as a result of an increase in average length of stay, increased physical therapy services and adding new services.

No costs were reflected in the MRI or heart catheterization cost centers in the base year cost report, but in 1990, the costs were $73,261 and $64,833, respectively.

A permanent adjustment to the TEFRA ceiling was made for the MRI and heart catheterization services not included in the base year target amount. This adjustment would be included in TEFRA target amount calculations for all cost reporting periods subsequent to 1990.

The illustrated calculation on the following page demonstrates the methodology for determining the total adjustment due the hospital facility for 1990 and demonstrates the permanent revision to the ceiling upon which the subsequent years' target amount per discharge is based. This amount is limited to the lesser of the original target amount plus the cost per discharge of the added services or the hospital's current operating cost per discharge.

Example 3-E: Methodology for Adjustment to Allowable Inpatient Operating Cost Adjustment Due to Additional Services (FY 1990)	
Part I	
1. FY 1990 total Medicare inpatient operating cost excluding pass-through costs (year for which adjustment is requested)	$3,200,000
2. Adjustment for Medicare operating room costs not included in base year target amount	$73,261
3. Adjustment for Medicare anesthesiology costs not included in base year target amount	$64,833
4. Adjustment for increased ALOS	$71,000
5. Adjustment for increased ancillary services	$92,000
6. Adjusted Medicare program inpatient operating cost (line 1 minus sum of lines 2-5)	$2,898,906
7. FY 1990 rate of increase ceiling	$2,935,123
8. Adjusted allowable inpatient operating costs [(lesser of line 6 or 7) plus lines 2-5]	$3,200,000
9. Allowable inpatient operating costs excluding pass-through costs before adjustment (per cost report)	$2,935,123
10. Adjustment due hospital (line 8 minus line 9)	$264,877
Part II	
Permanent Revised Target Amount Calculation Due to Additional Services (FY 1990)	
1. Lesser of Part I, line 7, plus lines 2 and 3, or line 8	$3,073,217
2. Revised FY 1990 target amount [$3,073,217 ÷ 394 (FY 1990 discharges)]	$7,800
3. FY 1991 rate of increase	1.047
4. Revised FY 1991 target amount per discharge ($1,800 x 1.047)	$8,166.60

Figure 9-6. Example 3-E: Adjustment Calculation for Addition/Deletion of Services

FREE-STANDING PSYCHIATRIC HOSPITALS AND DISTINCT PART PSYCHIATRIC UNITS

Reimbursement for services provided in these facilities is a prospective per diem rate that is adjusted annually. This per diem includes all services provided to inpatients, except for physician services which should be billed separately. All therapies (individual/group counseling or occupational therapy) should be included in the per diem.

OUTPATIENT REIMBURSEMENT

Interim payment to hospitals for outpatient services except laboratory and certain outpatient surgeries is made on the basis of 72% of billed charges. Final reimbursement will be determined from the hospital's cost report and will be based on the lower of the actual costs or the actual charges of the outpatient services, except for services subject to the Medicare Fee Schedule for laboratory services or outpatient surgeries.

Clinical diagnostic laboratory services provided by a hospital on an outpatient basis will be reimbursed at the lower of the billed charges or the Medicare Fee Schedule rate for that service. Charges and interim payments related to these services will be excluded from the cost report during the cost settlement determination.

Surgical procedures performed on an outpatient basis will be paid on a flat fee per service/occurrence, not to exceed the Medicare maximums for ambulatory surgeries in accordance with the following four groupings:

Group 1 $220.39

Group 2 $262.36

Group 3 $282.40

Group 4 $320.56

Charges and interim payments for these services are to be excluded from the cost report during cost settlement determination.

OUT-OF-STATE HOSPITAL REIMBURSEMENT

All out-of-state hospitals are reimbursed at 72% of total billed charges for both inpatient and outpatient claims relating to the treatment of Louisiana Medicaid patients.

LUMP SUM ADJUSTMENTS

The BHSF will consider making retroactive payments to providers that result from significant changes in operating costs of hospital services reflected in the Medicaid inpatient per diem. Such requests for lump sum adjustments should be made in writing to the BHSF. Approval is at the individual discretion of the director. The hospital must provide sufficient documentation of Medicaid paid days and calculations to substantiate the amount of the lump sum request.

CHAPTER 10
CLAIMS FILING

CHAPTER CONTENTS

Page

INTRODUCTION 10-3

UB-92 BILLING INSTRUCTIONS 10-3
UB-92 Form Instructions 10-5

MEDICAID REVENUE CODES 10-19

THIRD PARTY LIABILITY 10-29
TPL Codes 10-29

MEDICARE/MEDICAID COVERAGE 10-30
Crossover Process 10-30

THE REMITTANCE ADVICE 10-33
The Purpose of the Remittance Advice 10-33
What Happens to the Provider's Claim? 10-33
What Happens to a Processed Claim? 10-34
Remittance Advice Copy Requests 10-35

TIMELY FILING GUIDELINES 10-36
Claims for Dates of Service Over Two Years Old 10-37

UB-92 ADJUSTING/VOIDING CLAIMS 10-38
Locator 84 10-38
Locator 4 10-38

RETROACTIVE PAYMENT FOR INPATIENT HOSPITAL SERVICES 10-40
Retroactive Payment for Medicare-Eligible Persons 65 or Older 10-40

REFUND/RETURN CHECKS 10-41
Refund Checks 10-41
Return Checks 10-42

PROVIDER RELATIONS 10-43

RECIPIENT ELIGIBILITY VERIFICATION SYSTEMS (REVS) 10-44

INTRODUCTION

Provided in this chapter are the billing instructions for hospital providers and an explanation of what happens to a claim as it is processed.

UB-92 BILLING INSTRUCTIONS

Hospitals should use the UB-92 claim form to bill for hospital services provided to Medicaid recipients. A sample of the UB-92 claim form is provided as Figure 10-1. Please note that original copies of the UB-92 are printed in red ink to discourage photocopying. As a result, this Figure 10-1 will not be very clear. Refer to an original form for a better example. The instructions used to complete the claim form follow the sample. In addition, a list of revenue codes hospitals need to complete the claim form is provided after the instructions.

APPROVED OMB NO. 0938-0279

1

2

3 PATIENT CONTROL NO.

4 TYPE OF BILL

5 FED TAX NO.

6 STATEMENT COVERS PERIOD

7 COV'D

8 N.C.D.

9 C.I.D.

10 L.S.D.

11

12 PATIENT NAME

13 PATIENT ADDRESS

14 BIRTHDATE

15 SEX

16 MS

ADMISSION

21 D HR

22 STAT

23 MEDICAL RECORD NO.

CONDITION CODES

30

32 CODE

OCCURRENCE DATE

33 CODE

OCCURRENCE DATE

34 CODE

OCCURRENCE DATE

35 CODE

OCCURRENCE DATE

36 CODE

OCCURRENCE SPAN

37 A B C

39 CODE

VALUE CODES AMOUNT

40 CODE

VALUE CODES AMOUNT

41 CODE

VALUE CODES AMOUNT

42 REV. CD.

43 DESCRIPTION

44 HCPCS / RATES

45 SERV. DATE

46 SERV. UNITS

47 TOTAL CHARGES

48 NON-COVERED CHARGES

49

50 PAYER

51 PROVIDER NO.

52 REL. INFO

53 ASG. BEN.

54 PRIOR PAYMENTS

55 EST. AMOUNT DUE

56

57

DUE FROM PATIENT ▶

58 INSURED'S NAME

59 P. REL.

60 CERT. - SSN - HIC - ID NO.

61 GROUP NAME

62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES

64 ESC

65 EMPLOYER NAME

66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.

OTHER DIAG. CODES

68 CODE

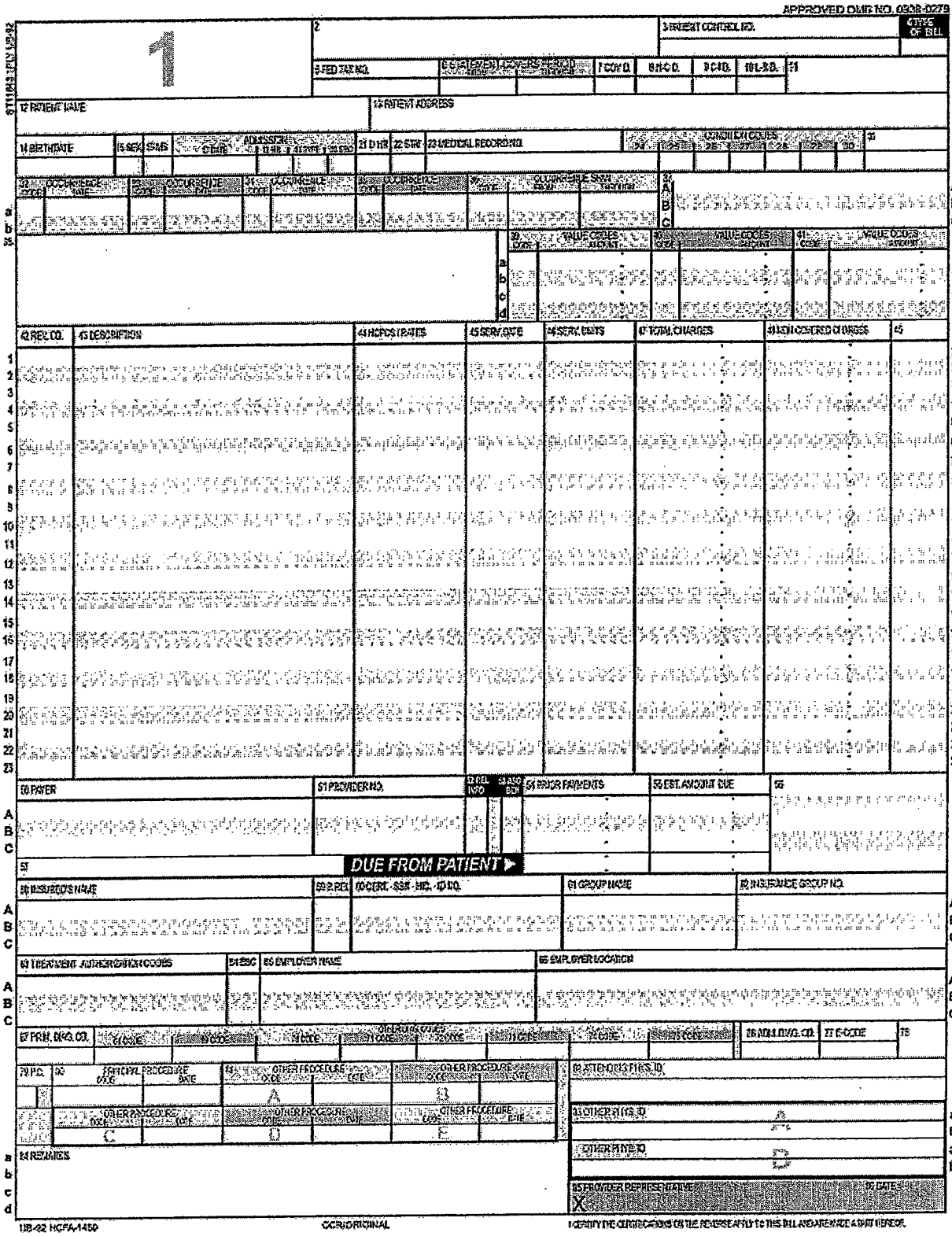
69 CODE

70 CODE

71 CODE

72 CODE

73 CODE



74 CODE

75 CODE

76 ADM. DIAG. CD.

77 E-CODE

78

79 P.C.

80 PRINCIPAL PROCEDURE

81 OTHER PROCEDURE

A

B

C

D

E

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID

A

OTHER PHYS. ID

B

84 REMARKS

85 PROVIDER REPRESENTATIVE

X

86 DATE

UB-92 HCFA-1450

OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 BILLING INSTRUCTIONS

Hospitals should use the UB-92 claim form to bill for hospital services provided to Medicaid recipients. The instructions used to complete the claim form follow the sample. In addition, a list of revenue codes hospitals need to complete the claim form is provided after the instructions. **Fields noted with an * are required and claim will be denied if not entered.**

UB-92 FORM INSTRUCTIONS

Locator #	Description	Instructions
*1	Provider Name, Address, Telephone #	Enter the name and address of the facility
2	Unlabeled Field (State)	Leave blank
3	Patient Control No.	Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 16 characters.
*4	Type of Bill	Enter the 3-digit code indicating the specific type of facility, bill classification and frequency. This 3-digit code requires one digit each, in the following format: a. First digit-type facility 1 Hospital 7 Clinic 8 Special Facility b. Second digit-classification 1 Inpatient Medicaid and/or Medicare Part A or Parts A & B 2 Inpatient Medicaid and Medicare Part B only 3 Outpatient or Ambulatory Surgical Center 4 Other (Non-patient) c. Third digit-frequency 0 Non-Payment claim 1 Admission through discharge 2 Interim-first claim 3 Interim-continuing 4 Interim-last claim 7 Replacement of prior claim 8 Void of prior claim

5	Federal Tax No.	
*6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	Enter the beginning and ending service
*7	Covered Days	**Required for inpatient -** Enter the number of days approved by the Utilization Review Committee as medically necessary. The number of covered days plus the number of non-covered days (Form Locator 8) must equal the number of days represented by the billing period in Form Locator 6. If the From and Through dates in Form Locator 6 are equal, enter "1" in "Covered Days."
8	Non-Covered Days	For inpatient, if applicable - Enter the number of days not approved by the Utilization Review Committee as medically necessary or leave days when not in the hospital for part of the stay. The number of non-covered days, plus the number of covered days (Form Locator 7), must equal the number of days represented by the billing period in Form Locator 6.
9	Co-Insurance Days	**Required for Medicare Crossover.**
10	Lifetime Reserve Days	**Required for Medicare Crossover.**
11	Patient's Phone No.	
*12	Patient's Name	Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.
13	Patient's Address (City, State, Zip)	Enter patient's permanent address.
14	Patient's Birthdate	Enter the patient's date of birth using 8 digits (MMDDYYYY). If only one digit appears in a field, enter a leading zero.
15	Patient's Sex	Enter sex of the patient as M = Male F = Female U = Unknown
16	Patient's Marital Status	
*17	Admission Date	**Required for inpatient** - Enter 6 digits for the date of admission (MMDDYY). If there is only one digit in a field, enter a leading zero.
*18	Admission Hour	**Required for inpatient services** - Enter the 2-digit code which corresponds to the hour the patient was admitted for inpatient care as:

		Code Time 00 12:00 - 12:59 midnight 01 01:00 - 01:59 A.M. 02 02:00 - 02:59 03 03:00 - 03:59 04 04:00 - 04:59 05 05:00 - 05:59 06 06:00 - 06:59 07 07:00 - 07:59 08 08:00 - 08:59 09 09:00 - 09:59 10 10:00 - 10:59 11 11:00 - 11:59 12 12:00 - 12:59 noon 13 01:00 - 01:59 P.M. 14 02:00 - 02:59 15 03:00 - 03:59 16 04:00 - 04:59 17 05:00 - 05:59 18 06:00 - 06:59 19 07:00 - 07:59 20 08:00 - 08:59 21 09:00 - 09:59 22 10:00 - 10:59 23 11:00 - 11:59
*19	Type Admission	**Required for inpatient** - Enter one of the appropriate codes indicating the priority of this admission. 1 Emergency 2 Urgent 3 Elective 4 Newborn
20	Source of Admission	**Required for inpatient** - enter the appropriate code from the list of "Code Structure for Adult and Pediatrics: shown below. * Newborn coding structure must be used when the type of admission code in Form Locator 19 is "4" Valid codes if type of admission is 1, 2, or 3 1 Physician Referral 2 Clinic Referral

		3 HMO Referral 4 Transfer from a Hospital 5 Transfer from a Skilled Nursing Facility 6 Transfer from Another Health Care Facility 7 Emergency Room 8 Court/Law Enforcement Valid code if type of admission is "4" 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth
21	Discharge Hour	Inpatient only - Enter the two-digit code which corresponds to the hour the patient was discharged. (See code structure under Admission Hour, Form Locator 19.)
*22	Patient Status	**Required for inpatient** - Enter the appropriate code to indicate patient status as of the Statement Covers through date. Valid codes are listed as follows: 01 Discharged (routine) 02 Discharged to another short-term general hospital 03 Discharged to Skilled Nursing Facility 04 Discharged to Intermediate Care Facility 05 Discharged to another type of institution 06 Discharged to home under care of organized home health services 07 Left against medical advice 08 Discharge/Transfer to home care of Home IV provider 20 Expired 30 Still Patient * If interim billing, the patient status code must be "30", (frequency code 2 or 3 under type bill).
23	Medical Record No.	Enter patient's medical record number (up to 16 characters)
*24-30	Condition Codes	Must be a valid code if entered. Valid

		codes are listed as follows: Insurance 01 Military service related 02 Condition is employment related 03 Patient is covered by insurance not reflected here 04 HMO Enrolled 05 Lien has been filed 06 End stage renal disease in first 18 months of entitlement covered by employer group insurance Accommodations 38 Semi-private room not available 39 Private room medically necessary 40 Same day transfer Special Program Indicators A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning PRO Approval C1 Approved as billed
31	Unlabeled Field	(National) Leave blank.
32-35	Occurrence Codes/Dates	a. Enter, if applicable. b. Each code must be two position numeric and have an associated date. c. Dates must be valid and in MMDDYY format. d. Valid codes are listed as follows: 01 Accident/Medical Coverage 02 Auto accident/no fault 03 Accident/tort liability 04 Accident/employment related 05 Accident/No Medical Coverage 06 Crime victim 21 UR/PSRO notice received 22 Date active care ended 24 Date insurance denied 25 Date benefits terminated by primary payer 40 Scheduled date of admission 41 Date of first test for pre-admission testing 42 Date of discharge when "Through" date in Form Locator

		6 (Statement Covers Period) is **not** the actual discharge date **and** the frequency code in Form Locator 4 is that of final bill. A3,B3,C3 Benefits exhausted
36	Occurrence Span (Code and Dates)	Enter, if applicable - A code and related dates that identity an event that relates to the payment of the claim. Code and date must be valid. Date must be (MMDDYY) format. Valid codes are listed as follows: 72 First/Last visit 74 Non-covered Level of Care
37	A,B,C ICN/DCN # Original Bill	Not used for an adjustment of a Medicaid paid claim. Continue to use remarks section, Form Locator 84.
38	Responsible Party Name and Address	
*39-41	Value Codes and Amounts	**Required for benefit determination**. The value code structure is intended to provide reporting capability for those data elements that are routinely used but do not warrant dedicated fields. Value codes are listed as follows: 02 Hospital has no semi-private rooms. Entering the code requires $0.00 amount to be shown. 06 Medicare blood deductible 08 Medicare lifetime reserve first CY 09 Medicare coinsurance first CY 10 Medicare lifetime reserve second year 11 Coinsurance amount second year 12 Working Aged Recipient/Spouse with employer group health plan 13 ESRD (End Stage Renal Disease) Recipient in the 12-month coordination period with

		an employer's group health plan 14 Automobile, no fault or any liability insurance 15 Worker's Compensation including Black Lung 16 VA, PHS, or other Federal Agency 30 Pre-admission testing - this code reflects charges for pre-admission outpatient diagnostic services in preparation for a previously scheduled admission. 37 Pints blood furnished 38 Blood not replaced - deductible is patient's responsibility 39 Blood pints replaced 80 Medicaid eligibility requirement that Medicare recipients utilize lifetime reserve days is not met. Recipient refuses to use available days. A1,B1,C1 Deductible A2,B2,C2 Coinsurance
*42	Revenue Code	Enter the applicable revenue code(s) which identifies a specific accommodation, and ancillary service. Accommodation codes require a rate in Form Locator 44. Revenue Code 490 for Outpatient Surgical procedures requires a CPT/HCPCS procedure code in Form Locator 44. Other revenue codes such as laboratory services, outpatient therapies, radiology etc. also require a CPT/HCPCS procedure based on current Medicaid policy. This must be a valid revenue code. Must be in ascending sequence except for final entry for total charges (001). If a revenue code is present, the amount charged must be present in Form Locator 47.
43	Revenue Description	For inpatient and outpatient claims. Enter the narrative description of the revenue code in the space preceding the dotted line.
*44	HCPCS/Rates	**Required for inpatient** - Enter the accommodation rate for any

	HCPCS/CPT Code (Outpatient DX Lab)	accommodation revenue codes entered in Form Locator 42. If present, must be numeric. For revenue code 490, enter the appropriate CPT/HCPCS procedure code for Ambulatory Surgical Services. Other revenue codes such as laboratory services, outpatient therapies, radiology etc. also require a CPT/HCPCS procedure based on current Medicaid policy.
*45	Date of Service (Outpatient Only)	Enter the date of service for outpatient services in the last six digits of the revenue description. The date must be a valid date in (MMDDYY) format.
*46	Units of Service	Enter the quantity of services rendered by Revenue Category for the recipient.
*47	Total Charges	Enter the total charges pertaining to the related revenue codes. Must be numeric. Revenue Code "001" represents the total amount charged for this bill, and must be the last entry.
48	Non-Covered Charges	Indicate charges included in column 47 which are not payable under the Medicaid Program.
49	Unlabeled Field (National)	Leave blank.
50-A,B,C	Payer ID	Enter Medicaid on Line "A" and other payers on Lines "B" and "C". If another insurance company is primary payer, enter name of insurer. If the patient is a Medically Needy Spend-down recipient or has made payment for non-covered services, indicate the patient as payer and the amount paid. The Medically Needy Spend-down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period. Value codes for payer identification are M = Medicaid Z = Medicare 4 = All other TPL carriers (specify)
*51-A,B,C	Provider Number	Enter the 7-digit numeric provider identification number which was assigned

		by the Medicaid Program. If the Medicaid provider number is not on line A, circle or otherwise highlight this number so that it can readily be recognized and keyed.
52-A,B,C	Release of Information	
53-A,B,C	Assignment of Benefits Cert. Ind.	
*54-A,B,C	Prior Payments	Enter the amount the hospital has received toward payment of this bill from private insurance carrier noted in Form Locator 50 B,C. If the patient has Medicare Part B only, enter the amount billed to Medicare.
55-A,B,C	Estimated Amt. Due	
56 & 57	Unlabeled Fields (56 State/57 National)	Leave blank.
*58-A,B,C	Insured's Name	Enter the name of the insured as it appears on the Medicaid identification card. Enter the last name first, first name, middle initial. If there is insurance coverage carried by someone other than the patient, enter the name of that individual to correspond with 50 A,B,C.
59-A,B,C	Pt's. Relationship Insured	Enter the patient's relationship to insured from Form Locator 50 A,B, and C that relates to the insured's name in Form Locator 58 A,B, and C. Acceptable codes are as follows: 01 Patient is insured 02 Spouse 03 Natural child/Insured has financial responsibility 04 Natural child/ Insured does not have financial responsibility 05 Step child 06 Foster child 07 Ward of the court 08 Employee 09 Unknown 10 Handicapped dependent 11 Organ donor 13 Grandchild 14 Niece/Nephew 15 Injured Plaintiff 16 Sponsored dependent 17 Minor dependent of minor dependent 18 Parent 19 Grandparent

*60-A,B,C	Insured's ID. No.	Enter the recipient/patient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60-A. If there are other payers, enter the recipient's identification number as assigned by the other payers.
*61-A,B,C	Insured's Group Name (Medicaid not Primary)	If there is third party insurance, enter carrier code of the insurance company indicated in 50, on the corresponding line.
62-A,B,C	Insured's Group No. (Medicaid not Primary)	Enter the number or code assigned by the carrier or administrator to identify the group under which the individual is covered.
*63-A,B,C	Treatment Auth. Code	For services, requiring prior authorization or pre-certification, enter the prior authorization or pre-certification number. Do not bill more than one treatment authorization code per UB-92 and bill only the services covered by that one prior authorization or pre-certification code.
64-A,B,C	Employment Status Code	To determine primary/secondary responsibility for the bill. Valid codes are listed as follows: 1 Employed full time 2 Employed part-time 3 Not employed 4 Self-employed 5 Retired 6 On active military duty 9 Unknown
65-A,B,C	Employer Name	Enter the name of the employer that may provide health coverage for the patient.
66-A,B,C	Employer Location	Not required.
*67	Principal Diagnosis Codes	Enter the ICD-9-CM code for principal diagnosis. Codes beginning with "E" or "M" are not acceptable for any diagnosis code.
68-75	Other Diag. Codes	Codes for diagnoses other than the principal diagnosis are entered in Form Locators 68-75.
76	Admit Diag. Code	Inpatient only.
77	External Cause Injury Code	
78	Unlabeled Field (State)	Leave blank.
79	Procedure Coding Method Used	
*80	Principal Procedure Code and Date	**Required for Inpatient.** Enter a valid

		ICD-9-CM VOL III code and date for principal procedure. Date must be (MMDD) format. Date must be within date period shown in Form Locator 6. **For Outpatient** required on dates of service prior to 03/01/05 for all surgical procedures.
*81-A-E	Other Procedure Codes and Dates	**Required for Inpatient.** Enter codes other than principal procedure performed during billing period. **For Outpatient** must be completed for all surgical procedures for dates of service prior to 03/01/05.
82	Attending Physician ID	Enter the name and/or number which identifies the physician. This can be the Medicaid ID No., the Louisiana Licensing NO., or the UPIN. ***Note: For sterilization procedures, the surgeon's name must appear in item 82.***
*83	Other Physician ID	Enter any other physician's licensing number (other than attending physician), i.e., surgeon when surgical procedure(s) are performed. ***Note: If the recipient is in the CommunityCARE program, enter the seven-digit referral/ authorization number from the primary care physician.***
84	Remarks	If Admission Source is "4" (transfer from a hospital) enter the name of the hospital the patient was transferred from. If adjustment or void (Form Locator 4, third digit equal "7" or "8") enter the ICN of the paid Medicaid claim and an "A" or "V" to indicate whether adjustment or void. Also enter a reason code: **Adj.** — **Void** 01 TPL Recovery — 10 Claim paid for wrong recipient 02 Provider correct — 11 Claim paid to wrong provider 03 Fiscal Agency error — 00 Other 99 Other
*85	Provider Rep. Signature	Enter the signature and title of the appropriate person at the facility who is authorized to submit Medicaid billing

		(Stamped signatures must be initialed).
*86	Date Bill Submitted	Enter the date the bill was signed and submitted for payment. Must be a valid date (MMDDYY) format. Must be greater than the through date in Form Locator 6.

* **Required Fields** - If not completed the claim will be denied.

MEDICAID REVENUE CODES

	Code	Description
	100	**All inclusive room and board plus** ancillary (Units required for all codes)
	101	**All inclusive room and board**
	110	**Room and Board - Private** (Units required for all codes)
	111	Medical/Surgical/Gyn - Private
	112	OB - Private
	113	Pediatric - Private
*	114	Psychiatric - Private
*	115	Hospice - Private
*	116	Detoxification - Private
	117	Oncology - Private
	119	Other - Private
	120	**Room and Board - Semi-Private Two Bed** (Units required for all codes)
	121	Medical/Surgical/Gyn - 2 Bed
	122	OB - 2 Bed
	123	Pediatric - 2 Bed
*	124	Psychiatric - 2 Bed
*	125	Hospice - 2 Bed
*	126	Detoxification - 2 Bed
	127	Oncology - 2 Bed
	129	Other - 2 Bed
	130	**Semi-Private - Three and Four Beds** (Units required for all codes)
	131	Medical/Surgical/Gyn - 3 and 4 Beds
	132	OB - 3 and 4 Beds
	133	Pediatric - 3 and 4 Beds
*	134	Psychiatric - 3 and 4 Beds
*	135	Hospice - 3 and 4 Beds
*	136	Detoxification - 3 and 4 Beds
	137	Oncology - 3 and 4 Beds
	139	Other - 3 and 4 Beds
	140	**Private - Deluxe - General Classification** (Units required)

	150	**Room and Board Ward (Medical and General)** (Units required for all codes)
	151	Medical/Surgical/Gyn - Ward
	152	OB - Ward
	153	Pediatric - Ward
*	154	Psychiatric - Ward
*	155	Hospice - Ward
*	156	Detoxification - Ward
	157	Oncology - Ward
	159	Other - Ward
	160	**Other Room and Board** (Units required for all codes)
	161	R&B - Sterile Environment
*	167	R&B - Self Care
	169	R&B - Other
	170	**Nursery** (Units required for all codes)
	171	Nursery/Newborn
	172	Nursery/Premature
*	175	Nursery/Neonatal ICU
	179	Nursery/Other
	180	**Leave of Absence - General Classification** (Units required for all codes)
*	183	Therapeutic Leave
	190	**Not Assigned**
	200	**Coronary Care - General Classification** (Units required for all codes)
	211	CCU/Myocardial Infarction
	212	CCU/Pulmonary Care
*	213	CCU/Heart Transplant
*	214	CCU/Post-CCU
	219	CCU/Other
	220	**Special Charges - General Classification**
	221	Admit Charge
	222	Technical Support Charge
	223	UR Service Charge
*	224	Late Discharge, Medically Necessary
	229	Other Special Charge

	230	**Incremental Nursing Care Rate - General Classification**
	231	Nursing Incr/Nursery
	232	Nursing Incr/OB
	233	Nursing Incr/ICU
	234	Nursing Incr/CCU
	235	Nursing Incr/Hospice
	239	Nursing Incr/Other
	240	**All Inclusive Ancillary - General Classification**
	249	All Inclusive Ancillary/Other
	250	**Pharmacy - General Classification**
	251	Pharmacy, Generic Drugs
	252	Pharmacy, Non-Generic Drugs
*	253	Pharmacy, Take Home Drugs
	254	Less than Effective Drugs
*	256	Pharmacy, Experimental Drugs
*	257	Pharmacy, Non-Prescription
*	258	Pharmacy, IV Solutions
	259	Pharmacy, Other Pharmacy
	260	**IV Therapy - General Classification**
	261	Infusion Pump
	269	Other IV Therapy
	270	**Medical/Surgical Supplies/Devices - General Classification**
	271	Temp Kit/Prob Covers/Service
	272	Sterile Supply
*	273	Take Home Supplies
*	274	Prosthetic Devices
*	275	Pacemaker
*	277	Oxygen-Take Home
	278	Other Implants
	279	Other Supplies/Devices
	280	**Oncology - General Classification**
	289	Other Oncology

290 **Durable Medical Equipment (Other Than Renal) - General Classification**
* 291 DME/Rental
* 292 DME/Purchase
* 299 DME/Other Equipment

* 300 **Laboratory - General Classification** (CPT-4/HCPCS Code Required in Form Locator 50 for Outpatient or Nonpatient Claims)
* 301 Chemistry
* 302 Immunology
* 303 Renal patient (home)
* 304 Non-Routine Dialysis
* 305 Hematology
* 306 Laboratory-Bacteriology and Microbiology
* 307 Laboratory - Urology
* 309 Laboratory - Other Laboratory

* 310 **Laboratory Pathological - General Classification** (CPT-R/HCPCS Code Required in Form Locator 50 for Outpatient or Nonpatient Claims)
* 311 Laboratory Pathological/Cytology
* 312 Laboratory Pathological/Histology
* 314 Laboratory Pathological/Biopsy
* 319 Laboratory Pathological/Other

320 **Radiology - Diagnostic - General Classification** (Units required for Outpatient for all codes)
* 321 Radiology - Dx - Angiocardiography
* 324 Radiology - Dx - Chest
* 329 Radiology - Dx - Other

330 **Radiology-Therapeutic/General Classification** (Units required for Outpatient for all codes)
* 331 Chemotherapy-injected
* 332 chemotherapy-oral
* 333 Radiation Therapy
* 335 Chemotherapy-IV
* 339 Other

340 **Nuclear Medicine/General Classification**
* 341 Diagnostic
* 342 Therapeutic
349 Other

	350	**CT Scan-General Classification**
	351	Head Scan
	352	Body Scan
	359	Other CT Scans
*	360	**Operating Room Services - General Classification**
	361	Operating Room Services - Minor Surgery
*	362	Operating Room Services - Organ Transplant - Other Than Kidney
*	367	Operating Room Services - Kidney Transplant
	369	Operating Room Services - Other
	370	**Anesthesia - General Classification**
*	374	Acupuncture
	379	Other Anesthesia
	380	**Blood - General Classification** (Units required for all codes)
*	381	Packed Red Cells
*	382	Whole Blood
	383	Plasma
	384	Platelets
	385	Leucocytes
	386	Other Components
	387	Other Derivatives (cyopricipitates)
	389	Other Blood
	390	**Blood/Storage-Processing - General Classification**
	391	Blood/Administration
	399	Blood/Other Storage and Processing
	400	**Other Imaging Services - General Classification**
	401	Mammography
*	402	Ultrasound
	403	Screening Mammography
	409	Other Imaging Services
	410	**Respiratory Services - General Classification** (Units required for Outpatient for all codes)
*	412	Inhalation Services
*	413	Hyperbaric Oxygen Therapy
	419	Other Respiratory Services

*	420	**Physical Therapy - General Classification** (Units required for Outpatient)
*	421	Visit Charge
*	422	Hourly Charge
*	423	Group Rate
*	424	Evaluation or Re-Evaluation
	429	Other Physical Therapy
*	430	**Occupational Therapy - General Classification** (Units required for Outpatient)
*	431	Visit Charge
*	432	Hourly Charge
*	433	Group Rate
*	434	Evaluation or Re-Evaluation
	439	Other Occupational Therapy
	440	**Speech-Language Pathology-General Classification** (Units required for Outpatient)
*	441	Visit Charge
*	442	Hourly Charge
*	443	Group Rate
*	444	Evaluation or Re-Evaluation
	449	Other Speech-Language Pathology
	450	**Emergency Room - General Classification**
	459	Other Emergency Room
	460	**Pulmonary Function - General Classification**
	469	Other Pulmonary Function
	470	**Audiology - General Classification**
*	471	Diagnostic
*	472	Treatment
		Other Audiology
	480	**Cardiology - General Classification**
*	481	Cardiac Cath Lab\
*	482	Stress Test
	489	Other Cardiology
	490	**Ambulatory Surgical Care - General Classification**
	499	Other Ambulatory Surgical Care

* 510 **Clinic - General Classification** (Units required for all codes)
511 Chronic Pain Center
* 512 Dental Clinic
519 Other Clinic

520 **Free Standing Clinic - General Classification** (Units required)

530 **Osteopathic Services - General Classification**

540 **Ambulance - General Classification** (Units required for all codes)
541 Supplies
542 Medical Transport
543 Heart Mobile
544 Oxygen
545 Air Ambulance
546 Neonatal Ambulance Service
549 Other Ambulance

550 **Skilled Nursing - General Classification**

560 **Medical Social Services - General Classification**

610 **MRI - General Classification**

600-649 Not Assigned

650 **Hospice Services - General Classification**

660-699 Not Assigned

700 **Cast Room - General Classification**

710 **Recovery Room - General Classification**
719 Other Recovery Room

720 **Labor Room/Delivery - General Classification**
721 Labor
722 Delivery
723 Circumcision
* 724 Birthing Center (Units required)
729 Other Labor Room/Delivery

	730	**EKG ECG (Electrocardiogram) - General Classification**
*	731	Holter Monitor
	732	Telemetry
	739	Other EKG/ECG
	740	**EEG (Electroencephalogram) - General Classification**
	741	Other EEG
	750	**Gastro-Intestinal Services - General Classification**
	759	Other Gastro-Intestinal
**	760	**Treatment Room/Observation Room** (see page XI-32)
	761	Treatment/Inpatient/Endo
	762	Treatment Room/Outpatient/Endo
	763	Treatment Room/Inpatient/Non-Endo
	764	Treatment Room/Outpatient/Non-Endo
	769	Treatment Room/Other
	880	**Dialysis/Miscellaneous**
	881	Dialy/Ultrafiltration
	889	Dialy/Misc/Other
	890	**Donor Bank - General Classification**
	891	Donor Bank/Bone
	892	Donor Bank/Organ (Other Than Kidney)
	893	Donor Bank/Skin
	899	Other Donor Bank
	900	**Psychiatric/Psychological Treatments - General Classification**
	910	**Psychiatric/Psychological Services - General Classification**
*	920	**Other Diagnostic Services - General Classification**
*	921	Peripheral Vascular Lab
*	922	Electromyelogram
	923	PAP Smear (Revenue Code 300 must be used with the CPT-4/HCPCS procedure code identified in Form Locator 50.)
*	924	Allergy Test
*	925	Pregnancy Test
*	926	Other Diagnostic Service

93X Not Assigned

* 940 **Other Therapeutic Service - General Classification**
941 Recreational Therapy
942 Education/Training
943 Cardiac Rehabilitation
944 Drug Rehabilitation
945 Alcohol Rehabilitation
949 Other Therapeutic Services

95X Not Assigned

960 **Professional Fees - General Classification** (These codes (960-989) may not be used for billing Medicaid. Professional fees must be billed on a Physician claim form (HCFA-1500.)
961 Psychiatric
962 Ophthalmology
963 Anesthesiologist
964 Anesthetist
969 Other Professional Fees

97X Professional Fees

Subcategory
971 Laboratory
972 Radiology - Diagnostic
973 Radiology - Therapeutic
974 Radiology - Nuclear Medicine
975 Operating Room
976 Respiratory - Therapy
977 Physical Therapy
978 Occupational Therapy
979 Speech Pathology

98X **Subcategory**
981 Emergency Room
982 Outpatient Services
983 Clinic
984 Medical Social Services
985 EKG
986 EEG

987	Hospital Visit
988	Consultation
989	Private Duty Nurse
990	**Patient Convenience Items - General Classification**
991	Cafeteria/Guest Tray
992	Private Linen Service
993	Telephone
994	TV/Radio
995	Nonpatient Room Rentals
996	Late Discharge Charge
997	Admission Kits
998	Beauty Shop/Barber
999	Other Patient Convenience Items

* **DETAIL REQUIRED**

** Medicaid does not track Medicare's definition for outpatient services which permits services beyond 24 hours duration to be billed as outpatient. Under Medicaid criteria, any outpatient service less than 24 hours in duration may be billed as outpatient if the patient is not admitted as an inpatient. In such instances, if the 24 hour time period is exceeded, then the patient is "deemed inpatient" and must be billed as an inpatient.

THIRD PARTY LIABILITY (TPL)

Reimbursement for Medicaid services is determined by federal regulations and state policy. Medicaid by law is intended to be the payor of last resort. Other available third party resources including private insurance must be used before Medicaid pays for the care of a Medicaid recipient. Medicaid uses "cost avoidance" to process most Medicaid claims involving third party liability. In cost avoidance, if probable third party liability is established at the time the claim is filed, Medicaid rejects the claim and returns it to the provider for determination of third party liability. When the amount of third party liability is determined, the agency pays the claim to the extent that payment allowed under Medicaid's fee schedule exceeds the amount of the third party's payment.

In those situations where the insurance payment is received after Medicaid has been billed and has made payment, the provider must reimburse Medicaid, not the recipient. Reimbursement must be made **immediately** to comply with federal regulations. Providers may reimburse Medicaid by forwarding a check or by submitting an adjustment request. Checks must have identifying information, such as date of service, Internal Claim Number (ICN), recipient name and number, and the reason for the reimbursement.

Congress enacted new provisions in Medicaid law in 1986 revising the methods of paying claims. The purpose of these changes was to alleviate the administrative burden associated with TPL efforts to encourage participation in the Medicaid program by providers of pediatric and obstetric care (including KIDMED/EPSDT services). The regulations set forth certain exceptions to the cost avoidance method of claims payment in TPL situations. These exceptions include KIDMED screening, EPSDT diagnostic services, and obstetric services. The exceptions do not include other treatment or therapy services. For these exceptions, Medicaid is mandated to pay the claim up to the full amount allowed under the Medicaid fee schedule and then seek reimbursement from any third party to the limit of legal liability. This method of claims payment is called "pay and chase."

TPL CODES

Providers must record the TPL carrier code that identifies the third-party insurance on the claim form. A list of the current TPL carrier codes may be obtained from the Unisys Provider Relations Unit.

MEDICARE/MEDICAID COVERAGE

Some Medicaid recipients who have insurance coverage under the Medicare Program, a medical insurance program funded through the Social Security Administration. The Medicaid Program will pay the deductible and co-insurance on inpatient and outpatient claims for services rendered to Medicare/Medicaid recipients subject to coverage limitations under Medicaid.

Eligibility for Medicare benefits is based on either age (65 or older) or disability. However, there are some persons who reach age 65 and do not have coverage because either 1) they do not have the required number of quarters under Social Security or Railroad Retirement for coverage or 2) they do not qualify for monthly benefits as dependents or survivors of insured workers. Claims for these recipients should be billed as regular Medicaid claims.

Medicare coverage consists of Part A benefits for hospital services and Part B benefits for professional services. Providers should note that recipients may have Part A coverage, Part B coverage, or coverage for both Part A and B. In addition, persons born before or during the year 1903 are automatically eligible for Medicare Part A benefits. If a patient meets the birthdate criteria, and is not enrolled in Medicare, providers should advise the responsible relative or nursing home staff to apply for these benefits on the patient's behalf at the local Social Security office. The Medicaid Program will not reimburse a claim for a person who is potentially Medicare eligible until that person has enrolled for Medicare coverage. Medicaid will pay for blood administered to these recipients, in accordance with the policy cited in chapter 4 of this manual, "Inpatient Hospital Services."

Refer to chapter 1 of this manual, "General Medicaid Information," for more information on Medicare/Medicaid coverage for Qualified Medicare Beneficiaries (QMB).

CROSSOVER PROCESS

The hospital should submit the claims for Medicare Part A inpatient charges and Medicare Part B ancillary charges to its Medicare intermediary for reimbursement. After Medicare makes its payment, the claims will cross over to Medicaid's Fiscal Intermediary, for payment of the co-insurance and deductible if the Medicare intermediary is either Blue Cross, Blue Shield, or Mutual of Omaha. In the event that the hospital does not receive any reimbursement for crossover claims, the hospital should contact the Provider Enrollment Section at the BHSF to ascertain that the correct Medicare provider number is indicated on the MMIS cross reference file. Although the Medicare register may indicate that a claim crossed over, the claim may fail to appear on the Medicaid remittance advice in some instances.

Note: If a claim does not appear on the hospital's remittance advice within four weeks of the date on the Medicare Explanation of Benefits (EOB), the hospital should submit a paper claim to the Fiscal Intermediary with the EOB attached to assure compliance with the timely filing limitations.

Medicare Part A Only Claims

If the recipient has Medicare Part A only coverage, the hospital should submit an inpatient claim including the ancillary charges to its Medicare intermediary for reimbursement. The claim will cross over automatically to Medicaid for payment of the co-insurance and deductible of the inpatient stay.

Medicare Part B Only Claims

If the recipient only has Medicare Part B coverage, then the hospital should submit a claim for the ancillary charges to its Medicare intermediary for reimbursement. After Medicare has made its payment, the hospital should submit a claim for all inpatient charges (including ancillary charges) to Unisys with the Medicare Part B EOB attached for processing. Providers should note that ancillary charges billed to Medicare Part B should not be backed out (deducted) from the inpatient charges billed to Medicaid. Providers should also note that the following items must be completed as directed in order for the claim to be reimbursed.

1. "121" must be entered in form locator 4 as the type of bill.

2. The amount in the "Total Charges" column of the Medicare EOB must be entered in form locator 54 as the third-party payment. Providers **should not**, under any circumstances, enter the Medicare payment amount in form locator 54.

3. "Medicare Part B Only" must be written in form locator 84.

The fiscal Intermediary will process the claim for the allowable days and multiply the number of days by the hospital's per diem rate. The total charges indicated in form locator 54 will then be deducted to calculate the interim payment for the claim.

Exhausted Medicare Part A Claims

Occasionally, a Medicare/Medicaid beneficiary will exhaust not only his 90 days of inpatient care under Medicare Part A, but also his 60 lifetime reserve days. When this situation occurs, the hospital still must submit its claims to its Medicare intermediary as previously instructed. However, only the Medicare Part B claim will cross over automatically to Unisys for payment, while the Medicare Part A claim will be denied for benefits exhausted. The hospital must then submit a paper claim with documentation of Medicare Part A claims being exhausted, such as a Notice of Medicare Claim Determination or the Medicare Part A EOB, to Unisys for processing.

The instructions for filing a claim for inpatient charges associated with a Medicare Part B only claim are applicable to this case, except that "111" must be entered in form locator 4 as the type of bill, and the message "Medicare Part A Benefits Exhausted" should be written in form locator 84. **Occurrence codes (FL 32, 33, 34,and 35 a-b) and date must be completed. Benefits Exhausted, codes "A3", "B3", or "C3" (as appropriate), must be denoted with the date Medicare benefits were exhausted.**

In addition, providers should note that the dates of service on the claim must match the dates of service on the Notice of Medicare Claim Determination or the Part A EOB to verify that the Part A benefits have been exhausted. The exceptions to this rule are medically needy spend-down claims, where the effective date of Medicaid eligibility is after the date of admission, and extended care claims from facilities designated as extended care hospitals by the Medicaid Program.

THE REMITTANCE ADVICE

This information will familiarize the provider with the design and content of the Remittance Advice (RA). This document plays an important communication role between the provider, the Medicaid Program, and the Fiscal Intermediary. Aside from providing a record of transactions, the Remittance Advice will assist providers in resolving and correcting possible errors and reconciling paid claims.

THE PURPOSE OF THE REMITTANCE ADVICE

The RA is the control document which informs the provider of the current status of submitted claims. It is sent out with all provider checks.

On the line immediately below each claim a code will be printed representing denial reasons, pended claim reasons, and payment reduction reasons. Messages explaining all codes found on the Remittance Advice will be found on a separate page following the status listing of all claims. The only type of claim status which will not have a code is one which is paid as billed.

If the provider uses a medical record number (it may consist of up to 16 alpha and/or numeric characters), it will appear on the line immediately following the recipient's number.

WHAT HAPPENS TO THE PROVIDER'S CLAIM?

When the provider's claim is received by the Fiscal Intermediary, addressed to the proper Post Office Box for the claim type, it is edited for missing data. If the signature, recipient Medicaid identification number, service dates, or provider name and/or number is missing, the claim is rejected and returned.

Returned Claims

If the claim is rejected because of missing or incomplete items, the original invoice submitted by the provider will be returned to the provider accompanied by a return letter. The return letter will indicate why the invoice has been returned. The provider should complete the missing or incomplete items on the original invoice, and resubmit it. A returned claim will not appear on the Remittance Advice because it will not enter the processing system. In addition, it will not be microfilmed and given a unique 13-digit Control Number before being returned to the provider.

Claims which have all the necessary items for claims processing completed pass the first screening process, are microfilmed, are given a unique 13-digit Control Number, and are entered into the computer for processing.

WHAT HAPPENS TO A PROCESSED CLAIM?

Claims which enter the processing system will be either approved (paid), denied, or pended to Medical Review.

All claims which have been processed will fall into one of these three classifications. The provider will receive a Remittance Advice for each payment cycle which has claims processed.

Approved Claims

A claim which is correctly completed for a covered service provided to an eligible recipient by an enrolled provider will be approved for payment and paid. It will appear on the Remittance Advice on the first page or the page which lists all claims to be paid on that Remittance Advice. If the payment is different from the billed charges, an explanation will appear on the RA via a three-digit message code.

Denied Claims

The following are some of the most common reasons as to why a claim will be denied:

- If the recipient is not eligible on the date of service
- If the provider is not enrolled on the date of service
- If prior authorization is required, but not reflected
- If the service is not covered by the program
- If the claim is a duplicate of a prior claim
- If the date is invalid or logically inconsistent
- If the program limitations are exceeded.

Three-digit message codes giving the reason(s) for the denial will be printed on the line immediately following the claim information. An explanation of all codes appearing on the Remittance Advice will be printed on a separate page.

Pended Claims

Pended claims are those claims held for in-house review by the Fiscal Intermediary. If after the claim is reviewed, it is determined that a correction by the provider is required, the claim will be denied. If the correction of a claim can be made during the review, the claim will be paid.

Claims can pend for many reasons. The following are a few examples.

- Errors were made in entering data from the claim into the processing system.
- Errors were made in submitting the claim. These errors can be corrected only by the provider who submitted the claim.
- The claim must receive Medical Review.
- Critical information is missing or incomplete.

REMITTANCE ADVICE COPY REQUESTS

A fee of $0.25 per page, which includes postage, is charged to any provider who requests an additional copy of a Remittance Advice of one or more pages. RAs can be requested for any of the reasons listed below.

- The RA was lost, destroyed, or misplaced by the provider
- The provider needs an additional copy of the RA
- The provider is requesting an advance copy pending receipt of the original from a central billing office.

Upon receipt of a written request, the provider will be notified of the number of pages to be copied and of the cost for the entire request. The Remittance Advice will be forwarded to the provider once payment has been received.

TIMELY FILING GUIDELINES

To be reimbursed for services rendered, all providers must comply with the following filing limits set by the Medicaid Program.

1. Straight Medicaid claims must be filed within 12 months of the date of service.

2. Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare Fiscal Intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulation.

   Claims which fail to cross over via tape and have to be filed hard copy must be filed within six months of the date on the Medicare Explanation of Medicare Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service.

3. Claims with third-party payment must be filed within 12 months of the date of service.

4. Claims for recipients with retroactive coverage, e.g., spend-down medically needy claims, should be sent to Unisys with a note of explanation AND a copy of Form 18-SSI (Medicaid Program Notice of Decision) or other official documentation from DHH indicating the recipient's retroactive status as soon as possible. The Unisys mailing address is as follows:

   Unisys
   Provider Relations
   P. O. Box 91024
   Baton Rouge, LA 70821

   All claims for recipients with retroactive medical coverage will be forwarded to the Medicaid Program for review and authorization.

5. KIDMED claims must be filed within sixty (60) days of the date of service.

Medicaid claims received after the maximum timely filing date cannot be processed unless the provider is able to furnish proof of timely filing. Such proof may include one of the following:

1. A Remittance Advice indicating that the claim was processed earlier (within the specified time frame).

2. Correspondence from either the Medicaid Program or local Medicaid eligibility staff concerning the claim and/or the eligibility of the recipient.

   *Note: **To ensure accurate processing when resubmitting the claim and documentation, providers must be certain that the claim is legible. Documentation must reference the individual recipient and date of service.***

CLAIMS FOR DATES OF SERVICE OVER TWO YEARS OLD

Claims with dates of service over two years old are not to be submitted to the Fiscal Intermediary or to the Medicaid Program for overriding of the timely filing edit unless one or more of the guidelines listed below is met.

- The recipient was certified for retroactive Medicaid benefits and the provider has filed his claim within 12 months of the date retroactive eligibility was granted.
- The recipient won a Medicare or SSI appeal in which he was granted retroactive Medicaid benefits.
- The failure of the claim to pay was the fault of the Medicaid Program rather than the provider's fault each time the claim was adjudicated.

*Note: **Documentation of retroactive eligibility or your attempts to resolve the billing problem must be attached to claim.***

UB-92 ADJUSTING/VOIDING CLAIMS

Unlike other types of adjustments/voids, a UB-92 adjustment/void is filed on the same type of claim form as the original claim; the claim and the adjustment/void are both filed on the UB-92 claim form. When filing an adjustment or void on the UB-92 (HCFA-1450) Form Locator 84 "Remarks" and Locator 4 "Type of Bill" must be completed.

LOCATOR 84

Providers should follow the instructions provided below.

1. Enter an "A" for an adjustment or a "V" for a void.

2. Enter the Internal Control Number (ICN) of the paid claim as it appears on the Remittance Advice.

3. Enter one of the appropriate reason codes:

   Adjustments

   01 - Third Party Liability Recovery
   02 - Provider Correction
   03 - Fiscal Agent Error
   90 - State Office Use Only - Recovery
   99 - Other - Please Explain

   Voids

   10 - Claim Paid for Wrong Recipient
   11 - Claim Paid to Wrong Provider
   00 - Other

LOCATOR 4

Providers should follow the instructions listed below.

1. Enter a three-digit code indicating the specific type of facility, bill classification and frequency.

- **First Digit - Type Facility**

  1 - Hospital
  8 - Special Facility

- **Second Digit - Classification**

  1 - Inpatient Medicaid and/or Medicare Part A or Parts A & B
  2 - Inpatient Medicaid and Medicare Part B Only
  3 - Outpatient or Ambulatory Surgical Center
  4 - Other - (Non-patient)

- **Third Digit - Frequency**

  6 - Adjustment for Prior Claim
  8 - Void of Prior Claim

Items which cannot be adjusted on the UB-92 claim form include the following:

- Recipient's ID Number
- Provider Number

* To adjust or void more than one claim line on an outpatient claim form, a separate UB-92 form is required for each claim line as each line has a different Internal Control Number which must be indicated in Form Locator 84.

Note: ***If a TPL payment was not processed by the Fiscal Intermediary, an adjustment must be filed using reason code '01' (Third Party Liability Recovery) for your reason code instead of '03' (Fiscal Agent Error).***

RETROACTIVE PAYMENT FOR INPATIENT HOSPITAL SERVICES

An individual may apply for Medicaid benefits during a hospital stay or after being discharged from a hospital stay. If the individual is determined to be retroactively eligible for Medicaid benefits for the applicable dates of service, the hospital has one year from the date that eligibility was determined to submit its claims for reimbursement. However, these claims must be submitted with documentation of the recipient's retroactive eligibility. Such documentation includes either a copy of the recipient's Medicaid identification card or a copy of the certification letter from the local eligibility certification office.

Claims submitted for retroactive payment should be mailed to the following address:

BHSF
P.O. Box 91030
Baton Rouge, LA 70821-9030
Attention: MMIS Claims Resolution Unit

RETROACTIVE PAYMENTS FOR MEDICARE-ELIGIBLE PERSONS 65 OR OLDER

Retroactive payment may be made under Medicare (Hospital Insurance) for a person who was eligible at the time the service was rendered (recipient had reached age 65) and who signs an application for health insurance any time within 12 months of service. When Medicare makes retroactive payments, Medicaid will pay the deductible provided the individual is an eligible recipient in one of the categories of eligibility at the time of hospitalization, or provided that the individual applies within three months of the hospitalization and is found eligible for the month the service was provided.

REFUND/RETURN CHECKS

REFUND CHECKS

When errors in billing occur, e.g., duplicate payments, instead of simply refunding payments, providers must initiate claim adjustments or voids. However, should providers find it necessary to refund a payment, they should make checks payable to the **Department of Health and Hospitals, Bureau of Health Services Financing.**

To reconcile an account with the Treasury Department, providers must attach a copy of the Remittance Advice to their return or refund. In addition, they must explain the reason for the return or refund.

To determine the amount of a refund, providers should consider the following rules.

- Whenever a duplicate payment is made, the full amount of the second payment must be refunded.

- If another insurance company pays after Medicaid has made its payment and the TPL is greater than the Medicaid payment, the full amount of the Medicaid payment must be refunded.

  Note: Checks should <u>not</u> be made payable to fiscal intermediary.

When making refunds, identify the claim or claims to which the refund is applied. The information necessary to identify these claims will help to reduce additional correspondence. This necessary information listed below can be found on the RA.

- Provider Number
- Date of Payment
- Control Number
- Recipient Name and Identification Number
- Date of Service
- Amount Paid
- Reason for Refund.

Refunds should be mailed to the following address:

Department of Health and Hospitals
Bureau of Fiscal Services
Financial Management Section
P. O. Box 3797
Baton Rouge, LA 70821-3797

RETURN CHECKS

All **return checks** should be mailed to the following address:

Department of Health and Hospitals
Division of Fiscal Management
Financial Management Section
P.O. Box 91117
Baton Rouge, LA 70821-9117

PROVIDER RELATIONS

Unisys, the Fiscal Intermediary for the Medicaid Program, has a Provider Relations staff ready to assist providers quickly and efficiently with questions they may have regarding claims. When the provider has questions concerning printed policy, claims processing problems, or when the provider needs to determine the status of a particular claim, Provider Relations should be contacted. All of the necessary information should be available when the call is made.

Provider Relations telephone representatives can be reached at the following telephone numbers:

Baton Rouge Providers (504) 924-5040

Providers Outside of Baton Rouge
(Louisiana Providers only) 1-800-473-2783

Telephone service is available Monday through Friday
from 8:00 A.M. to 5:00 P.M.

In addition, providers can mail written inquiries to the following address:

Unisys
Attention: Provider Relations
P.O. Box 91024
Baton Rouge, LA 70821

Provider Relations also has a staff of Field Analysts who are available to help providers with billing problems and to help train new provider staff members. To request a visit with a Field Analyst, providers can call or write to Provider Relations.

Note: Written inquiries should contain a note or a letter explaining the nature of the request.

Providers should telephone the Provider Relations directly; they should not call the main Unisys switchboard.

RECIPIENT ELIGIBILITY VERIFICATION SYSTEM (REVS)

Providers who wish to ask the following questions may use the Recipient Eligibility Verification System (REVS) telephone service.

- Is a particular recipient eligible for services on a specific date of service?
- What are the service limits for a particular recipient?
- What other payment source does a particular recipient have?
- What is the current check amount?

The system is operational 24 hours a day, 7 days a week, except for a short period on Sunday when the system is being updated.

To access the system, the provider should dial the toll-free number, 1-(800)-776-6323, on a touch-tone telephone. The provider should have the Medicaid number, appropriate recipient identification number, and date of service ready when the call is made. Once the provider is connected to the system, he or she will receive instructions via voice response prompt messages. If the provider is familiar with the procedures for entering information, the provider need not wait for the prompt messages. The provider can begin entering the required information as soon as the system is accessed.

Providers are encouraged to use REVS whenever possible if a conference with one of the Provider Relations representatives is not needed. It's quick and easy.

SECTION 11
FINANCIAL REQUIREMENTS

Page

REIMBURSEMENT 11-2
General Requirements 11-2
Federal Regulations 11-2
General Provision for Reimbursement 11-2
Information Transfer/Billing Schedule 11-3
PRIOR AUTHORIZATION PROCESS 11-3
Documentation Requirements 11-5
REIMBURSEMENT RATES 11-6

INTRODUCTION

To maintain the integrity of the Medicaid Program, providers must understand and follow the Medicaid Program's policy concerning fraud and abuse. This chapter of the manual defines the different types of fraud and abuse, and it sets forth specific sanctions for providers who commit fraud and who abuse Medicaid.

Federal regulations require that the Medicaid Program establish criteria that are consistent with principles recognized as affording due process of law for identifying situations where there may be fraud or abuse, for arranging prompt referral to authorities, and for developing methods of investigation or review that ascertain the facts without infringing on the legal rights of the individuals involved.

FRAUD

Fraud, in all aspects, is a matter of law rather than of ethics or abuse of privilege. The definition of fraud that governs between citizens and government agencies is found in Louisiana R.S. 14:67 and Louisiana R.S. 14:70.01. Legal action may also be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142 (HR-3).

Prosecution for fraud and the imposition of a penalty, if found guilty, are prescribed by law and are the responsibility of the law enforcement officials and the courts. All such legal action is subject to due process of law and to the protection of the rights of the individual under the law.

PROVIDER FRAUD

Cases involving one or more of these situations constitute grounds for a provider fraud referral.

- Billing for services, supplies, or equipment which are not rendered to, or used for, Medicaid patients
- Billing for supplies or equipment which are clearly unsuitable for the patient's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless
- Claiming costs for non-covered or non-chargeable services, supplies, or equipment disguised as covered items
- Materially misrepresenting dates and descriptions of services rendered, the identity of the individual who rendered the services, or of the recipient of the services
- Duplicate billing of the Medicaid Program or of the recipient, which appears to be a deliberate attempt to obtain additional reimbursement
- Arrangements by providers with employees, independent contractors, suppliers, and others, and various devices such as commissions and fee splitting, which appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from the Medicaid.

  *Note: **The anti-kickback provisions, codified at 42 U.S.C. 1320 a-7b (b), prohibit "the knowing and willful" solicitation, receipt, offer or payment of remuneration in return for or to induce the referral of Medicaid business. (Providers, however, may use lawful advertising that abides by BHSF rules and regulations.)***

RECIPIENT FRAUD

Cases involving one or more of these situations constitute grounds for a recipient fraud referral.

- The misrepresentation of facts in order to become or to remain eligible to receive benefits under the Medicaid Program or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined

- The transferring (by a recipient) of a Medicaid Eligibility Card to a person not eligible to receive services under the Medicaid Program or to a person whose benefits have been restricted or exhausted, thus enabling such a person to receive unauthorized medical benefits

- The unauthorized use of a Medicaid card by persons not eligible to receive medical benefits under Medicaid.

input
data. Furthermore, an agency should not submit a claim unless the MHR/MHS data system "Billing Report' indicates the claim is billable.

A. Documentation Requirements

Payment decisions are often made based on information contained in the recipient's record. If these records are not properly documented, incorrect payments may be made and over payments will be recouped. In some cases providers may be investigated for fraudulent billing. Proper documentation for MHR services include:

- Determination of eligibility for MHR services;
- Rehabilitation plan outlining the goals, objectives, frequency, and duration of recommended services;
- Services agreement outlining specific goals and objectives of the service to be provided; and
- Time sheets (service logs) for services provided and billed to the Medicaid Program.

III. Reimbursement Rates

The following procedure codes and reimbursement rates are applicable for the provision of Mental Health Rehabilitation services. Please note that services must be prior authorized and claims must be timely filed.

Mental Health Rehabilitation Codes		
Procedure Code	Description of Service	Rate
X0132	Low Need Adult	$350
X0133	Medium Need Adult	$750
X0134	High Need Adult	$1300
X0135	Low Need Child	$400
X0136	Medium Need Child	$840
X0137	High Need Child	$1415
X0138	Child Assessment	$800
X0139	Adult Assessment	$700

NOTE: **MHR providers must cease billing for direct mental health rehabilitation services when a recipient is admitted to an institution or hospital. Duplicate claims (same recipient, same or different provider on same day) will be denied and will be considered fraud and referred to the Program Integrity Section for further action.**

- The date of the REOMB (monthly on the 15th)
- The date of the service for the services provided
- A narrative description of the services provided
- The place of service for the services provided
- The provider of the services
- The amount paid for the services by the Medicaid Program.

On the reverse side of the REOMB, pre-printed instructions request the recipients to use the space provided to call attention to any mistakes they feel were made on their bill. For example, if a service is listed on the REOMB that was not received by a recipient, or if the recipient were made to pay for a service that is covered by the Medicaid Program, that recipient is expected to write a brief explanation of the error. The recipient should include his or her phone number, and he or she should return the REOMB, postage paid, to Unisys. Unisys will then research the **claim copy** and **provider remittance documents** to make sure that the recipient, provider, and services on the returned REOMB are accurately presented. If the information on the returned REOMB is not accurate, then the REOMB and all documentation will be reviewed by the SURS.

All situations that require further inquiry are reviewed by SURS. Situations that require criminal investigation are referred to the State Attorney's General's Medicaid Fraud Control Unit, by SURS.

COMPUTER PROFILING

The SURS system can identify potential fraud and abuse situations by means of profile reports. A profile report is produced by a computer from information gathered in the state's claims payment operation. Providers are classified into peer groups according to geographic location, medical specialties, and other categories.

Profile reports include the following information:

- A statistical profile of each peer group classification to be used as a base line for evaluation
- A statistical profile of each individual participant compatible with the peer group profile

- An evaluation of each individual participant profile against its appropriate group profile

- A listing of individual participants who deviate significantly from their group norm. (These individuals are reported as exceptional and are flagged for analysis.)

Each profile reported as exceptional is reviewed and analyzed by a trained staff and/or by medical consultants. The analysis can include a review of the provider's paid claims, a review of the provider's reply to the Medicaid Program's written request for information, a review of hospital charges and patient records, and a review of other relevant documents. The overall review is not necessarily limited to areas identified as exceptional on the profile report.

ADMINISTRATIVE SANCTIONS

Medicaid payments are reviewed by the Medicaid Program to ensure the quality, quantity, and need for services. Administrative sanctions may be imposed against any Medicaid provider who does not meet the guidelines listed in the following subsection. Administrative sanctions refer to any administrative actions taken by the Medicaid agency. Any such administrative action is designed to remedy inefficient and/or illegal practices which are not in compliance with the Medicaid Program policies and procedures, statutes, and regulations.

LEVELS OF ADMINISTRATIVE SANCTIONS

Listed below are the different levels of administrative sanctions that the Medicaid Program may impose against a Medicaid provider.

1. Issuing a warning to a provider through written notice or consultation

2. Requiring that the provider receive education in policies and billing procedures

3. Requiring that the provider receive prior authorization for services

4. Placing the provider's claims on manual review status before payment is made

   Note: ***Any provider of Medicaid services may be placed on prepayment review as an administrative sanction of misuse of the Medicaid Program. Prepayent review may be limited to those types of procedures for which misuse has been detected, or it may include a complete review of all of the provider's claims.***

5. Suspending the provider or withholding payments from the provider

   Note: ***The Medicaid Program may suspend or withhold payment to any provider who fails to meet the requirements for participation in the Medicaid Program.***

6. Recovering money from the provider by deducting from future payments or by requiring direct payment for money improperly or erroneously paid

7. Referring a provider to the appropriate state licensing authority for investigation

8. Referring a provider for review by the appropriate professional organizations

9. Referring a provider to the Attorney General's Medicaid Fraud Control Unit for fraud investigation

10. Suspending a provider from participating in the Medicaid Program

11. Refusing to allow a provider to participate in the Medicaid Program.

GROUNDS FOR SANCTIONING PROVIDERS

The Medicaid Program may impose sanctions against any provider of medical goods or services if it discovers that any of the following conditions apply.

1. A provider is not complying with the Medicaid Program's policy, rules, and regulations or with the terms and conditions prescribed by the Medicaid Program in its provider agreement and signed claim that set the terms and conditions applicable to each provider group's participation in the program.

2. A provider has submitted a false or fraudulent application for provider status.

3. Such a provider is not properly licensed or qualified, or such a provider's professional license, certificate, or other authorization has not been renewed or has been revoked, suspended, or otherwise terminated.

4. Such a provider has engaged in a course or conduct considered to be fraudulent; has performed an act for which official sanction has been applied by the licensing authority, professional peer group, or peer review board or organization; or has continued the poor conduct after having received notification by a licensing or reviewing, indication that his conduct should cease.

5. Such a provider has failed to correct deficiencies in his delivery of services or his billing practices after having received written notice of these deficiencies from the Medicaid Program.

6. Such a provider has been excluded from participation in Medicare because of fraudulent of abusive practices pursuant to Public Law 95-142, or **such a provider has been convicted of Medicaid fraud (Louisiana R.S. 14:70.1).**

7. Such a provider has been convicted of a criminal offense relating to performance of a provider agreement with the state, to fraudulent billing practices, or to negligent practice, resulting in death or injury to the provider's patient.

8. Such a provider has presented false or fraudulent claims for services or merchandise for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

9. Such a provider has engaged in a practice of charging and accepting payment (in whole or in part) from recipients for services for which a charge was already made to the Medicaid Program and for which payment was already made.

10. Such a provider has rebated or accepted a fee or a portion of a fee for a patient referral.

11. Such a provider has failed to repay or make arrangements to repay an identified overpayment or otherwise erroneous payment.

12. Such a provider has failed, after having received a written request from the Medicaid Program, to keep or to make available for inspection, audit, or copying, records regarding payments claimed for providing services.

13. Such a provider has failed to furnish any information requested by the Medicaid Program regarding payments for providing goods and services.

14. Such a provider has made, or caused to be made, a false statement or a misrepresentation of a material fact in connection with the administration of the Medicaid Program.

15. Such a provider has furnished goods or services to a recipient which are in excess of the recipient's needs, harmful to the recipient, or of grossly inadequate or inferior quality. (This determination would be based upon competent medical judgement and evaluation.)

16. The provider, a person with management responsibility for a provider, an officer or person owning (either directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate provider, an owner of a sole proprietorship which is a provider, or a partner in a partnership which is a provider is found to fall into one or more of the following categories:

    A. Was previously barred from participation in the Medicaid Program

    B. Was a person with management responsibility for a previously terminated provider during the time of conduct which was the basis for that provider's termination from participation in the Medicaid Program

    C. Was an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a previously terminated corporate

provider during the time of conduct which was the basis for that provider's termination from participation in the Medicaid Program

D. Was an owner of a sole proprietorship or a partner of a partnership which was previously terminated during the time of conduct which was the basis for that provider's termination from participation in the program

E. Was engaged in practices prohibited by federal or state law or regulation

F. Was a person with management responsibility for a provider at the time that such a provider engaged in practices prohibited by state or federal law or regulation

G. Was an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a provider at the time such a provider engaged in practices prohibited by federal or state law or regulation

H. Was an owner or a sole proprietorship or partner or a partnership which was a provider at the time such a provider engaged in practices prohibited by federal or state law or regulation

I. Was convicted of Medicaid fraud under federal or state law or regulation

J. Was a person with management responsibility for a provider at the time that such a provider was convicted of Medicaid fraud under federal or state law or regulation

K. Was an officer or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a provider at the time such a provider was convicted of Medicaid fraud under federal or state law or regulation

L. Was an owner or a sole proprietorship or partner or a partnership which was a provider at the time such a provider was convicted of Medicaid fraud under federal or state law or regulation.

PROVIDER APPEALS

The Louisiana Department of Health and Hospitals (DHH) provides a hearing to any provider who feels that he has been unfairly sanctioned. Specifically, the Bureau of Appeals in the Department of Health and Hospitals is responsible for conducting hearings for providers who have complaints. Requests for hearings explaining the reason for the request should be made in writing and sent directly to the Bureau of Appeals.

Detailed information regarding the appeals procedure may be obtained from the Bureau of Appeals at the following address:

DHH Bureau of Appeals
P.O. Box 4183
Baton Rouge, LA. 70821-4182

APPENDIX
OUTPATIENT SURGERY LIST

CHAPTER CONTENTS

Page

OUTPATIENT SURGICAL PROCEDURES REQUIRING PRE-ADMISSION APPROVAL IF PERFORMED ON AN INPATIENT BASIS A-2

OUTPATIENT SURGICAL PROCEDURES REQUIRING PRE-ADMISSION APPROVAL IF PERFORMED ON AN INPATIENT BASIS

The charts on the following pages list outpatient surgical procedures that require pre-admission approval if performed on an inpatient basis. **Procedure** refers to the surgical procedure code. **Description** refers to the description of the procedure. **Group** (1,2,3, or 4) refers to one of the four payment groups which the service will be reimbursed when performed on an outpatient basis.

PROCEDURE CODES			
Procedure	**Description**	**Group**	**Payment**
0406	Other Cranial or Peripheral Ganglionectomy	3	$569.32
0407	Other Excision or Avulsion of Cranial And Peripheral Nerves	4	$646.25
043	Suture of Cranial and Peripheral Nerves	4	$646.25
0443	Release of Carpal Tunnel	3	$569.32
0449	Other Peripheral Nerve or Ganglion Decompression or Lysis of Adhesions	3	$569.32
046	Transposition of Cranial and Peripheral Nerves	3	$569.32
067	Excision of Thyroglossal Duct or Tract	3	$569.32
0802	Severing of Blepharorrhaphy	2	$528.92
0890	Other Incision of Eyelid	2	$528.92
0820	Removal of Lesion of Eyelid, not Otherwise Specified	1	$444.25
0821	Excision of Chalazion	1	$444.25
0825	Destruction of Lesion of Eyelid	1	$444.25
0841	Repair of Entropion or Ectropion by Thermocauterization	3	$569.25
0842	Repair of Entropion or Ectropion by Suture Technique	3	$569.25
0843	Repair of Entropion or Ectropion with Wedge Resection	3	$569.25
0844	Repair of Entropion or Ectropion with Lid Reconstruction	3	$569.25
0852	Blepharorrhaphy	2	$528.92
0859	Other Adjustment of Lid Position	2	$528.92
0864	Reconstruction of Eyelid with Tarsoconjunctival Flap	2	$528.92
0943	Probing of Nasolacrimal Duct	1	$444.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
1044	Other Free Graft to Conjunctiva	4	$646.25
1099	Other Operations on Conjunctiva	1	$444.25
110	Magnetic Removal of Embedded Foreign Body from Cornea	1	$444.25
1131	Transposition of Pterygium	1	$444.25
1132	Excision of Pterygium with Corneal Graft	1	$444.25
1139	Other Excision of Pterygium	1	$444.25
1149	Other Removal or Destruction of Corneal	4	$646.25
1211	Iridotomy with Transfixion	4	$646.25
1214	Other Iridectomy	4	$646.25
1242	Excision of Lesion of Iris	4	$646.25
1284	Excision or Destruction of Lesion of Sclera	4	$646.25
1319	Other Intracapsular Extraction of Lens	4	$646.25
132	Extracapsular Extraction of Lens by Linear Extraction Technique	4	$646.25
133	Extracapsular Extraction of Lens by Simple Aspiration (and Irrigation) Technique	4	$646.25
1341	Phacoemulsification and Aspiration of Cataract	4	$646.25
1342	Mechanical Phacofragmentation and Aspiration of Cataract by Posterior Route	4	$646.25
1359	Other Extracapsular Extraction of Lens	4	$646.25
1365	Excision of Secondary Membrane (After Cataract)	4	$646.25
1371	Insertion of Intraocular Lens Prosthesis at Time of Cataract Extraction, One Stage	4	$646.25
1401	Removal of Foreign Body from Posterior Segment of Eye With Use of Magnet	1	$444.25
1402	Removal of Foreign Body from Posterior Segment of Eye Without Use of Magnet	1	$444.25
1511	Recession of One Extraocular Muscle	4	$646.25
1512	Advancement of One Extraocular Muscle	4	$646.25
1513	Resection of One Extraocular Muscle	4	$646.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
1519	Other Operations on One Extraocular Muscle Involving Temporary Detachment from Globe	4	$646.25
1521	Lengthening Procedure on One Extraocular Muscle	4	$646.25
1522	Shortening Procedure on One Extraocular Muscle	4	$646.25
1529	Other Operations on One Extraocular Muscle	4	$646.25
153	Operations on Two or More Extraocular Muscle	4	$646.25
154	Other Operations on Two or More Extraocular Muscles, One or Both Eyes	4	$646.25
1631	Removal of Ocular Contents with Synchronous Implant into Scleral Shell	4	$646.25
1639	Other Evisceration of Eyeball	4	$646.25
1642	Enucleation of Eyeball with Other Synchronous Implant	4	$646.25
1649	Other Enucleation of Eyeball	4	$646.25
1661	Secondary Insertion of Ocular Implant	4	$646.25
1662	Revision and Reinsertion of Ocular Implant	4	$646.25
1671	Removal of Ocular Implant	4	$646.25
1809	Other Incision of External Ear	2	$528.92
1811	Otoscopy	1	$444.25
1829	Excision or Destruction of Other Lesion	1	$444.25
1911	Stapedectomy with Incus Replacement	4	$646.25
1919	Other Stapedectomy	4	$646.25
193	Other Operations on Ossicular Chain	4	$646.25
194	Myringoplasty	4	$646.25
195	Other Tympanoplasty	4	$646.25
1952	Type II Tympanoplasty	4	$646.25
1953	Type III Tympanoplasty	4	$646.25
1954	Type IV Tympanoplasty	4	$646.25
1955	Type V Tympanoplasty	4	$646.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
196	Revision of Tympanoplasty	4	$646.25
2001	Myringotomy with Insertion of Tube	4	$646.25
2009	Other Myringotomy	1	$444.25
2041	Simple Mastoidectomy	4	$646.25
208	Operations on Eustachian Tube	1	$444.25
2121	Rhinoscopy	1	$444.25
2122	Biopsy of Nose	1	$444.25
2131	Local Excision or Destruction of Intranasal Lesion	2	$528.92
2132	Local Excision or Destruction of Other Lesion of Nose	1	$444.25
215	Submucous Resection of Nasal Septum	4	$646.25
2162	Fracture of the Turbinates	1	$444.25
2169	Other Turbinectomy	1	$444.25
217	Reduction of Nasal Fracture	1	$444.25
2171	Closed Reduction of Nasal Fracture	1	$444.25
2183	Total Nasal Reconstruction	4	$646.25
2187	Other Rhinoplasty	4	$646.25
2188	Other Septoplasty	4	$646.25
2199	Other Operations on Nose	1	$444.25
2200	Aspiration and Lavage of Nasal Sinus, Not Otherwise Specified	2	$528.92
2201	Puncture of Nasal Sinus for Aspiration or Lavage	2	$528.92
2202	Aspiration of Lavage of Nasal Sinus Through Natural Ostium	2	$528.92
2263	Ethmoidectomy	3	$569.32
230	Forceps Extraction of Tooth	1	$444.25
2301	Extraction of Deciduous Tooth	1	$444.25
2309	Extraction of Other Tooth	1	$444.25
231	Surgical Removal of Tooth	1	$444.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
2311	Removal of Residual Root	1	$444.25
2319	Other Surgical Extraction of Tooth	1	$444.25
232	Restoration of Tooth by Filling	1	$444.25
233	Restoration of Tooth by Inlay	1	$444.25
234	Other Dental Restoration	1	$444.25
2341	Application of Crown	1	$444.25
2342	Insertion of Fixed Bridge	1	$444.25
2343	Insertion of Removable Bridge	1	$444.25
2349	Other Dental Restoration	1	$444.25
235	Implantation of Tooth	1	$444.25
245	Alveoloplasty	1	$444.25
2501	Needle Biopsy of Tongue	1	$444.25
2502	Other Biopsy of Tongue	1	$444.25
2594	Other Glossotomy	2	$528.92
270	Drainage of Face and Floor of Mouth	2	$528.92
2741	Labial Frenectomy	4	$646.25
2742	Wide Excision of Lesion of Lip	3	$569.32
2743	Other Excision of Lesion or Tissue of Lip	1	$444.25
2792	Incision of Mouth, Unspecified Structure	2	$569.32
280	Incision and Drainage of Tonsil and Peritonsillar Structures	2	$569.32
282	Tonsillectomy without Adenoidectomy	4	$646.25
283	Tonsillectomy with Adenoidectomy	4	$646.25
284	Excision of Tonsil Tag	4	$646.25
286	Adenoidectomy without Tonsillectomy	4	$646.25
2911	Pharyngoscopy	1	$444.25
292	Excision of Branchial Cleft Cyst or Vestige	2	$528.92
3009	Other Excision or Destruction of Lesion	1	$444.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
313	Other Incision of Larynx or Trachea	1	$444.25
3142	Laryngoscopy and Other Tracheoscopy	1	$444.25
3143	Biopsy of Larynx	1	$444.25
3144	Biopsy of Trachea	1	$444.25
3321	Bronchoscopy Through Artificial Stoma	1	$444.25
3322	Fiber-Optic Bronchoscopy	1	$444.25
3323	Other Bronchoscopy	1	$444.25
3324	Endoscopic Bronchial Biopsy	1	$444.25
3409	Other Incision of Pleura	2	$528.92
3821	Biopsy of Blood Vessel	1	$444.25
3859	Ligation and Stripping of Lower Limb Varicose Veins	4	$646.25
3882	Other Surgical Occlusion of Other Vessel	1	$444.25
3889	Other Surgical Occlusion of Lower-Limb	4	$646.25
4011	Biopsy of Lymphatic Structure	2	$528.92
4021	Excision of Deep Cervical Lymph Node	2	$528.92
4221	Operative Esophagoscopy by Incision	1	$444.25
4222	Esophagoscopy Through Artificial Stoma	1	$444.25
4223	Other Esophagoscopy	1	$444.25
4224	Biopsy of Esophagus	1	$444.25
4232	Local Excision of Other Lesion or Tissue of Esophagus	1	$444.25
4239	Other Destruction of Lesion or Tissue of Esophagus	1	$444.25
4292	Dilation of Esophagus	1	$444.25
4342	Local Excision of Other Lesion or Tissue of Stomach	1	$444.25
4349	Other Destruction of Lesion or Tissue of Stomach	1	$444.25
4411	Transabdominal Gastroscopy	1	$444.25
4413	Other Gastroscopy	1	$444.25
4414	Brush Biopsy of Stomach	1	$444.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
4415	Other Biopsy of Stomach	1	444.25
4513	Other Endoscopy of Small Intestine	1	$444.25
4514	Brush Biopsy of Small Intestine	1	$444.25
4524	Other Endoscopy of Large Intestine	1	$444.25
4525	Brush Biopsy of Large Intestine	1	$444.25
4526	Other Biopsy of Large Intestine	1	$444.25
4532	Other Destruction of Lesion of Duodenum	1	$444.25
4541	Local Excision of Lesion or Tissue of Large Intestine	1	$444.25
4643	Other Revision of Stoma of Large Intestine	3	$569.32
4823	Other Proctosigmoidoscopy	1	$444.25
4824	Brush Biopsy of Rectum	1	$444.25
4825	Other Biopsy of Rectum	1	$444.25
4835	Local Excision of Rectal Lesion or Tissue	1	$444.25
4881	Incision of Perirectal Tissue	1	$444.25
4901	Incision of Perianal Abscess	1	$444.25
4912	Anal Fistulectomy	2	$528.92
493	Local Excision or Destruction of Other Lesion or Tissue of Anus	2	$528.92
4945	Ligation of Hemorrhoids	3	$569.32
4946	Excision of Hemorrhoids	3	$569.32
4947	Evacuation of Thrombosed Hemorrhoids	3	$569.32
4949	Other Procedures on Hemorrhoids	1	$444.25
4951	Left Lateral Anal Sphincterotomy	2	$528.92
4952	Posterior Anal Sphincterotomy	2	$528.92
4959	Other Anal Sphincterotomy	2	$528.92
5011	Percutaneous (Needle) Biopsy of Liver	2	$528.92
5300	Unilateral Repair of Inguinal Hernia, Not Otherwise Specified	4	$646.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
5301	Unilateral Repair or Direct Inguinal Hernia	4	$646.25
5302	Unilateral Repair of Indirect Inguinal Hernia	4	$646.25
5303	Unilateral Repair of Direct Inguinal Hernia	4	$646.25
5304	Unilateral Repair of Indirect Inguinal Hernia	4	$646.25
5305	Unilateral Repaid of Inguinal Hernia With Graft or Prosthesis, NOS	4	$646.25
5321	Unilateral Repair of Femoral Hernia With Graft or Prosthesis	4	$646.25
5329	Other Unilateral Femoral Herniorrhaphy	4	$646.25
5349	Other Unbilical Herniorrhaphy	4	$646.25
5359	Repair of Other Hernia of Anterior Abdominal Wall	4	$646.25
5369	Repair of Other Hernia of Anterior Abdominal Wall with Prosthesis	4	$646.25
5421	Laparoscopy	4	$646.25
5423	Biopsy of Peritoneum	4	$646.25
544	Excision or Destruction of Peritoneal Tissue	4	$646.25
545	Lysis of Peritoneal Adhesions	4	$646.25
5731	Cystoscopy Through Artificial Stoma	1	$444.25
5732	Other Cystoscopy	1	$444.25
5749	Other Transurethral Excision or Destruction of Lesion or Tissue of Bladder	1	$444.25
5791	Sphincterotomy of Bladder	1	$444.25
5792	Dilation of Bladder Neck	1	$444.25
581	Urethral Meatotomy	1	$444.25
5821	Perineal Urethroscopy	1	$444.25
5822	Other Urethroscopy	1	$444.25
583	Excision or Destruction of Lesion or Tissue of Urethra	1	$444.25
585	Release of Urethral Stricture	1	$444.25
586	Dilation of Urethra	1	$444.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
5919	Other Incision of Perivesical Tissue	2	$528.92
6011	Needle Biopsy of Prostate	1	$444.25
610	Incision and Drainage of Scrotum and Tunica Vaginalis	2	$528.92
612	Excision of Hydrocele of Tunica Vaginalis	2	$528.92
613	Excision or Destruction of Lesion or Tissue of Scrotum	1	$444.25
6191	Percutaneous Aspiration of Tunica Vagina	3	$569.32
620	Incision of Testis	2	$528.92
6211	Percutaneous Biopsy of Testis	1	$444.25
6212	Other Biopsy of Testis	1	$444.25
623	Unilateral Orchiectomy	2	$528.92
6241	Removal of Both Testes at Same Operative	2	$528.92
6242	Removal of Remaining Testis	2	$528.92
631	Excision of Varicocele and Hydrocele of Spermatic Cord	3	$569.32
6371	Ligation of Vas Deferens	4	$444.25
6373	Vasectomy	4	$444.25
6392	Epididymotomy	2	$528.92
640	Circumcision	3	$569.32
642	Local Excision or Destruction of Lesion	1	$444.25
6491	Dorsal or Lateral Slip of Prepuce	1	$444.25
6511	Aspiration Biopsy of Ovary	4	$646.25
6512	Other Biopsy of Ovary	4	$646.25
6529	Other Local Excision or Destruction of Ovary	4	$646.25
658	Lysis of Adhesions of Ovary and Fallopian Tube	4	$646.25
6611	Biopsy of Fallopian Tube	4	$646.25
662	Bilateral Endoscopic Destruction or Occlusion of Fallopian Tubes	4	$646.25
6621	Bilateral Endoscopic Ligation and Crushing of Fallopian Tubes	4	$646.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
6622	Bilateral Endoscopic Ligation and Division of Fallopian Tubes	4	$646.25
6629	Other Bilateral Endoscopic Destruction or Occlusion of Fallopian Tubes	4	$646.25
663	Other Bilateral Destruction or Occlusion of Fallopian Tubes	4	$646.25
6631	Other Bilateral Ligation and Crushing of Fallopian Tubes	4	$646.25
6632	Other Bilateral Ligation and Division of Fallopian Tubes	4	$646.25
6639	Other Bilateral Destruction or Occlusion of Fallopian Tubes	4	$646.25
6661	Excision or Destruction of Lesion of Fallopian Tubes	4	$646.25
6692	Unilateral Destruction or Occlusion of F	4	$646.25
670	Dilation of Cervical Canal	3	$569.32
6711	Endocervical Biopsy	1	$444.25
6712	Other Cervical Biopsy	1	$444.25
6732	Destruction of Lesion of Cervix by Cauterization	4	$646.25
6733	Destruction of Lesion of Cervix by Cryosurgery	4	$646.25
6739	Other Excision or Destruction of Lesion	4	$646.25
6901	Dilation and Curettage for Termination of Pregnancy	4	$646.25
6909	Other Dilation and Curettage of Uterus	3	$569.32
6951	Aspiration Curettage of Uterus for Termination of Pregnancy	4	$646.25
6952	Aspiration Curettage Following Delivery	3	$569.32
700	Culdocentesis	1	$444.25
7011	Hymenotomy	4	$646.25
7014	Other Vaginotomy	3	$569.32
7024	Vaginal Biopsy	1	$444.25
7031	Hymenectomy	4	$646.25
7033	Excision or Destruction of Lesion of Vagina	2	$528.92
7109	Other Incision of Vulva and Perineum	2	$528.92
7111	Biopsy of Vulva	1	$444.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
7121	Percutaneous Aspiration of Bartholin's Gland (Cyst)	1	$444.25
7122	Incision of Bartholin's Gland (Cyst)	1	$444.25
7123	Marsupialization of Bartholin's Gland (Cyst)	1	$444.25
713	Other Local Excision or Destruction of Vulva and Perineum	1	$444.25
7179	Other Repaid of Vulva and Perineum	2	$528.92
750	Intra-Amniotic Injection for Abortion	4	$646.25
762	Local Excision or Destruction of Lesion	3	$569.32
7671	Closed Reduction of Malar and Zygomatic	2	$528.92
7672	Open Reduction of Malar and Zygomatic Fracture	2	$528.92
7697	Removal of Internal Fixation Device From Facial Bone	2	$528.92
7702	Sequestrectomy of Humerus	2	$528.92
7723	Wedge Osteotomy of Radius and Ulna	4	$646.25
7724	Wedge Osteotomy of Carpals and Metacarpal	4	$646.25
7728	Wedge Osteotomy of Tarsals and Metatarsal	4	$646.25
7733	Other Division of Radius and Ulna	4	$646.25
7734	Other Division of Carpals and Metacarpal	4	$646.25
7738	Other Division of Tarsals and Metatarsal	4	$646.25
7739	Other Division of Other Bone	4	$646.25
7752	Bunionectomy with Soft Tissue Correction and Arthroclesis	4	$646.25
7753	Other Bunionectomy with Soft Tissue Correction	4	$646.25
7754	Excision of Bunionette	3	$569.32
7759	Other Bunionectomy	4	$646.25
7788	Other Partial Ostectomy of Tarsals and Metatarsals	3	$569.32
7789	Other Partial Ostectomy of Other Bone	2	$528.92
779	Total Ostectomy	4	$646.25
7838	Other Change in Bone Length of Tarsals	4	$646.25
7839	Other Change in Bone Length of Other Bones	4	$646.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
7858	Internal Fixation of Tarsals and Metatarsals	4	$646.25
786	Removal of Internal Fixation Device	2	$528.92
7861	Removal of Internal Fixation Device From Bone	2	$528.92
7862	Removal of Internal Fixation Device From Bone	2	$528.92
7864	Removal of Internal Fixation Device From Bone	4	$646.25
7865	Removal of Internal Fixation Device From Bone	2	$528.92
7866	Removal of Internal Fixation Device From Bone	2	$528.92
7867	Removal of Internal Fixation Device From Bone	2	$528.92
7868	Removal of Internal Fixation Device From Bone	2	$528.92
8003	Arthrotomy for Removal of Prosthesis of Wrist	4	$646.25
8012	Other Arthrotomy of Elbow	2	$528.92
8016	Other Arthrotomy of Knee	4	$646.25
8026	Arthroscopy of Knee	4	$646.25
8043	Division of Joint Capsule, Ligament, or Cartilage, Wrist	3	$569.32
8044	Division of Joint Capsule, Ligament, or Cartilage, Hand and Finger	3	$569.32
8048	Division of Joint Capsule, Ligament, or Cartilage, Foot and Toe	3	$569.32
806	Excision of Semilunar Cartilage of Knee	4	$646.25
8073	Synovectomy of Wrist	4	$646.25
8074	Synovectomy of Hand and Finger	4	$646.25
8078	Synovectomy of Food and Toe	4	$646.25
8087	Other Local Excision or Destruction of Lesion or Joint, Ankle	3	$569.32
809	Other Excision of Joint	4	$646.25
8094	Other Excision of Joint or Hand and Fingers	3	$569.32
8116	Metatarsophalangeal Fusion	4	$646.25
8118	Other Fusion of Toe	4	$646.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
8128	Interphalangeal Fusion	4	$646.25
8131	Arthroplasty of Foot and Toe with Synthetic Implant	4	$646.25
8139	Other Arthroplasty of Foot and Toe	4	$646.25
8171	Arthroplasty of Hand and Finger with Synthetic Implant	4	$646.25
8179	Other Repair of Hand and Finger	4	$646.25
8186	Arthroplasty of Carpals with Synthetic	4	$646.25
8201	Exploration of Tendon Sheath of Hand	1	$444.25
8203	Bursotomy of Hand	1	$444.25
8209	Other Incision of Soft Tissue of Hand	2	$528.92
8211	Tenotomy of Hand	1	$444.25
8212	Fasciotomy of Hand	4	$646.25
8221	Excision of Lesion of Tendon Sheath of Hand	3	$569.32
8232	Excision of Tendon of Hand for Graft	3	$569.32
8233	Other Tenonectomy of Hand	4	$646.25
8235	Other Fasciectomy of Hand	4	$646.25
8251	Advancement of Tendon of Hand	3	$569.32
8279	Plastic Operation on Hand with Other Graft or Implant	4	$646.25
8284	Repair of Mallet Finger	3	$569.32
8285	Other Tenodesis of Hand	3	$569.32
8286	Other Tenoplasty of Hand	3	$569.32
8289	Other Plastic Operations on Hand	4	$646.25
8291	Lysis of Adhesions of Hand	3	$569.32
8301	Exploration of Tendon Sheath	2	$528.92
8303	Bursotomy	2	$528.92
8309	Other Incision of Soft Tissue	2	$528.92
8314	Fasciotomy	4	$646.25
8321	Biopsy of Soft Tissue	2	$528.92

PROCEDURE CODES			
Procedure	Description	Group	Payment
8331	Excision of Lesion of Tendon Sheath	3	$569.32
8339	Excision of Lesion of Other Soft Tissue	3	$569.32
8341	Excision of Tendon for Graft	4	$646.25
8342	Other Tenonectomy	4	$646.25
8345	Other Myectomy	4	$646.25
835	Bursectomy	3	$569.32
8361	Suture of Tendon Sheath	3	$569.32
8364	Other Suture of Tendon	3	$569.32
8387	Other Plastic Operations on Muscle	3	$569.32
8388	Other Plastic Operations on Tendon	3	$569.32
8391	Lysis of Adhesions of Muscle, Tendon, Fascia, and Bursa	3	$569.32
8411	Amputation of Toe	2	$528.92
8412	Amputation Through Foot	2	$528.92
850	Mastotomy	3	$569.32
8511	Percutaneous (Needle) Biopsy of Breast	3	$569.32
8512	Other Biopsy of Breast	3	$569.32
8521	Local Excision of Lesion of Breast	3	$569.32
8524	Excision of Ectopic Breast Tissue	3	$569.32
8591	Aspiration of Breast	3	$569.32
8601	Aspiration of Skin and Subcutaneous Tissue	3	$569.32
8604	Other Incision with Drainage of Skin and Subcutaneous Tissue	2	$528.92
8605	Incision with Removal of Foreign Body From Skin and Subcutaneous Tissue	2	$528.92
8609	Other Incision of Skin and Subcutaneous Tissue	2	$528.92
8611	Biopsy of Skin and Subcutaneous Tissue	1	$444.25
8621	Excision of Pilonidal Cyst or Sinus	3	$569.32
8622	Debridement of Wound, Infection, or Burn	1	$444.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
8623	Removal of Nail, Nailbed, or Nail Fold	1	$444.25
8627	Debridement of Nail, Nailbed, or Nail Fold	1	$444.25
863	Other Local Excision or Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	1	$444.25
8660	Free Skin Graft, Not Otherwise Specified	3	$569.32
8662	Other Skin Graft to Hand	3	$569.32
8686	Onychoplasty	1	$444.25
8689	Other Repair and Reconstruction of Skin	2	$528.92
8782	Gas Contrast Hysterosalpingogram	2	$528.92
8783	Opaque Dye Contrast Hysterosalpingogram	2	$528.92
8926	Gynecological Examination	1	$444.25
9616	Other Vaginal Dilation	1	$444.25
9622	Dilation of Rectum	1	$444.25
9623	Dilation of Anal Sphincter	1	$444.25
9625	Therapeutic Distention of Bladder	1	$444.25
9649	Other Genitourinary Instillation	1	$444.25
9659	Other Irrigation of Wound	2	$528.92
9739	Removal of Other Therapeutic Device From Head and Neck	2	$528.92
9802	Removal of Intraluminal Foreign Body From Esophagus Without Incision	1	$444.25
9803	Removal of Intraluminal Foreign Body From Stomach and Small Intestine Without Incision	1	$444.25
9804	Removal of Intraluminal Foreign Body From Large Intestine Without Incision	1	$444.25
9805	Removal of Intraluminal Foreign Body From Rectum and Anus Without Incision	1	$444.25
9814	Removal of Intraluminal Foreign Body From Larynx Without Incision	1	$444.25
9815	Removal of Intraluminal Foreign Body From Trachea and Bronchus Without Incision	1	$444.25

PROCEDURE CODES			
Procedure	Description	Group	Payment
9821	Removal of Superficial Foreign Body From Eye Without Incision	1	$444.25
9822	Removal of Other Foreign Body Without Incision from Head and Neck	1	$444.25
9827	Removal of Foreign Body Without Incision From Upper Limb, Except Hand	2	$528.92

OUTPATIENT SURGICAL PROCEDURES

The charts on the following pages list outpatient surgical procedures. Outpatient surgeries must be billed using the appropriate HCPCS code from the listing below. Payment Group (1-9) refers to one of the nine payment groups which the service will be reimbursed when performed on an outpatient basis. Rates for the nine payment groups are listed at the end of this schedule.

These surgical procedures require pre admission approval if performed on an inpatient basis on the first or second day of the inpatient stay.

NOTE: Providers who are performing these services on an inpatient basis must continue to use the ICD-9 Procedure Codes on the pre-certification request and claim form.

HCPCS Code	Short Description	Payment Group	Payment Amount
10121	Remove foreign body	2	$468.30
10180	Complex drainage, wound	2	$468.30
11010	Debride skin, fx	2	$468.30
11011	Debride skin/muscle, fx	2	$468.30
11012	Debride skin/muscle/bone, fx	2	$468.30
11042	Debride skin/tissue	2	$468.30
11043	Debride tissue/muscle	2	$468.30
11044	Debride tissue/muscle/bone	2	$468.30
11404	Removal of skin lesion	1	$349.65
11406	Removal of skin lesion	2	$468.30
11424	Removal of skin lesion	2	$468.30
11426	Removal of skin lesion	2	$468.30
11444	Removal of skin lesion	1	$349.65
11446	Removal of skin lesion	2	$468.30
11450	Removal, sweat gland lesion	2	$468.30
11451	Removal, sweat gland lesion	2	$468.30
11462	Removal, sweat gland lesion	2	$468.30
11463	Removal, sweat gland lesion	2	$468.30
11470	Removal, sweat gland lesion	2	$468.30
11471	Removal, sweat gland lesion	2	$468.30
11604	Removal of skin lesion	2	$468.30
11606	Removal of skin lesion	2	$468.30
11624	Removal of skin lesion	2	$468.30
11626	Removal of skin lesion	2	$468.30
11644	Removal of skin lesion	2	$468.30
11646	Removal of skin lesion	2	$468.30
11770	Removal of pilonidal lesion	3	$535.50
11771	Removal of pilonidal lesion	3	$535.50
11772	Removal of pilonidal lesion	3	$535.50
11960	Insert tissue expander(s)	2	$468.30
11970	Replace tissue expander	3	$535.50
11971	Remove tissue expander(s)	1	$349.65
12005	Repair superficial wound(s)	2	$468.30
12006	Repair superficial wound(s)	2	$468.30
12007	Repair superficial wound(s)	2	$468.30
12016	Repair superficial wound(s)	2	$468.30
12017	Repair superficial wound(s)	2	$468.30
12018	Repair superficial wound(s)	2	$468.30
12020	Closure of split wound	1	$349.65
12021	Closure of split wound	1	$349.65
12034	Layer closure of wound(s)	2	$468.30
12035	Layer closure of wound(s)	2	$468.30
12036	Layer closure of wound(s)	2	$468.30
12037	Layer closure of wound(s)	2	$468.30
12044	Layer closure of wound(s)	2	$468.30
12045	Layer closure of wound(s)	2	$468.30
12046	Layer closure of wound(s)	2	$468.30
12047	Layer closure of wound(s)	2	$468.30
12054	Layer closure of wound(s)	2	$468.30

HCPCS Code	Short Description	Payment Group	Payment Amount
12055	Layer closure of wound(s)	2	$468.30
12056	Layer closure of wound(s)	2	$468.30
12057	Layer closure of wound(s)	2	$468.30
13100	Repair of wound or lesion	2	$468.30
13101	Repair of wound or lesion	3	$535.50
13120	Repair of wound or lesion	2	$468.30
13121	Repair of wound or lesion	3	$535.50
13131	Repair of wound or lesion	2	$468.30
13132	Repair of wound or lesion	3	$535.50
13150	Repair of wound or lesion	3	$535.50
13151	Repair of wound or lesion	3	$535.50
13152	Repair of wound or lesion	3	$535.50
13160	Late closure of wound	2	$468.30
14000	Skin tissue rearrangement	2	$468.30
14001	Skin tissue rearrangement	3	$535.50
14020	Skin tissue rearrangement	3	$535.50
14021	Skin tissue rearrangement	3	$535.50
14040	Skin tissue rearrangement	2	$468.30
14041	Skin tissue rearrangement	3	$535.50
14060	Skin tissue rearrangement	3	$535.50
14061	Skin tissue rearrangement	3	$535.50
14300	Skin tissue rearrangement	4	$661.50
14350	Skin tissue rearrangement	3	$535.50
15000	Skin graft	2	$468.30
15050	Skin pinch graft	2	$468.30
15100	Skin split graft	2	$468.30
15101	Skin split graft add-on	3	$535.50
15120	Skin split graft	2	$468.30
15121	Skin split graft add-on	3	$535.50
15200	Skin full graft	3	$535.50
15201	Skin full graft add-on	2	$468.30
15220	Skin full graft	2	$468.30
15221	Skin full graft add-on	2	$468.30
15240	Skin full graft	3	$535.50
15241	Skin full graft add-on	3	$535.50
15260	Skin full graft	2	$468.30
15261	Skin full graft add-on	2	$468.30
15350	Skin homograft	2	$468.30
15351	Skin homograft add-on	2	$468.30
15400	Skin heterograft	2	$468.30
15401	Skin heterograft add-on	2	$468.30
15570	Form skin pedicle flap	3	$535.50
15572	Form skin pedicle flap	3	$535.50
15574	Form skin pedicle flap	3	$535.50
15576	Form skin pedicle flap	3	$535.50
15600	Skin graft	3	$535.50
15610	Skin graft	3	$535.50
15620	Skin graft	4	$661.50
15630	Skin graft	3	$535.50

HCPCS Code	Short Description	Payment Group	Payment Amount
15650	Transfer skin pedicle flap	5	$752.85
15732	Muscle-skin graft, head/neck	3	$535.50
15734	Muscle-skin graft, trunk	3	$535.50
15736	Muscle-skin graft, arm	3	$535.50
15738	Muscle-skin graft, leg	3	$535.50
15740	Island pedicle flap graft	2	$468.30
15750	Neurovascular pedicle graft	2	$468.30
15760	Composite skin graft	2	$468.30
15770	Derma-fat-fascia graft	3	$535.50
15775	Hair transplant punch grafts	3	$535.50
15776	Hair transplant punch grafts	3	$535.50
15820	Revision of lower eyelid	3	$535.50
15821	Revision of lower eyelid	3	$535.50
15822	Revision of upper eyelid	3	$535.50
15823	Revision of upper eyelid	5	$752.85
15824	Removal of forehead wrinkles	3	$535.50
15825	Removal of neck wrinkles	3	$535.50
15826	Removal of brow wrinkles	3	$535.50
15828	Removal of face wrinkles	3	$535.50
15829	Removal of skin wrinkles	5	$752.85
15831	Excise excessive skin tissue	3	$535.50
15832	Excise excessive skin tissue	3	$535.50
15833	Excise excessive skin tissue	3	$535.50
15834	Excise excessive skin tissue	3	$535.50
15835	Excise excessive skin tissue	3	$535.50
15840	Graft for face nerve palsy	4	$661.50
15841	Graft for face nerve palsy	4	$661.50
15845	Skin and muscle repair, face	4	$661.50
15876	Suction assisted lipectomy	3	$535.50
15877	Suction assisted lipectomy	3	$535.50
15878	Suction assisted lipectomy	3	$535.50
15879	Suction assisted lipectomy	3	$535.50
15920	Removal of tail bone ulcer	3	$535.50
15922	Removal of tail bone ulcer	4	$661.50
15931	Remove sacrum pressure sore	3	$535.50
15933	Remove sacrum pressure sore	3	$535.50
15934	Remove sacrum pressure sore	3	$535.50
15935	Remove sacrum pressure sore	4	$661.50
15936	Remove sacrum pressure sore	4	$661.50
15937	Remove sacrum pressure sore	4	$661.50
15940	Remove hip pressure sore	3	$535.50
15941	Remove hip pressure sore	3	$535.50
15944	Remove hip pressure sore	3	$535.50
15945	Remove hip pressure sore	4	$661.50
15946	Remove hip pressure sore	4	$661.50
15950	Remove thigh pressure sore	3	$535.50
15951	Remove thigh pressure sore	4	$661.50
15952	Remove thigh pressure sore	3	$535.50
15953	Remove thigh pressure sore	4	$661.50

HCPCS Code	Short Description	Payment Group	Payment Amount
15956	Remove thigh pressure sore	3	$535.50
15958	Remove thigh pressure sore	4	$661.50
16015	Treatment of burn(s)	2	$468.30
19020	Incision of breast lesion	2	$468.30
19100	Bx breast percut w/o image	1	$349.65
19101	Biopsy of breast, open	2	$468.30
19102	Bx breast percut w/image	2	$468.30
19103	Bx breast percut w/device	2	$468.30
19110	Nipple exploration	2	$468.30
19112	Excise breast duct fistula	3	$535.50
19120	Removal of breast lesion	3	$535.50
19125	Excision, breast lesion	3	$535.50
19126	Excision, addl breast lesion	3	$535.50
19140	Removal of breast tissue	4	$661.50
19160	Removal of breast tissue	3	$535.50
19162	Remove breast tissue, nodes	7	$1,044.75
19180	Removal of breast	4	$661.50
19182	Removal of breast	4	$661.50
19290	Place needle wire, breast	1	$349.65
19291	Place needle wire, breast	1	$349.65
19316	Suspension of breast	4	$661.50
19318	Reduction of large breast	4	$661.50
19324	Enlarge breast	4	$661.50
19325	Enlarge breast with implant	9	$1,405.95
19328	Removal of breast implant	1	$349.65
19330	Removal of implant material	1	$349.65
19340	Immediate breast prosthesis	2	$468.30
19342	Delayed breast prosthesis	3	$535.50
19350	Breast reconstruction	4	$661.50
19355	Correct inverted nipple(s)	4	$661.50
19357	Breast reconstruction	5	$752.85
19366	Breast reconstruction	5	$752.85
19370	Surgery of breast capsule	4	$661.50
19371	Removal of breast capsule	4	$661.50
19380	Revise breast reconstruction	5	$752.85
20005	Incision of deep abscess	2	$468.30
20200	Muscle biopsy	2	$468.30
20205	Deep muscle biopsy	3	$535.50
20206	Needle biopsy, muscle	1	$349.65
20220	Bone biopsy, trocar/needle	1	$349.65
20225	Bone biopsy, trocar/needle	2	$468.30
20240	Bone biopsy, excisional	2	$468.30
20245	Bone biopsy, excisional	3	$535.50
20250	Open bone biopsy	3	$535.50
20251	Open bone biopsy	3	$535.50
20525	Removal of foreign body	3	$535.50
20650	Insert and remove bone pin	3	$535.50
20670	Removal of support implant	1	$349.65
20680	Removal of support implant	3	$535.50

HCPCS Code	Short Description	Payment Group	Payment Amount
20690	Apply bone fixation device	2	$468.30
20692	Apply bone fixation device	3	$535.50
20693	Adjust bone fixation device	3	$535.50
20694	Remove bone fixation device	1	$349.65
20900	Removal of bone for graft	3	$535.50
20902	Removal of bone for graft	4	$661.50
20910	Remove cartilage for graft	3	$535.50
20912	Remove cartilage for graft	3	$535.50
20920	Removal of fascia for graft	4	$661.50
20922	Removal of fascia for graft	3	$535.50
20924	Removal of tendon for graft	4	$661.50
20926	Removal of tissue for graft	4	$661.50
20975	Electrical bone stimulation	2	$468.30
21010	Incision of jaw joint	2	$468.30
21015	Resection of facial tumor	3	$535.50
21025	Excision of bone, lower jaw	2	$468.30
21026	Excision of facial bone(s)	2	$468.30
21029	Contour of face bone lesion	2	$468.30
21034	Removal of face bone lesion	3	$535.50
21040	Removal of jaw bone lesion	2	$468.30
21044	Removal of jaw bone lesion	2	$468.30
21046	Excision, benign tumor, mandible	2	$468.30
21047	Excision, benign tumor, mandible	2	$468.30
21050	Removal of jaw joint	3	$535.50
21060	Remove jaw joint cartilage	2	$468.30
21070	Remove coronoid process	3	$535.50
21100	Maxillofacial fixation	2	$468.30
21121	Reconstruction of chin	7	$1,044.75
21122	Reconstruction of chin	7	$1,044.75
21123	Reconstruction of chin	7	$1,044.75
21127	Augmentation, lower jaw bone	9	$1,405.95
21181	Contour cranial bone lesion	7	$1,044.75
21206	Reconstruct upper jaw bone	5	$752.85
21208	Augmentation of facial bones	7	$1,044.75
21209	Reduction of facial bones	5	$752.85
21210	Face bone graft	7	$1,044.75
21215	Lower jaw bone graft	7	$1,044.75
21230	Rib cartilage graft	7	$1,044.75
21235	Ear cartilage graft	7	$1,044.75
21240	Reconstruction of jaw joint	4	$661.50
21242	Reconstruction of jaw joint	5	$752.85
21243	Reconstruction of jaw joint	5	$752.85
21244	Reconstruction of lower jaw	7	$1,044.75
21245	Reconstruction of jaw	7	$1,044.75
21246	Reconstruction of jaw	7	$1,044.75
21248	Reconstruction of jaw	7	$1,044.75
21249	Reconstruction of jaw	7	$1,044.75
21267	Revise eye sockets	7	$1,044.75
21270	Augmentation, cheek bone	5	$752.85

HCPCS Code	Short Description	Payment Group	Payment Amount
21275	Revision, orbitofacial bones	7	$1,044.75
21280	Revision of eyelid	5	$752.85
21282	Revision of eyelid	5	$752.85
21295	Reconst lwr jaw w/o fixation	1	$349.65
21296	Reconst lwr jaw w/fixation	1	$349.65
21300	Treatment of skull fracture	2	$468.30
21310	Treatment of nose fracture	2	$468.30
21315	Treatment of nose fracture	2	$468.30
21320	Treatment of nose fracture	2	$468.30
21325	Treatment of nose fracture	4	$661.50
21330	Treatment of nose fracture	5	$752.85
21335	Treatment of nose fracture	7	$1,044.75
21336	Treat nasal septal fracture	4	$661.50
21337	Treat nasal septal fracture	2	$468.30
21338	Treat nasoethmoid fracture	4	$661.50
21339	Treat nasoethmoid fracture	5	$752.85
21340	Treatment of nose fracture	4	$661.50
21345	Treat nose/jaw fracture	7	$1,044.75
21355	Treat cheek bone fracture	3	$535.50
21400	Treat eye socket fracture	2	$468.30
21401	Treat eye socket fracture	3	$535.50
21421	Treat mouth roof fracture	4	$661.50
21440	Treat dental ridge fracture	3	$535.50
21445	Treat dental ridge fracture	4	$661.50
21450	Treat lower jaw fracture	3	$535.50
21451	Treat lower jaw fracture	4	$661.50
21452	Treat lower jaw fracture	2	$468.30
21453	Treat lower jaw fracture	3	$535.50
21454	Treat lower jaw fracture	5	$752.85
21461	Treat lower jaw fracture	4	$661.50
21462	Treat lower jaw fracture	5	$752.85
21465	Treat lower jaw fracture	4	$661.50
21480	Reset dislocated jaw	1	$349.65
21485	Reset dislocated jaw	2	$468.30
21490	Repair dislocated jaw	3	$535.50
21493	Treat hyoid bone fracture	3	$535.50
21494	Treat hyoid bone fracture	4	$661.50
21497	Interdental wiring	2	$468.30
21501	Drain neck/chest lesion	2	$468.30
21502	Drain chest lesion	2	$468.30
21555	Remove lesion, neck/chest	2	$468.30
21556	Remove lesion, neck/chest	2	$468.30
21600	Partial removal of rib	2	$468.30
21610	Partial removal of rib	2	$468.30
21700	Revision of neck muscle	2	$468.30
21720	Revision of neck muscle	3	$535.50
21725	Revision of neck muscle	3	$535.50
21800	Treatment of rib fracture	1	$349.65
21805	Treatment of rib fracture	2	$468.30

HCPCS Code	Short Description	Payment Group	Payment Amount
21820	Treat sternum fracture	1	$349.65
21925	Biopsy soft tissue of back	2	$468.30
21930	Remove lesion, back or flank	2	$468.30
21935	Remove tumor, back	3	$535.50
22305	Treat spine process fracture	1	$349.65
22310	Treat spine fracture	1	$349.65
22315	Treat spine fracture	2	$468.30
22505	Manipulation of spine	2	$468.30
22900	Remove abdominal wall lesion	4	$661.50
23000	Removal of calcium deposits	2	$468.30
23020	Release shoulder joint	2	$468.30
23030	Drain shoulder lesion	1	$349.65
23031	Drain shoulder bursa	3	$535.50
23035	Drain shoulder bone lesion	3	$535.50
23040	Exploratory shoulder surgery	3	$535.50
23044	Exploratory shoulder surgery	4	$661.50
23066	Biopsy shoulder tissues	2	$468.30
23075	Removal of shoulder lesion	2	$468.30
23076	Removal of shoulder lesion	2	$468.30
23077	Remove tumor of shoulder	3	$535.50
23100	Biopsy of shoulder joint	2	$468.30
23101	Shoulder joint surgery	7	$1,044.75
23105	Remove shoulder joint lining	4	$661.50
23106	Incision of collarbone joint	4	$661.50
23107	Explore treat shoulder joint	4	$661.50
23120	Partial removal, collar bone	5	$752.85
23125	Removal of collar bone	5	$752.85
23130	Remove shoulder bone, part	5	$752.85
23140	Removal of bone lesion	4	$661.50
23145	Removal of bone lesion	5	$752.85
23146	Removal of bone lesion	5	$752.85
23150	Removal of humerus lesion	4	$661.50
23155	Removal of humerus lesion	5	$752.85
23156	Removal of humerus lesion	5	$752.85
23170	Remove collar bone lesion	2	$468.30
23172	Remove shoulder blade lesion	2	$468.30
23174	Remove humerus lesion	2	$468.30
23180	Remove collar bone lesion	4	$661.50
23182	Remove shoulder blade lesion	4	$661.50
23184	Remove humerus lesion	4	$661.50
23190	Partial removal of scapula	4	$661.50
23195	Removal of head of humerus	5	$752.85
23330	Remove shoulder foreign body	1	$349.65
23331	Remove shoulder foreign body	1	$349.65
23395	Muscle transfer,shoulder/arm	5	$752.85
23397	Muscle transfers	7	$1,044.75
23400	Fixation of shoulder blade	7	$1,044.75
23405	Incision of tendon & muscle	2	$468.30
23406	Incise tendon(s) & muscle(s)	2	$468.30

HCPCS Code	Short Description	Payment Group	Payment Amount
23410	Repair of tendon(s)	5	$752.85
23412	Repair of tendon(s)	7	$1,044.75
23415	Release of shoulder ligament	5	$752.85
23420	Repair of shoulder	7	$1,044.75
23430	Repair biceps tendon	4	$661.50
23440	Remove/transplant tendon	4	$661.50
23450	Repair shoulder capsule	5	$752.85
23455	Repair shoulder capsule	7	$1,044.75
23460	Repair shoulder capsule	5	$752.85
23462	Repair shoulder capsule	7	$1,044.75
23465	Repair shoulder capsule	5	$752.85
23466	Repair shoulder capsule	7	$1,044.75
23480	Revision of collar bone	4	$661.50
23485	Revision of collar bone	7	$1,044.75
23490	Reinforce clavicle	3	$535.50
23491	Reinforce shoulder bones	3	$535.50
23500	Treat clavicle fracture	1	$349.65
23505	Treat clavicle fracture	1	$349.65
23515	Treat clavicle fracture	3	$535.50
23520	Treat clavicle dislocation	1	$349.65
23525	Treat clavicle dislocation	1	$349.65
23530	Treat clavicle dislocation	3	$535.50
23532	Treat clavicle dislocation	4	$661.50
23540	Treat clavicle dislocation	1	$349.65
23545	Treat clavicle dislocation	1	$349.65
23550	Treat clavicle dislocation	3	$535.50
23552	Treat clavicle dislocation	4	$661.50
23570	Treat shoulder blade fx	1	$349.65
23575	Treat shoulder blade fx	1	$349.65
23585	Treat scapula fracture	3	$535.50
23600	Treat humerus fracture	1	$349.65
23605	Treat humerus fracture	2	$468.30
23615	Treat humerus fracture	4	$661.50
23616	Treat humerus fracture	4	$661.50
23620	Treat humerus fracture	1	$349.65
23625	Treat humerus fracture	2	$468.30
23630	Treat humerus fracture	5	$752.85
23650	Treat shoulder dislocation	1	$349.65
23655	Treat shoulder dislocation	1	$349.65
23660	Treat shoulder dislocation	3	$535.50
23665	Treat dislocation/fracture	2	$468.30
23670	Treat dislocation/fracture	3	$535.50
23675	Treat dislocation/fracture	2	$468.30
23680	Treat dislocation/fracture	3	$535.50
23700	Fixation of shoulder	1	$349.65
23800	Fusion of shoulder joint	4	$661.50
23802	Fusion of shoulder joint	7	$1,044.75
23921	Amputation follow-up surgery	3	$535.50
23930	Drainage of arm lesion	1	$349.65

HCPCS Code	Short Description	Payment Group	Payment Amount
23931	Drainage of arm bursa	2	$468.30
23935	Drain arm/elbow bone lesion	2	$468.30
24000	Exploratory elbow surgery	4	$661.50
24006	Release elbow joint	4	$661.50
24066	Biopsy arm/elbow soft tissue	2	$468.30
24075	Remove arm/elbow lesion	2	$468.30
24076	Remove arm/elbow lesion	2	$468.30
24077	Remove tumor of arm/elbow	3	$535.50
24100	Biopsy elbow joint lining	1	$349.65
24101	Explore/treat elbow joint	4	$661.50
24102	Remove elbow joint lining	4	$661.50
24105	Removal of elbow bursa	3	$535.50
24110	Remove humerus lesion	2	$468.30
24115	Remove/graft bone lesion	3	$535.50
24116	Remove/graft bone lesion	3	$535.50
24120	Remove elbow lesion	3	$535.50
24125	Remove/graft bone lesion	3	$535.50
24126	Remove/graft bone lesion	3	$535.50
24130	Removal of head of radius	3	$535.50
24134	Removal of arm bone lesion	2	$468.30
24136	Remove radius bone lesion	2	$468.30
24138	Remove elbow bone lesion	2	$468.30
24140	Partial removal of arm bone	3	$535.50
24145	Partial removal of radius	3	$535.50
24147	Partial removal of elbow	2	$468.30
24155	Removal of elbow joint	3	$535.50
24160	Remove elbow joint implant	2	$468.30
24164	Remove radius head implant	3	$535.50
24201	Removal of arm foreign body	2	$468.30
24301	Muscle/tendon transfer	4	$661.50
24305	Arm tendon lengthening	4	$661.50
24310	Revision of arm tendon	3	$535.50
24320	Repair of arm tendon	3	$535.50
24330	Revision of arm muscles	3	$535.50
24331	Revision of arm muscles	3	$535.50
24340	Repair of biceps tendon	3	$535.50
24341	Repair arm tendon/muscle	3	$535.50
24342	Repair of ruptured tendon	3	$535.50
24345	Repr elbw med ligmnt w/tissu	2	$468.30
24350	Repair of tennis elbow	3	$535.50
24351	Repair of tennis elbow	3	$535.50
24352	Repair of tennis elbow	3	$535.50
24354	Repair of tennis elbow	3	$535.50
24356	Revision of tennis elbow	3	$535.50
24360	Reconstruct elbow joint	5	$752.85
24361	Reconstruct elbow joint	5	$752.85
24362	Reconstruct elbow joint	5	$752.85
24363	Replace elbow joint	7	$1,044.75
24365	Reconstruct head of radius	5	$752.85

HCPCS Code	Short Description	Payment Group	Payment Amount
24366	Reconstruct head of radius	5	$752.85
24400	Revision of humerus	4	$661.50
24410	Revision of humerus	4	$661.50
24420	Revision of humerus	3	$535.50
24430	Repair of humerus	3	$535.50
24435	Repair humerus with graft	4	$661.50
24470	Revision of elbow joint	3	$535.50
24495	Decompression of forearm	2	$468.30
24498	Reinforce humerus	3	$535.50
24500	Treat humerus fracture	1	$349.65
24505	Treat humerus fracture	1	$349.65
24515	Treat humerus fracture	4	$661.50
24516	Treat humerus fracture	4	$661.50
24530	Treat humerus fracture	1	$349.65
24535	Treat humerus fracture	1	$349.65
24538	Treat humerus fracture	2	$468.30
24545	Treat humerus fracture	4	$661.50
24546	Treat humerus fracture	5	$752.85
24560	Treat humerus fracture	1	$349.65
24565	Treat humerus fracture	2	$468.30
24566	Treat humerus fracture	2	$468.30
24575	Treat humerus fracture	3	$535.50
24576	Treat humerus fracture	1	$349.65
24577	Treat humerus fracture	1	$349.65
24579	Treat humerus fracture	3	$535.50
24582	Treat humerus fracture	2	$468.30
24586	Treat elbow fracture	4	$661.50
24587	Treat elbow fracture	5	$752.85
24600	Treat elbow dislocation	1	$349.65
24605	Treat elbow dislocation	2	$468.30
24615	Treat elbow dislocation	3	$535.50
24620	Treat elbow fracture	2	$468.30
24635	Treat elbow fracture	3	$535.50
24655	Treat radius fracture	1	$349.65
24665	Treat radius fracture	4	$661.50
24666	Treat radius fracture	4	$661.50
24670	Treat ulnar fracture	1	$349.65
24675	Treat ulnar fracture	1	$349.65
24685	Treat ulnar fracture	3	$535.50
24800	Fusion of elbow joint	4	$661.50
24802	Fusion/graft of elbow joint	5	$752.85
24925	Amputation follow-up surgery	3	$535.50
25000	Incision of tendon sheath	3	$535.50
25020	Decompress forearm 1 space	3	$535.50
25023	Decompress forearm 1 space	3	$535.50
25024	Decompress forearm 2 spaces	3	$535.50
25025	Decompress forarm 2 spaces	3	$535.50
25028	Drainage of forearm lesion	1	$349.65
25031	Drainage of forearm bursa	2	$468.30

HCPCS Code	Short Description	Payment Group	Payment Amount
25035	Treat forearm bone lesion	2	$468.30
25040	Explore/treat wrist joint	5	$752.85
25066	Biopsy forearm soft tissues	2	$468.30
25075	Remove forearm lesion subcut	2	$468.30
25076	Remove forearm lesion deep	3	$535.50
25077	Remove tumor, forearm/wrist	3	$535.50
25085	Incision of wrist capsule	3	$535.50
25100	Biopsy of wrist joint	2	$468.30
25101	Explore/treat wrist joint	3	$535.50
25105	Remove wrist joint lining	4	$661.50
25107	Remove wrist joint cartilage	3	$535.50
25110	Remove wrist tendon lesion	3	$535.50
25111	Remove wrist tendon lesion	3	$535.50
25112	Reremove wrist tendon lesion	4	$661.50
25115	Remove wrist/forearm lesion	4	$661.50
25116	Remove wrist/forearm lesion	4	$661.50
25118	Excise wrist tendon sheath	2	$468.30
25119	Partial removal of ulna	3	$535.50
25120	Removal of forearm lesion	3	$535.50
25125	Remove/graft forearm lesion	3	$535.50
25126	Remove/graft forearm lesion	3	$535.50
25130	Removal of wrist lesion	3	$535.50
25135	Remove & graft wrist lesion	3	$535.50
25136	Remove & graft wrist lesion	3	$535.50
25145	Remove forearm bone lesion	2	$468.30
25150	Partial removal of ulna	2	$468.30
25151	Partial removal of radius	2	$468.30
25210	Removal of wrist bone	3	$535.50
25215	Removal of wrist bones	4	$661.50
25230	Partial removal of radius	4	$661.50
25240	Partial removal of ulna	4	$661.50
25248	Remove forearm foreign body	2	$468.30
25250	Removal of wrist prosthesis	1	$349.65
25251	Removal of wrist prosthesis	1	$349.65
25260	Repair forearm tendon/muscle	4	$661.50
25263	Repair forearm tendon/muscle	2	$468.30
25265	Repair forearm tendon/muscle	3	$535.50
25270	Repair forearm tendon/muscle	4	$661.50
25272	Repair forearm tendon/muscle	3	$535.50
25274	Repair forearm tendon/muscle	4	$661.50
25275	Repair forearm tendon sheath	4	$661.50
25280	Revise wrist/forearm tendon	4	$661.50
25290	Incise wrist/forearm tendon	3	$535.50
25295	Release wrist/forearm tendon	3	$535.50
25300	Fusion of tendons at wrist	3	$535.50
25301	Fusion of tendons at wrist	3	$535.50
25310	Transplant forearm tendon	3	$535.50
25312	Transplant forearm tendon	4	$661.50
25315	Revise palsy hand tendon(s)	3	$535.50

HCPCS Code	Short Description	Payment Group	Payment Amount
25316	Revise palsy hand tendon(s)	3	$535.50
25320	Repair/revise wrist joint	3	$535.50
25332	Revise wrist joint	5	$752.85
25335	Realignment of hand	3	$535.50
25337	Reconstruct ulna/radioulnar	5	$752.85
25350	Revision of radius	3	$535.50
25355	Revision of radius	3	$535.50
25360	Revision of ulna	3	$535.50
25365	Revise radius & ulna	3	$535.50
25370	Revise radius or ulna	3	$535.50
25375	Revise radius & ulna	4	$661.50
25390	Shorten radius or ulna	3	$535.50
25391	Lengthen radius or ulna	4	$661.50
25392	Shorten radius & ulna	3	$535.50
25393	Lengthen radius & ulna	4	$661.50
25400	Repair radius or ulna	3	$535.50
25405	Repair/graft radius or ulna	4	$661.50
25415	Repair radius & ulna	3	$535.50
25420	Repair/graft radius & ulna	4	$661.50
25425	Repair/graft radius or ulna	3	$535.50
25426	Repair/graft radius & ulna	4	$661.50
25440	Repair/graft wrist bone	4	$661.50
25441	Reconstruct wrist joint	5	$752.85
25442	Reconstruct wrist joint	5	$752.85
25443	Reconstruct wrist joint	5	$752.85
25444	Reconstruct wrist joint	5	$752.85
25445	Reconstruct wrist joint	5	$752.85
25446	Wrist replacement	7	$1,044.75
25447	Repair wrist joint(s)	5	$752.85
25449	Remove wrist joint implant	5	$752.85
25450	Revision of wrist joint	3	$535.50
25455	Revision of wrist joint	3	$535.50
25490	Reinforce radius	3	$535.50
25491	Reinforce ulna	3	$535.50
25492	Reinforce radius and ulna	3	$535.50
25505	Treat fracture of radius	1	$349.65
25515	Treat fracture of radius	3	$535.50
25520	Treat fracture of radius	1	$349.65
25525	Treat fracture of radius	4	$661.50
25526	Treat fracture of radius	5	$752.85
25535	Treat fracture of ulna	1	$349.65
25545	Treat fracture of ulna	3	$535.50
25565	Treat fracture radius & ulna	2	$468.30
25574	Treat fracture radius & ulna	3	$535.50
25575	Treat fracture radius/ulna	3	$535.50
25605	Treat fracture radius/ulna	3	$535.50
25611	Treat fracture radius/ulna	3	$535.50
25620	Treat fracture radius/ulna	5	$752.85
25624	Treat wrist bone fracture	2	$468.30

HCPCS Code	Short Description	Payment Group	Payment Amount
25628	Treat wrist bone fracture	3	$535.50
25635	Treat wrist bone fracture	1	$349.65
25645	Treat wrist bone fracture	3	$535.50
25660	Treat wrist dislocation	1	$349.65
25670	Treat wrist dislocation	3	$535.50
25671	Pin radioulnar dislocation	1	$349.65
25675	Treat wrist dislocation	1	$349.65
25676	Treat wrist dislocation	2	$468.30
25680	Treat wrist fracture	2	$468.30
25685	Treat wrist fracture	3	$535.50
25690	Treat wrist dislocation	1	$349.65
25695	Treat wrist dislocation	2	$468.30
25800	Fusion of wrist joint	4	$661.50
25805	Fusion/graft of wrist joint	5	$752.85
25810	Fusion/graft of wrist joint	5	$752.85
25820	Fusion of hand bones	4	$661.50
25825	Fuse hand bones with graft	5	$752.85
25830	Fusion, radioulnar jnt/ulna	5	$752.85
25907	Amputation follow-up surgery	3	$535.50
25922	Amputate hand at wrist	3	$535.50
25929	Amputation follow-up surgery	3	$535.50
26011	Drainage of finger abscess	1	$349.65
26020	Drain hand tendon sheath	2	$468.30
26025	Drainage of palm bursa	1	$349.65
26030	Drainage of palm bursa(s)	2	$468.30
26034	Treat hand bone lesion	2	$468.30
26040	Release palm contracture	4	$661.50
26045	Release palm contracture	3	$535.50
26055	Incise finger tendon sheath	2	$468.30
26060	Incision of finger tendon	2	$468.30
26070	Explore/treat hand joint	2	$468.30
26075	Explore/treat finger joint	4	$661.50
26080	Explore/treat finger joint	4	$661.50
26100	Biopsy hand joint lining	2	$468.30
26105	Biopsy finger joint lining	1	$349.65
26110	Biopsy finger joint lining	1	$349.65
26115	Remove hand lesion subcut	2	$468.30
26116	Remove hand lesion, deep	2	$468.30
26117	Remove tumor, hand/finger	3	$535.50
26121	Release palm contracture	4	$661.50
26123	Release palm contracture	4	$661.50
26125	Release palm contracture	4	$661.50
26130	Remove wrist joint lining	3	$535.50
26135	Revise finger joint, each	4	$661.50
26140	Revise finger joint, each	2	$468.30
26145	Tendon excision, palm/finger	3	$535.50
26160	Remove tendon sheath lesion	3	$535.50
26170	Removal of palm tendon, each	3	$535.50
26180	Removal of finger tendon	3	$535.50

HCPCS Code	Short Description	Payment Group	Payment Amount
26185	Remove finger bone	4	$661.50
26200	Remove hand bone lesion	2	$468.30
26205	Remove/graft bone lesion	3	$535.50
26210	Removal of finger lesion	2	$468.30
26215	Remove/graft finger lesion	3	$535.50
26230	Partial removal of hand bone	7	$1,044.75
26235	Partial removal, finger bone	3	$535.50
26236	Partial removal, finger bone	3	$535.50
26250	Extensive hand surgery	3	$535.50
26255	Extensive hand surgery	3	$535.50
26260	Extensive finger surgery	3	$535.50
26261	Extensive finger surgery	3	$535.50
26262	Partial removal of finger	2	$468.30
26320	Removal of implant from hand	2	$468.30
26350	Repair finger/hand tendon	1	$349.65
26352	Repair/graft hand tendon	4	$661.50
26356	Repair finger/hand tendon	4	$661.50
26357	Repair finger/hand tendon	4	$661.50
26358	Repair/graft hand tendon	4	$661.50
26370	Repair finger/hand tendon	4	$661.50
26372	Repair/graft hand tendon	4	$661.50
26373	Repair finger/hand tendon	3	$535.50
26390	Revise hand/finger tendon	4	$661.50
26392	Repair/graft hand tendon	3	$535.50
26410	Repair hand tendon	3	$535.50
26412	Repair/graft hand tendon	3	$535.50
26415	Excision, hand/finger tendon	4	$661.50
26416	Graft hand or finger tendon	3	$535.50
26418	Repair finger tendon	4	$661.50
26420	Repair/graft finger tendon	4	$661.50
26426	Repair finger/hand tendon	3	$535.50
26428	Repair/graft finger tendon	3	$535.50
26432	Repair finger tendon	3	$535.50
26433	Repair finger tendon	3	$535.50
26434	Repair/graft finger tendon	3	$535.50
26437	Realignment of tendons	3	$535.50
26440	Release palm/finger tendon	3	$535.50
26442	Release palm & finger tendon	3	$535.50
26445	Release hand/finger tendon	3	$535.50
26449	Release forearm/hand tendon	3	$535.50
26450	Incision of palm tendon	3	$535.50
26455	Incision of finger tendon	3	$535.50
26460	Incise hand/finger tendon	3	$535.50
26471	Fusion of finger tendons	2	$468.30
26474	Fusion of finger tendons	2	$468.30
26476	Tendon lengthening	1	$349.65
26477	Tendon shortening	1	$349.65
26478	Lengthening of hand tendon	1	$349.65
26479	Shortening of hand tendon	1	$349.65

HCPCS Code	Short Description	Payment Group	Payment Amount
26480	Transplant hand tendon	3	$535.50
26483	Transplant/graft hand tendon	3	$535.50
26485	Transplant palm tendon	2	$468.30
26489	Transplant/graft palm tendon	3	$535.50
26490	Revise thumb tendon	3	$535.50
26492	Tendon transfer with graft	3	$535.50
26494	Hand tendon/muscle transfer	3	$535.50
26496	Revise thumb tendon	3	$535.50
26497	Finger tendon transfer	3	$535.50
26498	Finger tendon transfer	4	$661.50
26499	Revision of finger	3	$535.50
26500	Hand tendon reconstruction	4	$661.50
26502	Hand tendon reconstruction	4	$661.50
26504	Hand tendon reconstruction	4	$661.50
26508	Release thumb contracture	3	$535.50
26510	Thumb tendon transfer	3	$535.50
26516	Fusion of knuckle joint	1	$349.65
26517	Fusion of knuckle joints	3	$535.50
26518	Fusion of knuckle joints	3	$535.50
26520	Release knuckle contracture	3	$535.50
26525	Release finger contracture	3	$535.50
26530	Revise knuckle joint	3	$535.50
26531	Revise knuckle with implant	7	$1,044.75
26535	Revise finger joint	5	$752.85
26536	Revise/implant finger joint	5	$752.85
26540	Repair hand joint	4	$661.50
26541	Repair hand joint with graft	7	$1,044.75
26542	Repair hand joint with graft	4	$661.50
26545	Reconstruct finger joint	4	$661.50
26546	Repair nonunion hand	4	$661.50
26548	Reconstruct finger joint	4	$661.50
26550	Construct thumb replacement	2	$468.30
26555	Positional change of finger	3	$535.50
26560	Repair of web finger	2	$468.30
26561	Repair of web finger	3	$535.50
26562	Repair of web finger	4	$661.50
26565	Correct metacarpal flaw	5	$752.85
26567	Correct finger deformity	5	$752.85
26568	Lengthen metacarpal/finger	3	$535.50
26580	Repair hand deformity	5	$752.85
26587	Reconstruct extra finger	5	$752.85
26590	Repair finger deformity	5	$752.85
26591	Repair muscles of hand	3	$535.50
26593	Release muscles of hand	3	$535.50
26596	Excision constricting tissue	2	$468.30
26605	Treat metacarpal fracture	2	$468.30
26607	Treat metacarpal fracture	2	$468.30
26608	Treat metacarpal fracture	4	$661.50
26615	Treat metacarpal fracture	4	$661.50

HCPCS Code	Short Description	Payment Group	Payment Amount
26645	Treat thumb fracture	1	$349.65
26650	Treat thumb fracture	2	$468.30
26665	Treat thumb fracture	4	$661.50
26675	Treat hand dislocation	2	$468.30
26676	Pin hand dislocation	2	$468.30
26685	Treat hand dislocation	3	$535.50
26686	Treat hand dislocation	3	$535.50
26705	Treat knuckle dislocation	2	$468.30
26706	Pin knuckle dislocation	2	$468.30
26715	Treat knuckle dislocation	4	$661.50
26727	Treat finger fracture, each	7	$1,044.75
26735	Treat finger fracture, each	4	$661.50
26742	Treat finger fracture, each	2	$468.30
26746	Treat finger fracture, each	5	$752.85
26756	Pin finger fracture, each	2	$468.30
26765	Treat finger fracture, each	4	$661.50
26776	Pin finger dislocation	2	$468.30
26785	Treat finger dislocation	2	$468.30
26820	Thumb fusion with graft	5	$752.85
26841	Fusion of thumb	4	$661.50
26842	Thumb fusion with graft	4	$661.50
26843	Fusion of hand joint	3	$535.50
26844	Fusion/graft of hand joint	3	$535.50
26850	Fusion of knuckle	4	$661.50
26852	Fusion of knuckle with graft	4	$661.50
26860	Fusion of finger joint	3	$535.50
26861	Fusion of finger jnt, add-on	2	$468.30
26862	Fusion/graft of finger joint	4	$661.50
26863	Fuse/graft added joint	3	$535.50
26910	Amputate metacarpal bone	3	$535.50
26951	Amputation of finger/thumb	2	$468.30
26952	Amputation of finger/thumb	4	$661.50
26990	Drainage of pelvis lesion	1	$349.65
26991	Drainage of pelvis bursa	1	$349.65
27000	Incision of hip tendon	2	$468.30
27001	Incision of hip tendon	3	$535.50
27003	Incision of hip tendon	3	$535.50
27033	Exploration of hip joint	3	$535.50
27035	Denervation of hip joint	4	$661.50
27040	Biopsy of soft tissues	1	$349.65
27041	Biopsy of soft tissues	2	$468.30
27047	Remove hip/pelvis lesion	2	$468.30
27048	Remove hip/pelvis lesion	3	$535.50
27049	Remove tumor, hip/pelvis	3	$535.50
27050	Biopsy of sacroiliac joint	3	$535.50
27052	Biopsy of hip joint	3	$535.50
27060	Removal of ischial bursa	5	$752.85
27062	Remove femur lesion/bursa	5	$752.85
27065	Removal of hip bone lesion	5	$752.85

HCPCS Code	Short Description	Payment Group	Payment Amount
27066	Removal of hip bone lesion	5	$752.85
27067	Remove/graft hip bone lesion	5	$752.85
27080	Removal of tail bone	2	$468.30
27086	Remove hip foreign body	1	$349.65
27087	Remove hip foreign body	3	$535.50
27097	Revision of hip tendon	3	$535.50
27098	Transfer tendon to pelvis	3	$535.50
27100	Transfer of abdominal muscle	4	$661.50
27105	Transfer of spinal muscle	4	$661.50
27110	Transfer of iliopsoas muscle	4	$661.50
27111	Transfer of iliopsoas muscle	4	$661.50
27193	Treat pelvic ring fracture	1	$349.65
27194	Treat pelvic ring fracture	2	$468.30
27202	Treat tail bone fracture	2	$468.30
27230	Treat thigh fracture	1	$349.65
27238	Treat thigh fracture	1	$349.65
27246	Treat thigh fracture	1	$349.65
27250	Treat hip dislocation	1	$349.65
27252	Treat hip dislocation	2	$468.30
27257	Treat hip dislocation	3	$535.50
27265	Treat hip dislocation	1	$349.65
27266	Treat hip dislocation	2	$468.30
27275	Manipulation of hip joint	2	$468.30
27301	Drain thigh/knee lesion	3	$535.50
27305	Incise thigh tendon & fascia	2	$468.30
27306	Incision of thigh tendon	3	$535.50
27307	Incision of thigh tendons	3	$535.50
27310	Exploration of knee joint	4	$661.50
27315	Partial removal, thigh nerve	2	$468.30
27320	Partial removal, thigh nerve	2	$468.30
27323	Biopsy, thigh soft tissues	1	$349.65
27324	Biopsy, thigh soft tissues	1	$349.65
27327	Removal of thigh lesion	2	$468.30
27328	Removal of thigh lesion	3	$535.50
27329	Remove tumor, thigh/knee	4	$661.50
27330	Biopsy, knee joint lining	4	$661.50
27331	Explore/treat knee joint	4	$661.50
27332	Removal of knee cartilage	4	$661.50
27333	Removal of knee cartilage	4	$661.50
27334	Remove knee joint lining	4	$661.50
27335	Remove knee joint lining	4	$661.50
27340	Removal of kneecap bursa	3	$535.50
27345	Removal of knee cyst	4	$661.50
27347	Remove knee cyst	4	$661.50
27350	Removal of kneecap	4	$661.50
27355	Remove femur lesion	3	$535.50
27356	Remove femur lesion/graft	4	$661.50
27357	Remove femur lesion/graft	5	$752.85
27358	Remove femur lesion/fixation	5	$752.85

HCPCS Code	Short Description	Payment Group	Payment Amount
27360	Partial removal, leg bone(s)	5	$752.85
27372	Removal of foreign body	7	$1,044.75
27380	Repair of kneecap tendon	1	$349.65
27381	Repair/graft kneecap tendon	3	$535.50
27385	Repair of thigh muscle	3	$535.50
27386	Repair/graft of thigh muscle	3	$535.50
27390	Incision of thigh tendon	1	$349.65
27391	Incision of thigh tendons	2	$468.30
27392	Incision of thigh tendons	3	$535.50
27393	Lengthening of thigh tendon	2	$468.30
27394	Lengthening of thigh tendons	3	$535.50
27395	Lengthening of thigh tendons	3	$535.50
27396	Transplant of thigh tendon	3	$535.50
27397	Transplants of thigh tendons	3	$535.50
27400	Revise thigh muscles/tendons	3	$535.50
27403	Repair of knee cartilage	4	$661.50
27405	Repair of knee ligament	4	$661.50
27407	Repair of knee ligament	4	$661.50
27409	Repair of knee ligaments	4	$661.50
27418	Repair degenerated kneecap	3	$535.50
27420	Revision of unstable kneecap	3	$535.50
27422	Revision of unstable kneecap	7	$1,044.75
27424	Revision/removal of kneecap	3	$535.50
27425	Lateral retinacular release	7	$1,044.75
27427	Reconstruction, knee	3	$535.50
27428	Reconstruction, knee	4	$661.50
27429	Reconstruction, knee	4	$661.50
27430	Revision of thigh muscles	4	$661.50
27435	Incision of knee joint	4	$661.50
27437	Revise kneecap	4	$661.50
27438	Revise kneecap with implant	5	$752.85
27441	Revision of knee joint	5	$752.85
27442	Revision of knee joint	5	$752.85
27443	Revision of knee joint	5	$752.85
27496	Decompression of thigh/knee	5	$752.85
27497	Decompression of thigh/knee	3	$535.50
27498	Decompression of thigh/knee	3	$535.50
27499	Decompression of thigh/knee	3	$535.50
27500	Treatment of thigh fracture	1	$349.65
27501	Treatment of thigh fracture	2	$468.30
27502	Treatment of thigh fracture	2	$468.30
27503	Treatment of thigh fracture	3	$535.50
27508	Treatment of thigh fracture	1	$349.65
27509	Treatment of thigh fracture	3	$535.50
27510	Treatment of thigh fracture	1	$349.65
27516	Treat thigh fx growth plate	1	$349.65
27517	Treat thigh fx growth plate	1	$349.65
27520	Treat kneecap fracture	1	$349.65
27530	Treat knee fracture	1	$349.65

HCPCS Code	Short Description	Payment Group	Payment Amount
27532	Treat knee fracture	1	$349.65
27538	Treat knee fracture(s)	1	$349.65
27550	Treat knee dislocation	1	$349.65
27552	Treat knee dislocation	1	$349.65
27560	Treat kneecap dislocation	1	$349.65
27562	Treat kneecap dislocation	1	$349.65
27566	Treat kneecap dislocation	2	$468.30
27570	Fixation of knee joint	1	$349.65
27594	Amputation follow-up surgery	3	$535.50
27600	Decompression of lower leg	3	$535.50
27601	Decompression of lower leg	3	$535.50
27602	Decompression of lower leg	3	$535.50
27603	Drain lower leg lesion	2	$468.30
27604	Drain lower leg bursa	2	$468.30
27605	Incision of achilles tendon	1	$349.65
27606	Incision of achilles tendon	1	$349.65
27607	Treat lower leg bone lesion	2	$468.30
27610	Explore/treat ankle joint	2	$468.30
27612	Exploration of ankle joint	3	$535.50
27614	Biopsy lower leg soft tissue	2	$468.30
27615	Remove tumor, lower leg	3	$535.50
27618	Remove lower leg lesion	2	$468.30
27619	Remove lower leg lesion	3	$535.50
27620	Explore/treat ankle joint	4	$661.50
27625	Remove ankle joint lining	4	$661.50
27626	Remove ankle joint lining	4	$661.50
27630	Removal of tendon lesion	3	$535.50
27635	Remove lower leg bone lesion	3	$535.50
27637	Remove/graft leg bone lesion	3	$535.50
27638	Remove/graft leg bone lesion	3	$535.50
27640	Partial removal of tibia	2	$468.30
27641	Partial removal of fibula	2	$468.30
27647	Extensive ankle/heel surgery	3	$535.50
27650	Repair achilles tendon	3	$535.50
27652	Repair/graft achilles tendon	3	$535.50
27654	Repair of achilles tendon	3	$535.50
27656	Repair leg fascia defect	2	$468.30
27658	Repair of leg tendon, each	1	$349.65
27659	Repair of leg tendon, each	2	$468.30
27664	Repair of leg tendon, each	2	$468.30
27665	Repair of leg tendon, each	2	$468.30
27675	Repair lower leg tendons	2	$468.30
27676	Repair lower leg tendons	3	$535.50
27680	Release of lower leg tendon	3	$535.50
27681	Release of lower leg tendons	2	$468.30
27685	Revision of lower leg tendon	3	$535.50
27686	Revise lower leg tendons	3	$535.50
27687	Revision of calf tendon	3	$535.50
27690	Revise lower leg tendon	4	$661.50

HCPCS Code	Short Description	Payment Group	Payment Amount
27691	Revise lower leg tendon	4	$661.50
27692	Revise additional leg tendon	3	$535.50
27695	Repair of ankle ligament	2	$468.30
27696	Repair of ankle ligaments	2	$468.30
27698	Repair of ankle ligament	2	$468.30
27700	Revision of ankle joint	5	$752.85
27704	Removal of ankle implant	2	$468.30
27705	Incision of tibia	2	$468.30
27707	Incision of fibula	2	$468.30
27709	Incision of tibia & fibula	2	$468.30
27730	Repair of tibia epiphysis	2	$468.30
27732	Repair of fibula epiphysis	2	$468.30
27734	Repair lower leg epiphyses	2	$468.30
27740	Repair of leg epiphyses	2	$468.30
27742	Repair of leg epiphyses	2	$468.30
27745	Reinforce tibia	3	$535.50
27750	Treatment of tibia fracture	1	$349.65
27752	Treatment of tibia fracture	1	$349.65
27756	Treatment of tibia fracture	3	$535.50
27758	Treatment of tibia fracture	4	$661.50
27759	Treatment of tibia fracture	4	$661.50
27760	Treatment of ankle fracture	1	$349.65
27762	Treatment of ankle fracture	1	$349.65
27766	Treatment of ankle fracture	3	$535.50
27780	Treatment of fibula fracture	1	$349.65
27781	Treatment of fibula fracture	1	$349.65
27784	Treatment of fibula fracture	3	$535.50
27786	Treatment of ankle fracture	1	$349.65
27788	Treatment of ankle fracture	1	$349.65
27792	Treatment of ankle fracture	3	$535.50
27808	Treatment of ankle fracture	1	$349.65
27810	Treatment of ankle fracture	1	$349.65
27814	Treatment of ankle fracture	3	$535.50
27816	Treatment of ankle fracture	1	$349.65
27818	Treatment of ankle fracture	1	$349.65
27822	Treatment of ankle fracture	3	$535.50
27823	Treatment of ankle fracture	3	$535.50
27824	Treat lower leg fracture	1	$349.65
27825	Treat lower leg fracture	2	$468.30
27826	Treat lower leg fracture	3	$535.50
27827	Treat lower leg fracture	3	$535.50
27828	Treat lower leg fracture	4	$661.50
27829	Treat lower leg joint	2	$468.30
27830	Treat lower leg dislocation	1	$349.65
27831	Treat lower leg dislocation	1	$349.65
27832	Treat lower leg dislocation	2	$468.30
27840	Treat ankle dislocation	1	$349.65
27842	Treat ankle dislocation	1	$349.65
27846	Treat ankle dislocation	3	$535.50

HCPCS Code	Short Description	Payment Group	Payment Amount
27848	Treat ankle dislocation	3	$535.50
27860	Fixation of ankle joint	1	$349.65
27870	Fusion of ankle joint	4	$661.50
27871	Fusion of tibiofibular joint	4	$661.50
27884	Amputation follow-up surgery	3	$535.50
27889	Amputation of foot at ankle	3	$535.50
27892	Decompression of leg	3	$535.50
27893	Decompression of leg	3	$535.50
27894	Decompression of leg	3	$535.50
28002	Treatment of foot infection	3	$535.50
28003	Treatment of foot infection	3	$535.50
28005	Treat foot bone lesion	3	$535.50
28008	Incision of foot fascia	3	$535.50
28011	Incision of toe tendons	3	$535.50
28020	Exploration of foot joint	2	$468.30
28022	Exploration of foot joint	2	$468.30
28024	Exploration of toe joint	2	$468.30
28030	Removal of foot nerve	4	$661.50
28035	Decompression of tibia nerve	4	$661.50
28043	Excision of foot lesion	2	$468.30
28045	Excision of foot lesion	3	$535.50
28046	Resection of tumor, foot	3	$535.50
28050	Biopsy of foot joint lining	2	$468.30
28052	Biopsy of foot joint lining	2	$468.30
28054	Biopsy of toe joint lining	2	$468.30
28060	Partial removal, foot fascia	2	$468.30
28062	Removal of foot fascia	3	$535.50
28070	Removal of foot joint lining	3	$535.50
28072	Removal of foot joint lining	3	$535.50
28080	Removal of foot lesion	3	$535.50
28086	Excise foot tendon sheath	2	$468.30
28088	Excise foot tendon sheath	2	$468.30
28090	Removal of foot lesion	3	$535.50
28092	Removal of toe lesions	3	$535.50
28100	Removal of ankle/heel lesion	2	$468.30
28102	Remove/graft foot lesion	3	$535.50
28103	Remove/graft foot lesion	3	$535.50
28104	Removal of foot lesion	2	$468.30
28106	Remove/graft foot lesion	3	$535.50
28107	Remove/graft foot lesion	3	$535.50
28110	Part removal of metatarsal	3	$535.50
28111	Part removal of metatarsal	3	$535.50
28112	Part removal of metatarsal	3	$535.50
28113	Part removal of metatarsal	3	$535.50
28114	Removal of metatarsal heads	3	$535.50
28116	Revision of foot	3	$535.50
28118	Removal of heel bone	4	$661.50
28119	Removal of heel spur	4	$661.50
28120	Part removal of ankle/heel	7	$1,044.75

HCPCS Code	Short Description	Payment Group	Payment Amount
28122	Partial removal of foot bone	3	$535.50
28126	Partial removal of toe	3	$535.50
28130	Removal of ankle bone	3	$535.50
28140	Removal of metatarsal	3	$535.50
28150	Removal of toe	3	$535.50
28153	Partial removal of toe	3	$535.50
28160	Partial removal of toe	3	$535.50
28171	Extensive foot surgery	3	$535.50
28173	Extensive foot surgery	3	$535.50
28175	Extensive foot surgery	3	$535.50
28192	Removal of foot foreign body	2	$468.30
28193	Removal of foot foreign body	4	$661.50
28200	Repair of foot tendon	3	$535.50
28202	Repair/graft of foot tendon	3	$535.50
28208	Repair of foot tendon	3	$535.50
28210	Repair/graft of foot tendon	3	$535.50
28222	Release of foot tendons	1	$349.65
28225	Release of foot tendon	1	$349.65
28226	Release of foot tendons	1	$349.65
28234	Incision of foot tendon	2	$468.30
28238	Revision of foot tendon	3	$535.50
28240	Release of big toe	2	$468.30
28250	Revision of foot fascia	3	$535.50
28260	Release of midfoot joint	3	$535.50
28261	Revision of foot tendon	3	$535.50
28262	Revision of foot and ankle	4	$661.50
28264	Release of midfoot joint	1	$349.65
28270	Release of foot contracture	3	$535.50
28280	Fusion of toes	2	$468.30
28285	Repair of hammertoe	3	$535.50
28286	Repair of hammertoe	4	$661.50
28288	Partial removal of foot bone	3	$535.50
28289	Repair hallux rigidus	3	$535.50
28290	Correction of bunion	2	$468.30
28292	Correction of bunion	2	$468.30
28293	Correction of bunion	3	$535.50
28294	Correction of bunion	3	$535.50
28296	Correction of bunion	3	$535.50
28297	Correction of bunion	3	$535.50
28298	Correction of bunion	3	$535.50
28299	Correction of bunion	5	$752.85
28300	Incision of heel bone	2	$468.30
28302	Incision of ankle bone	2	$468.30
28304	Incision of midfoot bones	2	$468.30
28305	Incise/graft midfoot bones	3	$535.50
28306	Incision of metatarsal	4	$661.50
28307	Incision of metatarsal	4	$661.50
28308	Incision of metatarsal	2	$468.30
28309	Incision of metatarsals	4	$661.50

HCPCS Code	Short Description	Payment Group	Payment Amount
28310	Revision of big toe	3	$535.50
28312	Revision of toe	3	$535.50
28313	Repair deformity of toe	2	$468.30
28315	Removal of sesamoid bone	4	$661.50
28320	Repair of foot bones	4	$661.50
28322	Repair of metatarsals	4	$661.50
28340	Resect enlarged toe tissue	4	$661.50
28341	Resect enlarged toe	4	$661.50
28344	Repair extra toe(s)	4	$661.50
28345	Repair webbed toe(s)	4	$661.50
28400	Treatment of heel fracture	1	$349.65
28405	Treatment of heel fracture	2	$468.30
28406	Treatment of heel fracture	2	$468.30
28415	Treat heel fracture	3	$535.50
28420	Treat/graft heel fracture	4	$661.50
28435	Treatment of ankle fracture	2	$468.30
28436	Treatment of ankle fracture	2	$468.30
28445	Treat ankle fracture	3	$535.50
28456	Treat midfoot fracture	2	$468.30
28465	Treat midfoot fracture, each	3	$535.50
28476	Treat metatarsal fracture	2	$468.30
28485	Treat metatarsal fracture	4	$661.50
28496	Treat big toe fracture	2	$468.30
28505	Treat big toe fracture	3	$535.50
28525	Treat toe fracture	3	$535.50
28531	Treat sesamoid bone fracture	3	$535.50
28545	Treat foot dislocation	1	$349.65
28546	Treat foot dislocation	2	$468.30
28555	Repair foot dislocation	2	$468.30
28575	Treat foot dislocation	1	$349.65
28576	Treat foot dislocation	3	$535.50
28585	Repair foot dislocation	3	$535.50
28605	Treat foot dislocation	1	$349.65
28606	Treat foot dislocation	2	$468.30
28615	Repair foot dislocation	3	$535.50
28635	Treat toe dislocation	1	$349.65
28636	Treat toe dislocation	3	$535.50
28645	Repair toe dislocation	3	$535.50
28665	Treat toe dislocation	1	$349.65
28666	Treat toe dislocation	3	$535.50
28675	Repair of toe dislocation	3	$535.50
28705	Fusion of foot bones	4	$661.50
28715	Fusion of foot bones	4	$661.50
28725	Fusion of foot bones	4	$661.50
28730	Fusion of foot bones	4	$661.50
28735	Fusion of foot bones	4	$661.50
28737	Revision of foot bones	5	$752.85
28740	Fusion of foot bones	4	$661.50
28750	Fusion of big toe joint	4	$661.50

HCPCS Code	Short Description	Payment Group	Payment Amount
28755	Fusion of big toe joint	4	$661.50
28760	Fusion of big toe joint	4	$661.50
28810	Amputation toe & metatarsal	2	$468.30
28820	Amputation of toe	2	$468.30
28825	Partial amputation of toe	2	$468.30
29800	Jaw arthroscopy/surgery	3	$535.50
29804	Jaw arthroscopy/surgery	3	$535.50
29805	Shoulder arthroscopy, dx	3	$535.50
29806	Shoulder arthroscopy/surgery	3	$535.50
29807	Shoulder arthroscopy/surgery	3	$535.50
29819	Shoulder arthroscopy/surgery	3	$535.50
29820	Shoulder arthroscopy/surgery	3	$535.50
29821	Shoulder arthroscopy/surgery	3	$535.50
29822	Shoulder arthroscopy/surgery	3	$535.50
29823	Shoulder arthroscopy/surgery	3	$535.50
29824	Shoulder arthroscopy/surgery	5	$752.85
29825	Shoulder arthroscopy/surgery	3	$535.50
29826	Shoulder arthroscopy/surgery	3	$535.50
29827	Arthroscop rotator cuff repr	5	$752.85
29830	Elbow arthroscopy	3	$535.50
29834	Elbow arthroscopy/surgery	3	$535.50
29835	Elbow arthroscopy/surgery	3	$535.50
29836	Elbow arthroscopy/surgery	3	$535.50
29837	Elbow arthroscopy/surgery	3	$535.50
29838	Elbow arthroscopy/surgery	3	$535.50
29840	Wrist arthroscopy	3	$535.50
29843	Wrist arthroscopy/surgery	3	$535.50
29844	Wrist arthroscopy/surgery	3	$535.50
29845	Wrist arthroscopy/surgery	3	$535.50
29846	Wrist arthroscopy/surgery	3	$535.50
29847	Wrist arthroscopy/surgery	3	$535.50
29848	Wrist endoscopy/surgery	9	$1,405.95
29850	Knee arthroscopy/surgery	4	$661.50
29851	Knee arthroscopy/surgery	4	$661.50
29855	Tibial arthroscopy/surgery	4	$661.50
29856	Tibial arthroscopy/surgery	4	$661.50
29860	Hip arthroscopy, dx	4	$661.50
29861	Hip arthroscopy/surgery	4	$661.50
29862	Hip arthroscopy/surgery	9	$1,405.95
29863	Hip arthroscopy/surgery	4	$661.50
29870	Knee arthroscopy, dx	3	$535.50
29871	Knee arthroscopy/drainage	3	$535.50
29874	Knee arthroscopy/surgery	3	$535.50
29875	Knee arthroscopy/surgery	4	$661.50
29876	Knee arthroscopy/surgery	4	$661.50
29877	Knee arthroscopy/surgery	4	$661.50
29879	Knee arthroscopy/surgery	3	$535.50
29880	Knee arthroscopy/surgery	4	$661.50
29881	Knee arthroscopy/surgery	4	$661.50

HCPCS Code	Short Description	Payment Group	Payment Amount
29882	Knee arthroscopy/surgery	3	$535.50
29883	Knee arthroscopy/surgery	3	$535.50
29884	Knee arthroscopy/surgery	3	$535.50
29885	Knee arthroscopy/surgery	3	$535.50
29886	Knee arthroscopy/surgery	3	$535.50
29887	Knee arthroscopy/surgery	3	$535.50
29888	Knee arthroscopy/surgery	3	$535.50
29889	Knee arthroscopy/surgery	3	$535.50
29891	Ankle arthroscopy/surgery	3	$535.50
29892	Ankle arthroscopy/surgery	3	$535.50
29893	Scope, plantar fasciotomy	9	$1,405.95
29894	Ankle arthroscopy/surgery	3	$535.50
29895	Ankle arthroscopy/surgery	3	$535.50
29897	Ankle arthroscopy/surgery	3	$535.50
29898	Ankle arthroscopy/surgery	3	$535.50
29899	Ankle arthroscopy/surgery	3	$535.50
29900	Mcp joint arthroscopy, dx	3	$535.50
29901	Mcp joint arthroscopy, surg	3	$535.50
29902	Mcp joint arthroscopy, surg	3	$535.50
30115	Removal of nose polyp(s)	2	$468.30
30117	Removal of intranasal lesion	3	$535.50
30118	Removal of intranasal lesion	3	$535.50
30120	Revision of nose	1	$349.65
30125	Removal of nose lesion	2	$468.30
30130	Removal of turbinate bones	3	$535.50
30140	Removal of turbinate bones	2	$468.30
30150	Partial removal of nose	3	$535.50
30160	Removal of nose	4	$661.50
30310	Remove nasal foreign body	1	$349.65
30320	Remove nasal foreign body	2	$468.30
30400	Reconstruction of nose	4	$661.50
30410	Reconstruction of nose	5	$752.85
30420	Reconstruction of nose	5	$752.85
30430	Revision of nose	3	$535.50
30435	Revision of nose	5	$752.85
30450	Revision of nose	7	$1,044.75
30460	Revision of nose	7	$1,044.75
30462	Revision of nose	9	$1,405.95
30465	Repair nasal stenosis	9	$1,405.95
30520	Repair of nasal septum	4	$661.50
30540	Repair nasal defect	5	$752.85
30545	Repair nasal defect	5	$752.85
30560	Release of nasal adhesions	2	$468.30
30580	Repair upper jaw fistula	4	$661.50
30600	Repair mouth/nose fistula	4	$661.50
30620	Intranasal reconstruction	7	$1,044.75
30630	Repair nasal septum defect	7	$1,044.75
30801	Cauterization, inner nose	1	$349.65
30802	Cauterization, inner nose	1	$349.65

HCPCS Code	Short Description	Payment Group	Payment Amount
30903	Control of nosebleed	1	$349.65
30905	Control of nosebleed	1	$349.65
30906	Repeat control of nosebleed	1	$349.65
30915	Ligation, nasal sinus artery	2	$468.30
30920	Ligation, upper jaw artery	3	$535.50
30930	Therapy, fracture of nose	4	$661.50
31020	Exploration, maxillary sinus	2	$468.30
31030	Exploration, maxillary sinus	3	$535.50
31032	Explore sinus,remove polyps	4	$661.50
31050	Exploration, sphenoid sinus	2	$468.30
31051	Sphenoid sinus surgery	4	$661.50
31070	Exploration of frontal sinus	2	$468.30
31075	Exploration of frontal sinus	4	$661.50
31080	Removal of frontal sinus	4	$661.50
31081	Removal of frontal sinus	4	$661.50
31084	Removal of frontal sinus	4	$661.50
31085	Removal of frontal sinus	4	$661.50
31086	Removal of frontal sinus	4	$661.50
31087	Removal of frontal sinus	4	$661.50
31090	Exploration of sinuses	5	$752.85
31200	Removal of ethmoid sinus	2	$468.30
31201	Removal of ethmoid sinus	5	$752.85
31205	Removal of ethmoid sinus	3	$535.50
31233	Nasal/sinus endoscopy, dx	2	$468.30
31235	Nasal/sinus endoscopy, dx	1	$349.65
31237	Nasal/sinus endoscopy, surg	2	$468.30
31238	Nasal/sinus endoscopy, surg	1	$349.65
31239	Nasal/sinus endoscopy, surg	4	$661.50
31240	Nasal/sinus endoscopy, surg	2	$468.30
31254	Revision of ethmoid sinus	3	$535.50
31255	Removal of ethmoid sinus	5	$752.85
31256	Exploration maxillary sinus	3	$535.50
31267	Endoscopy, maxillary sinus	3	$535.50
31276	Sinus endoscopy, surgical	3	$535.50
31287	Nasal/sinus endoscopy, surg	3	$535.50
31288	Nasal/sinus endoscopy, surg	3	$535.50
31300	Removal of larynx lesion	5	$752.85
31320	Diagnostic incision, larynx	2	$468.30
31400	Revision of larynx	2	$468.30
31420	Removal of epiglottis	2	$468.30
31510	Laryngoscopy with biopsy	2	$468.30
31511	Remove foreign body, larynx	2	$468.30
31512	Removal of larynx lesion	2	$468.30
31513	Injection into vocal cord	2	$468.30
31515	Laryngoscopy for aspiration	1	$349.65
31525	Diagnostic laryngoscopy	1	$349.65
31526	Diagnostic laryngoscopy	2	$468.30
31527	Laryngoscopy for treatment	1	$349.65
31528	Laryngoscopy and dilation	2	$468.30

HCPCS Code	Short Description	Payment Group	Payment Amount
31529	Laryngoscopy and dilation	2	$468.30
31530	Operative laryngoscopy	2	$468.30
31531	Operative laryngoscopy	3	$535.50
31535	Operative laryngoscopy	2	$468.30
31536	Operative laryngoscopy	3	$535.50
31540	Operative laryngoscopy	3	$535.50
31541	Operative laryngoscopy	4	$661.50
31560	Operative laryngoscopy	5	$752.85
31561	Operative laryngoscopy	5	$752.85
31570	Laryngoscopy with injection	2	$468.30
31571	Laryngoscopy with injection	2	$468.30
31576	Laryngoscopy with biopsy	2	$468.30
31577	Remove foreign body, larynx	2	$468.30
31578	Removal of larynx lesion	2	$468.30
31580	Revision of larynx	5	$752.85
31582	Revision of larynx	5	$752.85
31585	Treat larynx fracture	1	$349.65
31586	Treat larynx fracture	2	$468.30
31588	Revision of larynx	5	$752.85
31590	Reinnervate larynx	5	$752.85
31595	Larynx nerve surgery	2	$468.30
31611	Surgery/speech prosthesis	3	$535.50
31612	Puncture/clear windpipe	1	$349.65
31613	Repair windpipe opening	2	$468.30
31614	Repair windpipe opening	2	$468.30
31615	Visualization of windpipe	1	$349.65
31622	Dx bronchoscope/wash	1	$349.65
31623	Dx bronchoscope/brush	2	$468.30
31624	Dx bronchoscope/lavage	2	$468.30
31625	Bronchoscopy with biopsy	2	$468.30
31628	Bronchoscopy with biopsy	2	$468.30
31629	Bronchoscopy with biopsy	2	$468.30
31630	Bronchoscopy with repair	2	$468.30
31631	Bronchoscopy with dilation	2	$468.30
31635	Remove foreign body, airway	2	$468.30
31640	Bronchoscopy & remove lesion	2	$468.30
31641	Bronchoscopy, treat blockage	2	$468.30
31643	Diag bronchoscope/catheter	2	$468.30
31645	Bronchoscopy, clear airways	1	$349.65
31646	Bronchoscopy, reclear airway	1	$349.65
31656	Bronchoscopy, inj for xray	1	$349.65
31700	Insertion of airway catheter	1	$349.65
31717	Bronchial brush biopsy	1	$349.65
31720	Clearance of airways	1	$349.65
31730	Intro, windpipe wire/tube	1	$349.65
31750	Repair of windpipe	5	$752.85
31755	Repair of windpipe	2	$468.30
31820	Closure of windpipe lesion	1	$349.65
31825	Repair of windpipe defect	2	$468.30

HCPCS Code	Short Description	Payment Group	Payment Amount
31830	Revise windpipe scar	2	$468.30
32000	Drainage of chest	1	$349.65
32400	Needle biopsy chest lining	1	$349.65
32405	Biopsy, lung or mediastinum	1	$349.65
32420	Puncture/clear lung	1	$349.65
33010	Drainage of heart sac	2	$468.30
33011	Repeat drainage of heart sac	2	$468.30
33222	Revise pocket, pacemaker	2	$468.30
33223	Revise pocket, pacing-defib	2	$468.30
35188	Repair blood vessel lesion	4	$661.50
35207	Repair blood vessel lesion	4	$661.50
35875	Removal of clot in graft	9	$1,405.95
35876	Removal of clot in graft	9	$1,405.95
36260	Insertion of infusion pump	3	$535.50
36261	Revision of infusion pump	2	$468.30
36262	Removal of infusion pump	1	$349.65
36555	Insert non-tunnel cv cath	1	$349.65
36556	Insert non-tunnel cv cath	1	$349.65
36557	Insert tunneled cv cath	2	$468.30
36558	Insert tunneled cv cath	2	$468.30
36560	Insert tunneled cv cath	3	$535.50
36561	Insert tunneled cv cath	3	$535.50
36563	Insert tunneled cv cath	3	$535.50
36565	Insert tunneled cv cath	3	$535.50
36566	Insert tunneled cv cath	3	$535.50
36568	Insert peripherally cv cath	1	$349.65
36569	Insert peripherally cv cath	1	$349.65
36570	Insert peripherally cv cath	3	$535.50
36571	Insert peripherally cv cath	3	$535.50
36575	Repair tunneled/non-tunneled	2	$468.30
36576	Repair cv access	2	$468.30
36578	Replace cv access	2	$468.30
36580	Replace complete non-tunnel	1	$349.65
36581	Replace complete tunneled	2	$468.30
36582	Replace complete tunneled	3	$535.50
36583	Replace complete tunneled	3	$535.50
36584	Replace complete peripherally	1	$349.65
36585	Replace complete peripherally	3	$535.50
36589	Remove tunneled cv cath	1	$349.65
36590	Remove tunneled cv access	1	$349.65
36640	Insertion catheter, artery	1	$349.65
36800	Insertion of cannula	3	$535.50
36810	Insertion of cannula	3	$535.50
36815	Insertion of cannula	3	$535.50
36819	Av fusion/uppr arm vein	3	$535.50
36820	Av fusion/forearm vein	3	$535.50
36821	Av fusion direct any site	3	$535.50
36825	Artery-vein graft	4	$661.50
36830	Artery-vein graft	4	$661.50

HCPCS Code	Short Description	Payment Group	Payment Amount
36831	Open thrombect av fistula	9	$1,405.95
36832	Av fistula revision, open	4	$661.50
36833	Av fistula revision	4	$661.50
36835	Artery to vein shunt	4	$661.50
36860	External cannula declotting	2	$468.30
36861	Cannula declotting	3	$535.50
36870	Percut thrombect av fistula	9	$1,405.95
37607	Ligation of a-v fistula	3	$535.50
37609	Temporal artery procedure	2	$468.30
37650	Revision of major vein	2	$468.30
37700	Revise leg vein	2	$468.30
37720	Removal of leg vein	3	$535.50
37730	Removal of leg veins	3	$535.50
37735	Removal of leg veins/lesion	3	$535.50
37760	Revision of leg veins	3	$535.50
37780	Revision of leg vein	3	$535.50
37785	Revise secondary varicosity	3	$535.50
37790	Penile venous occlusion	3	$535.50
38300	Drainage, lymph node lesion	1	$349.65
38305	Drainage, lymph node lesion	2	$468.30
38308	Incision of lymph channels	2	$468.30
38500	Biopsy/removal, lymph nodes	2	$468.30
38505	Needle biopsy, lymph nodes	1	$349.65
38510	Biopsy/removal, lymph nodes	2	$468.30
38520	Biopsy/removal, lymph nodes	2	$468.30
38525	Biopsy/removal, lymph nodes	2	$468.30
38530	Biopsy/removal, lymph nodes	2	$468.30
38542	Explore deep node(s), neck	2	$468.30
38550	Removal, neck/armpit lesion	3	$535.50
38555	Removal, neck/armpit lesion	4	$661.50
38570	Laparoscopy, lymph node biop	9	$1,405.95
38571	Laparoscopy, lymphadenectomy	9	$1,405.95
38572	Laparoscopy, lymphadenectomy	9	$1,405.95
38740	Remove armpit lymph nodes	2	$468.30
38745	Remove armpit lymph nodes	4	$661.50
38760	Remove groin lymph nodes	2	$468.30
40500	Partial excision of lip	2	$468.30
40510	Partial excision of lip	2	$468.30
40520	Partial excision of lip	2	$468.30
40525	Reconstruct lip with flap	2	$468.30
40527	Reconstruct lip with flap	2	$468.30
40530	Partial removal of lip	2	$468.30
40650	Repair lip	3	$535.50
40652	Repair lip	3	$535.50
40654	Repair lip	3	$535.50
40700	Repair cleft lip/nasal	7	$1,044.75
40701	Repair cleft lip/nasal	7	$1,044.75
40720	Repair cleft lip/nasal	7	$1,044.75
40761	Repair cleft lip/nasal	3	$535.50

HCPCS Code	Short Description	Payment Group	Payment Amount
40801	Drainage of mouth lesion	2	$468.30
40814	Excise/repair mouth lesion	2	$468.30
40816	Excision of mouth lesion	2	$468.30
40818	Excise oral mucosa for graft	1	$349.65
40819	Excise lip or cheek fold	1	$349.65
40831	Repair mouth laceration	1	$349.65
40840	Reconstruction of mouth	2	$468.30
40842	Reconstruction of mouth	3	$535.50
40843	Reconstruction of mouth	3	$535.50
40844	Reconstruction of mouth	5	$752.85
40845	Reconstruction of mouth	5	$752.85
41005	Drainage of mouth lesion	1	$349.65
41006	Drainage of mouth lesion	1	$349.65
41007	Drainage of mouth lesion	1	$349.65
41008	Drainage of mouth lesion	1	$349.65
41009	Drainage of mouth lesion	1	$349.65
41010	Incision of tongue fold	1	$349.65
41015	Drainage of mouth lesion	1	$349.65
41016	Drainage of mouth lesion	1	$349.65
41017	Drainage of mouth lesion	1	$349.65
41018	Drainage of mouth lesion	1	$349.65
41112	Excision of tongue lesion	2	$468.30
41113	Excision of tongue lesion	2	$468.30
41114	Excision of tongue lesion	2	$468.30
41116	Excision of mouth lesion	1	$349.65
41120	Partial removal of tongue	5	$752.85
41250	Repair tongue laceration	2	$468.30
41251	Repair tongue laceration	2	$468.30
41252	Repair tongue laceration	2	$468.30
41500	Fixation of tongue	1	$349.65
41510	Tongue to lip surgery	1	$349.65
41520	Reconstruction, tongue fold	2	$468.30
41800	Drainage of gum lesion	1	$349.65
41827	Excision of gum lesion	2	$468.30
41899	Gum surgery procedure	1	$349.65
42000	Drainage mouth roof lesion	2	$468.30
42107	Excision lesion, mouth roof	2	$468.30
42120	Remove palate/lesion	4	$661.50
42140	Excision of uvula	2	$468.30
42145	Repair palate, pharynx/uvula	5	$752.85
42180	Repair palate	1	$349.65
42182	Repair palate	2	$468.30
42200	Reconstruct cleft palate	5	$752.85
42205	Reconstruct cleft palate	5	$752.85
42210	Reconstruct cleft palate	5	$752.85
42215	Reconstruct cleft palate	7	$1,044.75
42220	Reconstruct cleft palate	5	$752.85
42226	Lengthening of palate	5	$752.85
42235	Repair palate	5	$752.85

HCPCS Code	Short Description	Payment Group	Payment Amount
42260	Repair nose to lip fistula	4	$661.50
42300	Drainage of salivary gland	1	$349.65
42305	Drainage of salivary gland	2	$468.30
42310	Drainage of salivary gland	1	$349.65
42320	Drainage of salivary gland	1	$349.65
42325	Create salivary cyst drain	2	$468.30
42340	Removal of salivary stone	2	$468.30
42405	Biopsy of salivary gland	2	$468.30
42408	Excision of salivary cyst	3	$535.50
42409	Drainage of salivary cyst	3	$535.50
42410	Excise parotid gland/lesion	3	$535.50
42415	Excise parotid gland/lesion	7	$1,044.75
42420	Excise parotid gland/lesion	7	$1,044.75
42425	Excise parotid gland/lesion	7	$1,044.75
42440	Excise submaxillary gland	3	$535.50
42450	Excise sublingual gland	2	$468.30
42500	Repair salivary duct	3	$535.50
42505	Repair salivary duct	4	$661.50
42507	Parotid duct diversion	3	$535.50
42508	Parotid duct diversion	4	$661.50
42509	Parotid duct diversion	4	$661.50
42510	Parotid duct diversion	4	$661.50
42600	Closure of salivary fistula	1	$349.65
42700	Drainage of tonsil abscess	1	$349.65
42720	Drainage of throat abscess	1	$349.65
42725	Drainage of throat abscess	2	$468.30
42802	Biopsy of throat	1	$349.65
42804	Biopsy of upper nose/throat	1	$349.65
42806	Biopsy of upper nose/throat	2	$468.30
42808	Excise pharynx lesion	2	$468.30
42810	Excision of neck cyst	3	$535.50
42815	Excision of neck cyst	5	$752.85
42820	Remove tonsils and adenoids	3	$535.50
42821	Remove tonsils and adenoids	5	$752.85
42825	Removal of tonsils	4	$661.50
42826	Removal of tonsils	4	$661.50
42830	Removal of adenoids	4	$661.50
42831	Removal of adenoids	4	$661.50
42835	Removal of adenoids	4	$661.50
42836	Removal of adenoids	4	$661.50
42860	Excision of tonsil tags	3	$535.50
42870	Excision of lingual tonsil	3	$535.50
42890	Partial removal of pharynx	7	$1,044.75
42892	Revision of pharyngeal walls	7	$1,044.75
42900	Repair throat wound	1	$349.65
42950	Reconstruction of throat	2	$468.30
42955	Surgical opening of throat	2	$468.30
42960	Control throat bleeding	1	$349.65
42962	Control throat bleeding	2	$468.30

HCPCS Code	Short Description	Payment Group	Payment Amount
42972	Control nose/throat bleeding	3	$535.50
43200	Esophagus endoscopy	1	$349.65
43201	Esoph scope w/submucous inj	1	$349.65
43202	Esophagus endoscopy, biopsy	1	$349.65
43204	Esophagus endoscopy & inject	1	$349.65
43205	Esophagus endoscopy/ligation	1	$349.65
43215	Esophagus endoscopy	1	$349.65
43216	Esophagus endoscopy/lesion	1	$349.65
43217	Esophagus endoscopy	1	$349.65
43219	Esophagus endoscopy	1	$349.65
43220	Esoph endoscopy, dilation	1	$349.65
43226	Esoph endoscopy, dilation	1	$349.65
43227	Esoph endoscopy, repair	2	$468.30
43228	Esoph endoscopy, ablation	2	$468.30
43231	Esoph endoscopy w/us exam	2	$468.30
43232	Esoph endoscopy w/us fn bx	2	$468.30
43234	Upper GI endoscopy, exam	1	$349.65
43235	Uppr gi endoscopy, diagnosis	1	$349.65
43236	Uppr gi scope w/submuc inj	2	$468.30
43239	Upper GI endoscopy, biopsy	2	$468.30
43240	Esoph endoscope w/drain cyst	2	$468.30
43241	Upper GI endoscopy with tube	2	$468.30
43242	Uppr gi endoscopy w/us fn bx	2	$468.30
43243	Upper gi endoscopy & inject	2	$468.30
43244	Upper GI endoscopy/ligation	2	$468.30
43245	Operative upper GI endoscopy	2	$468.30
43246	Place gastrostomy tube	2	$468.30
43247	Operative upper GI endoscopy	2	$468.30
43248	Uppr gi endoscopy/guide wire	2	$468.30
43249	Esoph endoscopy, dilation	2	$468.30
43250	Upper GI endoscopy/tumor	2	$468.30
43251	Operative upper GI endoscopy	2	$468.30
43255	Operative upper GI endoscopy	2	$468.30
43256	Uppr gi endoscopy w stent	3	$535.50
43258	Operative upper GI endoscopy	3	$535.50
43259	Endoscopic ultrasound exam	3	$535.50
43260	Endo cholangiopancreatograph	2	$468.30
43261	Endo cholangiopancreatograph	2	$468.30
43262	Endo cholangiopancreatograph	2	$468.30
43263	Endo cholangiopancreatograph	2	$468.30
43264	Endo cholangiopancreatograph	2	$468.30
43265	Endo cholangiopancreatograph	2	$468.30
43267	Endo cholangiopancreatograph	2	$468.30
43268	Endo cholangiopancreatograph	2	$468.30
43269	Endo cholangiopancreatograph	2	$468.30
43271	Endo cholangiopancreatograph	2	$468.30
43272	Endo cholangiopancreatograph	2	$468.30
43450	Dilate esophagus	1	$349.65
43453	Dilate esophagus	1	$349.65

HCPCS Code	Short Description	Payment Group	Payment Amount
43456	Dilate esophagus	2	$468.30
43458	Dilate esophagus	2	$468.30
43600	Biopsy of stomach	1	$349.65
43653	Laparoscopy, gastrostomy	9	$1,405.95
43750	Place gastrostomy tube	2	$468.30
43760	Change gastrostomy tube	1	$349.65
43870	Repair stomach opening	1	$349.65
44100	Biopsy of bowel	1	$349.65
44312	Revision of ileostomy	1	$349.65
44340	Revision of colostomy	3	$535.50
44360	Small bowel endoscopy	2	$468.30
44361	Small bowel endoscopy/biopsy	2	$468.30
44363	Small bowel endoscopy	2	$468.30
44364	Small bowel endoscopy	2	$468.30
44365	Small bowel endoscopy	2	$468.30
44366	Small bowel endoscopy	2	$468.30
44369	Small bowel endoscopy	2	$468.30
44370	Small bowel endoscopy/stent	9	$1,405.95
44372	Small bowel endoscopy	2	$468.30
44373	Small bowel endoscopy	2	$468.30
44376	Small bowel endoscopy	2	$468.30
44377	Small bowel endoscopy/biopsy	2	$468.30
44378	Small bowel endoscopy	2	$468.30
44379	S bowel endoscope w/stent	9	$1,405.95
44380	Small bowel endoscopy	1	$349.65
44382	Small bowel endoscopy	1	$349.65
44383	Ileoscopy w/stent	9	$1,405.95
44385	Endoscopy of bowel pouch	1	$349.65
44386	Endoscopy, bowel pouch/biop	1	$349.65
44388	Colon endoscopy	1	$349.65
44389	Colonoscopy with biopsy	1	$349.65
44390	Colonoscopy for foreign body	1	$349.65
44391	Colonoscopy for bleeding	1	$349.65
44392	Colonoscopy & polypectomy	1	$349.65
44393	Colonoscopy, lesion removal	1	$349.65
44394	Colonoscopy w/snare	1	$349.65
45000	Drainage of pelvic abscess	1	$349.65
45005	Drainage of rectal abscess	2	$468.30
45020	Drainage of rectal abscess	2	$468.30
45100	Biopsy of rectum	1	$349.65
45108	Removal of anorectal lesion	2	$468.30
45150	Excision of rectal stricture	2	$468.30
45160	Excision of rectal lesion	2	$468.30
45170	Excision of rectal lesion	2	$468.30
45190	Destruction, rectal tumor	9	$1,405.95
45305	Protosigmoidoscopy w/bx	1	$349.65
45307	Protosigmoidoscopy fb	1	$349.65
45308	Protosigmoidoscopy removal	1	$349.65
45309	Protosigmoidoscopy removal	1	$349.65

HCPCS Code	Short Description	Payment Group	Payment Amount
45315	Protosigmoidoscopy removal	1	$349.65
45317	Protosigmoidoscopy bleed	1	$349.65
45320	Protosigmoidoscopy ablate	1	$349.65
45321	Protosigmoidoscopy volvul	1	$349.65
45331	Sigmoidoscopy and biopsy	1	$349.65
45332	Sigmoidoscopy w/fb removal	1	$349.65
45333	Sigmoidoscopy & polypectomy	1	$349.65
45334	Sigmoidoscopy for bleeding	1	$349.65
45335	Sigmoidoscope w/submub inj	1	$349.65
45337	Sigmoidoscopy & decompress	1	$349.65
45338	Sigmoidoscpy w/tumr remove	1	$349.65
45339	Sigmoidoscopy w/ablate tumr	1	$349.65
45340	Sig w/balloon dilation	1	$349.65
45355	Surgical colonoscopy	1	$349.65
45378	Diagnostic colonoscopy	2	$468.30
45379	Colonoscopy w/fb removal	2	$468.30
45380	Colonoscopy and biopsy	2	$468.30
45381	Colonoscope, submucous inj	2	$468.30
45382	Colonoscopy/control bleeding	2	$468.30
45383	Lesion removal colonoscopy	2	$468.30
45384	Lesion remove colonoscopy	2	$468.30
45385	Lesion removal colonoscopy	2	$468.30
45386	Colonoscope dilate stricture	2	$468.30
45500	Repair of rectum	2	$468.30
45505	Repair of rectum	2	$468.30
45560	Repair of rectocele	2	$468.30
45900	Reduction of rectal prolapse	1	$349.65
45905	Dilation of anal sphincter	1	$349.65
45910	Dilation of rectal narrowing	1	$349.65
45915	Remove rectal obstruction	1	$349.65
46020	Placement of seton	3	$535.50
46030	Removal of rectal marker	1	$349.65
46040	Incision of rectal abscess	3	$535.50
46045	Incision of rectal abscess	2	$468.30
46050	Incision of anal abscess	1	$349.65
46060	Incision of rectal abscess	2	$468.30
46080	Incision of anal sphincter	3	$535.50
46200	Removal of anal fissure	2	$468.30
46210	Removal of anal crypt	2	$468.30
46211	Removal of anal crypts	2	$468.30
46220	Removal of anal tab	1	$349.65
46250	Hemorrhoidectomy	3	$535.50
46255	Hemorrhoidectomy	3	$535.50
46257	Remove hemorrhoids & fissure	3	$535.50
46258	Remove hemorrhoids & fistula	3	$535.50
46260	Hemorrhoidectomy	3	$535.50
46261	Remove hemorrhoids & fissure	4	$661.50
46262	Remove hemorrhoids & fistula	4	$661.50
46270	Removal of anal fistula	3	$535.50

HCPCS Code	Short Description	Payment Group	Payment Amount
46275	Removal of anal fistula	3	$535.50
46280	Removal of anal fistula	4	$661.50
46285	Removal of anal fistula	1	$349.65
46288	Repair anal fistula	4	$661.50
46608	Anoscopy/ remove for body	1	$349.65
46610	Anoscopy/remove lesion	1	$349.65
46611	Anoscopy	1	$349.65
46612	Anoscopy/ remove lesions	1	$349.65
46615	Anoscopy	2	$468.30
46700	Repair of anal stricture	3	$535.50
46750	Repair of anal sphincter	3	$535.50
46753	Reconstruction of anus	3	$535.50
46754	Removal of suture from anus	2	$468.30
46760	Repair of anal sphincter	2	$468.30
46761	Repair of anal sphincter	3	$535.50
46762	Implant artificial sphincter	7	$1,044.75
46917	Laser surgery, anal lesions	1	$349.65
46922	Excision of anal lesion(s)	1	$349.65
46924	Destruction, anal lesion(s)	1	$349.65
46937	Cryotherapy of rectal lesion	2	$468.30
46938	Cryotherapy of rectal lesion	2	$468.30
47000	Needle biopsy of liver	1	$349.65
47510	Insert catheter, bile duct	2	$468.30
47511	Insert bile duct drain	9	$1,405.95
47525	Change bile duct catheter	1	$349.65
47530	Revise/reinsert bile tube	1	$349.65
47552	Biliary endoscopy thru skin	2	$468.30
47553	Biliary endoscopy thru skin	3	$535.50
47554	Biliary endoscopy thru skin	3	$535.50
47555	Biliary endoscopy thru skin	3	$535.50
47556	Biliary endoscopy thru skin	9	$1,405.95
47560	Laparoscopy w/cholangio	3	$535.50
47561	Laparo w/cholangio/biopsy	3	$535.50
47630	Remove bile duct stone	3	$535.50
48102	Needle biopsy, pancreas	1	$349.65
49080	Puncture, peritoneal cavity	2	$468.30
49081	Removal of abdominal fluid	2	$468.30
49085	Remove abdomen foreign body	2	$468.30
49180	Biopsy, abdominal mass	1	$349.65
49250	Excision of umbilicus	4	$661.50
49320	Diag laparo separate proc	3	$535.50
49321	Laparoscopy, biopsy	4	$661.50
49322	Laparoscopy, aspiration	4	$661.50
49420	Insert abdominal drain	1	$349.65
49421	Insert abdominal drain	1	$349.65
49422	Remove perm cannula/catheter	1	$349.65
49426	Revise abdomen-venous shunt	2	$468.30
49495	Rpr ing hernia baby, reduc	4	$661.50
49496	Rpr ing hernia baby, blocked	4	$661.50

HCPCS Code	Short Description	Payment Group	Payment Amount
49500	Rpr ing hernia, init, reduce	4	$661.50
49501	Rpr ing hernia, init blocked	9	$1,405.95
49505	Rpr i/hern init reduc>5 yr	4	$661.50
49507	Rpr i/hern init block>5 yr	9	$1,405.95
49520	Rerepair ing hernia, reduce	7	$1,044.75
49521	Rerepair ing hernia, blocked	9	$1,405.95
49525	Repair ing hernia, sliding	4	$661.50
49540	Repair lumbar hernia	2	$468.30
49550	Rpr fem hernia, init, reduce	5	$752.85
49553	Rpr fem hernia, init blocked	9	$1,405.95
49555	Rerepair fem hernia, reduce	5	$752.85
49557	Rerepair fem hernia, blocked	9	$1,405.95
49560	Rpr ventral hern init, reduc	4	$661.50
49561	Rpr ventral hern init, block	9	$1,405.95
49565	Rerepair ventrl hern, reduce	4	$661.50
49566	Rerepair ventrl hern, block	9	$1,405.95
49568	Hernia repair w/mesh	7	$1,044.75
49570	Rpr epigastric hern, reduce	4	$661.50
49572	Rpr epigastric hern, blocked	9	$1,405.95
49580	Rpr umbil hern, reduc <5 yr	4	$661.50
49582	Rpr umbil hern, block < 5 yr	9	$1,405.95
49585	Rpr umbil hern, reduc > 5 yr	4	$661.50
49587	Rpr umbil hern, block > 5 yr	9	$1,405.95
49590	Repair spigelian hernia	3	$535.50
49600	Repair umbilical lesion	4	$661.50
49650	Laparo hernia repair initial	4	$661.50
49651	Laparo hernia repair recur	7	$1,044.75
50200	Biopsy of kidney	1	$349.65
50390	Drainage of kidney lesion	1	$349.65
50392	Insert kidney drain	1	$349.65
50393	Insert ureteral tube	1	$349.65
50395	Create passage to kidney	1	$349.65
50396	Measure kidney pressure	1	$349.65
50398	Change kidney tube	1	$349.65
50551	Kidney endoscopy	1	$349.65
50553	Kidney endoscopy	1	$349.65
50555	Kidney endoscopy & biopsy	1	$349.65
50557	Kidney endoscopy & treatment	1	$349.65
50561	Kidney endoscopy & treatment	1	$349.65
50688	Change of ureter tube	1	$349.65
50947	Laparo new ureter/bladder	9	$1,405.95
50948	Laparo new ureter/bladder	9	$1,405.95
50951	Endoscopy of ureter	1	$349.65
50953	Endoscopy of ureter	1	$349.65
50955	Ureter endoscopy & biopsy	1	$349.65
50957	Ureter endoscopy & treatment	1	$349.65
50961	Ureter endoscopy & treatment	1	$349.65
50970	Ureter endoscopy	1	$349.65
50972	Ureter endoscopy & catheter	1	$349.65

HCPCS Code	Short Description	Payment Group	Payment Amount
50974	Ureter endoscopy & biopsy	1	$349.65
50976	Ureter endoscopy & treatment	1	$349.65
50980	Ureter endoscopy & treatment	1	$349.65
51010	Drainage of bladder	1	$349.65
51020	Incise & treat bladder	4	$661.50
51030	Incise & treat bladder	4	$661.50
51040	Incise & drain bladder	4	$661.50
51045	Incise bladder/drain ureter	4	$661.50
51050	Removal of bladder stone	4	$661.50
51065	Remove ureter calculus	4	$661.50
51080	Drainage of bladder abscess	1	$349.65
51500	Removal of bladder cyst	4	$661.50
51520	Removal of bladder lesion	4	$661.50
51710	Change of bladder tube	1	$349.65
51715	Endoscopic injection/implant	3	$535.50
51726	Complex cystometrogram	1	$349.65
51772	Urethra pressure profile	1	$349.65
51785	Anal/urinary muscle study	1	$349.65
51880	Repair of bladder opening	1	$349.65
52000	Cystoscopy	1	$349.65
52001	Cystoscopy, removal of clots	2	$468.30
52005	Cystoscopy & ureter catheter	2	$468.30
52007	Cystoscopy and biopsy	2	$468.30
52010	Cystoscopy & duct catheter	2	$468.30
52204	Cystoscopy	2	$468.30
52214	Cystoscopy and treatment	2	$468.30
52224	Cystoscopy and treatment	2	$468.30
52234	Cystoscopy and treatment	2	$468.30
52235	Cystoscopy and treatment	3	$535.50
52240	Cystoscopy and treatment	3	$535.50
52250	Cystoscopy and radiotracer	4	$661.50
52260	Cystoscopy and treatment	2	$468.30
52270	Cystoscopy & revise urethra	2	$468.30
52275	Cystoscopy & revise urethra	2	$468.30
52276	Cystoscopy and treatment	3	$535.50
52277	Cystoscopy and treatment	2	$468.30
52281	Cystoscopy and treatment	2	$468.30
52282	Cystoscopy, implant stent	9	$1,405.95
52283	Cystoscopy and treatment	2	$468.30
52285	Cystoscopy and treatment	2	$468.30
52290	Cystoscopy and treatment	2	$468.30
52300	Cystoscopy and treatment	2	$468.30
52305	Cystoscopy and treatment	2	$468.30
52310	Cystoscopy and treatment	2	$468.30
52315	Cystoscopy and treatment	2	$468.30
52317	Remove bladder stone	1	$349.65
52318	Remove bladder stone	2	$468.30
52320	Cystoscopy and treatment	5	$752.85
52325	Cystoscopy, stone removal	4	$661.50

HCPCS Code	Short Description	Payment Group	Payment Amount
52327	Cystoscopy, inject material	2	$468.30
52330	Cystoscopy and treatment	2	$468.30
52332	Cystoscopy and treatment	2	$468.30
52334	Create passage to kidney	3	$535.50
52341	Cysto w/ureter stricture tx	3	$535.50
52342	Cysto w/up stricture tx	3	$535.50
52343	Cysto w/renal stricture tx	3	$535.50
52344	Cysto/uretero, stone remove	3	$535.50
52345	Cysto/uretero w/up stricture	3	$535.50
52346	Cystouretero w/renal strict	3	$535.50
52351	Cystouretro & or pyeloscope	3	$535.50
52352	Cystouretro w/stone remove	4	$661.50
52353	Cystouretero w/lithotripsy	4	$661.50
52354	Cystouretero w/biopsy	4	$661.50
52355	Cystouretero w/excise tumor	4	$661.50
52400	Cystouretero w/congen repr	3	$535.50
52450	Incision of prostate	3	$535.50
52500	Revision of bladder neck	3	$535.50
52510	Dilation prostatic urethra	3	$535.50
52601	Prostatectomy (TURP)	4	$661.50
52606	Control postop bleeding	1	$349.65
52612	Prostatectomy, first stage	2	$468.30
52614	Prostatectomy, second stage	1	$349.65
52620	Remove residual prostate	1	$349.65
52630	Remove prostate regrowth	2	$468.30
52640	Relieve bladder contracture	2	$468.30
52647	Laser surgery of prostate	9	$1,405.95
52648	Laser surgery of prostate	9	$1,405.95
52700	Drainage of prostate abscess	2	$468.30
53000	Incision of urethra	1	$349.65
53010	Incision of urethra	1	$349.65
53020	Incision of urethra	1	$349.65
53040	Drainage of urethra abscess	2	$468.30
53080	Drainage of urinary leakage	3	$535.50
53200	Biopsy of urethra	1	$349.65
53210	Removal of urethra	5	$752.85
53215	Removal of urethra	5	$752.85
53220	Treatment of urethra lesion	2	$468.30
53230	Removal of urethra lesion	2	$468.30
53235	Removal of urethra lesion	3	$535.50
53240	Surgery for urethra pouch	2	$468.30
53250	Removal of urethra gland	2	$468.30
53260	Treatment of urethra lesion	2	$468.30
53265	Treatment of urethra lesion	2	$468.30
53270	Removal of urethra gland	2	$468.30
53275	Repair of urethra defect	2	$468.30
53400	Revise urethra, stage 1	3	$535.50
53405	Revise urethra, stage 2	2	$468.30
53410	Reconstruction of urethra	2	$468.30

HCPCS Code	Short Description	Payment Group	Payment Amount
53420	Reconstruct urethra, stage 1	3	$535.50
53425	Reconstruct urethra, stage 2	2	$468.30
53430	Reconstruction of urethra	2	$468.30
53431	Reconstruct urethra/bladder	2	$468.30
53440	Correct bladder function	2	$468.30
53442	Remove perineal prosthesis	1	$349.65
53444	Insert tandem cuff	2	$468.30
53445	Insert uro/ves nck sphincter	1	$349.65
53446	Remove uro sphincter	1	$349.65
53447	Remove/replace ur sphincter	1	$349.65
53449	Repair uro sphincter	1	$349.65
53450	Revision of urethra	1	$349.65
53460	Revision of urethra	1	$349.65
53502	Repair of urethra injury	2	$468.30
53505	Repair of urethra injury	2	$468.30
53510	Repair of urethra injury	2	$468.30
53515	Repair of urethra injury	2	$468.30
53520	Repair of urethra defect	2	$468.30
53605	Dilate urethra stricture	2	$468.30
53665	Dilation of urethra	1	$349.65
53850	Prostatic microwave thermotx	9	$1,405.95
54000	Slitting of prepuce	2	$468.30
54001	Slitting of prepuce	2	$468.30
54015	Drain penis lesion	4	$661.50
54057	Laser surg, penis lesion(s)	1	$349.65
54060	Excision of penis lesion(s)	1	$349.65
54065	Destruction, penis lesion(s)	1	$349.65
54100	Biopsy of penis	1	$349.65
54105	Biopsy of penis	1	$349.65
54110	Treatment of penis lesion	2	$468.30
54111	Treat penis lesion, graft	2	$468.30
54112	Treat penis lesion, graft	2	$468.30
54115	Treatment of penis lesion	1	$349.65
54120	Partial removal of penis	2	$468.30
54150	Circumcision	1	$349.65
54152	Circumcision	1	$349.65
54160	Circumcision	2	$468.30
54161	Circumcision	2	$468.30
54162	Lysis penil circumcis lesion	2	$468.30
54163	Repair of circumcision	2	$468.30
54164	Frenulotomy of penis	2	$468.30
54205	Treatment of penis lesion	4	$661.50
54220	Treatment of penis lesion	1	$349.65
54300	Revision of penis	3	$535.50
54304	Revision of penis	3	$535.50
54308	Reconstruction of urethra	3	$535.50
54312	Reconstruction of urethra	3	$535.50
54316	Reconstruction of urethra	3	$535.50
54318	Reconstruction of urethra	3	$535.50

HCPCS Code	Short Description	Payment Group	Payment Amount
54322	Reconstruction of urethra	3	$535.50
54324	Reconstruction of urethra	3	$535.50
54326	Reconstruction of urethra	3	$535.50
54328	Revise penis/urethra	3	$535.50
54340	Secondary urethral surgery	3	$535.50
54344	Secondary urethral surgery	3	$535.50
54348	Secondary urethral surgery	3	$535.50
54352	Reconstruct urethra/penis	3	$535.50
54360	Penis plastic surgery	3	$535.50
54380	Repair penis	3	$535.50
54385	Repair penis	3	$535.50
54400	Insert semi-rigid prosthesis	3	$535.50
54401	Insert self-contd prosthesis	3	$535.50
54405	Insert multi-comp penis pros	3	$535.50
54406	Remove multi-comp penis pros	3	$535.50
54408	Repair multi-comp penis pros	3	$535.50
54410	Remove/replace penis prosth	3	$535.50
54415	Remove self-contd penis pros	3	$535.50
54416	Remv/repl penis contain pros	3	$535.50
54420	Revision of penis	4	$661.50
54435	Revision of penis	4	$661.50
54440	Repair of penis	4	$661.50
54450	Preputial stretching	1	$349.65
54500	Biopsy of testis	1	$349.65
54505	Biopsy of testis	1	$349.65
54512	Excise lesion testis	2	$468.30
54520	Removal of testis	3	$535.50
54522	Orchiectomy, partial	3	$535.50
54530	Removal of testis	4	$661.50
54550	Exploration for testis	4	$661.50
54600	Reduce testis torsion	4	$661.50
54620	Suspension of testis	3	$535.50
54640	Suspension of testis	4	$661.50
54660	Revision of testis	2	$468.30
54670	Repair testis injury	3	$535.50
54680	Relocation of testis(es)	3	$535.50
54690	Laparoscopy, orchiectomy	9	$1,405.95
54700	Drainage of scrotum	2	$468.30
54800	Biopsy of epididymis	1	$349.65
54820	Exploration of epididymis	1	$349.65
54830	Remove epididymis lesion	3	$535.50
54840	Remove epididymis lesion	4	$661.50
54860	Removal of epididymis	3	$535.50
54861	Removal of epididymis	4	$661.50
54900	Fusion of spermatic ducts	4	$661.50
54901	Fusion of spermatic ducts	4	$661.50
55040	Removal of hydrocele	3	$535.50
55041	Removal of hydroceles	5	$752.85
55060	Repair of hydrocele	4	$661.50

HCPCS Code	Short Description	Payment Group	Payment Amount
55100	Drainage of scrotum abscess	1	$349.65
55110	Explore scrotum	2	$468.30
55120	Removal of scrotum lesion	2	$468.30
55150	Removal of scrotum	1	$349.65
55175	Revision of scrotum	1	$349.65
55180	Revision of scrotum	2	$468.30
55200	Incision of sperm duct	2	$468.30
55250	Removal of sperm duct(s)	2	$468.30
55400	Repair of sperm duct	1	$349.65
55500	Removal of hydrocele	3	$535.50
55520	Removal of sperm cord lesion	4	$661.50
55530	Revise spermatic cord veins	4	$661.50
55535	Revise spermatic cord veins	4	$661.50
55540	Revise hernia & sperm veins	5	$752.85
55550	Laparo ligate spermatic vein	9	$1,405.95
55680	Remove sperm pouch lesion	1	$349.65
55700	Biopsy of prostate	2	$468.30
55705	Biopsy of prostate	2	$468.30
55720	Drainage of prostate abscess	1	$349.65
55725	Drainage of prostate abscess	2	$468.30
55859	Percut/needle insert, pros	9	$1,405.95
56440	Surgery for vulva lesion	2	$468.30
56441	Lysis of labial lesion(s)	1	$349.65
56515	Destroy vulva lesion/s compl	3	$535.50
56620	Partial removal of vulva	5	$752.85
56625	Complete removal of vulva	7	$1,044.75
56700	Partial removal of hymen	1	$349.65
56720	Incision of hymen	1	$349.65
56740	Remove vagina gland lesion	3	$535.50
56800	Repair of vagina	3	$535.50
56810	Repair of perineum	5	$752.85
57000	Exploration of vagina	1	$349.65
57010	Drainage of pelvic abscess	2	$468.30
57020	Drainage of pelvic fluid	2	$468.30
57023	I & d vag hematoma, non-ob	1	$349.65
57065	Destroy vag lesions, complex	1	$349.65
57105	Biopsy of vagina	2	$468.30
57130	Remove vagina lesion	2	$468.30
57135	Remove vagina lesion	2	$468.30
57180	Treat vaginal bleeding	1	$349.65
57200	Repair of vagina	1	$349.65
57210	Repair vagina/perineum	2	$468.30
57220	Revision of urethra	3	$535.50
57230	Repair of urethral lesion	3	$535.50
57240	Repair bladder & vagina	5	$752.85
57250	Repair rectum & vagina	5	$752.85
57260	Repair of vagina	5	$752.85
57265	Extensive repair of vagina	7	$1,044.75
57268	Repair of bowel bulge	3	$535.50

HCPCS Code	Short Description	Payment Group	Payment Amount
57289	Repair bladder & vagina	5	$752.85
57291	Construction of vagina	5	$752.85
57300	Repair rectum-vagina fistula	3	$535.50
57400	Dilation of vagina	2	$468.30
57410	Pelvic examination	2	$468.30
57415	Remove vaginal foreign body	2	$468.30
57513	Laser surgery of cervix	2	$468.30
57520	Conization of cervix	2	$468.30
57522	Conization of cervix	2	$468.30
57530	Removal of cervix	3	$535.50
57550	Removal of residual cervix	3	$535.50
57556	Remove cervix, repair bowel	5	$752.85
57700	Revision of cervix	1	$349.65
57720	Revision of cervix	3	$535.50
57820	D & c of residual cervix	3	$535.50
58120	Dilation and curettage	2	$468.30
58145	Removal of uterus lesion	5	$752.85
58350	Reopen fallopian tube	3	$535.50
58353	Endometr ablate, thermal	4	$661.50
58545	Laparoscopic myomectomy	9	$1,405.95
58546	Laparo-myomectomy, complex	9	$1,405.95
58550	Laparo-asst vag hysterectomy	9	$1,405.95
58555	Hysteroscopy, dx, sep proc	1	$349.65
58558	Hysteroscopy, biopsy	3	$535.50
58559	Hysteroscopy, lysis	2	$468.30
58560	Hysteroscopy, resect septum	3	$535.50
58561	Hysteroscopy, remove myoma	3	$535.50
58562	Hysteroscopy, remove fb	3	$535.50
58563	Hysteroscopy, ablation	4	$661.50
58660	Laparoscopy, lysis	5	$752.85
58661	Laparoscopy, remove adnexa	5	$752.85
58662	Laparoscopy, excise lesions	5	$752.85
58670	Laparoscopy, tubal cautery	3	$535.50
58671	Laparoscopy, tubal block	3	$535.50
58672	Laparoscopy, fimbrioplasty	5	$752.85
58673	Laparoscopy, salpingostomy	5	$752.85
58800	Drainage of ovarian cyst(s)	3	$535.50
58820	Drain ovary abscess, open	3	$535.50
58900	Biopsy of ovary(s)	3	$535.50
59160	D & c after delivery	3	$535.50
59320	Revision of cervix	1	$349.65
59812	Treatment of miscarriage	5	$752.85
59820	Care of miscarriage	5	$752.85
59821	Treatment of miscarriage	5	$752.85
59840	Abortion	5	$752.85
59841	Abortion	5	$752.85
59870	Evacuate mole of uterus	5	$752.85
59871	Remove cerclage suture	5	$752.85
60000	Drain thyroid/tongue cyst	1	$349.65

HCPCS Code	Short Description	Payment Group	Payment Amount
60200	Remove thyroid lesion	2	$468.30
60280	Remove thyroid duct lesion	4	$661.50
60281	Remove thyroid duct lesion	4	$661.50
61020	Remove brain cavity fluid	1	$349.65
61026	Injection into brain canal	1	$349.65
61050	Remove brain canal fluid	1	$349.65
61055	Injection into brain canal	1	$349.65
61070	Brain canal shunt procedure	1	$349.65
61215	Insert brain-fluid device	3	$535.50
61790	Treat trigeminal nerve	3	$535.50
61791	Treat trigeminal tract	3	$535.50
61885	Implant neurostim one array	2	$468.30
61886	Implant neurostim arrays	3	$535.50
61888	Revise/remove neuroreceiver	1	$349.65
62194	Replace/irrigate catheter	1	$349.65
62225	Replace/irrigate catheter	1	$349.65
62230	Replace/revise brain shunt	2	$468.30
62263	Lysis epidural adhesions	1	$349.65
62268	Drain spinal cord cyst	1	$349.65
62269	Needle biopsy, spinal cord	1	$349.65
62270	Spinal fluid tap, diagnostic	1	$349.65
62272	Drain cerebro spinal fluid	1	$349.65
62273	Treat epidural spine lesion	1	$349.65
62280	Treat spinal cord lesion	1	$349.65
62281	Treat spinal cord lesion	1	$349.65
62282	Treat spinal canal lesion	1	$349.65
62287	Percutaneous diskectomy	9	$1,405.95
62294	Injection into spinal artery	3	$535.50
62310	Inject spine c/t	1	$349.65
62311	Inject spine l/s (cd)	1	$349.65
62318	Inject spine w/cath, c/t	1	$349.65
62319	Inject spine w/cath l/s (cd)	1	$349.65
62350	Implant spinal canal cath	2	$468.30
62355	Remove spinal canal catheter	2	$468.30
62360	Insert spine infusion device	2	$468.30
62361	Implant spine infusion pump	2	$468.30
62362	Implant spine infusion pump	2	$468.30
62365	Remove spine infusion device	2	$468.30
63600	Remove spinal cord lesion	2	$468.30
63610	Stimulation of spinal cord	1	$349.65
63650	Implant neuroelectrodes	2	$468.30
63660	Revise/remove neuroelectrode	1	$349.65
63685	Implant neuroreceiver	2	$468.30
63688	Revise/remove neuroreceiver	1	$349.65
63744	Revision of spinal shunt	3	$535.50
63746	Removal of spinal shunt	2	$468.30
64410	Injection for nerve block	1	$349.65
64415	Injection for nerve block	1	$349.65
64417	Injection for nerve block	1	$349.65

HCPCS Code	Short Description	Payment Group	Payment Amount
64420	Injection for nerve block	1	$349.65
64421	Injection for nerve block	1	$349.65
64430	Injection for nerve block	1	$349.65
64470	Inj paravertebral c/t	1	$349.65
64472	Inj paravertebral c/t add-on	1	$349.65
64475	Inj paravertebral l/s	1	$349.65
64476	Inj paravertebral l/s add-on	1	$349.65
64479	Inj foramen epidural c/t	1	$349.65
64480	Inj foramen epidural add-on	1	$349.65
64483	Inj foramen epidural l/s	1	$349.65
64484	Inj foramen epidural add-on	1	$349.65
64510	Injection for nerve block	1	$349.65
64520	Injection for nerve block	1	$349.65
64530	Injection for nerve block	1	$349.65
64553	Implant neuroelectrodes	1	$349.65
64573	Implant neuroelectrodes	1	$349.65
64575	Implant neuroelectrodes	1	$349.65
64577	Implant neuroelectrodes	1	$349.65
64580	Implant neuroelectrodes	1	$349.65
64585	Revise/remove neuroelectrode	1	$349.65
64590	Implant neuroreceiver	2	$468.30
64595	Revise/remove neuroreceiver	1	$349.65
64600	Injection treatment of nerve	1	$349.65
64605	Injection treatment of nerve	1	$349.65
64610	Injection treatment of nerve	1	$349.65
64620	Injection treatment of nerve	1	$349.65
64622	Destr paravertebrl nerve l/s	1	$349.65
64623	Destr paravertebral n add-on	1	$349.65
64626	Destr paravertebrl nerve c/t	1	$349.65
64627	Destr paravertebral n add-on	1	$349.65
64630	Injection treatment of nerve	2	$468.30
64680	Injection treatment of nerve	2	$468.30
64702	Revise finger/toe nerve	1	$349.65
64704	Revise hand/foot nerve	1	$349.65
64708	Revise arm/leg nerve	2	$468.30
64712	Revision of sciatic nerve	2	$468.30
64713	Revision of arm nerve(s)	2	$468.30
64714	Revise low back nerve(s)	2	$468.30
64716	Revision of cranial nerve	3	$535.50
64718	Revise ulnar nerve at elbow	2	$468.30
64719	Revise ulnar nerve at wrist	2	$468.30
64721	Carpal tunnel surgery	2	$468.30
64722	Relieve pressure on nerve(s)	1	$349.65
64726	Release foot/toe nerve	1	$349.65
64727	Internal nerve revision	1	$349.65
64732	Incision of brow nerve	2	$468.30
64734	Incision of cheek nerve	2	$468.30
64736	Incision of chin nerve	2	$468.30
64738	Incision of jaw nerve	2	$468.30

HCPCS Code	Short Description	Payment Group	Payment Amount
64740	Incision of tongue nerve	2	$468.30
64742	Incision of facial nerve	2	$468.30
64744	Incise nerve, back of head	2	$468.30
64746	Incise diaphragm nerve	2	$468.30
64771	Sever cranial nerve	2	$468.30
64772	Incision of spinal nerve	2	$468.30
64774	Remove skin nerve lesion	2	$468.30
64776	Remove digit nerve lesion	3	$535.50
64778	Digit nerve surgery add-on	2	$468.30
64782	Remove limb nerve lesion	3	$535.50
64783	Limb nerve surgery add-on	2	$468.30
64784	Remove nerve lesion	3	$535.50
64786	Remove sciatic nerve lesion	3	$535.50
64787	Implant nerve end	2	$468.30
64788	Remove skin nerve lesion	3	$535.50
64790	Removal of nerve lesion	3	$535.50
64792	Removal of nerve lesion	3	$535.50
64795	Biopsy of nerve	2	$468.30
64802	Remove sympathetic nerves	2	$468.30
64821	Remove sympathetic nerves	4	$661.50
64831	Repair of digit nerve	4	$661.50
64832	Repair nerve add-on	1	$349.65
64834	Repair of hand or foot nerve	2	$468.30
64835	Repair of hand or foot nerve	3	$535.50
64836	Repair of hand or foot nerve	3	$535.50
64837	Repair nerve add-on	1	$349.65
64840	Repair of leg nerve	2	$468.30
64856	Repair/transpose nerve	2	$468.30
64857	Repair arm/leg nerve	2	$468.30
64858	Repair sciatic nerve	2	$468.30
64859	Nerve surgery	1	$349.65
64861	Repair of arm nerves	3	$535.50
64862	Repair of low back nerves	3	$535.50
64864	Repair of facial nerve	3	$535.50
64865	Repair of facial nerve	4	$661.50
64870	Fusion of facial/other nerve	4	$661.50
64872	Subsequent repair of nerve	2	$468.30
64874	Repair & revise nerve add-on	3	$535.50
64876	Repair nerve/shorten bone	3	$535.50
64885	Nerve graft, head or neck	2	$468.30
64886	Nerve graft, head or neck	2	$468.30
64890	Nerve graft, hand or foot	2	$468.30
64891	Nerve graft, hand or foot	2	$468.30
64892	Nerve graft, arm or leg	2	$468.30
64893	Nerve graft, arm or leg	2	$468.30
64895	Nerve graft, hand or foot	3	$535.50
64896	Nerve graft, hand or foot	3	$535.50
64897	Nerve graft, arm or leg	3	$535.50
64898	Nerve graft, arm or leg	3	$535.50

HCPCS Code	Short Description	Payment Group	Payment Amount
64901	Nerve graft add-on	2	$468.30
64902	Nerve graft add-on	2	$468.30
64905	Nerve pedicle transfer	2	$468.30
64907	Nerve pedicle transfer	1	$349.65
65091	Revise eye	3	$535.50
65093	Revise eye with implant	3	$535.50
65101	Removal of eye	3	$535.50
65103	Remove eye/insert implant	3	$535.50
65105	Remove eye/attach implant	4	$661.50
65110	Removal of eye	5	$752.85
65112	Remove eye/revise socket	7	$1,044.75
65114	Remove eye/revise socket	7	$1,044.75
65130	Insert ocular implant	3	$535.50
65135	Insert ocular implant	2	$468.30
65140	Attach ocular implant	3	$535.50
65150	Revise ocular implant	2	$468.30
65155	Reinsert ocular implant	3	$535.50
65175	Removal of ocular implant	1	$349.65
65235	Remove foreign body from eye	2	$468.30
65260	Remove foreign body from eye	3	$535.50
65265	Remove foreign body from eye	4	$661.50
65270	Repair of eye wound	2	$468.30
65272	Repair of eye wound	2	$468.30
65275	Repair of eye wound	4	$661.50
65280	Repair of eye wound	4	$661.50
65285	Repair of eye wound	4	$661.50
65290	Repair of eye socket wound	3	$535.50
65400	Removal of eye lesion	1	$349.65
65410	Biopsy of cornea	2	$468.30
65420	Removal of eye lesion	2	$468.30
65426	Removal of eye lesion	5	$752.85
65710	Corneal transplant	7	$1,044.75
65730	Corneal transplant	7	$1,044.75
65750	Corneal transplant	7	$1,044.75
65755	Corneal transplant	7	$1,044.75
65770	Revise cornea with implant	7	$1,044.75
65772	Correction of astigmatism	4	$661.50
65775	Correction of astigmatism	4	$661.50
65800	Drainage of eye	1	$349.65
65805	Drainage of eye	1	$349.65
65810	Drainage of eye	3	$535.50
65815	Drainage of eye	2	$468.30
65850	Incision of eye	4	$661.50
65865	Incise inner eye adhesions	1	$349.65
65870	Incise inner eye adhesions	4	$661.50
65875	Incise inner eye adhesions	4	$661.50
65880	Incise inner eye adhesions	4	$661.50
65900	Remove eye lesion	5	$752.85
65920	Remove implant of eye	7	$1,044.75

HCPCS Code	Short Description	Payment Group	Payment Amount
65930	Remove blood clot from eye	5	$752.85
66020	Injection treatment of eye	1	$349.65
66030	Injection treatment of eye	1	$349.65
66130	Remove eye lesion	7	$1,044.75
66150	Glaucoma surgery	4	$661.50
66155	Glaucoma surgery	4	$661.50
66160	Glaucoma surgery	2	$468.30
66165	Glaucoma surgery	4	$661.50
66170	Glaucoma surgery	4	$661.50
66172	Incision of eye	4	$661.50
66180	Implant eye shunt	5	$752.85
66185	Revise eye shunt	2	$468.30
66220	Repair eye lesion	3	$535.50
66225	Repair/graft eye lesion	4	$661.50
66250	Follow-up surgery of eye	2	$468.30
66500	Incision of iris	1	$349.65
66505	Incision of iris	1	$349.65
66600	Remove iris and lesion	3	$535.50
66605	Removal of iris	3	$535.50
66625	Removal of iris	3	$535.50
66630	Removal of iris	3	$535.50
66635	Removal of iris	3	$535.50
66680	Repair iris & ciliary body	3	$535.50
66682	Repair iris & ciliary body	2	$468.30
66700	Destruction, ciliary body	2	$468.30
66710	Destruction, ciliary body	2	$468.30
66720	Destruction, ciliary body	2	$468.30
66740	Destruction, ciliary body	2	$468.30
66821	After cataract laser surgery	2	$468.30
66825	Reposition intraocular lens	4	$661.50
66830	Removal of lens lesion	4	$661.50
66840	Removal of lens material	4	$661.50
66850	Removal of lens material	7	$1,044.75
66852	Removal of lens material	4	$661.50
66920	Extraction of lens	4	$661.50
66930	Extraction of lens	5	$752.85
66940	Extraction of lens	5	$752.85
66982	Cataract surgery, complex	8	$864.15
66983	Cataract surg w/iol, 1 stage	8	$864.15
66984	Cataract surg w/iol, i stage	8	$864.15
66985	Insert lens prosthesis	6	$709.80
66986	Exchange lens prosthesis	6	$709.80
67005	Partial removal of eye fluid	4	$661.50
67010	Partial removal of eye fluid	4	$661.50
67015	Release of eye fluid	1	$349.65
67025	Replace eye fluid	1	$349.65
67027	Implant eye drug system	4	$661.50
67030	Incise inner eye strands	1	$349.65
67031	Laser surgery, eye strands	2	$468.30

HCPCS Code	Short Description	Payment Group	Payment Amount
67036	Removal of inner eye fluid	4	$661.50
67038	Strip retinal membrane	5	$752.85
67039	Laser treatment of retina	7	$1,044.75
67040	Laser treatment of retina	7	$1,044.75
67107	Repair detached retina	5	$752.85
67108	Repair detached retina	7	$1,044.75
67112	Rerepair detached retina	7	$1,044.75
67115	Release encircling material	2	$468.30
67120	Remove eye implant material	2	$468.30
67121	Remove eye implant material	2	$468.30
67141	Treatment of retina	2	$468.30
67218	Treatment of retinal lesion	5	$752.85
67227	Treatment of retinal lesion	1	$349.65
67250	Reinforce eye wall	3	$535.50
67255	Reinforce/graft eye wall	3	$535.50
67311	Revise eye muscle	3	$535.50
67312	Revise two eye muscles	4	$661.50
67314	Revise eye muscle	4	$661.50
67316	Revise two eye muscles	4	$661.50
67318	Revise eye muscle(s)	4	$661.50
67320	Revise eye muscle(s) add-on	4	$661.50
67331	Eye surgery follow-up add-on	4	$661.50
67332	Rerevise eye muscles add-on	4	$661.50
67334	Revise eye muscle w/suture	4	$661.50
67335	Eye suture during surgery	4	$661.50
67340	Revise eye muscle add-on	4	$661.50
67350	Biopsy eye muscle	1	$349.65
67400	Explore/biopsy eye socket	3	$535.50
67405	Explore/drain eye socket	4	$661.50
67412	Explore/treat eye socket	5	$752.85
67413	Explore/treat eye socket	5	$752.85
67415	Aspiration, orbital contents	1	$349.65
67420	Explore/treat eye socket	5	$752.85
67430	Explore/treat eye socket	5	$752.85
67440	Explore/drain eye socket	5	$752.85
67450	Explore/biopsy eye socket	5	$752.85
67550	Insert eye socket implant	4	$661.50
67560	Revise eye socket implant	2	$468.30
67715	Incision of eyelid fold	1	$349.65
67808	Remove eyelid lesion(s)	2	$468.30
67830	Revise eyelashes	2	$468.30
67835	Revise eyelashes	2	$468.30
67880	Revision of eyelid	3	$535.50
67882	Revision of eyelid	3	$535.50
67900	Repair brow defect	4	$661.50
67901	Repair eyelid defect	5	$752.85
67902	Repair eyelid defect	5	$752.85
67903	Repair eyelid defect	4	$661.50
67904	Repair eyelid defect	4	$661.50

HCPCS Code	Short Description	Payment Group	Payment Amount
67906	Repair eyelid defect	5	$752.85
67908	Repair eyelid defect	4	$661.50
67909	Revise eyelid defect	4	$661.50
67911	Revise eyelid defect	3	$535.50
67914	Repair eyelid defect	3	$535.50
67916	Repair eyelid defect	4	$661.50
67917	Repair eyelid defect	4	$661.50
67921	Repair eyelid defect	3	$535.50
67923	Repair eyelid defect	4	$661.50
67924	Repair eyelid defect	4	$661.50
67935	Repair eyelid wound	2	$468.30
67950	Revision of eyelid	2	$468.30
67961	Revision of eyelid	3	$535.50
67966	Revision of eyelid	3	$535.50
67971	Reconstruction of eyelid	3	$535.50
67973	Reconstruction of eyelid	3	$535.50
67974	Reconstruction of eyelid	3	$535.50
67975	Reconstruction of eyelid	3	$535.50
68115	Remove eyelid lining lesion	2	$468.30
68130	Remove eyelid lining lesion	2	$468.30
68320	Revise/graft eyelid lining	4	$661.50
68325	Revise/graft eyelid lining	4	$661.50
68326	Revise/graft eyelid lining	4	$661.50
68328	Revise/graft eyelid lining	4	$661.50
68330	Revise eyelid lining	4	$661.50
68335	Revise/graft eyelid lining	4	$661.50
68340	Separate eyelid adhesions	4	$661.50
68360	Revise eyelid lining	2	$468.30
68362	Revise eyelid lining	2	$468.30
68500	Removal of tear gland	3	$535.50
68505	Partial removal, tear gland	3	$535.50
68510	Biopsy of tear gland	1	$349.65
68520	Removal of tear sac	3	$535.50
68525	Biopsy of tear sac	1	$349.65
68540	Remove tear gland lesion	3	$535.50
68550	Remove tear gland lesion	3	$535.50
68700	Repair tear ducts	2	$468.30
68720	Create tear sac drain	4	$661.50
68745	Create tear duct drain	4	$661.50
68750	Create tear duct drain	4	$661.50
68770	Close tear system fistula	4	$661.50
68810	Probe nasolacrimal duct	1	$349.65
68811	Probe nasolacrimal duct	2	$468.30
68815	Probe nasolacrimal duct	2	$468.30
69110	Remove external ear, partial	1	$349.65
69120	Removal of external ear	2	$468.30
69140	Remove ear canal lesion(s)	2	$468.30
69145	Remove ear canal lesion(s)	2	$468.30
69150	Extensive ear canal surgery	3	$535.50

HCPCS Code	Short Description	Payment Group	Payment Amount
69205	Clear outer ear canal	1	$349.65
69300	Revise external ear	3	$535.50
69310	Rebuild outer ear canal	3	$535.50
69320	Rebuild outer ear canal	7	$1,044.75
69421	Incision of eardrum	3	$535.50
69436	Create eardrum opening	3	$535.50
69440	Exploration of middle ear	3	$535.50
69450	Eardrum revision	1	$349.65
69501	Mastoidectomy	7	$1,044.75
69502	Mastoidectomy	7	$1,044.75
69505	Remove mastoid structures	7	$1,044.75
69511	Extensive mastoid surgery	7	$1,044.75
69530	Extensive mastoid surgery	7	$1,044.75
69550	Remove ear lesion	5	$752.85
69552	Remove ear lesion	7	$1,044.75
69601	Mastoid surgery revision	7	$1,044.75
69602	Mastoid surgery revision	7	$1,044.75
69603	Mastoid surgery revision	7	$1,044.75
69604	Mastoid surgery revision	7	$1,044.75
69605	Mastoid surgery revision	7	$1,044.75
69620	Repair of eardrum	2	$468.30
69631	Repair eardrum structures	5	$752.85
69632	Rebuild eardrum structures	5	$752.85
69633	Rebuild eardrum structures	5	$752.85
69635	Repair eardrum structures	7	$1,044.75
69636	Rebuild eardrum structures	7	$1,044.75
69637	Rebuild eardrum structures	7	$1,044.75
69641	Revise middle ear & mastoid	7	$1,044.75
69642	Revise middle ear & mastoid	7	$1,044.75
69643	Revise middle ear & mastoid	7	$1,044.75
69644	Revise middle ear & mastoid	7	$1,044.75
69645	Revise middle ear & mastoid	7	$1,044.75
69646	Revise middle ear & mastoid	7	$1,044.75
69650	Release middle ear bone	7	$1,044.75
69660	Revise middle ear bone	5	$752.85
69661	Revise middle ear bone	5	$752.85
69662	Revise middle ear bone	5	$752.85
69666	Repair middle ear structures	4	$661.50
69667	Repair middle ear structures	4	$661.50
69670	Remove mastoid air cells	3	$535.50
69676	Remove middle ear nerve	3	$535.50
69700	Close mastoid fistula	3	$535.50
69711	Remove/repair hearing aid	1	$349.65
69714	Implant temple bone w/stimul	9	$1,405.95
69715	Temple bne implnt w/stimulat	9	$1,405.95
69717	Temple bone implant revision	9	$1,405.95
69718	Revise temple bone implant	9	$1,405.95
69720	Release facial nerve	5	$752.85
69725	Release facial nerve	5	$752.85

HCPCS Code	Short Description	Payment Group	Payment Amount
69740	Repair facial nerve	5	$752.85
69745	Repair facial nerve	5	$752.85
69801	Incise inner ear	5	$752.85
69802	Incise inner ear	7	$1,044.75
69805	Explore inner ear	7	$1,044.75
69806	Explore inner ear	7	$1,044.75
69820	Establish inner ear window	5	$752.85
69840	Revise inner ear window	5	$752.85
69905	Remove inner ear	7	$1,044.75
69910	Remove inner ear & mastoid	7	$1,044.75
69915	Incise inner ear nerve	7	$1,044.75
69930	Implant cochlear device	7	$1,044.75
G0105	Colorectal scrn; hi risk ind	2	$468.30
G0121	Colon ca scrn; not high rsk ind	2	$468.30
G0260	Inj for sacroiliac jt anesth	1	$349.65

APPENDIX B
ORDERING INFORMATION

CHAPTER CONTENTS

Page

CPT-4 AND ICD-9-CM CODE BOOK B-2

FORM HCFA-1500 . . . . . B-3

BHSF FORM 96 AND BHSF FORM 96-A B-4

BHSF FORM 152-N B-4

FORMS PA01 AND PA02 . . . . . B-5

HCIA (LOS) B-5

INTERQUAL ISD B-5

CPT-4 AND ICD-9-CM CODE BOOK

The CPT-4 Procedure Code Book may be ordered from the following address:

American Medical Association OP 341/7
P.O. Box 10946
Chicago, IL 60610

ICD-9-CM Code Books are to be used to obtain diagnosis codes. Volume 1 is a numeric listing of diagnosis codes, and Volume 2 is an alphabetical listing (Volume 3 is a listing of ICD-9-CM procedure codes that are used by hospitals only). These books may be obtained from the following address:

ICD-9-CM
P.O. Box 971
Ann Arbor, MI 48106

Current prices for CPT and ICD-9-CM books may be obtained by phoning the publisher's office, 1-800-621-8335. Also, Tulane and LSU Medical School bookstores stock these books.

FORM HCFA-1500

Providers using the Form HCFA-1500 (12/90), Health Insurance Claim Form (approved by AMA Council on Medical Service), may obtain a supply of these forms from any office forms sales office or forms may be purchased from the Government Printing Office.

To order the Form HCFA-1500 (single $7 per 100) from the Government Printing Office, mail your order with accompanying check or money order to the following address:

U.S. Government Printing Office
Superintendent of Documents
Washington, D.C. 20402

To place an order using a credit card, phone (202) 783-3238. To order negatives which may be used for printing of the Form HCFA-1500, mail your order with accompanying check or money order ($20) payable to "The Public Printer" and forward to the following address:

Assistant Superintendent
Departmental Account Representative Division
U.S. Government Printing Office, Room C-830
Washington, D.C. 20401

For additional information concerning Form HCFA-1500, phone (202) 275-8099.

BHSF FORM 96 AND BHSF FORM 96-A

Supplies of Form 96 and Form 96-A may be obtained from BHSF at the following address:

Bureau of Health Services Financing
Program Operations
P. O. Box 91030
Baton Rouge, LA 70821-9030

(504) 342-9320

BHSF FORM 152-N

Supplies of Form 152-N must be requested **in writing.** Providers should send their requests to Unisys Systems Corporation at the following address:

Unisys Systems Corporation
8591 United Plaza Blvd.
Baton Rouge, LA 70809
Attention: Forms Distribution

Unisys Systems Corporation will then route the request to the State Division of Administration warehouse, which will be responsible for filling the request. The Eligibility Operations Section, which handles the deeming of eligibility process, cannot order forms, verify the order, or check on the status of the other forms. **Providers should ensure that the return address for the order is a street address, not a box number.**

FORMS PA01 AND PA02

Supplies of Form PA01 and PA02 must be requested **in writing**. Providers should send their requests to Unisys Systems Corporation at the following address:

Unisys Systems Corporation
8591 United Plaza Blvd.
Baton Rouge, LA 70809
Attention: Forms Distribution

HCIA (LOS)

Providers wishing to purchase copies of the HCIA (LOS) Southern Region book may do by sending their request to the following address:

HCIA (LOS)
300 E. Lombard St.
Baltimore, MD 21202

For additional information concerning HCIA (LOS), phone 1-800-568-3282.

INTERQUAL ISD

Providers wishing to purchase copies of the InterQual ISD criteria book may do so by sending their request to the following address:

InterQual
293 Boston Post Rd. West
Suite 180
Marlborough, MA 01752

For additional information concerning InterQual ISD, phone 1-800-274-8374.

APPENDIX C
BLANK MASTER FORMS

CHAPTER CONTENTS

Page

P.C.F01–REQUEST FOR HOSPITAL PRE-ADMISSION CERTIFICATION AND LOS ASSIGNMENT C-2

LONG TERM HOSPITAL LENGTH OF STAY CRITERIA C-3

DISTINCT PART PSYCHIATRIC UNIT ADMISSION/EXTENSION CRITERIA FOR ADULTS C-10

DISTINCT PART PSYCHIATRIC UNIT ADMISSION/EXTENSION CRITERIA FOR CHILDREN C-13

HOSPITAL-BASED ALCOHOLISM AND DRUG TREATMENT UNITS C-16

REHABILITATION HOSPITAL LENGTH OF STAY CRITERIA C-19

SUMMARY OF PRE-CERTIFICATION/LENGTH OF STAY POLICY C-22

PA01 FORM C-23

PA02 FORM C-24

Note: This appendix only includes forms of which Unisys can accept photocopied reproductions for processing. Please check Appendix B for ordering information for any other necessary forms.

Also note that providers must only submit the P.C.F01 for Pre-Admission Certification and Length of Stay Assignment. All other forms for the Pre-Certification Program are intended as reference tools for providers' internal use.

Mail to Unisys Louisiana Medicaid
Hospital Pre-Certification Program
Post Office Box 14849
Baton Rouge, LA 70898-4849

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM

REQUEST FOR HOSPITAL PRE-ADMISSION CERTIFICATION AND LOS ASSIGNMENT

Phone. 1-800-877-0666 Fax. 1-800-717-4329 CASE NUMBER (1)

TYPE: (2)
01 DISTINCT PART PSYCH (PRE-ADMISSION / LOS REVIEW)
02 LONG TERM HOSPITAL (PRE-ADMISSION / LOS REVIEW)
03 ACUTE CARE (MED-SURG) / REHAB (LOS REVIEW ONLY)

(3) INITIAL REQUEST
LOS EXTENSION REQUEST
RECONSIDERATION REQUEST

LEVEL OF CARE / UNIT OF CARE: (4)

RECIPIENT MEDICAID ID (5) AGE (6) SEX (7)

DATE OF BIRTH / / (8) MEDICARE PART-A BENEFITS EXHAUSTED (9)

RECIP LAST NAME (10) FIRST MI

HOSPITAL MEDICAID ID (11)

HOSPITAL CONTACT PERSON (12)

PHONE (13) FAX. (14)

ATTENDING PHYSICIAN MEDICAID ID (if Medicaid enrolled) (15)

ADMISSION DATE (actual or anticipated) / / (16)

DISCHARGE DATE (FOR RETROSPECTIVE REVIEWS ONLY) / / (17)

IF THIS IS A TRANSFER FROM ANOTHER FACILITY, ENTER THE TRANSFERRING FACILITY MEDICAID ID OR FACILITY NAME BELOW (18)

DIAGNOSIS (ICD-9-CM) (19)	DESCRIPTION
ADMITTING	
PRIMARY	
OTHER	
EXTENSION	

SURGERY DATE / / (20)

PROCEDURE CODE(S) (ICD-9-CM) (21)

I certify that all information given is accurate and complete, and that any incomplete or inaccurate data may result in certification denial

AUTHORIZED SIGNATURE _____ (22)

REQUEST DATE AND TIME / / (23) (MILITARY TIME) : (24)

THIS AREA FOR OFFICE USE ONLY

REVIEWER INITIALS (25) DATE / / (26)

STATUS (27) DAYS APPROVED (28)

02 = APPROVED
03 = DENIED
05 = RETURNED DUE TO INSUFFICIENT INFORMATION (See Attached Notes)

P.C.F01
ISSUED 8/94

LONG TERM HOSPITAL LENGTH OF STAY CRITERIA

It is the hospital's responsibility to provide Unisys with the specific information necessary for the case review nurse to determine that the patient meets length of stay criteria as specified on this form. Include the following items from the medical record: 1) ED record (if any), 2) admit note, 3) physician's orders, and 4) applicable progress notes.

NAME:	CASE #:
MEDICAID ID#:	CUSTODY:
ICD CODE #	

ADMISSION/EXTENSION REQUIREMENT: Level I: Patients must meet **ONE** Severity of Illness with **ALL** corresponding Intensities of Service. Level II: Patients must meet **TWO** Severities of Illness with **ALL** corresponding Intensities of Service. Level III: Patients must meet **THREE** Severities of Illness with **ALL** corresponding Intensities of Service.

LEVEL I

(Must meet **one or more** Severities of Illness with the corresponding Intensities of Service)

Severity of Illness

☐ 1. **Respiratory dysfunction** associated with the inability to maintain physiological ventilation or functional level without the need for mechanical support requiring **at least four** of the following Intensities of Service.

Intensity of Service

- ☐ **1a.** Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress
- ☐ **1b.** Respiratory therapy requiring licensed respiratory therapist for observation, monitoring, and maintenance of mechanical ventilatory support
- ☐ **1c.** Use of continuous monitoring devices
- ☐ **1d.** Suctioning at least every two hours
- ☐ **1e.** Pulmonary hygiene with bronchodilators at least every six hours

Specifics:_____

Severity of Illness

☐ 2. **Impaired integument** (i.e., infected and/or necrotic skin conditions, Stage III or IV decubiti, multiple decubiti, surgical wounds, burns) requiring any **two or more** of the following Intensities of Service.

Intensity of Service

- ☐ **2a.** Complex dressing changes using aseptic technique with the application of topical medications every eight hours
- ☐ **2b.** IV or IM medications administered at least every eight hours or per therapeutic regime
- ☐ **2c.** IM or IV antibiotics or antifungals per therapeutic regime
- ☐ **2d.** Daily whirlpool therapy
- ☐ **2e.** Wound management requiring 24-hour observation/monitoring and positioning every two hours by a licensed nurse
- ☐ **2f.** Wound debridement/dressing changes requiring IM or IV analgesic
- ☐ **2g.** Patient/family education related to initial phases of patient care
- ☐ **2h.** Hyperbaric oxygen or magnetic resonance therapy treatment at least daily

Specifics:_____

Severity of Illness

☐ 3. **Unstable medical** condition requiring at least **at least three** of the following Intensities of Service.

Intensity of Service

- ☐ **3a.** Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress, clinical complications, and/or cardiac signs and symptoms
- ☐ **3b.** IV or IM medications administered at least every eight hours or per therapeutic regime
- ☐ **3c.** IM or IV antibiotics or antifungals per therapeutic regime
- ☐ **3d.** Use of continuous monitoring devices
- ☐ **3e.** Licensed respiratory therapist providing respiratory treatment at least every eight hours
- ☐ **3f.** Surgical and/or invasive procedure
- ☐ **3g.** Post-operative care with or without associated complications
- ☐ **3h.** IV fluids (other than "keep open") and/or blood/blood component administration
- ☐ **3i.** Monitoring of **TWO** of the following every four hours:
  - ☐ **a.** VS - temperature, pulse, respirations, BP
  - ☐ **b.** Lab values/drug levels
  - ☐ **c.** Neurovital signs
  - ☐ **d.** Neurovascular checks - skin color, motor and sensory functions
  - ☐ **e.** Central pressure monitoring
  - ☐ **f.** Intake and output

Specifics:_____

Severity of Illness

☐ 4. **Mobility/neurological/cognitive** impairment or rehabilitation condition (i.e., seizure, toxin exposure, head injury-trauma) not due to psychiatric disorder with documented potential for improvement which no longer would quality for an acute rehabilitation program requiring **at least three** of the following Intensities of Service.

Intensity of Service

- ☐ **4a.** One hour of physical therapy per day at least five days per week
- ☐ **4b.** One hour of occupational therapy per day at least five days per week
- ☐ **4c.** One hour of speech pathology per day at least five days per week
- ☐ **4d.** Observation and monitoring by a licensed nurse
- ☐ **4e.** Specialized studies related to assessment and treatment of cognitive dysfunction

Specifics:_____

Severity of Illness

☐ 5. **Infectious process** with the inability to perform ADLs requiring **at least two** of the following Intensities of Service.

Intensity of Service

- ☐ **5a.** IV or IM medications administered at least every eight hours or per therapeutic regime
- ☐ **5b.** IM or IV antibiotics or antifungals per therapeutic regime
- ☐ **5c.** Category-specific isolation
- ☐ **5d.** Initiation of specialized treatment modalities, observation, and monitoring by licensed nurse

LONG TERM HOSPITAL LENGTH OF STAY CRITERIA

LEVEL II

(Must meet **two or more** criteria from Severity of Illness with the corresponding Intensities of Service)

Severity of Illness

☐ 1. **Respiratory dysfunction** associated with the inability to maintain physiological ventilation or functional level and/or the inability to perform ADLs without the need for mechanical support requiring **at least three** of the following Intensities of Service.

Intensity of Service

- ☐ **1a.** Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress
- ☐ **1b.** Respiratory therapy requiring licensed respiratory therapist for observation, monitoring, and maintenance of mechanical ventilatory support
- ☐ **1c.** Use of continuous monitoring devices
- ☐ **1d.** Suctioning at least every two hours
- ☐ **1e.** Pulmonary hygiene with bronchodilators at least every six hours

Specifics:_____

Severity of Illness

☐ 2. **Mobility dysfunction** necessitating the initial phase of training in stump care requiring **all** of the following Intensities of Service.

Intensity of Service

- ☐ **2a.** One hour of rehabilitation therapy at least five days per week with established goals
- ☐ **2b.** 24-hour observation and monitoring by a licensed nurse
- ☐ **2c.** Patient/family education related to initial phases of patient care

Specifics:_____

Severity of Illness

☐ 3. **Elimination dysfunction** secondary to neurological or surgical changes requiring **at least two** of the following Intensities of Service.

Intensity of Service

- ☐ **3a.** Intermittent catheterizations at least twice per day
- ☐ **3b.** Implementation and monitoring of specified medication regimens
- ☐ **3c.** 24-hour observation and monitoring by a licensed nurse
- ☐ **3d.** Initial stages of extensive bowel and bladder retraining
- ☐ **3e.** Initial instruction in self-care of an ostomy or suprapubic catheter, or patient/family education related to initial phases of patient care

Specifics:_____

Severity of Illness

☐ 4. **Impaired Integument** (infected and/or necrotic skin conditions Stage III or IV decubiti, multiple decubiti, surgical wounds, burns) requiring **one or more** of the following Intensities of Service.

Intensity of Service

- ☐ **4a.** Complex dressing changes using aseptic technique with application of topical medications every eight hours
- ☐ **4b.** IV or IM medications administered at least every eight hours or per therapeutic regime
- ☐ **4c.** IM or IV antibiotics or antifungals per therapeutic regime
- ☐ **4d.** Daily whirlpool therapy
- ☐ **4e.** Wound management requiring 24-hour observation/monitoring and positioning every two hours by a licensed nurse
- ☐ **4f.** Wound debridement/dressing changes requiring IM or IV analgesic
- ☐ **4g.** Hyperbaric oxygen or magnetic resonance therapy treatment at least daily
- ☐ **4h.** Patient/family education related to initial phases of patient care

Specifics:_____

Severity of Illness

☐ **5. Mobility/neurological/cognitive** impairment or rehabilitation condition (i.e., seizure, toxin exposure, head injury-trauma) not due to psychiatric disorder associated with the inability to perform ADLs requiring the following Intensity of Service.

Intensity of Service

☐ **5a.** At least two hours of rehabilitation therapy per day at least five days per week with established goals

Specifics:_____

Severity of Illness

☐ **6. Inadequate maintenance of nutritional status** with potential for improvement or stabilization requiring **at least one** of the following Intensities of Service.

Intensity of Service

☐ **6a.** Parenteral hyperalimentation

☐ **6b.** Dysphagia studies and treatment

Specifics:_____

Severity of Illness

☐ **7. Unstable medical condition** requiring **at least two** of the following Intensities of Service.

Intensity of Service

☐ **7a.** Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress, clinical complications, and/or cardiac signs and symptoms

☐ **7b.** IM or IV medications administration at least every eight hours or per therapeutic regime

☐ **7c.** IM or IV antibiotics or antifungals per therapeutic regime

☐ **7d.** Licensed respiratory therapist providing respiratory treatment at least every eight hours

☐ **7e.** Use of intermittent monitoring devices

☐ **7f.** IV fluids (other than "keep open") and/or blood/blood component administration

☐ **7g.** Monitoring of **TWO** of the following every four hours:

- ☐ **a.** VS - temperature, pulse, respirations, BP
- ☐ **b.** Lab values/drug levels
- ☐ **c.** Neurovital signs
- ☐ **d.** Neurovascular checks - skin color, motor and sensory functions
- ☐ **e.** Central pressure monitoring
- ☐ **f.** Intake and output

☐ **7h.** Surgical and/or invasive procedure or post-operative care with or without associated complications

Specifics:_____

Severity of Illness

☐ **8. Infectious process** requiring **at least one** of the following Intensities of Service.

Intensity of Service

☐ **8a.** IV or IM medications administered at least every eight hours or per therapeutic regime

☐ **8b.** IM or IV antibiotics or antifungals per therapeutic regime

☐ **8c.** Specialized treatment modalities, observation and monitoring by licensed nurse

☐ **8d.** Category-specific isolation

Specifics:_____

LEVEL III

(Must meet **three or more** criteria from Severity of Illness with the corresponding Intensity of Service)

Severity of Illness

☐ 1. **Respiratory dysfunction** associated with the inability to perform ADLs requiring **at least two** of the following Intensities of Service.

Intensity of Service

- ☐ **1a.** Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress
- ☐ **1b.** Pulmonary hygiene with bronchodilators at least every six hours
- ☐ **1c.** Use of continuous monitoring devices
- ☐ **1d.** Suctioning at least every two hours
- ☐ **1e.** Licensed nursing and respiratory care education in self-care of a tracheostomy or other pulmonary related procedures, equipment, and treatments

Specifics: _____

_____

Severity of Illness

☐ 2. **Mobility dysfunction** necessitating the initial phase of training in stump care requiring **all** of the following Intensities of Service.

Intensity of Service

- ☐ **2a.** Two hours of rehabilitation therapy at least five days per week with established goals
- ☐ **2b.** 24-hour observation and monitoring by a licensed nurse
- ☐ **2c.** Patient/family education related to initial phases of patient care

Specifics: _____

_____

Severity of Illness

☐ 3. **Mobility dysfunction** necessitating training in the maintenance and use of prosthesis requiring **all** of the following Intensities of Service.

Intensity of Service

- ☐ **3a.** Two hours of rehabilitation therapy at least five days per week with established goals
- ☐ **3b.** 24-hour observation and monitoring by a licensed nurse
- ☐ **3c.** Patient/family education related to initial phases of patient care

Specifics: _____

_____

Severity of Illness

☐ 4. **Elimination dysfunction** secondary to neurological or surgical changes requiring **at least two** of the following Intensities of Service.

Intensity of Service

- ☐ **4a.** Intermittent catheterizations at least twice per day
- ☐ **4b.** Implementation and monitoring of specified medication regimens
- ☐ **4c.** 24-hour observation and monitoring by a licensed nurse
- ☐ **4d.** Initial stages of extensive bowel and bladder retraining
- ☐ **4e.** Continued observation and education in self-care of an ostomy or suprapubic catheters, or patient/family education related to initial phases of patient care by a licensed nurse

Specifics: _____

_____

Severity of Illness

☐ 5. **Impaired Integument** (infected and/or necrotic skin conditions Stage III or IV decubiti, multiple decubiti, surgical wounds, burns) requiring **at least two** or more of the following Intensities of Service.

Intensity of Service

- ☐ **5a.** Complex dressing changes using aseptic technique with the application of topical medications every eight hours
- ☐ **5b.** IV or IM medications administered at least every eight hours or per therapeutic regime
- ☐ **5c.** IM or IV antibiotics or antifungals per therapeutic regime
- ☐ **5d.** Daily whirlpool therapy
- ☐ **5e.** Wound management requiring 24-hour observation/monitoring and positioning every two hours by a licensed nurse
- ☐ **5f.** Patient/family education related to initial phases of patient care
- ☐ **5g.** Hyperbaric oxygen or magnetic resonance therapy treatment at least daily

Specifics:_____

Severity of Illness

☐ 6. **Unstable medical** condition requiring **at least two** of the following Intensities of Service.

Intensity of Service

- ☐ **6a.** Physician, licensed nurse, and/or licensed respiratory therapist providing observation and monitoring for respiratory distress, clinical complications, and/or cardiac signs and symptoms
- ☐ **6b.** IM or IV medications at least every eight hours or per therapeutic regime
- ☐ **6c.** IM or IV antibiotics or antifungals per therapeutic regime
- ☐ **6d.** Licensed respiratory therapist providing respiratory treatment at least every eight hours
- ☐ **6e.** Instruction in the use of medications and treatment with licensed nursing observation and monitoring
- ☐ **6f.** IV fluids (other than "keep open") and/or blood/blood component administration
- ☐ **6g.** Monitoring of **TWO** of the following every four hours:
  - ☐ **a.** VS - temperature, pulse, respirations, BP
  - ☐ **b.** Lab values/drug levels
  - ☐ **c.** Neurovital signs
  - ☐ **d.** Neurovascular checks - skin color, motor and sensory functions
  - ☐ **e.** Central pressure monitoring
  - ☐ **f.** Intake and output
- ☐ **6h.** Surgical and/or invasive procedure or post-operative care with or without associated complications

Specifics:_____

Severity of Illness

☐ 7. **Mobility/neurological/cognitive** impairment or rehabilitation condition (i.e., seizure, toxin exposure, head injury-trauma) not due to psychiatric disorder associated with the inability to perform ADLs requiring the following intensity of service.

Intensity of Service

- ☐ **7a.** One hour of rehabilitation therapy per day at least five days per week with established goals to include at least one hour of physical therapy

Specifics:_____

Severity of Illness

☐ 8. **Inadequate maintenance of nutritional status** with the potential for improvement or stabilization requiring **at least one** of the following Intensities of Service.

Intensity of Service

- ☐ **8a.** IV fluids other than a "keep open" rate
- ☐ **8b.** Initiation and/or stabilization of enteral feedings
- ☐ **8c.** Assessment of nutritional status, initiation and/or stabilization of a special diet by a multidisciplinary team of licensed professionals

Specifics:_____

Severity of Illness

☐ 9. **Infectious process** requiring **one** of the following Intensities of Service.

Intensity of Service

- ☐ **9a.** IM or IV medications at least every eight hours or per therapeutic regime
- ☐ **9b.** IM or IV antibiotics or antifungals per therapeutic regime
- ☐ **9c.** Specialized treatment modalities

Specifics:_____

EXCLUSIONARY CRITERIA

If patient meets **one or more** of the following criteria, continued stay of care is denied.

- ☐ **1.** Patient does not require 24-hour physician coverage (can include physical medicine and rehabilitation specialist)
- ☐ **2.** Patient requires custodial services
- ☐ **3.** Patient could be treated on an outpatient basis or lower level of care (rehab services three times per week or less to achieve optimal level of functioning)
- ☐ **4.** Patient is unstable for transfer, in which transfer could result in further deterioration or death
- ☐ **5.** Patient is terminally ill with less than six-month survival rate and has requested no medical intervention for the disease process
- ☐ **6.** Patient has severe neurobehavioral disorder requiring a locked ward or specialized treatment team (i.e., Alzheimer's Disease, s/p head injury or toxin exposure).

DISCHARGE CRITERIA

Patient must meet **at least one** to be released.

- ☐ **1.** Patient refuses further treatment
- ☐ **2.** Patient's clinical condition remains stable and functional status remains unchanged for 21 days
- ☐ **3.** Patient and/or family members demonstrate ability to care for patient's physical/medical home care regime
- ☐ **4.** Documented evidence by physical therapy, speech therapy, and occupational therapy that the patient has reached maximum hospital benefit with no potential for further improvement
- ☐ **5.** Documented evidence that the patient has achieved stated goals
- ☐ **6.** Documented evidence of no change in pulmonary condition, mechanical ventilator parameters stabilized within a safe and appropriate range, and there is no potential for further improvement
  - ☐ **A.** Fi02 of 28% or less for 14 days
  - ☐ **B.** Absence of pressure support of greater than 5 cm for 30 days
  - ☐ **C.** No changes in ventilator parameters for 30 days
  - ☐ **D.** No incidence of mucus plugging or other untoward complications for 30 days
  - ☐ **E.** No introduction of respiratory depressant medications within 14 days
- ☐ **7.** Documented evidence that an adequate less intense level of care is available

DISTINCT PART PSYCHIATRIC UNIT ADMISSION/EXTENSION CRITERIA FOR ADULTS

It is the hospital's responsibility to provide Unisys with the specific information necessary for the case review nurse/LMHP to determine that the patient meets admission criteria as specified on this form. Include the following from the medical record: 1) ED record (if any), 2) admit note, 3) physician's orders, and 4) applicable progress notes.

NAME:	CASE #:
MEDICAID ID:	
ICD CODE # (MUST correspond to a DSM-III-R Diagnosis):	

ADMISSION/EXTENSION REFERRAL CRITERIA: At least **ONE** Severity of Illness Criteria must be met. **ALL** Intensity of Service Criteria must be met. No Exclusionary Criteria will be met.

SEVERITY OF ILLNESS CRITERIA

(Must meet **one or more** of 1, 2, or 3)

☐ **1.** Patient presents as a **danger to self** as evidenced by **one or more** of the following:

- ☐ **A.** Recent (within the past 72 hours) suicide attempt
- ☐ **B.** Documentation that the patient has a current suicide plan, specific suicide intent, or recurring suicidal ideation
- ☐ **C.** Documentation of self-mutilative behavior (occurring within the past 72 hours).

Specifics: _____

_____

☐ **2.** Patient presents as a **danger to others** due to a DSM-III-R Axis I diagnosis as evidenced by **one or more** of the following:

- ☐ **A.** Dangerously aggressive behavior during the past seven days due to a DSM-III-R Axis I diagnosis
- ☐ **B.** Threats to kill or seriously injure another person with the means to carry out the threat AND the threatening behavior is due to a DSM-III-R Axis I diagnosis
- ☐ **C.** Documentation that the patient has a current homicide plan, specific homicidal intent, or recurrent homicidal ideation AND this is due to a DSM-III-R Axis I diagnosis.

Specifics: _____

_____

☐ **3.** Patient is **gravely disabled and unable to care for self** due to a DSM-III-R Axis I diagnosis as evidenced by the following **(a selection of indicator A must be accompanied by B or C)**:

- ☐ **A.** Documentation of a serious impairment in function (as compared to others of the same age) in one or more major life role (school, job, family, interpersonal relations, self-care, etc.) due to a DSM-III-R Axis I diagnosis

AND (Indicator A must be accompanied by B **OR** C)

- ☐ **B.** Inability of patient to comply with prescribed psychiatric and/or medical health regimens as evidenced by the following:
  1) Patient has a history of decompensation without psychotropic medications and patient refuses to use these medications as an outpatient
  2) Patient is at risk of health or life due to non-compliance with medical regimens (e.g., insulin-dependent diabetes, etc.) and patient refuses these medical regimens as an outpatient.

OR

- ☐ **C.** Patient presents with acute onset or acute exacerbation of hallucinations, delusions, or illusions of such magnitude that the patient's well being is threatened.

Specifics: _____

_____

INTENSITY OF SERVICE CRITERIA

(Must meet all)

☐ 1. Ambulatory (outpatient) care resources in the community do not meet, and/or do not exist to meet the treatment needs of the patient, or the patient has been unresponsive to treatment at a less intensive level of care; For **each** service listed below, check the appropriate box to indicate the following codes:
Service Alternative ***Tried*** and patient unresponsive,
Service Alternative ***Needed*** (If service was available and/or adequate, it would have been tried),
Service Alternative does ***Not*** provide ***Sufficient*** level of restrictiveness.

SERVICE	TRIED	NEEDED	NOT SUFFICIENT
CRISIS MANAGEMENT			
IN-HOME CRISIS SERVICE			
RESIDENTIAL SERVICES			
PARTIAL HOSPITALIZATION			
DAY PROGRAMS			
MEDICATION MANAGEMENT			
FAMILY SUPPORT SERVICES			
COUNSELING AND THERAPY			
PSYCHOSOCIAL SKILLS TRAINING			
TREATMENT INTEGRATION			
TARGETED CASE MANAGEMENT			
OTHER (SPECIFY)			

AND

☐ 2. Services provided in the hospital can reasonably be expected to improve the patient's condition or prevent further regression so that patient will no longer need the services.

AND

☐ 3. Treatment of the patient's psychiatric condition requires services on an inpatient hospital basis requiring 24-hour nursing observation under the direction of a psychiatrist. **(The patient requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or a responsible other.)** These services include, but are not limited to

A. Suicide precautions, unit restrictions, and continuous observation and limiting of behavior to protect self or others
B. Active intervention by a psychiatric team to prevent assaultive behavior
C. The patient exhibits behaviors that indicate that a therapeutic level of medication has not been reached and this necessitates 24-hour observation and medication stabilization.

Specifics: _____

EXCLUSIONARY CRITERIA

The following categories of patients are not appropriate for admission to a distinct part psychiatric unit.

- ☐ 1. Patients with a major medical or surgical illness or injury that would prevent active participation in a psychiatric treatment program (patients must be medically stable)
- ☐ 2. Patients with criminal charges and who do not have a DSM-III-R Axis I diagnosis
- ☐ 3. Patients whose anti-social behaviors that are a danger to others and those anti-social behaviors are characterological rather than due to a DSM-III-R Axis I diagnosis
- ☐ 4. Patients who have a DSM-III-R Axis II diagnosis of mental retardation without an accompanying DSM-III-R Axis I diagnosis.

Specifics:_____

_____

DISCHARGE CRITERIA

(Must meet **at least one**)

- ☐ 1. Non-compliance with treatment program within three days of admission
- ☐ 2. No improvement within seven days of admission
- ☐ 3. Type/dosage of psychotropics unchanged in last two days
- ☐ 4. Documented by physician that maximum hospital benefit attained
- ☐ 5. Ability to appropriately control behavior
- ☐ 6. Alternative placement/follow-up care arranged
- ☐ 7. Ability to function cooperatively in hospital environment/community.

DATE ADMISSION CERTIFIED:_____ **LOS ASSIGNED:**_____

DATE EXTENSION APPROVED:_____ **LOS EXTENSION:**_____

DISTINCT PART PSYCHIATRIC UNIT ADMISSION/EXTENSION CRITERIA FOR CHILDREN

It is the hospital's responsibility to provide Unisys with the specific information necessary for the case review nurse/LMHP to determine that the patient meets admission criteria as specified on this form. Include the following from the medical record: 1) ED record (if any), 2) admit note, 3) physician's orders, and 4) applicable progress notes.

NAME:	CASE #:
MEDICAID ID#:	CUSTODY:
ICD CODE # (Must correspond to DSM III-R Diagnosis):	

ADMISSION/EXTENSION CRITERIA REQUIREMENTS: At least **ONE** Severity of Illness Criteria must be met. **ALL** Intensity of Service Criteria must be met. No Exclusionary Criteria will be met.

SEVERITY OF ILLNESS CRITERIA

(Child must meet **one** of the following three criteria)

☐ 1. Child presents as a **danger to self** due to a DSM III-R Axis I diagnosis as indicated by the following: (Indicator A, B, or C, **and** D must exist to meet criteria 1)

- ☐ **A.** Documented suicide attempt within the last 24 hours

OR

- ☐ **B.** Documented presence of self-mutilative behavior within the last 24 hours

OR

- ☐ **C.** Documented information from the child or a reliable source that the child has a current suicide plan, specific suicidal intent, or recurrent suicide thoughts, and lethal means available to follow the plan

AND (Indicators A, B, **or** C **must** be accompanied by D below)

- ☐ **D.** It is the judgement of a mental health professional that the child is at significant risk of making a suicide attempt without immediate inpatient intervention.

Specifics: _____

_____

☐ 2. Child presents as a **danger to others/property** due to a DSM III-R Axis I diagnosis as indicated by the following: (Indicator A, B, or C **and** D must exist to meet criteria 2. The criteria must arise from a DSM III-R Axis I diagnosis and include the specific criteria that were met to justify that diagnosis)

- ☐ **A.** Documented dangerously aggressive behavior that was harmful or potentially harmful to others or property within the last 72 hours

OR

- ☐ **B.** Documented threats to kill or seriously injure another person or seriously damage property, and the means to carry out the threats

OR

- ☐ **C.** Documented information from the child or a reliable source that the child has a current plan, specific intent, or recurrent thoughts to seriously harm others or property

AND (Indicators A, B, **or** C **must** be accompanied by D below)

- ☐ **D.** It is the judgement of a mental health professional that the child is at significant risk of making a homicide attempt or engaging in other seriously aggressive behavior without immediate inpatient intervention.

Specifics: _____

_____

☐ 3. Child presents as **gravely disabled** due to a DSM III-R Axis I diagnosis as indicated by the following (Indicator A and either B, C, or D must exist to meet criteria 3. The criteria must arise from a DSM III-R Axis I diagnosis and include the specific criteria that were met to justify that diagnosis)

☐ A. The child has serious impairment of functioning compared to others of the same age in one or more major life roles (school, family, interpersonal relations, self-care, etc.) Specific description of the following must be documented:

☐ 1) Deficits in control, cognition, or judgement

☐ 2) Circumstances resulting from those deficits in self-care, personal safety, social/family functioning, academic, or occupational performance

☐ 3) Prognostic indicators which predict the effectiveness of acute treatment.

AND (Indicator A **must** be accompanied by B, C, **or** D below)

☐ **B.** The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child unmanageable and unable to cooperate in non-hospital treatment

OR

☐ **C.** There is a need for medication therapy or complex diagnostic testing where the child's level of functioning precludes cooperation with treatment in an outpatient or non-hospital based regimen, and may involve forced administration of medication

OR

☐ **D.** A medical condition co-exists with a DSM III-R Axis I diagnosis which, if not monitored/treated appropriately, places the child's life or well-being at serious risk.

Specifics: _____

_____

INTENSITY OF SERVICE CRITERIA

(Child must meet criteria 1, 2, **and** 3)

☐ 1. Services in the community do not meet, and/or do not exist to meet the treatment needs of the child, or the child has been unresponsive to treatment at a less intensive level of care. For each service listed below, check the appropriate box using the following codes:

Service Alternative ***Tried*** and child unresponsive,

Service Alternative ***Needed*** (Service exists but no available slots or service does not exist; if service had been available it would have been tried),

Service Alternative does ***Not*** provide ***Sufficient*** level of restrictiveness.

SERVICE	TRIED	NEEDED	NOT SUFFICIENT
CRISIS MANAGEMENT			
IN-HOME CRISIS SERVICE			
RESIDENTIAL SERVICES			
PARTIAL HOSPITALIZATION			
DAY PROGRAMS			
MEDICATION MANAGEMENT			
FAMILY SUPPORT SERVICES			
COUNSELING AND THERAPY			
PSYCHOSOCIAL SKILLS TRAINING			
TREATMENT INTEGRATION			
TARGETED CASE MANAGEMENT			
OTHER (SPECIFY)			

AND

☐ 2. Services provided in the hospital can reasonably be expected to improve the child's condition or prevent further regression so that the services will no longer be needed by the child.

AND

☐ 3. Treatment of the child's psychiatric condition requires services on an inpatient basis including 24-hour nursing observation, under the direction of a psychiatrist. **(The child requiring this treatment must not be on independent passes or unit passes without observation or being accompanied by hospital personnel or a responsible other.)** These services include, but are not limited to

A. Suicide precautions, unit restrictions, and continual observation and limiting of behavior to protect self or others or property

B. Active intervention by a psychiatric team to prevent assaultive behavior

C. 24-hour observation and medication stabilization because the child exhibits behaviors that indicate that a therapeutic level of medication has not been reached.

Specifics: _____

_____

EXCLUSIONARY CRITERIA

If child meets **one or more** of the following criteria, admission is **denied.**

- ☐ **1.** The child has a major medical or surgical illness or injury that prevents active participation in a psychiatric treatment program.
- ☐ **2.** The child has criminal charges and does not meet severity and intensity criteria.
- ☐ **3.** The child has anti-social behaviors that are a danger to others and the anti-social behaviors are characterological rather than due to a DSM III-R Axis I diagnosis.
- ☐ **4.** The child has a DSM III-R Axis II diagnosis of mental retardation and does not meet severity and intensity criteria.
- ☐ **5.** The child lacks a place to live and/or family supports and does not meet severity and intensity criteria.
- ☐ **6.** The child has been suspended or expelled from school and does not meet severity and intensity criteria.

Specifics:_____

_____

DISCHARGE CRITERIA

(Must meet at least **one**)

- ☐ **1.** Failure to comply with treatment program within three days of admission
- ☐ **2.** Failure to improve within seven days of admission
- ☐ **3.** Type/dosage of psychotropics unchanged in last two days
- ☐ **4.** Documented by physician that maximum hospital benefit attained
- ☐ **5.** Ability to appropriately control behavior
- ☐ **6.** Alternative placement/follow-up care arranged
- ☐ **7.** Ability to function cooperatively in hospital environment.

DATE ADMISSION CERTIFIED:_____ **LOS ASSIGNED:**_____

DATE EXTENSION APPROVED:_____ **LOS EXTENSION:**_____

HOSPITAL-BASED ALCOHOLISM AND DRUG TREATMENT UNITS

It is the hospital's responsibility to provide Unisys with the specific information necessary for the case review nurse to determine if the patient meets all admission criteria as specified on these forms. Include the following from the medical record: 1) ED record (if any), 2) admit note, 3) physician's orders, and 4) applicable progress notes.

NAME:	CASE #:
MEDICAID ID:	
ICD CODE #:	

ADMISSION CRITERIA REQUIREMENTS: From the Severity of Illness, the patient must meet criteria 1 **AND** criteria 2 (by meeting indicator A, B, **OR** C), **AND** all Intensity of Service criteria.

SEVERITY OF ILLNESS CRITERIA

(Must meet 1 **AND** one or more indicators from 2)

☐ 1. Admit only patients assessed as meeting the criteria for substance use disorder and principle diagnosis of substance abuse as defined by the current revision of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* or "Mental Disorders" in the current revision of *International Classification of Diseases.*

Specifics:_____

_____

AND

☐ 2. Certify that the patient meets the specifications in one of the dimensions of A, B, or C as listed below.

- ☐ A. Acute alcohol and/or other drug intoxication and/or potential withdrawal (**one** of the following)
  - ☐ 1) Patient assessed as being at risk for severe withdrawal syndrome as evidenced by
    - ☐ **a)** CIWA-A (Clinical Institute Withdrawal Assessment-Alcohol) score (or other comparable standardized scoring system) greater than or equal to 20
    - ☐ **b)** Blood alcohol greater than 0.1 gm% with withdrawal symptoms present, or blood alcohol greater than 0.3 gm%
    - ☐ **c)** Pulse greater that 110 or blood pressure higher than 160/100 and CIWA-A or comparable score greater than 10
    - ☐ **d)** History of seizures, hallucinations, myoclonic contractions, or delirium tremens when withdrawing from similiar amounts of alcohol
    - ☐ **e)** Seizure, delirium tremens, hallucinations, myoclonic contractions, or hyperpyrexia
    - ☐ **f)** Daily ingestion of sedative hypnotics for over six months plus daily alcohol use, or regular use of another mind-altering drug known to have its own withdrawal syndrome, and the patient has an accompanying chronic mental/physical disorder
    - ☐ **g)** Daily ingestion of sedative hypnotics above the recommended therapeutic dosage level for at least four weeks and the patient has an accompanying chronic mental/physical disorder
    - ☐ **h)** Antagonist medication used in the withdrawal (e.g., pharmacological induction of opiate withdrawal and subsequent management)
    - ☐ **i)** Recent (within 24 hours) head trauma or loss of consciousness with resultant need to observe intoxicated patient closely
    - ☐ **j)** History of opioid use exhibiting grade two or above opioid withdrawal (e.g., muscle twitching, myalgia, arthralgia, anorexia, nausea, vomiting, diarrhea, extremes of vital signs, dehydration, or "curled up position") requiring acute nursing care for management
    - ☐ **k)** Drug overdose compromising mental status, cardiac functioning, or other vital signs
    - ☐ **l)** History of daily opioid use for at least two weeks prior to admission and past attempts to stop at similar doses have resulted in one or more of the following signs and symptoms of withdrawal: muscle twitching, myalgia, arthralgia, abdominal pain, rapid breathing, fever, anorexia, nausea, vomiting, diarrhea.
  - ☐ 2) There is a strong likelihood patient will not complete detoxification or enter into continuing addiction treatment as evidenced by
    - ☐ **a)** Past history of detoxification at a less intense level of care without completion of detoxification or entry into a continuing addictions treatment program
    - ☐ **b)** Current use of medications or presence of medical conditions known to interfere with ability to complete detoxification (MAO inhibitors in association with alprazolam)

☐ 3) This is the only available level of care that can provide the needed medical support and comfort for the patient as evidenced by
- ☐ a) Detoxification regimen or patient's response to the regimen requires monitoring at least every two hours (e.g., clonidine detoxification with opiates or high dose benzodiazepine withdrawal)
- ☐ b) Detoxification required while pregnant.

Specifics: _____

OR

☐ B. Biomedical conditions and complications due to a primary diagnosis of a substance use disorder (one of the following)
- ☐ 1) Biomedical complications of addiction requiring medical management and skilled nursing care
- ☐ 2) Concurrent biomedical illness or pregnancy needing stabilization and daily medical management with daily primary nursing interventions
- ☐ 3) Presence of biomedical problems requiring inpatient diagnosis and treatment such as
  - ☐ a) Liver disease or problems with impending hepatic decompensation
  - ☐ b) Acute pancreatitis requiring parenteral treatment
  - ☐ c) Active gastrointestinal bleeding
  - ☐ d) Cardiovascular disorders requiring monitoring
  - ☐ e) Multiple current medical problems
- ☐ 4) Recurrent or multiple seizures
- ☐ 5) Disulfiram-alcohol reaction
- ☐ 6) Life-threatening symptomatology related to excessive use of alcohol or other drugs (stupor, convulsions, etc.)
- ☐ 7) Chemical use gravely complicating or exacerbating previously diagnosed medical conditions
- ☐ 8) Changes in medical status such as a severe worsening of a medical condition making abstinence imperative, or significant improvement in a previously unstable medical condition allowing the patient to respond to chemical dependency treatment
- ☐ 9) The patient demonstrates other biomedical problems requiring 24-hour observation and evaluation.

Specifics: _____

OR

☐ C. Emotional/behavioral conditions and complications due to a primary diagnosis of a substance use disorder (one of the following)
- ☐ 1) Emotional/behavioral complications of addiction requiring medical management and skilled nursing care
- ☐ 2) Concurrent emotional/behavioral illness needing stabilization and daily medical management and primary nursing interventions
- ☐ 3) Uncontrolled behavior endangering self or others
- ☐ 4) Co-existing serious emotional/behavioral disorder which complicates the treatment of chemical dependency and requires differential diagnosis and treatment
- ☐ 5) Extreme depression presenting in patient resulting in the patient being a a danger to self or others
- ☐ 6) Thought process impairment, impairment in abstract thinking, limitation in ability to conceptualize to the degree that major life areas are severely impaired
- ☐ 7) Alcohol and other drug use gravely complicates or exacerbates previously diagnosed psychiatric or emotional/ behavioral condition
- ☐ 8) Altered medtal status with or without delirium as manifested by
  - ☐ a) Disorientation to self
  - ☐ b) Alcoholic hallucinations
  - ☐ c) Toxic psychosis.

Specifics: _____

INTENSITY OF SERVICE

(One or more must be met)
- ☐ 1. Intensive treatment with medications for delirium tremens
- ☐ 2. IV medications or total parenteral nutrition (T.P.N.)
- ☐ 3. Documented detoxification regime of decreasing drug dosage
- ☐ 4. Neurological checks and vital signs every two hours and "visual checks" every 15 minutes
- ☐ 5. Environmental control such that the patient is prevented from harming self or others.

Specifics: _____

DATE ADMISSION CERTIFIED:_____ LOS ASSIGNED:_____

EXTENSION CRITERIA - SEVERITY OF ILLNESS

Length of stay will vary with the severity of the illness and the response to treatment (**criteria 1 and 2 must be met**)

- ☐ 1. Patient continues to meet the diagnostic criteria required for admission.
- ☐ 2. To comply with criteria 2, one of the following must be met.
  - ☐ A. Acute alcohol and/or drug intoxication and/or potential withdrawal, persistence of acute withdrawal symptomatology or detoxification protocol requires continued medical and/or nursing management on a 24-hour basis
  - ☐ B. Biomedical conditions and complications
    - ☐ 1) Continued biomedical problem or intervening medical event which was serious enough to interrupt treatment, but the patient is again progressing in treatment
    - ☐ 2) Biomedical condition initially interfering with treatment is improving, yet the 24-hour continued medical management for this condition along with the treatment for the addiction is required
  - ☐ C. Emotional/behavioral conditions and complications
    - ☐ 1) Noted progress toward resolution of a concomitant emotional/behavioral problem, but continued medically managed and nursing interventions are needed before transfer to a less intensive level of care
    - ☐ 2) Assessed as having an Axis I psychiatric condition or disorder according to the current revision of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, or its equivalent, which in combination with alcohol and/or other drug use, continues to present a major health risk and is actively being treated (e.g., medication stabilization).

Specifics:_____

_____

INTENSITY OF SERVICE

(**One or more** must be met)

- ☐ 1. Intensive treatment with medications for delirium tremens
- ☐ 2. IV medications or total parenteral nutrition (T.P.N.)
- ☐ 3. Documented detoxification regime of decreasing drug dosage
- ☐ 4. Neurological checks and vital signs every two hours and "visual checks" every 15 minutes
- ☐ 5. Environmental control such that the patient is prevented from harming self or others.

Specifics:_____

_____

DISCHARGE CRITERIA

(Must meet criteria 1 **or** 2)

- ☐ 1. The patient is assessed post-admission as not having met the diagnostic criteria for psychoactive substance use disorder as defined by the current revision of American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* or the current revision of the *International Classification of Diseases*.

OR

- ☐ 2. Must meet one of the following:
  - ☐ A. Acute alcohol and/or other drug intoxification and/or potential withdrawal. Assessed as not being intoxicated or in alcohol or other drug withdrawal or the symptoms have diminished sufficiently to be managed in a less intensive level of care, and does not meet any extension criteria that indicate the need for further treatment
  - ☐ B. Biomedical conditions or complications
    - ☐ 1) Biomedical problems, if any, have diminished or stabilized to the extent that daily medical and nursing management for the condition is no longer necessary, and the patient does not meet any of the extension criteria that indicate the need for further treatment
    - ☐ 2) Biomedical condition has arisen or an identified biomedical problem which is being addressed is not responding to treatment and needs treatment in another setting
  - ☐ C. Emotional/behavior conditions and complications
    - ☐ 1) Emotional/behavioral problems have diminished in acuity and no longer necessitate daily medical and nursing management, and do not meet any of the extension criteria that indicate the need for further treatment
    - ☐ 2) An emotional/behavioral condition has arisen or an identified emotional/behavioral problem which is being addressed is not responding to treatment and needs treatment in another setting
  - ☐ D. Treatment resistance
    - ☐ 1) Consistently refuses continued treatment despite motivating interventions, and does not meet any of the extension criteria that indicate the need for further treatment.

DATE EXTENSION APPROVED:_____ LOS EXTENSION:_____

REHABILITATION HOSPITAL LENGTH OF STAY CRITERIA

It is the hospital's responsibility to provide Unisys with the specific information necessary for the case review nurse/LMHP to determine if the patient meets admission criteria as specified on this form. Include the following from the medical record: 1) ED record, if any, 2) admit date, 3) physician's orders, and 4) applicable progress notes.

NAME:	CASE #:
MEDICAID ID:	
ICD CODE #:	

EXTENSION REQUIREMENT: From the Severity of Illness, the patient must meet at least one element from criteria 1 **OR** 2, **AND**, from criteria 3, the patient must meet one element from A through E **AND** F **AND** G. All Intensity of Service criteria must be met.

SEVERITY OF ILLNESS

(Must meet either criteria 1 or 2, **and** from criteria 3 any one of the elements A through E **and** elements F **and** G)

☐ 1. Physical—Inability to function independently as demonstrated by meeting one element from A, B, or C, with the potential for significant practical improvement as measured against his/her condition prior to rehabilitation

- ☐ A. Activities of daily living (any one of)
  - ☐ 1) Feeding
  - ☐ 2) Personal hygiene
  - ☐ 3) Dressing

OR

- ☐ B. Mobility (any one of)
  - ☐ 1) Transfers
  - ☐ 2) Wheelchair
  - ☐ 3) Ambulation
  - ☐ 4) Stair climbing

OR

- ☐ C. Communicative/Cognitive (must be accompanied by either element A or B)
  - ☐ 1) Aphasia and major receptive and/or expressive components
  - ☐ 2) Cognitive dysfunction (e.g., attention span, confusion, memory, intelligence)
  - ☐ 3) Perceptual motor dysfunction area (e.g., spatial orientation, visual-motor, depth and distance perception).

Specifics:_____

_____

OR

☐ 2. Somatic Dysfunction

- ☐ A. Somatic dysfunction which significantly impairs the individual's efficiency of performance (e.g., spasticity, incoordination, paresis, bowel and bladder dysfunction, gait disturbance, dysarthria, dyskinesia).

Specifics:_____

_____

AND

☐ 3. Comprehensive Rehabilitative Status (any **one** of A through E **and** F **and** G)

- ☐ **A.** Has had no previous comprehensive rehabilitative effort or previous rehabilitative efforts for the same condition showed little or no improvement, but because of an intervening circumstance, rehabilitation is now considered reasonable
- ☐ **B.** Previously has been unable to attain rehabilitation goals which are currently considered attainable because of techniques or technology not previously available to the patient. This may include previous trials of outpatient therapy with unsatisfactory response
- ☐ **C.** Has lost previous level of attained functional independence due to complicating intercurrent illness, and reattainment of functional independence currently is feasible
- ☐ **D.** The patient is medically stable, but has complications which require special care during rehabilitation goals or attainment of goals
- ☐ **E.** Documented objective evidence of a significant change in a the patient's function requiring a planning evaluation or re-evaluation of rehabilitation goals or attainment of goals

AND

- ☐ **F.** Significant practical improvement expected in a reasonable period of time. It is not necessary that there be an expectation of complete independence in the activities of daily living, but there must be a reasonable expectation of improvement that will be of practical value to the patient, measured against his/her condition at the start of the rehabilitation program

AND

- ☐ **G.** The patient has sufficient mental alertness to participate in the program.

Specifics:_____

_____

INTENSITY OF SERVICE

(Must meet 1, 2, **and** 3)

☐ **1.** Medical management by a physician and a registered nurse

Specifics:_____

_____

AND

☐ **2.** The provision of at least one of the following services for a minimum of three hours per day and no less than five days a week:

- ☐ **A.** Occupational therapy
- ☐ **B.** Physical therapy
- ☐ **C.** Speech/language pathology services and/or prosthetic/orthotic services (must be a combination of these two services or one in conjunction with OT or PT)

Specifics:_____

_____

AND

☐ **3.** Evidence of periodic multi-disciplinary rehabilitation team review at least every two weeks with documentation of progress and recommendations for continuing rehabilitation program.

Specifics:_____

_____

DISCHARGE CRITERIA

(Must meet at least **ONE**)

- ☐ **1.** Evidence is in record that the patient has achieved stated goals
- ☐ **2.** Medical complications preclude intensive rehabilitative effort
- ☐ **3.** Multi-disciplinary therapy is no longer needed
- ☐ **4.** No additional function improvement is anticipated
- ☐ **5.** Patient's functional status has remained unchanged for 14 days.

DATE EXTENSION APPROVED:_____ **LOS EXTENSION:**_____

SUMMARY OF PRE-CERTIFICATION/LENGTH OF STAY POLICY

LENGTH OF STAY

PRE-CERT TYPE/LOC		INITIAL	1ST EXT.	SUBSEQUENT
Distinct part psych	(type 01)	50th percentile	75th percentile	3 days
Long-term hosp.	(type 02)	14 days	14 days	7 days
Acute hosp.	(type 03)	50th percentile	75th percentile	3 days
Rehab	(type 03)	14 days	7 days	7 days

ISD REVIEW RULES SUMMARY FOR ADULTS/CHILDREN

PRE-ADMISSION
- Planned *IS* must be met for scheduled admission/procedure

ADMISSION
- At time of admission *SI* and/or *IS* must be met

EXTENSION
- On renewal date, *IS* must be met. If *IS* met, *SI* must be met.

DISCHARGE
- When *IS* no longer met:
  - Clinical/functional DS met, schedule for discharge today
  - Clinical/functional DS not met, review next day
- When *IS* met and *IS* no longer met:
  - Clinical/functional DS met, explore options

MAXIMUM RESPONSE TIMES
(Begins When All Necessary Information Received)

	ACUTE CARE/REHAB	LONG-TERM HOSP.	PSYCH.
Initial LOS	24 hours	24 hours	4 hours
LOS Extension	4 hours	24 hours	24 hours
Pre-Cert Review	N/A	24 hours	4 hours
Retrospective Review	21 days	21 days	21 days

CONTACT PHONE NUMBERS

PRE-CERTIFICATION/LOS 1-800-877-0666

PRE-CERTIFICATION FAX 1-800-717-4329

PROVIDER RELATIONS 1-800-473-2783
(Billing, Inquiries, General Information, and Questions)

MAIL TO:
UNISYS / LA MEDICAID
P.O. BOX 14919
Baton Rouge, LA 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

ICN

PRIOR AUTHORIZATION TYPE:
- ☐ 01 INPATIENT
- ☐ 05 REHABILITATION
- ☐ 07 AIR AMBULANCE
- ☐ 09 DME
- ☐ 99 OTHER

RECIPIENT ID NUMBER

SOCIAL SECURITY NUMBER

RECIP LAST NAME FIRST MI

DATE OF BIRTH

PROVIDER NUMBER

DATES OF SERVICE
FROM THRU

INPATIENT EXT: ☐ YES ☐ NO
TOTAL DAYS: _____

DIAGNOSIS
PRIMARY CODE AND DESCRIPTION

SECONDARY CODE AND DESCRIPTION

P.A. REVIEWER SIGNATURE

STATUS CODES:
2 = APPROVED
3 = DENY
4 = PEND

PRESCRIBING PHYSICIANS NAME \ NUMBER

PRESCRIPTION DATE

PRIOR AUTHORIZATION NUMBER

DESCRIPTION OF SERVICES

SHADED FOR OFFICE USE ONLY

PROCEDURE CODE	DESCRIPTION	BILLED UNITS	BILLED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT	DATE	STATUS

PROVIDER NAME, ADDRESS, TELEPHONE

DATE OF REQUEST

PLACE OF RESIDENCE \ TREATMENT
HOME ☐ LTC ☐ INPATIENT ☐ OUTPATIENT ☐

COMMENTS:

PROVIDER SIGNATURE: _____

P A 01
ISSUED 1/91

MAIL TO:
UNISYS / LA MEDICAID
P.O. BOX 14919
Baton Rouge, LA 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
Medical Assistance Program
REHABILITATION SERVICES REQUEST

PATIENT NAME:_____ AGE:____ PROVIDER NAME: _____

BACKGROUND INFORMATION

DATE OF ACCIDENT OR SURGERY:_____

LIMITATIONS: ☐ AMBULATORY ☐ NON-AMBULATORY TRANSPORTATION AVAILABLE ☐ YES ☐ NO

AIDS NEEDED: ☐ WALKER ☐ CANE ☐ WHEELCHAIR ☐ LIMBS OR BRACE ☐ OTHER:_____

REHABILITATION PLAN

PLAN OF SERVICE. ☐ INITIAL ☐ EXTENSION

IF INITIAL, INITIAL EVALUATION DATA AND MD REFERRAL MUST BE ATTACHED.

IF EXTENSION, PRIOR ATTENDANCE: ☐ REGULAR ☐ NON-REGULAR

REQUESTED SERVICES:	PROCEDURE CODE	DESCRIPTION	FREQUENCY	TIME/ VISIT	TOTAL UNITS
PHYSICAL THERAPY:					
SPEECH THERAPY:					
OCCUPATIONAL THERAPY:					

LENGTH OF PLAN SERVICE: FROM:_____ TO:_____
MONTH DAY YEAR MONTH DAY YEAR

DATE OF RE-EVALUATION:_____
MONTH DAY YEAR

PROPOSED GOALS/COMMENTS:_____

REQUESTED BY:_____ DATE:_____

MANUAL UPDATES

It is very important to read all the following documentation, as it contains information in addition to that found in the Hospital Services Manual issued September 15, 1994.

Please note that the following pages were issued after the printing of the manual.

The information in the 1998 Hospital Training packet, Medicaid Issues for 1998, was published in September, 1998.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Edwin W. Edwards
GOVERNOR

LOUISIANA
Department of
HEALTH and
HOSPITALS
Rose V. Forrest
SECRETARY

M E M O R A N D U M

TO: HOSPITALS PARTICIPATING IN THE MEDICAID PROGRAM

FROM: THOMAS D. COLLINS
DIRECTOR

DATE: April 20, 1995

RE: NEW PROCEDURE FOR OBTAINING APPROVAL OF AN OUTPATIENT SURGERY PERFORMED ON AN INPATIENT BASIS

In the past we required that an approval for an outpatient surgery performed on an inpatient basis be obtained from the Unisys Prior Authorization Unit.

Recently we developed a new procedure for obtaining approval of outpatient surgeries performed on an inpatient basis so that an approval will now be obtained from the Pre-Certification Unit rather than the Prior Authorization Unit.

Some providers have advised that they feel this new procedure is a violation of the Department's agreement to approve the first 24 hours of the hospital stay for acute care cases for eligible recipients. We apologize for any misunderstanding. However, it was never our intention to give a blanket approval for the first 24 hours on any stay where medical necessity for a minimum of 24 hours inpatient care is not met, or when there is no length of stay for the diagnoses code. We cannot approve reimbursement for a planned outpatient surgical procedure provided on an inpatient basis for a recipient who has no medical reason to be admitted.

The following procedure has been implemented for an outpatient surgery performed on an inpatient basis when the procedure is planned within the first two days of the hospital stay.

1. The provider performing the surgery will complete the attached PCF02 form, Request for Hospitalization of an Outpatient Procedure, submit it to the hospital for transmission with the PCF01 request for Pre-Certification and LOS Assignment.

2. The BHSF Physician will review this information to determine the approval or denial status of the admission. If approved, LOS is assigned based on the primary diagnosis. If denied, no LOS is assigned and the hospital and provider performing the surgery are refused authorization.

3. The claim submitted by the provider performing the surgery may indicate the Pre-Certification number in Item #23 on the HCFA 1500 or the Prior-Authorization/Pre-Certification number field on the EMC record. If the claim is submitted without this number, Unisys will attempt to match Pre-Certification using the recipient identification number and dates of service.

If you have any questions or comments in reference to this correspondence, please telephone James Phillips at telephone number (504) 342-3935.

TDC\BEG\JRP

Attachment

cc: Gary Hulshoff, Ph.D.
Charles Lucey, MD
Peggy Misner

INSTRUCTIONS FOR FORM PCF02: REQUEST FOR ACUTE CARE EXTENSION, PHYSICIAN RECONSIDERATION REVIEW, OR HOSPITALIZATION FOR OUTPATIENT PROCEDURES

Notes for Acute Care Extension and Physician Reconsideration Revew:

1) **Every field must be filled in.**
2) When using this form for extension or review, you **must attach a completed P.C.F01.**

Notes for Hospitalization for Outpatient Procedures:

1) In the "Suggested Guidelines for Medical Documentation" sections (9 - 16), only fields 10, 11, 14, and 16 are **required.**
2) When using this form for hospitalization for outpatient procedures, you **must attach a completed P.C.F01.**

Any incomplete form WILL BE REJECTED.

1 Enter the assigned Pre-Certification Case Number if this is an extension or reconsideration. If this is an initial request for hospitalization for an outpatient procedure, leave this field blank.

2 Enter the 13-digit recipient Medicaid identification number.

3 Enter the recipient's last name, first name, and middle initial.

4 Enter the seven-digit hospital Medicaid number.

5 Enter the admitting and primary (if applicable) ICD-9-CM diagnosis codes if this is an initial request. If this is an extension request, enter the extension ICD-9-CM diagnosis code. **Either an admitting or an extension diagnosis code is required. Also, the description of the diagnosis is required.**

6 Enter the appropriate outpatient surgical procedure codes.The surgeon should enter the appropriate CPT codes and the hospital should enter the appropriate ICD-9-CM surgical procedure codes.

7 Enter the anticipated or actual date of surgery (if applicable).

8 Check in the appropriate box the type of request: hospital extension, physician review, or outpatient procedure.

9 Indicate the number of physician evaluations performed per 24 hours.

10-16 Use these fields to complete pertinent medical information regarding the recipient. If additional information is necessary, up to two pages may be submitted.

17 This field contains the signature of the UNISYS Pre-Cert medical reviewer.

18 This field is entered by the UNISYS Pre-Cert medical reviewer and contains the date of the review (MM/DD/YY).

19 **An authorized signature is required. Requests will not be accepted if not signed.**

20 Enter the date this request is submitted to UNISYS

STATE OF LOUISIANA DHH - BHSF
MEDICAL ASSISTANCE PROGRAM

Request for Acute Care Extension, Physician Reconsideration Review, or Hospitalization for Outpatient Procedures

Please Print or Type

(1) PRE-CERT CASE #

(2) RECIPIENT ID NUMBER	(3) RECIPIENT LAST NAME FIRST MI	(4) PROVIDER NUMBER

(5) ICD-9 DIAGNOSIS & DESCRIPTION	(6) SURGICAL PROCEDURE		(7) SURGERY DATE	(8) REQUEST TYPE
	CPT CODES (Physician)	ICD-9 (Hospital)		
ADMITTING.	1	1		Hospital Extension ☐
PRIMARY	2	2	___/___/___	Physician Reconsid-eration Review ☐
EXTENSION:	3	3		Outpatient Procedure ☐

SUGGESTED GUIDELINES FOR MEDICAL DOCUMENTATION

Please complete pertinent information for recipient. If additional information is necessary, up to two pages may be attached.

Physician Evaluations _____ ***times per 24 hours*** (9)

Past Medical History: (10)

Physical Exam Findings (Pertinent to request type) (11)

Vital Signs (List frequency If febrile, list date and time. If cultures done, list date and result): (12)

IV (List type and rate. Include ALL IV fluids and T.P.N.): (13)

Medications (List with dosage, route, and frequency, especially those relating to request type): (14)

Labs, X-Rays, and Procedures (List those pertinent to request type) (15)

Summary of Medical Necessity for Hospitalization: (16)

MEDICAL REVIEWER SIGNATURE (17)	DATE OF REVIEW (18)

PROVIDER SIGNATURE:_____ (19)

DATE OF REQUEST._____ (20)

STATE OF LOUISIANA DHH - BHSF

MEDICAL ASSISTANCE PROGRAM

Request for Acute Care Extension, Physician Reconsideration Review, or Hospitalization for Outpatient Procedures

Please Print or Type

PRE-CERT CASE #		
RECIPIENT ID NUMBER	RECIPIENT LAST NAME FIRST MI	PROVIDER NUMBER

ICD-9 DIAGNOSIS & DESCRIPTION	SURGICAL PROCEDURE		SURGERY DATE	REQUEST TYPE
ADMITTING	CPT CODES (Physician)	ICD-9 (Hospital)		Hospital Extension ☐
	1	1		
PRIMARY.			___/___/___	Physician Reconsid-eration Review ☐
	2	2		
EXTENSION				Outpatient Procedure ☐
	3	3		

SUGGESTED GUIDELINES FOR MEDICAL DOCUMENTATION

Please complete pertinent information for recipient. If additional information is necessary, up to two pages may be attached.

Physician Evaluations _____ times per 24 hours

Past Medical History:

Physical Exam Findings (Pertinent to request type):

al Signs (List frequency If febrile, list date and time. If cultures done, list date and result):

IV (List type and rate. Include ALL IV fluids and T.P.N.):

Medications (List with dosage, route, and frequency, especially those relating to request type).

Labs, X-Rays, and Procedures (List those pertinent to request type).

Summary of Medical Necessity for Hospitalization:

MEDICAL REVIEWER SIGNATURE	DATE OF REVIEW

PROVIDER SIGNATURE:_____ **DATE OF REQUEST:**_____

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS
Bobby P. Jindal
SECRETARY

JULY 23, 1996

MEMORANDUM

TO: HOSPITALS PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAM

FROM: THOMAS D. COLLINS
ACTING DIRECTOR

RE: MEDICAID BUDGET CUTS FOR OUTPATIENT REHABILITATION SERVICES

Effective August 1, 1996 the Department will discontinue the current Medicaid reimbursement methodology for physical therapy, occupational therapy, and speech therapy services provided in an outpatient hospital setting. Reimbursement will be made at the same rate at which we pay freestanding rehabilitation clinics. This action is necessary to avoid a budget deficit in the medical assistance programs due to the lack of sufficient state funds required to match federal financial participation mandated under Title XIX of the Social Security Act. It will also bring about uniformity in billing and reimbursement for these services regardless if provided in a hospital or freestanding rehabilitation clinic. We are publishing an emergency rule to affect this change.

Beginning with date of service August 1, 1996 and after, payment for these services will be made in accordance with the rates loaded for the procedure codes which begin with Y under Type of Service 03 (TOS 03). These codes are already being used in the Rehabilitation Clinic Program. Prior authorization procedures will remain the same, except that hospitals will be required to request services using the Y procedure codes in accordance with the descriptions given for them.

When billing for these services, hospitals will be required to use the applicable revenue code and the appropriate procedure code for the service which corresponds to that revenue code. The revenue code must be indicated in Form Locator 42 of the UB-92. The procedure code must be indicated in Form Locator 44 on the UB-92. The only valid revenue codes for rehabilitation services are:

420	421	422	424	430	431	432
434	440	441	442	443	444	454

If you fail to list the correct procedure code in conjunction with any of these revenue codes, the claim will deny with error code 114, invalid or missing hcpc. If you use a code which is not on the attached list, the claim will deny with error code 115, "hcpc code not on file".

A listing of the Y procedure codes, code descriptions, rates, and the corresponding revenue codes is attached. When more than one revenue code is given in the left column corresponding to the procedure code and its' file description, you may use any of the revenue codes given in that column.

Questions or comments regarding this memorandum should be directed to James Phillips at telephone number (504) 342-3935.

Attachments

REVENUE CODES AND PROCEDURE CODES

Revenue Code	Description of Procedure Code	Procedure Code	Rate
	Evaluation Procedures		
424	Physical therapy evaluation	Y7702	$43.74
434	Occupational therapy evaluation	Y7812	$41.31
444	Speech evaluation	Y2602	$36.45
444	Hearing evaluation	Y2612	$36.45
454	Wheelchair seating evaluation	Y7902	$41.31
	Physical Therapy Procedures		
420, 421	Physical therapy, one modality	Y7000	$12.96
420, 421	Physical therapy, 2 or more modalities	Y7050	$19.44
420, 421	P.T. - 1 or more proc. and/or mod., 15 min.	Y7106	$ 6.48
420, 421	P.T. - with procedures, 20 minutes	Y7105	$10.80
420, 421	P.T. - with procedures, 30 minutes	Y7100	$12.96
420, 421	P.T. - with procedures, 45 minutes	Y7101	$19.44
420, 421, 422	P.T. - with procedures, 60 minutes	Y7102	$25.92
420, 421, 422	P.T. - with proc. and mod., 60 minutes	Y7202	$28.80
420, 421	P.T. - with procedures, 75 minutes	Y7103	$36.00
420, 421	P.T. - with procedures, 90 minutes	Y7104	$43.20
	Occupational Therapy Procedures		
430, 431	Occupational therapy, 15 minutes	Y7810	$ 4.14
430, 431	Occupational therapy, 20 minutes	Y7811	$ 5.51
430, 431	Occupational therapy, 30 minutes	Y7813	$ 8.27
430, 431	Occupational therapy, 45 minutes	Y7814	$11.18
430, 431, 432	Occupational therapy, 60 minutes	Y7815	$14.10
	Speech Therapy Procedures		
440, 441	Speech and hearing therapy, 15 minutes	Y2609	$ 6.48
440, 441	Speech and hearing therapy, 20 minutes	Y2611	$ 8.10
440, 441	Speech therapy, 30 minutes	Y2613	$12.15
440, 441	Speech therapy, 45 minutes	Y2614	$18.63
440, 441, 442	Speech therapy, 60 minutes	Y2615	$24.30
	Group Speech Therapy Procedures		
443	Group speech therapy, 20 minutes	Y2510	$ 4.05
443	Group speech therapy, 30 minutes	Y2509	$ 6.48
443	Group speech therapy, additional 15 minutes	Y2511	$ 3.24
443	Group speech therapy, 1 hour	Y2512	$12.96

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS
Bobby P. Jindal
SECRETARY

August 6, 1996

M E M O R A N D U M

TO: HOSPITALS PARTICIPATING IN THE TITLE XIX MEDICAL ASSISTANCE PROGRAM

FROM: THOMAS D. COLLINS
ACTING DIRECTOR

RE: CHANGES IN MEDICAID REIMBURSEMENT RATES FOR OUTPATIENT LABORATORY SERVICES

Effective for dates of service August 1, 1996 and after, the Department of Health and Hospitals will reduce the reimbursement rate for outpatient hospital laboratory services subject to the Medicare fee schedule by five percent (5%).

This action is necessary to avoid a budget deficit in the medical assistance program due to the lack of sufficient funds required to match federal financial participation mandated under Title XIX of the Social Security Act.

Questions or comments regarding this memorandum should be directed to James Phillips at telephone number (504) 342-3935.

TC/JM/DP

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

Department of HEALTH and HOSPITALS
Bobby P. Jindal
SECRETARY

October 30, 1996

MEMORANDUM

TO: HOSPITALS PARTICIPATING IN THE TITLE XIX MEDICAL ASSISTANCE PROGRAM

FROM: THOMAS D. COLLINS
DIRECTOR

RE: MEDICAID BUDGET CUTS FOR OUTPATIENT REHABILITATION SERVICES

Recently we published an emergency rule that made the following changes in the reimbursement methodology for outpatient rehabilitation services effective with the date of service August 1, 1996: 1) the reimbursement rate for hospitals was reduced to the same flat rate of reimbursement as Rehabilitation Clinics; 2) hospitals were required to use the same procedure codes as the rehabilitation clinics when billing for services; and 3) outpatient rehabilitation services could no longer be included in the hospital's cost report.

We later rescinded this rule. However, since a rule cannot be rescinded retroactively, this rule was in effect from August 1, 1996 through September 4, 1996. Beginning with the date of service September 5, 1996 through date of service November 14, 1996, we are reimbursing at 60 percent (60%) of billed charges and cost settling at 83% of allowable costs.

A new rule will be published effective for date of service November 15, 1996. Under the new rule: 1) the rehabilitation clinics have been given a rate increase. Hospitals are approved at the same rate plus an additional ten percent (10%) per procedure to allow for higher overhead costs; 2) hospitals are to use the same procedure codes as the rehabilitation clinics when billing for services; and 3) outpatient rehabilitation services can no longer be included in the hospital's cost report.

Attached is a listing of the revenue codes, the corresponding Y procedure codes, a description of each code, and the new reimbursement rates. When more than one revenue code is given in the left column corresponding to the procedure code and its file description, providers may use any of the revenue codes given in that column. When requesting approval for payment of services, you only need to provide PAU with the Y procedure codes and approval will be given based on medical necessity. However, when billing you will be required to include both the Y procedure code at Form Locator 44 and the revenue code that corresponds to it on Form Locator 42 of the UB-92.

Group speech therapy procedures have not been added to the file for hospitals as these services will not be covered in a hospital setting.

Questions or comments regarding this notice should be directed to Patty Albritton at (504) 237-3224 or James Phillips at (504) 342-3935.

Attachment

REVENUE CODES AND PROCEDURE CODES

Revenue Code	Description of Procedure Code	Procedure Code	Rate
	Evaluation Procedures		
424	Physical therapy evaluation	Y7702	$59.40
434	Occupational therapy evaluation	Y7812	$56.10
444	Speech evaluation	Y2602	$49.50
444	Hearing evaluation	Y2612	$49.50
454	Wheelchair seating evaluation	Y7902	$56.10
	Physical Therapy Procedures		
420, 421	Physical therapy, one modality	Y7000	$22.00
420, 421	Physical therapy, 2 or more modalities	Y7050	$33.00
420, 421	P.T. - 1 or more proc. and/or mod., 15 min.	Y7106	$11.00
420, 421	P.T. - with procedures, 20 minutes	Y7105	$14.85
420, 421	P.T. - with procedures, 30 minutes	Y7100	$22.00
420, 421	P.T. - with procedures, 45 minutes	Y7101	$33.00
420, 421, 422	P.T. - with procedures, 60 minutes	Y7102	$44.00
420, 421, 422	P.T. - with proc. and mod., 60 minutes	Y7202	$44.00
420, 421	P.T. - with procedures, 75 minutes	Y7103	$55.00
420, 421	P.T. - with procedures, 90 minutes	Y7104	$66.00
	Occupational Therapy Procedures		
430, 431	Occupational therapy, 15 minutes	Y7810	$ 8.80
430, 431	Occupational therapy, 20 minutes	Y7811	$12.10
430, 431	Occupational therapy, 30 minutes	Y7813	$17.60
430, 431	Occupational therapy, 45 minutes	Y7814	$26.40
430, 431, 432	Occupational therapy, 60 minutes	Y7815	$35.20
	Speech Therapy Procedures		
440, 441	Speech and hearing therapy, 15 minutes	Y2609	$16.50
440, 441	Speech and hearing therapy, 20 minutes	Y2611	$11.00
440, 441	Speech therapy, 30 minutes	Y2613	$16.50
440, 441	Speech therapy, 45 minutes	Y2614	$24.75
440, 441, 442	Speech therapy, 60 minutes	Y2615	$33.00

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

January 27, 1997

LOUISIANA
Department of HEALTH and HOSPITALS
Bobby P. Jindal
SECRETARY

MEMORANDUM

TO: Hospitals Participating in the
Title XIX Medical Assistance Program

From: Thomas D. Collins
Director

RE: Implementation of a New Error Edit

ATTN: HOSPITAL ADMINISTRATOR

It has come to our attention that many hospitals are experiencing billing problems due to the denial of claims for error edit 164, billed days exceed percent authorized days. Our research reflects that these denials are caused by the submittal of claims with dates of service that were not authorized by the Precert Unit at the time of claims processing. Please note that claims should never be submitted to Unisys for processing with dates of service not authorized by the Precert Unit.

Effective February 1, 1997 a new error edit of 163, claim dates of service not Precert covered, will be implemented into the Unisys claims processing system. Any claim with dates of service not Precert authorized will be denied using this new error edit.

Questions or comments regarding this memorandum should be directed to James Phillips at telephone number (504) 342-3935.

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STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS

Bobby P. Jindal
SECRETARY

April 24, 1997

To: Medical Provider of Newborns

From: Thomas D. Collins, Director
Bureau of Health Services Financing

Re: Form 152-N Procedures
Medicaid Eligibility Determination

The Department of Health Hospitals, Bureau of Health Services Financing (BHSF) will implement the following procedures effective May 1, 1997. These procedures will ease the process of acquiring a Medicaid identification number for those eligible newborns born to a mother eligible for and receiving Medicaid on the child's date of birth. To expedite certification, Form 152-N's shall be sent within five working days from the child's birth.

Completed Form 152-N's shall be forwarded to the appropriate BHSF Regional Medicaid Office for distribution and processing according to the parish in which your facility is located. Attached is the current list of addresses for all BHSF Regional Offices and the parishes they serve.

If you need additional information, please telephone Susan Jackson at (504) 342-0311.

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REGION I - NEW ORLEANS
Florence Wicker - Regional Manager
1001 Howard Avenue, Suite 900
P. O. Box 13218
New Orleans, La. 70185
(504) 599-0616
PARISHES:

Jefferson - East	Jefferson - West
Orleans	Plaquemine
St. Bernard	

REGION II - BATON ROUGE
Yvonne Gulotta - Regional Manager
1933 Wooddale Blvd.
P. O. Box 45929
Baton Rouge, La. 70895
(504) 925-4375
PARISHES:

Ascension	East Baton Rouge
East Feliciana	Iberville
Pointe Coupee	West Baton Rouge
West Feliciana	

REGION III - THIBODAUX
Norris Barrilleaux - Regional Manager
1148 Tiger Drive
P. O. Box 1038
Thibodaux, La. 70302
(318) 449- 5029
PARISHES:

Assumption	Lafourche
St. Charles	St. James
St. John	St. Mary
Terrebonne	

REGION IV - LAFAYETTE
Ed Granger - Regional Manager
825 Kaliste Saloom Road, Suite 210
P. O. Box 80708
Lafayette, La. 70598
(318) 262-1230
PARISHES:

Acadia	Evangeline
Iberia	Lafayette
St. Landry	St. Martin
Vermillion	

REGION IX - MANDEVILLE
Samantha Gibson - Regional Manager
1518 Martens Dr.
Hammond, La. 70401
(504) 543-4219
PARISHES:

Livingston	St. Helena
St. Tammany	Tangipahoa
Washington	

REGION V - LAKE CHARLES
John Fralick, Jr. - Regional Manager
2300 Broad Street
P. O. Box 3250
Lake Charles, La. 70602
(318) 491-2180
PARISHES:

Allen	Beauregard
Calcasieu	Cameron
Jefferson Davis	

REGION VI - ALEXANDRIA
Lloyd Neel - Regional Manager
900 Murray Street
P. O. Box 932 (71301)
Alexandria, La. 71309
(318) 487-5205
PARISHES:

Avoyelles	Catahoula
Concordia	Grant
LaSalle	Rapides
Vernon	Winn

REGION VII - SHREVEPORT
A. Thomas Gates - Regional Manager
3020 Knight Street
P. O. Box 260 - B
Shreveport, La. 71105
(318) 862-9807
PARISHES:

Bienville	Bossier
Caddo	Claiborne
Desoto	Natchitoches
Red River	Sabine
Webster	

REGION VIII - MONROE
Ed Dewees - Regional Manager
122 St. John Street
State Office Building, Room 412
Monroe, La. 71201
(318) 362-3323
PARISHES:

Caldwell	East Carroll
Franklin	Jackson
Lincoln	Madison
Morehouse	Quachita
Richland	Tensas
Union	West Carroll

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS

David W. Hood
SECRETARY

May 20, 1998

To: **All Medicaid Enrolled Providers**

From: Thomas D. Collins

Re: Statutorily Mandated Revisions to all Provider Agreements

The 1997 Regular Session of the Legislature passed and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437.14. The provider agreement provisions of MAPIL statutorily establishes that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

(1) comply with all federal and state laws and regulations;
(2) provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
(3) have all necessary and required licenses or certificates;
(4) maintain and retain all records;
(5) allow for inspection of all records by governmental authorities;
(6) safeguard against disclosure of information in patient medical records;
(7) bill other insurers and third parties prior to billing Medicaid;
(8) report and refund any and all overpayments;
(9) accept payment in full for Medicaid recipients providing allowances for copay authorized by Medicaid;
(10) agree to be subject to claims review;
(11) the buyer and seller of a provider are liable for any administrative sanctions or civil judgements;
(12) notification prior to any change in ownership;
(13) inspection of facilities; and,
(14) posting of bond or letter of credit when required.

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MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive.

The provider agreement provisions of MAPIL also provide the Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997 or became effective on or after August 15, 1997 are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997 to contain the terms and conditions established in MAPIL.

Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify provider enrollment in writing within ten (10) working days of the date of this letter that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL.

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
David W. Hood
SECRETARY

August 6, 1998

To: All Physicians, Audiologist and EPSDT Service Providers

From: Thomas D. Collins
Director

Re: Cochlear Device Implantation Policy

The Bureau of Health Services Financing is pleased to announce that effective for the dates of service on or after August 1, 1998, reimbursement is available for the cochlear implant device for Medicaid recipients with profound-to-total bilateral hearing loss.

Only recipients two years of age through twenty years of age who meet the medical and social criteria listed below shall qualify for implantation.

Only one device per lifetime per eligible recipient shall be reimbursed unless the device fails or is damaged beyond repair, in which case reimbursement for another device and reimplantation will be considered.

RECIPIENT MEDICAL AND SOCIAL CRITERIA

The following criteria apply to all candidates for Cochlear Device Implantation. The recipient must:

1. have a profound bilateral sensorineural hearing loss which is a pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;

2. be a profoundly deaf child age two years or older or be a post linguistically deafened adult through the age of twenty years;

3. receive no significant benefit from hearing aids as validated by the cochlear implant team;

4. have high motivation to be part of the hearing community as validated by the cochlear implant team;

5. have appropriate expectations;

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6. have had radiologic studies that demonstrate no intracranial anomalies or malformations which would contraindicate implantation of the receiver-stimulator or the electrode array;

7. have no medical contraindications for undergoing implant surgery or post-implant rehabilitation; and

8. show that the candidate and his family are well-motivated, possess appropriate post-implant expectations and are prepared and willing to participate in and cooperate with pre and post implant assessment and rehabilitation programs as recommended by the implant team and in conjunction with Federal Drug Administration (FDA) guidelines.

Specific criteria:

A. Children Two Years Through Nine Years

In addition to documentation that candidates meet general criteria the requestor shall provide documentation:

1. that profound-to-total bilateral sensorineural hearing loss which is a pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;

2. that appropriate tests were administered and no significant benefit from a hearing aid was obtained in the best aided condition as measured by age appropriate speech perception materials; and

3. that no responses were obtained to Auditory Brainstem Response, Otacoustic Emission testing or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation.

B. Children 10 Years Through 17 Years

In additional to documentation that candidates meet general criteria, the requestor shall provide documentation:

1. that profound-to-total bilateral sensorineural hearing loss which is a pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;

2. that appropriate tests were administered and no significant benefit from a hearing aid was obtained in the best aided condition as measured by age and language appropriate speech perception materials;

3. that no responses were obtained to Auditory Brainstem Evoked Response, Otacoustic Emission Test or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation;

4. the candidate has received consistent exposure to effective auditory or phonological stimulation in conjunction with oral method of education and auditory training;

5. that candidate utilizes spoken language as his primary mode of communication through one of the following: an oral/aural (re)habilitation program, or total communications educational program with significant oral/aural; and

6. that the individual has at least six months' experience with a hearing aid or vibrotactile device except in the case of meningitis (in which case the 6 month period will be reduced to 3 months).

C. Adults—8 Years through 20 Years

In addition to documentation that candidates meet general criteria, the requestor shall provide documentation:

1. that the candidates for implant is post linguistically deafened with severe to profound bilateral sensorineural hearing loss which is a pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;

2. that no significant benefit from a hearing aid was obtained in the best aided condition for speech/sentence recognition material;

3. that no responses were obtained to Auditory Brainstem Response, Otacoustic Emission testing or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation;

4. that the candidate has received consistent exposure to effective auditory or phonological stimulation or auditory communication;

5. that the candidate utilizes spoken language as his primary mode of communication through one of the following:

   - an oral/aural (re)habilitation program, or
   - total communications educational program with significant oral/aural training; and

6. that the candidate has had at least six months experience with hearing aids or vibrotactile device except in the case of meningitis (in which case the 6 month period will be reduced to 3 months).

D. Multi-Handicapped Children

Criteria appropriate for the child's age group are applied.

NON-COVERED EXPENSES

The following expenses related to the maintenance of the cochlear device are the responsibility of either the recipient or his family or care giver(s):

1. All costs for service contracts and/or extended warranties;
2. All costs for insurance to protect against loss and theft.

PRIOR AUTHORIZATION

All aspects of this procedure (preoperative speech and language evaluation, implantation, device, repairs, supplies, therapy) must be prior authorized. The request to perform surgery must come from the multidisciplinary team which assessed the recipient's disability and determined him/her to be a possible candidate for implantation.

The multidisciplinary team shall consist of:

- a surgeon/otologist;
- an audiologist;
- a speech/language pathologist;
- a psychiatrist; and,
- an educator of the deaf with experience in oral/auditory instruction.

A Form PA-01 must be completed for the device and submitted to the Prior Authorization Unit as part of the multidisciplinary team's packet. A PA-01 form requesting approval to perform the surgery must be submitted to Prior Authorization by the surgeon as part of the multidisciplinary team's packet. The team's written decision regarding the recipient's candidacy for the implant and the results of all pre-operative testing (audiogram, tympanogram, speech and language evaluation, social evaluation, etc.) shall be included in the packet sent to Unisys. Post-operative speech and language evaluation services must be prior authorized, as well. The audiologist shall submit a PA-01 form requesting approval to Prior Authorization as part of the multidisciplinary team's packet.

The single packet requesting a Cochlear implant shall be submitted for review to Unisys labeled **Unisys Prior Authorization Unit—Request for Cochlear Implant** to:

Unisys
Prior Authorization Unit
Post Office Box 14919
Baton Rouge, LA 70898-4919

Requests for reimbursement for speech processor and/or microphone repairs, headset cords, headset replacements and batteries must be prior authorized and may be made on Form PA01 to the Prior Authorization Unit at the address given previously.

HOSPITAL BILLING FOR PROCEDURE

The hospital shall be reimbursed for the cochlear device and the hospital stay for the surgery. The hospital shall bill for the device on a HCFA 1500 claim form using HCPCS code L8614 (Cochlear Device System). The letters DME must be written in red on the top of the form, and the PA number must be written in Item 23. The device will be reimbursed at a fee of $11,496.

Note: Reimbursement for the device will not be authorized until the surgical procedure has been approved.

PHYSICIAN BILLING PROCEDURE

The surgeon shall bill for the implantation on a HCFA 1500 claim form using CPT-4 procedure code 69930 (Cochlear device implantation, with or without mastoidectomy). The assistant surgeon shall bill using the same CPT procedure code with a modifier 80. **This procedure shall not be billed as either a team surgery or co-surgery (modifiers 62 and 66 respectively).**

The surgeon's fee for CPT code 69930 will be $1319.24, and the assistant surgeon's fee will be $263.85. The anesthesiologist's fee will be eight base units of anesthesia plus the actual number of time units (1 = 15 minutes) multiplied by the co-efficient of $13.50. The surgeon's claim form must have the PA number written in Item 23. The assistant surgeon and anesthesiologist's claims may be submitted without a prior authorization number. These claim forms will pend to the Medical Review Unit for review and will be paid only if the surgeon's request for implantation has been approved.

AUDIOLOGIST BILLING PROCEDURES

The audiologist shall bill CPT procedure code 92506 (Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status) on a HCFA 1500 claim form to receive reimbursement for the pre-operative speech and language evaluation.

This service will be reimbursed for prospective cochlear implant candidates even if the candidate does not subsequently receive an implant.

Procedure code 92506 is reimbursed at a fee of $300. It is limited to only once per candidate per

lifetime and is restricted to the specialty of Audiology. The PA number must be printed on the claim form in Item 23 in order for payment to be obtained.

Post-Operative Rehabilitative Services

Only the audiologist will be reimbursed for the aural rehabilitation of the cochlear implant recipient after implantation of the device. Procedure code 92510, payable at $94.90, shall be billed on the HCFA 1500 for this service. This code does not require prior authorization.

Post-Operative Speech, Language and Hearing Therapy Services

Subsequent speech, language and hearing therapy services for cochlear implant recipients must be prior authorized like all other rehabilitation services. The request for prior authorization should be submitted to the Prior Authorization Unit on Forms PA-01 and PA-02 at the address previously given.

Billing for Speech Processor Repairs, Batteries, Headset Cords, etc.

The locally-assigned codes to use to request approval and reimbursement for these items and their fees are as follows:

L8700 Speech Processor Repair - $255
L8701 Headset Replacement - $360
L8702 Microphone Repair - $240
L8703 Speech Processor Battery - $6
L8704 Headset Cord - $12

Statistics show that, on the average, processors need repairing every 2.5 years and that headset cords need to be replaced from 2-4 times per year. Batteries require replacement every 10-12 months.

Requests for reimbursement for the items above should be made conservatively. The Prior Authorization Unit reserves the right to refuse reimbursement for these maintenance costs when/if it feels requests are being made too frequently due to patient negligence.

The procedure for obtaining reimbursement for the items above is the same as that for obtaining reimbursement for the device, i.e.,the provider shall submit the applicable HCPCS code on a HCFA 1500 claim form with the letters DME written in red on the top of the form. The PA number must be written in Item 23.

REPLACEMENT OF THE EXTERNAL SPEECH PROCESSOR

The Louisiana Medicaid Program will consider replacing the external speech processor only if one of the following occurs:

1. The recipient loses his processor
2. The processor is stolen OR
3. The processor is irreparably damaged

An upgrade to the speech processor because of cosmetic or technological advances in the hardware shall not qualify as a reason for replacement.

Prior authorization for replacement of the external speech processor (HCPCS code L8619) must be obtained when/if replacement becomes necessary.

The multidisciplinary team shall initiate a new request for approval and shall submit the following information with its request for replacement:

1. A copy of Prior Authorization's initial approval letter for the implant
2. Documentation explaining the reason a new processor is needed

Billing for Replacement of the External Speech Processor

Hospitals or professional services billers shall bill for this component by submitting HCPCS code L8619 on a HCFA 1500 claim form with the letters DME written in red on the top. The PA number must be written in Item 23.

Replacement of the external speech processor shall be reimbursed at a fee of $4,936.

BILLING FOR RE-PERFORMANCE OF THE IMPLANTATION SURGERY

Re-performance of the implantation surgery (CPT code 69930) because of infection, extrusion or other reasons must be prior authorized.

Documentation explaining the reason the initial implant surgery has to be repeated and the request for re-performance should be submitted simultaneously to the Prior Authorization Unit for review.

The PA number approving the re-performance must be on the claim form for reimbursement to be received.

If you have any questions, please contact Kandis McDaniel at (504) 342-9490. Your cooperation is greatly appreciated.

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

David W. Hood
SECRETARY

August 18, 1998

MEMORANDUM

TO: All Enrolled Medicaid Providers

FROM: Thomas D. Collins, Director of Bureau of Health Services Financing

RE: Office for Civil Rights Policy Memorandum

The Department of Health and Human Services, Office for Civil Rights, recently issued a policy memorandum regarding nondiscrimination based on national origin as it relates to individuals who are limited-English proficient. Enclosed is the Health Care Financing Administration (HCFA) Civil Rights Compliance Statement which expresses our Agency's commitment to ensuring that there is no discrimination in the delivery of health care services through HCFA programs.

We have committed ourselves to full compliance with the requirements contained in this policy statement. As our partner with the administration of the Medicaid program you likewise are obligated to comply with those statutory civil rights laws. As stipulated in the policy statement, these laws include: Act of 1990 as amended and Title IX of the Education Amendments of 1972. The Office of Civil Rights of the Department of Health and Human Services has previously advised HCFA that detailed implementation regulations for the Rehabilitation Act of 1973, as amended, are located at 45 Code of Federal Regulations, Part 85.

It has been asked that we share this policy statement with you and that you do likewise with health care providers and all others involved in the administration of HCFA programs.

Questions regarding this memorandum should be directed to Don Fontenot at 342-1316.

HEALTH CARE FINANCING ADMINISTRATION (HCFA)
CIVIL RIGHTS COMPLIANCE POLICY STATEMENT

The Health Care Financing Administration's vision in the current Strategic Plan guarantees that all our beneficiaries have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all HCFA program operations and activities. I want to emphasize my personal commitment to and responsibility for ensuring compliance with civil rights laws by recipients of HCFA funds. These laws include: Title VI of the Civil Rights Act, as amended; Section 504 of the Rehabilitation Act, as amended; the Age Discrimination Act of 1975, as amended; the Americans with Disabilities Act of 1990, as amended; and Title IX of the Education Amendments of 1972, as well as other related laws. The responsibility for ensuring compliance with these laws is shared by all HCFA operating components. Promoting attention to and ensuring HCFA program compliance with civil rights laws are among my highest priorities for HCFA, its employees, contractors, State agencies, health care providers, and all other partners directly involved in the administration of HCFA programs.

HCFA, as the agency legislatively charged with administering the Medicare, Medicaid and Children's Health Insurance Programs, is thereby charged with ensuring these programs do not engage in discriminatory actions on the basis of race, color, national origin, age, sex or disability. HCFA will, with your help continue to ensure that persons are not excluded from participation in or denied the benefits of its programs because of prohibited discrimination.

To achieve its civil rights goals, HCFA will continue to incorporate civil rights concerns into the culture of our agency and its programs, and we ask that all our partners do the same. We will include civil rights concerns in the regular program review and audit activities including: collecting data on access to, and the participation of, minority and disabled persons in our programs; furnishing information to recipients and contractors about civil rights compliance; reviewing HCFA publications, program regulations, and instructions to assure support for civil rights; and working closely with the Department of Health and Human Services (DHHS), Office of Civil Rights, to initiate orientation and training programs on civil rights. HCFA will also allocate financial resources to the extent feasible to: ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.

DHHS will seek voluntary compliance to resolve issues of discrimination whenever possible. If necessary, HCFA will refer matters to the Office for Civil Rights for appropriate handling. In order to enforce civil rights laws, the Office for Civil Rights may: 1) refer matters for an administrative hearing which could lead to suspending, terminating, or refusing to grant or continue Federal financial assistance; or 2) refer the matter to the Department of Justice for legal action.

HCFA's mission is to assure health care security for the diverse population that constitutes our nation's Medicare and Medicaid beneficiaries; i.e., our customers. We will enhance our communication with constituents, partners, and stakeholders. We will seek input from health care providers, states, contractors, and DHHS Office for Civil Rights, professional organizations, community advocates, and program beneficiaries. We will continue to vigorously assure that all Medicare and Medicaid beneficiaries have equal access to and receive the best health care possible regardless of race, color, national origin, age, sex, or disability.

Nancy-Ann Min DeParle

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

David W. Hood
SECRETARY

December 9, 1998

Memorandum

TO: All Hospitals

FROM: Thomas D. Collins
Director

RE: Hospital Pre-Cert Process Changes

As you know, according to our Pre-Admission Certification rules published in 1994, a hospital must request an extension of inpatient hospital days on or before the last day of the approved stay. Many hospitals are submitting a request on the day after the last approved day which is not timely according to the rule. In order to assist you in this matter and to improve the flow of recipients we are implementing the following changes:

1.
The Department of Health and Hospitals will now allow hospitals to submit an extension request on the expected discharge date instead of the day before the expected discharge date.

2.
In situations when a hospital is denied an extension request based on timely submittal of the medical information requested by Unisys and the patient is still in the hospital, the Department of Health and Hospitals will allow hospitals to request to re-open the Pre-Cert case under a new Pre-Cert number when the hospital submits current documentation to be reviewed as long as the patient continues to be an inpatient.

A new Pre-Cert number will be issued with the admit date being the date that the hospital submits current documentation to the Unisys Pre-Cert Department.

The days that were denied may be appealed through the DHH appeal process using the Pre-Cert number under which the days were denied.

PROCESS:

Hospitals must submit an initial PCFO1 with no Pre-Cert number. On the bottom of the PCFO1, write "Attention Janeen or Sandy". Also note the Pre-Cert number under which the extension request was denied. Hospitals will be assigned a new Pre-Cert number with the admit date being the date that Unisys receives the re-submitted PCFO1. This re-submitted request must have current documentation which supports the continued length of stay.

3.
Late submissions of an initial Pre-Cert case due to an incorrect response from a MEVS inquiry will be given consideration if a good faith effort is verified with the actual printout from the MEVS system that was accessed within the one business day of the admission.

Submit to Unisys Pre-Cert, ATTN: Sandy Whitcomb, RN

Any questions can be directed to Unisys Pre-Cert at (800) 877-0666.

********* 31302********** LOUISIANA MEDICA REMITTANCE VOUCHER ********** **********
TO:

DATE: 012699

REMITTANCE NO:

1191302

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER

***** PHARMACY PROVIDERS,PLEASE NOTE!!!*****
IF YOU ARE UNSURE ABOUT THE COVERAGE OF A DRUG PRODUCT, PLEASE CONTACT
THE PBM HELP DESK AT 1-800-648-0790
PLEASE MAKE THE FOLLOWING CHANGES TO THE 8/15/98 VERSION OF APPENDIX A:

DRUG	DOSAGE	STRGTH SIZE	MAC	EFF.DATE
ABACAVIR SULFATE	SOL	100MG/5ML		01/06/99
ABACAVIR SULFATE	TAB	10MG		01/06/99
CEFDINIR	SUSP RECON	125MG/5ML		01/04/99
CELECOXIB	CAP	100,200MG		01/04/99
CHLORDIAZEPOXIDE HCL	AMP	100MG		01/04/99
DILTIAZEM HCL	CAP SA	420MG		01/06/99
ENALAPRIL MALEATE/FELODIPINE	TAB SA	5-2 5MG		01/15/99
LOSARTIN POTASSIUM	TAB	100MG		12/31/98
OXYBUTYNIN CHLORIDE	TAB SA OSM	5,10MG		12/16/98

PLEASE FILE ADJUSTMENTS FOR CLAIMS WHICH MAY HAVE BEEN INCORRECTLY PAID

ATTENTION PHARMACY PROVIDERS:

LETTERS WILL SOON BE MAILED TO PHARMACY PROVIDERS CONCERNING THE RECOVERY OF PHARMACY DUPLICATE PAYMENTS AND/OR NON-PROCESSED POS PHARMACY CLAIM REVERSALS. PROVIDERS SHOULD CLOSELY REVIEW THESE DOCUMENTS AND RESPOND ACCORDING TO THE DIRECTIONS IN THE CORRESPONDENCES.

**********NOTICE TO PROVIDERS**********

WE HAVE RECENTLY BEEN ASKED FOR A CLARIFICATION IN BILLING MEDICARE PART A ONLY CLAIMS. IF THE RECIPIENT HAS MEDICARE PART A ONLY COVERAGE, THE HOSPITAL SHOULD SUBMIT AN INPATIENT CLAIM, INCLUDING THE ANCILLARY CHARGES, TO ITS MEDICARE INTERMEDIARY FOR REIMBURSEMENT. THE CLAIM WILL AUTOMATICALLY CROSS OVER TO MEDICAID FOR PAYMENT OF THE CO-INSURANCE AND DEDUCTIBLE AMOUNTS FOR THE INPATIENT STAY.
A REVISION TO PAGE 10-31 OF THE HOSPITAL MANUAL WILL BE ISSUED IN THE NEAR FUTURE.

VOID PRESCRIBER ONLY

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UPDATED COPY OF SURGERY CODES
(ICD - 9 PROCEDURES)
REQUIRING PA/PRECERT

(UPDATED FROM HOSPITAL MANUAL LISTING/REPLACES LIST
AT END OF HOSPITAL MANUAL)

DIAG	DESC
0406	OTHER CRANIAL OR PERIPHERAL GANGLIONECTO
0407	OTHER EXCISION OR AVULSION OF CRANIAL AN
043	SUTURE OF CRANIAL AND PERIPHERAL NERVES
0443	RELEASE OF CARPAL TUNNEL
0449	OTHER PERIPHERAL NERVE OR GANGLION DECOM
046	TRANSPOSITION OF CRANIAL AND PERIPHERAL
067	EXCISION OF THYROGLOSSAL DUCT OR TRACT
0802	SEVERING OF BLEPHARORRHAPHY
0809	OTHER INCISION OF EYELID
0820	REMOVAL OF LESION OF EYELID, NOT OTHERWI
0821	EXCISION OF CHALAZION
0825	DESTRUCTION OF LESION OF EYELID
0841	REPAIR OF ENTROPION OR ECTROPION BY THER
0842	REPAIR OF ENTROPION OR ECTROPION BY SUTU
0843	REPAIR OF ENTROPION OR ECTROPION WITH WE
0844	REPAIR OF ENTROPION OR ECTROPION WITH LI
0852	BLEPHARORRHAPHY
0859	OTHER ADJUSTMENT OF LID POSITION
0864	RECONSTRUCTION OF EYELID WITH TARSOCONJU
0943	PROBING OF NASOLACRIMAL DUCT
1044	OTHER FREE GRAFT TO CONJUNCTIVA
1099	OTHER OPERATIONS ON CONJUNCTIVA
110	MAGNETIC REMOVAL OF EMBEDDED FOREIGN BOD
1131	TRANSPOSITION OF PTERYGIUM
1132	EXCISION OF PTERYGIUM WITH CORNEAL GRAFT
1139	OTHER EXCISION OF PTERYGIUM
1149	OTHER REMOVAL OR DESTRUCTION OF CORNEAL
1211	IRIDOTOMY WITH TRANSFIXION
1214	OTHER IRIDECTOMY
1242	EXCISION OF LESION OF IRIS
1284	EXCISION OR DESTRUCTION OF LESION OF SCL
1319	OTHER INTRACAPSULAR EXTRACTION OF LENS
132	EXTRACAPSULAR EXTRACTION OF LENS BY LINE
133	EXTRACAPSULAR EXTRACTION OF LENS BY SIMP
1341	PHACOEMULSIFICATION AND ASPIRATION OF CA
1342	MECHANICAL PHACOFRAGMENTATION AND ASPIRA
1359	OTHER EXTRACAPSULAR EXTRACTION OF LENS
1362	EXCISION OF PRIMARY MEMBRANOUS CATARACT
1365	EXCISION OF SECONDARY MEMBRANE (AFTER CA
1371	INSERTION OF INTRAOCULAR LENS PROSTHESIS
1401	REMOVAL OF FOREIGN BODY FROM POSTERIOR S
1402	REMOVAL OF FOREIGN BODY FROM POSTERIOR S
1511	RECESSION OF ONE EXTRAOCULAR MUSCLE
1512	ADVANCEMENT OF ONE EXTRAOCULAR MUSCLE
1513	RESECTION OF ONE EXTRAOCULAR MUSCLE
1519	OTHER OPERATIONS ON ONE EXTRAOCULAR MUSC
1521	LENGTHENING PROCEDURE ON ONE EXTRAOCULAR
1522	SHORTENING PROCEDURE ON ONE EXTRAOCULAR
1529	OTHER OPERATIONS ON ONE EXTRAOCULAR MUSC
153	OPERATIONS ON TWO OR MORE EXTRAOCULAR MU
154	OTHER OPERATIONS ON TWO OR MORE EXTRAOCU
1631	REMOVAL OF OCULAR CONTENTS WITH SYNCHRON

LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEMS
LIST OF SURGERY CODES ON DIAGNOSIS FILE WITH PA = R

DIAG	DESC
1639	OTHER EVISCERATION OF EYEBALL
1642	ENUCLEATION OF EYEBALL WITH OTHER SYNCHR
1649	OTHER ENUCLEATION OF EYEBALL
1661	SECONDARY INSERTION OF OCULAR IMPLANT
1662	REVISION AND REINSERTION OF OCULAR IMPLA
1671	REMOVAL OF OCULAR IMPLANT
1809	OTHER INCISION OF EXTERNAL EAR
1811	OTOSCOPY
1829	EXCISION OR DESTRUCTION OF OTHER LESION
1911	STAPEDECTOMY WITH INCUS REPLACEMENT
1919	OTHER STAPEDECTOMY
193	OTHER OPERATIONS ON OSSICULAR CHAIN
194	MYRINGOPLASTY
195	OTHER TYMPANOPLASTY
1952	TYPE II TYMPANOPLASTY
1953	TYPE III TYMPANOPLASTY
1954	TYPE IV TYMPANOPLASTY
1955	TYPE V TYMPANOPLASTY
196	REVISION OF TYMPANOPLASTY
2001	MYRINGOTOMY WITH INSERTION OF TUBE
2009	OTHER MYRINGOTOMY
2041	SIMPLE MASTOIDECTOMY
208	OPERATIONS ON EUSTACHIAN TUBE
2121	RHINOSCOPY
2122	BIOPSY OF NOSE
2131	LOCAL EXCISION OR DESTRUCTION OF INTRANA
2132	LOCAL EXCISION OR DESTRUCTION OF OTHER L
215	SUBMUCOUS RESECTION OF NASAL SEPTUM
2162	FRACTURE OF THE TURBINATES
2169	OTHER TURBINECTOMY
217	REDUCTION OF NASAL FRACTURE
2171	CLOSED REDUCTION OF NASAL FRACTURE
2183	TOTAL NASAL RECONSTRUCTION
2187	OTHER RHINOPLASTY
2188	OTHER SEPTOPLASTY
2199	OTHER OPERATIONS ON NOSE
2200	ASPIRATION AND LAVAGE OF NASAL SINUS; NO
2201	PUNCTURE OF NASAL SINUS FOR ASPIRATION O
2202	ASPIRATION OR LAVAGE OF NASAL SINUS THRO
2263	ETHMOIDECTOMY
230	FORCEPS EXTRACTION OF TOOTH
2301	EXTRACTION OF DECIDUOUS TOOTH
2309	EXTRACTION OF OTHER TOOTH
231	SURGICAL REMOVAL OF TOOTH
2311	REMOVAL OF RESIDUAL ROOT
2319	OTHER SURGICAL EXTRACTION OF TOOTH
232	RESTORATION OF TOOTH BY FILLING
233	RESTORATION OF TOOTH BY INLAY
234	OTHER DENTAL RESTORATION
2341	APPLICATION OF CROWN
2342	INSERTION OF FIXED BRIDGE
2343	INSERTION OF REMOVABLE BRIDGE

DIAG	DESC
2349	OTHER DENTAL RESTORATION
235	IMPLANTATION OF TOOTH
245	ALVEOLOPLASTY
2501	NEEDLE BIOPSY OF TONGUE
2502	OTHER BIOPSY OF TONGUE
2594	OTHER GLOSSOTOMY
270	DRAINAGE OF FACE AND FLOOR OF MOUTH
2741	LABIAL FRENECTOMY
2742	WIDE EXCISION OF LESION OF LIP
2743	OTHER EXCISION OF LESION OR TISSUE OF LI
2792	INCISION OF MOUTH, UNSPECIFIED STRUCTURE
280	INCISION AND DRAINAGE OF TONSIL AND PERI
282	TONSILLECTOMY WITHOUT ADENOIDECTOMY
283	TONSILLECTOMY WITH ADENOIDECTOMY
284	EXCISION OF TONSIL TAG
286	ADENOIDECTOMY WITHOUT TONSILLECTOMY
2911	PHARYNGOSCOPY
292	EXCISION OF BRANCHIAL CLEFT CYST OR VEST
3009	OTHER EXCISION OR DESTRUCTION OF LESION
313	OTHER INCISION OF LARYNX OR TRACHEA
3142	LARYNGOSCOPY AND OTHER TRACHEOSCOPY
3143	BIOPSY OF LARYNX
3144	BIOPSY OF TRACHEA
3321	BRONCHOSCOPY THROUGH ARTIFICIAL STOMA
3322	FIBER-OPTIC BRONCHOSCOPY
3323	OTHER BRONCHOSCOPY
3324	ENDOSCOPIC BRONCHIAL BIOPSY
3409	OTHER INCISION OF PLEURA
3797	REPL CARDIVERT. / DFIB LEAD
3821	BIOPSY OF BLOOD VESSEL
3822	PERCUTANEOUS ANGIOSCOPY
3859	LIGATION AND STRIPPING OF LOWER LIMB VAR
3882	OTHER SURGICAL OCCLUSION OF OTHER VESSEL
3889	OTHER SURGICAL OCCLUSION OF LOWER LIMB V
4011	BIOPSY OF LYMPHATIC STRUCTURE
4021	EXCISION OF DEEP CERVICAL LYMPH NODE
4221	OPERATIVE ESOPHAGOSCOPY BY INCISION
4222	ESOPHAGOSCOPY THROUGH ARTIFICIAL STOMA
4223	OTHER ESOPHAGOSCOPY
4224	BIOPSY OF ESOPHAGUS
4232	LOCAL EXCISION OF OTHER LESION OR TISSUE
4239	OTHER DESTRUCTION OF LESION OR TISSUE OF
4292	DILATION OF ESOPHAGUS
4342	LOCAL EXCISION OF OTHER LESION OR TISSUE
4349	OTHER DESTRUCTION OF LESION OR TISSUE OF
4411	TRANSABDOMINAL GASTROSCOPY
4413	OTHER GASTROSCOPY
4414	BRUSH BIOPSY OF STOMACH
4415	OTHER BIOPSY OF STOMACH
4493	INSERT GASTRIC BALLOON
4494	REMOVAL GASTRIC BALLOON
4513	OTHER ENDOSCOPY OF SMALL INTESTINE

LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEMS
LIST OF SURGERY CODES ON DIAGNOSIS FILE WITH PA = R

DIAG	DESC
4514	BRUSH BIOPSY OF SMALL INTESTINE
4524	OTHER ENDOSCOPY OF LARGE INTESTINE
4525	BRUSH BIOPSY OF LARGE INTESTINE
4526	OTHER BIOPSY OF LARGE INTESTINE
4532	OTHER DESTRUCTION OF LESION OF DUODENUM
4541	LOCAL EXCISION OF LESION OR TISSUE OF LA
4595	SM BOWEL-ANUS ANASTOMOS
4643	OTHER REVISION OF STOMA OF LARGE INTESTI
4823	OTHER PROCTOSIGMOIDOSCOPY
4824	BRUSH BIOPSY OF RECTUM
4825	OTHER BIOPSY OF RECTUM
4835	LOCAL EXCISION OF RECTAL LESION OR TISSU
4881	INCISION OF PERIRECTAL TISSUE
4901	INCISION OF PERIANAL ABSCESS
4912	ANAL FISTULECTOMY
493	LOCAL EXCISION OR DESTRUCTION OF OTHER L
4945	LIGATION OF HEMORRHOIDS
4946	EXCISION OF HEMORRHOIDS
4947	EVACUATION OF THROMBOSED HEMORRHOIDS
4949	OTHER PROCEDURES ON HEMORRHOIDS
4951	LEFT LATERAL ANAL SPHINCTEROTOMY
4952	POSTERIOR ANAL SPHINCTEROTOMY
4959	OTHER ANAL SPHINCTEROTOMY
5011	PERCUTANEOUS (NEEDLE) BIOPSY OF LIVER
5300	UNILATERAL REPAIR OF INGUINAL HERNIA, NO
5301	UNILATERAL REPAIR OF DIRECT INGUINAL HER
5302	UNILATERAL REPAIR OF INDIRECT INGUINAL H
5303	UNILATERAL REPAIR OF DIRECT INGUINAL HER
5304	UNILATERAL REPAIR OF INDIRECT INGUINAL H
5305	UNILATERAL REPAIR OF INGUINAL HERNIA WIT
5321	UNILATERAL REPAIR OF FEMORAL HERNIA WITH
5329	OTHER UNILATERAL FEMORAL HERNIORRHAPHY
5349	OTHER UMBILICAL HERNIORRHAPHY
5359	REPAIR OF OTHER HERNIA OF ANTERIOR ABDOM
5369	REPAIR OF OTHER HERNIA OF ANTERIOR ABDOM
5421	LAPAROSCOPY
5423	BIOPSY OF PERITONEUM
5425	PERITONEAL LAVAGE
544	EXCISION OR DESTRUCTION OF PERITONEAL TI
545	LYSIS OF PERITONEAL ADHESIONS
5451	LAPAROSCOPE LYSIS OF PERTIONEAL ADHES
5459	OTHER LYSIS OF PERITONEAL ADHESIONS
5634	OPEN BIOPSY OF URETER
5635	ILEAL CONDUCT ENDOSCOPY
5731	CYSTOSCOPY THROUGH ARTIFICIAL STOMA
5732	OTHER CYSTOSCOPY
5749	OTHER TRANSURETHRAL EXCISION OR DESTRUCT
5791	SPHINCTEROTOMY OF BLADDER
5792	DILATION OF BLADDER NECK
581	URETHRAL MEATOTOMY
5821	PERINEAL URETHROSCOPY
5822	OTHER URETHROSCOPY

DIAG	DESC
583	EXCISION OR DESTRUCTION OF URETHRAL TISS
585	RELEASE OF URETHRAL STRICTURE
586	DILATION OF URETHRA
5903	LAPAROS LYS OF PERIRENAL OR PERIURET ADH
5912	LAPAROS LYS OF PERIVESICAL ADHESIONS
5919	OTHER INCISION OF PERIVESICAL TISSUE
6011	NEEDLE BIOPSY OF PROSTATE
610	INCISION AND DRAINAGE OF SCROTUM AND TUN
612	EXCISION OF HYDROCELE (OF TUNICA VAGINAL
613	EXCISION OR DESTRUCTION OF LESION OR TIS
6191	PERCUTANEOUS ASPIRATION OF TUNICA VAGINA
620	INCISION OF TESTIS
6211	PERCUTANEOUS BIOPSY OF TESTIS
6212	OTHER BIOPSY OF TESTIS
623	UNILATERAL ORCHIECTOMY
6241	REMOVAL OF BOTH TESTES AT SAME OPERATIVE
6242	REMOVAL OF REMAINING TESTIS
631	EXCISION OF VARICOCELE AND HYDROCELE OF
6371	LIGATION OF VAS DEFERENS
6373	VASECTOMY
6392	EPIDIDYMOTOMY
640	CIRCUMCISION
642	LOCAL EXCISION OR DESTRUCTION OF LESION
6491	DORSAL OR LATERAL SLIT OF PREPUCE
6501	LAPAROSCOPIC OOPHOROTOMY
6509	OTHER OOPHOROTOMY
6511	ASPIRATION BIOPSY OF OVARY
6512	OTHER BIOPSY OF OVARY
6513	LAPAROSCOPIC BIOPSY OF OVARY
6514	OTHER LAPAROS DIAG PROC ON OVARIES
6523	LAPAROS MARSUPIL OF OVATION CYST
6524	LAPAROS WEDGE RESECTION OF OVARY
6525	OTH LAPAROS LOC EXCIS OR DEST OF OVARY
6529	OTHER LOCAL EXCISION OR DESTRUCTION OF O
6531	LAPAROS UNILATERAL OOPHORECTOMY
6539	OTHER UNILATERAL OOPHORECTOMY
6541	LAPAROS UNICAT SALPINGO-OOPHORECTOMY
6549	OTHER UNILATERAL SALPINGO-OOPHORECTOMY
6553	LAPAROS REMOVAL OF BOTH OVARIES AT S.OP.
6554	LAPAROS REMOVAL OF REMAINING OVARY
6563	LAPAROS REMOVAL OF BOTH OVARIES & TUBES
6564	LAPAROS REMOVAL OF REMAINING OVARY& TUBE
6574	LAPAROSCOPIC SIMPLE SUTURE OF OVARY
6575	LAPAROSCOPIC REIMPLANTATION OF OVARY
658	LYSIS OF ADHESIONS OF OVARY AND FALLOPIA
6581	LAPAR LYS OF ADH OF OVARY AND FALL TUBE
6611	BIOPSY OF FALLOPIAN TUBE
662	BILATERAL ENDOSCOPIC DESTRUCTION OR OCCL
6621	BILATERAL ENDOSCOPIC LIGATION AND CRUSHI
6622	BILATERAL ENDOSCOPIC LIGATION AND DIVISI
6629	OTHER BILATERAL ENDOSCOPIC DESTRUCTION
663	OTHER BILATERAL DESTRUCTION OR OCCLUSION

DIAG	DESC
6631	OTHER BILATERAL LIGATION AND CRUSHING OF
6632	OTHER BILATERAL LIGATION AND DIVISION OF
6639	OTHER BILATERAL DESTRUCTION OR OCCLUSION
6661	EXCISION OR DESTRUCTION OF LESION OF FAL
6692	UNILATERAL DESTRUCTION OR OCCLUSION OF F
670	DILATION OF CERVICAL CANAL
6711	ENDOCERVICAL BIOPSY
6712	OTHER CERVICAL BIOPSY
6732	DESTRUCTION OF LESION OF CERVIX BY CAUTE
6733	DESTRUCTION OF LESION OF CERVIX BY CRYOS
6739	OTHER EXCISION OR DESTRUCTION OF LESION
6823	ENDOMETRIAL ABLATION
6901	DILATION AND CURETTAGE FOR TERMINATION O
6909	OTHER DILATION AND CURETTAGE OF UTERUS
6951	ASPIRATION CURETTAGE OF UTERUS FOR TERMI
6952	ASPIRATION CURETTAGE FOLLOWING DELIVERY
700	CULDOCENTESIS
7011	HYMENOTOMY
7014	OTHER VAGINOTOMY
7024	VAGINAL BIOPSY
7031	HYMENECTOMY
7033	EXCISION OR DESTRUCTION OF LESION OF VAG
7109	OTHER INCISION OF VULVA AND PERINEUM
7111	BIOPSY OF VULVA
7121	PERCUTANEOUS ASPIRATION OF BARTHOLIN'S G
7122	INCISION OF BARTHOLIN'S GLAND (CYST)
7123	MARSUPIALIZATION OF BARTHOLIN'S GLAND (C
713	OTHER LOCAL EXCISION OR DESTRUCTION OF V
7179	OTHER REPAIR OF VULVA AND PERINEUM
750	INTRA-AMNIOTIC INJECTION FOR ABORTION
762	LOCAL EXCISION OR DESTRUCTION OF LESION
7671	CLOSED REDUCTION OF MALAR AND ZYGOMATIC
7672	OPEN REDUCTION OF MALAR AND ZYGOMATIC FR
7697	REMOVAL OF INTERNAL FIXATION DEVICE FROM
7702	SEQUESTRECTOMY OF HUMERUS
7723	WEDGE OSTEOTOMY OF RADIUS AND ULNA
7724	WEDGE OSTEOTOMY OF CARPALS AND METACARPA
7728	WEDGE OSTEOTOMY OF TARSALS AND METATARSA
7733	OTHER DIVISION OF RADIUS AND ULNA
7734	OTHER DIVISION OF CARPALS AND METACARPAL
7738	OTHER DIVISION OF TARSALS AND METATARSAL
7739	OTHER DIVISION OF OTHER BONE, EXCEPT FAC
7752	BUNIONECTOMY WITH SOFT TISSUE CORRECTION
7753	OTHER BUNIONECTOMY WITH SOFT TISSUE CORR
7754	EXCISION OF BUNIONETTE
7759	OTHER BUNIONECTOMY
7788	OTHER PARTIAL OSTECTOMY OF TARSALS AND M
7789	OTHER PARTIAL OSTECTOMY OF OTHER BONE, E
779	TOTAL OSTECTOMY
7838	*OTHER CHANGE IN BONE LENGTH OF TARSALS
7839	OTHER CHANGE IN BONE LENGTH OF OTHER BON
7858	INTERNAL FIXATION OF TARSALS AND METATAR

DIAG	DESC
786	REMOVAL OF INTERNAL FIXATION DEVICE
7861	REMOVAL OF INTERNAL FIXATION DEVICE FROM
7862	REMOVAL OF INTERNAL FIXATION DEVICE FROM
7864	REMOVAL OF INTERNAL FIXATION DEVICE FROM
7865	REMOVAL OF INTERNAL FIXATION DEVICE FROM
7866	REMOVAL OF INTERNAL FIXATION DEVICE FROM
7867	REMOVAL OF INTERNAL FIXATION DEVICE FROM
7868	REMOVAL OF INTERNAL FIXATION DEVICE FROM
8003	ARTHROTOMY FOR REMOVAL OF PROSTHESIS OF
8012	OTHER ARTHROTOMY OF ELBOW
8016	OTHER ARTHROTOMY OF KNEE
8026	ARTHROSCOPY OF KNEE
8043	DIVISION OF JOINT CAPSULE, LIGAMENT, OR
8044	DIVISION OF JOINT CAPSULE, LIGAMENT, OR
8048	DIVISION OF JOINT CAPSULE, LIGAMENT, OR
8050	IV DISC EXCS / DSTRUCT NOS
806	EXCISION OF SEMILUNAR CARTILAGE OF KNEE
8073	SYNOVECTOMY OF WRIST
8074	SYNOVECTOMY OF HAND AND FINGER
8078	SYNOVECTOMY OF FOOT AND TOE
8087	OTHER LOCAL EXCISION OR DESTRUCTION OF L
809	OTHER EXCISION OF JOINT
8094	OTHER EXCISION OF JOINT OF HAND AND FING
8116	METATARSOPHALANGEAL FUSION
8118	OTHER FUSION OF TOE
8128	INTERPHALANGEAL FUSION
8131	ARTHROPLASTY OF FOOT AND TOE WITH SYNTHE
8139	OTHER ARTHROPLASTY OF FOOT AND TOE
8171	ARTHROPLASTY OF HAND AND FINGER WITH SYN
8179	OTHER REPAIR OF HAND AND FINGER
8186	ARTHROPLASTY OF CARPALS WITH SYNTHETIC P
8201	EXPLORATION OF TENDON SHEATH OF HAND
8203	BURSOTOMY OF HAND
8209	OTHER INCISION OF SOFT TISSUE OF HAND
8211	TENOTOMY OF HAND
8212	FASCIOTOMY OF HAND
8221	EXCISION OF LESION OF TENDON SHEATH OF H
8232	EXCISION OF TENDON OF HAND FOR GRAFT
8233	OTHER TENONECTOMY OF HAND
8235	OTHER FASCIECTOMY OF HAND
8251	ADVANCEMENT OF TENDON OF HAND
8279	PLASTIC OPERATION ON HAND WITH OTHER GRA
8284	REPAIR OF MALLET FINGER
8285	OTHER TENODESIS OF HAND
8286	OTHER TENOPLASTY OF HAND
8289	OTHER PLASTIC OPERATIONS ON HAND
8291	LYSIS OF ADHESIONS OF HAND
8301	EXPLORATION OF TENDON SHEATH
8303	BURSOTOMY
8309	OTHER INCISION OF SOFT TISSUE
8314	FASCIOTOMY
8321	BIOPSY OF SOFT TISSUE

LOUISIANA MEDICAID MAN T INFORMATION SYSTEMS
LIST OF SURGERY CODES ON DIAGNOSIS FILE WITH PA = R

DIAG	DESC
8331	EXCISION OF LESION OF TENDON SHEATH
8339	EXCISION OF LESION OF OTHER SOFT TISSUE
8341	EXCISION OF TENDON FOR GRAFT
8342	OTHER TENONECTOMY
8345	OTHER MYECTOMY
835	BURSECTOMY
8361	SUTURE OF TENDON SHEATH
8364	OTHER SUTURE OF TENDON
8387	OTHER PLASTIC OPERATIONS ON MUSCLE
8388	OTHER PLASTIC OPERATIONS ON TENDON
8391	LYSIS OF ADHESIONS OF MUSCLE, TENDON, FA
8411	AMPUTATION OF TOE
8412	AMPUTATION THROUGH FOOT
850	MASTOTOMY
8511	PERCUTANEOUS (NEEDLE) BIOPSY OF BREAST
8512	OTHER BIOPSY OF BREAST
8521	LOCAL EXCISION OF LESION OF BREAST
8524	EXCISION OF ECTOPIC BREAST TISSUE
8591	ASPIRATION OF BREAST
8595	INSRT BREAST TISS EXPAND
8596	REMOV BREAST TISS EXPAND
8601	ASPIRATION OF SKIN AND SUBCUTANEOUS TISS
8604	OTHER INCISION WITH DRAINAGE OF SKIN AND
8605	INCISION WITH REMOVAL OF FOREIGN BODY FR
8609	OTHER INCISION OF SKIN AND SUBCUTANEOUS
8611	BIOPSY OF SKIN AND SUBCUTANEOUS
8621	EXCISION OF PILONIDAL CYST OR SINUS
8622	DEBRIDEMENT OF WOUND, INFECTION, OR BURN
8623	REMOVAL OF NAIL, NAILBED, OR NAIL FOLD
8627	DEBRID,NAIL,BED,FOLD
863	OTHER LOCAL EXCISION OR DESTRUCTION OF L
8660	FREE SKIN GRAFT, NOT OTHERWISE SPECIFIED
8662	OTHER SKIN GRAFT TO HAND
8686	ONYCHOPLASTY
8689	OTHER REPAIR AND RECONSTRUCTION OF SKIN
8693	INSRT SKIN TISS EXPANDER
8782	GAS CONTRAST HYSTEROSALPINGOGRAM
8783	OPAQUE DYE CONTRAST HYSTEROSALPINGOGRAM
8926	GYNECOLOGICAL EXAMINATION
9618	OTHER VAGINAL DILATION
9622	DILATION OF RECTUM
9623	DILATION OF ANAL SPHINCTER
9625	THERAPEUTIC DISTENTION OF BLADDER
9649	OTHER GENITOURINARY INSTILLATION
9659	OTHER IRRIGATION OF WOUND
9739	REMOVAL OF OTHER THERAPEUTIC DEVICE FROM
9802	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO
9803	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO
9804	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO
9805	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO
9814	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO
9815	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO

DIAG	DESC
9821	REMOVAL OF SUPERFICIAL FOREIGN BODY FROM
9822	REMOVAL OF OTHER FOREIGN BODY WITHOUT IN
9827	REMOVAL OF FOREIGN BODY WITHOUT INCISION
9985	LOCALIZED HYPERTHERMIA
9986	PLACED EXT. BONE STIM

421 RECORDS PRINTED

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

David W. Hood
SECRETARY

March 10, 1999

TO: Enrolled Hospitals and Physicians

FROM: Thomas D. Collins
Director

RE: Selective Billing of Medicaid Covered Services

The Bureau of Health Services Financing adopted a rule governing the selective billing of Medicaid covered services (*Louisiana Register*, Volume 17, Number 3). The rule states that "practitioners who participate as providers of medical services shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted by the provider as a Medicaid patient."

The Health Care Financing Administration (HCFA) recently advised us that some physicians continue to inappropriately require Medicaid patients to make cash payments to them for Medicaid covered services. To illustrate the problem, HCFA gave the example of an anesthesiologist who refused to administer an epidural to a Medicaid patient unless the patient made an up-front payment for the anesthesia service.

HCFA recommends that we advise hospitals of their responsibilities under the Medicaid Program when a physician demands cash payment for a covered service as in the situation described above. When a hospital accepts a Medicaid patient for treatment, it also accepts the responsibility for ensuring that the patient receives all medically necessary services ordered by the attending physician. The conditions of participation that govern hospitals providing care to Medicaid and Medicare patients require that the governing body of the hospital assure the accountability of the medical staff for the quality of care provided to patients. If the physician does not accept a particular patient for treatment, the hospital has the responsibility of assuring the delivery of these medically necessary services without imposition of deductibles, cost sharing, or similar charges.

Each physician determines whether or not to accept an individual patient for treatment. A physician who participates in a State's Medicaid Program, and agrees to treat a Medicaid patient for a service covered by the state plan, may not require a co-payment for his or her services, but must accept payment by the State's Medicaid agency as payment in full. Under federal Medicaid law, deductibles, cost sharing or similar charges are not permitted for Medicaid services furnished to pregnant women. Thus, a participating physician's demand for these up-front payments would be a violation of the law. However, if a physician accepts a Medicaid recipient for treatment as a private patient and the Medicaid recipient accepts the arrangement as a condition of treatment for pregnancy and delivery; the arrangement is not governed by Medicaid regulations.

You may contact Kandis McDaniel in the Physician Program or Derek Stafford in the Hospital Program if you have any questions regarding this notice.

TDC/BEG/SV

**********1539856********** LOUISIANA MEDICAID REMITTANCE VOUCHER **********

TO:

DATE: 04/06/1999 PAGE:

REMITTANCE NO:

1539856

RECIPIENT NUMBER (MEDICAL RECORD NO)	RECIPIENT NAME	DATES OF SERVICE FROM	DATES OF SERVICE THRU	UNITS	PROCEDURE-ACCOMODATION DRUG CODE AND DESCRIPTIONS	AMOUNT BILLED	AMOUNT ALLOWED	DEDUCTIONS	AMOUNT PAID	CONTROL NUMBER
					SULFACT/PREDNIS SP OPH DROPS 0.25% 5ML OFF MAC 03/26/99					
					SULFACT/PREDNIS SP OPH DROPS 0.25% 10ML OFF MAC 03/26/99					

PLEASE MAKE THE FOLLOWING CHANGES TO THE 8/15/98 VERSION OF APPENDIX C:

LABELER	COMPANY	BEGIN	END
63807	EXCELSIOR MEDICAL CORP	04/01/99	

PLEASE FILE ADJUSTMENTS FOR CLAIMS WHICH MAY HAVE BEEN INCORRECTLY PAID

****

**********REMITTANCE ADVICE CHANGES**********

IN CONJUNCTION WITH THE YEAR 2000 READINESS TRNASITION, SEVERAL MINOR CHANGES ON THE HARDCOPY RA WILL OCCUR, BEGINNING WITH THE 4/6/99 RA. THE RA DATE IN THE UPPER RIGHT SECTION OF THE PAGE WILL APPEAR AS AN 8-DIGIT DATE WITH APPROPRIATE DIVISIONS BETWEEN THE MONTH, DAY, AND 4-DIGIT YEAR (EX:MM/DD/CCYY). THE "FROM" AND "THROUGH" DATES WILL REMAIN 6-DIGIT DATES (EX: MM DD YY). ALL OTHER DATES (ALL FINANCIAL PAGE DATES, DUPLICATE CLAIM DATES, ETC.) WILL APPEAR AS 8-DIGIT DATES WITHOUT DIVISIONS (EX: MMDDCCYY OR CCYYMMDD). ELECTRONIC RA'S AND REMITTANCE TAPES WILL NOT CHANGE (I.E., 6-DIGIT DATES). PLEASE BE AWARE OF THESE CHANGES IN YOUR UPCOMING HARDCOPY RA'S. UNISYS HAS IMPLEMENTED MODIFICATIONS TO PROCESSING LOGIC THAT WILL ACCURATELY PROCESS CLAIMS SUBMITTED WITH 6-DIGIT DATES, THUS ELIMINATING THE NEED FOR PROVIDERS TO MAKE ANY CHANGES IN THEIR SOFTWARE OR SUBMITTAL PROCESSES. CONTACT PROVIDER RELATIONS AT (800)473-2783 OR (225)924-5040 SHOULD YOU HAVE QUESTIONS CONCERNING THESE CHANGES.

**********BILLING RECIPIENTS WHEN PRECERTIFICATIONS ARE DENIED**********

WE HAVE BEEN RECEIVING INQUIRIES REGARDING THE BILLING OF RECIPIENTS IF A REQUEST FOR PRECERTIFICATION OF AN INPATIENT HOSPITAL STAY IS DENIED OR IF AN EXTENSION IS DENIED FOLLOWING APPROVAL OF THE INITIAL PRECERT. IF A REQUEST FOR PRECERT IS DENIED BECAUSE MEDICAL NECESSITY IS NOT MET, THE RECIPIENT CANNOT BE BILLED. IF THE CASE HAD MET MEDICAL NECESSITY, IT WOULD HAVE BEEN PRECERTED; THUS, IF IT WAS NOT MEDICALLY NECESSARY FOR THE RECIPIENT TO BE IN THE HOSPITAL, THE PROVIDER SHOULD NEVER HAVE ADMITTED THE PATIENT. THIS SAME LOGIC APPLIES TO THE EXTENSIONS-IF IT IS NOT MEDICALLY NECESSARY FOR THE PATIENT TO BE IN THE HOSPITAL, THEN DISCHARGE WOULD BE IN ORDER. PROVIDERS SHOULD ALSO NOT BILL RECIPIENTS SIMPLY BECAUSE THEY WERE LATE IN SUBMITTING THEIR PRECERTIFICATION INFORMATION. ONE SITUATION WHERE A PROVIDER COULD BILL THE RECIPIENT IS WHEN THE RECIPIENT PRESENTS HIMSELF TO THE HOSPITAL AS A PRIVATE-PAY PATIENT, NOT INFORMING THE HOSPITAL OF THEIR MEDICAID COVERAGE. WHEN A HOSPITAL'S PRECERT REQUEST(INITIAL REQUEST OR EXTENSION REQUEST)IS DENIED DUE TO TIMELY SUBMITTAL, THE PHYSICIAN CAN GET SERVICES PAID ONLY IF THE CLAIMS ALONG WITH AN ADMIT AND DISHCARGE SUMMARY AND A LETTER REQUESTING A PRECERT OVERRIDE, ARE SUBMITTED TO UNISYS PROVIDER RELATIONS CORRESPONDENCE UNIT,P.O.BOX91024,BATON ROUGE,LA.,70821.THESE CLAIMS MUST BE REVIEWED FOR MEDICAL NECESSITY AND SPECIAL HANDLED FOR PROCESSING.THIS IS THE SAME PROCEDURE FOLLOWED BY THE PHYSICIAN IF A HOSPITAL FAILS TO REQUEST INITIAL PRECERT. IF ADDITIONAL AID IS NEEDED REGARDING BILLING OF RECIPIENTS, PLEASE CONTACT UNISYS PROVIDER RELATIONS AT (225)924-5040 OR (800)473-2783.

**********END OF MESSAGES**********

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
David W. Hood
SECRETARY

October 28, 1999

MEMORANDUM

To: All Providers of Laboratory Services

From: Thomas D. Collins
Director

RE: Addition of Clinical Laboratory Improvement Amendment (CLIA) QW Modifiers

Previously, the Bureau has not required the use of QW modifiers when billing for certain laboratory procedures performed in physicians' offices that have CLIA waivered or provider performed microscopy (PPM) certificates.

Effective for dates of service on or after February 1, 2000, waived (certification type 2) or PPM (certification type 4) providers will be required to use the QW modifier when billing the attached CPT laboratory procedure codes. The QW is a modifier which has been assigned by HCFA as a mandated addition to the CLIA waived codes.

For your information the list of tests granted waiver status under CLIA, which is periodically updated, may be found online at the following Internet address:

http://www.hcfa.gov/medicaid/clia/waivetbl.htm

If there are any questions concerning this matter, you may contact Kandis McDaniel Whittington, Program Manager, at (225) 342-9490 or Marie Smith, Program Specialist, at (225) 342-9319.

TESTS GRANTED WAIVED STATUS UNDER CLIA
Revised 05/19/1999

TEST NAME	CPT CODE(S)	USE
Dipstick or tablet reagent urinalysis - non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen	81002	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
Fecal occult blood	82270	Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening)
Ovulation tests by visual color comparison for human luteinizing hormone	84830	Detection of ovulation (optimal for conception)
Urine pregnancy tests by visual color comparison	81025	Diagnosis of pregnancy
Erthrocyte sedimentation rate - non-automated	85651	Nonspecific screening test for inflammatory activity, increased for majority of infections, and most cases of carcinoma and leukemia
Hemoglobin by copper sulfate - non-automated	83026	Monitors hemoglobin level in blood
Blood glucose by glucose monitoring devices cleared by the FDA for home use	82962	Monitoring of blood glucose levels
Blood count; spun microhematocrit	85013	Screen for anemia
Hemoglobin by single instrument with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout	85018QW	Monitors hemoglobin level in blood
HemoCue B-Glucose Photometer	82947QW 82950QW 82951QW 82952QW	Diagnosis and monitoring of blood glucose levels
ChemTrak AccuMeter	82465QW	Cholesterol monitoring
Advanced Care	82465QW	Cholesterol monitoring
Boehringer Mannheim Chemstrip Micral	82044QW	Monitors low concentrations of albumin in urin which is helpful for early detection in patients at risk for renal disease.

TEST NAME	CPT CODE(S)	USE
Cholestech LDX	82465QW 83718QW 84478QW 82947QW 82950QW 82951QW 82952QW 80061QW	Measures total cholesterol, HDL cholesterol, triglycerides and glucose levels in whole blood.
Serim Pyloritek Test Kit	87072QW	Presumptive identification of *Helicobacter pylori* in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers).
QuickVue In-Line One-Step Strep A Test	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Boehringer Mannheim Accu-Chek InstantPlus Cholesterol	82465QW	Cholesterol monitoring
All qualitative color comparison pH testing - body fluids (other than blood)	83986QW	pH detection (acid-base balance) in body fluids such as semen, amniotic fluid and gastric aspirates
SmithKline Gastroccult	82273QW	Rapid screening test to detect the presence of gastric occult blood
QuickVue One-Step H. Pylori Test for Whole Blood	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood
Binax NOW Strep A Test	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Delta West CLOtest	87072QW	Presumptive identification of *Helicobacter pylori* in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers).
Wampole STAT-CRIT Hct	85014QW	Screen for anemia
SmithKline Diagnostics FlexSure HP Test for IgG Antibodies to H. pylori in Whole Blood	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood
Wyntek Diagnostics OSOM Strep A Test	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
GI Supply HP-FAST	87072QW	Presumptive identification of *Helicopbacter pylore* in gastric biopsy tissue, which has been shown to cause chronic active gastritis (ulcers).

TEST NAME	CPT CODE(S)	USE
Abbott FlexPak HP Test for whole blood	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood
Chemtrak AccuMeter H. pylori Test (for whole blood)	Pending	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood
BioStar Acceava Strep A Test (direct specimen only)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
LXN Fructosamine Test System	82985QW	Used to evaluate diabetic control, reflecting diabetic control over a 2-3 week period. Not a useful test for screening diabetes mellitus.
ITC Protime Microcoagulation System for Prothrombin Time	85610QW	Aid in screening for congenital deficiencies of factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumadin or warfarin effect; screen for vitamin K deficiency.
CoaguChek PST for Prothrombin Time	85610QW	Aid in screening for congenital deficiencies of factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumadin or warfarin effect; screen for vitamin K deficiency.
SmithKline ICON FxStrep A Test (from throat swab only)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Abbot Signify Strep A Test (from throat swab only)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Bayer Clinitek 50 Urine Chemistry Analyzer - qualitative dipstick for glucose, bilirubin, ketone, specific gravity, blood, pH, protein urobilinogen nitrite leukocytes - automated	81003QW	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
Bayer DCA 2000-glycosylated hemoglobin (HgbAlc)	83036QW	Measures the percent concentration of hemoglobin Alc in blood, which is used in monitoring the long-term care of people with diabetes.
Wampole Mono-Plus WB	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.

TEST NAME	CPT CODE(S)	USE
LXN Duet Glucose Control Monitoring System	82962 82985QW	Monitoring of blood glucose levels and measures fructosamine which is used to evaluate diabetic control, reflecting diabetic control over a 2-3 week period.
ENA.C.T Total Cholesterol Test	82465QW	Cholesterol monitoring
Genzyme Contrast Mono (whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
Applied Biotech SureStep Strep A (II) (direct from throat swab)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
STC Diagnostics Q.E.D. A150 Saliva Alcohol Test	Pending	Qualitative determination of alcohol (ethanol) in saliva
STC Diagnostics Q.E.D. A350 Saliva Alcohol Test	Pending	Qualitative determination of alcohol (ethanol) in saliva
Micro Diagnostics Spuncrit Model DRC-40 Infrared Analyzer for hematocrit	Pending	Screen for anemia
Chemstrip Mini UA - qualitative dipstick for glucose, bilirubin, ketone, specific gravity, blood, pH, protein, urobilinogen, nitrite, leukocytes - automated	81003/QW	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
Litmus Concepts FemExam TestCard (from vaginal swab)	84999QW Priced manually, individual consideration	Qualitative test of a vaginal fluid sample for elevated pH (pH greater than or equal to 4.7) and the presence of volatile amines
Wyntek Diagnostics OSOM Mono Test (whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
Meridian Diagnostics ImmunoCard STAT Strep A (direct from throat swab)	86588QW	Rapidly detects Group A streptococcal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Seradyn Color Q Mono (whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
Jant Pharmacal AccuStrip Strep A (II) (direct from throat swab)	86588QW	Rapidly detects Group A streptocaccal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.

TEST NAME	CPT CODE(S)	USE
BioStar Acceava Mono Test (whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
LifeSign UniStep Mono Test (whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
Becton Dickinson LINK 2 Strep A Rapid Test (direct from throat swab)	86588QW	Rapidly detects Group A streptocaccal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
DynaGen NicCheck I Test Strips	80101QW	Detects nicotine and/or its metabolites in urine, which is used as an aid in indicating the smoking status of an individual and as an aid in the identification of a smoker as a low or high nicotine consumer.
Mainline Confirms Strep A Dots Test (direct from throat swab)	86588QW	Rapidly detects Group A streptocaccal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Quidel Cards O.S. Mono (for whole blood)	86308QW	Qualitative screening test for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
Bayer Clinitek 50 Urine Chemistry Analyzer - for HCG, urine	84703QW	Diagnosis of pregnancy
Bayer Clinitek 50 Urine Chemistry Analyzer - for microalbumin, creatinine	82044QW	Detection of patients at risk for developing kidney damage
Bayer DCA 2000+ - glycosylated hemoglobin (Hgb Alc)	83036QW	Measures the percent concentration of hemoglobin Alc in blood, which is used in monitoring the long-term care of people with diabetes.
GDS Diagnostics HemoSite Meter - for hemoglobin	85018QW	Measures hemoglobin level in whole blood.
ActiMed Laboratories ENA.C.T. Total Cholesterol Test (PDU)	82465QW	Cholesterol monitoring
Genzyme Contrast Strep A (direct from throat swab)	86588QW	Rapidly detects Group A streptocaccal (GAS) antigen from throat swabs and used as an aid in the diagnosis of GAS infection which typically causes strep throat, tonsillitis and scarlet fever.
Roche/Boehringer Mannheim CoaguChek System for Professional Use	85610QW	Aid in screening for congenital deficiencies of Factors II, V, VII, X; screen for deficiency of prothrombin; evaluate heparin effect, coumadin or warfarin effect; screen for Vitamin K deficiency.

TEST NAME	CPT CODE(S)	USE
Applied Biotech SureStep Mono Test (whole blood)	86308QW	Qualitative screening ttest for the presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.
Becton Dickinson Link 2 H. Pylori Rapid Test (for whole blood)	86318QW	Immunoassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood.
Bion Diagnostic Sciences BTA stat Test (for home use)	83518QW	Immunoassay for the qualitative detection of bladder tumor associated antigen in urine of persons diagnosed with bladder cancer and used as an aid in the management of bladder cancer patients.
Diatech Diagnostics Uriscreen (for OTC use)	81007QW	Detects catalase in urine which is associated with urinary tract infections (UTIs). White blood cells and some bacteria associated with UTIs are positive for catalase.
Lifestream Technologies Cholesterol Monitor	82465QW	Cholesterol monitoring
Abbott TestPack Plus H. Pylori (for whole blood)	86318QW	Immunassay for rapid, qualitative detection of IgG antibodies specific to *Helicobacter pylori* in whole blood.
Jant Accutest Infectious Mononucleosis Test (whole blood)	86308QW	Qualitative screening test for presence of heterophile antibodies in human whole blood, which is used as an aid in the diagnosis of infectious mononucleosis.

http:/www.hcfa.gov/medicaid/clia/waivetbl.htm

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS
David W. Hood
SECRETARY

June 19, 2000

MEMORANDUM

TO: **ALL NURSING FACILITIES, DURABLE MEDICAL EQUIPMENT PROVIDERS AND REHABILITATION FACILITIES**

FROM: **BEN BEARDEN**
ACTING DIRECTOR

RE: **WHEELCHAIR SEATING EVALUATIONS AND TRANSPORTATION TO REHABILITATION FACILITIES FOR MEDICAID RECIPIENTS IN NURSING FACILITIES**

Medicaid policy requires that Durable Medical Equipment (DME) providers submit a copy of a wheelchair seating evaluation from a rehabilitation therapist along with their requests for prior authorization of customized wheelchairs for Medicaid recipients residing in nursing facilities (ICF I, II, & SNF). Previously, Medicaid has described three basic methods by which such evaluations may be obtained in nursing facilities. These were published in the *Provider Update* newsletter of August 1999, page 4. The three basic methods described in this article that may be utilized by DME providers are: (1) have a home health agency provide a physical therapist for the evaluation in the nursing facility; (2) utilize a therapist under contract with the nursing facility to provide therapy services for the recipient for the seating evaluation; or, (3) reimburse a therapist at the DME provider's own expense to perform a seating evaluation when neither of the first two methods are available to obtain an evaluation.

Effective August 1, 2000, Medicaid is revising the third method of obtaining wheelchair evaluations, as described in the above referenced *Provider Update* newsletter article, for nursing home Medicaid recipients. Effective for August 1, 2000 and after, DME providers can no longer reimburse rehabilitation therapists at their own expense to perform wheelchair seating evaluations for Medicaid recipients in nursing facilities. Since nursing facilities are required to provide medically necessary transportation services for Medicaid recipients residing in their facilities, nursing facilities must provide transportation of their Medicaid residents to outpatient rehabilitation facilities for wheelchair seating evaluations. Nursing facilities must provide such transportation, however, only when no home health agency is available to provide a therapist to perform such an evaluation in their facility and when no facility-contracted therapist is available for an individual recipient needing a wheelchair evaluation.

DME providers may continue to reimburse rehabilitation therapists for wheelchair seating evaluations in nursing homes in accordance with the provisions described in the above referenced August 1999 newsletter article, when no other method of obtaining such evaluations in the facility is available, for therapist evaluations that are performed through July 31, 2000. All rehabilitation therapist wheelchair evaluations for Medicaid recipients residing in nursing facilities, dated August 1, 2000 and after, must be performed in an outpatient rehabilitation therapy facility if no home health agency is available to provide a physical therapist for a seating evaluation in the nursing facility, or if no facility-contracted therapist is available to provide a seating evaluation for the individual. The outpatient rehabilitation facility must bill Medicaid for the wheelchair seating evaluation performed by their therapist and must not accept reimbursement from the DME provider for the service.

If further clarification or additional information is needed concerning these regulations, you may contact Gene King at 225-342-3930.

Sincerely,

Ben A. Bearden
Acting Director

BAB:GEK:slg

DME/Rehabilitation/Nursing Facilities

Wheelchair Seating Evaluations for Medicaid Recipients in Nursing Facilities

Since Medicaid policy for the prior authorization of customized wheelchairs requires DME providers to submit a wheelchair seating evaluation from a rehabilitation therapist, several DME providers have recently requested that BHSF clarify Medicaid policy with regard to the methods by which they may obtain such evaluations in nursing facilities. Three methods that may be utilized by DME providers to obtain seating evaluations for nursing home recipients:

First, Medicaid does reimburse home health agencies for the provision of physical or occupational therapists to perfrom wheelchair seating evaluations for Medicaid recipients in nursing facilities. If therapy services are available from a home health agency for a facility resident, a DME provider may work with that home health agency to have a therapist perform a seating evaluation. (Please note, however, that Medicaid does not reimburse rehabilitation centers for the provision of therapists for wheelchair seating evaluations in nursing facilities).

Second, since nursing facilities are required to provide rehabilitation services for skilled care Medicaid recipients residing in their facilities, they often employ physical and occupational therapists on staff to render rehabilitation services to these recipients. A DME provider, therefore, may work with a therapist, who is employed by a facility to obtain a wheelchair seating evaluation for a facility resident.

Third, some DME providers, at their own expense, reimburse therapists to perform seating evaluations for nursing home recipients when no other method is available for their reimbursement. Medicaid policy does not specifically address this as an option for DME providers, but since policy does not prohibit it, and since policy does require a seating evaluation by a therapists as a prerequisite for prior authorization of a customized wheelchair, BHSF recognizes that DME provider reimbursement for a therapist's evaluation of a nursing home recipient may be necessary in those circumstances where there is no other method of reimbursement. DME providers, however, should document in their records that no facility contracted therapist, home health agency therapist, or other funding source is available for an evaluation for that individual recipient. (Please note, also, that Medicaid regulations do not permit a DME provider to pay a therapist for seating evaluation services for a recipient when that therapist is already employed by a home health agency, a nursing home, or a rehabilitation center to provide rehabilitation services for that recipient.)

Home Health

Filling Out Home Health Services Claims

When filing claims for home health services, Block 19, "Patient Status," on the Home Health Services claim form must be completed.

There must be a date in either Block A - Date of Discharge , Block B - Date of Death, or Block C - Visits Exhausted or an X must be placed in Block D - Still Receives. Failure to fill in one of these blocks will cause the claim to be denied.

Previous *Provider Update* Correction

The June/July 1999 issue of the Provider Update included an article for Home Health Agencies entitled, "*RN Qualifications for Psychiatric Home Health Visits.*"

The last paragraph of this article incorrectly stated that the services must be prior authorized. The correct wording of the paragraph is "Additionally, the services must be medically necesary and providsd only to recipents who meet Medicaid's homebound criteria."

We apologize for any inconvenience this may have caused.

Louisiana Medicaid

Provider Update

Volume 16, Issue 4 August 1999

Y2K Readiness Update

As you are aware, the Department of Health and Hospitals and Unisys have been working diligently to ensure that all Louisiana Medicaid systems are Year 2000 ready. As of June 30, 1999, the remediation and testing of code for Y2K readiness (including mirroring, bridging, and expansion of critical date fields) is complete, implemented, and currently in production. We are presently conducting the final phase of our Y2K project which involves extensive end-to-end testing of the system using future Year 2000 dates.

As part of our outreach initiative ensure that recipients and providers are ot adversely affected by our Y2K changes, we would like to provide the following information on key areas:

PERMANENT 13-DIGIT IDENTIFICATION NUMBER

The Medicaid recipient identification number previously assigned to recipients is a 13-digit "intelligent" number that houses certain pieces of information used in Medicaid billing. Use of this "intelligent" number has caused billing difficulty for the provider community. In an effort to resolve these issues, beginning July 1, 1999, a new permanent 13-digit number was assigned to each Medicaid recipient. The most current 13-digit recipient ID number was frozen and became the permanent person number for all individuals on the Unisys recipient file on June 30, 1999. Recipients added to the file as of July 1, 1999 and after are being assigned a new permanent 13-digit number, which may look somewhat different to you. Information previously obtained from the "intelligent" number is currently available and will be supplied as a part of the response given when making eligibility inquiries through MEVS or REVS. Providers must access and verify eligibility through REVS or MEVS

USE OF PREVIOUSLY ISSUED RECIPIENT IDENTIFICATION NUMBERS

This does not mean that other identification numbers previously issued to recipients may not be used to bill claims for services rendered. Any 13-digit number that was a valid number and is still on the recipient file may be used to bill claims. In situations where services were pre-certified or prior authorized using a number other than the permanent 13-digit person number, it is necessary to bill using the number under which the pre-certification or prior authorization was issued.

As of July, 1999, we encourage providers to make note of the identification number confirmed or obtained from Unisys REVS or MEVS eligibility inquiries as this number will be the PERMANENT number. For dates of service and pre-certification and prior authorization after July 1, 1999, the permanent 13-digit person number will be used by all DHH and Unisys systems. PLEASE REMEMBER THAT THIS 13-DIGIT PERSON NUMBER DOES NOT REPLACE THE 16-DIGIT CARD CONTROL NUMBER (CCN) CONTAINING LEADING DIGITS OF "777."

PLASTIC IDENTIFICATION CARD/CARD CONTROL NUMBER

Medicaid recipients now have a plastic swipe ID card which is encoded with a 16-digit Card Control Number (CCN) containing the lead digits of "777". This card number is used to access Medicaid eligibility, benefit, and service limit information. The CCN should never be used for billing with the exception of pharmacy POS. Claims submitted with this number will deny. (Pharmacy

Continued on Page 5

FOR INFORMATION OR ASSISTANCE, CALL US!

Provider Relations	**1-800-473-2783** **(225) 924-5040**
REVS Line	**1-800-776-6323** **(225) 216-REVS(7387)**
Point of Sale Help Desk	**1-800-648-0790** **(225) 237-3381**
Prior Authorization	
Home Health/EPSDT - PCS	**1-800-807-1320**
Dental	**1-504-619-8589**
DME & All Other	**1-800-488-6334** **(225) 928-5263**
Hospital Pre-Certification	**1-800-488-6334**

Following is an updated list of all ICD-9 procedures that fall within one of the four surgical groupings in the hospital outpatient surgical program. This is the most current list available and replaces all previous lists, including the one on pp. 32-39 of the 2000 Hospital Training Medicaid Issues for 2000.

DX	DESCRIPTION	SURG,GRP	FEE
0406	OTHER CRANIAL OR PERIPHERAL GANGLIONECTO	3	282.40
0407	OTHER EXCISION OR AVULSION OF CRANIAL AN	4	320.56
043	SUTURE OF CRANIAL AND PERIPHERAL NERVES	4	320.56
0443	RELEASE OF CARPAL TUNNEL	3	282.40
0449	OTHER PERIPHERAL NERVE OR GANGLION DECOM	3	282.40
046	TRANSPOSITION OF CRANIAL AND PERIPHERAL	3	282.40
067	EXCISION OF THYROGLOSSAL DUCT OR TRACT	3	282.40
0802	SEVERING OF BLEPHARORRHAPHY	2	262.36
0809	OTHER INCISION OF EYELID	2	262.36
0820	REMOVAL OF LESION OF EYELID, NOT OTHERWI	1	220.39
0821	EXCISION OF CHALAZION	1	220.39
0825	DESTRUCTION OF LESION OF EYELID	1	220.39
0841	REPAIR OF ENTROPION OR ECTROPION BY THER	3	282.40
0842	REPAIR OF ENTROPION OR ECTROPION BY SUTU	3	282.40
0843	REPAIR OF ENTROPION OR ECTROPION WITH WE	3	282.40
0844	REPAIR OF ENTROPION OR ECTROPION WITH LI	3	282.40
0852	BLEPHARORRHAPHY	2	262.36
0859	OTHER ADJUSTMENT OF LID POSITION	2	262.36
0864	RECONSTRUCTION OF EYELID WITH TARSOCONJU	2	262.36
0943	PROBING OF NASOLACRIMAL DUCT	1	220.39
1044	OTHER FREE GRAFT TO CONJUNCTIVA	4	320.56
1099	OTHER OPERATIONS ON CONJUNCTIVA	1	220.39
110	MAGNETIC REMOVAL OF EMBEDDED FOREIGN BOD	1	220.39
1131	TRANSPOSITION OF PTERYGIUM	1	220.39
1132	EXCISION OF PTERYGIUM WITH CORNEAL GRAFT	1	220.39
1139	OTHER EXCISION OF PTERYGIUM	1	220.39
1149	OTHER REMOVAL OR DESTRUCTION OF CORNEAL	4	320.56
1211	IRIDOTOMY WITH TRANSFIXION	4	320.56
1214	OTHER IRIDECTOMY	4	320.56
1242	EXCISION OF LESION OF IRIS	4	320.56
1284	EXCISION OR DESTRUCTION OF LESION OF SCL	4	320.56
1319	OTHER INTRACAPSULAR EXTRACTION OF LENS	4	320.56
132	EXTRACAPSULAR EXTRACTION OF LENS BY LINE	4	320.56
133	EXTRACAPSULAR EXTRACTION OF LENS BY SIMP	4	320.56
1341	PHACOEMULSIFICATION AND ASPIRATION OF CA	4	320.56
1342	MECHANICAL PHACOFRAGMENTATION AND ASPIRA	4	320.56
1359	OTHER EXTRACAPSULAR EXTRACTION OF LENS	4	320.56
1362	EXCISION OF PRIMARY MEMBRANOUS CATARACT	4	320.56
1365	EXCISION OF SECONDARY MEMBRANE (AFTER CA	4	320.56
1371	INSERTION OF INTRAOCULAR LENS PROSTHESIS	4	320.56
1401	REMOVAL OF FOREIGN BODY FROM POSTERIOR S	1	220.39
1402	REMOVAL OF FOREIGN BODY FROM POSTERIOR S	1	220.39
1511	RECESSION OF ONE EXTRAOCULAR MUSCLE	4	320.56
1512	ADVANCEMENT OF ONE EXTRAOCULAR MUSCLE	4	320.56
1513	RESECTION OF ONE EXTRAOCULAR MUSCLE	4	320.56
1519	OTHER OPERATIONS ON ONE EXTRAOCULAR MUSC	4	320.56
1521	LENGTHENING PROCEDURE ON ONE EXTRAOCULAR	4	320.56
1522	SHORTENING PROCEDURE ON ONE EXTRAOCULAR	4	320.56
1529	OTHER OPERATIONS ON ONE EXTRAOCULAR MUSC	4	320.56
153	OPERATIONS ON TWO OR MORE EXTRAOCULAR MU	4	320.56
154	OTHER OPERATIONS ON TWO OR MORE EXTRAOCU	4	320.56
1631	REMOVAL OF OCULAR CONTENTS WITH SYNCHRON	4	320.56

DX	DESCRIPTION	SURG,GRP	FEE
1639	OTHER EVISCERATION OF EYEBALL	4	320.56
1642	ENUCLEATION OF EYEBALL WITH OTHER SYNCHR	4	320.56
1649	OTHER ENUCLEATION OF EYEBALL	4	320.56
1661	SECONDARY INSERTION OF OCULAR IMPLANT	4	320.56
1662	REVISION AND REINSERTION OF OCULAR IMPLA	4	320.56
1671	REMOVAL OF OCULAR IMPLANT	4	320.56
1809	OTHER INCISION OF EXTERNAL EAR	2	262.36
1811	OTOSCOPY	1	220.39
1829	EXCISION OR DESTRUCTION OF OTHER LESION	1	220.39
1911	STAPEDECTOMY WITH INCUS REPLACEMENT	4	320.56
1919	OTHER STAPEDECTOMY	4	320.56
193	OTHER OPERATIONS ON OSSICULAR CHAIN	4	320.56
194	MYRINGOPLASTY	4	320.56
195	OTHER TYMPANOPLASTY	4	320.56
1952	TYPE II TYMPANOPLASTY	4	320.56
1953	TYPE III TYMPANOPLASTY	4	320.56
1954	TYPE IV TYMPANOPLASTY	4	320.56
1955	TYPE V TYMPANOPLASTY	4	320.56
196	REVISION OF TYMPANOPLASTY	4	320.56
2001	MYRINGOTOMY WITH INSERTION OF TUBE	4	320.56
2009	OTHER MYRINGOTOMY	1	220.39
2041	SIMPLE MASTOIDECTOMY	4	320.56
208	OPERATIONS ON EUSTACHIAN TUBE	1	220.39
2121	RHINOSCOPY	1	220.39
2122	BIOPSY OF NOSE	1	220.39
2131	LOCAL EXCISION OR DESTRUCTION OF INTRANA	2	262.36
2132	LOCAL EXCISION OR DESTRUCTION OF OTHER L	1	220.39
215	SUBMUCOUS RESECTION OF NASAL SEPTUM	4	320.56
2162	FRACTURE OF THE TURBINATES	1	220.39
2169	OTHER TURBINECTOMY	1	220.39
217	REDUCTION OF NASAL FRACTURE	1	220.39
2171	CLOSED REDUCTION OF NASAL FRACTURE	1	220.39
2183	TOTAL NASAL RECONSTRUCTION	4	320.56
2187	OTHER RHINOPLASTY	4	320.56
2188	OTHER SEPTOPLASTY	4	320.56
2199	OTHER OPERATIONS ON NOSE	1	220.39
2200	ASPIRATION AND LAVAGE OF NASAL SINUS, NO	2	262.36
2201	PUNCTURE OF NASAL SINUS FOR ASPIRATION O	2	262.36
2202	ASPIRATION OR LAVAGE OF NASAL SINUS THRO	2	262.36
2263	ETHMOIDECTOMY	3	282.40
230	FORCEPS EXTRACTION OF TOOTH	1	220.39
2301	EXTRACTION OF DECIDUOUS TOOTH	1	220.39
2309	EXTRACTION OF OTHER TOOTH	1	220.39
231	SURGICAL REMOVAL OF TOOTH	1	220.39
2311	REMOVAL OF RESIDUAL ROOT	1	220.39
2319	OTHER SURGICAL EXTRACTION OF TOOTH	1	220.39
232	RESTORATION OF TOOTH BY FILLING	1	220.39
233	RESTORATION OF TOOTH BY INLAY	1	220.39
234	OTHER DENTAL RESTORATION	1	220.39
2341	APPLICATION OF CROWN	1	220.39
2342	INSERTION OF FIXED BRIDGE	1	220.39
2343	INSERTION OF REMOVABLE BRIDGE	1	220.39

DX	DESCRIPTION	SURG,GRP	FEE
2349	OTHER DENTAL RESTORATION	1	220.39
235	IMPLANTATION OF TOOTH	1	220.39
245	ALVEOLOPLASTY	1	220.39
2501	NEEDLE BIOPSY OF TONGUE	1	220.39
2502	OTHER BIOPSY OF TONGUE	1	220.39
2594	OTHER GLOSSOTOMY	2	262.36
270	DRAINAGE OF FACE AND FLOOR OF MOUTH	2	262.36
2741	LABIAL FRENECTOMY	4	320.56
2742	WIDE EXCISION OF LESION OF LIP	3	282.40
2743	OTHER EXCISION OF LESION OR TISSUE OF LI	1	220.39
2792	INCISION OF MOUTH, UNSPECIFIED STRUCTURE	2	262.36
280	INCISION AND DRAINAGE OF TONSIL AND PERI	2	262.36
282	TONSILLECTOMY WITHOUT ADENOIDECTOMY	4	320.56
283	TONSILLECTOMY WITH ADENOIDECTOMY	4	320.56
284	EXCISION OF TONSIL TAG	4	320.56
286	ADENOIDECTOMY WITHOUT TONSILLECTOMY	4	320.56
2911	PHARYNGOSCOPY	1	220.39
292	EXCISION OF BRANCHIAL CLEFT CYST OR VEST	2	262.36
3009	OTHER EXCISION OR DESTRUCTION OF LESION	1	220.39
313	OTHER INCISION OF LARYNX OR TRACHEA	1	220.39
3142	LARYNGOSCOPY AND OTHER TRACHEOSCOPY	1	220.39
3143	BIOPSY OF LARYNX	1	220.39
3144	BIOPSY OF TRACHEA	1	220.39
3321	BRONCHOSCOPY THROUGH ARTIFICIAL STOMA	1	220.39
3322	FIBER-OPTIC BRONCHOSCOPY	1	220.39
3323	OTHER BRONCHOSCOPY	1	220.39
3324	ENDOSCOPIC BRONCHIAL BIOPSY	1	220.39
3409	OTHER INCISION OF PLEURA	2	262.36
3797	REPL CARDIVERT / DFIB LEAD	1	220.39
3821	BIOPSY OF BLOOD VESSEL	1	220.39
3822	PERCUTANEOUS ANGIOSCOPY	4	320.56
3859	LIGATION AND STRIPPING OF LOWER LIMB VAR	4	320.56
3882	OTHER SURGICAL OCCLUSION OF OTHER VESSEL	1	220.39
3889	OTHER SURGICAL OCCLUSION OF LOWER LIMB V	4	320.56
4011	BIOPSY OF LYMPHATIC STRUCTURE	2	262.36
4021	EXCISION OF DEEP CERVICAL LYMPH NODE	2	262.36
4221	OPERATIVE ESOPHAGOSCOPY BY INCISION	1	220.39
4222	ESOPHAGOSCOPY THROUGH ARTIFICIAL STOMA	1	220.39
4223	OTHER ESOPHAGOSCOPY	1	220.39
4224	BIOPSY OF ESOPHAGUS	1	220.39
4232	LOCAL EXCISION OF OTHER LESION OR TISSUE	1	220.39
4239	OTHER DESTRUCTION OF LESION OR TISSUE OF	1	220.39
4292	DILATION OF ESOPHAGUS	1	220.39
4342	LOCAL EXCISION OF OTHER LESION OR TISSUE	1	220.39
4349	OTHER DESTRUCTION OF LESION OR TISSUE OF	1	220.39
4411	TRANSABDOMINAL GASTROSCOPY	1	220.39
4413	OTHER GASTROSCOPY	1	220.39
4414	BRUSH BIOPSY OF STOMACH	1	220.39
4415	OTHER BIOPSY OF STOMACH	1	220.39
4493	INSERT GASTRIC BALLOON	1	220.39
4494	REMOVAL GASTRIC BALLOON	1	220.39
4513	OTHER ENDOSCOPY OF SMALL INTESTINE	1	220.39

DX	DESCRIPTION	SURG,GRP	FEE
4514	BRUSH BIOPSY OF SMALL INTESTINE	1	220.39
4524	OTHER ENDOSCOPY OF LARGE INTESTINE	1	220.39
4525	BRUSH BIOPSY OF LARGE INTESTINE	1	220.39
4526	OTHER BIOPSY OF LARGE INTESTINE	1	220.39
4532	OTHER DESTRUCTION OF LESION OF DUODENUM	1	220.39
4541	LOCAL EXCISION OF LESION OR TISSUE OF LA	1	220.39
4595	SM BOWEL-ANUS ANASTOMOS	4	320.56
4643	OTHER REVISION OF STOMA OF LARGE INTESTI	3	282.40
4823	OTHER PROCTOSIGMOIDOSCOPY	1	220.39
4824	BRUSH BIOPSY OF RECTUM	1	220.39
4825	OTHER BIOPSY OF RECTUM	1	220.39
4835	LOCAL EXCISION OF RECTAL LESION OR TISSU	1	220.39
4881	INCISION OF PERIRECTAL TISSUE	1	220.39
4901	INCISION OF PERIANAL ABSCESS	1	220.39
4912	ANAL FISTULECTOMY	2	262.36
493	LOCAL EXCISION OR DESTRUCTION OF OTHER L	2	262.36
4945	LIGATION OF HEMORRHOIDS	3	282.40
4946	EXCISION OF HEMORRHOIDS	3	282.40
4947	EVACUATION OF THROMBOSED HEMORRHOIDS	3	282.40
4949	OTHER PROCEDURES ON HEMORRHOIDS	1	220.39
4951	LEFT LATERAL ANAL SPHINCTEROTOMY	2	262.36
4952	POSTERIOR ANAL SPHINCTEROTOMY	2	262.36
4959	OTHER ANAL SPHINCTEROTOMY	2	262.36
5011	PERCUTANEOUS (NEEDLE) BIOPSY OF LIVER	2	262.36
5300	UNILATERAL REPAIR OF INGUINAL HERNIA, NO	4	320.56
5301	UNILATERAL REPAIR OF DIRECT INGUINAL HER	4	320.56
5302	UNILATERAL REPAIR OF INDIRECT INGUINAL H	4	320.56
5303	UNILATERAL REPAIR OF DIRECT INGUINAL HER	4	320.56
5304	UNILATERAL REPAIR OF INDIRECT INGUINAL H	4	320.56
5305	UNILATERAL REPAIR OF INGUINAL HERNIA WIT	4	320.56
5321	UNILATERAL REPAIR OF FEMORAL HERNIA WITH	4	320.56
5329	OTHER UNILATERAL FEMORAL HERNIORRHAPHY	4	320.56
5349	OTHER UMBILICAL HERNIORRHAPHY	4	320.56
5359	REPAIR OF OTHER HERNIA OF ANTERIOR ABDOM	4	320.56
5369	REPAIR OF OTHER HERNIA OF ANTERIOR ABDOM	4	320.56
5421	LAPAROSCOPY	4	320.56
5423	BIOPSY OF PERITONEUM	4	320.56
5425	PERITONEAL LAVAGE	3	282.40
544	EXCISION OR DESTRUCTION OF PERITONEAL TI	4	320.56
545	LYSIS OF PERITONEAL ADHESIONS	4	320.56
5634	OPEN BIOPSY OF URETER	4	320.56
5635	ILEAL CONDUCT ENDOSCOPY	3	282.40
5731	CYSTOSCOPY THROUGH ARTIFICIAL STOMA	1	220.39
5732	OTHER CYSTOSCOPY	1	220.39
5749	OTHER TRANSURETHRAL EXCISION OR DESTRUCT	1	220.39
5791	SPHINCTEROTOMY OF BLADDER	1	220.39
5792	DILATION OF BLADDER NECK	1	220.39
581	URETHRAL MEATOTOMY	1	220.39
5821	PERINEAL URETHROSCOPY	1	220.39
5822	OTHER URETHROSCOPY	1	220.39
583	EXCISION OR DESTRUCTION OF URETHRAL TISS	1	220.39
5831	ENDOSCOPIC EXC OR DEST LESION TISS URETH	2	262.36

DX	DESCRIPTION	SURG,GRP	FEE
5839	OTH LOC EXC OR DEST LES-TIS URETH	2	262.36
585	RELEASE OF URETHRAL STRICTURE	1	220.39
586	DILATION OF URETHRA	1	220.39
5919	OTHER INCISION OF PERIVESICAL TISSUE	2	262.36
6011	NEEDLE BIOPSY OF PROSTATE	1	220.39
610	INCISION AND DRAINAGE OF SCROTUM AND TUN	2	262.36
612	EXCISION OF HYDROCELE (OF TUNICA VAGINAL	3	282.40
613	EXCISION OR DESTRUCTION OF LESION OR TIS	1	220.39
6191	PERCUTANEOUS ASPIRATION OF TUNICA VAGINA	3	282.40
620	INCISION OF TESTIS	2	262.36
6211	PERCUTANEOUS BIOPSY OF TESTIS	1	220.39
6212	OTHER BIOPSY OF TESTIS	1	220.39
623	UNILATERAL ORCHIECTOMY	2	262.36
6241	REMOVAL OF BOTH TESTES AT SAME OPERATIVE	2	262.36
6242	REMOVAL OF REMAINING TESTIS	2	262.36
631	EXCISION OF VARICOCELE AND HYDROCELE OF	3	282.40
6371	LIGATION OF VAS DEFERENS	4	320.56
6373	VASECTOMY	4	320.56
6392	EPIDIDYMOTOMY	2	262.36
640	CIRCUMCISION	3	282.40
642	LOCAL EXCISION OR DESTRUCTION OF LESION	1	220.39
6491	DORSAL OR LATERAL SLIT OF PREPUCE	1	220.39
6511	ASPIRATION BIOPSY OF OVARY	4	320.56
6512	OTHER BIOPSY OF OVARY	4	320.56
6529	OTHER LOCAL EXCISION OR DESTRUCTION OF O	4	320.56
658	LYSIS OF ADHESIONS OF OVARY AND FALLOPIA	4	320.56
6611	BIOPSY OF FALLOPIAN TUBE	4	320.56
662	BILATERAL ENDOSCOPIC DESTRUCTION OR OCCL	4	320.56
6621	BILATERAL ENDOSCOPIC LIGATION AND CRUSHI	4	320.56
6622	BILATERAL ENDOSCOPIC LIGATION AND DIVISI	4	320.56
6629	OTHER BILATERAL ENDOSCOPIC DESTRUCTION	4	320.56
663	OTHER BILATERAL DESTRUCTION OR OCCLUSION	4	320.56
6631	OTHER BILATERAL LIGATION AND CRUSHING OF	4	320.56
6632	OTHER BILATERAL LIGATION AND DIVISION OF	4	320.56
6639	OTHER BILATERAL DESTRUCTION OR OCCLUSION	4	320.56
6661	EXCISION OR DESTRUCTION OF LESION OF FAL	4	320.56
6692	UNILATERAL DESTRUCTION OR OCCLUSION OF F	4	320.56
670	DILATION OF CERVICAL CANAL	3	282.40
6711	ENDOCERVICAL BIOPSY	1	220.39
6712	OTHER CERVICAL BIOPSY	1	220.39
6732	DESTRUCTION OF LESION OF CERVIX BY CAUTE	4	320.56
6733	DESTRUCTION OF LESION OF CERVIX BY CRYOS	4	320.56
6739	OTHER EXCISION OR DESTRUCTION OF LESION	4	320.56
6901	DILATION AND CURETTAGE FOR TERMINATION O	4	320.56
6909	OTHER DILATION AND CURETTAGE OF UTERUS	3	282.40
6951	ASPIRATION CURETTAGE OF UTERUS FOR TERMI	4	320.56
6952	ASPIRATION CURETTAGE FOLLOWING DELIVERY	3	282.40
700	CULDOCENTESIS	1	220.39
7011	HYMENOTOMY	4	320.56
7014	OTHER VAGINOTOMY	3	282.40
7024	VAGINAL BIOPSY	1	220.39
7031	HYMENECTOMY	4	320.56

DX	DESCRIPTION	SURG,GRP	FEE
7033	EXCISION OR DESTRUCTION OF LESION OF VAG	2	262.36
7109	OTHER INCISION OF VULVA AND PERINEUM	2	262.36
7111	BIOPSY OF VULVA	1	220.39
7121	PERCUTANEOUS ASPIRATION OF BARTHOLIN'S G	1	220.39
7122	INCISION OF BARTHOLIN'S GLAND (CYST)	1	220.39
7123	MARSUPIALIZATION OF BARTHOLIN'S GLAND (C	1	220.39
713	OTHER LOCAL EXCISION OR DESTRUCTION OF V	1	220.39
7179	OTHER REPAIR OF VULVA AND PERINEUM	2	262.36
750	INTRA-AMNIOTIC INJECTION FOR ABORTION	4	320.56
762	LOCAL EXCISION OR DESTRUCTION OF LESION	3	282.40
7671	CLOSED REDUCTION OF MALAR AND ZYGOMATIC	2	262.36
7672	OPEN REDUCTION OF MALAR AND ZYGOMATIC FR	2	262.36
7697	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2	262.36
7702	SEQUESTRECTOMY OF HUMERUS	2	262.36
7723	WEDGE OSTEOTOMY OF RADIUS AND ULNA	4	320.56
7724	WEDGE OSTEOTOMY OF CARPALS AND METACARPA	4	320.56
7728	WEDGE OSTEOTOMY OF TARSALS AND METATARSA	4	320.56
7733	OTHER DIVISION OF RADIUS AND ULNA	4	320.56
7734	OTHER DIVISION OF CARPALS AND METACARPAL	4	320.56
7738	OTHER DIVISION OF TARSALS AND METATARSAL	4	320.56
7739	OTHER DIVISION OF OTHER BONE, EXCEPT FAC	4	320.56
7752	BUNIONECTOMY WITH SOFT TISSUE CORRECTION	4	320.56
7753	OTHER BUNIONECTOMY WITH SOFT TISSUE CORR	4	320.56
7754	EXCISION OF BUNIONETTE	3	282.40
7759	OTHER BUNIONECTOMY	4	320.56
7788	OTHER PARTIAL OSTECTOMY OF TARSALS AND M	3	282.40
7789	OTHER PARTIAL OSTECTOMY OF OTHER BONE, E	2	262.36
779	TOTAL OSTECTOMY	4	320.56
7838	*OTHER CHANGE IN BONE LENGTH OF TARSALS	4	320.56
7839	OTHER CHANGE IN BONE LENGTH OF OTHER BON	4	320.56
7858	INTERNAL FIXATION OF TARSALS AND METATAR	4	320.56
786	REMOVAL OF INTERNAL FIXATION DEVICE	2	262.36
7861	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2	262.36
7862	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2	262.36
7864	REMOVAL OF INTERNAL FIXATION DEVICE FROM	4	320.56
7865	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2	262.36
7866	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2	262.36
7867	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2	262.36
7868	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2	262.36
8003	ARTHROTOMY FOR REMOVAL OF PROSTHESIS OF	4	320.56
8012	OTHER ARTHROTOMY OF ELBOW	2	262.36
8016	OTHER ARTHROTOMY OF KNEE	4	320.56
8026	ARTHROSCOPY OF KNEE	4	320.56
8043	DIVISION OF JOINT CAPSULE, LIGAMENT, OR	3	282.40
8044	DIVISION OF JOINT CAPSULE, LIGAMENT, OR	3	282.40
8048	DIVISION OF JOINT CAPSULE, LIGAMENT, OR	3	282.40
8050	IV DISC EXCS / DSTRUCT NOS	3	282.40
806	EXCISION OF SEMILUNAR CARTILAGE OF KNEE	4	320.56
8073	SYNOVECTOMY OF WRIST	4	320.56
8074	SYNOVECTOMY OF HAND AND FINGER	4	320.56
8078	SYNOVECTOMY OF FOOT AND TOE	4	320.56
8087	OTHER LOCAL EXCISION OR DESTRUCTION OF L	3	282.40

DX	DESCRIPTION	SURG,GRP	FEE
809	OTHER EXCISION OF JOINT	4	320.56
8094	OTHER EXCISION OF JOINT OF HAND AND FING	3	282.40
8116	METATARSOPHALANGEAL FUSION	4	320.56
8118	OTHER FUSION OF TOE	4	320.56
8128	INTERPHALANGEAL FUSION	4	320.56
8131	ARTHROPLASTY OF FOOT AND TOE WITH SYNTHE	4	320.56
8139	OTHER ARTHROPLASTY OF FOOT AND TOE	4	320.56
8171	ARTHROPLASTY OF HAND AND FINGER WITH SYN	4	320.56
8179	OTHER REPAIR OF HAND AND FINGER	4	320.56
8186	ARTHROPLASTY OF CARPALS WITH SYNTHETIC P	4	320.56
8201	EXPLORATION OF TENDON SHEATH OF HAND	1	220.39
8203	BURSOTOMY OF HAND	1	220.39
8209	OTHER INCISION OF SOFT TISSUE OF HAND	2	262.36
8211	TENOTOMY OF HAND	1	220.39
8212	FASCIOTOMY OF HAND	4	320.56
8221	EXCISION OF LESION OF TENDON SHEATH OF H	3	282.40
8232	EXCISION OF TENDON OF HAND FOR GRAFT	3	282.40
8233	OTHER TENONECTOMY OF HAND	4	320.56
8235	OTHER FASCIECTOMY OF HAND	4	320.56
8251	ADVANCEMENT OF TENDON OF HAND	3	282.40
8279	PLASTIC OPERATION ON HAND WITH OTHER GRA	4	320.56
8284	REPAIR OF MALLET FINGER	3	282.40
8285	OTHER TENODESIS OF HAND	3	282.40
8286	OTHER TENOPLASTY OF HAND	3	282.40
8289	OTHER PLASTIC OPERATIONS ON HAND	4	320.56
8291	LYSIS OF ADHESIONS OF HAND	3	282.40
8301	EXPLORATION OF TENDON SHEATH	2	262.36
8303	BURSOTOMY	2	262.36
8309	OTHER INCISION OF SOFT TISSUE	2	262.36
8314	FASCIOTOMY	4	320.56
8321	BIOPSY OF SOFT TISSUE	2	262.36
8331	EXCISION OF LESION OF TENDON SHEATH	3	282.40
8339	EXCISION OF LESION OF OTHER SOFT TISSUE	3	282.40
8341	EXCISION OF TENDON FOR GRAFT	4	320.56
8342	OTHER TENONECTOMY	4	320.56
8345	OTHER MYECTOMY	4	320.56
835	BURSECTOMY	3	282.40
8361	SUTURE OF TENDON SHEATH	3	282.40
8364	OTHER SUTURE OF TENDON	3	282.40
8387	OTHER PLASTIC OPERATIONS ON MUSCLE	3	282.40
8388	OTHER PLASTIC OPERATIONS ON TENDON	3	282.40
8391	LYSIS OF ADHESIONS OF MUSCLE, TENDON, FA	3	282.40
8411	AMPUTATION OF TOE	2	262.36
8412	AMPUTATION THROUGH FOOT	2	262.36
850	MASTOTOMY	3	282.40
8511	PERCUTANEOUS (NEEDLE) BIOPSY OF BREAST	3	282.40
8512	OTHER BIOPSY OF BREAST	3	282.40
8521	LOCAL EXCISION OF LESION OF BREAST	3	282.40
8524	EXCISION OF ECTOPIC BREAST TISSUE	3	282.40
8591	ASPIRATION OF BREAST	3	282.40
8595	INSRT BREAST TISS EXPANL	2	262.36
8596	REMOV BREAST TISS EXPAND	2	262.36

DX	DESCRIPTION	SURG,GRP	FEE
8601	ASPIRATION OF SKIN AND SUBCUTANEOUS TISS	3	282.40
8604	OTHER INCISION WITH DRAINAGE OF SKIN AND	2	262.36
8605	INCISION WITH REMOVAL OF FOREIGN BODY FR	2	262.36
8609	OTHER INCISION OF SKIN AND SUBCUTANEOUS	2	262.36
8611	BIOPSY OF SKIN AND SUBCUTANEOUS TISSUE	1	220.39
8621	EXCISION OF PILONIDAL CYST OR SINUS	3	282.40
8622	DEBRIDEMENT OF WOUND, INFECTION, OR BURN	1	220.39
8623	REMOVAL OF NAIL, NAILBED, OR NAIL FOLD	1	220.39
8627	DEBRID.NAIL,BED,FOLD	1	220.39
863	OTHER LOCAL EXCISION OR DESTRUCTION OF L	1	220.39
8660	FREE SKIN GRAFT, NOT OTHERWISE SPECIFIED	3	282.40
8662	OTHER SKIN GRAFT TO HAND	3	282.40
8686	ONYCHOPLASTY	1	220.39
8689	OTHER REPAIR AND RECONSTRUCTION OF SKIN	2	262.36
8693	INSRT SKIN TISS EXPANDER	2	262.36
8782	GAS CONTRAST HYSTEROSALPINGOGRAM	2	262.36
8783	OPAQUE DYE CONTRAST HYSTEROSALPINGOGRAM	2	262.36
8926	GYNECOLOGICAL EXAMINATION	1	220.39
9616	OTHER VAGINAL DILATION	1	220.39
9622	DILATION OF RECTUM	1	220.39
9623	DILATION OF ANAL SPHINCTER	1	220.39
9625	THERAPEUTIC DISTENTION OF BLADDER	1	220.39
9649	OTHER GENITOURINARY INSTILLATION	1	220.39
9659	OTHER IRRIGATION OF WOUND	2	262.36
9739	REMOVAL OF OTHER THERAPEUTIC DEVICE FROM	2	262.36
9802	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1	220.39
9803	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1	220.39
9804	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1	220.39
9805	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1	220.39
9814	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1	220.39
9815	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1	220.39
9821	REMOVAL OF SUPERFICIAL FOREIGN BODY FROM	1	220.39
9822	REMOVAL OF OTHER FOREIGN BODY WITHOUT IN	1	220.39
9827	REMOVAL OF FOREIGN BODY WITHOUT INCISION	2	262.36
9985	LOCALIZED HYPERTHERMIA	1	220.39
9986	PLACED EXT. BONE STIM	1	220.39

TOTAL RECORDS : 400

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

David W. Hood
SECRETARY

June 28, 2001

TO: Medicaid Enrolled Hospitals

FROM: Ben A. Bearden
Director

RE: Retrospective Reviews of Length of Stays

Effective with a date of service of June 20,2001, a hospital may request a retrospective review for inpatient hospital services only in two situations:

- Retroactive recipient eligibility - Providers have up to one year from the date that the recipient was added to the eligibility file to request a retrospective review.

- A dually eligible recipient has exhausted his/her Medicare Part A benefits - Providers have up to sixty (60) days from the date of the Medicare Part A Explanation of Benefits (EOB) verifying that the benefits have been exhausted to request a retrospective review.

The two year requirement for timely filing is applicable for retrospective reviews.

If you have questions regarding this notice, Derek Stafford may be contacted at (225) 342-2495

BAB/PSU

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030
PHONE #: 225/342-3956 OR 225/342-5774 • FAX #: 225/342-3893
"AN EQUAL OPPORTUNITY EMPLOYER"

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

David W. Hood
SECRETARY

May 24, 2002

Dear Prescribing Practitioners and Pharmacy Providers:

In January 2002 you were notified that the Department of Health and Hospitals (DHH) planned to establish a pharmacy prior authorization (PA) process with a preferred drug list (PDL) for certain drugs covered under the Medicaid Pharmacy Benefits Program. Workshops on the new prior authorization process were held in February and March. On May 22, 2002 the Louisiana Legislature's Joint Committee on Health and Welfare approved the Department to implement this process **effective June 10, 2002.**

With the implementation of the PA process, drugs will be considered "preferred" or "non-preferred". Non-preferred drugs will require PA as a condition for payment by the program. The PDL is established by selected therapeutic classes for those drugs that PA is not required. Drugs in these therapeutic classes that are not included on the PDL shall require PA and prescribing practitioners must obtain PA by contacting the University of Louisiana at Monroe (ULM), College of Pharmacy Prior Authorization Unit. Information on the process is included in the attached documents. Providers will be notified of drugs selected for placement on the PDL by selected therapeutic classes prior to the effective dates.

Implementation of the PA process will be by a phased-in approach starting with the Proton Pump Inhibitors and the COX2 Inhibitors therapeutic classes on June 10, 2002. The following material is attached to assist you in the new process:

1. A listing of drugs in the first group of therapeutic classes to be included in the PA process with effective implementation dates.
2. A process and procedures document, "Louisiana Medicaid Pharmacy Benefits Management Prior Authorization Program".
3. "Request For Prescription Prior Authorization" Form.

Information on the Prior Authorization process, including the PDL, is also available on the Louisiana Medicaid website (www.lamedicaid.com). This website will be updated when changes (additions or deletions) are made to the PDL. PDL changes will also be in a message on the provider's remittance advice.

Thank you for your cooperation as we implement this new process. We appreciate your participation in the Medicaid program

Sincerely,

Ben A. Bearden
Director

BAB/mjt

Attachments (3)

OFFICE OF MANAGEMENT AND FINANCE * BUREAU OF HEALTH SERVICES FINANCING
PHARMACY BENEFITS MANAGEMENT UNIT
1201 CAPITOL ACCESS ROAD * P.O. BOX 91030 * BATON ROUGE, LOUISIANA 70821-9030
PHONE #: 225-342-9768 * FAX #: 225-342-1980

LOUISIANA MEDICAID PHARMACY BENEFITS MANAGEMENT PRIOR AUTHORIZATION PROGRAM EFFECTIVE JUNE 10, 2002

Louisiana Medicaid Website - www.lamedicaid.com

AUTHORIZING LEGISLATION

Act 395 of the Regular Session of the 2001 Louisiana Legislature amends R.S. 46:153.3 (B) and (C) and permits the Department of Health and Hospitals (DHH) to utilize a prior approval process for its Medicaid prescription drug program

In State Fiscal Year 2001, the Louisiana Medicaid Program paid 12,545,632 prescriptions. Between 1995 and 1999, the drug expenditures percentage has risen from 10% to 12% of the total Medicaid budget. This pattern of increasing expenditures is projected to continue. Until the current legislative session, Louisiana was prohibited from utilizing a prescription prior approval process within the Louisiana Medicaid Program. With the passage of this legislation, this restriction has been removed, and DHH has elected to implement a drug Prior Authorization (PA) process.

DHH is utilizing the services of both Unisys and the University of Louisiana at Monroe (ULM), College of Pharmacy to operate the Prior Authorization system. The effective implementation date is June 10, 2002 and will be phased-in by therapeutic classes.

DRUGS REQUIRING PRIOR AUTHORIZATION

With the implementation of the Prior Authorization Program, drugs will be considered "preferred" or "non-preferred". "Non-preferred" drugs will require prior authorization. Listings of these drugs will be supplied to you prior to the targeted implementation date for each therapeutic class added to the Prior Authorization system.

HOW TO OBTAIN PRIOR AUTHORIZATION

Prior authorization is obtained through the University of Louisiana at Monroe (ULM), College of Pharmacy. Prior authorizations may be requested by (1) phone, (2) Fax, or (3) mail.

Phone:	(1-866-730-4357)
Fax:	(1-866-797-2329) **Do not send a cover sheet with the FAX.**
Mail:	ULM College of Pharmacy – Rx PA Program 1401 Royal Avenue Monroe, LA 71201

The hours of operation for the ULM Prior Authorization Unit are 8 a.m. to 6 p.m. Central Time, Monday through Saturday.

(NOTE: The POS Help Desk has NO relationship to the PA Unit or the PA request process.)

WHO CAN OBTAIN PRIOR AUTHORIZATION:

The prescribing practitioner is responsible for obtaining prior authorization. (No pharmacist or recipient calls/requests will be accepted.)

Prescribing practitioners include:

Physicians (MD & DO, including interns, residents and fellows)
Dentists
Podiatrists
Optometrists
Nurse Practitioners with Prescribing Authority
Nurse Midwives with Prescribing Authority
Clinical Nurse Specialists with Prescribing Authority

The prescribing practitioner must have and provide his/her valid individual LA Medicaid prescribing provider number to obtain prior authorization. (Only individual provider numbers will be accepted.)

HOW TO OBTAIN A PROVIDER NUMBER:

If a prescribing practitioner does not currently have an individual LA Medicaid provider number, it is important to request a number immediately in order to prevent prior authorization delays/denials following implementation of the program.

Contact Unisys Provider Enrollment @ 225/923-8510 to obtain a LA Medicaid provider number.

PA APPROVAL PROCESS: APPROVALS, DENIALS, and VOIDS:

- When a prior authorization request is received, the ULM Prior Authorization Unit **has 24-hours** from the date and time received to (1) approve, (2) deny, or (3) void the request. **NO retroactive PA approvals will be given.**

- A prior authorization will be approved for a specific period of time with a maximum approval period of one (1) year. Approvals are not given based on prescriptions or number of refills. (Example: PA may be given for a particular drug for a one-year period during which multiple prescriptions with multiple refills may be written; subsequent prescriptions for the same authorized drug do not need to be prior authorized so long as the prescription and refills fall within the one-year period since the drug is authorized for a period of one year.)

- The prior authorization prescription time limit and number of refills edit will supercede the prescription time and refill program limits.
  - Example (1): A drug is prior authorized for a period of one (1) month. The prescribing practitioner issues a prescription for 6 months (original plus five refills). The claim for the first month dispensed will process and pay based on the one-month authorization. Any refills dispensed will deny because there is no authorization for the additional drug.

  - Example (2): A drug is prior authorized for a period of twelve (12) months. The prescriber issues a prescription for 6 months (original plus five refills). When the prescription refills reach five or 6 months, the prescriber must issue a new prescription for the remaining 6 months of the authorization, but does not need a new prior authorization at that time as 6 months of authorization remain.

Approvals:
When a request is approved, the prescribing practitioner will be notified by either phone or fax.

The authorization will be established in the PA system and POS claims processing system to allow claims for authorized medications to process without further intervention by the pharmacist.

Denials:
When a request is denied, the prescribing practitioner will be notified by either fax or written correspondence via first class mail through the U.S. Postal Service.

Voids:
When a request is voided, the prescribing practitioner will be notified by phone or fax. Requests will be voided for the following reasons:

- Incomplete fax or mail request form;
- Fax or mail request not submitted on the accepted form;
- Phone call is terminated prematurely by ULM PA staff;
- Phone call is terminated prematurely by requestor;
- Phone call is terminated prematurely for unknown/other reason;
- PA request received from a non-prescribing practitioner;
- Prescribing practitioner is not on file;
- Recipient is not on file;
- Drug is not on the non-preferred drug list;
- Drug is not on file.

MEDICAL REVIEW PROCESS

In cases where a prior authorization request is denied, the prescribing provider may request a phone consultation with a ULM Prior Authorization Unit physician.

A final determination (approval or denial) through the ULM Prior Authorization Unit will be made by the physician consultant within 48 hours following this phone conference. This decision will be based on the clinical aspects of the case.

APPEAL PROCESS

DHH will administer the appeals process.

THE PRIOR AUTHORIZATION FORM (*COPY ATTACHED)*

FOR PHONE REQUESTS:

- The information on the approved form will be asked verbally for phone requests.
- Information provided must be complete. Incomplete requests will not be processed; they will be voided.
- Phone requests will receive phone responses.

FOR FAXED OR MAILED REQUESTS:

- ONLY the completed, legible, designated form will be accepted (attached).
- The PA form should be a single-sheet transmission – **DO NOT include a Cover Sheet.**
- Ensure that the required fields on the form are completed (some fields are required and some are optional).
- Both the individual provider number and the billing provider number are requested on the form. ONLY THE INDIVIDUAL PROVIDER NUMBER – THE PRESCRIBING PRACTITIONER PROVIDER NUMBER – IS REQUIRED. The billing provider number is optional.
- The form MUST be signed by the prescribing practitioner (if a stamp is used, the stamped signature MUST be initialed by the prescribing practitioner).
- Incomplete forms will be returned unprocessed (request voided).
- A faxed or mailed request will receive a faxed or phone response (Responses will be mailed only if a fax or phone number is not available.)

EMERGENCY PROCEDURES

Prescriptions indicating emergency situations shall be dispensed in a MINIMUM quantity of a 3-day supply. **Refills for the dispensing of the non-preferred products in these emergency situations are not permitted.** The recipient's practitioner must contact the Prior Authorization Unit to request authorization to continue the medication past the emergency supply, and a new prescription must be issued.

This process may be used when the Prior Authorization Unit is closed (Sundays; Monday-Saturday before 8 a.m. and after 6 p.m.) or when the PA system is unavailable. The pharmacist may also use professional judgment in situations that would necessitate an emergency supply.

The prescribing practitioner must indicate that the prescription is an emergency Rx on the face of the prescription if hard copy or if the prescription is called in to the pharmacy, the emergency status of the prescription must be communicated to the pharmacist who must indicate "Emergency Rx" on the hard copy prescription. When the pharmacist determines the prescription is an emergency, the pharmacist must indicate "Emergency by Pharmacist" on the hard copy prescription. The pharmacist must code the claim as an emergency prescription (enter "03" in NCPDP Field #487). An NCPDP educational alert will notify the pharmacist that the drug requires prior authorization.

Recipients are exempt from paying co-payments for emergency situations.

DHH will monitor emergency prescriptions/recipients on an ongoing basis through management reports, pharmacy provider audits, and other review programs to review the number of these prescriptions and the reasons for them.

PRESCRIPTIONS ISSUED PRIOR TO THE IMPLEMENTATION OF PRIOR AUTHORIZATION

The prior authorization process will not impact original prescriptions (or refills) issued by a prescribing practitioner prior to the start date of the Prior Authorization Process or prior to the effective PA dates of drugs as they are added to the PA Process. Refills of prescriptions issued prior to an effective PA date will not be impacted as long as they are within the 5 refills and 6-month program limits.

Upon implementation of the prior authorization process, an educational alert will notify the pharmacist that prescriptions issued prior to this date **(and their refills)** are exempt from this process. The educational alert will state "Drug Requires PA".

PRESCRIPTIONS ISSUED AFTER THE IMPLEMENTATION OF PRIOR AUTHORIZATION

After the implementation of the prior authorization process, if a recipient elects to self-pay for an original prescription, then attempts to have Medicaid pay for a refill of the prescription for a drug requiring PA, the pharmacy claim for the refill will be denied for lack of an approved authorization.

IMPORTANT FACTS

- If an approved prior authorization exists in the system, the pharmacy claim will pass the PA edit and continue with existing POS edits. If an approved prior authorization does not exist, the pharmacy claim will be denied through the POS system.

- An approved prior authorization does not guarantee payment of the claim by Medicaid. It only indicates that the drug has been approved as a course of treatment within the Medicaid Program. All existing POS claim edits will continue to be applied.

- The prior authorization process does not verify recipient Medicaid eligibility. It only verifies that the recipient is "on file" (i.e., has a valid Medicaid ID number on file – not that the recipient is eligible on the date of service). Recipient eligibility will continue to be verified by the Pharmacy POS subsystem or through the MEVS or REVS automated recipient eligibility systems.

- When dispensing prescriptions for recipients with retroactive Medicaid eligibility, the pharmacist must file these claims hard copy for special handling. These claims should be sent to:

  Bureau of Health Services Financing
  MMIS Unit
  P.O. Box 91030
  Baton Rouge, LA 70821

- With the implementation of the Prior Authorization Process, only practitioners' individual prescriber numbers will be accepted to request prior authorization of a non-preferred drug. Any provider number other than an individual prescribing provider number WILL NOT be accepted to prior authorize non-preferred drugs.

- ***In the past, pharmacies were allowed to use the provider numbers of hospitals, clinics, etc., as prescriber numbers for claims processing purposes. At this time, prescriber numbers other than individual provider numbers will be accepted through the POS system for claims involving drugs that do not require prior authorization. This exception will be phased out, effective July 2002. At that time, only individual prescribing provider numbers will be accepted for processing and paying all pharmacy claims.***

CONTACTS

University of Louisiana at Monroe 1-866-730-4357
Prior Authorization Unit
1401 Royal Avenue
Monroe, LA 71201

Unisys POS Help Desk 1-800-648-0790
P.O. Box 91024
Baton Rouge, LA 70821

Unisys Provider Relations 1-800-473-2783
P.O. Box 91024
Baton Rouge, LA 70821

Unisys Provider Enrollment 1-225-923-8510
P.O. Box 80159
Baton Rouge, LA 70898-0159

Charity and Teaching Hospitals Contacts:

Baton Rouge General Medical Center Triage Nurse, Family Medicine Residency	225-381-6620	Chabert Office of the Medical Director	985-873-1265
E.A. Conway Hospital Office of the Medical Director	318-330-7513	Earl K. Long Office of the Medical Director	225-358-1085
Huey P. Long (LSU/Tulane Residents) Office of the Medical Director	318-473-1426	Lallie Kemp Office of the Medical Director	985-878-1305
LSU-NEW ORLEANS Cynthia Scott, Resident Coordinator Kelly Sherman (alternate)	504-568-8632 504-568-4006	LSU-SHREVEPORT Chasidy Mangham, Resident Coordinator	318-675-5053
Ochsner Foundation Hospital Reonda Victor, Resident Coordinator	800-752-6768	Tulane Hospital Chris Antczak, Resident Coordinator	504-588-5464
University Medical Center, Lafayette Office of the Medical Director	337-261-6156	Washington-St. Tammany Office of the Medical Director	985-735-1322
Walter O. Moss Office of the Medical Director	337-475-8106		

PHARMACY PA and PRESCRIBER NUMBER POS EDITS

NCPDP CODE	POS EDIT #	E/D	DESCRIPTION
75	484	Educational	New RX Will Require PA after **DATE**
75	485	Denial	PA Required – MD Must Call ULM Operations Staff
75	486	Denial	PA Expired – MD Must Call ULM Operations Staff
75	487	Educational	Emergency Override of a Drug That Requires PA
25	489	Denial	Provider Type Not Authorized to Prescribe
25	491	Educational	Prescriber Number Not For Individual Prescriber

Fax or Mail this form to:
LA Medicaid Rx PA Operations
ULM College of Pharmacy
1401 Royal Avenue
Monroe, LA 71201
Fax: 866-RX PA FAX
(866-797-2329)

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form RXPAOT
Issue Date: 3/1/2002

Voice Phone:
866-730-4357

Please type or print legibly (fields followed with an asterisk * are required, all other fields are requested).

Date of Request:*	Number of Fax Pages:*
Practitioner Information	**Patient Information**
Name:*	Name (last, first):*
LA Medicaid Prescribing Provider Number:*	LA Medicaid CCN or Recipient Number:*
LA Medicaid Billing Provider Number:	Date of Birth (m/d/y):* / /
Call-Back Phone Number (include area code):* - -	
Fax Number (include area code)*: - -	Projected Duration:*
Requested Drug Information	
Drug Name:*	Drug Strength:
Diagnosis Code (ICD-9-CM): .	Diagnosis Description:*

Please answer the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred product(s)? ☐ YES ☐ NO
2. Does the patient have a condition that prevents the use of the preferred product(s)? ☐ YES ☐ NO
   If YES, list the condition(s) in the box below:
3. Is there a potential drug interaction between another medication and the preferred product(s)? ☐ YES ☐ NO
   If YES, list the interaction(s) in the box below:
4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐ YES ☐ NO
   If YES, list the side effects in the box below:

Practitioner Signature:* _____

(If a signature stamp is used, then the prescribing practitioner must initial the signature)

CONFIDENTIALITY NOTICE
The documents accompanying this facsimile transmission may contain confidential information which is legally privileged. The information is intended only for the use of the individual or entity to which it is addressed. If you are not the intended recipient, you are hereby notified that any review, disclosure/redisclosure, copying, distribution, or the taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy this information.

Louisiana Pharmacy Benefits Management Program

Prior Authorization PDL Implementation Schedule

		Drugs on PDL	Drugs which Require PA	Implementation Date
1.	**Proton Pump Inhibitors**	Lansoprazole (Prevacid®) Pantoprazole (Protonix®)	Esomeprazole (Nexium®) Omeprazole (Prilosec®) Rabeprazole (Aciphex®)	June 10, 2002
2.	**Selective Cyclooxygenase Cox 2 Inhibitors**	Valdecoxib (Bextra®) Celecoxib (Celebrex®)	Rofecoxib (Vioxx®)	June 10, 2002
3.	**Statins**	Atorvastin (Lipitor®) Fluvastatin (Lescol®) Fluvastatin XL (Lescol XL®) Lovastatin (Mevacor®) Pravastatin (Pravachol®)	Simvastatin (Zocor®)	June 24, 2002
4.	**Leukotriene Modifiers**	Montelukast (Singulair®) Zafirlukast (Accolate®)	Zileuton (Zyflo®)	July 1, 2002
5.	**Oral Diabetic Medications**			
	Prandin/Starlix	Nateglinide (Starlix®)	Repaglinide (Prandin®)	July 1, 2002
	Precose/Glyset	Acarbose (Precose®)	Miglitol (Glyset®)	July 1, 2002
6.	**Nasal Steroids**	Beclomethasone (Beconase ®) Beclomethasone (Beconase AQ®) Mometasone (Nasonex®) Triamcinolone (Tri-Nasal®)	Beclomethasone (Vancenase®) (Vancenase AQ®) Budesonide (Rhinocort®) Budesonide aqua (Rhinocort Aqua®) Flunisolide (Nasarel®) Flunisolide (Nasalide®) Fluticasone (Flonase®) Triamcinolone (Nasacort®) Triamcinolone (Nasacort AQ®)	July 15, 2002

Louisiana Pharmacy Benefits Management Program

Prior Authorization PDL Implementation Schedule

	Drugs on PDL	Drugs which Require PA	Implementation Date
7.	**Inhaled Steroids**		July 15, 2002
	Budesonide (Pulmicort Respules)	Beclomethasone Dipropionate (Beclovent®)	
	Fluticasone (Flovent/Flovent Rotadisk®)	Beclomethasone Dipropionate (Vanceril®)	
	Triamcinolone (Azmacort®)	Beclomethasone Dipropionate (Vanceril DS®)	
		Beclomethasone Dipropionate HFA (Qvar®)	
		Budesonide (Pulmicort Turbuhaler®)	
		Flunisolide (Aerobid®, Aerobid-M®)	
		Fluticasone/Salmeterol (Advair®)	

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS

David W. Hood
SECRETARY

July 16, 2002

Dear Prescribing Practitioners and Pharmacy Providers:

Effective June, 10, 2002 the Department of Health and Hospitals (DHH) established a pharmacy prior authorization (PA) process with a preferred drug list (PDL) for certain drugs covered under the Medicaid Pharmacy Benefits Management (PBM) Program. The implementation process uses a phased-in approach by gradually adding therapeutic classes of drugs to the PDL.

The initial phase has been very successful, and DHH is ready to implement the second group of therapeutic classes to include in the PA process. Attached is a listing of the drugs with effective implementation dates. Please add this list to the one sent on May 24, 2002. Also, attached is another copy of the Prior Authorization Request Form.

The Medicaid PBM Program is also initiating a numbering system to assist providers in maintaining the lists disseminated. You will note the list included with this correspondence is **"02-02"**. The list sent on May 24, 2002 contains seven (7) therapeutic classes. Please number that list **"02-01"**.

Information on the Prior Authorization process, including the PDL and Prior Authorization Request Form, is also available on the Louisiana Medicaid website (**www.lamedicaid.com**). This website will be updated when changes (additions or deletions) are made to the PDL. The program may also utilize the provider remittance advices to notify providers of PDL changes that must be implemented in short time frames.

Thank you for your continued cooperation. We appreciate your participation in the Medicaid program.

Sincerely,

Ben A. Bearden
Director

BAB/mjt

Attachments (2)

OFFICE OF MANAGEMENT AND FINANCE • BUREAU OF HEALTH SERVICES FINANCING • PHARMACY BENEFITS MANAGEMENT UNIT
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030
PHONE #: 225-342-9768 • FAX#: 225-342-3893
"AN EQUAL OPPORTUNITY EMPLOYER"

Louisiana Pharmacy Benefits Management Program

Notification 02-02

Prior Authorization PDL Implementation Schedule

	Therapeutic Class	Drugs on PDL	Drugs which Require PA	Implementation Date
8.	**H2 Antagonists**			August 5, 2002
		Cimetidine	Nizatidine (Axid)	
		Famotidine	Famotidine RPD (Pepcid RPD)	
		Ranitidine	Ranitidine Efferdose (Zantac Efferdose)	
			Ranitidine Granules (Zantac Granules)	
9.	**Selective Serotonin Reuptake Inhibitors**			August 5, 2002
		Citalopram (Celexa)	Fluoxetine (Sarafem)	
		Paroxetine (Paxil)	Fluoxetine Weekly (Prozac Weekly)	
		Fluoxetine	Sertraline (Zoloft)	
		Fluvoxamine		
10.	**Minimally Sedating Antihistamines**			August, 5, 2002
		Loratadine (Claritin)	Cetirizine (Zyrtec)	
		Loratadine/Pseudoephedrine (Claritin-D 12, 24 hour)	Cetirizine/Pseudoephedrine (Zyrtec-D)	
			Fexofenadine (Allegra)	
		Desloratadine (Clarinex)	Fexofenadine/Pseudoephedrine (Allegra-D)	
11.	**ACE Inhibitors**			August 12, 2002
		Benazepril (Lotensin)	Perindopril (Aceon)	
		Benazepril/HCTZ (Lotensin HCT)	Ramipril (Altace)	
		Captopril		
		Captopril/HCTZ		
		Enalapril		
		Enalapril/HCTZ		
		Fosinopril (Monopril)		
		Fosinopril/HCTZ (Monopril-HCT)		
		Lisinopril; Lisinopril/HCTZ		
		Moexipril (Univasc)		
		Moexipril/HCTZ (Uniretic)		
		Quinapril (Accupril)		
		Quinapril/HCTZ (Accuretic)		
		Trandolapril (Mavik)		

Louisiana Pharmacy Benefits Management Program

Notification 02-02

Prior Authorization PDL Implementation Schedule

	Therapeutic Class	Drugs on PDL	Drugs which Require PA	Implementation Date
12.	**Angiotensin II Receptor Blockers (ARBS)**			August 12, 2002
		Telmisartan (Micardis)	Candesartan (Atacand)	
		Telmisartan/HCTZ (Micardis HCT)	Candesartan/HCTZ (Atacand HCT)	
		Valsartan (Diovan)	Eprosartan (Teveten)	
		Valsartan/HCTZ (Diovan HCT)	Irbesartan (Avapro)	
			Irbesartan/HCTZ (Avalide)	
			Losartin (Cozaar)	
			Losartin/HCTZ (Hyzaar)	
13.	**Calcium Channel Blockers**			August 12, 2002
		Diltiazem HCL	Amlodipine (Norvasc)	
		Diltiazem SR	Bepridil (Vascor)	
		Diltiazem XR	Diltiazem ER (Tiazac)	
		Felodipine (Plendil)	Isradipine (Dynacirc)	
		Nicardipine	Isradipine SR (Dynacirc CR)	
		Nifedipine	Nicardipine SR (Cardene SR)	
		Nifedipine SR	Nimodipine (Nimotop)	
		Nisoldipine (Sular)		
		Verapamil	Verapamil ER (Covera HS)	
		Verapamil SR	Verapamil SR (Verelan PM)	
14.	**Triptans**			August 19, 2002
		Almotriptan (Axert)	Naratriptan (Amerge)	
		Zolmitriptan (Zomig, Zomig ZMT)	Rizatriptan (Maxalt, Maxalt MLT)	
			Sumatriptan (Imitrex-tablets, nasal spray and injection)	

Notification 02-02

Prior Authorization PDL Implementation Schedule

	Therapeutic Class	Drugs on PDL	Drugs which Require PA	Implementation Date
15.	**Oral Diabetic Medications**			
	A. Sulfonylureas	Acetohexamide Chlorpropamide Glimepiride (Amaryl) Glipizide Glipizide XL (Glucotrol XL) Glyburide Glyburide extended release Tolazamide Tolbutamide	None	August 19, 2002
	B. Biguanides	Metformin	Metformin XR (Glucophage XR) Metformin/Glyburide (Glucovance)	August 19, 2002
	C. Thiazolidinediones	Pioglitazone (Actos) Rosiglitazone (Avandia)	None	August 19, 2002
16.	**Cephalosporin and Related Antibiotics**	Amoxicillin/Clavulanate (Augumentin) Amoxicillin/Clavulanate (Augumentin ES-600)		August 26, 2002
		Cefaclor Cefaclor ER Cefadroxil Monohydrate Cefdinir (Omnicef) Cefditoren Pivoxil (Spectracef) Cefixime (Suprax) Cefprozil (Cefzil) Cefuroxime Axetil Cephalexin Cephradine	Cefpodoxime Proxetil (Vantin) Ceftibuten (Cedax) Cephalexin HCL Monohydrate (Keftab) Loracarbef (Lorabid)	

Notification 02-02

Prior Authorization PDL Implementation Schedule

	Therapeutic Class	Drugs on PDL	Drugs which Require PA	Implementation Date
17.	**Fluoroquinolones**	Ciprofloxacin (Cipro) Gatifloxacin (Tequin) Moxifloxacin (Avelox; Avelox ABC Packs	Levofloxacin (Levaquin) Lomefloxacin (Maxaquin) Norfloxacin (Noroxin) Ofloxacin (Floxin) Sparfloxacin (Zagam)	August 26, 2002
18.	**Macrolides**	Azithromycin (Zithromax) Dirithromycin (Dynabac) Erythromycin Base Erythromycin Estolate Erythromycin Ethylsuccinate Erythromycin Stearate	Clarithromycin (Biaxin) Clarithromycin SA (Biaxin XL) Erythromycin Base (PCE 333mg & 500mg) Troleandomycin (TAO)	August 26, 2002
19.	**Antivirals**	Acyclovir Amantadine HCL Ganciclovir (Cytovene) Oseltamivir (Tamiflu) Rimantadine HCL Valacyclovir (Valtrex)	Famciclovir (Famvir) Valganciclovir (Valcyte) Zanamivir (Relenza)	September 3, 2002
20.	**Oral Antifungals**	Fluconazole (Diflucan) Griseofulvin Ketoconazole Nystatin Terbinafine (Lamisil)	Clotrimazole (Mycelex Troche) Flucytosine (Ancobon) Itraconazole (Sporanox)	September 3, 2002

Notification 02-02

Prior Authorization PDL Implementation Schedule

	Therapeutic Class	Drugs on PDL	Drugs which Require PA	Implementation Date
21.	**ACE Inhibitors/Calcium Channel Blockers Combination Products**	Amlodipine/Benazepril (Lotrel) Verapamil SR/Trandolapril (Tarka)	Felodipine/Enalapril (Lexxel)	September 9, 2002
22.	**Intermittent Claudication Medications**	Pentoxifylline	Cilostazol (Pletal)	September 9, 2002
23.	**Platelet Aggregation Inhibitors**	Aspirin/Dipyridamole ER (Aggrenox) Clopidogrel (Plavix) Dipyridamole Ticlopidine	None	September 9, 2002
24.	**Antiincontinence Agents**	Flavoxate (Urispas) Oxybutynin Oxybutynin XL (Ditropan XL)	Tolterodine (Detrol) Tolterodine LA (Detrol LA)	September 16, 2002

Notification 02-02

Prior Authorization PDL Implementation Schedule

Therapeutic Class	Drugs on PDL	Drugs which Require PA	Implementation Date
25. **Beta-Adrenergic Agents**			September 16, 2002
	INHALATIOIN		
	Albuterol Sulfate (Nebulizer and Inhaler)	Albuterol Sulfate Nebulizer Solution (Accuneb)	
	Albuterol Sulfate (Proventil HFA: Ventolin HFA)	Albuterol Sulfate/Ipratropium (Duoneb)	
	Albuterol Sulfate/Ipratropium (Combivent)	Bitolterol Mesylate (Tornalate)	
	Metaproterenol Sulfate (Nebulizer Only)	Levalbuterol HCL (Xopenex)	
		Metaproterenol Sulfate (Alupent Inhalant)	
		Pirbuterol (Maxair, Autohaler)	
		Salmeterol Xinafoate (Serevent; Serevent/Diskus)	
		Terbutaline Sulfate Inhaler	
	ORAL		
	Albuterol Sulfate	Albuterol Sulfate (Proventil Repetabs)	
	Formoterol (Foradil)	Albuterol Sulfate (Ventolin Rotacaps)	
	Metaproterenol Sulfate	Albuterol Sulfate SA (Volmax)	
	Terbutaline Sulfate		
26. **Bone Resorption Suppression Agents**			
	Alendronate (Fosamax)	Etidronate (Didronel)	
	Calcitonin-salmon (Miacalcin)	Raloxifene (Evista)	
		Risendronate (Actonel)	
		Tiludronate (Skelid)	

Louisiana Pharmacy Benefits Management Program

Notification 02-02

Prior Authorization PDL Implementation Schedule

Therapeutic Class	Drugs on PDL	Drugs which Require PA	Implementation Date
27. **Narcotics**	Acetaminophen w/Codeine Acetaminophen/Caffeine/Dihydrocodeine bitartrate (Panlor SS) Aspirin w/Codeine Belladonna & Opium Butalbital Compound w/Codeine Butalbital/Caff/APAP/Codeine Butorphanol Tartrate Carisoprodol Compound/Codeine Codeine Phosphate Codeine Sulfate Dihydrocodeine/APAP/Caffeine Fentanyl Transdermal (Duragesic) Fiortal w/Codeine #3 Hydrocodone/Acetaminophen Hydrocodone bitartrate/ibuprofen (Vicoprofen) Hydromorphone HCL Meperidine HCL Meperidine w/ Promethazine Methadone HCL Methadose Morphine Sulfate (Oral) Morphine Sulfate (Rectal) Morphine Sulfate ER (Avinza) Morphine Sulfate IR Oxycodone HCL (except Roxicodone, Roxicodone Intensol) Oxycodone w/Acetaminophen (Roxicet) Oxycodone/Acetaminophen Oxycodone w/Asprirn Pentazocine/Naloxone HCL Pentazocine/Acetaminophen Propoxyphene HCL Propoxyphene HCL Compound Propoxyphene HCL w/APAP Propoxyphene Napsylate w/APAP Tramadol (Ultram) Tramadol/Acetaminophen (Ultracet)	Aspirin/Caffeine/dihydrocodeine bitartrate (Synalgos-DC) Acetaminophen with Codeine (Capital with Codeine) Fentanyl Citrate (Actiq) Hydrocodone/Acetaminophen (Maxidone; Zydone) Morphine Sulfate ER (Kadian) Opium Tincture Oxycodone (Roxicodone; Roxicodone Intensol) Oxycodone/Acetaminophen (Percocet 10/325,g; 2.5/325mg; 7.5/325mg) Oxycodone CR (Oxycontin) Oxymorphone (Numorphan) Pentazocine/Aspirin (Talwin Compound) Propoxyphene Napsylate (Darvon-N)	September 23, 2002

Fax or Mail this form to:
LA Medicaid Rx PA Operations
ULM College of Pharmacy
1401 Royal Avenue
Monroe, LA 71201
Fax: 866-RX PA FAX
(866-797-2329)

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form RXPA01
Issue Date: 3/1/2002

Voice Phone:
866-730-4357

Please type or print legibly (fields followed with an asterisk * are required, all other fields are requested).

Date of Request:*	Number of Fax Pages:*
Practitioner Information	**Patient Information**
Name:*	Name (last, first):*
LA Medicaid Prescribing Provider Number:*	LA Medicaid CCN or Recipient Number:*
LA Medicaid Billing Provider Number:	Date of Birth (m/d/y):*
Call-Back Phone Number (include area code):*	
Fax Number (include area code)*:	Projected Duration:*
Requested Drug Information	
Drug Name:*	Drug Strength:
Diagnosis Code (ICD-9-CM):	Diagnosis Description:*

Please answer the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred product(s)? ☐ YES ☐ NO

2. Does the patient have a condition that prevents the use of the preferred product(s)? ☐ YES ☐ NO
   If YES, list the condition(s) in the box below:

3. Is there a potential drug interaction between another medication and the preferred product(s)? ☐ YES ☐ NO
   If YES, list the interaction(s) in the box below:

4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐ YES ☐ NO
   If YES, list the side effects in the box below:

Practitioner Signature:* _____

(If a signature stamp is used, then the prescribing practitioner must initial the signature)

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STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

David W. Hood
SECRETARY

July 24, 2002

Dear Health Professional:

The Louisiana Medicaid Pharmacy Benefits Management (LMPBM) program implemented the duration of therapy module for the H2 antagonists, proton pump inhibitors (PPIs) and sucralfate in April 1997. At that time, acute dosage guidelines for these drugs were being monitored. The chronic use of these agents at full therapeutic dosages is generally not indicated. Effective August 11, 2002, LMPBM will implement changes to the acute dosage schedule of these drugs as follows:

Proton Pump Inhibitors

Generic Description	Acute mg/day dose	Duration of Therapy
Omeprazole	20 mg	16 weeks (120 days)
Lansoprazole	30 mg	16 weeks (120 days)
Pantoprazole	40 mg	16 weeks (120 days)
Rabeprazole	20 mg	16 weeks (120 days)
Esomeprazole	40 mg	16 weeks (120 days)

H2 Antagonist & Sucralfate

Generic Description	Acute mg/day dose	Duration of Therapy
Ranitidine HCl	300 mg	12 weeks (90 days)
Cimetidine	1200 mg	12 weeks (90 days)
Nizatidine	300 mg	12 weeks (90 days)
Famotidine	40 mg	12 weeks (90 days)
Sucralfate	4000 mg	12 weeks (90 days)

Effective August 11, 2002, claims exceeding the appropriate acute duration of therapy will deny with NCPDP rejection code #88 and our EOB #656. Maintenance drug therapy will continue to be payable after the 90 days or 120 days of the appropriate drug therapy.

If, in the professional judgment of the prescriber, a determination is made to continue acute therapy beyond the appropriate duration of therapy, the physician must indicate in writing on the prescription or an attachment, a diagnosis code necessitating the continuation of acute therapy. Recipient specific diagnosis information from the prescriber via facsimile is acceptable. For acute therapy to continue as a reimbursable service beyond the above listed duration of therapy, the pharmacy provider must supply the conflict code, intervention code and outcome code with POS submission of the claim and have the information recorded on the hard copy.

Acceptable diagnosis codes include:

041.86	H. Pylori
202.60 through 202.68	Systemic Mastocytosis
237.4	Multiple Endocrine Adenomas
251.5	Zollinger-Ellison Syndrome

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PHARMACY BENEFITS MANAGEMENT UNIT
1201 CAPITOL ACCESS ROAD * P.O. BOX 91030 * BATON ROUGE, LOUISIANA 70821-9030
PHONE #: 225-342-9768 * FAX #: 225-342-1980

530.10	Esophagitis
530.11	Gastroesophageal Reflux Disease (GERD)
530.19	Esophagitis
530.81	Gastroesophageal Reflux Disease (GERD)
530.20	Barrett's Esophagitis
531.00 through 531.91	Gastric Ulcer
532.00 through 532.91	Duodenal Ulcer
533.00 through 533.91	Peptic Ulcer (H. Pylori)
535.00 through 535.51	Gastritis
535.50	Gastroduodenitis
535.51	Gastroduodenitis
535.60	Duodenitis
535.61	Duodenitis
536.80	Dyspepsia
536.80	Gastric hypersecretion
537.90	Unspecified disorder of stomach and duodenum
555.9	Crohn's Disease
569.9	Unspecified disorder of the intestines
577.1	Chronic Pancreatitis
578.9	Gastrointestinal Bleeding

For non-POS claims, pharmacy providers will receive a claim denial for acute therapy exceeding the duration of therapy limits. The pharmacists must intervene with the prescriber prior to dispensing the prescription which exceeds the duration limits. Documentation on the prescription hard copy is required in the cases where, in the professional judgment of the prescriber, acute therapy is continued. If the prescriber has previously authorized continuing acute therapy beyond the appropriate duration, the appropriate diagnosis, as identified by the prescriber, must be entered into that field on the pharmacy facsimile. The facsimile will be sent to the provider with the remittance advice. The pharmacy provider should then sign the facsimile which signifies: (1) the prescriber and pharmacist are aware that the duration of therapy has been exceeded, (2) an appropriate diagnosis justifies continuing therapy at an acute dose and (3) the pharmacy provider is compliant with all Medicaid rules and regulations.

Procedures in the pharmacy audit program have been established to verify the provider's documentation associated with duration of therapy and compliance with program regulations. Therefore, pharmacists are reminded to document all interventions and outcomes on the prescription hard copies for access during the pharmacy audit process as well as documenting those actions in the claim record.

Questions concerning claims processing or coverage of medications should be directed to the Unisys POS Help Desk at 1-800-648-0790 or 225-237-3381.

We appreciate your continued cooperation and support.

Sincerely,

Ben A. Bearden
Director

BAB/MJT/rpb

STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

David W. Hood
SECRETARY

February 14, 2003

Dear Prescribing Practitioners and Pharmacy Providers:

Attached is a listing of drugs to be added to the Medicaid Prior Authorization (PA) Process' Preferred Drug List (PDL). The listing includes preferred drugs and those drugs requiring prior authorization with effective implementation dates shown. Please add this list to the ones previously sent.

The PA process, in accordance with the program's "Continuity of Care" policy, does not impact original prescriptions (or refills) issued by a prescribing practitioner prior to effective PA dates of drugs as they are added to the PA process ***as long as they are within the 5 refills and 6-month program limits.*** An educational alert will notify the pharmacist that prescriptions (and their refills) will require a new prescription and prior authorization if the prescription life exceeds six months or the refill exceeds the 5 refill limit. The educational alert will state, "NEW RX WILL REQUIRE PA AFTER (DATE)."

The Medicaid PBM Program utilizes a numbering system to assist providers in maintaining the lists disseminated. You will note the list included with this correspondence is **"03-02".** Please be advised this attachment contains updates to the previously issued Prior Authorization PDL Implementation Schedules issued July 16, 2002 (Issuance 02-02), October 1, 2002 (Issuance 02-03), and February 4, 2003 (Issuance 03-01). These updates are noted on the attachment in **bold** and include the following therapeutic classes: Statins, Triptans, and Macrolides. Some drugs in these therapeutic classes which previously required prior authorization have been moved to the PDL and some drugs in these therapeutic classes which previously were on the PDL now require prior authorization. The effective dates of these changes are also shown on the chart. It is recommended that you make notations with effective dates on transmittals whenever changes occur in therapeutic classes to ensure you are referencing the most current status of a drug.

Information on the Prior Authorization process, including the PDL and Prior Authorization Request Form (copy is attached, Form RXPA01), is also available on the Louisiana Medicaid website (**www.lamedicaid.com**). This website will be updated when changes (additions or deletions) are made to the PDL. The program may also utilize the provider remittance advices to notify providers of PDL changes that must be implemented in short time frames.

The Department has received inquiries that drug products requiring PA are not reimbursable by Medicaid. Medicaid does reimburse for drug products requiring prior authorization when the prior authorization process is followed.

Thank you for your continued cooperation. We appreciate your participation in the Medicaid program.

Sincerely,

Ben A. Bearden
Director

BAB/rpb

Attachments

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#03-02 Prior Authorization PDL Implementation Schedule
UPDATES

		Drugs on PDL	Drugs which Require PA	Implementation Date
3.	**Statins**	Fluvastatin (Lescol) Fluvastatin XL (Lescol XL) Lovastatin **Lovastatin ER (Altocor)** **Simvastatin (Zocor)**	**Atorvastatin (Lipitor)** **Pravastatin (Pravachol)**	March 26, 2003
14.	**Triptans**	Almotriptan (Axert) Rizatriptan (Maxalt; Maxalt MLT) **Sumatriptan (Imitrex)**	**Frovatriptan (Frova)** Naratriptan (Amerge) Zolmitriptan (Zomig, Zomig ZMT)	March 26, 2003
18.	**Macrolides**	Azithromycin (Zithromax) Dirithromycin (Dynabac) Erythromycin Base Erythromycin Estolate Erythromycin Ethylsuccinate Erythromycin Stearate **Clarithromycin (Biaxin)** **Clarithromycin SA (Biaxin XL)**	Erythromycin Base (PCE 333mg & 500mg) Troleandomycin (TAO)	March 26, 2003

#03-02 Prior Authorization PDL Implementation Schedule

		Drugs on PDL	Drugs which Require PA	Implementation Date
55.	**Anticoagulants, Injectable**	Dalteparin (Fragmin) Fondaparinux (Arixtra) Enoxaparin (Lovenox) - Pediatric use only (Under 21 years old)	Enoxaparin (Lovenox) Tinzaparin (Innohep)	March 26, 2003
56.	***H. Pylori* Agents**	Bismuth Subsalicylate/Metronidazole/Tetracycline (Helidac) Amoxicillin Prevacid	Lansoprazole /Amoxicillin / Clarithromycin (Prevpac)	March 26, 2003

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
David W. Hood
SECRETARY

February 17, 2003

MEMORANDUM

TO: Prescribing Providers

FROM: Ben A. Bearden, Director

RE: Monthly Prescription Limits; Clinical Drug Inquiry Applications

This correspondence supersedes the January 13, 2003 memorandum regarding the monthly prescription limits.

Monthly Prescription Limits

Effective for services beginning **March 3, 2003**, the Department of Health and Hospitals, Bureau of Health Services Financing will establish an eight (8) prescription limit per recipient per calendar month in the Medicaid Pharmacy Program.

The following federally mandated recipient groups are exempt from the 8 prescription monthly limitation:

1. **Persons under the age of twenty-one (21) years.** The exemption will expire the month following the recipient's 21st birthday;
2. **Persons living in long term care facilities such as nursing homes and ICF-MR facilities** (TYPE CASES – 05, 23, 24, 25, 51, 62, 63, 64, 65, 90, 99). The exemption will expire the month following the recipient's discharge date; or
3. **Pregnant women**
   When a prescribing practitioner issues a prescription to a pregnant woman, he/she shall indicate on the prescription that the recipient is pregnant. In the case of a telephoned prescription, the information that the recipient is pregnant shall be communicated to the pharmacist; and the pharmacist must document on the prescription that the recipient is pregnant.

Recipients who are not exempt from the 8 prescription monthly limitation will be allowed a maximum of 8 prescriptions per calendar month. The 8 prescription monthly limit can be overridden when the prescribing practitioner authorizes the medical necessity of the drug and follows the process listed below. **Claims, including those for emergency prescriptions and prior authorized prescriptions, which are in excess of 8 per calendar month per recipient, will be denied.**

PROCESS FOR THE OVERRIDE OF THE RX-LIMIT OF 8 RXS PER MONTH

STEP 1: **The prescription limit override will occur when a prescribing practitioner communicates either in writing, by phone, or electronically on each prescription over 8 per month the following:**
"medically necessary override" and the "ICD-9-CM Diagnosis". (NOTE: A valid ICD-9-CM Diagnosis Code that directly relates to each drug prescribed over 8 is required. ICD-9-CM literal description is not acceptable.)

STEP 2: When a pharmacist dispenses the prescription with the above requirements in Step 1, the 8 prescription limit per month will not apply.

Overrides will apply to the original prescription and its refills when the requirements in Step 1 are followed, up to the pharmacy program's maximum which is up to 5 refills or 6 months from the date of the prescription. Printed statements without the prescribing practitioner's signature, check-off boxes or stamped signatures are not acceptable documentation. An acceptable statement and ICD-9-CM code are required for each prescription in excess of 8 for that month. Prescribers are required to maintain documentation to support the override of a prescription limitation.

The "**medically necessary override**" stated in Step 1 does not replace the "**brand necessary**" written requirement needed to prescribe a "brand necessary" drug product when the prescriber certifies that a specified brand is medically necessary for a particular recipient. If "**brand necessary**" is needed in addition to the "**medically necessary override**", both statements shall be written on the prescription.

Clinical Drug Inquiry (CDI) Application

We are pleased to furnish you with the CDI Web Page, which provides you with a listing of all of the drugs that have been dispensed to a Medicaid recipient by all types of prescribers over a four-month period. The CDI data is available 24 hours a day, updated on a daily basis, only accessible by an authorized Medicaid provider and is available in a print friendly version.

The **major benefits** of the CDI data are:

- Allows you to evaluate a Medicaid recipient's drug usage over a four month period;
- Displays whether the recipient has been prescribed similarly clinically effective drugs;
- Facilitates assessment of your patient, based on your clinical expertise and knowledge, the drug(s) that have been prescribed by yourself and /or other providers---determining whether to discontinue some of the drugs, prescribe less costly drugs, or prescribe drugs that are more clinically appropriate;
- **Assist the prescriber in deciding if a Medicaid recipient requires more than 8 prescriptions per month based upon your clinical assessment of the patient's disease state or medical condition.**

The Medicaid Clinical Drug Inquiry (CDI) data can be accessed by:

Step 1: Using your Internet browser, access the Internet Web page: **www.lamedicaid.com**;
Step 2: Click on the **"Provider Log-In"** button in the upper left margin of the home page;
Step 3: Enter **"your 7-digit Medicaid Provider ID number"** in the data entry box;
Step 4: Follow the instructions for establishing **"your online account"**;
Step 5: Follow the instructions for **"activation of your online account"**;
NOTE: Provider enrollment instructions are available in a print friendly version for steps 4 & 5 by clicking the provider instructions link;
Step 6: Follow the instructions for the **"use of the CDI link to view recipient prescription information".**
NOTE: Instructions for step 6 are available in a print friendly version.

NOTE: For assistance with any of the above steps, please call 1-800-648-0790.

We strongly encourage you to take advantage of this state-of-the-art Internet accessible recipient drug history. Thank you for your continued support of the Medicaid Pharmacy Benefits Management Program for providing the best health care including the most clinically appropriate and cost effective drug regimes to Medicaid patients.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

Department of HEALTH and HOSPITALS

David W. Hood
SECRETARY

February 17, 2003

TO: Pharmacy Providers

FROM: Ben A. Bearden
Director

SUBJECT: Package Size/Decimal Quantity Edits

Effective **April 1, 2003** the Medicaid Pharmacy Program will deny any pharmacy claim submitted with a metric decimal quantity other than the package size of the product that is available or a multiple of the package size. The claim will deny with the deny edit code, **#120-Quantity invalid/missing** which is linked to NCPDP rejection code **#18-Missing or Invalid Metric Quantity** when the incorrect quantity is submitted on the pharmacy claim. These pharmacy claims can be re-submitted for processing with the correct decimal quantity or package size.

The attached NDC numbers will be added to the list of medications that will deny should the incorrect metric decimal quantity or package size be submitted on the pharmacy claims. The Medicaid Pharmacy program will add additional medications available in decimal quantity or unbreakable package sizes to this list in the future.

We appreciate your continued participation in the Louisiana Medicaid Pharmacy Benefits Management Program. Should you have any questions concerning the adjudication of pharmacy claims, please call the Pharmacy POS Help Desk at 1-800-648-0790 or 225-237-3381.

BAB/MJT/kal

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PHONE #: 225-342-9768 • FAX#: 225-342-1980
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DEPARTMENT OF HEALTH AND HOSPITALS

Edits Added for April 1, 2003 Implementation:

NDC	Drug Name	Strength	package size		Examples of Decimal Quantities		
59627000103	Avonex Administration Pack	30MCG	4	kits	4	8	12
55513019001	Neulasta	10mg/ml	0.6	ml	0.6	1.2	1.8
59930156001	ALBUTEROL	90MCG	17	gm	17	34	51
53706100101	TBC	None listed	113.4	ml	113.4	226.8	340.2
53706100102	TBC	None listed	56.7	ml	56.7	113.4	170.1
59366285502	Desonide	.05%	59	ml	59	118	177
59366285504	Desonide	.05%	118	ml	118	236	354
00075085084	NITROLINGUAL	.4 MG/DOSE`	14.49	GM	14.49	28.98	43.47
59630030020	NITROLINGUAL	.4 MG/DOSE`	12	GM	12	24	36
00078036964	DENAVIR	1%	1.5	GM	1.5	3	4.5
00597008214	ATROVENT	18MG	14	GM	14	28	42
58768010002	VOLTAREN	0.1%	2.5	ml	2.5	5	7.5
58768025136	GENTAMICIN SULFATE	0.3%	3.5	GM	3.5	7	10.5
58768025236	DEXACINE	0.1%	3.5	GM	3.5	7	10.5
00046087505	Prempro	0.625-2.5	28	gm	28	56	84
00046087506	Prempro	0.625-2.5	28	gm	28	56	84
00046097505	Prempro	0.625-5mg	28	gm	28	56	84
00075150543	Nasacort	55 mcg	10	ml	10	20	30
00075150616	Nasacort AQ	55 mcg	16.5	gm	16.5	33	49.5
00075245201	DDAVP	0.1mg/ml	2.5	ml	2.5	5	7.5
00085020901	Proventil Solution	0.83mg/ml	3	ml	3	6	9
00085064902	Vancenase	42mcg	7	gm	7	14	21

*Rhinocort Aqua, NDC 00186107808 has recently changed their package size from 8.4 ml to 8.6gm. On January 3, 2003, coinciding with the reporting of this change to First Data Bank, the State amended the package size edit for this drug from a multiple of 8.4 to a multiple of 8.6.

STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

June 14, 2004

Dear Pharmacy Provider:

Attached is the complete, most current listing of drugs on the Medicaid Prior Authorization (PA) Process' Preferred Drug List (PDL) **"04-02."** The listing includes preferred drugs and those drugs requiring prior authorization.

The PA process, in accordance with the program's "Continuity of Care" policy, does not impact original prescriptions (or refills) issued by a prescribing practitioner prior to effective PA dates of drugs as they are added to the PA process ***as long as they are within the 5 refills and 6-month program limits***. An educational alert will notify the pharmacist that prescriptions (and their refills) will require a new prescription and prior authorization, if the prescription life exceeds six months or the refill exceeds the 5 refill limit. The educational alert will state, "NEW RX WILL REQUIRE PA AFTER (DATE)."

Information on the Prior Authorization process, including the PDL and Prior Authorization Request Form (copy is attached, Form RXPA01), is also available on the Louisiana Medicaid website (**www.lamedicaid.com**). This website will be updated when changes (additions or deletions) are made to the PDL. The program may also utilize the provider remittance advices to notify providers of PDL changes that must be implemented in short time frames.

The Department has received inquiries that drug products requiring PA are not reimbursable by Medicaid. Medicaid does reimburse for drug products requiring prior authorization when the prior authorization process is followed. Additionally, should a claim deny because a PA is required, you may want to 1) verify that the PA was actually obtained and the dates of service for the PA; 2) verify that the filling date on the claim is subsequent to the start date of the PA. (Remember: PAs are not retroactive); and 3) call the POS help desk at 1-800-648-0790 for further assistance.

Please note that for drugs available over-the-counter (OTC) shall not be billed to the Medicaid Program with the NDC for the legend product. The OTC NDCs will not be covered by the Department. NDCs of the legend product that remain covered will be subject to PA and POS requirements.

Also, attached is Appendix D detailing the information required to review retroactive eligibility. Please be advised that pharmacy claims will only be overridden for the prior authorization edit for **eligibles with certified retroactive eligibility.** Claims submitted for eligibles who do not have retroactive eligibility will not have the PA edit overridden.

Thank you for your continued cooperation. We appreciate your participation in the Medicaid Program.

Sincerely,

Ben A. Bearden
Medicaid Director

BAB/ht

Attachments (3)

OFFICE OF MANAGEMENT AND FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LA 70821-9030
PHONE #: 225/342-5774 • FAX #: 225/342-3893
"AN EQUAL OPPORTUNITY EMPLOYER"

Prior Authorization PDL Implementation Schedule

5/12/2004

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
1	ADD/ADHD			
	Stimulants and Related Agents	Amphetamine Salts Combo	Atomoxetine (Strattera®)	
		Amphetamine Salts Combo/XR (Adderall XR)	Methamphetamine (Desoxyn®)	
		Dexmethylphenidate (Focalin®)	Modafinil (Provigil®)	
		Desmethylphenidate Sulfate		
		Methylphenidate		
		Methylphenidate ER (Metadate CD)		
		Methylphenidate ER (Concerta®)		
		Methylphenidate LA (Ritalin LA)		
		Methylphenidate/SR (Ritalin SR/Generic)		
		Pemoline		
2	ALLERGY			
	Anticholinergic Agents - Nasal	Ipratropium (Atrovent®)	NONE	
	Antihistamines - Minimally Sedating	Cetirizine Syrup (Zyrtec Syrup) - children 12 years old and under	Cetirizine Syrup (Zyrtec Syrup) - over 12 years old	
		Desloratadine (Clarinex®)	Cetirizine tablets (Zyrtec tablets)	
			Cetirizine/Pseudoephedrine (Zyrtec-D®)	
			Fexofenadine (Allegra®)	
			Fexofenadine/Pseudoephedrine (Allegra-D®)	
	Antihistamines - Nasal	Azelastine (Astelin®)	NONE	
	Corticosteroids, Nasal	Flunisolide Spray	Beclomethasone AQ (Beconase AQ®)	
		Fluticasone (Flonase®)	Budesonide Aqua (Rhinocort Aqua®)	
		Mometasone (Nasonex®)	Flunisolide Aqueous (Nasarel®)	
			Triamcinolone (Nasacort®)	
			Triamcinolone AQ (Nasacort AQ®)	
3	ALZHEIMER'S			
	Alzheimer's Agents	Donepezil (Aricept®)	Tacrine (Cognex®)	
	Cholinesterase Inhibitors	Galantamine (Reminyl®)		
		Rivastigmine (Exelon®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
4	**ASTHMA/COPD**			
	Beta-Adrenergic Agents			
		INHALATION		
		Albuterol Sulfate (Nebulizer and Inhaler)	Albuterol Sulfate/Ipratropium (DuoNeb®)	
		Albuterol Sulfate HFA MDI(Proventil HFA®)	Albuterol Sulfate HFA MDI(Ventolin HFA®)	
		Albuterol Sulfate Nebulizer Solution (Accuneb®)	Formoterol DPI (Foradil®)	
		Albuterol Sulfate/Ipratropium MDI (Combivent®)	Metaproterenol Sulfate (Alupent Inhalant®)	
		Levalbuterol HCL (Xopenex®)	Pirbuterol (Maxair, Maxair Autohaler)	
		Metaproterenol Sulfate (Nebulizer Only)		
		Salmeterol Xinafoate (Serevent Diskus)		
		ORAL		
		Albuterol Sulfate	Albuterol Sulfate ER (Volmax; Vospire ER®)	
		Metaproterenol Sulfate		
		Terbutaline Sulfate		
	Corticosteroids, Inhalation	Beclomethasone MDI (QVAR®)		
		Budesonide Suspension (Pulmicort - Respules®) - 21 years old and under	Budesonide Suspension (Pulmicort - Respules®) - Over 21 years only	
		Fluticasone DPI (Flovent Diskus; Flovent Rotadisk®)	Budesonide DPI (Pulmicort Turbuhaler®)	
		Fluticasone MDI (Flovent®)		
		Fluticasone/Salmeterol DPI (Advair Diskus®)		
		Triamcinolone MDI (Azmacort®)		
		Flunisolide MDI (Aerobid; Aerobid M®)		
	Leukotriene Modifiers	Montelukast (Singulair®)	Zileuton (Zyflo®)	
		Zafirlukast (Accolate®)		
5	**DEPRESSION**			
	Antidepressants, Other	Bupropion	Mirtazapine (Remeron SolTab®)	
		Bupropion XR (Wellbutrin SR®)		
		Mirtazapine		
		Nefazodone		
		Trazodone		
		Venlafaxine (Effexor®)		
		Venlafaxine XR (Effexor XR®)		
	Selective Serotonin	Excitalopram (Lexapro®)	Citalopram (Celexa®)	
	Reuptake Inhibitors (SSRIs)	Fluoxetine (except Sarafem®)	Fluoxetine ER (Prozac Weekly®)	
		Fluvoxamine Maleate	Fluoxetine (Sarafem®)	
		Paroxetine (Paxil®)		
		Paroxetine CR (Paxil CR®)		
		Sertraline (Zoloft®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
6	**DERMATOLOGY**			
	Antifungals - Topical	Butenafine (Mentax®)	Ciclopirox (Loprox®)	
		Clotrimazole	Ciclopirox (Penlac®)	
		Clotrimazole/Betamethasone	Terbinafine (Lamisil®)	
		Econazole		
		Ketoconazole		
		Ketoconazole (Nizoral Shampoo - Rx ONLY)		
		Naftifine (Naftin®)		
		Nystatin		
		Nystatin w/ Triamcinolone		
		Oxiconazole (Oxistat®)		
		Sulconazole (Exelderm)		
	Atopic Dermatitis	Pimecrolimus (Elidel®)	NONE	
	Immunomodulators	Tacrolimus (Protopic®)		
7	**DIABETES**			
	Hypoglycemics, Alpha - Glucosidase Inhibitors	Acarbose (Precose®)	NONE	
		Miglitol (Glyset®)		
	Hypoglycemics, Meglitinides	Nateglinide (Starlix®)	NONE	
		Repaglinide (Prandin®)		
	Hypoglycemics, Metformin Containing	Glyburide/Metformin (Glucovance®)	Glipizide/Metformin (Metaglip®)	
		Metformin	Metformin XR (Glucophage XR®)	
		Rosiglitazone/Metformin (Avandamet®)		
	Hypoglycemics, Sulfonylureas	Acetohexamide	NONE	
		Chlorpropamide		
		Glimepiride (Amaryl®)		
		Glipizide		
		Glipizide XL (Glucotrol XL®)		
		Glyburide		
		Glyburide Extended Release		
		Tolazamide		
		Tolbutamide		
	Hypoglycemics, Thiazolidinediones (TZDs)	Pioglitazone (Actos®)	NONE	
		Rosiglitazone (Avandia®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
7	DIABETES cont'			
	Insulins	Humalog (Children 18 years and under)	Humalog (Over 18 years)	
		Imsulin Glargine (Lantus®)	Humalog Mix 75/25	
		Novolin N	Humulin L	
		Novolin R	Humulin N	
		Novolin 70/30	Humulin R	
		Novolog	Humulin U	
		Novolog Mix	Humulin 50/50	
		Relion R	Humulin 70/30	
		Relion N		
		Relion 70/30		
8	DIGESTIVE DISORDERS			
	Antiemetic Agents	ORAL		
		Aprepitant (Emend®)	Dolasetron (Anzemet®)	
		Dronabinol (Marinol®)	Granisetron (Kytril®)	
		Metoclopramide		
		Ondansetron (Zofran, Zofran ODT®)		
		INJECTABLE		
		Metoclopramide Injection	Dolasetron Injection (Anzemet®)	
		Ondansetron Injection (Zofran®)	Granisetron Injection (Kytril®)	
	Antivertigo Agents			
		Scopolamine, Transdermal (Transderm Scop)	Scopolamine, Oral (Scopace)	
	GERD AND RELATED DISORDERS			
	H2 Antagonists	Cimetidine	Nizatidine (Axid®)	
		Famotidine	Famotidine RPD (Pepcid RPD®)	
		Ranitidine	Ranitidine Efferdose (Zantac Efferdose®)	
			Ranitidine Granules (Zantac Granules®)	
	H. Pylori Agents	Amoxicillin	Bismuth Subsalicylate/Metronidazole/Tetracycline (Helidac®)	
		Clarithromycin (Biaxin®)	Lansoprazole/Amoxicillin/Clarithromycin (Prevpac®)	
		Lansoprazole (Prevacid®)		
	Proton Pump Inhibitors	Lansoprazole (Prevacid®)	Esomeprazole (Nexium®)	
		Omeprazole	Rabeprazole (Aciphex®)	
		Pantoprazole (Protonix®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
8	DIGESTIVE DISORDERS cont'			
	ULCERATIVE COLITIS	Balsalazide (Colazal®)	Mesalamine Enemas (Rowasa®)	
	Ulcerative Colitis Agents	Mesalamine (Asacol®)		
		Mesalamine (Pentasa®)		
		Mesalamine Suppositories (Canasa®)		
		Olsalazine (Dipentum®)		
		Sulfasalazine		
9	GROWTH DEFICIENCY			
	Growth Hormones	Somatropin (Genotropin®)	Somatrem (Protropin®)	
		Somatropin (Norditropin®)	Somatropin (Humatrope®)	
		Somatropin (Nutropin®)	Somatropin (Saizen®)	
		Somatropin (Nutropin AQ®)	Somatropin (Serostim®)	
		Somatropin (Nutropin Depot)		
10	HEART DISEASE			
	HYPERLIPIDEMIA			
	Antihyperlipidemic Agents -	Cholestyramine	Colesevelam (Welchol®)	
	Non Statins	Colestipol (Colestid®)	Ezetimibe (Zetia)	
		Gemfibrozil	Fenofibrate (Lofibra®)	
		Fenofibrate (Tricor®)		
		Niacin ER (Niaspan®)		
		Niacin ER/Lovastatin (Advicor®)		
	Statins	Atorvastatin (Lipitor®)	Pravastatin/Buffered Aspirin (Pravigard PAC)	
		Fluvastatin (Lescol®)	Rosuvastatin (Crestor®)	
		Fluvastatin XL (Lescol XL®)		
		Lovastatin		
		Lovastatin ER (Altocor®)		
		Pravastatin (Pravachol®)		
		Simvastatin (Zocor®)		
	HYPERTENSION			
	ACE Inhibitors	Benazepril (Lotensin®)	Perindopril (Aceon®)	
		Benazepril/HCTZ (LotensinHCT®)	Quinapril (Accupril®)	
		Captopril	Quinapril/HCTZ (Accuretic®)	
		Captopril/HCTZ	Ramipril (Altace®)	
		Enalapril		
		Enalapril/HCTZ		
		Fosinopril (Monopril®)		
		Fosinopril/HCTZ (Monopril-HCT®)		
		Lisinopril		
		Lisinopril/HCTZ		
		Moexipril (Univasc®)		
		Moexipril/HCTZ (Uniretic®)		
		Trandolapril (Mavik®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
10	HEART DISEASE cont'			
	HYPERTENSION			
	ACE Inhibitors/Calcium Channel	Amlodipine/Benazepril (Lotrel®)	Felodipine/Enalapril (Lexxel®)	
	Blockers Combination Products	Verapamil SR/Trandolapril (Tarka®)		
	Angiotensin II Receptor	Irbesartan (Avapro®)	Candesartan (Atacand®)	
	Blockers (ARBS)	Irbesartan/HCTZ (Avalide®)	Candesartan/HCTZ (Atacand HCT®)	
		Olmesartan (Benicar®)	Eprosartan (Teveten®)	
		Telmisartan (Micardis®)	Eprosartan/HCTZ (Teveten HCT®)	
		Telmisartan/HCTZ (Micardis HCT®)	Losartan (Cozaar®)	
		Valsartan (Diovan®)	Losartan/HCTZ (Hyzaar®)	
		Valsartan/HCTZ (Diovan HCT®)		
	Beta Adrenergic Receptor	Acebutolol	Carteolol (Cartrol®)	
	Blocking Agents	Atenolol	Penbutolol (Levatol®)	
		Betaxolol	Propranolol LA (Inderal LA®)	
		Bisoprolol Fumarate		
		Carvedilol (Coreg®)		
		Labetalol		
		Metoprolol Tartrate		
		Metoprolol XL (Toprol XL)		
		Nadolol		
		Pindolol		
		Propanolol		
		Propranolol XL (Innopran XL®)		
		Sotalol		
		Sotalol (Betapace AF®)		
		Timolol Maleate		
	Calcium Channel Blockers	Diltiazem	Amlodipine (Norvasc®)	
		Diltiazem ER	Bepridil (Vascor®)	
		Diltiazem ER (Cardizem LA)	Isradipine (Dynacirc®)	
		Felodipine (Plendil®)	Isradipine SR (Dynacirc CR®)	
		Nicardipine	Nicardipine SR (Cardene SR®)	
		Nifedipine	Nimodipine (Nimotop®)	
		Nifedipine SR	Verapamil ER (Covera HS®)	
		Nisoldipine (Sular®)	Verapamil ER (Verelan PM®)	
		Verapamil		
		Verapamil SR		
	INTERMITTENT CLAUDICATION AGENTS			
	Intermittent Claudication	Cilostazol (Pletal®)	NONE	
	Agents	Pentoxifylline		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
10	HEART DISEASE cont'			
	PLATELET AGGREGATION INHIBITORS			
	Platelet Aggregation Inhibitors	Aspirin/Dipyridamole ER (Aggrenox®)	Ticlopidine	
		Clopidogrel (Plavix®)		
		Dipyridamole		
	ANTICOAGULANTS, INJECTABLES			
	Anticoagulants,	Dalteparin (Fragmin®)		
	Injectable	Fondaparinux (Arixtra®)		
		Enoxaparin (Lovenox®) - Pediatric use only (21 years old and Under)	Enoxaparin (Lovenox®) Over 21 years old	
		Tinzaparin (Innohep®)		
11	HEMATOLOGIC AGENTS			
	HEMATOPOIETIC AGENTS			
	Erythropoietins	Epoetin alfa (Procrit®)	Epoetin alfa (Epogen®)	
		Darbepoetin alfa (Aranesp®)		
	Anticoagulants - refer to			
	HEART DISEASE			
12	HEMODIALYSIS			
	Phosphate Binders	Calcium Acetate (PhosLo®)	NONE	
		Magnesium Carbonate, Calcium Carbonate, Folic Acid (Magnebind 400 Rx)		
		Sevelamer (RenaGel®)		
13	HORMONE THERAPY			
	Contraceptives	MONOPHASIC	MONOPHASIC	
	All covered contraceptives are	Alesse; Apri; Aviane	NONE	
	on the PDL.	Brevicon		
		Demulen; Desogen		
		Lessina; Levien; Levlite; Levora		
		Lo/Ovral; Loestrin, FE; Low-Ogestrel		
		Microgestin FE; Modicon		
		Necon; Nelova; Nordette; Norinyl; Notrel		
		Ogestrel; Ortho-Cept; Ortho-Cyclen; Ortho-Novum		
		Ovcon; Ovral		
		Portia		
		Yasmin		
		Zovia 1/50		
		BIPHASIC	BIPHASIC	
		Karvia	NONE	
		Mircette		
		Necon		
		Ortho-Novum 10/11		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
13	HORMONE THERAPY Cont'			
	Contraceptives	TRIPHASIC	TRIPHASIC	
	All covered contraceptives are	Cyclessa	NONE	
	on the PDL.	Enpresse; Estrostep		
		Ortho TriCyclen; Ortho-Novum 7/7/7		
		Tri-Levlen; Tri-Norinyl; Triphasil; Trivora		
		PROGESTIN ONLY	PROGESTIN ONLY	
		Nor-Q.D.	NONE	
		Ortho Micronor		
		Ovrette		
		EMERGENCY CONTRACEPTION	EMERGENCY CONTRACEPTION	
		Preven	NONE	
		TRANSDERMAL & VAGINAL RING	TRANSDERMAL & VAGINAL RING	
		NuvaRing	NONE	
		Ortho Evra		
	Estrogen Agents - Oral and	ORAL		
	Transdermal	Conjugated Estrogens (Premarin®)	Esterified Estrogens (Estratab)	
		Diethylstilbestrol		
		Esterified Estrogens (Menest®)		
		Estradiol		
		Estropipate		
		Synthetic Conjugated Estrogens (Cenestin®)		
		TRANSDERMAL PATCH		
		Estradiol	Estradiol (Climara®)	
	Combination Estrogen Agents	17β-Estradiol/Norgestimate (Ortho-Prefest®)	17β-Estradiol/Norethindrone Acetate (Activella®)	
		Conjugated Estrogens (CE)/Medroxyprogesterone Acetate (MPA) (Premphase)	17β-Estradiol/Norethindrone Acetate (CombiPatch)	
		Conjugated Estrogens /Medroxyprogesterone Acetate (Prempro)	Ethinyl Estradiol/Norethindrone Acetate (Femhrt)	
14	HYPERLIPIDEMIA - REFER TO HEART DISEASE			
15	IMMUNE DISORDERS - REFER TO MULTIPLE SCLEROSIS			
16	INFECTIOUS DISORDERS			
	ANTIBIOTICS			
	Cephalosporin and Related	Amoxicillin/Clavulanate	Cefprozil (Cefzil®)	
	Antibiotics	Amoxicillin/Clavulanate (Augmentin ES-600®)	Cefpodoxime Proxetil (Vantin®)	
		Amoxicillin/Clavulanate XR (Augmentin XR®)	Ceftibuten (Cedax®)	
		Cefaclor	Loracarbef (Lorabid®)	
		Cefaclor ER (Ceclor CD®)		
		Cefadroxil Monohydrate		
		Cefdinir (Omnicef®)		
		Cefditoren Pivoxil (Spectracef®)		
		Cefuroxime Axetil		
		Cephalexin		
		Cephradine		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
16	INFECTIOUS DISORDERS Cont'			
	ANTIBIOTICS	INJECTABLE		
	Fluoroquinolones	Ciprofloxacin (Cipro®)	Ofloxacin (Floxin®)	
		Gatifloxacin (Tequin®)		
		Levofloxacin (Levaquin®)		
		Moxifloxacin (Avelox®)		
		ORAL		
		Ciprofloxacin (Cipro®)	Iomefloxacin (Maxaquin®)	
		Ciprofloxacin ER (Cipro XR®)	Norfloxacin (Noroxin®)	
		Gatifloxacin (Tequin®)	Ofloxacin (Floxin®)	
		Levofloxacin (Levaquin®)	Sparfloxacin (Zagam®)	
		Moxifloxacin (Avelox®)		
	Macrolides	Azithromycin (Zithromax®)	Erythromycin Base (PCE 333mg & 500mg)	
		Clarithromycin (Biaxin®)		
		Clarithromycin ER (Biaxin XL®)		
		Dirithromycin (Dynabac®)		
		Erythromycin Base		
		Erythromycin Estolate		
		Erythromycin Esthylsuccinate		
		Erythromycin Stearate		
	OPTHALMIC ANTIBIOTICS - refer to Opthalmic Disorders			
	OTIC ANTIBIOTICS - refer to OTIC Agents			
	ANTIFUNGALS			
	Antifungals, Oral	Fluconazole (Diflucan®)	Clotrimazole (Mycelex Troche®)	
		Griseofulvin	Flucytosine (Ancobon®)	
		Ketoconazole	Itraconazole (Sporanox®)	
		Nystatin	Nystatin (Mycostatin pastiles)	
		Terbinafine (Lamisil®)	Voriconazole (VFEND)	

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
17	MULTIPLE SCLEROSIS			
	Multiple Sclerosis Agents	Interferon beta - 1a (Avonex®)	Glatiramer (Copaxone®)	
	(Immunomodulatory Agents)	Interferon beta - 1a (Betaseron®)	Interferon beta - 1a (Rebif®)	
18	OPHTHALMIC DISORDERS			
	Allergic Conjunctivitis	Azelastine Hydrochloride (Optivar®)	Ketotifen Fumarate (Zaditor®)	
		Cromolyn Sodium	Lodoxamine Tromethamine (Alomide®)	
		Emedastine Difumarate (Emadine®)	Nedocromil Sodium (Alocril®)	
		Ketorolac Tromethamine (Acular®)		
		Levocabastine (Livostin®)		
		Loteprednol (Alrex®)		
		Olopatadine Hydrochloride (Patanol®)		
		Pemirolast Potassium (Alamast®)		
	Glaucoma Agents			
	Intraocular Pressure (IOP)	Bextaxolol	NONE	
	Reducers	Bextaxolol (Betoptic S®)		
		Brimonidine (Alphagen P®)		
		Brimonidine Tartrate		
		Brinzolamide (Azopt®)		
		Carteolol		
		Dipivefrin		
		Dorzolamide (Trusopt®)		
		Dorzolamide/Timolol (Cosopt®)		
		Epinephrine		
		Levobunolol		
		Metipranolol		
		Pilocarpine		
		Timolol (Betimol®)		
		Timolol Maleate		
	Prostaglandin Inhibitors	Bimatoprost (Lumigan®)	Unoprostone (Rescula®)	
		Latanoprost (Xalatan®)		
		Travoprost (Travatan®)		
	Antibiotics, Ophthalmic	Bacitracin	Gatifloxacin (Zymar®)	
		Ciprofloxan (Ciloxan®)		
		Erythromycin		
		Gentamicin Sulfate		
		Levofloxacin (Quixin®)		
		Moxifloxacin (Vigamox®)		
		Ofloxacin (Ocuflox®)		
		Tobramycin Sulfate		
19	OTIC AGENTS			
	Antibiotics, Others	Neomycin/Colistin/Thonzonium/HC (Coly-Mycin S)	Neomycin/Colistin/Thonzonium/HC (Cortisporin - TC)	
		Neomycin/Polymyxin/HC (Pediotic®)		
		Neomycin/Polymyxin/HC		
	Fluoroquinolones	Ciprofloxacin/Dexamethasone (Ciprodex OTIC®)	Ciprofloxacin/Hydrocortisone (Cipro HC OTIC®)	
		Ofloxacin (Floxin OTIC®)		
20	OSTEOPOROSIS			
	Bone Resorption Suppression	Alendronate (Fosamax®)	Etidronate (Didronel®)	
	Agents	Calcitonin-salmon (Miacalcin®)	Raloxifene (Evista®)	
		Risedronate (Actonel®)	Teriparatide (Forteo)	

Prior Authorization PDL Implementation Schedule

5/12/2004

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
21	PAIN MANAGEMENT			
	Narcotics	Acetaminophen w/Codeine	Aspirin/Caffeine/Dihydrocodeine Bitartrate	
		Acetaminophen w/Codeine (Capital w/Codeine)	(Synalgos-DC)	
		Acetaminophen/Caffeine/Dihydrocodeine Bitartrate	Fentanyl Citrate (Actiq®)	
		(Panlor DC, Panlor SS)	Opium Tincture	
		Aspirin w/Codeine	Oxycodone SR	
		Belladonna & Opium	Oxymorphone (Numorphan®)	
		Butalbital Compound w/Codeine	Propoxyphene Napsylate (Darvon-N®)	
		Butalbital/Caff/APAP/Codeine		
		Butorphanol Tartrate		
		Carisoprodol Compound/Codeine		
		Codeine Phosphate		
		Codeine Sulfate		
		Fentanyl Transdermal (Duragesic®)		
		Flortal w/Codeine #3		
		Hydrocodone/Acetaminophen		
		Hydrocodone/Acetaminophen (Maxidone; Zydone®)		
		Hydrocodone Bitartrate/ibuprofen (Vicoprofen®)		
		Hydromorphone HCL		
		Meperidine HCL		
		Meperidine w/Promethazine		
		Methadone HCL		
		Methadose		
		Morphine Sulfate (Oral)		
		Morphine Sulfate (Rectal)		
		Morphine Sulfate ER (Avinza®)		
		Morphine Sulfate ER (Kadian®)		
		Morphine Sulfate IR		
		Oxycodone HCL		
		Oxycodone/Acetaminophen		
		Oxycodone/Acetaminophen (Percocet 10/325mg;		
		2.5/325mg;7.5/325mg®)		
		Oxycodone w/Acetaminophen (Roxicet®)		
		Oxycodone w/Aspirin		
		Pentazocine/Naloxone HCL		
		Pentazocine/Acetaminophen		
		Propoxyphene HCL		
		Propoxyphene HCL Compound		
		Propoxyphene HCL w/APAP		
		Propoxyphene Napsylate w/APAP		
		Tramadol (Ultram®)		
		Tramadol/Acetaminophen (Ultracet®)		

Prior Authorization PDL Implementation Schedule

5/12/2004

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
21	PAIN MANAGEMENT Cont'			
	Nonsteroidal Anti - Inflammatories	Diclofenac	Diclofenac/Misoprostol (Arthrotec®)	
	(NSAIDs)	Etodolac		
		Fenoprofen		
		Flurbiprofen		
		Ibuprofen		
		Indomethacin		
		Ketoprofen		
		Ketorolac		
		Meclofenamate Sodium		
		Mefenamic Acid (Ponstel®)		
		Meloxicam (Mobic®)		
		Nabumetone		
		Naproxen		
		Naproxen Sodium		
		Oxaprozin		
		Piroxicam		
		Sulindac		
		Tolmetin Sodium		
	Selective Cyclooxygenase	Rofecoxib (Vioxx®)	Celecoxib (Celebrex®)	
	Cox 2 Inhibitors	Valdecoxib (Bextra®)		
	Immunomodulators and Related Agents	Adalimumab (Humira®)	Anakinra (Kineret®)	
	for Arthritis	Etanercept (Enbrel®)	Infliximab (Remicade®)	
		Leflunomide (Arava®)		
	Skeletal Muscle Relaxants	Baclofen	Dantrolene (Dantrium®)	
		Carisoprodol		
		Chlorzoxazone		
		Cyclobenzaprine		
		Diazepam		
		Metaxalone (Skelaxin®)		
		Methocarbamol		
		Orphenadrine Citrate		
		Tizanidine (Zanaflex®)		
	Triptans	Almotriptan (Axert®)	Eletriptan (Relpax®)	
		Rizatriptan (Maxalt, Maxalt MLT®)	Frovatriptan (Frova®)	
		Sumatriptan (Imitrex Nasal)	Naratriptan (Amerge®)	
		Sumatriptan (Imitrex Oral)	Zolmitriptan (Zomig, ZMT®)	
		Sumatriptan (Imitrex Subcutaneous)	Zolmitriptan (Zomig nasal)	

Prior Authorization PDL Implementation Schedule

5/12/2004

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2004
22	PARKINSON'S			
	Antiparkinson Agents -	Benztropine Mesylate	Procyclidine (Kemadrin®)	
	Anticholinergic and Other	Entacapone (Comtan®)	Tolcapone (Tasmar®)	
		Levodopa (Larodopa®)		
		Levodopa/Carbidopa		
		Levodopa/Carbidopa/Entacapone (Stalevo®)		
		Pergolide		
		Pramipexole (Mirapex®)		
		Ropinirole (Requip®)		
		Selegiline		
		Trihexyphenidyl		
23	SEDATIVE/HYPNOTICS			
	Sedative/Hypnotics	Chloral Hydrate	Quazepam (Doral®)	
		Estazolam	Zaleplon (Sonata®)	
		Flurazepam		
		Temazepam		
		Triazolam		
		Zolpidem (Ambien®)		
24	UROLOGY			
	INCONTINENCE			
	Antiincontinence Agents	Flavoxate (Urispas®)	Oxybutynin transdermal (Oxytrol®)	
		Oxybutynin	Tolterodine (Detrol®)	
		Oxybutynin extended-release (Ditropan XL®)	Tolterodine extended-release (Detrol LA®)	
	PROSTATE			
	Drug for Treatment of Benign	Alfuzosin (Uroxatral®)	NONE	
	Prostatic Hyperplasia (BPH)	Doxazosin		
		Dutasteride (Avodart®)		
		Finasteride (Proscar®)		
		Tamsulosin (Flomax®)		
		Terazosin		

Fax or Mail this form to:
LA Medicaid Rx PA Operations
ULM College of Pharmacy
1401 Royal Avenue
Monroe, LA 71201
Fax: 866-RX PA FAX
(866-797-2329)

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form RXPA01
Issue Date: 3/1/2002

Voice Phone:
866-730-4357

Please type or print legibly (fields followed with an asterisk * are required, all other fields are requested).

Date of Request:*	Number of Fax Pages:*
Practitioner Information	**Patient Information**
Name:*	Name (last, first):*
LA Medicaid Prescribing Provider Number:*	LA Medicaid CCN or Recipient Number:*
LA Medicaid Billing Provider Number:	Date of Birth (m/d/y):*
Call-Back Phone Number (include area code):*	
Fax Number (include area code)*:	Projected Duration:*
Requested Drug Information	
Drug Name:*	Drug Strength:
Diagnosis Code (ICD-9-CM):	Diagnosis Description:*

Please answer the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred product(s)? ☐ YES ☐ NO

2. Does the patient have a condition that prevents the use of the preferred product(s)? ☐ YES ☐ NO
   If YES, list the condition(s) in the box below:

3. Is there a potential drug interaction between another medication and the preferred product(s)? ☐ YES ☐ NO
   If YES, list the interaction(s) in the box below:

4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐ YES ☐ NO
   If YES, list the side effects in the box below:

Practitioner Signature:* _____

(If a signature stamp is used, then the prescribing practitioner must initial the signature)

CONFIDENTIALITY NOTICE
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Appendix D. Retroactive Eligibility Process for Rx PA

Recipient → **Pharmacy**



Rx filled prior to eligibility
(No proof of eligibility)

Pharmacy Charged | **Cash Sale**

Retroactive Eligibility established for Recipient
√ Paper Eligibility **Form 18** processed by DHH
√(Example: Form 18-LTC indicates LTC eligibility. Form 18 does not always certify retroactive eligibility.)
√ Plastic Card issued to recipient with CCN

POS Claim is denied with **"PA Required"** edit

Scenario 1: Rx credited the Recipient

1. Acct Receivable credited
2. Pharmacy submission of:
   a. Claim
   b. Form 18
   c. Cover letter requesting RxPA override.
   To:
   DHH MMIS Unit
   P.O. Box 91030
   Baton Rouge, LA 70821.
3. PA override applied by DHH.
4. Unisys processes claim.
5. Payment to Pharmacy.

Scenario 2: Recipient paid cash

1. Cash refund to recipient refused.
2. Recipient contacts parish office.
3. Parish office mails pharmacy form RRP-P.
4. Pharmacy completes form RRP-P and returns to parish office.
5. DHH processes form RRP-P
   a. PA override applied.
   b. Sent to Unisys for data entry.
6. Payment to Recipient.

Scenario 3: Recipient paid cash (Full cash refund to the Recipient)

1. Full amount cash refund to recipient.
2. Pharmacy submission of:
   a. Claim
   b. Form 18
   c. Cover letter requesting RxPA override.
   To:
   DHH MMIS Unit
   P.O. Box 91030
   Baton Rouge, LA 70821.
3. PA override applied by DHH.
4. Unisys processes claim.
5. Payment to Pharmacy.

STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

September 17, 2004

Dear Prescribing Practitioner:

Attached is the complete, most current listing of drugs on the Medicaid Prior Authorization (PA) Process' Preferred Drug List (PDL) **"04-03."** The listing includes preferred drugs and those drugs requiring prior authorization. **This list will be effective October 1, 2004.**

The PA process, in accordance with the program's "Continuity of Care" policy, does not impact original prescriptions (or refills) issued by a prescribing practitioner prior to effective PA dates of drugs as they are added to the PA process ***as long as they are within the 5 refills and 6-month program limits.*** An educational alert will notify the pharmacist that prescriptions (and their refills) will require a new prescription and prior authorization, if the prescription life exceeds six months or the refill exceeds the 5 refill limit. The educational alert will state, "NEW RX WILL REQUIRE PA AFTER (DATE)."

Information on the Prior Authorization process, including the PDL and Prior Authorization Request Form (copy is attached, Form RXPA01), is also available on the Louisiana Medicaid website (www.lamedicaid.com). This website will be updated when changes (additions or deletions) are made to the PDL. The program may also utilize the provider remittance advices to notify providers of PDL changes that must be implemented in short time frames.

The Department has received inquiries that drug products requiring PA are not reimbursable by Medicaid. Medicaid does reimburse for drug products requiring prior authorization when the prior authorization process is followed.

Also, attached is Appendix D detailing the information required to review retroactive eligibility. Please be advised that pharmacy claims will only be overridden for the prior authorization edit for **eligibles with certified retroactive eligibility.** Claims submitted for eligibles who do not have retroactive eligibility will not have the PA edit overridden.

Thank you for your continued cooperation. We appreciate your participation in the Medicaid Program.

Sincerely,

Ben A. Bearden
Medicaid Director

BAB/ht

Attachments (3)

OFFICE OF MANAGEMENT AND FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LA 70821-9030
PHONE #: 225/342-5774 • FAX #: 225/342-3893
"AN EQUAL OPPORTUNITY EMPLOYER"

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
1	ADD/ADHD			
	Stimulants and Related Agents	Amphetamine Mixed Salt	Atomoxetine (Strattera®)	
		Amphetamine Mixed Salt ER (Adderall XR)	Modafinil (Provigil®)	
		Dexmethylphenidate (Focalin®)		
		Dextroamphetamine		
		Methamphetamine HCL		
		Methylphenidate		
		Methylphenidate ER		
		Methylphenidate ER (Concerta®, Metadate CD®)		
		Methylphenidate LA (Ritalin LA®)		
		Pemoline		
2	ALLERGY			
	Anticholinergic Agents - Nasal	Ipratropium (Atrovent®)	NONE	
	Antihistamines - Minimally Sedating	Cetirizine Syrup (Zyrtec Syrup®) - children 12 years old and under	Cetirizine Syrup (Zyrtec Syrup) - 13 years old and over	
		Desloratadine (Clarinex®)	Cetirizine	
			Cetirizine/Pseudoephedrine (Zyrtec-D®)	
			Fexofenadine (Allegra®)	
			Fexofenadine/Pseudoephedrine (Allegra-D®)	
	Antihistamines - Nasal	Azelastine (Astelin®)	NONE	
	Corticosteroids, Nasal	Flunisolide Spray	Beclomethasone AQ (Beconase AQ®)	
		Fluticasone (Flonase®)	Budesonide Aqua (Rhinocort Aqua®)	
			Flunisolide Aqueous (Nasarel®)	
			Mometasone (Nasonex®)	
			Triamcinolone AQ (Nasacort AQ®)	
3	ALZHEIMER'S			
	Alzheimer's Agents	Donepezil (Aricept®)	Tacrine (Cognex®)	
	Cholinesterase Inhibitors	Galantamine (Reminyl®)		
		Rivastigmine (Exelon®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
4	**ASTHMA/COPD**			
	Beta-Adrenergic Agents			
		INHALATION		
		Albuterol Sulfate (Nebulizer and Inhaler)	Albuterol Sulfate/Ipratropium (DuoNeb®)	
		Albuterol Sulfate HFA MDI(Proventil HFA®)	Albuterol Sulfate HFA MDI(Ventolin HFA®)	
		Albuterol Sulfate Nebulizer Solution (Accuneb®)	Formoterol DPI (Foradil®)	
		Albuterol Sulfate/Ipratropium MDI (Combivent®)	Metaproterenol Sulfate (Alupent Inhalant®)	
		Levalbuterol HCL (Xopenex®)	Pirbuterol (Maxair®, Maxair Autohaler®)	
		Metaproterenol Sulfate (Nebulizer Only)		
		Salmeterol Xinafoate (Serevent Diskus®)		
		ORAL		
		Albuterol Sulfate	Albuterol Sulfate ER (Volmax®; Vospire ER®)	
		Metaproterenol Sulfate		
		Terbutaline Sulfate		
	Corticosteroids, Inhalation	Beclomethasone MDI (QVAR®)		
		Budesonide Respules (Pulmicort Respules®) - 21 years old and under	Budesonide Respules (Pulmicort Respules®)- 22 years old and over	
		Flunisolide MDI (Aerobid®)	Budesonide DPI (Pulmicort Turbuhaler®)	
		Flunisolide MDI (Aerobid M®)		
		Fluticasone MDI (Flovent Inhaler®)		
		Fluticasone MDI (Flovent Rotadisc®)		
		Triamcinolone MDI (Azmacort®)		
		Fluticasone/Salmeterol DPI (Advair Diskus®)		
	Leukotriene Modifiers	Montelukast (Singulair®)	NONE	
		Zafirlukast (Accolate®)		
5	**DEPRESSION**			
	Antidepressants, Other	Bupropion	NONE	
		Bupropion SR		
		Bupropion ER (Wellbutrin XL®)		
		Mirtazapine		
		Mirtazapine Soltab		
		Nefazodone		
		Trazodone		
		Venlafaxine (Effexor®)		
		Venlafaxine ER (Effexor XR®)		
	Selective Serotonin	Escitalopram (Lexapro®)	Citalopram (Celexa®)	
	Reuptake Inhibitors (SSRIs)	Fluoxetine (except Sarafem®)	Fluoxetine ER (Prozac Weekly®)	
		Fluvoxamine	Fluoxetine (Sarafem®)	
		Paroxetine HCL		
		Paroxetine HCL CR (Paxil CR®)		
		Paroxetine Mesylate (Pexeva®)		
		Sertraline (Zoloft®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
6	**DERMATOLOGY**			
	Antifungals - Topical	Butenafine (Mentax®)	Ciclopirox (Loprox®)	
		Clotrimazole	Ciclopirox (Penlac®)	
		Clotrimazole/Betamethasone	Terbinafine (Lamisil®)	
		Econazole		
		Ketoconazole		
		Ketoconazole (Nizoral Shampoo - Rx ONLY)		
		Naftifine (Naftin®)		
		Nystatin		
		Nystatin w/ Triamcinolone		
		Oxiconazole (Oxistat®)		
		Sulconazole (Exelderm)		
	Atopic Dermatitis	Pimecrolimus (Elidel®)	NONE	
	Immunomodulators	Tacrolimus (Protopic®)		
7	**DIABETES**			
	Hypoglycemics, Alpha - Glucosidase Inhibitors	Miglitol (Glyset®)	Acarbose (Precose®)	
	Hypoglycemics, Meglitinides	Nateglinide (Starlix®)	Repaglinide (Prandin®)	
	Hypoglycemics, Metformin Containing	Metformin	NONE	
		Metformin ER (Fortamet®)		
		Metformin XR		
		Metformin Oral Solution (Riomet®)		
		Metformin/Glipizide (Metaglip®)		
		Metformin/Glyburide		
		Metformin/Rosiglitazone (Avandamet®)		
	Hypoglycemics, Sulfonylureas	Acetohexamide	NONE	
		Chlorpropamide		
		Glimepiride (Amaryl®)		
		Glipizide		
		Glipizide XL (Glucotrol XL®)		
		Glyburide		
		Glyburide Extended Release		
		Tolazamide		
		Tolbutamide		
	Hypoglycemics, Thiazolidinediones (TZDs)	Pioglitazone (Actos®)	NONE	
		Rosiglitazone (Avandia®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
7	**DIABETES cont'**			
	Insulins	Humalog (Children 18 years and under)	Humalog (Over 18 years)	
		Imsulin Glargine (Lantus®)	Humalog Mix 75/25	
		Novolin N	Humulin L	
		Novolin R	Humulin N	
		Novolin 70/30	Humulin R	
		Novolog	Humulin U	
		Novolog Mix	Humulin 50/50	
		Relion R	Humulin 70/30	
		Relion N		
		Relion 70/30		
8	**DIGESTIVE DISORDERS**			
	Antiemetic Agents	**ORAL**		
		Aprepitant (Emend®)	Dolasetron (Anzemet®)	
		Dronabinol (Marinol®)	Granisetron (Kytril®)	
		Metoclopramide		
		Ondansetron (Zofran, Zofran ODT®)		
		INJECTABLE		
		Metoclopramide Injection	Dolasetron Injection (Anzemet®)	
		Ondansetron Injection (Zofran®)	Granisetron Injection (Kytril®)	
	Antivertigo Agents			
		Scopolamine, Transdermal (Transderm Scop)	Scopolamine, Oral (Scopace®)	
	GERD AND RELATED DISORDERS			
	H2 Antagonists	Cimetidine	Nizatidine (Axid®)	
		Famotidine	Famotidine RPD (Pepcid RPD®)	
		Ranitidine	Ranitidine Efferdose (Zantac Efferdose®)	
			Ranitidine Granules (Zantac Granules®)	
	***H. Pylori* Agents**	Amoxicillin	Bismuth Subsalicylate/Metronidazole/Tetracycline (Helidac®)	
		Clarithromycin (Biaxin®)	Lansoprazole/Amoxicillin/Clarithromycin (Prevpac®)	
		Lansoprazole (Prevacid®)		
	Proton Pump Inhibitors	Esomeprazole (Nexium®)	Pantoprazole (Protonix®)	
		Lansoprazole (Prevacid®)	Rabeprazole (Aciphex®)	
		Omeprazole		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
8	DIGESTIVE DISORDERS cont'			
	ULCERATIVE COLITIS	Balsalazide (Colazal®)	Mesalamine Enemas (Rowasa®)	
	Ulcerative Colitis Agents	Mesalamine (Asacol®)		
		Mesalamine (Pentasa®)		
		Mesalamine Suppositories (Canasa®)		
		Olsalazine (Dipentum®)		
		Sulfasalazine		
9	GROWTH DEFICIENCY			
	Growth Hormones	Somatropin (Genotropin®)	Somatrem (Protropin®)	
		Somatropin (Norditropin®)	Somatropin (Humatrope®)	
		Somatropin (Nutropin®)	Somatropin (Saizen®)	
		Somatropin (Nutropin AQ®)	Somatropin (Serostim®)	
		Somatropin (Nutropin Depot)		
10	HEART DISEASE			
	HYPERLIPIDEMIA			
	Antihyperlipidemic Agents -	Cholestyramine	Colesevelam (Welchol®)	
	Non Statins	Colestipol (Colestid®)	Ezetimibe (Zetia)	
		Gemfibrozil	Fenofibrate (Lofibra®)	
		Fenofibrate (Tricor®)		
		Niacin ER (Niaspan®)		
		Niacin ER/Lovastatin (Advicor®)		
	Statins	Atorvastatin (Lipitor®)	Pravastatin/Buffered Aspirin (Pravigard PAC)	
		Fluvastatin (Lescol®)	Rosuvastatin (Crestor®)	
		Fluvastatin XL (Lescol XL®)		
		Lovastatin		
		Lovastatin ER (Altocor®)		
		Pravastatin (Pravachol®)		
		Simvastatin (Zocor®)		
	HYPERTENSION			
	ACE Inhibitors	Benazepril	Quinapril (Accupril®)	
		Benazepril/HCTZ		
		Captopril		
		Captopril/HCTZ		
		Enalapril		
		Enalapril/HCTZ		
		Fosinopril		
		Fosinopril/HCTZ (Monopril-HCT®)		
		Lisinopril		
		Lisinopril/HCTZ		
		Moexipril		
		Moexipril/HCTZ (Uniretic®)		
		Perindopril (Aceon®)		
		Quinapril/HCTZ (Accuretic®)		
		Ramipril (Altace®)		
		Trandolapril (Mavik®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
10	**HEART DISEASE cont'**			
	HYPERTENSION			
	ACE Inhibitors/Calcium Channel	Amlodipine/Benazepril (Lotrel®)	Felodipine/Enalapril (Lexxel®)	
	Blockers Combination Products	Verapamil SR/Trandolapril (Tarka®)		
	Angiotensin II Receptor	Eprosartan (Teveten®)	Candesartan (Atacand®)	
	Blockers (ARBS)	Eprosartan/HCTZ (Teveten HCT®)	Candesartan/HCTZ (Atacand HCT®)	
		Irbesartan (Avapro®)		
		Irbesartan/HCTZ (Avalide®)		
		Iosartan (Cozaar®)		
		Iosartan/HCTZ (Hyzaar®)		
		Olmesartan (Benicar®)		
		Olmesartan/HCTZ (Benicar HCT®)		
		Telmisartan (Micardis®)		
		Telmisartan/HCTZ (Micardis HCT®)		
		Valsartan (Diovan®)		
		Valsartan/HCTZ (Diovan HCT®)		
	Beta Adrenergic Receptor	Acebutolol	Carteolol (Cartrol®)	
	Blocking Agents	Atenolol	Penbutolol (Levatol®)	
		Betaxolol	Propranolol LA (Inderal LA®)	
		Bisoprolol Fumarate		
		Carvedilol (Coreg®)		
		Labetalol		
		Metoprolol Tartrate		
		Metoprolol XL (Toprol XL)		
		Nadolol		
		Pindolol		
		Propranolol		
		Propranolol XL (Innopran XL®)		
		Sotalol		
		Sotalol (Betapace AF®)		
		Timolol Maleate		
	Calcium Channel Blockers	Amlodipine (Norvasc®)	Bepridil (Vascor®)	
		Diltiazem	Nicardipine SR (Cardene SR®)	
		Diltiazem ER	Nimodipine (Nimotop®)	
		Diltiazem SR	Verapamil ER (Covera HS®)	
		Diltiazem LA (Cardizem LA)	Verapamil ER (Verelan PM®)	
		Felodipine (Plendil®)		
		Isradipine (Dynacirc®)		
		Isradipine SR (Dynacirc CR®)		
		Nicardipine		
		Nifedipine		
		Nifedipine SR		
		Nisoldipine (Sular®)		
		Verapamil		
		Verapamil SR		
	INTERMITTENT CLAUDICATION AGENTS			
	Intermittent Claudication	Cilostazol (Pletal®)	NONE	
	Agents	Pentoxifylline		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
10	HEART DISEASE cont'			
	PLATELET AGGREGATION INHIBITORS			
	Platelet Aggregation Inhibitors	Aspirin/Dipyridamole ER (Aggrenox®)	Ticlopidine	
		Clopidogrel (Plavix®)		
		Dipyridamole		
	ANTICOAGULANTS, INJECTABLES			
	Anticoagulants,	Dalteparin (Fragmin®)		
	Injectable	Fondaparinux (Arixtra®)		
		Enoxaparin (Lovenox®) - Pediatric use only (21 years old and Under)	Enoxaparin (Lovenox®) Over 21 years old	
		Tinzaparin (Innohep®)		
11	HEMATOLOGIC AGENTS			
	HEMATOPOIETIC AGENTS			
	Erythropoietins	Epoetin alfa (Procrit®)	Epoetin alfa (Epogen®)	
		Darbepoetin alfa (Aranesp®)		
	Anticoagulants - refer to			
	HEART DISEASE			
12	HEMODIALYSIS			
	Phosphate Binders	Calcium Acetate (PhosLo®)	NONE	
		Magnesium Carbonate, Calcium Carbonate, Folic Acid (Magnebind 400 Rx)		
		Sevelamer (RenaGel®)		
13	HORMONE THERAPY			
	Contraceptives	MONOPHASIC	MONOPHASIC	
	All covered contraceptives are	Alesse; Apri; Aviane	NONE	
	on the PDL.	Brevicon		
		Demulen; Desogen		
		Lessina; Levien; Levlite; Levora		
		Lo/Ovral; Loestrin, FE; Low-Ogestrel		
		Microgestin FE; Modicon		
		Necon; Nelova; Nordette; Norinyl; Notrel		
		Ogestrel; Ortho-Cept; Ortho-Cyclen; Ortho-Novum		
		Ovcon; Ovral		
		Portia		
		Yasmin		
		Zovia 1/50		
		BIPHASIC	BIPHASIC	
		Kariva	NONE	
		Mircette		
		Necon		
		Ortho-Novum 10/11		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
13	HORMONE THERAPY Cont'			
	Contraceptives	TRIPHASIC	TRIPHASIC	
	All covered contraceptives are	Cyclessa	NONE	
	on the PDL.	Enpresse; Estrostep		
		Ortho TriCyclen; Ortho-Novum 7/7/7		
		Tri-Levlen; Tri-Norinyl; Triphasil; Trivora		
		PROGESTIN ONLY	PROGESTIN ONLY	
		Nor-Q.D.	NONE	
		Ortho Micronor		
		Ovrette		
		EMERGENCY CONTRACEPTION	EMERGENCY CONTRACEPTION	
		Preven	NONE	
		TRANSDERMAL & VAGINAL RING	TRANSDERMAL & VAGINAL RING	
		NuvaRing	NONE	
		Ortho Evra		
	Estrogen Agents - Oral and	ORAL		
	Transdermal	Conjugated Estrogens (Premarin®)	Esterified Estrogens (Estratab)	
		Diethylstilbestrol		
		Esterified Estrogens (Menest®)		
		Estradiol		
		Estropipate		
		Synthetic Conjugated Estrogens (Cenestin®)		
		TRANSDERMAL PATCH		
		Estradiol	Estradiol (Climara®)	
	Combination Estrogen Agents	17β-Estradiol/Norgestimate (Ortho-Prefest®)	17β-Estradiol/Norethindrone Acetate (Activella®)	
		Conjugated Estrogens (CE)/Medroxyprogesterone Acetate (MPA) (Premphase)	17β-Estradiol/Norethindrone Acetate (CombiPatch)	
		Conjugated Estrogens /Medroxyprogesterone Acetate (Prempro)	Ethinyl Estradiol/Norethindrone Acetate (Femhrt)	
14	HYPERLIPIDEMIA - REFER TO HEART DISEASE			
15	IMMUNE DISORDERS - REFER TO MULTIPLE SCLEROSIS			
16	INFECTIOUS DISORDERS			
	ANTIBIOTICS			
	Cephalosporin and Related	Amoxicillin/Clavulanate	Cefaclor (Raniclor®)	
	Antibiotics	Amoxicillin/Clavulanate (Augmentin ES-600®)	Ceftibuten (Cedax®)	
		Amoxicillin/Clavulanate XR (Augmentin XR®)	Cephalexin (Panixene®)	
		Cefaclor	Loracarbef (Lorabid®)	
		Cefaclor ER		
		Cefadroxil Monohydrate		
		Cefdinir (Omnicef®)		
		Cefditoren Pivoxil (Spectracef®)		
		Cefixime (Suprax®)		
		Cefpodoxime Proxetil		
		Cefprozil (Cefzil®)		
		Cefuroxime axetil		
		Cephalexin		
		Cephradine (Velosef®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
16	INFECTIOUS DISORDERS Cont'			
	ANTIBIOTICS	INJECTABLE		
	Fluoroquinolones	Ciprofloxacin (Cipro®)	NONE	
		Gatifloxacin (Tequin®)		
		Levofloxacin (Levaquin®)		
		Moxifloxacin (Avelox®)		
		Ofloxacin (Floxin®)		
		ORAL		
		Ciprofloxacin (Cipro®)	Lomefloxacin (Maxaquin®)	
		Ciprofloxacin ER (Cipro XR®)	Norfloxacin (Noroxin®)	
		Gatifloxacin (Tequin®)		
		Levofloxacin (Levaquin®)		
		Moxifloxacin (Avelox®)		
		Ofloxacin		
	Macrolides	Azithromycin (Zithromax®)	NONE	
		Clarithromycin (Biaxin®)		
		Clarithromycin ER (Biaxin XL®)		
		Erythromycin Stearate		
		Erythromycin Base		
		Erythromycin Estolate		
		Erythromycin Ethylsuccinate		
	OPTHALMIC ANTIBIOTICS - refer to Opthalmic			
	OTIC ANTIBIOTICS - refer to OTIC Agents			
	ANTIFUNGALS			
	Antifungals, Oral	Fluconazole (Diflucan®)	Clotrimazole (Mycelex Troche®)	
		Griseofulvin	Flucytosine (Ancobon®)	
		Ketoconazole	Itraconazole (Sporanox®)	
		Nystatin	Nystatin (Mycostatin pastiles)	
		Terbinafine (Lamisil®)	Voriconazole (VFEND)	

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
17	MULTIPLE SCLEROSIS			
	Multiple Sclerosis Agents	Interferon beta - 1a (Avonex®)	Glatiramer (Copaxone®)	
	(Immunomodulatory Agents)	Interferon beta - 1b (Betaseron®)	Interferon beta - 1a (Rebif®)	
18	OPHTHALMIC DISORDERS			
	Allergic Conjunctivitis	Azelastine Hydrochloride (Optivar®)	Ketotifen Fumarate (Zaditor®)	
		Cromolyn Sodium	Lodoxamine Tromethamine (Alomide®)	
		Emedastine Difumarate (Emadine®)	Nedocromil Sodium (Alocril®)	
		Ketorolac Tromethamine (Acular®)		
		Levocabastine (Livostin®)		
		Loteprednol (Alrex®)		
		Olopatadine Hydrochloride (Patanol®)		
		Pemirolast Potassium (Alamast®)		
	Glaucoma Agents			
	Intraocular Pressure (IOP)	Betaxolol HCL	NONE	
	Reducers	Betaxolol HCL (Betoptic S®)		
		Brimonidine (Alphagen P®)		
		Brimonidine Tartrate		
		Brinzolamide (Azopt®)		
		Carteolol		
		Dipivefrin		
		Dorzolamide (Trusopt®)		
		Dorzolamide/Timolol (Cosopt®)		
		Epinephrine		
		Levobunolol		
		Metipranolol		
		Pilocarpine		
		Timolol (Betimol®)		
		Timolol Maleate		
	Prostaglandin Inhibitors	Bimatoprost (Lumigan®)	Unoprostone (Rescula®)	
		Latanoprost (Xalatan®)		
		Travoprost (Travatan®)		
	Antibiotics, Ophthalmic	Bacitracin	Gatifloxacin (Zymar®)	
		Ciprofloxan (Ciloxan®)		
		Erythromycin		
		Gentamicin Sulfate		
		Levofloxacin (Quixin®)		
		Moxifloxacin (Vigamox®)		
		Ofloxacin (Ocuflox®)		
		Tobramycin Sulfate		
19	OTIC AGENTS			
	Antibiotics, Others	Neomycin/Colistin/Thonzonium/HC (Coly-Mycin S)	Neomycin/Colistin/Thonzonium/HC (Cortisporin - TC®)	
		Neomycin/Polymyxin/HC (Pediotic®)		
		Neomycin/Polymyxin/HC		
	Fluoroquinolones	Ciprofloxacin/Dexamethasone (Ciprodex OTIC®)	Ciprofloxacin/Hydrocortisone (Cipro HC OTIC®)	
		Ofloxacin (Floxin OTIC®)		
20	OSTEOPOROSIS			
	Bone Resorption Suppression	Alendronate (Fosamax®)	Etidronate (Didronel®)	
	Agents	Calcitonin-salmon (Miacalcin®)	Raloxifene (Evista®)	
		Risedronate (Actonel®)	Teriparatide (Forteo)	

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
21	PAIN MANAGEMENT			
	Narcotics	Acetaminophen w/Codeine	Aspirin/Caffeine/Dihydrocodeine Bitartrate	
		Acetaminophen w/Codeine (Capital w/Codeine)	(Synalgos-DC®)	
		Acetaminophen/Caffeiene/Dihydrocodeine Bitartrate	Fentanyl Citrate (Actiq®)	
		(Panlor DC®, Panlor SS®)	Opium Tincture	
		Aspirin w/Codeine	Oxycodone SR	
		Belladonna & Opium	Oxymorphone (Numorphan®)	
		Butalbital Compound w/Codeine	Propoxyphene Napsylate (Darvon-N®)	
		Butalbital/Caff/APAP/Codeine		
		Butorphanol Tartrate		
		Carisoprodol Compound/Codeine		
		Codeine Phosphate		
		Codeine Sulfate		
		Fentanyl Transdermal (Duragesic®)		
		Fiortal w/Codeine #3		
		Hydrocodone/Acetaminophen		
		Hydrocodone/Acetaminophen (Maxidone®; Zydone®)		
		Hydrocodone Bitartrate/Ibuprofen (Vicoprofen®)		
		Hydromorphone HCL		
		Meperidine HCL		
		Meperidine w/Promethazine		
		Methadone HCL		
		Methadose		
		Morphine Sulfate (Oral)		
		Morphine Sulfate (Rectal)		
		Morphine Sulfate ER (Avinza®)		
		Morphine Sulfate ER (Kadian®)		
		Morphine Sulfate IR		
		Oxycodone HCL		
		Oxycodone/Acetaminophen		
		Oxycodone/Acetaminophen (Percocet 10/325mg;		
		2.5/325mg;7.5/325mg®)		
		Oxycodone w/Acetaminophen (Roxicet®)		
		Oxycodone w/Aspirin		
		Pentazocine/Naloxone HCL		
		Pentazocine/Acetaminophen		
		Propoxyphene HCL		
		Propoxyphene HCL Compound		
		Propoxyphene HCL w/APAP		
		Propoxyphene Napsylate w/APAP		
		Tramadol (Ultram®)		
		Tramadol/Acetaminophen (Ultracet®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
21	PAIN MANAGEMENT Cont'			
	Nonsteroidal Anti - Inflammatories	Diclofenac	Diclofenac/Misoprostol (Arthrotec®)	
	(NSAIDs)	Etodolac		
		Fenoprofen		
		Flurbiprofen		
		Ibuprofen		
		Indomethacin		
		Ketoprofen		
		Ketorolac		
		Lansoprazole/Naproxen (Prevacid NapraPAC)		
		Meclofenamate Sodium		
		Mefenamic Acid (Ponstel®)		
		Meloxicam (Mobic®)		
		Nabumetone		
		Naproxen		
		Naproxen Sodium		
		Oxaprozin		
		Piroxicam		
		Sulindac		
		Tolmetin Sodium		
	Selective Cyclooxygenase	Celecoxib (Celebrex®)	NONE	
	Cox 2 Inhibitors	Rofecoxib (Vioxx®)		
		Valdecoxib (Bextra®)		
	Immunomodulators and Related Agents	Adalimumab (Humira®)	Anakinra (Kineret®)	
	for Arthritis	Etanercept (Enbrel®)	Infliximab (Remicade®)	
		Leflunomide (Arava®)		
	Skeletal Muscle Relaxants	Baclofen	Dantrolene (Dantrium®)	
		Carisoprodol		
		Chlorzoxazone		
		Cyclobenzaprine		
		Diazepam		
		Metaxalone (Skelaxin®)		
		Methocarbamol		
		Orphenadrine Citrate		
		Tizanidine (Zanaflex®)		
	Triptans	Rizatriptan (Maxalt®, Maxalt MLT®)	Almotriptan (Axert®)	
		Sumatriptan (Imitrex Nasal)	Eletriptan (Relpax®)	
		Sumatriptan (Imitrex Oral)	Frovatriptan (Frova®)	
		Sumatriptan (Imitrex Subcutaneous)	Naratriptan (Amerge®)	
			Zolmitriptan (Zomig, Zomig-ZMT®)	
			Zolmitriptan (Zomig nasal)	

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: October 1, 2004
22	**PARKINSON'S**			
	Antiparkinson Agents -	Benztropine Mesylate	Procyclidine (Kemadrin®)	
	Anticholinergic and Other	Entacapone (Comtan®)	Tolcapone (Tasmar®)	
		Levodopa (Larodopa®)		
		Levodopa/Carbidopa		
		Levodopa/Carbidopa/Entacapone (Stalevo®)		
		Pergolide		
		Pramipexole (Mirapex®)		
		Ropinirole (Requip®)		
		Selegiline		
		Trihexyphenidyl		
23	**SEDATIVE/HYPNOTICS**			
	Sedative/Hypnotics	Chloral Hydrate	Quazepam (Doral®)	
		Estazolam	Zaleplon (Sonata®)	
		Flurazepam		
		Temazepam		
		Triazolam		
		Zolpidem (Ambien®)		
24	**UROLOGY**			
	INCONTINENCE			
	Antiincontinence Agents	Flavoxate	Tolterodine (Detrol®)	
		Oxybutynin	Tolterodine extended-release (Detrol LA®)	
		Oxybutynin extended-release (Ditropan XL®)		
		Oxybutynin transdermal (Oxytrol®)		
	PROSTATE			
	Drug for Treatment of Benign	Alfuzosin (Uroxatral®)	NONE	
	Prostatic Hyperplasia (BPH)	Doxazosin		
		Dutasteride (Avodart®)		
		Finasteride (Proscar®)		
		Tamsulosin (Flomax®)		
		Terazosin		

Fax or Mail this form to:
LA Medicaid Rx PA Operations
ULM College of Pharmacy
1401 Royal Avenue
Monroe, LA 71201
Fax: 866-RX PA FAX
(866-797-2329)

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form RXFA01
Issue Date: 3/1/2002

Voice Phone:
866-730-4357

Please type or print legibly (fields followed with an asterisk * are required, all other fields are requested).

Date of Request:*	Number of Fax Pages:*
Practitioner Information	**Patient Information**
Name:*	Name (last, first):*
LA Medicaid Prescribing Provider Number:*	LA Medicaid CCN or Recipient Number:*
LA Medicaid Billing Provider Number:	Date of Birth (m/d/y):*
Call-Back Phone Number (include area code):*	
Fax Number (include area code)*:	Projected Duration:*
Requested Drug Information	
Drug Name:*	Drug Strength:
Diagnosis Code (ICD-9-CM):	Diagnosis Description:*

Please answer the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred product(s)? ☐ YES ☐ NO
2. Does the patient have a condition that prevents the use of the preferred product(s)? ☐ YES ☐ NO
   If YES, list the condition(s) in the box below:
3. Is there a potential drug interaction between another medication and the preferred product(s)? ☐ YES ☐ NO
   If YES, list the interaction(s) in the box below:
4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐ YES ☐ NO
   If YES, list the side effects in the box below:

Practitioner Signature:* _____

(If a signature stamp is used, then the prescribing practitioner must initial the signature)

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Appendix D. Retroactive Eligibility Process for Rx PA

Recipient → **Pharmacy**



Rx filled prior to eligibility
(No proof of eligibility)

Pharmacy Charged | **Cash Sale**

Retroactive Eligibility established for Recipient
√ Paper Eligibility **Form 18** processed by DHH
√(Example: Form 18-LTC indicates LTC eligibility. Form 18 does not always certify retroactive eligibility.)
√ Plastic Card issued to recipient with CCN

POS Claim is denied with **"PA Required"** edit

Scenario 1: Rx credited the Recipient

1. Acct Receivable credited
2. Pharmacy submission of:
   a. Claim
   b. Form 18
   c. Cover letter requesting RxPA override.
   To:
   DHH MMIS Unit
   P.O. Box 91030
   Baton Rouge, LA 70821.
3. PA override applied by DHH.
4. Unisys processes claim.
5. Payment to Pharmacy.

Scenario 2: Recipient paid cash

1. Cash refund to recipient refused.
2. Recipient contacts parish office.
3. Parish office mails pharmacy form RRP-P.
4. Pharmacy completes form RRP-P and returns to parish office.
5. DHH processes form RRP-P
   a. PA override applied.
   b. Sent to Unisys for data entry.
6. Payment to Recipient.

Scenario 3: Recipient paid cash (Full cash refund to the Recipient)

1. Full amount cash refund to recipient.
2. Pharmacy submission of:
   a. Claim
   b. Form 18
   c. Cover letter requesting RxPA override.
   To:
   DHH MMIS Unit
   P.O. Box 91030
   Baton Rouge, LA 70821.
3. PA override applied by DHH.
4. Unisys processes claim.
5. Payment to Pharmacy.

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

January 27, 2005

To: All Hospital Providers

From: Ben Bearden
Director

Subject: Billing Instructions for Mother/Baby Claims

In the past, Medicaid has required all claims for Mother/Baby to be combined for reimbursement. Effective February 1, 2005, all Mother/Baby claims must be submitted separately for those claims with a date of service on or after February 1, 2005.

When billing the Mother's claim, all Non-State Hospitals are still required to obtain pre-certification. That number is still required on the claim and the claim is to include only her room/board and ancillary charges. The separate baby claim must include only nursery and ancillary charges for the baby. The mother's pre-cert number is not required on this claim. All baby claims will zero pay and receive an EOB of 519 (Newborn zero paid). State Hospitals will continue to have no pre-certification requirements.

In those instances when a Non-Medicaid Mother gives birth to a deemed Medicaid eligible newborn, current policy will remain the same. A pre-certification will still be required for the baby only.

The instructions provided only apply to Newborn Well Baby Claims with a Type of Admission code 4 and Source of Admission code 1. As we transition, those claims filed incorrectly between the dates of February 1, 2005 and March 31, 2005 will not deny and edits received on the Remittance Advice (RA) will provide hospitals with notification of the incorrect filing. The Explanation of Benefit (EOB) code 522 (Mother/Newborn must be billed separately) will be used during this period. Effective April 1, 2005 any claim submitted incorrectly will be denied and EOB code 522 will convert to a denial reason.

Questions concerning these changes should be directed to Unisys Provider Relations at (800) 473-2783 or (225) 924-5040.

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030
PHONE #: 225/342-3891 • FAX #: 225/342-9508
"AN EQUAL OPPORTUNITY EMPLOYER"

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

January 27, 2005

To: All Hospital Providers

From: Ben Bearden
Director

Subject: Changes in Billing Ambulatory Surgical Procedures

Currently hospital outpatient claims for ambulatory surgical procedures are billed using revenue code 490 in Form Locator 42 and the appropriate ICD-9 surgical procedure code(s) in Form Locators 80 and 81 on the UB-92 claim form or the corresponding field on electronic specifications. Claim pricing is based on the ICD-9 surgical procedure code billed. A CPT/HCPCS code is not required.

Health Insurance Portability and Accountability Act (HIPAA) regulations mandate that ICD-9 surgical procedure codes may no longer be used for billing outpatient claims for ambulatory surgical procedures. As a result of this mandate, effective with date of service March 1, 2005, the Louisiana Medicaid program will require the use of CPT/HCPCS codes for billing these procedures. At that time providers must begin using the most appropriate CPT/HCPCS code in Form Locator 44 to accompany revenue code 490 which will continue to be used. Only one CPT/HCPCS code may be entered in the field.

Services performed in conjunction with ambulatory surgical procedures should continue to be billed on the claim form and will be denied 774 (included in related procedure). Currently these claim lines deny 266 (revenue code invalid for ambulatory surgical procedure).

Medicaid is adopting Medicare's current payment structure for paying these claims. Claim pricing will be based on Medicare's 9 ambulatory surgery groupings and the allowable payment for each group plus 5%.

Attached are revised Medicaid Program Hospital Services Manual pages, UB-92 claim form with instructions and the fee schedule. Please review these revisions carefully and prepare to begin using them beginning with date of service March 1, 2005.

Questions concerning this transition in payment methodology may be directed to Unisys Provider Relations at (800) 473-2783 or (225) 924-5040 or to Darlene White at (225) 342-2119.

BAB/DG
Attachments

STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

June 20, 2005

Dear Prescribing Practitioner:

Attached is the complete, most current listing of drugs on the Medicaid Prior Authorization (PA) Process' Preferred Drug List (PDL) **"05-01."** The listing includes preferred drugs and those drugs requiring prior authorization. **This list will be effective July 1, 2005**.

The PA process, in accordance with the program's "Continuity of Care" policy, does not impact original prescriptions (or refills) issued by a prescribing practitioner prior to effective PA dates of drugs as they are added to the PA process ***as long as they are within the 5 refills and 6-month program limits***. An educational alert will notify the pharmacist that prescriptions (and their refills) will require a new prescription and prior authorization, if the prescription life exceeds six months or the refill exceeds the 5 refill limit. The educational alert will state, "NEW RX WILL REQUIRE PA AFTER (DATE)."

Information on the Prior Authorization process, including the PDL and Prior Authorization Request Form (copy is attached, Form RXPA01), is also available on the Louisiana Medicaid website (**www.lamedicaid.com**). This website will be updated when changes (additions or deletions) are made to the PDL. The program may also utilize the provider remittance advices to notify providers of PDL changes that must be implemented in short time frames.

The Department has received inquiries that drug products requiring PA are not reimbursable by Medicaid. Medicaid does reimburse for drug products requiring prior authorization when the prior authorization process is followed.

Thank you for your continued cooperation. We appreciate your participation in the Medicaid Program.

Sincerely,

Ben A. Bearden
Medicaid Director

BAB/gb

Attachments (2)

OFFICE OF MANAGEMENT AND FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LA 70821-9030
PHONE #: 225/342-5774 • FAX #: 225/342-3893
"AN EQUAL OPPORTUNITY EMPLOYER"

Prior Authorization PDL Implementation Schedule

3/9/2005

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2005
1	ADD/ADHD			
	Stimulants and Related Agents	Amphetamine Mixed Salt	Atomoxetine (Strattera®)	
		Amphetamine Mixed Salt ER (Adderall XR)	Modafinil (Provigil®)	
		Dexmethylphenidate (Focalin®)		
		Dextroamphetamine		
		Methamphetamine HCl		
		Methylphenidate		
		Methylphenidate ER		
		Methylphenidate ER (Concerta®, Metadate CD®)		
		Methylphenidate LA (Ritalin LA®)		
		Pemoline		
2	ALLERGY			
	Anticholinergic Agents - Nasal	Ipratropium (Atrovent®)	NONE	
	Antihistamines - Minimally Sedating	Desloratadine Syrup (Clarinex Syrup®)		
		Loratadine Syrup OTC	Cetirizine (Zyrtec®)	
		Loratadine OTC	Cetirizine Chewable (Zyrtec® Chewable)	
		Loratadine-D OTC	Cetirizine Syrup (Zyrtec® Syrup)	
			Cetirizine/Pseudoephedrine (Zyrtec-D®)	
			Desloratadine (Clarinex®)	
			Fexofenadine (Allegra®)	
			Fexofenadine/Pseudoephedrine (Allegra-D®)	
	Antihistamines - Nasal	Azelastine (Astelin®)	NONE	
	Corticosteroids, Nasal	Flunisolide Spray	Beclomethasone AQ (Beconase AQ®)	
		Fluticasone (Flonase®)	Budesonide Aqua (Rhinocort Aqua®)	
			Flunisolide Aqueous (Nasarel®)	
			Mometasone (Nasonex®)	
			Triamcinolone AQ (Nasacort AQ®)	
3	ALZHEIMER'S			
	Alzheimer's Agents	Donepezil (Aricept®)	Tacrine (Cognex®)	
	Cholinesterase Inhibitors	Galantamine (Reminyl®)		
		Rivastigmine (Exelon®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2005
4	ASTHMA/COPD			
	Beta-Adrenergic Agents			
		INHALATION		
		Albuterol Sulfate (Nebulizer and Inhaler)	Albuterol Sulfate/Ipratropium (DuoNeb®)	
		Albuterol Sulfate HFA MDI(Proventil HFA®)	Albuterol Sulfate HFA MDI(Ventolin HFA®)	
		Albuterol Sulfate Nebulizer Solution (Accuneb®)	Formoterol DPI (Foradil®)	
		Albuterol Sulfate/Ipratropium MDI (Combivent®)	Metaproterenol Sulfate (Alupent Inhalant®)	
		Levalbuterol HCL (Xopenex®)	Pirbuterol (Maxair®, Maxair Autohaler®)	
		Metaproterenol Sulfate (Nebulizer Only)		
		Salmeterol Xinafoate (Serevent Diskus®)		
		ORAL		
		Albuterol Sulfate	Albuterol Sulfate ER (Volmax®; Vospire ER®)	
		Metaproterenol Sulfate		
		Terbutaline Sulfate		
	Corticosteroids, Inhalation	Beclomethasone MDI (QVAR®)		
		Budesonide Respules (Pulmicort - Respules®) - 21 years old and under	Budesonide Respules (Pulmicort - Respules®)	
		Flunisolide MDI (Aerobid®)	Budesonide DPI (Pulmicort Turbuhaler®)	
		Flunisolide MDI (Aerobid M®)		
		Fluticasone MDI (Flovent Inhaler®)		
		Fluticasone MDI (Flovent Rotadisc®)		
		Triamcinolone MDI (Azmacort®)		
		Fluticasone/Salmeterol DPI (Advair Diskus®)		
	Leukotriene Modifiers	Montelukast (Singulair®)	NONE	
		Zafirlukast (Accolate®)		
5	DEPRESSION			
	Antidepressants, Other	Bupropion IR	Bupropion ER (Wellbutrin XL®)	
		Bupropion SR	Duloxetine (Cymbalta®)	
		Mirtazapine		
		Mirtazapine Soltab		
		Nefazodone		
		Trazodone		
		Venlafaxine (Effexor®)		
		Venlafaxine ER (Effexor XR®)		
	Selective Serotonin	Escitalopram (Lexapro®)	Citalopram (Celexa®)	
	Reuptake Inhibitors (SSRIs)	Fluoxetine (except Sarafem®)	Fluoxetine ER (Prozac Weekly®)	
		Fluvoxamine	Fluoxetine (Sarafem®)	
		Paroxetine HCl		
		Paroxetine HCl CR (Paxil CR®)		
		Paroxetine Mesylate (Pexeva®)		
		Sertraline (Zoloft®)		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2005
6	DERMATOLOGY			
	Antifungals - Topical	Butenafine (Mentax®)	Ciclopirox (Loprox®)	
		Clotrimazole	Ciclopirox (Penlac®)	
		Clotrimazole/Betamethasone	Terbinafine (Lamisil®)	
		Econazole		
		Ketoconazole		
		Ketoconazole (Nizoral Shampoo - Rx ONLY)		
		Naftifine (Naftin®)		
		Nystatin		
		Nystatin w/ Triamcinolone		
		Oxiconazole (Oxistat®)		
		Sulconazole (Exelderm)		
	Atopic Dermatitis	Pimecrolimus (Elidel®)	NONE	
	Immunomodulators	Tacrolimus (Protopic®)		
7	DIABETES			
	Hypoglycemics, Alpha - Glucosidase Inhibitors	Miglitol (Glyset®)	Acarbose (Precose®)	
	Hypoglycemics, Meglitinides	Nateglinide (Starlix®)	Repaglinide (Prandin®)	
	Hypoglycemics, Metformin Containing	Metformin	NONE	
		Metformin ER (Fortamet®)		
		Metformin XR		
		Metformin Oral Solution (Riomet®)		
		Metformin/Glipizide (Metaglip®)		
		Metformin/Glyburide		
		Metformin/Rosiglitazone (Avandamet®)		
	Hypoglycemics, Sulfonylureas	Acetohexamide	NONE	
		Chlorpropamide		
		Glimepiride (Amaryl®)		
		Glipizide		
		Glipizide XL (Glucotrol XL®)		
		Glyburide		
		Glyburide Extended Release		
		Tolazamide		
		Tolbutamide		
	Hypoglycemics, Thiazolidinediones (TZDs)	Pioglitazone (Actos®)	Rosiglitazone (Avandia®)	

Prior Authorization PDL Implementation Schedule

Item Nbr.	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2005
7	DIABETES cont'			
	Insulins	Humalog (Children 18 years and under)	Humalog (Over 18 years)	
		Imsulin Glargine (Lantus®)	Humalog Mix 75/25	
		Novolin N	Humulin L	
		Novolin R	Humulin N	
		Novolin 70/30	Humulin R	
		Novolog	Humulin U	
		Novolog Mix	Humulin 50/50	
		Relion R	Humulin 70/30	
		Relion N		
		Relion 70/30		
8	DIGESTIVE DISORDERS			
	Antiemetic Agents	ORAL		
		Aprepitant (Emend®)	Dolasetron (Anzemet®)	
		Dronabinol (Marinol®)	Granisetron (Kytril®)	
		Metoclopramide		
		Ondansetron (Zofran, Zofran ODT®)		
		INJECTABLE		
		Metoclopramide Injection	Dolasetron Injection (Anzemet®)	
		Ondansetron Injection (Zofran®)	Granisetron Injection (Kytril®)	
	Antivertigo Agents			
		Scopolamine, Transdermal (Transderm Scop)	Scopolamine, Oral (Scopace®)	
	GERD AND RELATED DISORDERS			
	H2 Antagonists	Cimetidine	Nizatidine (Axid®)	
		Famotidine	Famotidine RPD (Pepcid RPD®)	
		Ranitidine	Ranitidine Efferdose (Zantac Efferdose®)	
			Ranitidine Granules (Zantac Granules®)	
	H. Pylori Agents	Amoxicillin	Bismuth Subsalicylate/Metronidazole/Tetracycline (Helidac®)	
		Clarithromycin (Biaxin®)	Lansoprazole/Amoxicillin/Clarithromycin (Prevpac®)	
		Lansoprazole (Prevacid®)		
	Proton Pump Inhibitors	Lansoprazole Capsule (Prevacid®)	Esomeprazole (Nexium®)	
		Lansoprazole Solutab (Prevacid®)	Omeprazole (legend products only)	
		Lansoprazole Suspension (Prevacid®)	Omeprazole (Zegerid®)	
			Pantoprazole (Protonix®)	
			Rabeprazole (Aciphex®)	

Prior Authorization PDL Implementation Schedule

3/9/2005

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2005
8	DIGESTIVE DISORDERS cont'			
	ULCERATIVE COLITIS	Balsalazide (Colazal®)	Mesalamine (Asacol®)	
	Ulcerative Colitis Agents	Mesalamine Enemas	Mesalamine Suppositories (Canasa®)	
		Mesalamine (Pentasa®)	Olsalazine (Dipentum®)	
		Sulfasalazine		
9	GROWTH DEFICIENCY			
	Growth Hormones	Somatropin (Norditropin®)	Somatropin (Genotropin®)	
		Somatropin (Nutropin AQ®)	Somatropin (Humatrope®)	
		Somatropin (Tev-Tropin®)	Somatropin (Nutropin®)	
			Somatropin (Saizen®)	
			Somatropin (Serostim®)	
10	HEART DISEASE			
	HYPERLIPIDEMIA			
	Antihyperlipidemic Agents -	Cholestyramine	Colesevelam (Welchol®)	
	Non Statins	Colestipol (Colestid®)	Ezetimibe (Zetia®)	
		Fenofibrate (Tricor®)	Fenofibrate (Antara®)	
		Gemfibrozil	Fenofibrate (Lofibra®)	
		Niacin ER (Niaspan®)		
		Niacin Rx		
	Statins	Ezetimibe/Simvastatin (Vytorin®)	Atorvastatin (Caduet®)	
		Fluvastatin (Lescol®)	Atorvastatin (Lipitor®)	
		Fluvastatin XL (Lescol XL®)	Pravastatin (Pravachol®)	
		Lovastatin	Pravastatin/Buffered Aspirin (Pravigard PAC®)	
		Lovastatin ER (Altoprev®)		
		Niacin ER/Lovastatin (Advicor®)		
		Rosuvastatin (Crestor®)		
		Simvastatin (Zocor®)		
	HYPERTENSION			
	ACE Inhibitors	Benazepril	Quinapril (Accupril®)	
		Benazepril/HCTZ	Quinapril/HCTZ (Accuretic®)	
		Captopril		
		Captopril/HCTZ		
		Enalapril		
		Enalapril/HCTZ		
		Fosinopril		
		Fosinopril/HCTZ (Monopril-HCT®)		
		Lisinopril		
		Lisinopril/HCTZ		
		Moexipril		
		Moexipril/HCTZ (Uniretic®)		
		Perindopril (Aceon®)		
		Quinapril/HCTZ (Accuretic®)		
		Ramipril (Altace®)		
		Trandolapril (Mavik®)		

Prior Authorization PDL Implementation Schedule

3/9/2005

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2005
10	HEART DISEASE cont'			
	HYPERTENSION			
	ACE Inhibitors/Calcium Channel	Amlodipine/Benazepril (Lotrel®)	Felodipine/Enalapril (Lexxel®)	
	Blockers Combination Products	Verapamil SR/Trandolapril (Tarka®)		
	Angiotensin II Receptor	Iosartan (Cozaar®)	Candesartan (Atacand®)	
	Blockers (ARBS)	Iosartan/HCTZ (Hyzaar®)	Candesartan/HCTZ (Atacand HCT®)	
		Telmisartan (Micardis®)	Eprosartan (Teveten®)	
		Telmisartan/HCTZ (Micardis HCT®)	Eprosartan/HCTZ (Teveten HCT®)	
		Valsartan (Diovan®)	Irbesartan (Avapro®)	
		Valsartan/HCTZ (Diovan HCT®)	Irbesartan/HCTZ (Avalide®)	
			Olmesartan (Benicar®)	
			Olmesartan/HCTZ (Benicar HCT®)	
	Beta Adrenergic Receptor	Acebutolol	Carteolol (Cartrol®)	
	Blocking Agents	Atenolol	Carvedilol (Coreg®)	
		Betaxolol	Penbutolol (Levatol®)	
		Bisoprolol Fumarate		
		Labetalol		
		Metoprolol Tartrate		
		Metoprolol XL (Toprol XL®)		
		Nadolol		
		Pindolol		
		Propranolol		
		Propranolol LA (Inderal LA®)		
		Propranolol XL (Innopran XL®)		
		Sotalol		
		Sotalol AF		
		Timolol Maleate		
	Calcium Channel Blockers		Amlodipine (Norvasc®)	
		Diltiazem ER	Isradipine (Dynacirc®)	
		Diltiazem IR	Nicardipine SR (Cardene SR®)	
		Diltiazem LA (Cardizem LA®)	Nimodipine (Nimotop®)	
		Diltiazem SA	Verapamil ER (Covera HS®)	
		Felodipine ER		
		Isradipine SR (Dynacirc CR®)		
		Nicardipine		
		Nifedipine IR		
		Nifedipine ER		
		Nisoldipine (Sular®)		
		Verapamil ER (Verelan PM®)		
		Verapamil IR		
		Verapamil SA		
	INTERMITTENT CLAUDICATION AGENTS			
	Intermittent Claudication	Cilostazol (Pletal®)	NONE	
	Agents	Pentoxifylline		

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2005
10	HEART DISEASE cont'			
	PLATELET AGGREGATION INHIBITORS			
	Platelet Aggregation Inhibitors	Aspirin/Dipyridamole ER (Aggrenox®)	Ticlopidine	
		Clopidogrel (Plavix®)		
		Dipyridamole		
	ANTICOAGULANTS, INJECTABLES			
	Anticoagulants,	Dalteparin (Fragmin®)	Fondaparinux (Arixtra®)	
	Injectable	Enoxaparin (Lovenox®)	Tinzaparin (Innohep®)	
11	HEMATOLOGIC AGENTS			
	HEMATOPOIETIC AGENTS			
	Erythropoietins	Epoetin alfa (Procrit®)	Epoetin alfa (Epogen®)	
		Darbepoetin alfa (Aranesp®)		
	Anticoagulants - refer to			
	HEART DISEASE			
12	HEMODIALYSIS			
	Phosphate Binders	Calcium Acetate (PhosLo®)	Sevelamer (RenaGel®)	
		Lanthanum (Fosrenol®)		
		Magnesium Carbonate, Calcium Carbonate, Folic Acid (Magnebind 400 Rx)		
13	HORMONE THERAPY			
	Contraceptives	**MONOPHASIC**	**MONOPHASIC**	
	All covered contraceptives are	Alesse; Apri; Aviane	NONE	
	on the PDL.	Brevicon		
		Demulen; Desogen		
		Lessina; Levien; Levlite; Levora		
		Lo/Ovral; Loestrin, FE; Low-Ogestrel		
		Microgestin FE; Modicon		
		Necon; Nelova; Nordette; Norinyl; Notrel		
		Ogestrel; Ortho-Cept; Ortho-Cyclen; Ortho-Novum		
		Ovcon; Ovral		
		Portia		
		Yasmin		
		Zovia 1/50		
		BIPHASIC	**BIPHASIC**	
		Karvia	NONE	
		Mircette		
		Necon		
		Ortho-Novum 10/11		

Prior Authorization PDL Implementation Schedule

Item Nbr.	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2005
13	HORMONE THERAPY Cont'			
	Contraceptives	**TRIPHASIC**	**TRIPHASIC**	
	All covered contraceptives are	Cyclessa	NONE	
	on the PDL.	Enpresse; Estrostep		
		Ortho TriCyclen; Ortho-Novum 7/7/7		
		Tri-Levlen; Tri-Norinyl; Triphasil; Trivora		
		PROGESTIN ONLY	**PROGESTIN ONLY**	
		Nor-Q.D.	NONE	
		Ortho Micronor		
		Ovrette		
		EMERGENCY CONTRACEPTION	**EMERGENCY CONTRACEPTION**	
		Preven	NONE	
		TRANSDERMAL & VAGINAL RING	**TRANSDERMAL & VAGINAL RING**	
		NuvaRing	NONE	
		Ortho Evra		
	Estrogen Agents - Oral and	**ORAL**		
	Transdermal	Conjugated Estrogens (Premarin®)	Esterified Estrogens (Estratab)	
		Diethylstilbestrol		
		Esterified Estrogens (Menest®)		
		Estradiol		
		Estropipate		
		Synthetic Conjugated Estrogens (Cenestin®)		
		TRANSDERMAL PATCH		
		Estradiol	Estradiol (Climara®)	
	Combination Estrogen Agents	17β-Estradiol/Norethindrone Acetate (Activella®)	17β-Estradiol/Levonorgestrel (Climara Pro®)	
		17β-Estradiol/Norethindrone Acetate (CombiPatch®)		
		17β-Estradiol/Norgestimate (Ortho-Prefest®)		
		Conjugated Estrogens (CE)/Medroxyprogesterone Acetate (MPA) (Premphase®)		
		Conjugated Estrogens /Medroxyprogesterone Acetate (Prempro®)		
		Ethinyl Estradiol/Norethindrone Acetate (Femhrt®)		
14	HYPERLIPIDEMIA - REFER TO HEART DISEASE			
15	IMMUNE DISORDERS - REFER TO MULTIPLE SCLEROSIS			
16	INFECTIOUS DISORDERS			
	ANTIBIOTICS			
	Cephalosporin and Related	Amoxicillin/Clavulanate	Cefaclor (Raniclor®)	
	Antibiotics	Amoxicillin/Clavulanate (Augmentin ES-600®)	Ceftibuten (Cedax®)	
		Amoxicillin/Clavulanate XR (Augmentin XR®)	Cephalexin (Panixene®)	
		Cefaclor	Loracarbef (Lorabid®)	
		Cefaclor ER		
		Cefadroxil Monohydrate		
		Cefdinir (Omnicef®)		
		Cefditoren Pivoxil (Spectracef®)		
		Cefixime (Suprax®)		
		Cefpodoxime Proxetil		
		Cefprozil (Cefzil®)		
		Cefuroxime axetil		
		Cephalexin		
		Cephradine (Velosef®)		

Prior Authorization PDL Implementation Schedule

3/9/2005

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2005
16	INFECTIOUS DISORDERS Cont'			
	ANTIBIOTICS	**INJECTABLE**		
	Fluoroquinolones	Ciprofloxacin (Cipro®)	NONE	
		Gatifloxacin (Tequin®)		
		Levofloxacin (Levaquin®)		
		Moxifloxacin (Avelox®)		
		Ofloxacin (Floxin®)		
		ORAL		
		Ciprofloxacin (Cipro®)	Lomefloxacin (Maxaquin®)	
		Ciprofloxacin ER (Cipro XR®)	Norfloxacin (Noroxin®)	
		Gatifloxacin (Tequin®)		
		Levofloxacin (Levaquin®)		
		Moxifloxacin (Avelox®)		
		Ofloxacin		
	Macrolides	Azithromycin (Zithromax®)	NONE	
		Clarithromycin (Biaxin®)		
		Clarithromycin ER (Biaxin XL®)		
		Erythromycin Stearate		
		Erythromycin Base		
		Erythromycin Estolate		
		Erythromycin Esthyl succinate		
	OPTHALMIC ANTIBIOTICS - refer to Opthalmic			
	OTIC ANTIBIOTICS - refer to OTIC Agents			
	ANTIFUNGALS			
	Antifungals, Oral	Fluconazole (Diflucan®)	Clotrimazole (Mycelex Troche®)	
		Griseofulvin	Flucytosine (Ancobon®)	
		Ketoconazole	Itraconazole (Sporanox®)	
		Nystatin	Nystatin (Mycostatin pastiles)	
		Terbinafine (Lamisil®)	Voriconazole (VFEND)	

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2005
17	MULTIPLE SCLEROSIS	Interferon beta - 1a (Avonex®)	NONE	
	Multiple Sclerosis Agents	Interferon beta - 1b (Betaseron®)		
	(Immunomodulatory Agents)	Glatiramer (Copaxone®)		
		Interferon beta - 1a (Rebif®)		
18	OPHTHALMIC DISORDERS			
	Allergic Conjunctivitis	Azelastine Hydrochloride (Optivar®)	Ketotifen Fumarate (Zaditor®)	
		Cromolyn Sodium	Lodoxamine Tromethamine (Alomide®)	
		Emedastine Difumarate (Emadine®)	Nedocromil Sodium (Alocril®)	
		Ketorolac Tromethamine (Acular®)		
		Levocabastine (Livostin®)		
		Loteprednol (Alrex®)		
		Olopatadine Hydrochloride (Patanol®)		
		Pemirolast Potassium (Alamast®)		
	Glaucoma Agents			
	Intraocular Pressure (IOP)	Bextaxolol	NONE	
	Reducers	Bextaxolol (Betoptic S®)		
		Brimonidine (Alphagen P®)		
		Brimonidine Tartrate		
		Brinzolamide (Azopt®)		
		Carteolol		
		Dipivefrin		
		Dorzolamide (Trusopt®)		
		Dorzolamide/Timolol (Cosopt®)		
		Epinephrine		
		Levobunolol		
		Metipranolol		
		Pilocarpine		
		Timolol (Betimol®)		
		Timolol Maleate		
	Prostaglandin Inhibitors	Bimatoprost (Lumigan®)	Unoprostone (Rescula®)	
		Latanoprost (Xalatan®)		
		Travoprost (Travatan®)		
	Antibiotics, Ophthalmic	Bacitracin	Gatifloxacin (Zymar®)	
		Ciprofloxan (Ciloxan®)		
		Erythromycin		
		Gentamicin Sulfate		
		Levofloxacin (Quixin®)		
		Moxifloxacin (Vigamox®)		
		Ofloxacin (Ocuflox®)		
		Tobramycin Sulfate		
19	OTIC AGENTS			
	Antibiotics, Others	Neomycin/Colistin/Thonzonium/HC (Coly-Mycin S®)	Neomycin/Colistin/Thonzonium/HC (Cortisporin - TC®)	
		Neomycin/Polymyxin/HC (Pediotic®)		
		Neomycin/Polymyxin/HC		
	Fluoroquinolones	Ciprofloxacin/Dexamethasone (Ciprodex OTIC®)	Ciprofloxacin/Hydrocortisone (Cipro HC OTIC®)	
		Ofloxacin (Floxin OTIC®)		
20	OSTEOPOROSIS			
	Bone Resorption Suppression	Alendronate (Fosamax®)	Etidronate (Didronel®)	
	Agents	Calcitonin-salmon (Miacalcin®)	Raloxifene (Evista®)	
		Risedronate (Actonel®)	Teriparatide (Forteo)	

Prior Authorization PDL Implementation Schedule

Item Nbr	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2005
21	PAIN MANAGEMENT			
	Narcotics	Acetaminophen w/Codeine	Acetaminophen/Caffeine/Dihydrocodeine Bitartrate	
		Acetaminophen w/Codeine (Capital w/Codeine®)	(Panlor DC®, Panlor SS®)	
		Aspirin w/Codeine	Aspirin/Caffeine/Dihydrocodeine Bitartrate	
		Belladonna & Opium	(Synalgos-DC®)	
		Butalbital Compound w/Codeine	Fentanyl Citrate (Actiq®)	
		Butalbital/Caff/APAP/Codeine	Hydromorphone ER (Palladone®)	
		Butorphanol Tartrate	Morphine Sulfate ER (Avinza®)	
		Carisoprodol Compound/Codeine	Opium Tincture	
		Codeine Phosphate	Oxycodone ER	
		Codeine Sulfate	Oxycodone (Oxycontin®)	
		Fentanyl Transdermal (Duragesic®)	Oxymorphone (Numorphan®)	
		Fiortal w/Codeine #3	Propoxyphene Napsylate (Darvon-N®)	
		Hydrocodone/Acetaminophen		
		Hydrocodone/Acetaminophen (Maxidone®; Zydone®)		
		Hydrocodone Bitartrate/ibuprofen (Vicoprofen®)		
		Hydromorphone HCL		
		Meperidine HCL		
		Meperidine w/Promethazine		
		Methadone HCL		
		Methadose		
		Morphine Sulfate (Oral)		
		Morphine Sulfate (Rectal)		
		Morphine Sulfate ER (Kadian®)		
		Morphine Sulfate IR		
		Oxycodone HCL		
		Oxycodone/Acetaminophen		
		Oxycodone/Acetaminophen (Percocet 10/325mg;		
		2.5/325mg;7.5/325mg®)		
		Oxycodone w/Acetaminophen (Roxicet®)		
		Oxycodone w/Aspirin		
		Pentazocine/Naloxone HCL		
		Pentazocine/Acetaminophen		
		Propoxyphene HCL		
		Propoxyphene HCL Compound		
		Propoxyphene HCL w/APAP		
		Propoxyphene Napsylate w/APAP		
		Tramadol (Ultram®)		
		Tramadol/Acetaminophen (Ultracet®)		

Prior Authorization PDL Implementation Schedule

3/9/2005

Item Nbr.	Descriptive Therapeutic Class	Drugs on PDL	Drugs which Require PA	Effective Date: July 1, 2005
21	PAIN MANAGEMENT Cont'			
	Nonsteroidal Anti - Inflammatories	Diclofenac	Diclofenac/Misoprostol (Arthrotec®)	
	(NSAIDs)	Etodolac		
		Fenoprofen		
		Flurbiprofen		
		Ibuprofen		
		Indomethacin		
		Ketoprofen		
		Ketorolac		
		Lansoprazole/Naproxen (Prevacid NapraPAC)		
		Meclofenamate Sodium		
		Mefenamic Acid (Ponstel®)		
		Meloxicam (Mobic®)		
		Nabumetone		
		Naproxen		
		Naproxen Sodium		
		Oxaprozin		
		Piroxicam		
		Sulindac		
		Tolmetin Sodium		
	Selective Cyclooxygenase	Celecoxib (Celebrex®)	NONE	
	Cox 2 Inhibitors	Rofecoxib (Vioxx®)		
		Valdecoxib (Bextra®)		
	Immunomodulators and Related Agents	Adalimumab (Humira®)	Anakinra (Kineret®)	
	for Arthritis	Etanercept (Enbrel®)	Infliximab (Remicade®)	
		Leflunomide (Arava®)		
	Skeletal Muscle Relaxants	Baclofen	Dantrolene (Dantrium®)	
		Carisoprodol		
		Chlorzoxazone		
		Cyclobenzaprine		
		Diazepam		
		Metaxalone (Skelaxin®)		
		Methocarbamol		
		Orphenadrine Citrate		
		Tizanidine (Zanaflex®)		
	Triptans	Almotriptan (Axert®)	Eletriptan (Relpax®)	
		Rizatriptan (Maxalt®, Maxalt MLT®)	Frovatriptan (Frova®)	
		Zolmitriptan (Zomig, ZMT®)	Naratriptan (Amerge®)	
		Zolmitriptan (Zomig® nasal)	Sumatriptan (Imitrex® Nasal)	
		Sumatriptan (Imitrex® Subcutaneous)	Sumatriptan (Imitrex® Oral)	

Fax or Mail this form to:
LA Medicaid Rx PA Operations
ULM College of Pharmacy
1401 Royal Avenue
Monroe, LA 71201
Fax: 866-RX PA FAX
(866-797-2329)

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program

REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form:RXPA01
Issue Date: 3/1/2002

Voice Phone:
866-730-4357

*Please type or print legibly (fields followed with an asterisk * are required, all other fields are requested).*

Date of Request:*	Number of Fax Pages:*
Practitioner Information	**Patient Information**
Name:*	Name (last, first):*
LA Medicaid Prescribing Provider Number:*	LA Medicaid CCN or Recipient Number:*
LA Medicaid Billing Provider Number:	Date of Birth (m/d/y):*
Call-Back Phone Number (include area code):*	
Fax Number (include area code)*:	Projected Duration:*
Requested Drug Information	
Drug Name:*	Drug Strength:
Diagnosis Code (ICD-9-CM):	Diagnosis Description:*

Please answer the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred product(s)? ☐ YES ☐ NO
2. Does the patient have a condition that prevents the use of the preferred product(s)? ☐ YES ☐ NO
   If YES, list the condition(s) in the box below:
3. Is there a potential drug interaction between another medication and the preferred product(s)? ☐ YES ☐ NO
   If YES, list the interaction(s) in the box below:
4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐ YES ☐ NO
   If YES, list the side effects in the box below:

Practitioner Signature:* _____

(If a signature stamp is used, then the prescribing practitioner must initial the signature)

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STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

July 25, 2005

Dear Health Care Provider:

Louisiana Medicaid's Pharmacy Benefits Management staff (LMPBM) and Louisiana Medicaid's Drug Utilization Review Board are charged with assuring that prescriptions billed to Medicaid are appropriate and medically necessary. In 2005, our Drug Utilization Review program is focusing on behavioral health issues and pain disorders. The purpose of this correspondence is to notify prescribers of upcoming edits and limitations the LMPBM is implementing regarding antipsychotic agents and anti-anxiety drugs. The goal is to assure appropriate use of antipsychotic agents and anti-anxiety agents based on established clinical practice guidelines and available diagnostic information.

Procedures in the pharmacy audit program have been established to verify the provider's documentation and compliance associated with program policy. Therefore, prescribers are asked to assist pharmacists in obtaining required documentation and notations.

If you have concerns or comments regarding this correspondence, you may contact Melwyn B. Wendt at 225-342-9768 or send a fax to 225-342-1980. We appreciate your continued cooperation and support of our Drug Utilization Review (DUR) efforts to assure prescriptions paid by Medicaid are appropriate for the individual patient.

Sincerely,

Ben A. Bearden
Medicaid Director

BAB/MJT/mbw

Attachment

OFFICE OF MANAGEMENT AND FINANCE · BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD · P. O. BOX 91030 · BATON ROUGE, LA 70821-9030
PHONE #: 225/342-5774 · FAX #: 225/342-3893
"AN EQUAL OPPORTUNITY EMPLOYER"

ANTIPSYCHOTIC AGENTS

Medicaid's Drug Utilization Review Board joined the Department of Health and Hospitals Office of Mental Health to establish parameters for reviewing antipsychotic agents. To help ensure the safety and well being of Medicaid patients, and to avoid duplication of benefits, effective August 10, 2005, prescriptions for antipsychotic agents:

- will require an appropriate ICD-9 diagnosis code on all new prescriptions. The accepted diagnosis codes fall in the range from 290.0 through 319.9. The numeric code must be documented on the hardcopy prescription by either the prescriber or the pharmacist. The ICD-9 code may be transmitted to the pharmacist electronically or via telephone or facsimile;

- will be screened per recipient to search for two active prescriptions for antipsychotic agents. Any incoming pharmacy claim for an antipsychotic agent will deny when the recipient has two active antipsychotic prescriptions on their file. An active prescription is a prescription in which the days supply has not expired;

- that are classified as atypical agents, will be screened for doses exceeding the maximum recommended dose.

(1) Pharmacy claims for new prescriptions for antipsychotic agents shall be submitted with an ICD-9 diagnosis code. Claims submitted without an appropriate diagnosis code or without any diagnosis code will deny. If the prescriber does not indicate a diagnosis code, and the pharmacist determines the patient cannot wait to receive the medication, the pharmacy provider may override the denial.

(2) Incoming pharmacy claims for antipsychotic agents billed for recipients who have two (2) active prescriptions for any antipsychotic medications (either typical or atypical agents) on file will deny with a therapeutic duplication. The pharmacist may override the denial upon consultation with the prescriber. The pharmacist must document on the hardcopy prescription the reason the prescriber required the patient to receive a third antipsychotic agent. Listed below are the current antipsychotic agents reviewed in the screening process. As new antipsychotic agents are made available, they will be included in the screening process.

Typical Antipsychotic Agents

Chlorpromazine	Thiothixene	Haloperidol
Perphenazine	Fluphenazine	Mesoridazine
Trifluoperazine	Prochlorperazine	Thioridazine
Loxapine	Pimozide	Molindone

Atypical Antipsychotic Agents

Generic Name	Brand Name	Maximum Dose Per Day
Aripiprazole	Abilify	30mg/day
Clozapine	Clozaril	900mg/day
Olanzapine	Zyprexa	40mg/day
Quetiapine	Seroquel	1200mg/day
Risperidone	Risperdal	16mg/day
Ziprasidone	Geodon	200mg/day

(3) Pharmacy claims for doses for atypical antipsychotic agents (listed above) which exceed the maximum recommended doses will deny. After consultation with the prescriber, the pharmacist may override the claim. The pharmacist must note on the hardcopy prescription, the reason the prescriber requires a dose above the maximum recommended dose.

ANTIANXIETY AGENTS

Effective August 10, 2005 an incoming pharmacy claim for a recipient who has an active prescription for an anti-anxiety agent on file will deny as a therapeutic duplication. The pharmacist may override the denial upon consultation with the prescriber. The pharmacist must document on the hardcopy prescription the reason an additional anti-anxiety agent was requested by the prescriber.

Alprazolam	Halazepam
Buspirone	Hydroxyzine
Chlordiazepoxide	Lorazepam
Chlorazepate	Meprobamate
Diazepam	Oxazepam