

PRE-CERTIFICATION TRAINING

Medicaid Issues for 2002

Revisions in Blue are for 2008

**LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING**

UNISYS

ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency which establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, to administer certain aspects of Louisiana Medicaid according to policy, procedures, and guidelines established by DHH. This includes payment of Medicaid claims; processing of certain financial transactions; utilization review of provider claim submissions and payments; processing of precertification and prior authorization requests; and assisting providers in understanding Medicaid policy and procedure and correctly filing claims to obtain reimbursement.

This training packet has been developed for presentation at the 2002 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis in the workshops is on policy and procedures which affect Medicaid billing.

This packet does not present general Medicaid policy such as standards for participation, recipient eligibility and ID cards, and third party liability. Such information is presented **only** in the Basic Medicaid Information Training packet. The Basic Medicaid Information Training packet may be obtained by attending a Basic Medicaid Information workshop or by requesting a copy from Unisys Provider Relations.

Providers should use this packet in conjunction with the Louisiana Medicaid Precertification provider manual.

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POLICY

CLARIFICATION OF PRE-CERTIFICATION PROCESS

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. The “expected discharge date” is shown on the provider letter sent with each pre-certification transaction.

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-certification case under a new pre-certification number when the hospital submits current documentation to be reviewed as long as the patient continues to be an inpatient.

The hospital must submit an initial PCF01 with no pre-certification number. At the top of the PCF01, the provider must write “Attention: Sandy.” On the bottom of the PCF01 the provider should put “see old case # _____” (this will be the precert # under which the case was denied for timeliness). This new request must have the current documentation which supports the continued length of stay. This resubmitted request must have current documentation which supports the continued length of stay.

In order to minimize days lost for timely submittal, the provider should:

- A. Submit PCF01, that they know is late, expecting a denial for timeliness. It is not necessary to send chart documentation with the late PCF01.
- B. The same day send the PCF01 marked as initial for new case number as described above.

By not waiting to receive the denial letter for timeliness before submitting your request, you will only lose the days which cannot be precerted due to lateness.

This process can only be offered for EXTENSION REQUESTS when the patient is still in-house – NOT INITIAL requests or requests for patients already discharged.

If you have questions about the process described, please call Sandy in Pre-Cert.

The hospital will be assigned a new pre-certification number, with the admit date being the date that Unisys receives the current request. The days that were denied may be appealed through the DHH appeal process using the pre-certification number under which the days were denied.

3. Late submissions of an initial pre-certification 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 one business day of the admission. Such cases should be submitted to Unisys Pre-certification Department, ATTN: Sandy Whitcomb, R.N.

SUBMISSION OF HOSPITAL “COMMON WORKING FILE” (CWF) SCREENS FOR PRE-CERTIFICATION DOCUMENTATION OF MEDICARE PART A BENEFITS EXHAUSTED

The Unisys Pre-certification department will accept the hospital CWF screen printouts as documentation that Medicare Part A benefits are exhausted. HOWEVER, they will only accept these screens if it is indicated VERY CLEARLY that Medicare was billed and a portion of the days were denied because **benefits were exhausted**, OR that Medicare Part A benefits were exhausted as of the date of admission. Some of the screens submitted do not state clearly the information above in either form, so these have been rejected.

Please remember that as of July 1, 2001, the DHH has clarified that a provider only has 60 days from the date on the EOB to file the retrospective request for precertification of a Medicare A exhaust. This clarification was published in the July/August Provider Update.

POLICY REMINDERS AND CLARIFICATIONS

Hospital Pre-certification and Length of Stay (LOS) Review Program (other than state operated facility)

Effective July 1, 1994 for in-state (non-charity facility).

1. Unisys Working Hours

- a. Monday through Friday 8:00 a.m. - 5:00 p.m. (except holidays)

2. Inpatient Services

- a. Acute Care: Adult and Peds
- b. Rehab
- c. Psych/Substance Abuse
- d. Long-Term Care

3. Case Review Nurses are Registered Nurses.

All cases are assigned a designated case number to enhance access and communication between provider and Unisys Pre-certification personnel.

4. Initial Length of Stay (LOS)/Registration

(Definitions of timely submittal: Initial – page 3; Extension – page 4; Resubmittal – in letter; Reconsideration – page 4)

a. Acute Care and Rehab

- 1. Medicaid recipients may be registered for admission by completing the PCF01 form and faxing recipients' information to Unisys. No prior approval is accepted for acute care facilities.
- 2. Medicaid recipients may be registered no later than one business day after admission by completing the PCF01 form and faxing recipient information to Unisys.
- 3. Any outpatient that becomes an inpatient admission must register with Unisys and will be assigned a LOS to include the outpatient day.
- 4. Initial LOS for acute care is assigned according to the 1999 HCIA Recommended LOS Southern Region criteria. The assignment will be set at the grand total of the 50th percentile of the ICD-9 code number.
- 5. Rehab will be assigned up to an initial LOS of 14 days.

****Should medical documentation submitted be insufficient, the Pre-certification Department reserves the right to exercise the option of requesting additional information.****

5. Extension Request

a. Acute Care and Rehab

1. Request for an extension must be requested no later than the expected discharge date or the next business day after the expected discharge date by fax. If the discharge date is a weekend or holiday, the extension request may be submitted on the next business day.

2. Extension request for Acute Care:

a. Fax **completed** PCF02 form or your facility's own abstract.

3. Extension request for Rehab:

a. Fax complete established criteria **and**

b. PCF03 **or**

1. Completed established criteria **and**

2. Multidiscipline staff report

b. Extension approval for Acute Care is given up to the 75th percentile (HCIA). Subsequent extension is up to 3 days.

c. Extension approval for Rehab is given up to 14 days. Subsequent extension is up to 7 days.

d. Approved, denied, or returned cases will be faxed to the facility within the allowed time.

e. Reconsideration process for denial: for all cases denied, the provider (physician or designee) has 24 hours to submit a reconsideration. After a denial, the provider may request a written reconsideration. Submitting all supporting medical documentation and a PCF01 does this. If reconsideration is denied, then the provider needs to contact Unisys Pre-certification Department to set up physician to physician conference.

Reconsideration request not for timely submittal on page 8.

f. Appeal process occurs when both the initial request and the physician to physician review have been denied. Providers have the option at that time to file a formal appeal to DHH. Appeals should be addressed to:

**Bureau of Appeals, DHH
P. O. Box 4183
Baton Rouge, LA 70821-4183**

****Should medical documentation submitted be insufficient, the Pre-certification Department reserves the right to exercise the option of requesting additional information.****

6. Pre-Admission/Admission

- a. Psych/Substance Abuse and Long-Term Care
(DPP and Freestanding no prior approval. Long term psych – pre-admit.)
 1. Admissions may be requested prior to actual admission or within one business day.
 2. All of the following medical data must accompany the pre-admission/admission request for Psych/Substance Abuse:
 - a. PCF01 Form **and**
 - b. Appropriate criteria (psych/substance abuse) **and**
 - c. **Certificate of Need for Recipients under 21 years or over 65 years and**
 - d. PCF05 or all of the following:
 1. a, b, c, **and**
 2. Psychiatric physician evaluation (if available) **and**
 3. Initial assessment by registered nurse or licensed mental health professional **and**
 4. Psychiatric physician admit orders
 3. LOS for Psych is assigned according to the HCIA Recommended LOS Southern Region criteria. Initial LOS for Psych will be up to the grand total of the ICD-9 code number at the 50th percentile.
 4. All of the following medical data must accompany the pre-admission/admission request for Long-Term Care:
 - a. PCF01 Form **and**
 - b. Established criteria **and**
 - c. Discharge summary from transferring hospital **or all** of the following:
 1. a, b **and**
 2. PCF06
 5. Long-Term Care will be assigned an initial LOS of up to 14 days.
 6. Approval, denial, and return of cases will be determined after review of the above recipient data.

****Should medical documentation submitted be insufficient, the Pre-certification Department reserves the right to exercise the option of requesting additional information.****

7. Extension Request

a. Psych/Substance Abuse and Long-Term Care

1. All of the following medical data must accompany the extension request for Psych/Substance Abuse:
 - a. Appropriate criteria (psych/substance abuse) **and**
 - b. PCF05 **or all** of the following:
 1. Psychiatric physician evaluation if not previously submitted with the initial admit request.
 2. Medical documentation pertinent for the requested period to include:
 - a) Last (current) 48 hours of nurses notes
 - b) Last (current) 48 hours of physician orders
 - c) Last (current) 48 hours of physician progress notes
2. All of the following medical data must accompany the extension request for Long-Term Care:
 - a. Established criteria **and**
 - b. PCF06 **or all** of the following:
 1. Established criteria
 2. Multidiscipline staffing report
3. Request for an extension must be completed no later than the expected discharge day. If the discharge date falls on a weekend or Unisys holiday, the fax must be sent the next business day.
4. Extension approval for Psych is given up to the 75th percentile (HCIA). Subsequent extension is up to 3 days.
5. Extension approval for Long-Term Care is given for up to 14 days. Subsequent extension is up to 7 days.
6. Unisys fax response will be made to the provider within the time frame outlined in the Hospital Services provider manual for each type of case.

****Should medical documentation submitted be insufficient, the Pre-certification Department reserves the right to exercise the option of requesting additional information.****

8. Retrospective Review Based on Patient Retroactive Eligibility

- a. Only one situation is recognized for retrospective review based on eligibility: Positive determination of Medicaid eligibility cannot be made during the admission period. This refers to state's determining eligibility.
- b. If patients stay exceeded the admission LOS, an extension should be requested concurrently with the admission LOS review.
- c. Case review nurses will utilize established criteria to determine admit need where applicable and LOS.
- d. If the approved LOS days are less than actual days of stay, only the number of approved LOS days will appear on the notification.
- e. Cases denied will follow same denial and appeal procedures.

****Should medical documentation submitted be insufficient, the Pre-certification Department reserves the right to exercise the option of requesting additional information.****

Pre-certification Requirements (for recipients with Medicare and Medicaid)

Coverage	Pre-certification Required?
Medicare Part A only - not exhausted	No
Medicare Part A only - exhausted	Yes - must have Medicare EOB to show the days are exhausted (with PCF01). EOMB should show the first denial date of Medicare exhaust for days. (See p. 1 regarding the use of CWF screen printouts.)
Medicare Part B only	Yes
Medicare Parts A and B - Part A not exhausted	No
Medicare Parts A and B - Part A exhausted	Yes - must have Medicare EOB to show the days are exhausted (with PCF01). (See p. 1 regarding the use of CWF screen printouts.)

Remember that the provider has only 60 days from the notification date on the EOB to precert.

Newborns

A sick newborn who is eligible for Precert can be submitted with no Medicaid number. Ill newborns (with a Medicaid-eligible mother) who are admitted to NICU or who remain after the mother's discharge will receive an pre-certification case number and LOS. It is the provider's responsibility to provide Unisys with the 13-digit Medicaid number as soon as received along with appropriate admission information and relevant medical records. Ill newborn to NICU, precert then. Ill newborn that doesn't go to NICU, needs to stay after mom's D/C – precert admit date as mom's D/C date (page 12).

Policy Clarification

- Effective March 1, 1995, providers will receive only fax letters from the pre-certification department rather than mailed letters.
- Outpatient procedures done on day of admit or day after.
- To receive pre-certification approval for outpatient procedures performed on an inpatient basis on the day of admission or the day after admission (which are the only or primary ICD-9-CM codes listed), please remember to attach medical documentation to justify inpatient services. For these procedures, providers must complete and send in both a PCF01 and a PCF02. For list of outpatient procedures defined by DHH, see Appendix A.

NOTE: This is not a violation of the Department's agreement to approve the first 24 hours of the hospital stay for acute care cases for eligible recipients. It was never our intention to give a blanket approval for the first 24 hours on any stay where medically necessary 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.

Pre-certification Reminders

- On your fax cover letters, you identify the **total number of pages** submitted in that particular fax. This enables you to know if all the pages you intended to fax did go through.
- Check your fax transmittal receipt to verify that all pages were sent successfully.
- If your fax transmittal shows that some pages did not go through, please refax the entire submission.
- Please list an extension diagnosis for each extension request. This extension diagnosis should be the attending physician's diagnosis at the time of the extension request and may or may not be the same as the admitting and/or primary diagnosis.

- Reconsideration requests are only for denied cases that do not meet medical criteria on initial, extension, or retrospective requests. Cases denied for timely submittal do not have a reconsideration process.

Pre-certification Manuals

The following manuals will be used as criteria:

InterQual:	Pediatric ISD® Criteria and Review System
InterQual:	Adult ISD® Criteria and Review System
HCIA:	Psychiatric Length of Stay by Diagnosis, Southern Region
HCIA:	Adult Length of Stay by Diagnosis and Operation, Southern Region
HCIA:	Pediatric Length of Stay by Diagnosis and Operation, Southern Region

These manuals may be obtained by contacting the InterQual and HCIA offices:

InterQual	<u>or</u>	InterQual
44 Lafayette		293 Boston Post Road West
P. O. Box 988		Suite 180
North Hampton, NH 93862-0988		Malborough, MA 01752
(603) 964-7255		(508) 481-1181

HCIA, Inc.
 300 E. Lombard Street
 Baltimore, MD 21202
 (800) 568-3282
 (410) 539-5220 – FAX

Pre-certification Turnaround Times

Maximum response time begins when all necessary information is received.

Acute Care

LOS	24 Hours
Extension	24 Hours
Pre-certification	N/A
Retro Review	21 Days

Rehab

Initial LOS	24 Hours
Extension	24 Hours
Pre-certification	N/A
Retro Review	21 Days

Psych and Substance Abuse

Initial LOS	24 Hours
Extension	24 Hours
Pre-certification	24 Hours
Retro Review	21 Days

Long-Term Care

Initial LOS	24 Hours
Extension	24 Hours
Pre-certification	24 Hours
Retro Review	21 Days

Phone Numbers

Pre-certification: (800) 877-0666

Provider Relations: (800) 473-2783
(225) 924-5040

Recipient Eligibility: (800) 776-6323

Pre-certification Fax Numbers

(800) 717-4329 (225) 216-6219 – Do not use unless requested by a Precert staff member.
(800) 348-5658

Mailing Addresses

Unisys Louisiana Medicaid
Hospital Pre-certification Program
P. O. Box 14849
Baton Rouge, Louisiana 70898-4849

Unisys Louisiana Medicaid (for Certified Mail or Federal Express Only)
Pre-certification
8591 United Plaza Blvd., Suite 300
Baton Rouge, Louisiana 70809

Overnight Delivery Address

Office of Secretary
Bureau of Appeals
617 North Blvd.
Baton Rouge, Louisiana 70821

Postal Address

Office of Secretary
Bureau of Appeals
P. O. Box 4183
Baton Rouge, Louisiana 70821-4183

Pre-certification Program Update

This August marks the seven year anniversary for the Pre-certification Program.

One issue consistently raised and identified is the definition of terms used in completing and processing PCF01 forms. The following is a glossary of our terms:

Approved: Admission and/or extension is approved.

Denied: Admission and/or extension is denied because documentation does not meet the **criteria** to warrant medical necessity after being reviewed by the consulting physician or psychiatrist.

Rejected: Admission and/or extension is rejected because **documentation** is insufficient and additional information is needed in order to process the case.

Resubmittal: Hospitals may send additional documentation/information for requests that have been **rejected**. If rejected, then provider is **resubmitting** the request, not a reconsideration.

Reconsideration: Hospitals may request reconsideration of cases **denied** for lack of medical necessity.

Update: Hospitals may request the addition of newborn Medicaid ID numbers and/or outpatient procedures performed on an inpatient basis if it is the primary or only procedure performed within the first two days of the hospital stay. Please indicate what items need to be updated by circling the item. All update requests should include the Pre-certification case number.

Retrospective: Hospitals may request certification for cases where the Medicaid eligibility was not determined during the admission period. All retros should include a summary or abstract of entire stay – do not send the hospital chart, just what documents criteria.

Another issue involving the PCF01 form is the problem of supporting documentation. In April 1995, an update was sent to each hospital with the new PCF01 forms, abstracts, and instructions for the completion of these forms. Please note that all requests for certification should be submitted in a timely manner and should follow the guidelines outlined in Chapter 7 of the Hospital manual.

Timeliness is a Unisys goal as well; to help us respond to your request in a timely manner, please do the following:

- **For Rejection/Resubmittal:** Please review the three-digit rejection code and its corresponding description on the fax letter, which is sent with all rejected cases. **To resubmit your request, please resubmit a copy of the fax rejection letter, the PCF01 or Abstract (depending on which was used), as well as the additional information requested by the Pre-certification Program.**
- Write the description of the ICD-9 codes submitted.
- Indicate the level of care when using only the abstracts for extensions.
- Include start and stop dates for medication, and date all lab values and vital signs.

- Write legibly and large.
- Transcribe the requested physician progress notes if they are not legible.
- Do not fax copies of photographs since they copy very poorly. Instead, please submit description or mail pictures of wounds/decubiti.
- Submit documentation which supports intensity of service for the extension diagnoses' body system.

Retrospective cases: Retrospective cases need pertinent information to assist the review nurse in determining medical necessity. Suggested pertinent information includes:

PCF01 (all cases)
 Discharge summary (all cases)
 Admission history and physical (acute/rehab, long-term)
 Physician orders (psych only)
 Physician psychiatric evaluation (psych only)
 Certificate of Need (free-standing psych only)
 Nursing Assessment (psych only)
 Nursing progress notes (psych only)
 Multidisciplinary Team Notes (Rehab, Long-Term)

Finally, there are three more issues that need clarification.

1. Newborns that are either admitted to NICU or that become ill require a pre-certification case number. If the newborn is admitted to NICU on the day of his/her birth, the admit date is the birth date. If a newborn becomes ill and his/her mother is discharged, then the mother's discharge date becomes the ill newborn's admit date.
2. In compliance with HCFA regulations, Certificate of Need (CON) must be signed by the independent admit team unless this can be documented as an emergency psychiatric admission. Emergency admissions supported by appropriate documentation may have the CON signed by the hospital admit team.
3. Explanation of Medicare Benefits (EOMB), or the CWF screen printout as discussed on p. 1, from Medicare indicating Medicare Part A benefits are exhausted must accompany requests for Medicaid certification.

The Pre-certification Department routinely announces changes in the *Provider Update* sent to all providers, and on remittance advice (RA) messages sent to all hospital billing departments. We strongly recommend that copies of the *Provider Update* and RA messages pertaining to Pre-certification be sent to the Utilization Review Department.

NOTE: When calling Unisys for case results, please utilize the following information:

- If you are calling to get **medical information** on a pre-certification case, call (800) 877-0666.
- If you are calling to obtain the billing **status** of a pre-certification case, call Provider Relations at (800) 473-2783 or (225) 924-5040.

The pre-certification fax system receives information from providers across the state, 7 days a week, 24 hours a day. Therefore, you may fax a request from your facility at 10:00 a.m. but that fax may not arrive in print form to the Pre-certification Department until after noon on that same day.

Be sure to compare the number of pages on your cover letter with the number of pages your fax transmittal report shows successfully transmitted. If not all pages went through, refax the entire submittal of that case.

Due to issues of patient confidentiality, we are to send case information only to authorized fax numbers. If you are sending your fax from a different location or if your authorization fax number is discontinued or broken, you must contact the Pre-certification Department for instructions about how to have another fax destination authorized for pre-certification data.

Hospital Pre-certification Reconsideration/Appeal Process

All types of inpatient hospital stays must be approved through the Pre-certification Department at Unisys. In the event that an admission or extension is denied and the facility feels that there is a valid need for the admission or extension, the following procedure should be followed.

Once the facility has received the denial from the Pre-certification Department, the facility may request a written reconsideration. The reconsideration must be submitted in writing to the Pre-certification Department. The reconsideration will be reviewed by a physician, and a status determination will be faxed to the provider. If the reconsideration is approved, the facility will continue with extension requests if additional days are needed. If the reconsideration is denied, the facility will want to schedule a physician to physician review as the next step.

If the Unisys physician upholds the denial and the facility still feels that a valid need exists to admit or extend the stay of a patient, then a formal appeal may be initiated through the Bureau of Appeals in DHH.

When initiating a formal appeal, please include the following information in the letter to the Bureau of Appeals:

1. The recipient's full name and Medicaid number.
2. The first date which was not reimbursed through the date of discharge.
3. The total number of days under appeal (please remember that discharge date is not reimbursable).
4. The official name and address of the facility and the provider number.
5. The name and telephone number of a contact person.
6. The name, address, and telephone number of your attorney when one will be representing the facility.

In addition, please send the last denial from the Unisys Pre-certification Department.

This information must be sent to:

**Gerard N. Torry, Director
Bureau of Appeals
P. O. Box 4183
Baton Rouge, LA 70821-4183**

What Providers Can Do To Help The Process

The following are things providers can do to help the Unisys Pre-certification Department expedite the review and processing of your pre-certification requests.

1. The notification letter to the provider will contain the status of the request and, using 3-digit codes, will inform the provider of any additional information needed. Providers need to respond by sending the requested information or by writing an explanation of why the information is not available.
2. Read over what is to be sent to Unisys. Often providers send conflicting documentation among disciplines. These cases are reviewed based on the preponderance of information.
3. Often information is difficult to read. This may be the result of copier quality or writing legibility. Please be as clear as possible. Colored pages do not fax well.
4. Psychiatric cases are evaluated using scientific/medical criteria established by the Department of Health and Hospitals. This criteria requires that documentation show the patient to be homicidal, suicidal, or gravely disabled. Unisys Pre-certification staff are reading for descriptions of this behavior which are contained in the submitted documentation. Judgmental or speculative comments regarding a patient's behavior are not usually supportive of the criteria.
5. Unisys Pre-certification staff always require current, up-to-date information on medications and therapies supporting the criteria. Lack of current or time-sensitive information usually results in an unfavorable decision.

Thank you, in advance, for helping the Unisys Hospital Pre-certification Department serve the provider community.

Policy Notes: Providers

Tracing Lost Faxes: Unisys Pre-certification Department

The Unisys Pre-certification Department relies heavily on its fax machines to provide prompt service to providers. Sometimes, however, faxes get lost on their way from provider to Pre-certification. That is why the Unisys fax server system has a mechanism to track or trace lost faxes.

This system works in a two-fold manner to retrieve faxes that are important in Unisys business dealings. For incoming faxes, the system can actually "visualize" faxes as they are received by the fax/computer. The benefit of this feature is that Unisys is able to track a fax from the time it enters the system until the time it is printed in Pre-certification. If a provider has an ongoing problem with faxes sent, Unisys can utilize this tracking system. The limitation of this mechanism is that Unisys can track faxes for only six (6) days after they've been sent and only if the provider has his CSID number on each faxed page. Remember that the CSID number is a federal regulation, not a Unisys requirement.

The second unique feature of the Pre-certification fax server is its written reports, generated each hour, documenting failed faxes. (These are faxes Pre-certification is sending to providers). This allows Pre-certification staff to refax information listed as having failed. If groups of faxes sent to the same facility continue to fail in transmission, the Pre-certification staff contacts that facility to alert its staff to potential problems with the provider's fax machine. Every 24 hours, Pre-certification receives a written log of all faxes sent, those received by the providers as well as those which failed and were re-sent.

If, despite these features, providers have an ongoing fax problem with either sending data to or receiving data from Pre-certification, providers are encouraged to contact Unisys Pre-certification Department at (225) 237-3205. Please ask to speak with Janeen or Sandy, who will assist in identifying the problem and in advising of its solution.

Hospital Pre-certification Error Message 147

Error message 147 states "Only a portion of the days needed are approved; the remaining days on this request are denied. Submit reconsideration." That means 24 hours.

As a provider, you may have seen this message on your Pre-certification notification letters.

Error message 147 is used when a Unisys physician has reviewed all data submitted by the provider for this request. The physician has determined that only part of the days being requested meets criteria; therefore, a portion of the days requested is approved but the remaining days being requested are denied. The provider should then submit a reconsideration request and appropriate data for the remaining days needed for the hospitalization. This offers the provider the opportunity to send to Unisys Pre-certification additional information which documents the patient's severity of illness and intensity of hospital service needed.

REQUIRED MEDICAL DOCUMENTATION FOR ALL TYPES OF ADMISSIONS AND EXTENSIONS

Shown on the following pages are forms used in the pre-certification process and instructions for completing them.

**Required Medical Documentation for
Pre-certification Type 03 Acute Care (Med-Surg)/Rehab
March 24, 1995**

The following is required for an **ACUTE CARE INITIAL REQUEST**.

1. A fully completed P.C.F. 01

All of the following documentation is required for an **ACUTE CARE EXTENSION REQUEST**.

1. A completed abstract form (yours or P.C.F. 02) to include **all** of the following.
 - a. Number of daily visits by the physician.
 - b. Current treatment and medications with corresponding frequencies.
 - c. Recent or newly discovered changes in lab values, x-ray, or imaging results with appropriate dates of these results.
 - d. Most current changes or exacerbation of vital signs to include dates.
 - e. Recent outpatient surgical procedures to include dates, if applicable.
 - f. Last (current) 48 hours of physician orders upon request.

SHOULD MEDICAL DOCUMENTATION SUBMITTED BE INSUFFICIENT, THE PRE-CERTIFICATION UNIT RESERVES THE RIGHT TO EXERCISE THE OPTION OF REQUESTING ADDITIONAL INFORMATION.

**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 Review:

- 1) **Every field must be filled in.**

Notes for Hospitalization for Outpatient Procedures:

- 1) In the "Suggested Guidelines for Medical Documentation" sections (10-17), only fields 11, 12, 15, and 17 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 current level of care for the recipient.
- 2 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.
- 3 Enter the 13-digit recipient Medicaid identification number.
- 4 Enter the recipient's last name, first name, and middle initial.
- 5 Enter the seven-digit hospital Medicaid number.
- 6 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.**
- 7 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.
- 8 Enter the anticipated or actual date of surgery (if applicable).
- 9 Check in the appropriate box the type of request: hospital extension, physician review, or outpatient procedure.
- 10 Indicate the number of physician evaluations performed per 24 hours.
- 11-17 Use these fields to complete pertinent medical information regarding the recipient. If additional information is necessary, up to two pages may be submitted.
- 18 This field contains the signature of the UNISYS Pre-Cert medical reviewer.
- 19 This field is entered by the UNISYS Pre-Cert medical reviewer and contains the date of the review (MM/DD/YY).
- 20 **An authorized signature is required. Requests will not be accepted if not signed.**
- 21 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

LEVEL OF CARE	1	2	PRE-CERT CASE #
RECIPIENT ID NUMBER	3	RECIPIENT LAST NAME FIRST MI	PROVIDER NUMBER
	4		5
ICD-9 DIAGNOSIS & DESCRIPTION ADMITTING:	6	SURGICAL PROCEDURE CPT CODES ICD-9 (Physician) (Hospital) 1 1 2 2 3 3	SURGERY DATE
PRIMARY:	7		8
EXTENSION:			REQUEST TYPE
			Hospital Extension <input type="checkbox"/>
			Physician Reconsideration Review <input type="checkbox"/>
			Outpatient Procedure <input type="checkbox"/>
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: 11			
Physical Exam Findings (Pertinent to request type): 12			
Vital Signs (List frequency. If febrile, list date and time. If cultures done, list date and result): 13			
IV (List type and rate. Include ALL IV fluids and T.P.N.): 14			
Medications (List with dosage, route, and frequency, especially those relating to request type): 15			
Labs, X-Rays, and Procedures (List those pertinent to request type): 16			
Summary of Medical Necessity for Hospitalization: 17			
MEDICAL REVIEWER SIGNATURE		DATE OF REVIEW	
18		19	

PROVIDER SIGNATURE: _____

20

DATE OF REQUEST: _____

21

P.C. F02 Issued: 3/95

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

LEVEL OF CARE		PRE-CERT CASE #	
RECIPIENT ID NUMBER		RECIPIENT LAST NAME FIRST MI	
		PROVIDER NUMBER	
ICD-9 DIAGNOSIS & DESCRIPTION ADMITTING: PRIMARY: EXTENSION:	SURGICAL PROCEDURE CPT CODES ICD-9 (Physician) (Hospital) 1 1 2 2 3 3	SURGERY DATE ____/____/____	REQUEST TYPE Hospital Extension <input type="checkbox"/> Physician Reconsideration Review <input type="checkbox"/> Outpatient Procedure <input type="checkbox"/>
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): Vital 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: _____

P.C. F02 Issued: 3/95

STATE OF LOUISIANA DHH - BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Rehab Extension

Please Print or Type

PAGE 1 of 2

PRE-CERT CASE #		
RECIPIENT ID NUMBER (2)	RECIPIENT LAST NAME FIRST MI (3)	PROVIDER NUMBER (4)
ICD-9-CM EXTENSION DIAGNOSIS AND DESCRIPTION (5)	CHECK HERE IF THIS REQUEST IS FOR A RECONSIDERATION <input type="checkbox"/> (6)	SURGICAL PROCEDURE ICD-9 (Hospital) 1 (7) 2 3
SURGERY DATE (8)		
SUGGESTED GUIDELINES FOR MEDICAL DOCUMENTATION		
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>1) Physician evaluations (9) times per 24 hours.</p> <p>3) Past medical history (Pertinent to extension diagnosis): (11)</p> <p>4) Physical exam findings (Pertinent to extension diagnosis): (12)</p> <p>Vital signs (List frequency. If febrile, list date and time. If cultures done, list date and result): (13)</p> <p>6) IV (List type and rate. Include ALL IV fluids and T.P.N.). Include type of access (peripheral, central): (14)</p> <p>7) Medications (List with dosage, route, and frequency, especially those relating to extension diagnosis): (15)</p> <p>8) Labs, x-rays, and procedures (List those pertinent to extension diagnosis): (16)</p> <p>Decubitus ulcers? Yes _____ No _____ If yes, list #, stage, and location. List applicable treatment(s) (dsqs, whirlpool, hyperbarics, etc.) (17)</p> </div> <div style="width: 45%; text-align: right;"> <p>2) Last multidisciplinary staffing date (10)</p> </div> </div>		

P.C. F03

Issued: 3/95

STATE OF LOUISIANA DHH - BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Rehab Extension
PAGE 2 of 2

PRE-CERT CASE #

10) Wounds other than decubitus ulcers? Yes _____ No _____ If Yes, list number, stage (if applicable), and location. List treatment(s) performed.

18

11) Pulmonary: Is patient on ventilator? Yes _____ No _____
Is patient weanable? Yes _____ No _____ If yes, tell how this is being accomplished. If no, explain why.

19

Respiratory treatments? Yes _____ No _____ If yes, list time and frequency.

12) Nutritional Status: A) Mode of nutrition: _____ TPN, _____ NGT, _____ GT/JT, or _____ Oral.

20

B) Diet type: _____

13) Physical Therapy (Please summarize) 21

14) Occupational Therapy (Please summarize) 22

15) Speech Therapy (Please summarize) 23

16) Summary of medical necessity for hospitalization:

24

17) Discharge planning and/or estimated discharge date:

25

Provider Signature: _____

Date: _____

Up to two additional pages may be attached if necessary.

P.C. F03 Issued: 3/95

STATE OF LOUISIANA DHH - BHSP
MEDICAL ASSISTANCE PROGRAM
Request for Rehab Extension

Please Print or Type

PAGE 1 of 2

PRE-CERT CASE #

RECIPIENT ID NUMBER	RECIPIENT LAST NAME	FIRST	MI	PROVIDER NUMBER
ICD-9-CM EXTENSION DIAGNOSIS AND DESCRIPTION		CHECK HERE IF THIS REQUEST IS FOR A RECONSIDERATION <input type="checkbox"/>		SURGICAL PROCEDURE ICD-9 (Hospital) 1 2 3
SURGERY DATE ____/____/____				

SUGGESTED GUIDELINES FOR MEDICAL DOCUMENTATION

- 1) Physician evaluations _____ times per 24 hours.
- 2) Last multidisciplinary staffing date _____
- 3) Past medical history (Pertinent to extension diagnosis):
- 4) Physical exam findings (Pertinent to extension diagnosis):
- 5) Vital signs (List frequency. If febrile, list date and time. If cultures done, list date and result):
- 6) IV (List type and rate. Include ALL IV fluids and T.P.N.). Include type of access (peripheral, central):
- 7) Medications (List with dosage, route, and frequency, especially those relating to extension diagnosis):
- 8) Labs, x-rays, and procedures (List those pertinent to extension diagnosis):
- 9) Decubitus ulcers? Yes _____ No _____ If yes, list #, stage, and location. List applicable treatment(s) (dsqs, whirlpool, hyperbarics, etc.)

P.C. F03 Issued: 3/95

STATE OF LOUISIANA DHH - BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Renab Extension
PAGE 2 of 2

PRE-CERT CASE #

- 0) Wounds other than decubitus ulcers? Yes _____ No _____ If Yes, list number, stage (if applicable), and location. List treatment(s) performed.
- 11) Pulmonary: Is patient on ventilator? Yes _____ No _____
Is patient weanable? Yes _____ No _____ If yes, tell how this is being accomplished. If no, explain why.
- Respiratory treatments? Yes _____ No _____ If yes, list time and frequency.
- 12) Nutritional Status: A) Mode of nutrition: _____ TPN, _____ NGT, _____ GT/ST, or _____ Oral.
B) Diet type: _____
- 13) Physical Therapy (Please summarize):
- 14) Occupational Therapy (Please summarize):
- 15) Speech Therapy (Please summarize):
- 16) Summary of medical necessity for hospitalization:
- 17) Discharge planning and/or estimated discharge date:

Provider Signature: _____

Date: _____

Up to two additional pages may be attached if necessary.

P.C. F03 Issued: 3/95

STATE OF LOUISIANA DHH - BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Neonatal ICU Extension

Please Print or Type

PRE-CERT CASE # <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>		
RECIPIENT ID NUMBER <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	RECIPIENT LAST NAME <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	FIRST MI PROVIDER NUMBER <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
ICD-9-CM EXTENSION DIAGNOSIS AND DESCRIPTION <div style="border: 1px solid black; width: 100%; height: 40px;"></div>	CHECK HERE IF THIS REQUEST IS FOR A RECONSIDERATION <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	LEVEL OF CARE Nursery 2 <input type="checkbox"/> Nursery 3 <input type="checkbox"/>
SURGICAL PROCEDURE (ICD-9 (Hospital)) 1 <input type="checkbox"/> 2 <input type="checkbox"/>		SURGERY DATE <div style="border: 1px solid black; width: 100%; height: 20px;"></div>

SUGGESTED GUIDELINES FOR MEDICAL DOCUMENTATION OF AN NICU INFANT

Please complete pertinent information for recipient. If additional information is necessary, up to two pages may be added.

10 Physician Evaluations _____ times per 24 hours

PAST MEDICAL HISTORY AND MATERNAL CONDITIONS (Pertinent to diagnosis): _____

12 PHYSICAL EXAM FINDINGS

Birth weight in grams: _____ Current weight in grams: _____ Corrected gestational age: _____

Other: _____

CARE ENVIRONMENT: ☐ Radiant Warmer ☐ Isolette ☐ Open Cnb

OXYGEN NEEDS: ☐ Nasal Cannula ☐ Ventilator ☐ CPAP ☐ Jet Vent ☐ Oxyhood at _____ % oxygen

RESPIRATORY TREATMENT: ☐ Pulse Ox ☐ IPPB ☐ Nebulizer

16 VITAL SIGNS

Number of apnea/bradycardia per 24-hour period: ☐ Numerous (>10) ☐ Occasional (3-10) ☐ Infrequent (<3) ☐ None

☐ Continuous cardio monitoring ☐ No Monitoring ☐ Apnea Monitoring

Frequency of vital signs: ☐ >Hourly ☐ Hourly ☐ Every 2 hours ☐ Every 4 hours

17 NUTRITION/IV FLUIDS/TPN: (List ALL IV fluids and TPN)

Feedings: ☐ Continuous OG ☐ OG every _____ hours ☐ Nippling _____ times per day

Trend in weight gain: _____ grams per week

18 MEDICATION

Antibiotics: _____

Aminophylline/Theophylline: _____

Vitamins: _____

Blood Products: Date: _____

Other: _____

Labs, X-rays, Ultrasound, Procedures (List those pertinent to extension diagnosis): _____

Phototherapy (number of lights): Date started: _____

Parental Issues/Discharge Issues: _____

19 Provider Signature: _____

20 Date: _____

P.C. F04 Issued: 3/95

INSTRUCTIONS FOR FORM PCF04: NEONATAL ICU EXTENSION

NOTE: Fields 1 - 7 MUST be filled in and you must attach a completed P.C.F01.

Any incomplete form WILL BE REJECTED.

- 1 Enter the assigned Pre-Certification Case Number.
- 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 extension ICD-9-CM diagnosis code. **An extension diagnosis code is required. Also, the description of the diagnosis is required.**
- 6 If this is a reconsideration request, check this box.
- 7 Check the appropriate box to show level of care nursery.
- 8 Enter the appropriate outpatient surgical procedure codes. The hospital should enter the appropriate ICD-9-CM surgical procedure codes.
- 9 Enter the anticipated or actual date of surgery (if applicable).
- 10 Indicate the number of physician evaluations performed per 24 hours.
- 11-18 Use these fields to complete pertinent medical information regarding the recipient. If additional information is necessary, up to two pages may be submitted.
- 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 Neonatal ICU Extension
Please Print or Type

PRE-CERT CASE # _____			
RECIPIENT ID NUMBER _____	RECIPIENT LAST NAME _____	FIRST _____	MI _____ PROVIDER NUMBER _____
ICD-9-CM EXTENSION DIAGNOSIS AND DESCRIPTION _____	CHECK HERE IF THIS REQUEST IS FOR A RECONSIDERATION <input type="checkbox"/>	LEVEL OF CARE Nursery 2 <input type="checkbox"/> Nursery 3 <input type="checkbox"/>	SURGICAL PROCEDURE (ICD-9 (Hospital)) 1 <input type="checkbox"/> 2 <input type="checkbox"/>
SURGERY DATE _____			
<p>SUGGESTED GUIDELINES FOR MEDICAL DOCUMENTATION OF AN NICU INFANT</p> <p>Please complete pertinent information for recipient. If additional information is necessary, up to two pages may be added.</p> <p><i>Physician Evaluations _____ times per 24 hours</i></p> <p>PAST MEDICAL HISTORY AND MATERNAL CONDITIONS (Pertinent to diagnosis):</p> <p>_____</p> <p>PHYSICAL EXAM FINDINGS</p> <p>Birth weight in grams: _____ Current weight in grams: _____ Corrected gestational age: _____</p> <p>Other: _____</p> <p>_____</p> <p>CARE ENVIRONMENT: <input type="checkbox"/> Radiant Warmer <input type="checkbox"/> Isolette <input type="checkbox"/> Open Crib</p> <p>OXYGEN NEEDS: <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Ventilator <input type="checkbox"/> CPAP <input type="checkbox"/> Jet Vent <input type="checkbox"/> Oxyhood at _____ % oxygen</p> <p>RESPIRATORY TREATMENT: <input type="checkbox"/> Pulse Ox <input type="checkbox"/> IPPB <input type="checkbox"/> Nebulizer</p> <p>VITAL SIGNS</p> <p>Number of apnea/bradycardia in 24-hour period: <input type="checkbox"/> Numerous (>10) <input type="checkbox"/> Occasional (3-10) <input type="checkbox"/> Infrequent (<3) <input type="checkbox"/> None</p> <p><input type="checkbox"/> Continuous cardio monitoring <input type="checkbox"/> No Monitoring <input type="checkbox"/> Apnea Monitoring</p> <p>Frequency of vital signs <input type="checkbox"/> >Hourly <input type="checkbox"/> Hourly <input type="checkbox"/> Every 2 hours <input type="checkbox"/> Every 4 hours</p> <p>NUTRITION/IV FLUIDS/TPN: (List ALL IV fluids and TPN)</p> <p>Feedings: <input type="checkbox"/> Continuous OG <input type="checkbox"/> OG every _____ hours <input type="checkbox"/> Nippling _____ times per day</p> <p>Trend in weight gain: _____ grams per week</p> <p>MEDICATION</p> <p>Antibiotics: _____</p> <p>Aminophylline/Theophylline: _____</p> <p>Vitamins: _____</p> <p>Blood Products: Date: _____</p> <p>Other: _____</p> <p>Labs, X-rays, Ultrasound, Procedures (List those pertinent to extension diagnosis)</p> <p>_____</p> <p>Phototherapy (number of lights): Date started: _____</p> <p>Parental Issues/Discharge Issues: _____</p>			

Provider Signature: _____

Date: _____
P.C. F04 Issued: 3/95

Required Medical Documentation for
Pre-Certification Type 01 Distinct Part Psych and
Pre-Certification Type 04 Free-Standing Psych
March 24, 1995

All of the following documentation is required for a **PSYCHIATRIC AND SUBSTANCE ABUSE INITIAL REQUEST**.

1. A fully completed P.C.F01.
2. Established DHH psychiatric criteria (adult or child) or established substance abuse criteria.
3. Certificate of Need (required for free-standing facilities only).
4. P.C. F05 **OR** all of the following.
 - A. Psychiatric physician evaluation (if available).
 - B. Initial assessment by registered nurse or licensed mental health professional.
 - C. Psychiatric physician admit orders.

All of the following documentation is required for a **PSYCHIATRIC AND SUBSTANCE ABUSE EXTENSION REQUEST**.

1. Established DHH extension criteria for psychiatric/substance abuse (adult or child) with specifics.
2. A completed P.C.F05 **OR** all of the following.
 - A. Psychiatric physician evaluation if not previously submitted with the initial admit request.
 - B. Medical documentation pertinent for the requested period to include
 - 1) Last (current) 48 hours of nurse's notes.
 - 2) Last (current) 48 hours of physician orders.
 - 3) Last (current) 48 hours of physician progress notes.

SHOULD MEDICAL DOCUMENTATION SUBMITTED BE INSUFFICIENT, THE PRE-CERTIFICATION UNIT RESERVES THE RIGHT TO EXERCISE THE OPTION OF REQUESTING ADDITIONAL INFORMATION.

STATE OF LOUISIANA DHH - BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Psychiatric/Substance Abuse Extension/Reconsideration

Please Print or Type
PAGE 1 of 2

PRE-CERT CASE # <div style="border: 1px solid black; width: 100px; height: 15px; margin: 2px;"></div>	
RECIPIENT ID NUMBER <div style="border: 1px solid black; width: 100%; height: 15px; margin: 2px;"></div>	RECIPIENT LAST NAME FIRST MI PROVIDER NUMBER <div style="border: 1px solid black; width: 100%; height: 15px; margin: 2px;"></div>
ICD-9-CM ADMISSION/EXTENSION DIAGNOSIS AND DESCRIPTION <div style="border: 1px solid black; width: 100%; height: 40px; margin: 2px;"></div>	REQUEST TYPE PSYCHIATRIC <input type="checkbox"/> EXTENSION <input type="checkbox"/> SUBSTANCE ABUSE <input type="checkbox"/> RECONSIDERATION <input type="checkbox"/>
INSTRUCTIONS: When providing supporting documentation, mark areas specific to topics addressed.	
ADMISSION CRITERIA 1) Presenting problem and course of illness: _____ When did it start: _____ (Provide supporting medical documentation.) 2) Presence of suicidal/homicidal ideations, intent, plan, and/or attempt, if any. (Describe in detail with dates, and provide supporting medical documentation). 3) Can patient or family care for himself/herself? If not, describe specifics. (Provide supporting medical documentation.) 4) Presence of sleep and/or appetite disturbances, if any, and indicate onset of each or both if present. (Provide supporting medical documentation.) 5) Presence of psychosis, if any, with date of onset. Describe specific hallucinations, behavior aberration, and present treatments – OPD and hospital. (Provide supporting medical documentation.) 6) Presence of intoxication with substance abuse requiring detoxification. Specify substance(s): _____ How long used (for each substance)? Provide supporting medical information about the amount used and frequency for each substance specified. Also provide date of last use for each substance specified. 7) Presence of major mood disorders with vegetative symptoms or delusions? For how long? 8) Previous psychiatric hospitalization and/or substance abuse treatment. List each hospitalization with dates, and specify inpatient or outpatient.	

P.C. F05 Issued: 3/95

STATE OF LOUISIANA DHH - BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Psychiatric/Substance Abuse Extension/Reconsideration

Please Print or Type

PAGE 2 of 2

PRE-CERT CASE #

9) Does patient have history of withdrawal symptoms or complications? If yes, describe when and give specifics.

15

EXTENSION CRITERIA

Please use space to answer and provide documentation to the eight extension criteria issues.

1) Treatment plan goals.

16

2) Methods used to address treatment plan goals.

17

3) Course of hospitalization, to date.

18

4) Patient's level of functioning on unit.

19

5) Presence of special precautions.

20

6) Is behavior on unit dangerous? Compliant?

21

7) Have medication dosages been changed recently?

22

8) How would further hospitalization benefit this patient?

23

24

PROVIDER SIGNATURE: _____

25

DATE: _____

INSTRUCTIONS FOR FORM PCF05: PSYCHIATRIC/SUBSTANCE ABUSE EXTENSION OR RECONSIDERATION

NOTE: Fields 1 - 6 **MUST** be filled in.

Any incomplete form WILL BE REJECTED

- 1 Enter the assigned Pre-Certification Case Number if this is a request other than an initial.
- 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 diagnoses 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 Check in the appropriate box the type of request: psychiatric or substance abuse, extension or reconsideration.
- 7-15 Use these fields to complete pertinent medical information regarding the recipient for an admission request. If additional information is necessary, up to two pages may be submitted.
- 16-23 Use these fields to complete pertinent medical information regarding the recipient for an extension request. If additional information is necessary, up to two pages may be submitted.
- 24 **An authorized signature is required. Requests will not be accepted if not signed.**
- 25 Enter the date this request is submitted to UNISYS.

STATE OF LOUISIANA DHH - BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Psychiatric/Substance Abuse Extension/Reconsideration

Please Print or Type

PAGE 1 of 2

PRE-CERT CASE # _____

RECIPIENT ID NUMBER	RECIPIENT LAST NAME	FIRST	MI	PROVIDER NUMBER

ICD-9-CM ADMISSION/EXTENSION DIAGNOSIS AND DESCRIPTION	REQUEST TYPE PSYCHIATRIC <input type="checkbox"/> EXTENSION <input type="checkbox"/> SUBSTANCE ABUSE <input type="checkbox"/> RECONSIDERATION <input type="checkbox"/>
--	--

INSTRUCTIONS: When providing supporting documentation, mark areas specific to topics addressed.

ADMISSION CRITERIA

- 1) Presenting problem and course of illness: _____
 When did it start: _____
 (Provide supporting medical documentation)

- 2) Presence of suicidal/homicidal ideations, intent, plan, and/or attempt, if any. (Describe in detail with dates, and provide supporting medical documentation).

- 3) Can patient or family care for himself/herself? If not, describe specifics. (Provide supporting medical documentation.)

- 4) Presence of sleep and/or appetite disturbances, if any, and indicate onset of each or both if present. (Provide supporting medical documentation.)

- 5) Presence of psychosis, if any, with date of onset. Describe specific hallucinations, behavior aberration, and present treatments – OPD and Hospital. (Provide supporting medical documentation.)

- 6) Presence of intoxication with substance abuse requiring detoxification. Specify substance(s): _____
 How long used (for each substance)? Provide supporting medical information about the amount used and frequency for each substance specified. Also provide date of last use for each substance specified.

- 7) Presence of major mood disorders with vegetative symptoms or delusions? For how long?

- 8) Previous psychiatric hospitalization and/or substance abuse treatment. List each hospitalization with dates, and specify inpatient or outpatient.

P.C. F05 issued: 3/95

STATE OF LOUISIANA DHH - BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Psychiatric/Substance Abuse Extension/Reconsideration

Please Print or Type

PAGE 2 of 2

PRE-CERT CASE #

9) Does patient have history of withdrawal symptoms or complications? If yes, describe when and give specifics.

EXTENSION CRITERIA

Please use space to answer and provide documentation to the eight extension criteria issues.

1) Treatment plan goals.

2) Methods used to address treatment plan goals.

3) Course of hospitalization, to date.

4) Patient's level of functioning on unit.

5) Presence of special precautions.

6) Is behavior on unit dangerous? Compliant?

7) Have medication dosages been changed recently?

8) How would further hospitalization benefit this patient?

PROVIDER SIGNATURE: _____

DATE: _____

P.C. F05 Issued: 3/95

Required Medical Documentation for
Pre-Certification Type 02 Long Term Hospital
March 24, 1995

All of the following documentation is required for a **LONG TERM INITIAL REQUEST**.

1. A fully completed P.C.F01.
2. Established DHH long-term criteria with appropriate level of care.
3. Discharge summary from transferring hospital **OR** a P.C.F06.
4. Physician admit orders **OR** a P.C.F06.

All of the following documentation is required for a **LONG TERM EXTENSION REQUEST**.

1. Established DHH long term criteria with appropriate level of care.
2. A completed P.C.F06 **OR** a multidiscipline staffing report.

SHOULD MEDICAL DOCUMENTATION SUBMITTED BE INSUFFICIENT, THE PRE-CERTIFICATION UNIT RESERVES THE RIGHT TO EXERCISE THE OPTION OF REQUESTING ADDITIONAL INFORMATION.

STATE OF LOUISIANA DHH - BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Long Term Extension/Reconsideration

Please Print or Type

PAGE 1 of 2

PRE-CERT CASE #		
RECIPIENT ID NUMBER <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	RECIPIENT LAST NAME <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	FIRST MI PROVIDER NUMBER <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>
ICD-9-CM ADMISSION/EXTENSION DIAGNOSIS AND DESCRIPTION <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	SURGICAL PROCEDURE ICD-9 (Hospital) 1 2 3	SURGERY DATE ____/____/____ REQUEST TYPE EXTENSION RECONSIDERATION
<p>SUGGESTED GUIDELINES FOR MEDICAL DOCUMENTATION</p> <p>1) Physician evaluations _____ times per 24 hours. 2) Last multidisciplinary staffing date _____</p> <p>3) Past medical history (Pertinent to extension diagnosis):</p> <p>4) Physical exam findings (Pertinent to extension diagnosis):</p> <p>Vital signs (List frequency. If febrile, list date and time. If cultures done, list date and result):</p> <p>6) IV (List type and rate. Include ALL IV fluids and T.P.N.). Include type of access (peripheral, central):</p> <p>7) Medications (List with dosage, route, and frequency, especially those relating to extension diagnosis):</p> <p>8) Labs, x-rays, and procedures (List those pertinent to extension diagnosis):</p> <p>Decubitus ulcers? Yes _____ No _____ If yes, list #, stage, and location. List applicable treatment(s) (dsqs, whirlpool, hyperbarics, etc.)</p>		

P.C. F06

Issued: 3/95

STATE OF LOUISIANA DHH - BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Long Term Extension/Reconsideration
PAGE 2 of 2

PRE-CERT CASE #

10) Wounds other than decubitus ulcers? Yes _____ No _____ If Yes, list number, stage (if applicable), and location. List treatment(s) performed.

18

11) Pulmonary: Is patient on ventilator? Yes _____ No _____
Is patient weanable? Yes _____ No _____ If yes, tell how this is being accomplished. If no, explain why.

19

Respiratory treatments? Yes _____ No _____ If yes, list time and frequency.

12) Nutritional Status: A) Mode of nutrition: _____ TPN _____ NGT _____ GT/JT, or _____ Oral.

20

B) Diet type: _____

13) Physical Therapy (Please summarize):

21

14) Occupational Therapy (Please summarize):

22

15) Speech Therapy (Please summarize):

23

16) Summary of medical necessity for hospitalization:

24

17) Discharge planning and/or estimated discharge date:

25

Provider Signature: _____

Date: _____

Up to two additional pages may be attached if necessary.

P.C. F06

Issued: 3/95

INSTRUCTIONS FOR FORM PCF06: LONG TERM EXTENSION OR RECONSIDERATION

NOTE: Fields 1 - 5 and field 8 MUST be filled in and 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 diagnoses 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 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 or reconsideration.
- 9 Indicate the number of physician evaluations performed per 24 hours.
- 15 Use these fields to complete pertinent medical information regarding the recipient. If additional information is necessary, up to two pages may be submitted.
- 26 **An authorized signature is required. Requests will not be accepted if not signed.**
- 27 Enter the date this request is submitted to UNISYS.

PAGE 1 of 2

PRE-CERT CASE #

P.C. F06 issued: 3/95

STATE OF LOUISIANA DHH - BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Long Term Extension/Reconsideration
PAGE 2 of 2

PRE-CERT CASE #

10) Wounds other than decubitus ulcers? Yes _____ No _____ If Yes, list number, stage (if applicable), and location. List treatment(s) performed.

11) Pulmonary: Is patient on ventilator? Yes _____ No _____
Is patient weanable? Yes _____ No _____ If yes, tell how this is being accomplished. If no, explain why.

Respiratory treatments? Yes _____ No _____ If yes, list time and frequency.

12) Nutritional Status: A) Mode of nutrition: _____ TPN, _____ NGT, _____ GT/JT, or _____ Oral.

B) Diet type: _____

13) Physical Therapy (Please summarize):

14) Occupational Therapy (Please summarize):

15) Speech Therapy (Please summarize):

16) Summary of medical necessity for hospitalization:

17) Discharge planning and/or estimated discharge date:

Provider Signature: _____

Date: _____

Up to two additional pages may be attached if necessary.

P.C. F06

Issued: 3/95

PRE-ADMISSION CERTIFICATION/LENGTH OF STAY

TAKEN FROM CHAPTER 7 OF THE HOSPITAL SERVICES PROVIDER MANUAL CHAPTER CONTENTS

INTRODUCTION

- Pre-Admission Certification
- Length of Stay
- Extensions

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

- Functional Operations
- Maximum Turnaround Times
- Instructions for Completing P.C.F01 Form

LONG TERM HOSPITAL PRE-ADMISSION

- Certification Guidelines
- Definition of Terms
- Long Term Hospital Criteria

DISTINCT PART PSYCHIATRIC UNIT

- Admission Criteria for Adults
- Extension Criteria for Adults
- Admission Criteria for Children
- Extension Criteria for Children
- Community Based Psychiatric Service Definitions

ALCOHOLISM AND DRUG TREATMENT UNITS

- Admission Criteria
- Extension Criteria

REHABILITATION HOSPITALS

- Length of Stay Criteria

OUTPATIENT SURGERY PERFORMED AS INPATIENT

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.

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 are provided.

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).

LENGTH OF STAY

Acute care and rehabilitation hospitals and psych 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.

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 extension must be requested no later than the expected discharge date or the last business day before the expected discharge date. 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).

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 and fax it to Unisys. Admission certification will occur prior to or concurrent with the admission. Medicaid reimbursement will not be made without admission certification.

2. Case review nurse 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 uses established criteria and procedures to determine medical necessity of admission and length of stay. Medical necessity 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. 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 up to 14 days.
4. Case review nurse determines admission certification status (approved, denied, or rejected due to lack of information).
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 fax.
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.

Extension Request

1. Complete form P.C.F01 and fax it to Unisys. Extension of days can be requested any time during the approved stay; however, the extension must be requested no later than the expected discharge date or the last business day before the expected discharge date. 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). 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.

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 and fax it to Unisys. 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 in the 1999 Hospital provider training packet 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 up to 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 fax.

Extension Request

1. Complete form P.C.F01 and fax it to Unisys. Extension of days can be requested any time during the approved stay; however, the extension must be requested no later than the expected discharge date or the last business day before the expected discharge date. 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 fax. 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. 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.
4. 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.
5. Approved cases are assigned an authorization number and LOS days, and a notification indicating approval and assigned LOS days is faxed 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.
6. 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.
7. 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.	24 hrs.
LOS Extension	24 hrs.	24 hrs.	24 hrs.
Pre-certification Review	N/A	24 hrs.	24 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.

INSTRUCTIONS FOR COMPLETING P.C.F01 FORM

<u>Block</u>	<u>Description</u>	<u>Instructions</u>
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. <div> <div>BURN</div> <div>CCU</div> <div>GEN</div> <div>ICU</div> <div>NICU</div> <div>OU</div> <div>PICU</div> <div>PSYCH</div> <div>REHAB</div> <div>SAU</div> <div>TU</div> </div> <div> <div>Burn Unit</div> <div>Coronary Care Unit</div> <div>General Unit</div> <div>Intensive Care Unit</div> <div>Neonatal Intensive Care Unit</div> <div>Observation Unit</div> <div>Pediatric Intensive Care Unit</div> <div>Psychiatric Unit</div> <div>Rehabilitation Unit</div> <div>Substance Abuse Unit</div> <div>Telemetry Unit</div> </div>
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. FiO₂ 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: _____

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 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 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

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 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: _____

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: _____

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: _____

Long Term Hospital Length of Stay Criteria Form (Page 5 of 7)

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: _____

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. FiO2 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

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: _____

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:

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: _____

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: _____

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: _____

Distinct Part Psychiatric Unit Admission Criteria for Children (Page 2 of 3)

DISTINCT PART PSYCHIATRIC UNIT ADMISSION/EXTENSION CRITERIA FOR CHILDREN

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: _____

COMMUNITY BASED PSYCHIATRIC SERVICE DEFINITIONS

The following is a list of alternatives to inpatient psychiatric treatment as listed in Distinct Part Psychiatric Unit Admission Criteria.

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 than 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 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 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
<p>Figure 7-5. Hospital-Based Alcoholism and Drug Treatment Units (Page 1 of 3)</p>	<p><input type="checkbox"/> 3) This is the only available level of care that can provide the needed medical support and comfort for the patient</p> <p><input type="checkbox"/> 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)</p> <p><input type="checkbox"/> b) Detoxification required while pregnant.</p> <p>Specifies: _____</p>	
OR		
<p><input type="checkbox"/> B. Biomedical conditions and complications due to a primary diagnosis of a substance use disorder (one of the following)</p> <p><input type="checkbox"/> 1) Biomedical complications of addiction requiring medical management and skilled nursing care</p> <p><input type="checkbox"/> 2) Concurrent biomedical illness or pregnancy needing stabilization and daily medical management with daily primary nursing interventions</p> <p><input type="checkbox"/> 3) Presence of biomedical problems requiring inpatient diagnosis and treatment such as</p> <p style="margin-left: 20px;"><input type="checkbox"/> a) Liver disease or problems with impending hepatic decompensation</p> <p style="margin-left: 20px;"><input type="checkbox"/> b) Acute pancreatitis requiring parenteral treatment</p> <p style="margin-left: 20px;"><input type="checkbox"/> c) Active gastrointestinal bleeding</p> <p style="margin-left: 20px;"><input type="checkbox"/> d) Cardiovascular disorders requiring monitoring</p> <p style="margin-left: 20px;"><input type="checkbox"/> e) Multiple current medical problems</p> <p><input type="checkbox"/> 4) Recurrent or multiple seizures</p> <p><input type="checkbox"/> 5) Disulfiram-alcohol reaction</p> <p><input type="checkbox"/> 6) Life-threatening symptomatology related to excessive use of alcohol or other drugs (stupor, convulsions, etc.)</p> <p><input type="checkbox"/> 7) Chemical use gravely complicating or exacerbating previously diagnosed medical conditions</p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> 9) The patient demonstrates other biomedical problems requiring 24-hour observation and evaluation.</p> <p>Specifies: _____</p>		
OR		
<p><input type="checkbox"/> C. Emotional/behavioral conditions and complications due to a primary diagnosis of a substance use disorder (one of the following)</p> <p><input type="checkbox"/> 1) Emotional/behavioral complications of addiction requiring medical management and skilled nursing care</p> <p><input type="checkbox"/> 2) Concurrent emotional/behavioral illness needing stabilization and daily medical management and primary nursing interventions</p> <p><input type="checkbox"/> 3) Uncontrolled behavior endangering self or others</p> <p><input type="checkbox"/> 4) Co-existing serious emotional/behavioral disorder which complicates the treatment of chemical dependency and requires differential diagnosis and treatment</p> <p><input type="checkbox"/> 5) Extreme depression presenting in patient resulting in the patient being a danger to self or others</p> <p><input type="checkbox"/> 6) Thought process impairment, impairment in abstract thinking, limitation in ability to conceptualize to the degree that major life areas are severely impaired</p> <p><input type="checkbox"/> 7) Alcohol and other drug use gravely complicates or exacerbates previously diagnosed psychiatric or emotional/behavioral condition</p> <p><input type="checkbox"/> 8) Altered mental status with or without delirium as manifested by</p> <p style="margin-left: 20px;"><input type="checkbox"/> a) Disorientation to self</p> <p style="margin-left: 20px;"><input type="checkbox"/> b) Alcoholic hallucinations</p> <p style="margin-left: 20px;"><input type="checkbox"/> c) Toxic psychosis.</p> <p>Specifies: _____</p>		
<p>INTENSITY OF SERVICE</p> <p>(One or more must be met)</p> <p><input type="checkbox"/> 1. Intensive treatment with medications for delirium tremens</p> <p><input type="checkbox"/> 2. IV medications or total parenteral nutrition (T.P.N.)</p> <p><input type="checkbox"/> 3. Documented detoxification regime of decreasing drug dosage</p> <p><input type="checkbox"/> 4. Neurological checks and vital signs every two hours and "visual checks" every 15 minutes</p> <p><input type="checkbox"/> 5. Environmental control such that the patient is prevented from harming self or others.</p> <p>Specifies: _____</p>		

Hospital-Based Alcoholism and Drug Treatment Units (Page 2 of 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 intoxication 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 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, 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

Rehabilitation Hospital Length of Stay Criteria Form (Page 1 of 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 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: _____

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 is provided in the appendix of this training packet. 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. 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
Attn: Hospital Pre-Certification Dept.
P. O. Box 14919
Baton Rouge, LA 70898-4919**

APPENDIX A

PROCEDURES REQUIRING PRE- CERTIFICATION IF PERFORMED INPATIENT ON THE FIRST OR SECOND DAY OF ADMISSION

DX	DESC	SURCIND
0406	OTHER CRANIAL OR PERIPHERAL GANGLIONECTO	3
0407	OTHER EXCISION OR AVULSION OF CRANIAL AN	4
043	SUTURE OF CRANIAL AND PERIPHERAL NERVES	4
0443	RELEASE OF CARPAL TUNNEL	3
0449	OTHER PERIPHERAL NERVE OR GANGLION DECON	3
046	TRANSPOSITION OF CRANIAL AND PERIPHERAL	3
067	EXCISION OF THYROGLOSSAL DUCT OR TRACT	3
0802	SEVERING OF BLEPHARORRHAPHY	2
0809	OTHER INCISION OF EYELID	2
0820	REMOVAL OF LESION OF EYELID, NOT OTHERWI	1
0821	EXCISION OF CHALAZION	1
0825	DESTRUCTION OF LESION OF EYELID	1
0841	REPAIR OF ENTROPION OR ECTROPION BY THER	3
0842	REPAIR OF ENTROPION OR ECTROPION BY SUTU	3
0843	REPAIR OF ENTROPION OR ECTROPION WITH WE	3
0844	REPAIR OF ENTROPION OR ECTROPION WITH LI	3
0852	BLEPHARORRHAPHY	2
0859	OTHER ADJUSTMENT OF LID POSITION	2
0864	RECONSTRUCTION OF EYELID WITH TARSOCONJU	2
0943	PROBING OF NASOLACRIMAL DUCT	1
1044	OTHER FREE GRAFT TO CONJUNCTIVA	4
1099	OTHER OPERATIONS ON CONJUNCTIVA	1
110	MAGNETIC REMOVAL OF EMBEDDED FOREIGN BOD	1
1131	TRANSPOSITION OF PTERYGIUM	1
1132	EXCISION OF PTERYGIUM WITH CORNEAL GRAFT	1
1139	OTHER EXCISION OF PTERYGIUM	1
1149	OTHER REMOVAL OR DESTRUCTION OF CORNEAL	4
1211	IRIDOTOMY WITH TRANSFIXION	4
1214	OTHER IRIDECTOMY	4
1242	EXCISION OF LESION OF IRIS	4
1284	EXCISION OR DESTRUCTION OF LESION OF SCL	4
1319	OTHER INTRACAPSULAR EXTRACTION OF LENS	4
132	EXTRACAPSULAR EXTRACTION OF LENS BY LINE	4
133	EXTRACAPSULAR EXTRACTION OF LENS BY SIMP	4
1341	PHACOEMLUSIFICATION AND ASPIRATION OF CA	4
1342	MECHANICAL PHACOFAGMENTATION AND ASPIRA	4
1359	OTHER EXTRACAPSULAR EXTRACTION OF LENS	4
1362	EXCISION OF PRIMARY MEMBRANOUS CATARACT	4
1365	EXCISION OF SECONDARY MEMBRANE (AFTER CA	4
1371	INSERTION OF INTRAOCULAR LENS PROSTHESIS	4
1401	REMOVAL OF FOREIGN BODY FROM POSTERIOR S	1
1402	REMOVAL OF FOREIGN BODY FROM POSTERIOR S	1
1511	RESECTION OF ONE EXTRAOCULAR MUSCLE	4
1512	ADVANCEMENT OF ONE EXTRAOCULAR MUSCLE	4
1513	RESECTION OF ONE EXTRAOCULAR MUSCLE	4
1519	OTHER OPERATIONS ON ONE EXTRAOCULAR MUSC	4
1521	LENGTHENING PROCEDURE ON ONE EXTRAOCULAR	4
1522	SHORTENING PROCEDURE ON ONE EXTRAOCULAR	4
1529	OTHER OPERATIONS ON ONE EXTRAOCULAR MUSC	4
153	OPERATIONS ON TWO OR MORE EXTRAOCULAR MU	4
154	OTHER OPERATIONS ON TWO OR MORE EXTRAOCU	4
1631	REMOVAL OF OCULAR CONTENTS WITH SYNCHRON	4

DX	DESC	SURGI	IND
1639	OTHER EVISCERATION OF EYEBALL	4	
1642	ENUCLEATION OF EYEBALL WITH OTHER SYNCHR	4	
1649	OTHER ENUCLEATION OF EYEBALL	4	
1661	SECONDARY INSERTION OF OCULAR IMPLANT	4	
1662	REVISION AND REINSERTION OF OCULAR IMPLA	4	
1671	REMOVAL OF OCULAR IMPLANT	4	
1809	OTHER INCISION OF EXTERNAL EAR	2	
1811	OTOSCOPY	1	
1829	EXCISION OR DESTRUCTION OF OTHER LESION	1	
1911	STAPEDECTOMY WITH INCUS REPLACEMENT	4	
1919	OTHER STAPEDECTOMY	4	
193	OTHER OPERATIONS ON OSSICULAR CHAIN	4	
194	MYRINGOPLASTY	4	
195	OTHER TYMPANOPLASTY	4	
1952	TYPE II TYMPANOPLASTY	4	
1953	TYPE III TYMPANOPLASTY	4	
1954	TYPE IV TYMPANOPLASTY	4	
1955	TYPE V TYMPANOPLASTY	4	
196	REVISION OF TYMPANOPLASTY	4	
2001	MYRINGOTOMY WITH INSERTION OF TUBE	4	
2009	OTHER MYRINGOTOMY	1	
2041	SIMPLE MASTOIDECTOMY	4	
208	OPERATIONS ON EUSTACHIAN TUBE	1	
2121	RHINOSCOPY	1	
2122	BIOPSY OF NOSE	1	
2131	LOCAL EXCISION OR DESTRUCTION OF INTRANA	2	
2132	LOCAL EXCISION OR DESTRUCTION OF OTHER L	1	
215	SUBMUCOUS RESECTION OF NASAL SEPTUM	4	
2162	FRACTURE OF THE TURBINATES	1	
2169	OTHER TURBINECTOMY	1	
217	REDUCTION OF NASAL FRACTURE	1	
2171	CLOSED REDUCTION OF NASAL FRACTURE	1	
2183	TOTAL NASAL RECONSTRUCTION	4	
2187	OTHER RHINOPLASTY	4	
2188	OTHER SEPTOPLASTY	4	
2199	OTHER OPERATIONS ON NOSE	1	
2200	ASPIRATION AND LAVAGE OF NASAL SINUS, NO	2	
2201	PUNCTURE OF NASAL SINUS FOR ASPIRATION O	2	
2202	ASPIRATION OR LAVAGE OF NASAL SINUS THRO	2	
2263	ETHMOIDECTOMY	3	
230	FORCEPS EXTRACTION OF TOOTH	1	
2301	EXTRACTION OF DECIDUOUS TOOTH	1	
2309	EXTRACTION OF OTHER TOOTH	1	
231	SURGICAL REMOVAL OF TOOTH	1	
2311	REMOVAL OF RESIDUAL ROOT	1	
2319	OTHER SURGICAL EXTRACTION OF TOOTH	1	
232	RESTORATION OF TOOTH BY FILLING	1	
233	RESTORATION OF TOOTH BY INLAY	1	
234	OTHER DENTAL RESTORATION	1	
2341	APPLICATION OF CROWN	1	
2342	INSERTION OF FIXED BRIDGE	1	
2343	INSERTION OF REMOVABLE BRIDGE	1	

DX	DESC	SURGIN D
2349	OTHER DENTAL RESTORATION	1
235	IMPLANTATION OF TOOTH	1
245	ALVEOLOPLASTY	1
2501	NEEDLE BIOPSY OF TONGUE	1
2502	OTHER BIOPSY OF TONGUE	1
2594	OTHER GLOSSOTOMY	2
270	DRAINAGE OF FACE AND FLOOR OF MOUTH	2
2741	LABIAL FRENECTOMY	4
2742	WIDE EXCISION OF LESION OF LIP	3
2743	OTHER EXCISION OF LESION OR TISSUE OF LI	1
2792	INCISION OF MOUTH, UNSPECIFIED STRUCTURE	2
280	INCISION AND DRAINAGE OF TONSIL AND PERI	2
282	TONSILLECTOMY WITHOUT ADENOIDECTOMY	4
283	TONSILLECTOMY WITH ADENOIDECTOMY	4
284	EXCISION OF TONSIL TAG	4
286	ADENOIDECTOMY WITHOUT TONSILLECTOMY	4
2911	PHARYNGOSCOPY	1
292	EXCISION OF BRANCHIAL CLEFT CYST OR VEST	2
3009	OTHER EXCISION OR DESTRUCTION OF LESION	1
313	OTHER INCISION OF LARYNX OR TRACHEA	1
3142	LARYNGOSCOPY AND OTHER TRACHEOSCOPY	1
3143	BIOPSY OF LARYNX	1
3144	BIOPSY OF TRACHEA	1
3321	BRONCHOSCOPY THROUGH ARTIFICIAL STOMA	1
3322	FIBER-OPTIC BRONCHOSCOPY	1
3323	OTHER BRONCHOSCOPY	1
3324	ENDOSCOPIC BRONCHIAL BIOPSY	1
3409	OTHER INCISION OF PLEURA	2
3797	REPL CARDIVERT / DFIB LEAD	1
3821	BIOPSY OF BLOOD VESSEL	1
3822	PERCUTANEOUS ANGIOSCOPY	4
3859	LIGATION AND STRIPPING OF LOWER LIMB VAR	4
3882	OTHER SURGICAL OCCLUSION OF OTHER VESSEL	1
3889	OTHER SURGICAL OCCLUSION OF LOWER LIMB V	4
4011	BIOPSY OF LYMPHATIC STRUCTURE	2
4021	EXCISION OF DEEP CERVICAL LYMPH NODE	2
4221	OPERATIVE ESOPHAGOSCOPY BY INCISION	1
4222	ESOPHAGOSCOPY THROUGH ARTIFICIAL STOMA	1
4223	OTHER ESOPHAGOSCOPY	1
4224	BIOPSY OF ESOPHAGUS	1
4232	LOCAL EXCISION OF OTHER LESION OR TISSUE	1
4239	OTHER DESTRUCTION OF LESION OR TISSUE OF	1
4292	DILATION OF ESOPHAGUS	1
4342	LOCAL EXCISION OF OTHER LESION OR TISSUE	1
4349	OTHER DESTRUCTION OF LESION OR TISSUE OF	1
4411	TRANSABDOMINAL GASTROSCOPY	1
4413	OTHER GASTROSCOPY	1
4414	BRUSH BIOPSY OF STOMACH	1
4415	OTHER BIOPSY OF STOMACH	1
4493	INSERT GASTRIC BALLOON	1
4494	REMOVAL GASTRIC BALLOON	1
4513	OTHER ENDOSCOPY OF SMALL INTESTINE	1

DX	DESC	SURGINO
4514	BRUSH BIOPSY OF SMALL INTESTINE	1
4524	OTHER ENDOSCOPY OF LARGE INTESTINE	1
4525	BRUSH BIOPSY OF LARGE INTESTINE	1
4526	OTHER BIOPSY OF LARGE INTESTINE	1
4532	OTHER DESTRUCTION OF LESION OF DUODENUM	1
4541	LOCAL EXCISION OF LESION OR TISSUE OF LA	1
4595	SM BOWEL-ANUS ANASTOMOS	4
4643	OTHER REVISION OF STOMA OF LARGE INTESTI	3
4823	OTHER PROCTOSIGMOIDOSCOPY	1
4824	BRUSH BIOPSY OF RECTUM	1
4825	OTHER BIOPSY OF RECTUM	1
4835	LOCAL EXCISION OF RECTAL LESION OR TISSU	1
4881	INCISION OF PERIRECTAL TISSUE	1
4901	INCISION OF PERIANAL ABSCESS	1
4912	ANAL FISTULECTOMY	2
493	LOCAL EXCISION OR DESTRUCTION OF OTHER L	2
4945	LIGATION OF HEMORRHOIDS	3
4946	EXCISION OF HEMORRHOIDS	3
4947	EVACUATION OF THROMBOSED HEMORRHOIDS	3
4949	OTHER PROCEDURES ON HEMORRHOIDS	1
4951	LEFT LATERAL ANAL SPHINCTEROTOMY	2
4952	POSTERIOR ANAL SPHINCTEROTOMY	2
4959	OTHER ANAL SPHINCTEROTOMY	2
5011	PERCUTANEOUS (NEEDLE) BIOPSY OF LIVER	2
5300	UNILATERAL REPAIR OF INGUINAL HERNIA, NO	4
5301	UNILATERAL REPAIR OF DIRECT INGUINAL HER	4
5302	UNILATERAL REPAIR OF INDIRECT INGUINAL H	4
5303	UNILATERAL REPAIR OF DIRECT INGUINAL HER	4
5304	UNILATERAL REPAIR OF INDIRECT INGUINAL H	4
5305	UNILATERAL REPAIR OF INGUINAL HERNIA WIT	4
5321	UNILATERAL REPAIR OF FEMORAL HERNIA WITH	4
5329	OTHER UNILATERAL FEMORAL HERNIORRHAPHY	4
5349	OTHER UMBILICAL HERNIORRHAPHY	4
5359	REPAIR OF OTHER HERNIA OF ANTERIOR ABDOM	4
5369	REPAIR OF OTHER HERNIA OF ANTERIOR ABDOM	4
5421	LAPAROSCOPY	4
5423	BIOPSY OF PERITONEUM	4
5425	PERITONEAL LAVAGE	3
544	EXCISION OR DESTRUCTION OF PERITONEAL TI	4
545	LYSIS OF PERITONEAL ADHESIONS	4
5451	LAPAROSCOPE LYSIS OF PERTIONEAL ADHES	0
5459	OTHER LYSIS OF PERITONEAL ADHESIONS	0
5634	OPEN BIOPSY OF URETER	4
5635	ILEAL CONDUCT ENDOSCOPY	3
5731	CYSTOSCOPY THROUGH ARTIFICIAL STOMA	1
5732	OTHER CYSTOSCOPY	1
5749	OTHER TRANSURETHRAL EXCISION OR DESTRUCT	1
5791	SPHINCTEROTOMY OF BLADDER	1
5792	DILATION OF BLADDER NECK	1
581	URETHRAL MEATOTOMY	1
5821	PERINEAL URETHROSCOPY	1
5822	OTHER URETHROSCOPY	1

DX	DESC	SURGINO
583	EXCISION OR DESTRUCTION OF URETHRAL TISS	1
585	RELEASE OF URETHRAL STRICTURE	1
586	DILATION OF URETHRA	1
5903	LAPAROS LYS OF PERIRENAL OR PERIURET ADH	0
5912	LAPAROS LYS OF PERIVESICAL ADHESIONS	0
5919	OTHER INCISION OF PERIVESICAL TISSUE	2
6011	NEEDLE BIOPSY OF PROSTATE	1
610	INCISION AND DRAINAGE OF SCROTUM AND TUN	2
612	EXCISION OF HYDROCELE (OF TUNICA VAGINAL	3
613	EXCISION OR DESTRUCTION OF LESION OR TIS	1
6191	PERCUTANEOUS ASPIRATION OF TUNICA VAGINA	3
620	INCISION OF TESTIS	2
6211	PERCUTANEOUS BIOPSY OF TESTIS	1
6212	OTHER BIOPSY OF TESTIS	1
623	UNILATERAL ORCHIECTOMY	2
6241	REMOVAL OF BOTH TESTES AT SAME OPERATIVE	2
6242	REMOVAL OF REMAINING TESTIS	2
631	EXCISION OF VARICOCELE AND HYDROCELE OF	3
6371	LIGATION OF VAS DEFERENS	4
6373	VASECTOMY	4
6392	EPIDIDYMYOTOMY	2
640	CIRCUMCISION	3
642	LOCAL EXCISION OR DESTRUCTION OF LESION	1
6491	DORSAL OR LATERAL SLIT OF PREPUCE	1
6501	LAPAROSCOPIC OOPHOROTOMY	0
6509	OTHER OOPHOROTOMY	0
6511	ASPIRATION BIOPSY OF OVARY	4
6512	OTHER BIOPSY OF OVARY	4
6513	LAPAROSCOPIC BIOPSY OF OVARY	0
6514	OTHER LAPAROS DIAG PROC ON OVARIES	0
6523	LAPAROS MARSUPIUM OF OVATION CYST	0
6524	LAPAROS WEDGE RESECTION OF OVARY	0
6525	OTH LAPAROS LOC EXCIS OR DEST OF OVARY	0
6529	OTHER LOCAL EXCISION OR DESTRUCTION OF O	4
6531	LAPAROS UNILATERAL OOPHORECTOMY	0
6539	OTHER UNILATERAL OOPHORECTOMY	0
6541	LAPAROS UNILAT SALPINGO-OOPHORECTOMY	0
6549	OTHER UNILATERAL SALPINGO-OOPHORECTOMY	0
6553	LAPAROS REMOVAL OF BOTH OVARIES AT S.OP.	0
6554	LAPAROS REMOVAL OF REMAINING OVARY	0
6563	LAPAROS REMOVAL OF BOTH OVARIES & TUBES	0
6564	LAPAROS REMOVAL OF REMAINING OVARY& TUBE	0
6574	LAPAROSCOPIC SIMPLE SUTURE OF OVARY	0
6575	LAPAROSCOPIC REIMPLANTATION OF OVARY	0
658	LYSIS OF ADHESIONS OF OVARY AND FALLOPIA	4
6581	LAPAR LYS OF ADH OF OVARY AND FALL TUBE	0
6611	BIOPSY OF FALLOPIAN TUBE	4
662	BILATERAL ENDOSCOPIC DESTRUCTION OR OCCL	4
6621	BILATERAL ENDOSCOPIC LIGATION AND CRUSH	4
6622	BILATERAL ENDOSCOPIC LIGATION AND DIVISI	4
6629	OTHER BILATERAL ENDOSCOPIC DESTRUCTION	4
663	OTHER BILATERAL DESTRUCTION OR OCCLUSION	4

DX	DESC	SURGINO
6631	OTHER BILATERAL LIGATION AND CRUSHING OF	4
6632	OTHER BILATERAL LIGATION AND DIVISION OF	4
6639	OTHER BILATERAL DESTRUCTION OR OCCLUSION	4
6661	EXCISION OR DESTRUCTION OF LESION OF FAL	4
6692	UNILATERAL DESTRUCTION OR OCCLUSION OF F	4
670	DILATION OF CERVICAL CANAL	3
6711	ENDOCERVICAL BIOPSY	1
6712	OTHER CERVICAL BIOPSY	1
6732	DESTRUCTION OF LESION OF CERVIX BY CAUTE	4
6733	DESTRUCTION OF LESION OF CERVIX BY CRYOS	4
6739	OTHER EXCISION OR DESTRUCTION OF LESION	4
6823	ENDOMETRIAL ABLATION	0
6901	DILATION AND CURETTAGE FOR TERMINATION O	4
6909	OTHER DILATION AND CURETTAGE OF UTERUS	3
6951	ASPIRATION CURETTAGE OF UTERUS FOR TERM	4
6952	ASPIRATION CURETTAGE FOLLOWING DELIVERY	3
700	CULDOCENTESIS	1
7011	HYMENOTOMY	4
7014	OTHER VAGINOTOMY	3
7024	VAGINAL BIOPSY	1
7031	HYMENECTOMY	4
7033	EXCISION OR DESTRUCTION OF LESION OF VAG	2
7109	OTHER INCISION OF VULVA AND PERINEUM	2
7111	BIOPSY OF VULVA	1
7121	PERCUTANEOUS ASPIRATION OF BARTHOLIN'S G	1
7122	INCISION OF BARTHOLIN'S GLAND (CYST)	1
7123	MARSUPIALIZATION OF BARTHOLIN'S GLAND (C	1
713	OTHER LOCAL EXCISION OR DESTRUCTION OF V	1
7179	OTHER REPAIR OF VULVA AND PERINEUM	2
750	INTRA-AMNIOTIC INJECTION FOR ABORTION	4
762	LOCAL EXCISION OR DESTRUCTION OF LESION	3
7671	CLOSED REDUCTION OF MALAR AND ZYGOMATIC	2
7672	OPEN REDUCTION OF MALAR AND ZYGOMATIC FR	2
7697	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
7702	SEQUESTRECTOMY OF HUMERUS	2
7723	WEDGE OSTEOTOMY OF RADIUS AND ULNA	4
7724	WEDGE OSTEOTOMY OF CARPALS AND METACARPA	4
7728	WEDGE OSTEOTOMY OF TARSALS AND METATARSA	4
7733	OTHER DIVISION OF RADIUS AND ULNA	4
7734	OTHER DIVISION OF CARPALS AND METACARPAL	4
7738	OTHER DIVISION OF TARSALS AND METATARSAL	4
7739	OTHER DIVISION OF OTHER BONE, EXCEPT FAC	4
7752	BUNIONECTOMY WITH SOFT TISSUE CORRECTION	4
7753	OTHER BUNIONECTOMY WITH SOFT TISSUE CORR	4
7754	EXCISION OF BUNIONETTE	3
7759	OTHER BUNIONECTOMY	4
7788	OTHER PARTIAL OSTEOTOMY OF TARSALS AND M	3
7789	OTHER PARTIAL OSTEOTOMY OF OTHER BONE, E	2
779	TOTAL OSTEOTOMY	4
7838	*OTHER CHANGE IN BONE LENGTH OF TARSALS	4
7839	OTHER CHANGE IN BONE LENGTH OF OTHER BON	4
7858	INTERNAL FIXATION OF TARSALS AND METATAR	4

DX	DESC	SURGINO
786	REMOVAL OF INTERNAL FIXATION DEVICE	2
7861	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
7862	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
7864	REMOVAL OF INTERNAL FIXATION DEVICE FROM	4
7865	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
7866	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
7867	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
7868	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
8003	ARTHROTOMY FOR REMOVAL OF PROSTHESIS OF	4
8012	OTHER ARTHROTOMY OF ELBOW	2
8016	OTHER ARTHROTOMY OF KNEE	4
8026	ARTHROSCOPY OF KNEE	4
8043	DIVISION OF JOINT CAPSULE, LIGAMENT, OR	3
8044	DIVISION OF JOINT CAPSULE, LIGAMENT, OR	3
8048	DIVISION OF JOINT CAPSULE, LIGAMENT, OR	3
8050	IV DISC EXCS / DSTRUCT NOS	3
806	EXCISION OF SEMILUNAR CARTILAGE OF KNEE	4
8073	SYNOVECTOMY OF WRIST	4
8074	SYNOVECTOMY OF HAND AND FINGER	4
8078	SYNOVECTOMY OF FOOT AND TOE	4
8087	OTHER LOCAL EXCISION OR DESTRUCTION OF L	3
809	OTHER EXCISION OF JOINT	4
8094	OTHER EXCISION OF JOINT OF HAND AND FING	3
8116	METATARSOPHALANGEAL FUSION	4
8118	OTHER FUSION OF TOE	4
8128	INTERPHALANGEAL FUSION	4
8131	ARTHROPLASTY OF FOOT AND TOE WITH SYNTH	4
8139	OTHER ARTHROPLASTY OF FOOT AND TOE	4
8171	ARTHROPLASTY OF HAND AND FINGER WITH SYN	4
8179	OTHER REPAIR OF HAND AND FINGER	4
8186	ARTHROPLASTY OF CARPALS WITH SYNTHETIC P	4
8201	EXPLORATION OF TENDON SHEATH OF HAND	1
8203	BURSOTOMY OF HAND	1
8209	OTHER INCISION OF SOFT TISSUE OF HAND	2
8211	TENOTOMY OF HAND	1
8212	FASCIOTOMY OF HAND	4
8221	EXCISION OF LESION OF TENDON SHEATH OF H	3
8232	EXCISION OF TENDON OF HAND FOR GRAFT	3
8233	OTHER TENONECTOMY OF HAND	4
8235	OTHER FASCIECTOMY OF HAND	4
8251	ADVANCEMENT OF TENDON OF HAND	3
8279	PLASTIC OPERATION ON HAND WITH OTHER GRA	4
8284	REPAIR OF Mallet FINGER	3
8285	OTHER TENODESIS OF HAND	3
8286	OTHER TENOPLASTY OF HAND	3
8289	OTHER PLASTIC OPERATIONS ON HAND	4
8291	LYSIS OF ADHESIONS OF HAND	3
8301	EXPLORATION OF TENDON SHEATH	2
8303	BURSOTOMY	2
8309	OTHER INCISION OF SOFT TISSUE	2
8314	FASCIOTOMY	4
8321	BIOPSY OF SOFT TISSUE	2

DX	DESC	SURGI ND
8331	EXCISION OF LESION OF TENDON SHEATH	3
8339	EXCISION OF LESION OF OTHER SOFT TISSUE	3
8341	EXCISION OF TENDON FOR GRAFT	4
8342	OTHER TENONECTOMY	4
8345	OTHER MYECTOMY	4
835	BURSECTOMY	3
8361	SUTURE OF TENDON SHEATH	3
8364	OTHER SUTURE OF TENDON	3
8387	OTHER PLASTIC OPERATIONS ON MUSCLE	3
8388	OTHER PLASTIC OPERATIONS ON TENDON	3
8391	LYSIS OF ADHESIONS OF MUSCLE, TENDON, FA	3
8411	AMPUTATION OF TOE	2
8412	AMPUTATION THROUGH FOOT	2
850	MASTOTOMY	3
8511	PERCUTANEOUS (NEEDLE) BIOPSY OF BREAST	3
8512	OTHER BIOPSY OF BREAST	3
8521	LOCAL EXCISION OF LESION OF BREAST	3
8524	EXCISION OF ECTOPIC BREAST TISSUE	3
8591	ASPIRATION OF BREAST	3
8595	INSRT BREAST TISS EXPAND	2
8596	REMOV BREAST TISS EXPAND	2
8601	ASPIRATION OF SKIN AND SUBCUTANEOUS TISS	3
8604	OTHER INCISION WITH DRAINAGE OF SKIN AND	2
8605	INCISION WITH REMOVAL OF FOREIGN BODY FR	2
8609	OTHER INCISION OF SKIN AND SUBCUTANEOUS	2
8611	BIOPSY OF SKIN AND SUBCUTANEOUS TISSUE	1
8621	EXCISION OF PILONIDAL CYST OR SINUS	3
8622	DEBRIDEMENT OF WOUND, INFECTION, OR BURN	1
8623	REMOVAL OF NAIL, NAILBED, OR NAIL FOLD	1
8627	DEBRID.NAIL,BED,FOLD	1
863	OTHER LOCAL EXCISION OR DESTRUCTION OF L	1
8660	FREE SKIN GRAFT, NOT OTHERWISE SPECIFIED	3
8662	OTHER SKIN GRAFT TO HAND	3
8686	ONYCHOPLASTY	1
8689	OTHER REPAIR AND RECONSTRUCTION OF SKIN	2
8693	INSRT SKIN TISS EXPANDER	2
8782	GAS CONTRAST HYSTEROSALPINGOGRAM	2
8783	OPAQUE DYE CONTRAST HYSTEROSALPINGOGRAM	2
8926	GYNECOLOGICAL EXAMINATION	1
9616	OTHER VAGINAL DILATION	1
9622	DILATION OF RECTUM	1
9623	DILATION OF ANAL SPHINCTER	1
9625	THERAPEUTIC DISTENTION OF BLADDER	1
9649	OTHER GENITOURINARY INSTILLATION	1
9659	OTHER IRRIGATION OF WOUND	2
9739	REMOVAL OF OTHER THERAPEUTIC DEVICE FROM	2
9802	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1
9803	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1
9804	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1
9805	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1
9814	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1
9815	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1

DX	DESC	SURGIN D
9821	REMOVAL OF SUPERFICIAL FOREIGN BODY FROM	1
9822	REMOVAL OF OTHER FOREIGN BODY WITHOUT IN	1
9827	REMOVAL OF FOREIGN BODY WITHOUT INCISION	2
9985	LOCALIZED HYPERTHERMIA	1
9986	PLACED EXT. BONE STIM	1
8850	GAMETOLOGICAL EXAMINATION	1
8423	ALYMPH GLE CONTINUED: 1121F029741M029741	2