



# **HOSPITAL SERVICES PROVIDER MANUAL**

*Chapter Twenty-five of the Medicaid Services Manual*

**Issued July 1, 2011**

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis/surgical procedure codes that reflect the policy intent. References in this manual to ICD-9 diagnosis/surgical procedure codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

**State of Louisiana  
Bureau of Health Services Financing**

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION: TABLE OF CONTENTS**

**PAGE(S) 5**

---

**HOSPITAL SERVICES**

**TABLE OF CONTENTS**

| <b>SUBJECT</b>   | <b>SECTION</b> |
|--|----------------|
| <b>OVERVIEW</b>  | <b>25.0</b>    |
| <b>PROVIDER REQUIREMENTS</b>   | <b>25.1</b>    |
| Licensure  |                |
| Clinical Laboratory Improvement Amendments of 1988 (CLIA)                        |                |
| Distinct Part Psychiatric Units  |                |
| <b>INPATIENT SERVICES</b>  | <b>25.2</b>    |
| Preadmission Certification and Length of Stay Assignment                         |                |
| Distinct Part Psychiatric Units  |                |
| Obstetrical and Gynecological Services Requiring Special Procedures              |                |
| Sterilizations   |                |
| Exceptions to Sterilization Policy   |                |
| Informed Consent   |                |
| Abortions  |                |
| Dilations and Curettage  |                |
| Ectopic Pregnancies  |                |
| Molar Pregnancies  |                |
| Hysterectomies   |                |
| Exceptions to the Hysterectomy Policy  |                |
| Deliveries with Non-Payable Sterilizations                                       |                |
| Other Inpatient Services   |                |
| Blood  |                |
| Hospital-Based Ambulance Services  |                |
| Mother/Newborn/Nursery   |                |
| Inpatient Hospital Definition of Discharge                                       |                |
| Discharge and Readmit on the Same Day  |                |
| Direct Transfers   |                |
| Date of Discharge or Death   |                |
| Out-of-State Hospitals in Acute Care Hospitals (Psychiatric and Substance Abuse) |                |
| Rehabilitation Units in Acute Care Hospitals                                     |                |
| Psychiatric Diagnosis Within an Acute Care Hospital                              |                |

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION: TABLE OF CONTENTS****PAGE(S) 5**

---

|  |             |
|--|-------------|
| <b>OUTPATIENT SERVICES</b>   | <b>25.3</b> |
| Therapeutic and Diagnostic Services  |             |
| Radiology Utilization Management   |             |
| Special Circumstances  |             |
| Denials  |             |
| Emergency Room Services  |             |
| Hospital-Based Ambulances (Air or Ground)                                  |             |
| Hospitals Laboratory Services  |             |
| Hyperbaric Oxygen Therapy  |             |
| Outpatient Rehabilitation Services   |             |
| Outpatient Surgery   |             |
| Intraocular Lens Implants  |             |
| Observation Room Charges   |             |
| Outpatient Hospital Clinic Services  |             |
| Diabetes Self-Management Training  |             |
| <br>   |             |
| <b>HOSPITAL-BASED PHYSICIANS</b>   | <b>25.4</b> |
| Enrollment of Hospital-Based Physicians                                    |             |
| <br>   |             |
| <b>PRE-CERTIFICATION AND ADMISSION</b>                                     | <b>25.5</b> |
| Length of Stay   |             |
| Admissions   |             |
| Acute Care Adult or Pediatric Hospital Stays/Admission Process             |             |
| Adult or Pediatric Extension Process                                       |             |
| Rejections of Acute Care Pre-certification Requests                        |             |
| Denials of Acute Care Pre-certification Requests                           |             |
| Outpatient Status vs. Inpatient Status                                     |             |
| Outpatient Status Changing to Inpatient Status                             |             |
| Outpatient Ambulatory Surgeries  |             |
| Outpatient Procedures Performed on Day of Admission or Day after Admission |             |
| Pre-certification of Newborns  |             |
| Newborn Initial Admissions   |             |
| Newborn Extension Request  |             |
| Pre-certification for NICU Levels of Care                                  |             |
| Pre-certification for OB Care and Delivery                                 |             |
| Vaginal Delivery Pre-certification Example                                 |             |
| C-Section Pre-certification Example  |             |
| Short Cervical Length Guidelines – Length in Pregnancy                     |             |
| Rehabilitation Admission/Level of Care                                     |             |
| Rehabilitation Admissions  |             |
| Rehabilitation Extension   |             |

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION: TABLE OF CONTENTS**

**PAGE(S) 5**

---

- Process for Rejected Extensions for Acute Care and Rehabilitation
- Process for Denied Extensions for Acute Care and Rehabilitation
- Long-Term Acute Care Hospital Stays
- Long-Term Acute Care Extension
- Psychiatric/Substance Abuse Hospital Stays-Admissions
  - Psychiatric/Substance Abuse Extension
- Late Requests for Initial Stay Due to Conflicting Medicaid Eligibility
- Retrospective Review Based on Recipient Retroactive Eligibility
  - Retrospective Review Based on Provider Retroactive Eligibility
- Pre-Certification Requirements for Dual Recipients
- Submission of Hospital Common Working File Screens for Pre-certification Documentation
- Denial of Extension Requests for Lack of Timely Submittal Medical Information
- Hospital Pre-certification Reconsideration/Appeal Process
- Pre-certification Department General Information
  - Working Hours and Holidays of Current Fiscal Intermediary
  - Pre-certification Department Fax System
  - Helpful Tips
  - Pre-certification Turnaround Times
  - Pre-certification Reference Guides
  - Pre-certification Contact Information
  - Pre-certification Reminders
  - What Providers Can do to Help the Process
  - Pre-certification Glossary

**PRIOR AUTHORIZATION 25.6**

- Requests for Prior Authorization
- Outpatient Rehabilitation Services
- Outpatient Surgery Performed on an Inpatient Basis
- Organ Transplant
  - Required Documentation for Organ Transplant Authorization Requests
  - Standards for Coverage
- Cochlear Implementations
  - Medical and Social Criteria
    - General Criteria
    - Age-Specific Criteria
      - Children Two through Nine Years
      - Children 10 -17 Years
      - Adults 18 – 20 Years
- Reimbursement
  - Billing for the Device
  - Re-performance of the Surgery
  - Replacement of the External Speech Processor

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION: TABLE OF CONTENTS**

**PAGE(S) 5**

---

Billing for the Replacement of the External Speech Processor  
Non-Covered Expenses  
Vagus Nerve Stimulator  
Intrathecal Baclofen Therapy  
    Criteria for Patient Selection  
    Exclusion Criteria for Recipients  
Out-of-State Non Emergency Hospitalizations  
Reconsiderations  
    Instructions for Submitting Reconsideration

**REIMBURSEMENT**

**25.7**

History  
Inpatient Reimbursement  
    State-Owned Hospitals  
    Small Rural Hospitals  
    Non-small Rural / Non-state Hospitals  
Acute Care Hospitals Peer Group Assignment  
Changing Peer Group Status  
Specialty Hospitals  
Boarder Baby per Diem  
Well Baby per Diem  
Qualifications for Well Baby Rate  
Continuing Qualification for Well Baby Rate  
Specialty Units  
Neonatal Intensive Care Units  
Pediatric Intensive Care Units  
Change in Level of Care in Specialty Unit  
Burn Units  
Transplant Services  
Outliers  
Qualifying Loss Review Process  
Permissible Basis  
    Basis Not Allowable  
    Burden of Proof  
    Required Documentation  
    Consideration Factors for Additional Reimbursement Requests  
    Determination to Award Relief  
    Notification of Relief Awarded  
    Effect of Decision  
    Administrative Appeal  
    Judicial Review  
Reimbursement Methodology for Acute Care Inpatient Hospital Services

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION: TABLE OF CONTENTS**

**PAGE(S) 5**

---

- Small Rural Hospitals
- State-Owned Hospitals
- Out of State Hospitals
- Out of State Inpatient Psychiatric Services
- Inpatient Psychiatric (Free-Standing and Distinct Part Psychiatric) Hospitals
- Outpatient Hospital
  - Rehabilitation Services (Physical, Occupational, and Speech Therapy)
  - Other Outpatient Hospital Services
  - In-State Non-Small Rural Private Hospital Outpatient Services
  - In-State State – Owned Hospital Outpatient Services
  - In-State Small Rural Hospital Outpatient Services
- Cost Reporting
- Supplemental Payments
- Disproportionate Share (DSH)

**CLAIMS RELATED INFORMATION**

**25.8**

- Provider Preventable Conditions
- Other Provider Preventable Conditions (OPPC's)
- Outpatient Hospital Claims
- Blood
- Hospital-Based Ambulance Services
- Mother/Newborn
- Deliveries with Non-Payable Sterilizations
- Split-Billing
- Claims Filing for Outpatient Rehabilitation Services
- Billing for the Implantation of the Infusion Pump Catheter
- Billing for the Cost of the Infusion Pump
- Billing for Replacement Pumps and Catheters
- The Crossover Claims Process
  - Inpatient Part A Crossovers
  - Medicare Part A and B Claims
  - Medicare Part A Only Claims
  - Exhausted Medicare Part A Claims
  - Medicare Part B Only Claims

**FORMS AND LINKS**

**APPENDIX A**

**CONTACT/REFERRAL INFORMATION**

**APPENDIX B**

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.0: OVERVIEW****PAGE(S) 1**

---

**OVERVIEW**

This chapter applies to services provided to eligible Medicaid recipients in an inpatient and/or outpatient hospital setting unless otherwise stated. Hospital providers are to ensure that the services provided to Medicaid recipients are medically necessary, appropriate and within the scope of current medical practice and Medicaid guidelines.

This chapter consists of several sections that will address issues such as provider requirements, prior authorization, covered services and limitations and reimbursement.

A hospital is defined as any institution, place, building, or agency, public or private, whether for profit or not, maintaining and operating facilities, 24 hours a day, seven days a week, having 10 licensed beds or more. The hospital must be properly staffed and equipped for the diagnosis, treatment and care of persons admitted for overnight stay or longer who are suffering from illness, injury, infirmity or deformity or other physical or mental conditions for which medical, surgical and/or obstetrical services would be available and appropriate. Such hospitals must meet DHH licensing requirements.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.1: PROVIDER REQUIREMENTS****PAGE(S) 1**

---

**PROVIDER REQUIREMENTS**

Enrollment in the Louisiana Medicaid Hospital Services Program is entirely voluntary. Participating providers must accept the Medicaid payment as payment in full for those services covered by Medicaid and the Medicaid recipient cannot be charged the difference between the usual and customary charge and Medicaid's payment. All Medicaid covered services must be billed to Medicaid. However, services not covered under the Medicaid program can be billed directly to the Medicaid recipient. **The provider must inform the Medicaid recipient that the service is not covered by Medicaid before performing the service.**

Provider enrollment information and forms are located on the Louisiana Medicaid web site (see appendix B for web site).

**Licensure**

The Department of Health and Hospitals, Health Standards Section (HSS) is the only licensing authority for hospitals in the State of Louisiana. Providers participating in the program must meet all certification and licensing requirements.

Detailed information regarding licensing requirements can be obtained from the HSS (see appendix B).

**Clinical Laboratory Improvement Amendments**

In accordance with federal regulations 42 CFR 493.1 hospital laboratories must meet certain conditions to be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

**Distinct Part Psychiatric Units**

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



---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.2: INPATIENT SERVICES****PAGE(S) 14**

---

**INPATIENT SERVICES**

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

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

The number of days of care charged to a recipient for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for Medicaid reporting purposes. A part of a day, including the day of admission, counts as a full day. However, the day of discharge or death is not counted as a day unless discharge or death occurs on the day of admission. If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

**Pre-Admission Certification and Length of Stay Assignment**

The Bureau of Health Services Financing (BHSF)/Medicaid, requires registration and length of stay (LOS) assignment for all admissions to acute care and rehabilitation hospitals. Pre-admission certification and length of stay assignment is required for long-term hospitals and inpatient psychiatric/substance abuse services hospitals. Additional information regarding pre-admission certification and length of stay procedures can be found in Section 25.5 of this chapter.

**NOTE:** Inpatient admissions for dual **Medicare/Medicaid** recipients are not subject to these requirements except when Medicare Part A benefits have been exhausted or the recipient has Medicare Part B only.

**Distinct Part Psychiatric Units**

Medicaid recognizes Distinct Part Psychiatric Units within an acute care general hospital differently for reimbursement purposes if the unit meets Medicare's criteria for exclusion from Medicare's Prospective Payment System (PPS excluded unit). The unit must have the Health

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.2: INPATIENT SERVICES****PAGE(S) 14**

---

Standards Section verify that the Unit is in compliance with the PPS criteria and identify the number and location of beds in the psychiatric unit.

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

Providers bill on a UB-04 for these services. The hospital must set up the distinct part psychiatric unit as a separate cost center and be identified as a sub-provider on the hospital's cost report. The costs for this unit are not subject to cost settlement. Additional information regarding Distinct Part Psychiatric Units can be found in the section entitled Pre-Admission Certification/Length of Stay.

### **Obstetrical and Gynecological Services Requiring Special Procedures**

Federal and state laws and regulations dictate strict guidelines for Medicaid reimbursement for sterilizations, abortions and hysterectomies. The information below provides more guidance.

#### **Sterilizations**

Sterilization is any medical procedure, treatment, or operation that is performed for the sole purpose of rendering an individual permanently incapable of reproducing. The physician is responsible for obtaining the signed Informed Consent to Sterilization form which can be downloaded from the U.S. Department of Health and Human Services (HHS) web site (see Appendix B).

Title XIX regulations require a 30-day waiting period after the consent form is signed. The procedure **cannot** be performed prior to the 31<sup>st</sup> day from the day the consent form is signed.

Sterilizations are reimbursable only if:

- The recipient is at least 21 years old at time the informed consent form is signed;
- The recipient is mentally competent. According to federal regulations an individual can be considered legally incompetent only if found to be so by a court of competent jurisdiction or so identified by virtue of a provision of state law; and

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.2: INPATIENT SERVICES****PAGE(S) 14**

---

- The recipient voluntarily gave informed consent by signing the consent form not less than 30 days, but no more than 180 days prior to performing sterilization.

**Exceptions to Sterilization Policy**

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

In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery, or in the case of emergency abdominal surgery, the emergency must be described.

**Informed Consent**

An eligible recipient will be considered informed only if all the conditions described in this section are met.

The professional who obtains the consent for the sterilization procedure must offer to answer any questions the recipient may have concerning the procedure, provide a copy of the consent form, and orally give all of the following information or advice to the recipient:

- The recipient is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federal benefits to which the recipient might be otherwise entitled.
- The recipient is provided a description of available alternative methods of family planning and birth control. Recipient is informed that sterilization is considered irreversible.
- The recipient is provided a thorough explanation of the specific sterilization procedure to be performed.
- The recipient is given a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used.

---

CHAPTER 25: HOSPITAL SERVICES

---

SECTION 25.2: INPATIENT SERVICES

PAGE(S) 14

---

- The sterilization will not be performed for at least 30 days, except under the circumstances specified under the subtitle “Exceptions to Sterilization Policy”.

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

An interpreter was provided if the recipient did not understand the language used on the consent form or the language used by the person obtaining consent.

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

Informed consent **must not be obtained** while the recipient is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the recipient’s state of awareness.

The recipient must be given the consent form by the physician or clinic. All blanks on the form must be completed and the following individuals must sign the form:

- The recipient to be sterilized;
- The interpreter, if one was provided;
- The hospital professional who obtained the consent; and
- The physician who performed the sterilization procedure. (If the physician who performs the sterilization procedure is the one who also obtained the consent, the physician must sign both statements).

A copy of the consent form must be attached to all claims for sterilization, including attending physician, assistant surgeon, anesthesiologist, and hospital claims. The physician who signs the (Consent Form) must be the physician listed as the attending physician on the UB-04. Therefore, **only hard-copy claims will be processed.**

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.2: INPATIENT SERVICES****PAGE(S) 14**

---

**Abortions**

Medicaid only covers an abortion performed by a physician and related hospital charges when it has been determined medically necessary to save the life of the mother or when the pregnancy is the result of rape or incest.

**NOTE:** All federal and state laws related to abortions must be adhered to.

Abortions claims will be reviewed by the fiscal intermediary (FI) and must meet the following criteria for one of the following circumstances:

**Life Endangerment**

- A physician certifies in writing that on the basis of his/her professional judgment that the life of the woman would be endangered if the fetus were carried to term.
- The claim form must be submitted with the treating physician's certification statement including the complete name and address of the recipient and appropriate ICD-9 diagnosis that makes the pregnancy life endangering.
- The recipient's medical record must include the medical diagnosis and physician's documentation that made the abortion medically necessary to save the life of the mother.

**Incest / Rape**

- The recipient must report the act of incest or rape to law enforcement unless the treating physician's written certification statement documents that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the incident(s).
- The recipient must certify in writing that the pregnancy is a result of incest or rape and the treating physician must witness the recipient's certification by signature.
- The certification statements must be attached to the claim and include the complete name and address of the recipient and appropriate ICD-9 diagnosis.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.2: INPATIENT SERVICES****PAGE(S) 14**

---

- The recipient's medical record must include the medical diagnosis and physician's documentation to support the abortion and certification statements.

All claims associated with an abortion, including the attending physician, hospital, assistant surgeon, and anesthesiologist submitted for processing must be accompanied by a copy of the attending physician's written certification and statement of medical necessity. Therefore, **only hard-copy claims will be processed.**

Informed consent shall not be obtained while the recipient to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the recipient's state of awareness.

**Spontaneous / Missed Abortions**

Must be coded with the appropriate ICD-9 code and the operative report must be attached to the claim.

**Threatened Abortions**

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

**Dilation and Curettage**

Claims for a Dilation and Curettage (D&C) for an incomplete or missed abortion will be denied until the following is submitted:

- The written sonogram results with operative report, pathology report and history must be submitted with the claim; and
- The documentation that substantiates that the fetus was not living at the time of the D&C and the documentation must indicate that this was not an abortion or pregnancy termination.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.2: INPATIENT SERVICES****PAGE(S) 14**

---

Listed below are examples of information and documentation necessary for proper claim review and to substantiate reimbursement.

- A sonogram report showing no fetal heart tones;
- A history showing passage of fetus at home, in the ambulance, or in the emergency room;
- A pathology report showing degeneration products of conception; or
- An operative report showing products of conception in the vagina.

**Ectopic Pregnancies**

To receive reimbursement for the termination of an ectopic pregnancy (tubal pregnancy), hospitals must submit billing on hardcopy with a copy of the operative report attached and an appropriate ICD-9 surgical procedure code that denotes the termination of an ectopic pregnancy. A sterilization procedure code cannot be used. Use of an improper ICD-9 surgical procedure may cause the claim to deny.

**Molar Pregnancies**

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

**Hysterectomy**

Federal regulations governing Medicaid payment of hysterectomies prohibit payment under the following circumstances:

- If the hysterectomy is performed solely for the purpose of terminating reproductive capability; or
- If there is more than one purpose for performing the hysterectomy, but the procedure would not be performed except for the purpose of rendering the recipient permanently incapable of reproducing.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.2: INPATIENT SERVICES****PAGE(S) 14**

---

Louisiana Medicaid guidelines only allow payment to be made for a hysterectomy when:

- The person securing authorization to perform the hysterectomy has informed the recipient and her representative (if any), both orally and in writing, that the hysterectomy will make the recipient permanently incapable of reproducing; and
- The recipient or her representative (if any) has signed a written acknowledgement of receipt of that information. (**Acknowledgement of Receipt of Hysterectomy Information** (BHSF Form 96-A) is available on the Louisiana Medicaid website under the “Forms/Files/User Manuals: link.)

These regulations apply to all hysterectomy procedures, regardless of the woman’s age, fertility, or reason for surgery.

**Consent for Hysterectomy**

The hysterectomy consent form must be signed and dated by the recipient on or before the date of the hysterectomy. The consent must include signed acknowledgement from the recipient stating she has been informed orally and in writing that the hysterectomy will make her permanently incapable of reproducing.

The physician who obtains the consent should share the consent form with all providers involved in that recipient’s care, (e.g., attending physician, hospital, anesthesiologist, and assistant surgeon) as each of these claims must have the valid consent form attached. To avoid a “system denial”, **the consent must be attached to any claim submission related to a hysterectomy.**

When billing for services that require a hysterectomy consent form, the name on the Medicaid file for the date of service in which the form was signed should be the same as the name signed at the time consent was obtained. If the recipient’s name is different, the provider must attach a letter from the physician’s office from which the consent was obtained. The letter should be signed by the physician and should state that the recipient’s name has changed and should include the recipient’s social security number and date of birth. This letter should be attached to all claims requiring consent upon submission for claims processing.



---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.2: INPATIENT SERVICES****PAGE(S) 14**

---

A witness signature is needed on the hysterectomy consent when the recipient meets one of the following criteria:

- Recipient is unable to sign her name and must indicate “x” on the signature line; or
- There is a diagnosis on the claim that indicates mental incapacity.

If a witness signs the consent form, the signature date **must** match the date of the recipient’s signature. If the dates do not match, or the witness does not sign and date the form, claims related to the hysterectomy will be denied.

**Exceptions**

Obtaining consent for a hysterectomy is unnecessary in the following circumstances:

- The recipient was already sterile before the hysterectomy, and the physician who performed the hysterectomy certifies in writing that the recipient was sterile at the time of the hysterectomy and states the cause of sterility;
- The recipient required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible, and the physician certifies in writing that the hysterectomy was performed under these conditions and includes in the narrative a description of the nature of the emergency; or
- The recipient was retroactively certified for Medicaid benefits, and the physician who performed the hysterectomy certifies in writing that the recipient was informed before the operation that the hysterectomy would make her permanently incapable of reproducing. In addition, if the recipient was certified retroactively for benefits, the physician must certify in writing that the hysterectomy was performed under one of the above two conditions and that the recipient was informed, in advance, of the reproductive consequences of having a hysterectomy.

The written certification from the physician **must** be attached to the hard copy of the claim in order for the claim to be considered for payment.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.2: INPATIENT SERVICES****PAGE(S) 14**

---

**Deliveries with Non-Payable Sterilizations**

Payment of an inpatient hospital claim for a delivery/C-section is allowed when a non-payable sterilization is performed during the same hospital stay.

**NOTE:** A sterilization procedure is considered non-payable if the sterilization consent form is either missing or invalid.

When there is no valid sterilization form obtained, the procedure code for the sterilization and the diagnosis code associated with the sterilization should not be reported on the claim form, and charges related to the sterilization process should not be included on the claim form. In these cases, providers will continue to receive their per diem for covered charges. Claims for the covered charges will not require any prior or post-authorization (other than precertification) and may be billed via electronic media claims (EMC) or on paper.

**Long-Acting Reversible Contraceptives**

Additional payment is allowed for the insertion of long-acting reversible contraceptives (LARCs) for women newly post-partum prior to discharge. The payment for the LARC is equal to the fee on the Durable Medical Equipment (DME) fee schedule in addition to the hospital's per diem payment. Providers should consult the DME fee schedule for covered LARCs are covered and their reimbursement.

Hospitals should bill the LARC claim using the appropriate J code to the FI on a CMS 1500 claim form. If the hospital bills electronically, the 837P must be used with the DME file extension. If the hospital bills a paper claim, the paper claim must be submitted with the word "DME" written in bold, black print on the top of the form.

**Other Inpatient Services****Blood**

The Medicaid Program will pay for all necessary blood while the recipient is hospitalized if other provisions to obtain blood cannot be made. However, every effort must be made to have the blood replaced.

**NOTE:** See section 25.8 for specific information for billing blood.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.2: INPATIENT SERVICES**

**Hospital-Based Ambulance Services**

If a recipient is transported to a hospital by a hospital-based ambulance (ground or air) and is admitted, the ambulance charges may be covered and are to be billed as part of inpatient services.

Air ambulance services are not covered unless the recipient is transported to the facility which owns the ambulance.

**NOTE:** Refer to section 25.8 for specific billing.

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

**Mother/Newborn/Nursery**

Louisiana Medicaid requires that all Mother/Newborn claims be submitted separately. The National UB Manual contains information for specific type and source of admit codes when billing newborn claims.

A separate claim for the newborn must include only nursery and ancillary charges for the baby. The mother's precertification number is not required on this claim. The newborn claim will zero pay and receive an EOB code of 519.

**NOTE:** Refer to the fee schedule for the required billing procedures for newborn infant and mother (see Appendix B for fee schedule information).

**Inpatient Hospital Definition of Discharge**

An inpatient or outpatient is considered to be discharged from the hospital and paid under the prospective payment system (PPS) when:

- The recipient is formally discharged from the hospital; or
- The recipient dies in the hospital

**NOTE:** See other discharge criteria below.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.2: INPATIENT SERVICES****PAGE(S) 14**

---

Non-medically necessary circumstances are not considered in determining the discharge time; therefore, hospitals will not be reimbursed under these circumstances (e.g., recipient does not have a ride home, does not want to leave, etc.).

If non-medical circumstances arise and the recipient does not leave the hospital when he/she is discharged and the hospital is not reimbursed, the recipient may be billed but only after hospital personnel have informed him/her that Medicaid will not cover that portion of the stay.

**Discharge and Readmit on the Same Day**

When a recipient is discharged and **readmitted to the same hospital** on the same day, the pre-administration certification length of stay process as described in Section 25.5 is applicable.

If the recipient is **readmitted to a different hospital** than the discharging hospital, the readmitting hospital should enter the name of the discharging hospital, as well as the discharge date, in the appropriate field on the UB-04 claim form.

**Direct Transfers**

When recipients must be transferred from one hospital to another including a transfer from an acute care unit to a distinct part psychiatric unit in the same hospital, for additional medical care, the pre-admission certification and length of stay assignment below must be followed.

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

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

**Date of Discharge or Death**

The date of discharge or the date of death for an inpatient hospital stay is not reimbursed unless the date of discharge/death is the same date as the date of admission.

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.2: INPATIENT SERVICES**

**Out-of-State Acute Care Hospitals**

**Psychiatric and Substance Abuse**

Inpatient psychiatric or substance abuse treatment in out-of-state hospitals are covered for a maximum of two days in the case of a medical emergency. Outpatient psychiatric or substance abuse treatment is not covered.

**Trade Area**

In-state acute care provider resources must be utilized prior to referring a recipient to out-of-state providers. Acute care out-of state providers in “trade areas” are treated the same as in-state providers. Trade areas are defined as being counties located in Mississippi, Arkansas and Texas that border the State of Louisiana. Acute care out-of state providers in the above states that are not located in counties that border Louisiana are required to obtain prior authorization for all inpatient services unless it is of an emergent nature.

A referral or transfer made by a ‘trade area’ hospital to another hospital does not constitute approval by Louisiana Medicaid unless it is to either a Louisiana hospital or another ‘trade area’ hospital. Prior authorization **is** required for all other referrals or transfers.

Below is list of counties located in the trade area:

| <b>Louisiana Trade Area</b> |                             |                       |
|-----------------------------|-----------------------------|-----------------------|
| <b>Arkansas Counties</b>    | <b>Mississippi Counties</b> | <b>Texas Counties</b> |
| Chicot County               | Hancock County              | Cass County           |
| Ashley County               | Pearl River County          | Marion County         |
| Union County                | Marion County               | Harrison County       |
| Columbia County             | Walthall County             | Panola County         |
| Lafayette County            | Pike County                 | Shelby County         |
| Miller County               | Amite County                | Sabine County         |
|                             | Wilkerson County            | Newton County         |

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.2: INPATIENT SERVICES**

| Louisiana Trade Area |                      |                  |
|----------------------|----------------------|------------------|
| Arkansas Counties    | Mississippi Counties | Texas Counties   |
|                      | Adams County         | Orange County    |
|                      | Jefferson County     | Jefferson County |
|                      | Claiborne County     |                  |
|                      | Washington County    |                  |
|                      | Issaquena County     |                  |
|                      | Warren County        |                  |

**Rehabilitation Units in Acute Care Hospitals**

Rehabilitation Units are considered part of the acute care hospital, and services are to be billed with the acute care provider number. Reimbursement rates are the same as for the acute care hospital. Separate provider numbers are not issued for rehabilitation units.

**Psychiatric Diagnosis Within an Acute Care Hospital**

When the primary diagnosis on the pre-certification file is in the 290-319 or 648.30-648.44 payment will be on the psychiatric per diem and not the long-term or acute care rate.

**NOTE:** Refer to Appendix B for website addresses and contacts mentioned in this section.

<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/Hosp/Hosp.pdf>

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

**OUTPATIENT SERVICES**

Outpatient hospital services are defined as diagnostic and therapeutic services rendered under the direction of a physician or dentist to an outpatient in an enrolled, licensed and certified hospital. The hospital must also be Medicare certified. Covered outpatient hospital services provided to Medicaid recipients are reimbursable.

Included in this section are general guidelines pertaining to Medicaid coverage of outpatient services.

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

The following requirements apply:

- All outpatient services except outpatient therapy performed within 24 hours of an inpatient admission shall be included on the inpatient claim.
- All outpatient services except outpatient therapy performed within 24 hours before an inpatient admission and 24 hours after the discharge shall be included on the inpatient claim. This includes outpatient services that are either related or unrelated to the inpatient stay.
- If an inpatient in one hospital has outpatient services performed at another hospital, the inpatient hospital is responsible for reimbursing the hospital providing the outpatient services. The inpatient hospital may reflect the outpatient charges on its claim.

If a recipient is treated in the emergency room and requires surgery which cannot be performed for several hours because arrangements need to be made, the services may be billed as outpatient provided that the recipient is not admitted as an inpatient.

Physicians responsible for a recipient's care at the hospital are responsible for deciding whether the recipient should be admitted as an inpatient. Physicians should use a 24 hour period as a

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

benchmark, i.e., they should order admission for recipients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors. Admissions of particular recipients are not covered or non-covered solely on the basis of the length of time the recipient actually spends in the hospital.

Medicaid will reimburse up to 30 medically necessary hours for a recipient to be in an outpatient status. This time frame is for the physician to observe the recipient and to determine the need for further treatment, admission to an inpatient status or for discharge. If the recipient is admitted as an inpatient, the admit date will go back to the beginning of the outpatient services.

**NOTE:** Outpatient ambulatory surgery and other applicable revenue codes associated with the surgery may now be billed as outpatient regardless of the duration of the outpatient stay.

**Therapeutic and Diagnostic Services**

All outpatient services, including, but not limited to, therapeutic and diagnostic radiology services, chemotherapy, end stage renal disease (ESRD) (formerly referred to as hemodialysis), and laboratory services, are subject to nationally mandated code editing limits. These services must be medically necessary as substantiated by the recipient's medical records.

**Radiology Utilization Management**

Radiology utilization management (RUM) establishes provisions requiring prior authorization (PA) for certain outpatient high-tech imaging. PA is based on best evidence medical practices as developed and evaluated by board certified physician reviewers, including board-certified radiologists and additional physical specialists who will assist in the claim evaluation process.

This program became effective February 15, 2010. The program excludes recipients who are:

- Family Planning Waivers recipients
- Dual eligible (Medicaid secondary to Medicare)
- PACE recipients



---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

- LaCHIP Affordable Plan recipients
- Native American recipients
- Third party liability recipients (Medicaid secondary to any other insurance)

The program will include recipients not otherwise excluded above.

Services requiring PA are noted on the Medicaid fee schedule and shall include, but are not limited to the following radiology service groups:

- Magnetic resonance (MRI, MRA, MRS);
- Computerized tomography (CT/CTA); and
- Nuclear cardiac imaging.

Prior authorization applies to high tech imaging studies that are:

- Outpatient
- Elective/Non-emergent
- Outpatient Urgent/Emergent Studies (retrospective review required)

The CPT codes that require PA can be located on the Louisiana Medicaid website (see Appendix B for web site address). Reimbursement for these services is contingent upon PA.

Authorizations for Louisiana Medicaid are good for 60 days from the date issued. The authorization number must be submitted on the claim.

Prior authorization does not apply to high tech imaging studies that are:

- Performed in an emergency room as part of an ER visit.
- Performed while in 23 hour observation.
- Performed when the recipient is an inpatient in an inpatient hospital.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

**Special Circumstances**

Changes can be made to an approved study. The providers or requesting physicians are allowed to request a facility change, down code a study, add a study and up code a study. If there is a request to add a study to an existing authorization or up code a study then medical necessity applies and each request will be reviewed for medical necessity.

Outpatient Urgent/Emergent studies should not be delayed by the PA. Providers should provide the necessary care. These cases require retrospective review. Providers are required to contact Med Solutions, Incorporated (MSI) within 30 days of the study to provide notification and clinical information. MSI will conduct a retrospective medical review. The study must meet urgent criteria and be medically necessary. Claims should not be submitted until authorization is granted.

**Denials**

If a coverage denial is issued an MSI representative will attempt to call the ordering physician's office to communicate the denial determination. A fax determination is also sent to the ordering physician. If the physician is available, MSI will communicate via telephone the rationale for the denial and the ordering physician will be given an opportunity for a peer review. The peer-to-peer review process is available to the ordering physician for three days after the denial is issued. If peer review is requested, MSI will schedule the review at a time convenient to the ordering physician. The ordering physician will discuss the case with one of MSI's physician reviewers. Written notification of the final determination is faxed to the ordering physician, mailed to the requested facility and to the recipient.

Ordering providers are allowed to start a new case in situations where the initial request is denied due to insufficient information/documentation or if the peer-to-peer conference could not be arranged within the allotted three day time period.

If a procedure delegated to the RUM program is denied then any associated charges related to that procedure are not payable by Louisiana Medicaid. Any and all associated charges are subject to post payment review by Program Integrity.

**Emergency Room Services**

Louisiana Medicaid is not obligated to pay for non-emergency (routine) care provided in the emergency room, unless the person has presenting symptoms of sufficient severity (including severe

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

- Placing the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy
- Serious impairment of bodily function
- Serious dysfunction of any organ or body part

Hospitals are required by EMTALA (Emergency Medical Treatment and Labor Act) to perform a Medical Screening Exam (MSE) on all persons who present to the emergency room for services. If the MSE does not reveal the existence of an emergency medical condition, the recipient should be advised that Medicaid does not cover routine/non-emergent care provided in the emergency room when the presenting symptoms do not meet the prudent layperson standard of an emergency condition and that he/she may receive a bill if they are treated in the emergency room. The enrollee should be referred back to his/her primary care physician (PCP) for follow-up and evaluation.

Providers must bill revenue code 450 or 459 when submitting claims for outpatient emergency room services, along with the appropriate HCPCS code. Only one revenue code 450 or 459 may be used per emergency room visit. Claims for emergency room services are not to be billed as a single line item. Claims must include all revenue codes (i.e., pharmacy, lab, x-rays and supplies) which were utilized in the recipient's treatment, using the appropriate revenue code and HCPCS where applicable.

When an emergency visit results in an inpatient admit, providers must bill all charges associated with the emergency visit on the inpatient bill. This policy applies to recipients admitted from the ER or if the recipient has been seen in the ER within 24 hours either prior to admit or after the inpatient discharge. The ER charges must be billed as a separate line. All associated charges for the emergency visit must be included by revenue code with the total charges for the inpatient stay.

**Hospital-Based Ambulances (Air or Ground)**

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

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

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

Non-emergency transport by a hospital-based ambulance is not covered. Claims for hospital-based ambulance services must be filed on the UB-04 as outpatient services under the hospital provider number. However, if the recipient is admitted to the hospital, the services must be billed on the UB-04 as part of the inpatient services, as the reimbursement for the services will be included in the per diem rate.

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

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

### **Hospital Laboratory Services**

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

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

### **Hyperbaric Oxygen Therapy**

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

- Acute carbon monoxide intoxication
- Decompression illness

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

- Gas embolism
- Gas gangrene
- Acute traumatic peripheral ischemia
- Crush injuries and suturing of severed limbs
- Progressive necrotizing infections
- Acute peripheral arterial insufficiency
- Preparation and preservation of compromised skin grafts
- Chronic refractory osteomyelitis
- Osteoradionecrosis
- Soft tissue radionecrosis
- Cyanide poisoning
- Actinomycosis
- Diabetic wounds of the lower extremities in recipients who meet the following three criteria:
  - Recipient has type 1 or 2 diabetes and has a lower extremity wound that is due to diabetes;
  - Recipient has a wound classified as Wagner grade 111 or higher; and
  - Recipient has failed an adequate course of standard wound therapy.

**NOTE:** This list may not be all-inclusive.

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.3: OUTPATIENT SERVICES**

The covered diagnosis should be entered as the primary diagnosis for hyperbaric oxygen therapy claims. These claims will be reviewed by the Medical Director and/or other physicians in the fiscal intermediary’s (FI) Medical Review Unit.

Requests for approval for hyperbaric oxygen therapy for other diagnoses must be submitted to the FI Medical Review Unit.

**Outpatient Rehabilitation Services**

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

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

**Cardiac and Pulmonary/Respiratory therapy are not covered under Louisiana Medicaid. These services should not be prior authorized or billed using covered rehabilitation codes.** Hospitals are reimbursed based on covered HCPCS for outpatient rehabilitation services including speech, occupational and physical therapies at a flat fee for service which is not cost settled (with the exception of designated small rural hospitals).

**Initial therapy and extended therapy plans require PA.** Evaluation codes do not require PA, but are limited to one evaluation per 180 days.

| Description                           | HCPC  |
|---------------------------------------|-------|
| Speech/Language Evaluation            | 92506 |
| Hearing Evaluation                    | 92506 |
| Speech/Lang/Hear Therapy – per 15 min | 92507 |
| Physical Therapy Evaluation           | 97001 |

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.3: OUTPATIENT SERVICES**

| <b>Description</b>                | <b>HCPC</b> |
|-----------------------------------|-------------|
| Physical therapy – per 15 min     | 97110       |
| Occupational Therapy Evaluation   | 97003       |
| Occupational Therapy – per 15 min | 97530       |

Initial requests must include a physician’s referral or prescription, a therapist’s evaluation/plan of service, the completed Request for Prior Authorization (PA-01), and Rehabilitation Services Request (PA-02) forms. Requests should be submitted within the first week of therapy. In instances where delay of therapy would result in deterioration of a medical condition (i.e., burn cases, accidents or surgery) the authorization may be obtained later.

Extension requests should be submitted at least 25 days prior to the end of the approved period. This request must include both PA-01 and PA-02 forms along with progress reports from the prior period. Authorizations may be approved for up to one year for recipients under the age of 21 and for up to six months for recipients 21 and over.

When a recipient is being discharged from an inpatient acute care stay and requires outpatient rehab services immediately, a PA request should be submitted using the recipient’s anticipated discharge date as the beginning date of service.

Physician recommended durable medical equipment (DME) must be approved by the Prior Authorization Unit (PAU) whether provided by a hospital or an independent DME provider.

Initial and extension requests must also be submitted to the PAU for approval.

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

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

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

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

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

**Outpatient Surgery**

Certain surgical procedures usually are covered by the Medicaid Program if they are performed as outpatient services. Reimbursement to hospitals for the performance of these outpatient surgical procedures is made on a flat-fee per service basis.

Hospitals must bill all outpatient surgery charges for the specified surgeries using revenue code "490" – Ambulatory Surgery Care. All other charges associated with the surgery (for example, observation, labs, radiology) must be billed on the same claim form as the Ambulatory surgery charges. The only revenue code that will be paid will be the flat rate fee for the Ambulatory Surgery. The current payment rate for groupings can be found on the Louisiana Medicaid web site. The most appropriate CPT/HCPCS code for the surgical procedure must be entered in Form Locator 44 on the UB-04 claim form. Only one CPT/HCPCS code may be entered in the field. A list of the surgical procedures is provided on the Louisiana Medicaid web site (see appendix B). These same surgical procedures may be performed on an inpatient basis and must be prior authorized if performed on the first or second day of the inpatient stay when medically necessary. Refer to 25.5, Pre-certification and Admission section for further information.

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

**Operating Room Services-Minor Surgery** (HR361) is now payable for billing minor surgeries that are medically necessary to be performed in the operating room but the associated CPT code is not included in the ambulatory surgery listing.

Ambulatory surgery and other applicable revenue codes associated with the surgery may now be billed as outpatient regardless of the duration of the outpatient stay.

**Intraocular Lens Implants**

Intraocular lens (IOL) may be billed separately by the hospital if the hospital provides the device. Only one provider may bill for the IOL. Payment for the IOL is a flat fee-for-service.



---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

Medicaid will pay for IOLs implanted during or subsequent to cataract extraction surgery performed on an outpatient basis. Lenses will be covered under the DME program but will not require PA as for other DME. When billing on an outpatient basis, claims must be submitted on the CMS-1500 by the provider who actually supplies the lens.

Providers are required to submit separate claim forms for the surgery and for the lens. The claim form for the lens **must** be submitted to a different post office box in order to be processed correctly. Failure to follow this procedure will result in denied claims. The initials “**DME**” should be written in **bold** letters on the very top of the claim form. The address to file DME claims can be found in Appendix B.

Refer to the DME manual for procedure codes and place of service codes that should be used. These procedure codes must be in conjunction with an ICD-9 CM diagnosis code for cataracts.

**NOTE:** If billing as an inpatient, the charges for the lens must be included on the inpatient claim form (UB-04). The claim will be denied on an inpatient basis unless the stay has been approved through a length of stay determination.

**Observation Room Charges**

When applicable, hospitals should bill for treatment or observation room charges with the appropriate covered revenue codes. The entire outpatient visit, including observation, may not exceed 30 hours duration.

When billing for these services, hospitals must include the admission hour and discharge hour in addition to the other required items on the outpatient hospital claim.

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

**Outpatient Hospital Clinic Services**

The payable revenue codes are 510, 514, 515, 517, and 519. These revenue codes must be billed with the appropriate accompanying CPT codes of 99201, 99202, 99203, 99204, 99205, 99211, 99213, 99214, and 99215.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

**Diabetes Self-Management Training**

Diabetes self-management training (DSMT) is a collaborative process through which recipients with diabetes gain knowledge and skills needed to modify behavior and successfully manage the disease and its related conditions. DSMT programs, at a minimum, must include the following:

- Instructions for blood glucose self-monitoring,
- Education regarding diet and exercise,
- Individualized insulin treatment plan (for insulin dependent recipients), and
- Encouragement and support for use of self-management skills.

DSMT programs should be aimed at educating recipients on the following topics to promote successful self-management:

- Diabetes overview, including current treatment options and disease process,
- Diet and nutritional needs,
- Increasing activity and exercise,
- Medication management, including instructions for self-administering injectable medications (as applicable),
- Management of hyperglycemia and hypoglycemia,
- Blood glucose monitoring and utilizations of results,
- Prevention, detection, and treatment of acute and chronic complications associated with diabetes (including discussions on foot care, skin care, etc.),
- Reducing risk factors, incorporating new behaviors into daily life, and setting goals to promote successful outcomes,
- Importance of preconception care and management during pregnancy,

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

- Managing stress regarding adjustments being made in daily life, and
- Importance of family and social support.

All educational material must be pertinent and age appropriate for each recipient. Recipients under the age of 18 must be accompanied by a parent or legal guardian. Claims for these services shall be submitted under the child's Medicaid number.

**Provider Qualifications**

Providers of DSMT services must be:

- Enrolled as a Louisiana Medicaid provider,
- Employed by an enrolled Louisiana Medicaid provider, or
- Contracted to provide services by an enrolled Louisiana Medicaid provider.

Providers must be enrolled as a Louisiana Medicaid provider through the Professional Services (Physician Directed Services), Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), or Outpatient Hospital programs and must meet all of the required criteria. **DSMT is not a separately recognized provider type**; therefore, Louisiana Medicaid will not enroll a person or entity for the sole purpose of performing DSMT.

**Accreditation**

DSMT programs must be accredited as meeting quality standards by a national accreditation organization. Louisiana Medicaid recognizes the following as approved accreditation organizations:

- American Diabetes Association (ADA),
- American Association of Diabetes Educators (AADE), and
- Indian Health Service (IHS).

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

Services provided by a program without accreditation by one of the listed organizations are **not covered**. Providers must maintain and provide proof of accreditation, as requested by the Louisiana Medicaid or its fiscal intermediary.

At a minimum, the instructional team must consist of a registered dietician, a registered nurse, or a pharmacist. Each member of the instructional team must be a certified diabetes educator (CDE) or have recent didactic and experiential preparation in education and diabetes management, and at least one member of the instructional team must be a CDE who has been certified by the National Certification Board for Diabetes Educators (NCBDE). Providers must maintain and provide proof of certification, as requested, for staff members.

**All enrolled Diabetes Self-Management Programs must adhere to the National Standards for Diabetes Self-Management Education.**

**Coverage Requirements**

Louisiana Medicaid provides coverage of DSMT for eligible Medicaid recipients who have a written order from their primary care provider, and have been diagnosed with Type I, Type II, or gestational diabetes.

The ordering provider is required to maintain a copy of all DSMT orders. Each written order must be signed and must specify the total number of hours being ordered, not to exceed the below coverage limitations:

- A **maximum** of 10 hours of initial training (one hour of individual and nine hours of group sessions) are allowed during the first 12 month period beginning with the initial training date.
- A **maximum** of two hours of individual sessions are allowed for each subsequent year.

If special circumstances occur in which the ordering provider determines a recipient would benefit from individual sessions rather than group sessions, the order must also include a statement specifying that individual sessions would be more appropriate, along with an explanation.

If a DSMT order must be modified, the updated order must be signed by the primary care provider and copies must be retained in the medical record.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

Recipients enrolled in Bayou Health will receive DSMT through their health plan.

**Medicaid Recipients Not Eligible for DSMT**

The following recipients are not eligible for DSMT:

- Recipients residing in an inpatient hospital or other institutional setting such as a nursing care facility, or a residential care facility, or
- Recipients receiving hospice services.
- Recipients enrolled in a Bayou Health Plan.

**Initial DSMT**

Initial DSMT training may begin after receiving the initial order date and is allowed for a continuous 12 month period, following the initial training date. In order for services to be considered initial, the recipient must not have previously received initial or follow up DSMT training.

The 10 hours of initial training may be provided in any combination of 30 minute increments over the 12 month period. Louisiana Medicaid does not reimburse for sessions that last less than 30 minutes.

Group sessions may be provided in any combination of 30 minute increments. Sessions that are less than 30 minutes are not covered. Each group session shall contain between 2-20 recipients.

**Follow-Up DSMT**

After receiving the initial training, a recipient is eligible to receive a maximum of two hours of follow-up training each year, if ordered by their primary care provider.

Follow-up training is based on a **12 month calendar year following completion of initial training**. If a recipient completes 10 hours of initial training, the recipient would be eligible for two hours of follow-up training for the next **calendar year**. If all 10 hours of initial training are

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

not used within the first calendar year, then the recipient has 12 months to complete the initial training prior to follow up training.

- Example #1:

If a recipient receives his first training in April 2011 and completes the initial 10 hours by April 2012, the recipient would be eligible for two hours of subsequent training beginning May 2012, since that would be the 13<sup>th</sup> month. If the recipient completes the two hours of subsequent training in November 2012, then he is not eligible for additional training until January 2013.

- Example #2:

If a recipient receives his first training in February 2011 and exhausts all 10 hours of initial training by November 2011, the recipient would be eligible for two hours of subsequent training beginning January 2012. If the recipient completes the two subsequent hours of training by May 2012, then he is not eligible for additional training until January 2013.

Providers are encouraged to communicate with recipients to determine if the recipient has previously received DSMT services or has exhausted the maximum hours of DSMT services for the given year.

Louisiana Medicaid will **only** cover up to 10 hours of initial training (for the first 12 months) and two hours of follow-up training (for each subsequent year) regardless of who provides the service.

**Provider Responsibilities**

Providers must assure the following conditions are met in order to receive reimbursement for DSMT services:

- **The recipient meets one of the following requirements:**
  - Is a newly diagnosed diabetic, gestational diabetic, pregnant with a history of diabetes, or has received no previous diabetes education,
  - Demonstrates poor glycemic control (A1c>7),

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

- Has documentation of acute episode of severe hypoglycemia or hyperglycemia occurring in the past 12 months, or
- Has received a diagnosis of a complication, a diagnosis of a co-morbidity, or prescription for new equipment such as an insulin pump.
- **The provider maintains the following documentation requirements:**
  - A copy of the order for DSMT from the recipient's primary care provider,
  - A comprehensive plan of care documented in the medical record,
  - Start and stop time of services,
  - Clinical notes, documenting recipient progress,
  - Original and ongoing pertinent lab work,
  - Individual education plan,
  - Assessment of the individual education needs,
  - Evaluation of achievement of self-management goals,
  - Proof of correspondence with ordering provider regarding recipient progress, and
  - All other pertinent documentation.

Recipient records, facility accreditation, and proof of staff licensure, certification, and educational requirements must be kept readily available to be furnished, as requested, to the DHH, its authorized representatives, or the state's Attorney General's Medicaid Fraud Control Unit.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.3: OUTPATIENT SERVICES****PAGE(S) 19**

---

**Reimbursement**

Reimbursement for DSMT services is a flat fee based on the fee schedule established by the Bureau of Health Services Financing Professional Services Program minus the amount which any third party coverage would pay. The following HCPCS codes should be billed for DSMT services:

- G0108-Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109- Diabetes self-management training services, group session (two or more) per 30 minutes

**NOTE:** Services provided to pregnant women with diabetes must be billed with the TH modifier.

Hospitals would bill the above HCPCS codes in the outpatient setting along with Revenue code 942. These would be the only HCPCS codes allowed to be billed with HR942.

Outpatient hospitals will be reimbursed a flat fee for these services. The flat fee is posted on the fee schedule.

**Trade Area**

In-state acute care provider resources must be utilized prior to referring a recipient to out-of-state providers. Acute care out-of state providers in “trade areas” are treated the same as in-state providers. Trade areas are defined as being counties located in Mississippi, Arkansas and Texas that border the State of Louisiana. Acute care out-of state providers in the above states that are not located in counties that border Louisiana are required to obtain prior authorization for all outpatient services unless it is of an emergent nature.

A referral or transfer made by a ‘trade area’ hospital to another hospital does not constitute approval by Louisiana Medicaid unless it is to either a Louisiana hospital or another ‘trade area’ hospital. Prior authorization **is** required for all other referrals or transfers.



**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.3: OUTPATIENT SERVICES**

Below is list of counties located in the trade area:

| <b>Louisiana Trade Area</b> |                             |                       |
|-----------------------------|-----------------------------|-----------------------|
| <b>Arkansas Counties</b>    | <b>Mississippi Counties</b> | <b>Texas Counties</b> |
| Chicot County               | Hancock County              | Cass County           |
| Ashley County               | Pearl River County          | Marion County         |
| Union County                | Marion County               | Harrison County       |
| Columbia County             | Walthall County             | Panola County         |
| Lafayette County            | Pike County                 | Shelby County         |
| Miller County               | Amite County                | Sabine County         |
|                             | Wilkerson County            | Newton County         |
|                             | Adams County                | Orange County         |
|                             | Jefferson County            | Jefferson County      |
|                             | Claiborne County            |                       |
|                             | Washington County           |                       |
|                             | Issaquena County            |                       |
|                             | Warren County               |                       |

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.4: HOSPITAL-BASED PHYSICIANS****PAGE(S) 1**

---

**HOSPITAL-BASED PHYSICIANS**

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

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

**Enrollment of Hospital-Based Physicians**

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

The hospital must complete a provider enrollment form to obtain the hospital's group physician number. Refer to the Louisiana Medicaid website for enrollment information.

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

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

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

**PRE-CERTIFICATION AND ADMISSION**

The Louisiana Medicaid Program has performed hospital inpatient pre-certification reviews since 1994. This review process helps to control and monitor inpatient admissions, length of stay (LOS) and program expenditures and is an important adjunct to the hospital prospective payment methodology used by the Department of Health and Hospitals (DHH). The pre-certification and length of stay review/assignment impacts acute-care hospitals, rehabilitation facilities, private distinct-part psychiatric facilities, free-standing psychiatric hospitals and long-term acute care (LTAC) hospitals.

The major functions/procedures of the Hospital Pre-Certification/Length of Stay process are:

- Registration and LOS assignment for all acute care and rehabilitation hospitals admissions.
- Pre-admission certification and LOS assignment for admissions to long term acute care hospitals, private distinct part psychiatric/substance abuse units in acute care general hospitals and free-standing psychiatric hospitals.
- Reviews are conducted by nurses and physicians. Physicians are available to discuss any denied stay with the hospital designated physician.
- Hospitals submit all requests, including required forms and limited documentation when requested, via fax to the fiscal intermediary (FI). The **web** application e-pre-cert can be used for submission of **initial** acute care requests only or for **updating** an existing authorization.
- Hospitals are notified by written notification of approval, rejection and denial of requests. Hospitals can also obtain a copy of the pre-certification letter by accessing the Pre-Cert Inquiry application via the Louisiana Medicaid website.
- A reconsideration process is available for denied requests as well as a formal appeal process through DHH.
- Timely updating of clinical criteria and length of stay data bases occurs annually.
- Medical documentation submitted by the provider on required forms is utilized when the FI's pre-cert reviewer inputs data into the system to make a decision.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

- All initial requests are assigned a designated pre-certification case number to enhance access and communication between the provider and the FI's pre-certification personnel.

The types of requests for inpatient hospital stays include:

- Acute Care: Adult and Pediatrics
- Rehabilitation
- Psychiatric/Substance Abuse
- Long-Term Acute Care

**Length of Stay**

Acute care and rehabilitation hospitals must register each Medicaid admission no later than one business day after admission. *Length of stay (LOS)* for each acute care/rehabilitation case will be determined by the FI using department specified criteria including Southern Region grand totals, customized criteria, and clinical information for the case provided by the hospital. The initial length of stay for acute care and psychiatric admissions will be assigned at the 50<sup>th</sup> percentile of Thomson Reuters Southern Region averages based on the admitting diagnosis. The initial length of stay for rehabilitation will be assigned 14 days based on the lowest average length of stay from the American Hospital Association Average Study for Rehabilitation conditions.

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

**Admissions**

Medicaid hospital admission/LOS reviews will reference current InterQual Adult and Pediatric intensity severity discharge (ISD) criteria sets (edition currently used by the Louisiana Medicaid program), current InterQual Procedures Guidelines, current Thomson Reuters LOS (grand total percentages based upon the admitting diagnosis) Southern Region data and customized criteria. Reviews will be conducted by the FI nurses and physicians. The FI review staff will be divided into specialty groups representing those services requiring pre-admission certification and LOS assignment.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

**Acute Care Adult or Pediatric Hospital Stays/Admissions Process**

Acute Care admissions include the following levels of care: General, Burn, ICU, PICU, CCU and NICU (additional information on NICU and low-birth weight babies is in **Pre-certification for NICU Levels of Care** (see Pre-certification for NICU Levels of Care later in this section).

Initial requests whether approved, rejected or denied are assigned a pre-certification case number.

Medicaid recipients should be registered for admission by completing the Form PCF01 and faxing to the FI. No requests prior to the admission date are accepted for acute care facilities.

All initial admission requests must be submitted within 24 hours of admit except for weekends or the FI holidays. In these instances, submit the next business day.

Approved, denied, or rejected case decisions will be faxed to the facility within the required 24 hours from the date and time of receipt in pre-cert.

The hospital should only register a recipient and submit a PCF01 **if** there is medical necessity present for an inpatient admission, **if** the case meets InterQual Criteria and **if** there is a physician order for inpatient status.

Initial LOS for acute care is assigned according to the current Thomson-Reuters Recommended LOS Southern Region average. The assignment will be set at age appropriate. All Stays of the 50th percentile of the ICD-9 primary and/or admitting diagnosis code submitted.

**Adult or Pediatric Extension Process**

Acute care extensions include the following levels of care: General, Burn, ICU, PICU, CCU and NICU (additional information on NICU and low-birth weight babies is in **Pre-certification for NICU Levels of Care**).

Request for an extension must be submitted via fax no later than the expected discharge date. If the discharge date is a weekend or FI holiday, the extension request may be submitted on the next business day. The “expected discharge date” is shown on the provider notification received after each approved request.

Forms PCF01 and PCF02 must be submitted for each acute care extension request. There are to be no attachments to the PCF02 unless requested by the nurse reviewer with a limit of no more than two additional pages of documentation. All pertinent information must be included on the form itself or on the accepted forms by the Provider Link system.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

Extension LOS requests will be reviewed by a nurse to determine if the stay meets InterQual® criteria based on the recipient information submitted on the Form PCF02 for the appropriate Level of Care.

Extension LOS for acute care is assigned according to the current Thomson-Reuters recommended LOS Southern Region average. The first extension assignment will be set at the age appropriate ALL stays up to the 75th percentile of the ICD-9 diagnosis code submitted. Subsequent extensions will be assigned a LOS up to five days for a general level of care and up to seven days for the named levels of care. All approvals are based on criteria being met.

Approved, denied, or rejected case decisions will be faxed to the facility within the required 24 hours from the date and time of receipt in pre-cert.

For infants or children who move to a more intensive level of care, the nurse reviewer will use **both** Severity of Illness **and** Intensity of Service criteria reviews to determine if the stay meets criteria for NICU or PICU.

If an Intensity of Service criterion has limitations on appropriateness of hospitalization based on the specific criteria used then the nurse reviewer will shorten the approved number of days accordingly.

**Rejections of Acute Care Pre-Certification Requests**

All initial pre-cert requests that are rejected (no assignment of stay given) should be returned to pre-cert as an **Initial Resubmittal**. The PCF01 must be used for the **resubmittal request**. The resubmitted PCF01 must include the case number assigned on the initial pre-cert request and must be returned to pre-cert within 48 hours (two business days) from the date faxed from pre-cert. Exceeding 48 hours (two business days) will result in a denial for timeliness.

All extension requests that are rejected should be returned to pre-cert on a PCF02 as a **resubmittal**. The **resubmittal** should be returned to pre-cert within 48 hours (two business days) from the date faxed from pre-cert. Exceeding 48 hours (two business days) will result in a denial for timeliness.

**Denials of Acute Care Pre-certification Requests**

Only a physician can issue medical necessity denials. InterQual criteria are used by the registered nurse to determine approval of all LOS extension requests.

If submitted documentation does not meet current InterQual criteria, the request is sent for a physician review. A denial is issued when the physician determines (based on submitted documentation) that medical necessity for the requested length of stay is not supported.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

The hospital provider has three options following a denial as listed below:

- Submit written reconsideration. Must be submitted the next business day following the denial.
- Request a scheduled physician to physician telephone conference.
- Submit to Division of Administrative (DOA) Law for appeal through the Administrative Court. The provider must schedule the appeal within 30 days of the first denial date.

A written **reconsideration** is submitted to pre-cert within one business day of the denial notification faxed by the FI. For denial of an initial admission, the PCF01 must be used for the reconsideration request and must include the case number assigned on the initial pre-certification request. For denial after an extension request, the PCF02 must be used for the reconsideration request.

The previously submitted documentation did not meet current InterQual criteria, thus it was denied. The provider should send documentation that does show InterQual criteria is met for the denied days.

The reconsideration documentation will be reviewed by a pre-cert physician. If an InterQual criterion is met; a LOS will be approved. The provider will then submit routine extension requests if the recipient remains inpatient. If InterQual is not met, the reconsideration will be denied.

Following a denial of a reconsideration request, the provider has two remaining options:

- Schedule physician to physician conference through the FI's Pre-certification Department.
- Submit to Division of Administrative (DOA) Law for appeal through the Administrative Court. The provider must schedule the within 30 days of the first denial date.

The physician to physician conference is an opportunity for the facility physician to discuss a denied case with a pre-cert physician. The hospital may "designate" a physician from their facility to participate in the conference.

The hospital will contact the telephone representative in pre-cert. The pre-cert representative will fax to the hospital, a schedule of conference date and time availability. The hospital will contact

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

their physician for his/her availability. The hospital will then contact the pre-cert telephone representative to set up the conference day and time based on the availability of the participating physicians.

The hospital contact person will be given specific instructions for what documentation will need to be sent to pre-cert and the deadline date for submitting that documentation. Documentation not faxed to pre-cert within the required time frame for pre-cert physician review, will not be accepted and the conference will be cancelled.

The Department allows a hospital up to two appointment cancellations per pre-cert denied case. If the conference is cancelled after two appointments, the hospital will need to submit an appeal for further action on the denial.

**Outpatient Status vs. Inpatient Status**

Physicians responsible for a recipient's care at the hospital are responsible for deciding whether the recipient should be admitted as an inpatient. Place of treatment should be based on medical necessity.

Medicaid will allow up to 30 hours for a recipient to be in an outpatient status. This time frame is for the physician to observe the patient and to determine the need for further treatment, admission to an inpatient status or for discharge. (Exception: Outpatient Ambulatory Surgeries).

The hospital should **ONLY** register a recipient and submit a PCF01 if there is **MEDICAL NECESSITY** present for an inpatient admission, if the case meets InterQual criteria and if there is a physician order for inpatient status. All claims submitted are subject to post payment review by Program Integrity.

**Outpatient Status Changing to Inpatient Status**

If the physician converts the recipient from an outpatient to an inpatient status, a PCF01 must be submitted within 24 hours of the admit order (next business day). When the inpatient order is written on a weekend or holiday, the PCF01 must be submitted the next business day after the inpatient order is written.

The physician must write the order to admit within 30 hours of the recipient being registered as an outpatient.

If the situation is where the recipient is an outpatient on hospital day one and converts to inpatient after hours on hospital day two, the PCF01 must be submitted the next business day. The hospital should indicate on the PCF01 by the admit date that hospital day one was an



---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

outpatient day. This will prevent denials for timely submission. The outpatient “admit day” becomes the inpatient “admit day” for this type of case.

**Case Example:** A recipient is referred to the hospital on 9/1 at 10:00am from the doctor’s office with chest pain. Orders are to admit in an outpatient status and observe on a telemetry unit (EKG monitoring, cardiac enzymes q8hrs x3 sets). At 1:00 pm on 9/2 chest pain continues and enzymes are positive. The physician writes an order to convert the patient to inpatient. In this situation send a PCF01 with the admit date being 9/1.

The hospital should indicate on the PCF01 that the patient came in as outpatient via emergency room or observation on 9/1. On 9/2, physician wrote orders to admit as inpatient. Admit date on the PCF-01 is 9/1. In the above example, all services performed on 9/1 are included in the inpatient stay and billed accordingly. The provider cannot bill an outpatient claim for 9/1.

**NOTE:** The FI reserves the right to request a copy of the inpatient order.

**Outpatient Ambulatory Surgeries**

Certain surgical procedures are covered by the Medicaid Program only when performed outpatient unless otherwise authorized. A list of these procedures is provided online (see Appendix A for web site).

Outpatient surgical cases that have a physician order for outpatient statuses do not need to be pre-certified. There are no time limitations for an outpatient surgery.

**State operated hospitals** that previously requested authorization for ambulatory outpatient surgeries from the FI’s **Prior Authorization** Department will no longer do so effective 8/30/2010.

**Outpatient Procedures Performed on Day of Admission or Day after Admission**

In certain circumstances, recipients may require inpatient admission for surgical procedures normally covered by the Medicaid Program only when performed outpatient as referenced in **Outpatient Ambulatory Surgeries**.

Inpatient approval of these outpatient procedures will be granted when one or more of the following exception criteria exist:

- There is a physician order for inpatient status.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

- Documented medical conditions exist that make prolonged pre-operative and post-operative observation by a nurse or skilled medical personnel a necessity.
- Procedure is likely to be time consuming or followed by complications.
- An unrelated procedure is being performed simultaneously that requires hospitalization.
- The procedure carries high patient risk.

Hospitals must submit both Forms PCF01 and PCF02 to request pre-cert approval for outpatient surgical procedure(s) performed on an inpatient basis on the day of or the day after admission within 24 hours of the admit order (or next business day).

The PCF02 information supports the medical necessity for the procedure being performed inpatient. If the PCF01 is received without the PCF02, the request will be rejected. If the initial authorization is submitted via the e-pre-cert application then the PCF02 is not required as there is space on the electronic form to include the medical necessity information.

The outpatient “admit day” becomes the inpatient “admit day” for this type of case.

**Case example:** On 9/1 a 55 year old has an appendectomy with orders for outpatient status. He has a fever post op and stays overnight for observation. On 9/2 his fever continues and his WBC = 22.3. The physician starts IV antibiotics and writes an order to change to inpatient status. The hospital must submit a PCF01 and PCF02. The admit date will be 9/1.

In the above example, the hospital must submit the pre-cert request by 9/3 or the case will be denied for submission after allotted time.

The request will be reviewed by a nurse to determine if either InterQual® procedures criteria are met and/or InterQual admission criteria are met.

**NOTE:** We cannot approve an inpatient hospital stay for a planned outpatient surgical procedure provided on an inpatient basis for a recipient who has no medical reason to be admitted. It was never DHH’s intention to give a blanket approval for the first 24 hours on any stay where medical necessity for inpatient care is not met, or when there is no length of stay for the diagnoses code.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

**Pre-certification of Newborns****Newborn Initial Admissions**

Healthy babies born to Medicaid mothers are **not** pre-certed. They will be in the general nursery for up to 48 hours for vaginal delivery or up to 96 hours for C-section delivery.

Healthy babies, born to non-Medicaid eligible mothers **can** be pre-certed. You must submit a **completed** PCF01 with all “zeros” for the 13 digit Medicaid identification (ID) number.

In the “description” area on the PCF01 you must state “Mom not Medicaid Eligible” and include the mother’s Social Security number.

The Admit and/or Primary ICD-9 diagnosis will be submitted as follows:

- V3000 will be used for baby “delivered vaginally.”
- V3001 will be used for baby “delivered by C-section.”

If mother does not have Medicaid, the baby will be pre-approved 48 hours for V3000 (vaginal delivery) or 96 hours for V3001 (C-section).

Ill newborns (with Medicaid eligible mothers) who remain after the mother’s discharge date and are **not** admitted to NICU are pre-certed with the mother’s discharge date as the ill newborn’s admit date on form PCF-01.

The notification fax sent from the FI will note that the newborn case has been pre-approved pending eligibility since there is no Medicaid ID number. It is the hospital’s responsibility to submit an “update” to pre-cert as soon as the Medicaid ID number is obtained. The following must be included or the update request will be rejected:

- Fully completed PCF01 checked as an update.
- The PCF01 must include the 13-digit Medicaid ID number, the baby’s name **before** the Medicaid ID number was assigned, the baby’s name **now** associated with the ID number and the **provider’s signature**. The FI staff member is changing the name designation on the case and therefore must have signed authorization.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

**Newborn Extension Request**

All extension requests for additional days, past the current assignment of days, for **newborns**, and/or **NICU Level of Care (LOC)** must be submitted on a completed PCF04.

All extension requests for newborns and/or NICU level of care that are **rejected**, must be returned to pre-cert on a completed PCF04 as a **Resubmittal**.

All extension requests for newborns and/or NICU level of care that are denied must be returned to pre-cert on a completed PCF04 as **Reconsideration**.

**Pre-certification for NICU Levels of Care**

Ill newborns (with Medicaid eligible mothers) who are admitted to NICU are pre-certed with an admit date of the day that they are admitted to NICU.

The pre-cert request is submitted on a fully completed PCF01 with all zeros for the 13 digit Medicaid ID number.

Initial NICU admissions for short gestation and low birth weight (less than 2500 gms)

- The length of stay assignment will be based on revisions to the Louisiana Medicaid defined LOS.
- The Initial requests that are submitted for low birth weight or short gestation require only the PCF01 for the Initial.
- The admission ICD-9 diagnosis code should be reported as the specific low birth weight or short gestational age.
- The initial LOS will be based on the ICD-9 diagnosis codes for specific low birth weight or short gestational age.

Initial NICU admissions for other than short gestation and low birth weight

- Initial LOS for NICU is assigned referencing the ICD-9 primary and/or admitting diagnosis code submitted by the hospital, and
- Current Thomson-Reuters 50th percentile of the Southern Region and/or Louisiana customized LOS.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

- PCF01 will be required for initial admissions to NICU for diagnosis other than low birth weight/short gestation.

Extension requests for NICU for Short Gestation and Low Birth Weight (less than 2500 gms)

- Fully completed PCF04 will be required for all extension requests.
- Extension LOS assignment will be based on the Louisiana Medicaid defined Length of Stay.
- Current InterQual Intensity of Service (IS) criteria will be used for review of all extension requests for continued stay.
- The birth weight or short gestation ICD-9 diagnosis code used on the Initial admission should **always** be the first extension ICD-9 code entered in diagnosis block 1 on the PCF04 for all subsequent extension requests.
- Include additional diagnosis codes affecting intensity of service and supporting the continued stay.

Extensions Other Than Short Gestation and Low Birth Weight

- First extension assignment of stay will be based on current Thomson-Reuters up to the 75th percentile of the Southern Region and/or Louisiana customized LOS.
- Current InterQual Intensity of Service (IS) criteria will be used for the review of all extension requests for continued stay.

**Pre-certification for OB Care and Delivery**

Effective with the dates of service on or after August 30, 2010, deliveries are approved via the claims processing edit in accordance with the Newborn Protection Act when the following conditions are met:

- Three days are authorized for vaginal deliveries if the admission date is equal to the date of delivery.
- Four days are authorized for vaginal deliveries if the delivery occurs the day after admission.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

- Five days are authorized for C-Sections if the admission date is equal to the date of delivery.
- Six days are authorized for C-sections if the delivery date occurs the day after admission.

The three days approved for a vaginal delivery and four days approved for a C-section are in accordance with federal guidelines pertaining to the Newborn Protection Act. Days beyond the three and four days that are approved in via the pre-certification edit are to account for admissions or deliveries late in the evening. Any days approved via the claims processing edit that are greater than the three and four days mandated by federal guidelines may be subject to medical necessity review retrospectively. Facility specific LOS reports are generated monthly to compare delivery LOS data pre and post implementation of this policy. Medical necessity should guide the physician decision-making process related to discharge and patients should be kept in the hospital for medical necessity only.

Additional information:

- Complete PCF01 and PCF02 with clinical information supporting stays beyond these periods of time.
- The PCF02 should include clinical information supporting stays beyond the periods of time listed above.
- The PCF01 and PCF02 must be submitted on the expected discharge date. If the expected discharge date falls on a weekend or FI holiday then submit the PCF01 and PCF02 the next business day following the expected discharge date.
- If an ambulatory surgical procedure is performed on the first or second day of the inpatient stay for a delivery, pre-certification is required. Refer to the Louisiana Medicaid web site for the list of ambulatory surgical procedures, sterilization procedures are excluded from this list starting June 7, 2011. Pre-certification is no longer required if performed on the first or second day of an inpatient hospitalization.
- When billing for the sterilization/delivery all required forms **must** be attached and correctly completed.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

**Vaginal Delivery Pre-certification Example:**

If the vaginal delivery day is equal to the admission date to the hospital then the patient must discharge home by day four of the hospitalization in order to be excluded from pre-cert. If the mother does not discharge home on the fourth day of her hospitalization then the PCF01 & PCF02 must be submitted on the fourth day of hospitalization.

The fourth day is the expected discharge day. If the fourth day falls on a weekend then the PCF01 & PCF02 are due on the next business day.

**C-Section Pre-certification Example:**

If the C-Section delivery date is the day after the admission date to the hospital then the patient must discharge home by day seven of the hospitalization in order to be excluded from pre-cert. If the mother does not discharge home on day seven then pre-cert is required. Submit a PCF01 & PCF02 on day seven of the hospitalization. Day seven is the expected discharge date. If the seventh day falls on a weekend then the PCF01 & PCF02 are due on the next business day.

**Short Cervical Length Guidelines – Length in Pregnancy**

A shortened cervical length, as measured by transvaginal ultrasound, has been associated with increased risk of pre-term birth in some pregnancies. However, there is no clear published guidance on management of these pregnancies, or that intervention results in improved outcomes. Use of antenatal steroids has shown benefit in appropriately selected patients. The following protocol is suggested as a guide for selection of patients for inpatient evaluation / management. It is not intended to be a strict protocol and should be adapted as clinical conditions warrant, as provided by the patient’s provider. Patients with cervical lengths of > 25 mm (20-37 weeks gestation) are generally considered to be at low risk for preterm birth and are not considered in this management protocol.

**NOTE:** See appendix A for information regarding Cervix Guide.

**Rehabilitation Admission/Level of Care**

**Rehabilitation Admissions**

Medicaid recipients may be registered for admission by completing the Form PCF01 and faxing it to the FI. No requests prior to the admission date are accepted for acute care facilities. If the recipient is transferred from an Acute Care to Rehab within the same facility, no new case number is needed. The acute care case number must be noted on the rehab PCF01.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

Rehabilitation initial requests require a Form PCF01 and current DHH established criteria that will be reviewed by a nurse for the assignment of LOS up to 14 days.

**Rehabilitation Extension**

Request for an extension must be submitted via fax no later than the expected discharge date. If the discharge date is a weekend or holiday, the extension request may be submitted on the next business day. The “expected discharge date” is shown on the provider notification received after each approved request.

Rehab extension LOS requests will be reviewed by a nurse to determine if the stay meets the current DHH established criteria.

All of the following medical data must accompany the Rehab extension request:

- PCF01
- PCF03
- Established criteria
- Multidiscipline staffing report

The first extension approval for Rehab is given up to 14 days. Subsequent extensions are up to seven days.

Approved, denied, or returned cases will be faxed to the facility within the required 24 hours from the receipt in pre-cert.

**Process for Rejected Extensions for Acute Care and Rehabilitation:**

- The provider has 48 hours to “resubmit” with additional documentation that supports InterQual criteria.
- The provider will check the “resubmittal” box on the PFC01 and PCF03.
- If the case was rejected for not meeting criteria, you must submit with additional information. Do not submit the same PCF02 that was originally rejected.



---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

**Process for Denied Extensions for Acute Care and Rehabilitation:**

- The provider has 24 hours to request a written reconsideration by submitting the requested supporting medical documentation and a Form PCF02 for the denied days.
- If the request is denied, the provider may contact the FI's Pre-certification Department to set up physician-to-physician conference.
- There is no reconsideration process for requests denied for lack of a timely submittal.
- If the request and the physician-to-physician review have been denied, providers may file an official appeal with the Division of Administrative Law-Health and Hospitals Section (see appendix B for contact information).

**NOTE:** Additional information can be found on the pre-cert notification letter or refer to Hospital Pre-certification Reconsideration/Appeal Process for additional information on the appeals process.

**Long-Term Acute Care Hospital Stays**

Long-Term Acute Care (LTAC) facilities are the only facilities that are allowed to submit for a pre-certification prior to the recipient's actual admit date.

All of the following medical data must accompany the preadmission/admission request for LTAC:

- Form PCF01,
- Established criteria,
- Either Discharge summary from transferring hospital **or** Form PCF06, **and**
- Long-Term Acute Care will be assigned an initial LOS of up to 14 days.

**Long-Term Acute Care Extension**

All of the following medical data must accompany the extension request for LTAC to determine if the stay meets criteria:

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

- Form PCF01,
- Established criteria, **and**
- Form PCF06.

Request for an extension must be submitted no later than the expected discharge day. If the discharge date falls on a weekend or FI holiday, the fax must be submitted the next business day. The expected discharge date is shown on the provider notification after each approved request.

The first extension approval for Long-Term Acute Care is given for up to 14 days. Subsequent extension is up to seven days.

Approved, denied, or returned cases will be faxed to the facility within the required 24 hours from the receipt in pre-cert.

**Psychiatric/Substance Abuse Hospitals Stays - Admissions**

All of the following medical data must accompany the admission request for Psychiatric/Substance Abuse: (SAU)

- Form PCF01,
- Appropriate criteria (psych/substance abuse),
- **Certificate of Need for Recipients under 21 years and**
- Form PCF05 or **all** of the following:
  - a, b, c,
  - Psychiatric physician evaluation (if available),
  - Initial assessment by registered nurse or licensed mental health professional, **and**
  - Psychiatric physician admit orders.

LOS for psych is assigned according to the Thomson-Reuters Recommended LOS Southern Region average. The assignment will be set at age appropriate all stays of the 50<sup>th</sup> percentile of the ICD-09 diagnosis code submitted.

**NOTE:** In compliance with Centers for Medicare and Medicaid Services (CMS) regulations, the Certificate of Need (CON) must be signed by the independent admit team unless it is

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

documented as an emergency psychiatric admission. Emergency admissions supported by appropriate documentation may have the CON signed by the hospital interdisciplinary team.

**Psychiatric/Substance Abuse Extension**

All of the following medical data must accompany the extension request for psych/substance abuse:

- Appropriate criteria (psych/substance abuse) **and**
- Form PCF05 **or all** of the following:
  - Psychiatric physician evaluation if not previously submitted with the initial admit request.
  - Medical documentation pertinent to the requested period includes:
    - Last (current) 48 hours of nurses notes
    - Last (current) 48 hours of psychiatric physician orders
    - Last (current) 48 hours of psychiatric physician progress notes

The first extension approval is assigned according to the current Thomson-Reuters recommended LOS Southern Region average. The assignment will be set up at the age appropriate **all stays** up to the 75th percentile of the ICD-9 diagnosis code submitted. Subsequent extensions are up to three days.

**Late Requests for Initial Stay Due to Conflicting Medicaid Eligibility**

Late submissions of an initial case due to an incorrect response from a Medicaid Eligibility Verification System (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, along with supporting documentation, should be submitted to the FI's Pre-Certification Department.

**Retrospective Review Based on Recipient Retroactive Eligibility**

Only one situation is recognized for retrospective review based on recipient eligibility. This occurs when positive determination of Medicaid eligibility cannot be made during the admission period. This refers to the State's determination of eligibility.

If a recipient's stay exceeded the recommended LOS, an extension should be requested concurrently with the admission LOS review. All retrospective LOS must be supported by

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

criteria. Approval of the request will follow the procedures required for the type of admission/extended stay being requested.

The recipient’s discharge date must be indicated on the PCF01.

If the approved LOS days are less than actual days of stay, only the number of approved LOS days will appear on the provider notification.

Cases denied will follow the same denial and appeal procedures described in **Outpatient Ambulatory Surgeries**.

**Retrospective Review Based on Provider Retroactive Eligibility**

If an in-state hospital is enrolled as a Louisiana Medicaid provider with a retroactive begin date of eligibility; the hospital may request retroactive review for Medicaid patient stays during the retroactive period.

If the recipient has been discharged, the request should be for the entire stay and must be supported by criteria.

If the approved LOS days are less than the actual days of stay, only the approved LOS will appear on the provider notification.

**NOTE:** Cases denied will follow same denial and appeal procedures described in Hospital Reconsideration/Appeal Process.

**Pre-certification Requirements for Dual Recipients**

| Coverage                                      | Pre-certification Required?  |
|---|--|
| Medicare Part A only – benefits not exhausted | No   |
| Medicare Part A only – benefits exhausted     | Yes –Form PCF01 and Medicare EOMB (Explanation of Medical Benefits) to verify days are exhausted. EOMB should show the first date of Medicare exhausted benefits for denied days. (See <b>Submission of Hospital “Common Working File” (CWF) Screens for Pre-certification Documentation of Medicare Part A Benefits Exhausted, below.</b> ) |
| Medicare Part B only                          | Yes  |

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

|  |  |
|--|--|
| Medicare Parts A and B - Part A Benefits not exhausted | No   |
| Medicare Parts A and B - Part A Benefits exhausted     | Yes –Must submit Form PCF01 and Medicare EOMB (Explanation of Medical Benefits) to verify days are exhausted. EOMB should show the first date of Medicare Part A only exhausted benefits for denied days. (See <b>Submission of Hospital “Common Working File” (CWF) Screens for Pre-certification Documentation of Medicare Part A Benefits Exhausted, below.</b> ) |
| Medicare Replacement Plans                             | No   |

**NOTE:** The provider has only 60 days from the notification date on the Medicare EOMB to submit a pre-cert request.

**“Common Working File” Screens for Pre-Certification Documentation**

The FI’s Pre-Certification Department will accept the hospital Common Working File (CWF) screen printouts as documentation that Medicare Part A benefits are exhausted. However, they will only accept these screens if it is clearly indicated 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.

**Denial of Extension Requests for Lack of Timely Submittal of Medical Information**

In situations when a hospital is denied an extension request based on timely submittal of the medical information requested by the FI, and the recipient is still in the hospital, the DHH allows 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: Pre-certification Supervisor.” On the bottom of the PCF01 the provider should put “see old case # \_\_\_\_\_” (this will be the pre-cert # under which the case was denied for timeliness). This new request must have the current documentation which supports the continued LOS.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

**NOTE:** This process can only be offered for **extension** requests when the recipient is still in-house – **not initial** requests or requests for recipients already discharged. If you have questions about the process described, please call the Pre-certification Department (see appendix B).

The hospital will be assigned a new pre-certification number, with the admit date being the date that the FI 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.

**Hospital Pre-certification Reconsideration/Appeal Process**

All types of inpatient hospital stays must be approved through the FI's Pre-certification Department. 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 procedures as documented below 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 within one business day from the date of the notification letter. 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 FI's physician upholds the denial and the facility still feels that a valid need exists to admit or extend the stay of a recipient, then a formal appeal may be initiated through the Division of Administrative Law.

When initiating a formal appeal, please include the following information in the letter to the Division of Administrative Law:

- The recipient's full name and Medicaid number.
- The first date which was not reimbursed through the actual discharge date.
- The total number of days under appeal (the discharge date is not reimbursable).
- The official name and address of the facility and the provider number.
- The name and telephone number of a contact person.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

- The name, address, and telephone number of your attorney when one will be representing the facility.
- The last denial notification from the FI's Pre-certification Department.

**Pre-certification Department General Information****Working Hours and Holidays of Current Fiscal Intermediary**

The working hours are Monday through Friday 8:00 a.m. - 5:00 p.m. (except FI holidays).

Holidays are as follows:

- New Year's Day (observed)
- Martin Luther King Day
- Memorial Day
- July 4<sup>th</sup>
- Labor Day
- Thanksgiving and the day after
- Christmas

**Pre-certification Department Fax System**

The Pre-certification Department relies heavily on its fax machines to provide prompt service to providers. Sometimes, however, faxes get lost on their way from the provider to Pre-certification. The FI's fax server system addresses this issue with a mechanism to track or trace lost faxes.

The pre-certification fax system receives information from providers across the state, seven 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.

Often information is difficult to read. This may be the result of copier quality or writing legibility. Colored pages DO NOT fax well.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

This system works in a two-fold manner to retrieve faxes that are important in the FI's 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 it 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, this tracking system can be utilized. The limitation of this mechanism is that it can track faxes for only six days after they've been sent and only if the provider has his CSID (Communication Sender Identification) number on each faxed page. The CSID number is a federal regulation, not an FI 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 the FI's Pre-certification Department who will assist in identifying the problem and advising of its solution.

**Helpful tips:**

- Every fax to the Pre-cert Department should have a cover page.
- On your fax cover letters, the total number of pages submitted in that particular fax must be identified. 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.

Due to issues of recipient 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.

**NOTE:** See appendix B for all contact information.



**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

**Pre-certification Turnaround Times**

Maximum response time begins when all necessary information is received in the Pre-cert Department.

**Acute Care**

|                   |          |
|-------------------|----------|
| 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  |

**Rehab**

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

**Long-Term Acute Care**

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

**Pre-certification Reference Guides**

The following reference guides will be used as criteria:

- Most current McKesson InterQual® Level of Care Criteria
  - Acute Care Adult
  - Acute Care Pediatric
- Most current McKesson InterQual® Level of Care Criteria
  - Procedures Volume I Adult
  - Procedures Volume II Adult
  - Procedures – Pediatric

Most recent data from Thomson-Reuters recommended LOS Southern Region Average. These manuals may be obtained by contacting the InterQual® and Thomson-Reuters offices.

**NOTE:** Refer to appendix B for McKesson Health Solutions and Thomson Reuters contact information.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

**Pre-certification Reminders**

- 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.
- Write the description of the ICD-9 codes submitted.
- Include start and stop dates for medication, and date all lab values and vital signs. Per Interqual Criteria: "All PRN medication must be noted by the number of times administered and by what route."
- Transcribe the requested physician progress notes if they are not legible. Do not send additional documentation unless specifically requested for acute inpatient stays.
- Do not fax copies of photographs since they copy very poorly. Instead, please submit description or mail pictures of wounds/decubiti.
- In compliance with CMS regulations, the CON must be signed, as introduced in the CMS (Combined Medicare/Medicaid Service) required form, 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 interdisciplinary team.
- 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 your Utilization Review Department.

**NOTE:** The Provider Update and RA messages can be found on the Louisiana Medicaid web site.

**What Providers Can Do To Help the Process**

The information below details things providers can do to help the FI's Pre-certification Department expedite the review and processing of your pre-certification requests.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

The notification letter to the provider will contain the status of the request and, uses three-digit codes to inform the provider of any additional information needed. Providers need to respond by sending the requested information on the appropriate required Forms (PCFO1, PCFO2, PCFO4 for acute inpatient and non general level of care) or by writing an explanation of why the information is not available.

Proofread the information being sent to the FI. Often providers send conflicting documentation among disciplines. These cases are reviewed based on the preponderance of information.

Often information is difficult to read. This may be the result of copier quality or writing legibility. Colored pages do not fax well.

Pre-certification staff always requires 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. Only that information pertinent to the request from the last request is required. Do not resubmit information previously submitted unless requested. Information must be on mandatory forms required.

**Pre-certification Glossary**

**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 review 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, the provider is **resubmitting** the request, not reconsideration. A resubmittal must be submitted within 48 hours (two business days) from the date faxed from pre-cert.

**Reconsideration:** Hospitals may request reconsideration of cases **denied** for lack of medical necessity. Reconsideration must be submitted within 24 hours from the date faxed from pre-cert, except for weekends or FI holidays. In these instances, submit by the next business day.

**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. Indicate what items need to be updated by circling the item. All update requests should include the pre-certification case number.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.5: PRE-CERTIFICATION AND ADMISSION PAGE(S) 26**

---

*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, only what documents criteria.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

**PRIOR AUTHORIZATION**

Prior Authorization (PA) of certain services is necessary from a quality assurance and also from a cost benefit standpoint. This section contains the inpatient and outpatient services which require review prior to reimbursement being authorized. This section also contains the policy regarding PA and refers to Appendix A which includes the forms and instructions used to secure the PA.

Besides the services found below, Medicaid has included a process for emergency authorization of certain equipment which are considered life threatening should a delay in their receipt occur. These include Apnea monitors, breathing equipment, hyperalimentation therapy aids (parenteral and enteral) and suction machines. In addition to these items for life threatening situations, emergency requests may be made for the temporary rental of wheelchairs for post-operative needs after a hospital discharge. The providers of emergency items must contact the Prior Authorization Unit (PAU) immediately by telephone and provide the following information:

- The recipient's name, age, and 13-digit Medicaid identification number;
- The treating physician's name;
- The diagnosis;
- The time period of need for the item(s);
- A complete description of the item(s) requested;
- The reason that the request is a medical emergency; and
- The cost of the item.

The decision will be made by the PAU within two working days of the date the completed request is received, and the PAU will contact the provider by telephone and also follow up in writing.

**Requests for Prior Authorization**

Providers may submit requests for PA by completion of the Louisiana Request for Prior Authorization Form, the PA-01. No other form will be accepted. Completed requests must be sent to the PAU. Requests may be mailed, faxed or submitted through electronic PA (e-PA). **The preferred method is e-PA.**

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.6: PRIOR AUTHORIZATION**

**Outpatient Rehabilitation Services**

Outpatient rehabilitation is one of the services prior authorized on the PA01 (see Appendix A for information regarding this form) and is reimbursed at a flat fee-for-service. Hospitals are reimbursed by HCPCs for outpatient rehabilitation services including:

- Physical therapy;
- Occupational therapy; and
- Speech and hearing therapy.

A licensed physician must make the referral. The referral must include the diagnosis, the date of the accident (or onset of illness), the address of the referring physician, his/her specialty (if known), and the date of the referral. The hospital must retain a copy of the physician’s referral on file.

The rehabilitation services department must evaluate the recipient. Initial therapy and extended therapy plans require prior authorization. Evaluation codes do not require prior authorization, but are limited to one evaluation per 180 days.

| Description                           | HCPC  |
|---------------------------------------|-------|
| Speech/Language Evaluation            | 92506 |
| Hearing Evaluation                    | 92506 |
| Speech/Lang/Hear Therapy – per 15 min | 92507 |
| Physical Therapy Evaluation           | 97001 |
| Physical therapy – per 15 min         | 97110 |
| Occupational Therapy Evaluation       | 97003 |
| Occupational Therapy – per 15 min     | 97530 |

When requesting PA for outpatient rehabilitation services, the following information must be included, or the request will be denied:

- Completed copies of the PA-01 and PA-02 (see Appendix A for information on forms);
- Initial therapy and extended therapy plans;

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

- Number of services, visits being requested;
- Physician's referral;
- Evaluation results; and
- Revenue Code and the HCPCS code.

**NOTE:** The request should be sent to the PAU.

Extension requests should be submitted at least 25 days prior to the end of the approved period. The requests should have at a minimum the following information attached:

- Therapy notes;
- Current evaluation results;
- Goals and objectives; and
- Copy of the physician's referral.

In cases where a delay in therapy would result in deterioration of the medical condition (e.g., burn cases, accidents, or surgery) the treatment may be instituted subject to later approval. The request for therapy should be submitted within the first week of therapy, with an explanation and a request for approval from the start of therapy.

Reimbursement for rehabilitation services provided without an approved plan for therapy will be dependent on the approval of the treatment plan.

To expedite the approval process, if it is known that outpatient rehabilitation services will be required upon discharge, a PA request can be submitted using anticipated discharge date as the beginning date of service.

Services may be provided by any enrolled Medicaid provider even if furnished as part of an Individual Family Service Plan (IFSP) or Individual Service Plan or provided in a school setting. These services may be received at home from a provider of home services or home health agency.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

**Outpatient Surgery Performed On An Inpatient Basis**

Certain surgical procedures are covered only when performed as outpatient unless otherwise authorized. These procedures are usually performed on an outpatient basis but can be performed inpatient if it is medically necessary and PA is obtained. Request for PA must be submitted on form PA-01. When both the primary and secondary procedures require PA, list all procedures on the PA-01. A list of outpatient procedures requiring PA to be performed on an inpatient basis may be found on the Louisiana Medicaid website under fee schedules.

**NOTE:** Refer to Section 25.3 for more information on Outpatient Services and 25.8 for specific billing instructions.

The PCF01 form should be submitted prior to performance of the surgery. However, post authorization may be requested in emergency situations. See post authorization information below.

Providers requesting length of stay (LOS) for outpatient surgery performed as inpatient must use the PCF01 form. To expedite the review process, the appropriate medical data should be attached 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 post-operative observation by a nurse or skilled medical personnel a necessity.
- The procedure is likely to be time consuming or followed by complications.
- 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 recipient risk.



---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

**NOTE:** Authorization is not required if the procedure is performed in a hospital based ambulatory surgery center.

Reimbursement for the performance of these specified surgical procedures on an outpatient basis will be made on a flat fee-for-service basis. Reimbursement for surgical procedures approved for an inpatient performance will be made in accordance with the prospective reimbursement methodology for acute care inpatient hospital services.

**Organ Transplants**

Transplants must be prior authorized by the Department of Health and Hospitals (DHH). Transplants (other than bone marrow and stem cell) must be performed in a hospital that is a Medicare approved transplant center for the procedure. Hospitals seeking Medicaid coverage for transplant procedures must submit documentation verifying that they are a Medicare approved center for each type of transplant other than bone marrow and stem cell transplants. A completed attestation form must be submitted to Provider Enrollment (see Appendix B for contact information). The Medicaid Director may grant an exception to a transplant center for a specific procedure if the transplant surgeon can demonstrate experience with that specific procedure and a history of positive outcomes in another hospital. The other hospital must be a Medicare approved transplant center for that specific procedure.

In addition to the above criteria, transplant centers located in-state shall meet the following criteria for Medicaid coverage of transplant services:

- Be a member of the Organ Procurement and Transplant Network (OPTN) or the National Marrow Donor Program (NMDP), if the hospital only performs bone marrow/stem cell transplants;
- Have an organ receiving and tissue typing facility (Centers for Medicare and Medicaid Services (CMS) approved for histocompatibility) or an agreement for such services;
- Maintain a written records tracking mechanism for all grafts and recipients including:
  - Patient and/or graft loss with the reason specified for failure;
  - Date of the procedure; and
  - Source of the graft.
- Have written policy for contacting recipients and appropriate governmental officials when an infectious agent is involved;

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

- Have a written criteria for acceptable donors for each type of organ for which transplants are performed;
  - Have adequate ancillary departments and qualified staff necessary for pre-, intra-, and post-operative care including, but not limited to:
    - Assessment team;
    - Surgical suite;
    - Intensive care;
    - Radiology;
    - Laboratory pathology;
    - Infectious disease;
    - Dialysis; and
    - Therapy (rehabilitation).
  - Have minimum designated transplant staff which includes:
    - Transplant surgeon- adopt standards as delineated and updated by the OPTN;
    - Transplant physician - same standards as above;
    - Clinical transplant coordinator:
      - Registered nurse licensed in Louisiana; and
      - Certified by NATCO or in training and certified within 18 months of hire date.
    - Transplant social worker;
    - Transplant dietician;
    - Transplant data coordinator; and
    - Transplant financial coordinator.
- NOTE:** For individuals identified in the bullets immediately above this note, continuing education is required to maintain licensure and certification as applicable.
- Written recipient selection criteria and an implementation plan for application of criteria;
  - Facility plan, commitment and resources for a program capable of performing the following minimum number of transplants per year/per organ:

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

- Heart: 12;
- Liver: 12;
- Kidney: 15;
- Pancreas: 6;
- Bone marrow: 10; and
- Other organs as established per Medicare and/or OPTN.

**NOTE:** If the level falls below the required volume, the hospital shall be evaluated by DHH for continued recognition as a transplant center.

- Facility must demonstrate survival rates per organ type per year which meet or exceed the mean survival rates per organ type per year as published annually by the OPTN. (If rates fall below this level, the hospital shall supply adequate written documentation for evaluation and justification to DHH.)

All organ transplants must be authorized by the PAU prior to the performance of the surgery via a prior authorization letter. The only exception is for recipients with retroactive eligibility.

Transplant charges are to be included in the inpatient hospital charges using the revenue codes 300 and 800 range. This includes donor search charges and all procedures involved in harvesting the organ from the donor. Costs associated with the search will not be covered on an outpatient basis. Costs are not covered when the Medicaid recipient donates an organ to a non-Medicaid recipient.

**Required Documentation for Organ Transplant Authorization Requests**

All transplants must be prior authorized using a TP-01 (Transplant Form). The only exception is for recipients with retroactive eligibility. All documentation supporting the performance of the transplant must be attached to the letter.

**NOTE:** The TP-01 can be located on the Louisiana Medicaid web site.

When billing for the transplant services, the hospital and all physicians involved must attach a copy of the above mentioned approval letter, and a dated operative report to the claims they submit for payment. Hospitals should comply with all applicable privacy and Health Insurance Portability and Accountability Act (HIPAA) regulations when sharing a copy of the organ transplant approval letter with all other providers involved in the recipient's transplant.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

**Standards for Coverage**

Requests for transplants are reviewed on a case-by-case basis by applying the following criteria:

- Transplant procedure to be performed is compatible with the diagnosis.
- All alternative forms of treatment have been tried, and the only viable alternative is the transplant procedure.
- Death would be imminent if the procedure were not performed is a reasonable medical probability.
- The procedure has met with a reasonable degree of success in the past.
- The procedure may be performed out of the state, if the facilities in state are not available.
- Services to the organ donor and organ procurement costs are included in the reimbursement methodology.

**Cochlear Implantation**

Only recipients who meet the medical and social criteria shall qualify for implantation.

All aspects (pre-operative speech and language evaluation, implantation, device, repairs, supplies and therapy) must be prior authorized on a PA-01. The request to perform surgery must come from a multi-disciplinary team consisting of an otologist, audiologist, speech/language pathologist, psychiatrist, and a deaf educator with experience in oral/auditory instruction. This team performs the assessment on the recipient to determine the recipient's possible candidacy for implantation.

The team's recommendation for the request and the results of all evaluations (audiogram, acoustic reflexes, auditory brainstem responses, otoacoustic emissions, speech and language evaluation, social/psychological evaluation, medical evaluation, and other pertinent testing or evaluation) must be submitted with the requests in a packet to the PAU.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

**Medical and Social Criteria****General Criteria**

The following criteria apply to all candidates:

- Have a profound bilateral sensor-neural hearing loss with pure tone average of 90 dB HL or greater for frequencies of 1000, 2000, and 4000Hz.
- Have no response to Auditory Brainstem Response, Otoacoustic testing or any other special testing or any other special testing that would be required to determine if the hearing loss is valid and severe enough to qualify for cochlear implantation;
- Be a child age one year or older with a profound sensorineural hearing loss or be an adult through the age of twenty years; with a profound post lingual sensorineural hearing loss;
- Receive no significant benefit from hearing aids as validated by the implant team;
- Have a high motivation to be part of the hearing community as validated by the implant team;
- Have appropriate expectations;
- Had radiologic studies that demonstrate no intra cranial anomalies or malformations which contraindicate implanting the receiver-stimulator or the electrode array;
- Have no medical contraindication for undergoing implant surgery or post implant rehabilitation; and
- Show that the recipient and his/her family are well motivated, have appropriate expectations and are prepared and willing to participate and cooperate in the pre and post implant assessment and rehabilitation programs recommended by the implant team and in conjunction with the Food and Drug Administration (FDA) Guidelines.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION**

**PAGE(S) 16**

---

**Age-Specific Criteria**

**Children One through Nine Years**

Children one through nine years must not receive any significant benefit from a hearing aid that was obtained in the best aided condition as measured by age appropriate speech perception material.

**Children 10-17 Years**

Children in this age range must meet the following criteria:

- Receive no significant benefit from a hearing aid that was obtained in the best aided condition as measured by age and language appropriate speech perception material;
- Have received consistent exposure to effective auditory or phonological stimulation in conjunction with the oral method of education and auditory training;
- Utilizes spoken language as the primary mode of communication through one of the following: an oral/aural (re) habilitation program or total communications educational program with significant oral/aural; and
- Have at least six months' experience with a hearing aid or vibrotactile device in the case of meningitis (in which case the six month period will be reduced to three months).

**Adults - 18-20 Years**

The following criteria must be met:

- Have a severe to profound post lingual bilateral sensorineural hearing loss;
- Receive no significant benefit from a hearing aid that was obtained in the best aided condition for speech/sentence recognition material;
- Have received consistent exposure to effective auditory or phonological stimulation or auditory communication;

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

- Have no medical contraindication for the undergoing implant surgery or post-implant rehabilitation; and
- Show that the recipient and his/her family are well-motivated, have appropriate post-implant expectations and are prepared and willing to participate and cooperate in the pre and post implant assessment and rehabilitation programs recommended by the implant team and in conjunction with the Food and Drug Administration (FDA) guidelines.

The criteria utilized must be appropriate for the child's age.

**Reimbursement**

Reimbursement for the speech processor and/or microphone repairs, headset cords, headset replacement, and batteries must be prior authorized. Request should be made on Form PA-01 to the PAU.

Requests for reimbursement for these items should be made conservatively. The PAU reserves the right to refuse authorization of these items if it feels requests are being made too frequently due to the recipient's negligence. On an average, processors require repairing every two and half years, head cords need to be replaced two to four times per year, and batteries replaced every 10-12 months.

**Billing for the Device(s)**

Reimbursement will be made to the hospital for both the device(s) and the per diem. The device(s) must be prior authorized by using the PA-01 to request approval of the surgery. After approval has been granted, the hospital shall bill for the device(s) by submitting the appropriate HCPCS code on a CMS 1500 claim form. Write the letters DME in bold, black print on the top of the form and the PA number must be written in item 23. The reimbursement fee can be obtained from the fiscal intermediary (FI).

**Re-Performance of the Surgery**

Prior Authorization is required for re-performance of the surgery because of infection, extrusion, or other reason. The request should be submitted to the PAU and contain sufficient documentation explaining the reason the surgery must be repeated. The PA number for the re-performance must be included on the claim form.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

**Replacement of the External Speech Processor**

Replacement of the external speech processor will be considered only if the processor is lost, stolen, or damaged beyond repair.

Upgrades due to cosmetic reasons or technological advances in the hardware do not qualify as reasons for a replacement.

When it is necessary to replace the external speech processor, the multidisciplinary team must initiate the required PA request by submitting a copy of PA's initial approval letter for the implant and documentation of the need for a new processor.

**Billing for the Replacement of the External Speech Processor**

Hospitals or professional services billers shall bill for this component by submitting the appropriate HCPCS code on a CMS1500 with the letter DME written in bold, black print on the top. The PA number must be written in Item 23.

**Non-Covered Expenses**

Service contracts and/or extended warranties and insurance to protect against loss and theft are the responsibility of the family.

**Vagus Nerve Stimulator**

The vagus nerve stimulator (VNS) is an implantable device used to assist in the control of seizures related to epilepsy and must be prescribed by a physician.

Effective June 14, 2010, a PA-01 is no longer required for hospital providers for the VNS device. However, reimbursement of the device continues to be dependent upon approval of the surgeon to perform the procedure. Hospitals should confirm that the surgeon has received an authorization for the procedure prior to submitting their claim in order to prevent denials.

The hospital will bill their VNS claim using HCPCS procedure code C1767 (VNS generator) and/or C1778 (VNS leads) to the FI on a CMS 1500 claim form with the words DME written in bold, black print on the top of the form and the PA number written in Item 23 or through the electronic claims submission.

The claim will pend to the FI's Medical Review Department for review of the surgeon's approved PA request. If approved, the hospital claim will be allowed to process for payment; if there is no valid authorization, the hospital claim will deny with edit 191 (PA required).



---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

**Intrathecal Baclofen Therapy**

Intrathecal Baclofen Therapy (ITB) is for the treatment of severe spasticity of the spinal cord or cerebral origin and for the surgical implantation of the programmable infusion pump by which ITB is delivered. This treatment must be **prior authorized** before its administration. To obtain pre-certification for the stay, the pre-certification process must be followed.

**Criteria for Recipient Selection**

Consideration will be given for reimbursement for implanting an ITB infusion pump if the treatment is considered medically necessary, the recipient is four years of age or older with a body mass sufficient to support the implanted system, and any one or more of the following criteria is met:

- Inclusive criteria for candidates with spasticity of cerebral origin:
  - There is severe spasticity of cerebral origin with no more than mild athetosis;
  - The injury is older than one year;
  - There has been a drop in Ashworth scale of one or more;
  - Spasticity of cerebral origin is resistant to conservative management;
  - The candidate has a positive response to the test dose of ITB.
  
- Inclusive criteria for candidates with spasticity of spinal cord origin:
  - Spasticity of spinal cord that is resistant to oral antispasmodics or side effects are unacceptable in effective doses;
  - There has been a drop in Ashworth scale of two or more; or
  - The candidate has a positive response to the test dose of ITB.

Caution should be exercised when considering ITB infusion pump implantation for candidates who:

- Have a history of autonomic dysreflexia;
- Suffer from psychotic disorders;
- Have other implanted devices; or
- Utilize spasticity to increase function such as posture, balance, and locomotion.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

**Exclusion Criteria for Recipients**

- Fails to meet any of the inclusion criteria;
- Is pregnant, refuses or fails to use adequate methods of birth control;
- Has a severely impaired renal or hepatic function;
- Has a traumatic brain injury of less than one year pre-existent to the date of the screening dose;
- Has a history of hypersensitivity to oral baclofen;
- Has a systematic or localized infection which could infect the implanted pump; or
- Does not respond positively to a 50, 75, or 100 mcg intrathecal bolus of Lioresal during the screening trial procedure.

Prior Authorization for chronic infusion of ITB shall be requested after the screening trial procedure has been completed but prior to the pump implantation.

The request to initiate chronic infusion shall come from the multi-disciplinary team that evaluates the recipient. The multi-disciplinary team should consist of a neurosurgeon or an orthopedic surgeon, a physiatrist and/or neurologist, the recipient's attending physician, a nurse, a social worker and allied professionals (physical therapists, occupational therapist, etc.).

These professionals shall have expertise in the evaluation, management, and treatment of spasticity of cerebral and spinal cord origin and shall have undergone training in infusion therapy and pump implantation by Medtronic or an equally recognized product supplier with expertise in intrathecal baclofen.

A recent history with documentation of assessments in the following areas must be sent to the PAU:

- Medical and physical;
- Neurological;
- Functional;
- Psychosocial;

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION****PAGE(S) 16**

---

- Ashworth scores taken before and after the administration of the IBT test dose(s);
- Documentation of any other findings about the recipient's condition which would be of interest to or would assist the PAU in making a decision regarding the recipient's need for chronic infusion, i.e., a videotape of the trial dosage.

**Out-of-State Non-Emergency Hospitalizations**

Out-of-state non-emergency hospitalizations require authorization, unless the request for hospitalization is for a dual Medicare/Medicaid eligible recipient. Authorization is required for dual eligible recipients only if transportation services are being requested in addition to the hospitalization.

To obtain authorization for out-of-state non-emergency hospitalizations, send a facsimile (fax) of a "Letter of Referral" to the attention of the PAU. The referring physician should sign the "Letter of Referral" and answer the following questions:

- What is the recipient's name and Medicaid identification number?
- What is the name and telephone number of the contact person representing the recipient?
- Is the recipient both Medicare and Medicaid eligible?
- Does the recipient require transportation services as well?
- Is the facility where the recipient will be hospitalized a Louisiana Medicaid provider with a valid seven-digit provider number?
- Why is the situation so unique that it cannot be provided in Louisiana or in one of the Louisiana trade areas?
- What referrals were made in Louisiana before a referral was made to an out-of-state provider/hospital?

**NOTE:** Emergency out-of-state hospitalizations do not require PA.

**Reconsiderations**

If a request for PA is denied, a provider may submit the request for reconsideration.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.6: PRIOR AUTHORIZATION**

**PAGE(S) 16**

---

**Instructions for Submitting a Reconsideration**

- Write the word “Reconsideration” across the top of the denial letter, and write the reason the request for reconsideration at the bottom of the page.
- Attach all of the original documentation, as well as any additional documentation or information which supports medical necessity, to the letter.
- Mail the letter and all documentation to the PAU (see Appendix B for contact information).

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25****REIMBURSEMENT**

This chapter is an overview of inpatient hospital services' reimbursement methodology and does not address all issues or questions that a hospital may have regarding reimbursement. If a provider has a question about this chapter, or any issue regarding hospital reimbursement, the provider may e-mail the Louisiana Department of Health (LDH), Bureau of Health Services Financing, Rate Setting and Audit Section (see Appendix B for contact information).

**History**

On July 1, 1994, hospitals were assigned acute care per diems according to their hospital specific cost/charge data in accordance with their 1991 cost report. The payment rates for operating costs and movable equipment were determined according to a peer group capped amount. Fixed capital payment rates were based on a statewide capped amount. Medical education costs were reimbursed as a hospital-specific per diem amount. Also, at the time of this rate methodology implementation, peer group per diems were developed and used to determine appropriate rates for hospitals wishing to change their peer group designation through means of a blended rate methodology or assignment of rates for newly established hospitals. Since implementation, all hospital and peer group per diems were increased or decreased at various times due to state budget needs.

**Inpatient Reimbursement**

For reimbursement purposes, hospitals enrolled in Louisiana Medicaid are classified as:

- State-owned;
- Small rural; or
- Non-small rural/non-state.

**NOTE:** The three types of hospitals each have separate inpatient reimbursement methodologies.

**State-Owned Hospitals**

State-owned hospitals are hospitals that are owned and operated by the state of Louisiana.

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

---

**Small Rural Hospitals**

Small rural hospitals are those hospitals which are defined as a rural hospital by the Rural Hospital Preservation Act (Act No. 327 of the 2007 Louisiana Legislative regular session, Louisiana Revised Statutes 40:1300.142 – 144). Although a hospital may in fact be located in a rural parish or area, only those hospitals meeting the requirements to qualify as a small rural hospital by the legislation noted above fall into this category.

**Non-Small Rural/Non-State Hospitals**

Non-small rural/non-state hospitals refer to a hospital not falling into either of the previous two designations. Therefore, it may be publicly or privately owned as a profit, or non-profit hospital. The fact that it is not owned by the state, or that it is not a small rural hospital, makes it a non-small rural/non-state hospital for purposes of Louisiana Medicaid reimbursement.

**Acute Care Hospitals Peer Group Assignment**

As of October 1, 2009, existing qualifying non-small rural/non-state hospitals classified as one of the peer groups listed below, shall receive not less than a specified percentage (see below) of the peer group per diem to which they are assigned, and may receive more than the current peer group per diem (only if their September 30, 2009, per diem was more than the per diem of the peer group to which they were classified). On and after October 1, 2009, newly qualifying non-rural/non-state hospitals will be assigned the specified percentage of the peer group per diem for the peer group to which they are classified.

Reimbursement for non-small rural/non-state hospitals for inpatient acute care is a prospective per diem rate. All non-small rural/non-state hospitals enrolled in Louisiana Medicaid are classified as one of the following five peer groups, or as a specialty hospital:

- **Peer Group 1 – Major Teaching Hospitals**  
Qualifying hospitals will receive not less than 80 percent of the current peer group rate.
- **Peer Group 2 – Minor Teaching Hospitals**  
Qualifying hospitals will receive not less than 103 percent of the current peer group rate.

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

- **Peer Group 3 – Non-Teaching Hospitals with less than 58 beds**  
Qualifying hospitals will receive not less than 103 percent of the current peer group rate.
- **Peer Group 4 – Non-Teaching Hospitals with 59 to 138 beds**  
Qualifying hospitals will receive not less than 122 percent of the current peer group rate.
- **Peer Group 5 – Non-Teaching Hospitals with more than 138 beds**  
Qualifying hospitals will receive not less than 103 percent of the current peer group rate.

**Changing Peer Group Status**

**Hospitals wishing to change their status as defined above must submit a request to Provider Enrollment within 90 days prior to the desired effective date.** If the requested change is approved, the effective date will be the beginning of the next state fiscal year. In addition to notifying the FI's Provider Relations Section of its desire to change peer groups, a hospital should also notify the LDH/Rate Setting and Audit in order to be apprised of any specific issues that may affect the hospital's peer group change, and possible new acute care per diem. Refer to Appendix B for LDH/Rate Setting and Audit contact information.

**Specialty Hospitals**

For each specialty hospital listed below, qualifying hospitals will receive the current peer group rate.

- Children's Hospitals;
- Neuro Hospitals;
- Freestanding Psychiatric Hospitals;
- Distinct Part Psychiatric (DPP) Hospitals; and
- Long Term Acute Care (LTAC) Hospitals.

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

---

**Boarder Baby per Diem**

The boarder baby per diem is paid for boarder babies that remain in the regular nursery of the hospital after the mother's discharge. In these cases, this per diem is paid to hospitals billing the appropriate and covered nursery revenue codes.

**Well Baby per Diem**

Private hospitals that perform more than 1,500 Louisiana Medicaid deliveries per state fiscal year (SFY) qualify to be paid a per diem for well babies that are discharged at the same time the mother is discharged. This well baby per diem rate is the lesser of the hospital's actual costs or the boarder baby rate.

**Qualification for Well Baby Rate**

**In order for a hospital to qualify for the well-baby per diem, it must notify Rate Setting and Audit at any time during a SFY, or not later than six months after the end of a SFY that it indeed had more than 1,500 Medicaid deliveries in that SFY.**

The Rate Setting and Audit Section generates an annual report to determine if there are any new hospitals that might qualify. **However, if Rate Setting and Audit cannot determine from the hospital's billing data available at the time of the report that it had 1,500 Medicaid deliveries, the hospital will not qualify until it notifies Rate Setting and Audit and the section confirms the information.** If there were Medicaid deliveries that a hospital has not billed at the time the report is run, they will not be reflected on the report.

Medicaid eligibles do count as Medicaid deliveries, but unless they have been billed to Medicaid, we have no record to count that delivery. **Therefore, it is the responsibility of the hospital to notify us timely (as described above) that it qualifies.** Rate Setting and Audit will then verify qualifying information. Once a hospital has qualified, it will begin receiving the well-baby per diem for dates of service on and after the beginning of the SFY following its qualification.

**Well Baby Example 1:**

A hospital determines that it had 1,500 Medicaid deliveries from July 1, 2007, to June 30, 2008 (SFY 2008), and it notifies Rate Setting and Audit on December 31, 2008, that it has qualified. After verification and implementation of the rate, the hospital would receive the well-baby per diem for dates of service retroactive to July 1, 2008.



**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****Well Baby Example 2:**

A hospital determines that it had 1,500 Medicaid deliveries from July 1, 2007 to June 30, 2008 (SFY 2008), and it notifies Rate Setting and Audit on January 1, 2009 that it has qualified. The hospital was too late in notifying Rate Setting and Audit; thus, it does not qualify to receive the well-baby per diem. The hospital can qualify later, but only after it has notified Rate Setting and Audit that it has had more than 1,500 Medicaid deliveries in SFY 2009.

**Well Baby Example 3:**

A hospital determines that it had 1,500 Medicaid deliveries from July 1, 2008 to January 31, 2009 (first seven months of SFY 2009), and it notifies Rate Setting and Audit on February 1, 2009 that it has qualified. After verification and implementation of the rate, the hospital would receive the well-baby per diem for dates of service on and after July 1, 2009.

**Continuing Qualification for Well Baby Rate**

After each SFY, Medicaid will run a report to determine if hospitals currently receiving the well-baby per diem continue to qualify. If the report shows that a hospital did not qualify, additional information will be requested from the hospital to determine if there will be any subsequently billed Medicaid deliveries. After determining that there is no more Medicaid deliveries to count, eligibility will be determined and LDH will either continue or discontinue paying the well-baby per diem in accordance with the number of Medicaid deliveries for that hospital.

If it is determined that a hospital does not continue to qualify, the well-baby per diem will be discontinued and retroactively recouped if necessary back to dates of service beginning July 1 of the SFY year following that hospital's failure to qualify.

**Specialty Units**

Certain resource intensive inpatient services have historically been recognized through a separate reimbursement methodology by Louisiana Medicaid. Separate per diems are established for the following resource intensive inpatient services: neonatal intensive care units, pediatric intensive care units, and burn units.

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

---

**Neonatal Intensive Care Units**

Reimbursement methodology recognizes four categories of neonatal units based on the certification of a hospital to provide neonatal intensive care services at a minimum standard for each category of Neonatal Intensive Care Units (NICUs): **NICU I; NICU II; NICU III; and NICU III Regional.**

In order for a hospital to qualify to be reimbursed for NICU services, certification must be obtained and maintained through the Health Standards Section (HSS) of the LDH.

**NOTE:** Details regarding these NICUs can be found within the Hospital Licensing Standards (see Appendix B for the HSS website).

If a hospital has implemented an NICU, it **must notify Rate Setting and Audit at least 90 days prior to the beginning of the subsequent SFY** in order to be compensated with an appropriate NICU rate at the beginning of the following SFY.

**NICU Example**

Hospital plans to have an NICU, and determines when it will begin delivering NICU services.

Hospital notifies HSS (to schedule an on-site survey for certification) and Rate Setting and Audit (for rate implementation). These **notifications must occur at least 90 days prior to the next subsequent SFY** in order to assure that the hospital may receive NICU per diem on dates of service beginning on the first day of the next SFY. The on-site survey should be completed and documented by HSS prior to the next SFY so that the rate will be implemented.

The NICU per diem may be paid only when a hospital bills the appropriate revenue code.

**Per Diem Adjustments**

Effective for dates of service on or after March 1, 2011, the per diem rates for Medicaid inpatient services rendered by NICU level III and NICU level III regional units, recognized by the Department as such on December 31, 2010, shall be adjusted to include an increase.

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.7: REIMBURSEMENT**

The per diem adjustment will vary based on the following five tiers:

| <b>If the qualifying hospital's average percentage:</b>   | <b>Tier</b> | <b>Additional Per Diem</b> |
|---|-------------|----------------------------|
| Exceeds 10 percent  | 1           | \$601.98                   |
| Exceeds 5 percent but is less than or equal 10 percent  | 2           | \$624.66                   |
| Exceeds 1.5 percent but is less than or equal to 5 percent  | 3           | \$419.83                   |
| Exceeds 0 percent but is less than or equal to 1.5 percent; and the<br><br>Hospital received greater than .25 percent of the outlier payments for dates of service in: <ul style="list-style-type: none"> <li>• SFY 2008,</li> <li>• SFY 2009, and</li> <li>• Calendar year 2010</li> </ul> | 4           | \$263.33                   |
| <b>If the qualifying hospital:</b>  | <b>Tier</b> | <b>Additional Per Diem</b> |
| Exceeds 0 percent but received less than .25 percent of outlier payments for dates of service in: <ul style="list-style-type: none"> <li>• SFY 2008,</li> <li>• SFY 2009, and</li> <li>• Calendar year 2010</li> </ul>  | 5           | \$35.00                    |

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.7: REIMBURSEMENT**

A qualifying hospital's placement into a tier will be determined by the average of its percentage of paid NICU Medicaid days for SFY 2010 dates of service to the total of all qualifying hospitals' paid NICU days for the same time period, and its percentage of NICU patient outlier payments made as of December 31, 2010 for dates of service in SFY 2008 and SFY 2009 and calendar year 2010 to the total NICU outlier payments made to all qualifying hospitals for these same time periods.

This average shall be weighted to provide that each hospital's percentage of paid NICU days will comprise 25 percent of this average, while the percentage of outlier payments will comprise 75 percent. In order to qualify for tiers 1-4, a hospital must have received at least .25 percent of outlier payments in SFY 2008, SFY 2009, and calendar year 2010.

SFY 2010 is used as the base period to determine the allocation of NICU and PICU outlier payments for hospitals having both NICU and PICU units.

If the daily paid outlier amount per paid NICU day for any hospital is greater than the mean plus one standard deviation of the same calculation for all NICU level III and NICU level III regional hospitals, then the basis for calculating the hospital's percentage of NICU patient outlier payments shall be to substitute a payment amount equal to the highest daily paid outlier amount of any hospital not exceeding this limit, multiplied by the exceeding hospital's paid NICU days for SFY 2010, to take the place of the hospital's actual paid outlier amount.

**Exclusion Criteria**

Children's specialty hospitals are not eligible for the tier determined per diem adjustments.

**Assessment/Evaluation**

The Department shall evaluate all rates and tiers two years after implementation.

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

---

**Pediatric Intensive Care Units**

Reimbursement methodology recognizes two categories of pediatric intensive care units (PICUs) based on the certification of a hospital to provide pediatric intensive care services at a minimum standard for each category of PICU: **PICU II; and PICU I.**

In order for a hospital to qualify to be reimbursed for PICU services, certification must be obtained and maintained through the LDH/HSS.

**NOTE:** Details regarding these NICU units can be found within the Hospital Licensing Standards (see Appendix B for the HSS web site).

If a hospital has implemented a PICU, it **must notify Rate Setting and Audit at least 90 days prior to the beginning of the subsequent SFY** in order to initiate compensation with an appropriate PICU rate at the beginning of the following SFY.

**PICU Example**

Hospital plans to have a PICU, and determines when they will begin delivering PICU services.

Hospital notifies HSS (to schedule an on-site survey for certification) and Rate Setting and Audit (for rate implementation). These **notifications must occur at least 90 days prior to the next subsequent SFY** in order to assure that the hospital may receive PICU per diem on dates of service beginning on the first day of the next SFY. The on-site survey should be completed and documented by HSS prior to the next SFY so that the rate will be implemented.

Only when a hospital bills the appropriate and covered revenue code in accordance with the UB-04 National Billing Guidelines, will the PICU per diem be paid.

Effective for dates of service on or after March 1, 2011, the per diem rates for Medicaid inpatient services rendered by PICU level I and PICU level II units, recognized by the Department as such on December 31, 2010, shall be adjusted to include an increase.

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.7: REIMBURSEMENT**

The per diem adjustment will vary based on the following four tiers:

| <b>If the qualifying hospital's average percentage</b>   | <b>Tier</b> | <b>Additional Per Diem</b> |
|--|-------------|----------------------------|
| Exceeds 20 percent   | 1           | \$418.34                   |
| Exceeds 10 percent but is less than or equal to 20 percent   | 2           | \$278.63                   |
| Exceeds 0 percent but is less than or equal to 10 percent; and the<br><br>Hospital received greater than .25 percent of the outlier payments for dates of service in: <ul style="list-style-type: none"> <li>• SFY 2008,</li> <li>• SFY 2009, and</li> <li>• Calendar year 2010</li> </ul> | 3           | \$178.27                   |
| <b>If the qualifying hospital:</b>   | <b>Tier</b> | <b>Additional Per Diem</b> |
| Exceeds 0 percent but received less than .25 percent of outlier payments for dates of service in: <ul style="list-style-type: none"> <li>• SFY 2008,</li> <li>• SFY 2009, and</li> <li>• Calendar year 2010</li> </ul>   | 4           | \$35.00                    |

A qualifying hospital's placement into a tier will be determined by the average of its percentage of paid PICU Medicaid days for SFY 2010 dates of service to the total of all qualifying hospitals' paid PICU days for the same time period, and its percentage of PICU patient outlier payments made as of December 31, 2010 for dates of service in SFY 2008 and SFY 2009 and calendar year 2010 to the total PICU outlier payments made to all qualifying hospitals for these same time periods.

This average shall be weighted to provide that each hospital's percentage of paid PICU days will comprise 25 percent of this average, while the percentage of outlier payments will comprise 75

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

---

percent. In order to qualify for tiers 1-4, a hospital must have received at least .25 percent of outlier payments in SFY 2008, SFY 2009, and calendar year 2010.

SFY 2010 is used as the base period to determine the allocation of NICU and PICU outlier payments for hospitals having both NICU and PICU units.

If the daily paid outlier amount per paid PICU day for any hospital is greater than the mean plus one standard deviation of the same calculation for all PICU level I and PICU level II hospitals, then the basis for calculating the hospital's percentage of PICU patient outlier payments shall be to substitute a payment amount equal to the highest daily paid outlier amount of any hospital not exceeding this limit, multiplied by the exceeding hospital's paid PICU days for SFY 2010, to take the place of the hospital's actual paid outlier amount.

**Exclusion Criteria**

Children's specialty hospitals are not eligible for the tier determined per diem adjustments.

**Assessment/Evaluation**

The Department shall evaluate all rates and tiers two years after implementation.

**Change in Level of Care in a Specialty Unit**

When a hospital wishes to change the level of care in a NICU or PICU, it must notify HSS and Rate Setting and Audit. Compliance with the specialized unit criteria shall be verified via an on-site survey within 30 days after receipt of application. **The rate implementation for a change in level of care of a NICU or PICU can only occur at the beginning of the hospital's subsequent cost reporting period.**

If it is subsequently discovered that a hospital does not meet the level of care for which it has previously been certified, recoupment of any inappropriate payments shall be made.

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****Burn Units**

Only when a hospital bills the appropriate and covered revenue code in accordance with the UB-04 National Billing Guidelines, will the burn unit per diem be paid.

**Transplant Services**

In-state transplant services are reimbursed at costs subject to a hospital-specific per diem limit that is based on each hospital's actual cost in the base year established for each type of approved transplant. Out of state transplant services are 40 percent of billed charges for adults and 60 percent of billed charges for children ages 0-21.

**Outliers**

In compliance with the requirement of §1902(s) (1) of the Social Security Act, additional payment shall be made for catastrophic costs associated with services provided to:

- Children under age six who received inpatient services in a disproportionate share hospital setting, and
- Infants who have not attained the age of one year who received inpatient services in any acute care setting.

Cost is defined as the hospital-specific cost to charge ratio based on the hospital's cost report period ending in SFY2000 (July 1, 1999 through June 30, 2000).

For new hospitals and hospitals that did not provide Medicaid NICU services in SFY 2010, the hospital specific cost to charge ratio will be calculated based on the first full year cost reporting period that the hospital was open or that Medicaid NICU services were provided.

The hospital specific cost to charge ratio will be reviewed bi-annually to determine the need for adjustment to the outlier payment. A deadline of six months subsequent to the date that the final claim is paid shall be established for receipt of the written request filing for outlier payments. Additionally, effective March 1, 2011, outlier claims for dates of service on or before February 28, 2011 must be received by the Department on or before May 31, 2011 in order to qualify for payment. Claims for this time period received by the Department after May 31, 2011 shall not qualify for payment.



**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

---

**NOTE:** Outlier payments are not payable for transplant procedures, and services provided to recipients with Medicaid coverage that is secondary to other payer sources.

Effective for dates of service on or after March 1, 2011, a catastrophic outlier pool shall be established with annual payments limited to \$10,000,000. In order to qualify for payments from this pool, the following conditions must be met:

- The claims must be for children less than six years of age who received inpatient services in a disproportionate share hospital setting; or infants less than one year of age who receive inpatient services in any acute care hospital setting; and
- The costs of the case must exceed \$150,000. The hospital specific cost to charge ratio utilized to calculate the claim costs shall be calculated using the Medicaid NICU or PICU costs and charge data from the most current cost report.

The initial outlier pool will cover eligible claims with admission dates from the period beginning March 1, 2011 through June 30, 2011.

- Payment for the initial partial year pool will be \$3,333,333 and shall be the costs of each hospital's qualifying claims net of claim payments divided by the sum of all qualifying claims cost in excess of payments, multiplied by \$3,333,333;
- Cases with admission dates on or before February 28, 2011 that continue beyond the March 1, 2011 effective date, and that exceed the \$150,000 cost threshold, shall be eligible for payment in the initial catastrophic outlier pool; and
- Only the costs of the cases applicable to dates of service on or after March 1, 2011, shall be allowable for determination of payment from this pool.

Beginning with SFY 2012, the outlier pool will cover eligible claims with admission dates during the SFY (July 1 through June 30) and shall not exceed \$10,000,000 annually. Payment shall be the costs of each hospital's eligible claims less the prospective payment, divided by the sum of all eligible claims costs in excess of payments, multiplied by \$10,000,000.

Outlier claims must be for a single continuous inpatient stay. Some hospital charges will be considered non-covered charges and will be removed from the total billed charges. For example, experimental drugs would be identified by revenue code, and removed from the total billed charges for a claim.

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

---

To submit an outlier claim, a copy of all of the UB-04s and corresponding remittance advice (RA) for a qualifying recipients entire inpatient stay (along with documentation of payment from third parties on the recipient's behalf for the stay, if applicable) must be received in Medicaid's Rate Setting and Audit Section office no later than six months after the latest RA date on that claim. **Failure to meet this six-month deadline will result in the outlier claim being denied.** If there are unresolved payment issues from third parties, the outlier claim should still be submitted in accordance with this timely filing requirement above, along with notification of the unresolved issues.

**Qualifying Loss Review Process**

Any hospital seeking an adjustment to the operations, movable, fixed capital, or education component of its rate shall submit a written request for administrative review within 30 days after receipt of the letter notifying the hospital of its rate. Rate notification date is considered to be five days from the date of the letter or the postmark date, whichever is later.

"Qualifying loss" in this context refers to that amount by which the hospital's operating costs, movable equipment costs, fixed capital costs, or education costs (excluding disproportionate share payment adjustments) exceed the Medicaid reimbursement for each component.

"Costs" when used in the context of operating costs, movable equipment costs, fixed capital costs, and education costs, means a hospital's costs incurred in providing covered inpatient services to Medicaid recipients as allowed by the *Medicare Provider Reimbursement Manual*.

**Permissible Basis**

Consideration for qualifying loss review is available only if one of the following conditions exists:

- Rate-setting methodologies or principles of reimbursement are incorrectly applied; or
- Incorrect or incomplete data or erroneous calculations were used in the establishment of the hospital's rate; or
- The amount allowed for a component in the hospital's prospective rate is 70 percent or less of the component cost it incurs in providing services that conform to the applicable state and federal laws of quality and safety standards.

**Basis Not Allowable**

The following matters are not subject to a qualifying loss review:

- The use of peer group weighted medians to establish operations component of the per diem;
- The use of peer group medians to establish movable equipment component of the per diem;
- The use of statewide median to establish fixed capital component of the per diem;
- The percentages used to blend peer group and hospital-specific costs during the three-year phase-in period;
- The use of teaching and non-teaching status, specialty hospital status, and bed-size as criteria for hospital peer groups;
- The use of Council of Teaching Hospitals full membership as criteria for major teaching status;
- The use of fiscal year 1991 medical education costs to establish a hospital-specific medical education component;
- The use of the DATA Resources, Inc. (DRI). DRI Type Hospital Market Basket Index as the prospective escalator;
- The decision not to escalate fixed capital beyond the implementation year;
- The criteria used to establish the levels of neonatal intensive care;
- The criteria used to establish the levels of pediatric intensive care;
- The methodology used to calculate the boarder baby rates for nursery;
- The criteria used to identify specialty hospital peer groups; and
- The criteria used to establish the level of burn care.

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.7: REIMBURSEMENT**

**Burden of Proof**

The hospital shall bear the burden of proof in establishing the facts and circumstances necessary to support a rate adjustment. Any costs that the provider cites as a basis for relief under this provision must be calculable and auditable.

**Required Documentation**

All requests for qualifying loss review shall specify the following:

- The nature of the adjustment sought;
- The amount of the adjustment sought;
- The reasons or factors that the hospital believes justify an adjustment; and
- An analysis demonstrating the extent to which the hospital is incurring or expects to incur a qualifying loss. However, such analysis is not required if the request is limited to a claim that:
  - The rate-setting methodology or criteria for classifying hospitals or hospital claims were incorrectly applied;
  - Incorrect or incomplete data or erroneous calculations were used in establishment of the hospital rates; or
  - The hospital has incurred additional costs because of a catastrophe.

**Consideration Factors for Additional Reimbursement Requests**

In determining whether to award additional reimbursement to a hospital that has made the showing required, the factors described below shall be considered.

Unreimbursed costs are generated by factors generally not shared by other hospitals in the hospital's peer group. Such factors may include, but are not limited to, extraordinary circumstances beyond the control of the hospital, and improvements required complying with licensing or accrediting standards. The request for rate adjustment may be denied where it

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

---

appears from the evidence presented that the hospital's costs are controllable through good management practices or cost containment measures.

Financial ratio data indicative of the hospital's performance quality in particular areas of hospital operation may require the hospital to provide additional data.

Even if reasonable action to contain costs on a hospital-wide basis has been taken, the hospital may be required to provide audited cost data or other quantitative data, including but not limited to: occupancy statistics, average hourly wages paid, nursing salaries per adjusted patient day, average length of stay, cost per ancillary procedure, average cost per meal served, average cost per pound of laundry, average cost per pharmacy prescription, housekeeping costs per square foot, medical records costs per admission, full-time equivalent employees per occupied bed, age of receivables, bad debt percentage, inventory turnover rate, and information about actions that the hospital has taken to contain costs.

**Determination to Award Relief**

Additional reimbursement shall be awarded to a hospital that demonstrates to the LDH by clear and convincing evidence that:

- The hospital demonstrated a qualifying loss; and
- The hospital's current prospective rate jeopardized the hospital's long-term financial viability; and
- The Medicaid population served by the hospital has no reasonable access to other inpatient hospitals for the services that the hospital provides and that the hospital contends are under-reimbursed.

**Notification of Relief Awarded**

Notification of decision regarding qualifying loss review shall be provided in writing. Should the decision be to award relief, relief consists of making appropriate adjustments so as to correctly apply the rate-setting methodology or to correct calculations, data errors, or omissions. A hospital's corrected rate component shall not exceed the lesser of its recalculated cost for that component or 150 percent of the provider's peer group rate for that component.

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.7: REIMBURSEMENT**

If subsequent discovery reveals that the provider was not eligible for qualifying loss relief, any relief awarded under this qualifying loss process shall be recouped.

**Effect of Decision**

Decisions to recognize omitted, additional, or increased costs incurred by any hospital; to adjust the hospital rates; or to otherwise award additional reimbursement to any hospital shall not result in any change in the peer group calculations for any rate component.

Rate adjustments granted under this provision shall be effective from the first day of the rate period to which the hospital's request for qualifying loss review relates, and shall continue in effect during subsequent rate periods, and be inflated for subsequent years.

However, no retroactive adjustment will be made to the rate or rates that were paid during any SFY prior to the year for which qualifying loss review was requested.

**Administrative Appeal**

The hospital may appeal an adverse qualifying loss decision to the Division of Administrative Law (DOA)/LDH Section (see Appendix B for contact information). The appeal must be lodged in writing within 30 days of receipt of the written decision, and state the basis for the appeal. Rate notification date is considered to be five days from the date of the letter or the postmark date, whichever is later. The administrative appeal shall be conducted in accordance with the Louisiana Administrative Procedures Act (L.R.S. 49:951 et seq.). The DOA shall submit a recommended decision to the Secretary of the Department, who will issue the final decision.

**Judicial Review**

Judicial review of the Secretary's decision shall be in accordance with the Louisiana Administrative Procedures Act (L.R.S. 49:951 et seq) and shall be filed in the 19th Judicial District Court.

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

---

**Reimbursement Methodology for Acute Care Inpatient Hospital Services****Small Rural Hospitals**

Small rural hospitals must meet the qualifications and definition as described earlier in this section under Inpatient Reimbursement.

Effective for dates of service on or after July 1, 2008, small rural hospitals shall be reimbursed at a prospective per diem rate. The payment rate for inpatient acute services in small rural hospitals shall be the median cost amount plus 10 percent. The median cost and rates shall be rebased at least every other year using the latest filed full period cost reports as filed in accordance with Medicare timely filing guidelines.

**State-Owned Hospitals**

State-owned acute hospitals are reimbursed costs for inpatient Medicaid services. Payment is made during the year based on an interim per diem rate. Final payment is based on costs determined per the Medicare/Medicaid cost report.

**Out-of-State Hospitals**

The Louisiana Medicaid program will reimburse claims for emergency medical services provided to Louisiana Medicaid eligible recipients who are temporarily absent from the state when:

- An emergency is caused by accident or illness;
- The health of the recipient would be endangered if the recipient undertook travel to return to Louisiana; and
- The health of the recipient would be endangered if medical care were postponed until the recipient returns to Louisiana.

Out-of-state hospital emergency room visits and related inpatient admissions do not require prior authorization. **Any other acute care services to be billed by a hospital require prior authorization for out-of-state services** (both inpatient and outpatient). Reimbursement for inpatient acute care for eligible Louisiana Medicaid recipients is made at: the lesser of the Medicaid per diem of the state where the facility is located; or 60 percent of billed charges for

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

recipients under age 21 years of age and 40 percent of billed charges for recipients 21 years of age and over. The list of out-of-state hospitals that have per diems assigned to them are found on the [lamedicaid.com](http://lamedicaid.com) website under the broad heading of “Inpatient Hospital Per Diems” after opening the “Fee Schedules” link.

Reimbursement is only made to enrolled Louisiana Medicaid hospital providers. Any hospital may enroll in Louisiana Medicaid and then bill for eligible (and properly authorized) services already provided. However, **the enrollment process must be completed**, and the bill must be submitted **prior to one year after the date of service**.

**Out-of-State Inpatient Psychiatric Services**

Inpatient stays for psychiatric or substance abuse treatment are only covered in out-of-state hospitals in the event of a medical emergency, for a maximum of two days, to allow time for the recipient to be stabilized and transferred to a Louisiana psychiatric hospital when appropriate. Outpatient psychiatric and substance abuse services provided by an out-of-state hospital are not covered.

**Inpatient Psychiatric (Free-Standing and Distinct Part Psychiatric Hospitals)**

Reimbursement for services provided in these facilities is a prospective per diem rate. This per diem includes all services provided to inpatients, except for physician services which should be billed separately. All therapies (individual/group counseling or occupational therapy) should be included in the per diem. Federal regulations prohibit Medicaid payment for recipients the ages of 22 and 64 in a free-standing psychiatric hospital.

**Outpatient Hospitals**

There are six different outpatient hospital fee schedules posted on the Louisiana Medicaid website:

- Hospital Outpatient Ambulatory Surgery Fee Schedule for Rural and State Hospitals;
- Hospital Outpatient Ambulatory Surgery Fee Schedule for Non-Rural, Non-State Hospitals;
- Hospital Outpatient Services Fee Schedule (non-ambulatory surgery);



**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.7: REIMBURSEMENT**

- Small Rural Hospital Outpatient Services Fee Schedule (non-ambulatory surgery);
- Sole Community Hospital Outpatient Services Fee Schedule (clinical diagnostic laboratory services); and
- State Hospital Outpatient Services Fee Schedule (non-ambulatory surgery).

**Clinical diagnostic laboratory services** are reimbursed at the lower of:

- Billed charges;
- The state maximum Medicaid amount for CPT codes in the corresponding Outpatient Hospital Services Fee Schedule which is based on the Medicare fee schedule; or
- Medicare Fee schedule amount.

Reimbursement for clinical diagnostic laboratory services complies with Upper Payment Limit (UPL) requirements for these services.

**NOTE: State-owned hospitals and small rural hospitals** - Effective for dates of service on and after July 1, 2008, these hospitals shall be reimbursed for outpatient clinical laboratory services at 100 percent of the current Medicare Fee Schedule.

**Outpatient hospital facility fees for office/outpatient visits** are reimbursed at the lower of:

- Billed charges; or
- The State maximum amount (70 percent of the Medicare Ambulatory Payment Classification (APC) payment rates as published in the 8/9/02 Federal Register).

Effective for dates of service July 1, 2008, small rural hospitals are reimbursed the above rate as an interim payment. Final reimbursement shall be 110 percent of allowable cost as calculated through the cost settlement process.

**Outpatient hospital facility surgery fees** are reimbursed at the lower of:

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.7: REIMBURSEMENT**

- Billed charges; or
- Established Medicaid payment rates assigned to each Healthcare Common Procedure Coding System (HCPCS) code based on the Medicare payment rates for ambulatory surgery center services.

Current HCPCS codes and modifiers shall be used to bill for all outpatient surgery services.

Effective for dates of service July 1, 2008, small rural hospitals are reimbursed the above rate as an interim payment. Final reimbursement shall be 100 percent of allowable cost as calculated through the cost settlement process.

**Rehabilitation Services (Physical, Occupational, and Speech Therapy)**

Rates for rehabilitation services are calculated using the base rate from fees on file in 1997. The maximum rate for outpatient rehabilitation services is set using the State maximum rates for rehabilitation services plus an additional 10 percent.

Rates for outpatient rehabilitation services provided to **recipients up to the age of three** are included in the fee schedule.

Effective for dates of service July 1, 2008, small rural hospitals are reimbursed the above rate as an interim payment. Final reimbursement shall be 110 percent of allowable cost as calculated through the cost settlement process.

**Other Outpatient Hospital Services**

Outpatient hospital services other than clinical diagnostic laboratory, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees for office/outpatient visits are paid as described below.

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.7: REIMBURSEMENT**

**In-State Non- Small Rural Private Hospital Outpatient Services**

Interim reimbursement is based on a hospital specific cost to charge ratio calculation from the latest filed cost reports. Updated cost to charge ratios are calculated as the cost reports are filed.

Final reimbursement is adjusted as follows:

| <b>Dates of Services</b>                | <b>Percentage of Costs</b> |
|---|----------------------------|
| Dates before August 1, 2006             | 83                         |
| August 1,2006 to February 19, 2009      | 86.2                       |
| February 20, 2009 to August 3, 2009     | 83.18                      |
| August 4, 2009 to February 2, 2010      | 78.48                      |
| February 3, 2010 to July 31, 2010       | 74.56                      |
| August 1, 2010 to December 31, 2010     | 71.13                      |
| January 1, 2011 to July 31, 2012        | 69.71                      |
| August 1, 2012 through January 31, 2013 | 67.13                      |
| February 1, 2013 and forward            | 66.46                      |

**In-State State-Owned Hospital Outpatient Services**

Interim reimbursement shall be 100 percent of each hospital’s cost to charge ratio as calculated from the latest filed cost report. Final reimbursement shall be 90 percent of allowable cost as calculated through the cost report settlement process.

**In-State Small Rural Hospital Outpatient Services**

Interim reimbursement shall be 110 percent of each hospital’s cost to charge ration as calculated from the latest filed cost report. Final reimbursement shall be 110 percent of allowable cost as calculated through the cost report settlement process.

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

---

**Out of State Hospital Outpatient Services**

Approved outpatient hospital services will be reimbursed at 31.04 percent of billed charges except for those outpatient services reimbursed based on a fee schedule. The Medicaid Program does not cost settle out-of-state hospitals.

**Cost Reporting**

The LDH is currently contracted with Leblanc, Robertson, Chisholm & Associates, LLC, formerly known as Cypress Audit Team, LLC for audit of Medicaid cost reports (see Appendix B for contact information). The Louisiana Medicaid Program tracks Medicare requirements for timely filing of cost reports. In accordance with the Medicare filing deadlines, all Louisiana hospitals enrolled in the Title XIX Medical Assistance (Medicaid) Program must submit a copy of their annual cost report to the current contractor.

The following must be included with your hospital cost report submission:

- Electronic cost report data file (ECR File);
- PDF copy of the cost report (hard copy if PDF not available);
- Working Trial Balance (cost center order if available);
- Completed Centers for Medicare and Medicaid Services (CMS) 339 questionnaire;
- Copy of Medicaid crosswalks for all units;
- Hospitals with a DPP Unit, NICU, PICU, Burn Unit, and/or Transplant Unit must complete a separate Worksheet S-3, D Part I, II, III, IV, D-1, and D-4 for each of the units to separately identify program costs, charges, and statistics associated with each specialty unit. The above worksheets for the non-specialty portion of the hospital are to exclude all specialty unit data;
- A detailed log of Medicaid recipients for carve out specialty units (NICU, PICU, Burn Unit, and/or Transplant Unit) which correlates with the filed cost report and includes the following data elements: recipient name, dates of service, number of patient days, number of discharges, room and ancillary charges. Only statistics

**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.7: REIMBURSEMENT****PAGE(S) 25**

---

related to the days that the recipient is physically in the specialty unit are includable in the specialty unit carve out. All other days and charges associated with these patients' stays, for instance - nursery, must be included with the non-specialty unit hospital statistics;

- Completed M Series Worksheets for all hospital based rural health clinics; and
- Medicare Inpatient Part B Detail from the Medicare Provider Statistical and Reimbursement (PS&R) Report.

**Supplemental Payments**

Upon approval from the CMS, various types of supplemental payment programs can be implemented given that funding is available. Some examples of these are payments related to hospitals impacted by hurricanes, high Medicaid utilization hospitals, graduate medical education (GME), teaching hospitals, low income and needy care collaboration hospitals, and payments made related to the UPL.

**Disproportionate Share**

Upon approval from CMS, various categories of Disproportionate Share (DSH) programs can be implemented given that funding is available. Examples of these are small rural hospital DSH, high Medicaid utilization DSH, DSH for community hospital uncompensated care, and DSH for public state-operated hospitals.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.8: CLAIMS RELATED INFORMATION****PAGE(S) 10**

---

**CLAIMS RELATED INFORMATION**

Hospital claims are to be billed using the Health Insurance Portability and Accountability Act (HIPAA) 837I or most current UB-04 claim form.

This section provides specific billing information for the services outlined below.

**Provider Preventable Conditions**

Effective for dates of service July 1, 2012, and thereafter; Louisiana Medicaid is mandated to meet the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for Provider Preventable Conditions (PPC's). The guidance below applies to fee-for-service claims including the shared savings Bayou Health Plans. The Prepaid Bayou Health Plans are required to implement their own procedures for non-payment for the same events when applicable to their enrollees. Providers should contact the plans to obtain additional information.

Provider Preventable Conditions are defined into two separate categories:

- Healthcare Acquired Conditions (HCAC's) and
- Other Provider Preventable Conditions (OPPC's).

Health Care Acquired Conditions include Hospital Acquired Conditions (HAC's) as outlined below. Other Provider Preventable Conditions refer to OPPCs (surgery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient).

No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for the patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

- The identified provider preventable conditions would otherwise result in an increase in payment.
- The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.

Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.8: CLAIMS RELATED INFORMATION**

The following diagnoses that were not present on admission are considered HCAC:

| HCAC   | Complications and Comorbidities (CC)/ Major Complications and Comorbidities (MCC) (ICD-9-CM Codes)  |
|--|---|
| Foreign Object Retained After Surgery  | 998.4 (CC)<br>998.7 (CC)  |
| Air Embolism   | 999.1 (MCC)   |
| Blood Incompatibility  | 999.60(CC)<br>999.61(CC)<br>999.62(CC)<br>999.63(CC)<br>999.69(CC)  |
| Pressure Ulcer Stages III & IV   | 707.23 (MCC)<br>707.24 (MCC)  |
| Falls and Trauma: <ul style="list-style-type: none"> <li>• Fracture</li> <li>• Dislocation</li> <li>• Intracranial Injury</li> <li>• Crushing Injury</li> <li>• Burn</li> <li>• Other Injuries</li> </ul>  | Codes within these ranges on the CC/MCC list:<br>800 – 829<br>830 - 839<br>850 - 854<br>925 - 929<br>940 - 949<br>991 - 994   |
| Catheter-Associated Urinary Tract Infection (UTI)  | 996.64 (CC)<br>Also excludes the following from acting as a CC/MCC:<br>112.2 (CC)<br>590.10 (CC)<br>590.11 (MCC)<br>590.2 (MCC)<br>590.3 (CC)<br>590.80 (CC)<br>590.81 (CC)<br>595.0 (CC)<br>597.0 (CC)<br>599.0 (CC) |
| Vascular Catheter-Associated Infection   | 999.31 (CC)   |
| Manifestations of Poor Glycemic Control: <ul style="list-style-type: none"> <li>• Diabetic Ketoacidosis</li> <li>• Nonketotic Hyperosmolar Coma</li> <li>• Hypoglycemic Coma</li> <li>• Secondary Diabetes with Ketoacidosis</li> <li>• Secondary Diabetes with Hyperosmolarity</li> </ul> | 250.10-250.13(MCC)<br>250.20-250.23(MCC)<br>251.0(CC)<br>249.10-249.11(MCC)<br>249.20-249.21(MCC)   |

**CHAPTER 25: HOSPITAL SERVICES**

**SECTION 25.8: CLAIMS RELATED INFORMATION**

| HCAC  | Complications and Comorbidities (CC)/ Major Complications and Comorbidities (MCC) (ICD-9-CM Codes)  |
|---|---|
| Surgical Site Infection, Mediastinitis, following Coronary Artery Bypass Graft (CABG)   | 519.2 (MCC)<br>And one of the following procedure codes:36.10-36.19   |
| Surgical Site Infection Following Certain Orthopedic Procedures: <ul style="list-style-type: none"> <li>• Spine</li> <li>• Neck</li> <li>• Shoulder</li> <li>• Elbow</li> </ul>   | 996.67 (CC)<br>998.59 (CC)<br><br>And one of the following procedure codes:81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85                           |
| Surgical Site Infection Following Bariatric Surgery for Obesity: <ul style="list-style-type: none"> <li>• Laparoscopic Gastric Bypass</li> <li>• Gastroenterostomy</li> <li>• Laparoscopic Gastric Restrictive Surgery</li> </ul>                 | <i>Principal Diagnosis:</i> 278.01<br><br>539.01 (CC)<br>539.81 (CC)<br>998.59 (CC)<br><br>And one of the following procedure codes: 44.38, 44.39, or 44.95 |
| Deep Vein Thrombosis and Pulmonary Embolism Following certain Orthopedic Procedures (with exception for pediatric and obstetric population) <ul style="list-style-type: none"> <li>• Total Knee Replacement</li> <li>• Hip Replacement</li> </ul> | 415.11 (MCC)<br>415.13 (MCC)<br>415.19 (MCC)<br>453.40-453.42 (MCC)<br><br>And one of the following procedure codes:00.85-00.87, 81.51-81.52, or 81.54      |

It will be the responsibility of the hospital to determine if the HCAC was the cause for any additional days added to the length of stay.

If there are any days that are attributable to the HCAC, these days are to be reported on the UB-04 as non-covered days utilizing the bill type of 110.

Medicaid will require the Present on Admission (POA) indicators as listed below with all reported diagnosis codes. Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered as present on admission.



**CHAPTER 25: HOSPITAL SERVICES****SECTION 25.8: CLAIMS RELATED INFORMATION****PAGE(S) 10****Present on Admission Reporting Options**

| <u>Code</u> | <u>Definition</u>  |
|-------------|--|
| Y           | Present at the time of inpatient admission   |
| N           | Not present at the time of inpatient admission   |
| U           | Documentation is insufficient to determine if condition is present on admission              |
| W           | Provider is unable to clinically determine whether condition was present on admission or not |

**Other Provider Preventable Conditions (OPPC's)**

Louisiana Medicaid also will not reimburse providers for other provider preventable conditions in any setting as follows:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

If there are any days that are attributable to the OPPC, these days are to be reported on the UB-04 as non-covered days utilizing the bill type of 110.

When a provider encounters a provider preventable condition listed above, they should use the appropriate ICD-9-CM diagnosis code reported in diagnosis position 2-9.

- E876.5-Performance of wrong operation (procedure) on correct patient (existing code)
- E876.6-Performance of operation (procedure) on patient not scheduled for surgery
- E876.7-Performance of correct operation (procedure) on wrong side/body part

Note: The above codes shall not be reported in the External Cause of Injury (E-code) field.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.8: CLAIMS RELATED INFORMATION****PAGE(S) 10**

---

**Outpatient Hospital Claims**

Providers are required to append one of the following applicable HCPCS modifiers to all lines related to the erroneous surgery(s)/procedure(s):

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

In summary, it is the responsibility of the provider to identify and report (through the UB-04) any PPC and not seek payment from Medicaid for any additional expenses incurred as a result of the PPC. Provider payments may be disallowed or reduced based on a post-payment review of the medical record.

**Blood**

The Medicaid Program will pay for all necessary blood while the recipient is hospitalized if other provisions to obtain blood cannot be made. However, every effort must be made to have the blood replaced. To bill for blood on the UB-04 form locator blocks 39 through 41 must be completed, and the total number of units billed must be entered in the Description of Services block.

**Hospital-Based Ambulance Services**

If a recipient is transported to a hospital that owns the hospital-based ambulance (ground or air) and is admitted, the ambulance charges must be billed on the UB-04 as part of the inpatient services using revenue code 540.

**Mother/Newborn**

Mother and newborn claims must be billed separately. The claim is to include only the mother's room/board and ancillary charges.

When a newborn remains hospitalized after the mother's discharge, the claim must be split billed. The first billing of the newborn claim should be for charges incurred on the dates that the mother was hospitalized. The second billing should be for the days after the mother's discharge. The newborn assumes the mother's discharge date as his/her admit date and the hospital will be required to obtain pre-certification.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.8: CLAIMS RELATED INFORMATION****PAGE(S) 10**

---

**Deliveries with Non-Payable Sterilizations**

Medicaid allows payment of an inpatient claim for a delivery/c-section when a non-payable sterilization is performed during the same hospital stay. When there is no valid sterilization form obtained, the procedure code for the sterilization and the diagnosis code associated with the sterilization should not be reported on the claim form, and charges related to the sterilization process should not be included on the claim form.

Providers will continue to receive their per diem for covered charges for these services. Claims for these services will not require any prior or post authorization (other than pre-certification) and may be billed via Electronic Media Claims (EMC) or on paper.

**Split-Billing**

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

- Hospitals must split-bill claims at the hospital's fiscal year end.
- Hospitals must split-bill claims when the hospital changes ownership.
- Hospitals must split-bill claims if the charges exceed \$999,999.99.
- Hospitals must split-bill claims with more than one revenue code that utilizes specialized per diem pricing (PICU, NICU, etc.).

Hospitals have discretion to split bill claims as warranted by other situations that may arise.

**Split-Billing Procedures**

Specific instructions for split-billing on the UB-04 claim form are provided below.

In the *Type of Bill* block (form locator 4), the hospital must enter code 112, 113, or 114 to indicate the specific type of facility, the bill classification, and the frequency for both the first part and the split-billing interim and any subsequent part of the split-billing interim.

In the *Patient Status* block (form locator 17), the hospital must enter a 30 to show that the recipient is "still a patient."

**NOTE:** When split-billing, the hospital should never code the first claim as a discharge.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.8: CLAIMS RELATED INFORMATION****PAGE(S) 10**

---

In the *Remarks* section of the claim form, the hospital must write in the part of stay for which it is split-billing. For example, the hospital should write in "Split-billing for Part 1," if it is billing for Part 1.

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

**Claims Filing For Outpatient Rehabilitation Services**

All outpatient hospital claims for therapy must have a prior authorization (PA) number in form locator 63.

When the revenue code listed at form locator 42 on the UB-04 is 420-424, 430-431, 434, 440-444 or 454, the correct procedure code corresponding to the revenue code must be entered in form locator 44, or the claim will be denied.

Durable medical equipment and medical supplies for the recipient must be prior authorized whether it is provided by the hospital or the DME provider.

**Billing for the Implantation of the Infusion Pump and Catheter**

Implantation of the infusion pump must be prior authorized. The surgeon who implants the pump shall submit a PA-01 Form to the Prior Authorization Unit (PAU) as part of the disciplinary team's packet. The surgeon must use his/her individual, rather than the group's provider number on the PA-01. The provider shall bill for the implantation of the intraspinal catheter by using the appropriate code.

These codes are to be billed on the CMS 1500 with the PA number included in item 23. Additionally, assistant surgeons, anesthesiologists and non-anesthesiologists-directed CRNA's may receive payment for appropriate codes associated with this surgery. All billers must include the PA number issued to the requesting physician in order to be reimbursed for the services.

**Billing for the Cost of the Infusion Pump**

The cost of the pump is a separate billable item. Hospitals will be reimbursed by Medicaid for their purchase of the infusion pump but must request PA for it by submitting a PA-01 to the PAU. The PA-01 should be submitted as part of the multidisciplinary team's packet. Hospitals will not be given a PA number for the pump until a PA request for the surgery has been received from the surgeon who will perform the procedure. If the surgeon's request is approved, the hospital will be given a PA number for the pump. To be reimbursed for the device the hospitals

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.8: CLAIMS RELATED INFORMATION****PAGE(S) 10**

---

shall use HCPCS code E0783 (implantable programmable infusion pump) on a CMS 1500 claim form with the letters “DME” written in red across the top of the form.

When preparing to bill for any of these services remember these simple steps:

- When completing the PA-01 use the hospital facility number.
- When billing on the CMS-1500 include the hospital facility number in form locator #33.

**Billing For Replacement Pumps and Catheters**

Replacement pumps shall be billed on a CMS 1500 claim form with the letters “DME” in red across the top. A copy of the original authorization letter should be attached for either the pump or the catheter. Use the appropriate covered codes for replacement pumps and catheter.

**The Crossover Claims Process**

Hospitals must submit claims for Medicare Part A (inpatient) and Medicare Part B (ancillary) charges to their Medicare intermediary for reimbursement. After Medicare makes payment, the claims will crossover to the Medicaid fiscal intermediary for payment of the co-insurance and deductible. Medicare and Medicaid recipient’s claims must be filed to Medicare within one year from the date of service.

**Inpatient Part A Crossovers**

The Medicare payment will be compared to the number of days billed times the Medicaid inpatient per diem rate. If the Medicare payment is more than what the Medicaid payment would have been, Medicaid will approve the claim at “zero”. If the Medicare payment is less, then Medicaid will pay on the Deductible and Coinsurance, up to what Medicaid would have paid as a Medicaid only claim not to exceed the coinsurance and deductible amounts. These claims will be indicated on the Remittance Advice as “Approved Claims”, with an EOB of 996 (“deductible and or coinsurance reduced to max allowable”), and a reduced or zero payment. These are considered paid claims and may not be billed to the recipient.

**Medicare Part A and B Claims**

The hospital should bill the Medicare intermediary for the inpatient portion covered by Part A and the ancillaries covered by Part B. The Medicare intermediary will make payment and cross the claims over to the Medicaid fiscal intermediary for payment up to co-insurance and deductible amounts.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.8: CLAIMS RELATED INFORMATION****PAGE(S) 10**

---

**Medicare Part A Only Claims**

If the recipient only has Medicare Part A coverage, then the hospital should submit an inpatient claim, including the ancillary charges, to its Medicare intermediary for reimbursement. The claim will cross over automatically to Medicaid for payment of the co-insurance and deductible amounts for the inpatient stay.

**Exhausted Medicare Part A Claims**

Occasionally Medicare/Medicaid recipients will exhaust not only their 90 days of inpatient care under Medicare Part A, but also their 60 lifetime reserve days. When this situation occurs, the hospital must submit a claim for the ancillary charges to its Medicare intermediary for reimbursement. Then the hospital must submit a paper claim with documentation of Medicare Part A being exhausted, e.g., a Notice of Medicare Claim Determination or the Medicare Part A EOB, and a copy of the Medicare Part B EOB to the Medicaid fiscal intermediary for processing. The following items must be completed for the claim to be paid:

- 121 must be entered in form locator 4 as the type of bill.
- The amount in the Total Charges column of the Medicare EOB (the dollar amount billed to Medicare Part B, not what has been paid by Part B) must be entered in form locator 54 as a third party payment.
- “Medicare Part A Benefits Exhausted” should be written in form locator 80.

The dates of service on the claim must match the dates of service on the Notice of Medicare Claim Determination or the Part A EOB to verify that Part A benefits have been exhausted. The exceptions to this rule are Medically Needy Spend-down claims where the effective date of Medicaid eligibility is after the date of admission and extended care claims from facilities designated as extended care hospitals by Medicaid.

**Medicare Part B Only Claims**

If the recipient only has Medicare Part B coverage, then the hospital should submit a claim for the ancillary charges to its Medicare intermediary for reimbursement. After Medicare has made its payment, the hospital should submit a claim for the inpatient charges (including ancillary charges), with the Medicare Part B EOB attached, to the Medicaid fiscal intermediary. The following items must be completed for the claim to be paid.

- 121 must be entered in form locator 4 as the type of bill.

---

**CHAPTER 25: HOSPITAL SERVICES**

---

**SECTION 25.8: CLAIMS RELATED INFORMATION****PAGE(S) 10**

---

- The amount in the Total Charges column of the Medicare EOB (the dollar amount billed to Medicare Part B, not what has been paid by Part B) must be entered in form locator 54.
- “Medicare Part B Only” must be written in form locator 80.

The Medicaid fiscal intermediary will process the claim for the allowable days and multiply the number of days by the hospital's per diem rate. The total Part B charges indicated in form locator 54 would then be deducted to calculate the payment for the claim.

**NOTE:** When filing for coinsurance and deductible on the ancillary charges, make sure that total charges filed to Part B equal total charges being filed on the UB04. A copy of the Medicare Part B EOB must be attached to the claim.

## **FORMS AND LINKS**

The hospital fee schedules can be obtained from the Louisiana Medicaid web site at:

[http://www.lamedicaid.com/provweb1/fee\\_schedules/feeschedulesindex.htm](http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm).

An updated list of the ambulatory surgery codes can be obtained from the Louisiana Medicaid web site at:

[http://www.lamedicaid.com/provweb1/fee\\_schedules/Out\\_Amb\\_FS\\_non-Rural\\_non-State.pdf](http://www.lamedicaid.com/provweb1/fee_schedules/Out_Amb_FS_non-Rural_non-State.pdf)

[http://www.lamedicaid.com/provweb1/fee\\_schedules/Out\\_Amb\\_FS\\_Rural\\_State.pdf](http://www.lamedicaid.com/provweb1/fee_schedules/Out_Amb_FS_Rural_State.pdf)

Other hospital related forms can be obtained from the Louisiana Medicaid web site at:

<http://www.lamedicaid.com/provweb1/Forms/forms.htm>

The Short Cervix Guide is included in this appendix.

The most recent instructions for completing the UB 04 form along with samples of UB 04 claim forms for hospital services routine billing are located on the home page of the Louisiana Medicaid website. The billing instructions and examples may also be accessed by using the below hyperlink.

[http://www.lamedicaid.com/provweb1/billing\\_information/UB04\\_Hospitals\\_NDC.pdf](http://www.lamedicaid.com/provweb1/billing_information/UB04_Hospitals_NDC.pdf)



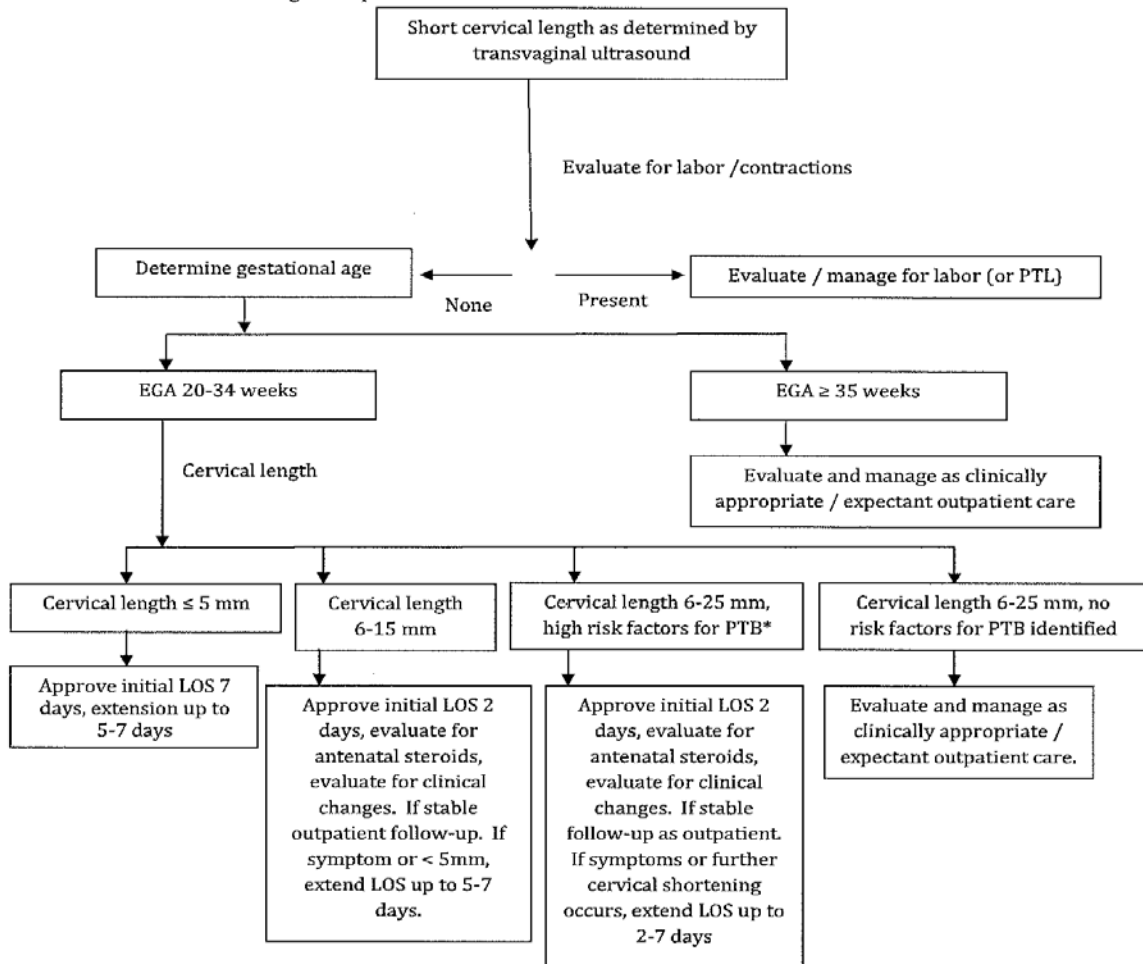
CHAPTER 25: HOSPITALS SERVICES

APPENDIX A: FORMS AND LINKS

Short Cervix Guide

Short Cervical Length in Pregnancy

A shortened cervical length, as measured by transvaginal ultrasound, has been associated with increased risk of preterm birth in some pregnancies. However, there is no clear published guidance on management of these pregnancies, or that intervention results in improved outcomes. Use of antenatal steroids has shown benefit in appropriately selected patients. The following protocol is suggested as a guide for selection of patients for inpatient evaluation / management. It is not intended to be a strict protocol and should be adapted as clinical conditions warrant, as provided by the patient's provider. Patients with cervical lengths of > 25 mm (20-37 weeks gestation) are generally considered to be at low risk for preterm birth and are not considered in this management protocol.



\*Risk factors include, but not limited to, multiple gestation, prior preterm birth / labor, incompetent cervix, FFN status.

Revised 08/24/10

**CHAPTER 25: HOSPITAL SERVICES****APPENDIX B: CONTACT/REFERRAL INFORMATION****PAGE(S) 4****CONTACT/REFERRAL INFORMATION****Molina Medicaid Solutions**

The Medicaid Program's fiscal intermediary, Molina Medicaid Solutions can be contacted for assistance with the following:

| TYPE OF ASSISTANCE  | CONTACT INFORMATION   |
|---|---|
| <b>e-CDI technical support</b>  | Molina Medicaid Solutions<br>(877) 598-8753 (Toll Free)   |
| <b>Electronic Media Interchange (EDI)</b><br>Electronic Claims testing and assistance | P.O. Box 91025<br>Baton Rouge, LA 70898<br>Phone: (225) 216-6000<br>Fax: (225) 216-6335   |
| <b>Pre-Certification Unit (Hospital)</b><br>Pre-certification issues and forms        | P.O. Box 14849<br>Baton Rouge, LA 70809-4849<br>Phone: (800) 877-0666<br>Fax: (800) 717-4329  |
| <b>Pharmacy Point of Sale (POS)</b>   | P.O. Box 91019<br>Baton Rouge, LA 70821<br>Phone: (800) 648-0790 (Toll Free)<br>Phone: (225) 216-6381 (Local)<br><i>*After hours, please call REVS</i>            |
| <b>Prior Authorization Unit (PAU)</b>   | Molina Medicaid Solutions – Prior Authorization<br>P.O. Box 14919<br>Baton Rouge, LA 70898-4919<br>Phone: (800) 807-1320<br>Fax: (225) 216-6476                   |
| <b>Provider Enrollment Unit (PEU)</b>   | Molina Medicaid Solutions-Provider Enrollment<br>P. O. Box 80159<br>Baton Rouge, LA 70898-0159<br>Phone: (225) 216-6370<br>Fax: (225) 216-6392                    |
| <b>Provider Relations Unit (PR)</b>   | Molina Medicaid Solutions – Provider Relations Unit<br>P. O. Box 91024<br>Baton Rouge, LA 70821<br>Phone: (225) 924-5040 or (800) 473-2783<br>Fax: (225) 216-6334 |
| <b>Recipient Eligibility Verification (REVS)</b>                                      | Phone: (800) 766-6323 (Toll Free)<br>Phone: (225) 216-7387 (Local)  |

**CHAPTER 25: HOSPITAL SERVICES**

**APPENDIX B: CONTACT/REFERRAL INFORMATION**

**Department of Health and Hospitals (DHH)**

| TYPE OF ASSISTANCE   | CONTACT INFORMATION  |
|--|--|
| <b>General Medicaid Information</b>  | General Hotline (888) 342-6207 (Toll Free)<br>www.lamedicaid.com   |
| <b>Health Standards Section (HHS)</b><br>Licensing Standards                             | P.O. Box 3767<br>Baton Rouge, LA 70821<br>Phone: (225) 342-0128<br>Fax: (225) 342-5292<br><a href="http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1623">http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1623</a>  |
| <b>Louisiana Children’s Health Insurance Program (LaCHIP)</b>                            | (225) 342-0555 (Local)<br>(877) 252-2447 (Toll Free)<br><a href="http://new.dhh.louisiana.gov/index.cfm/page/222">http://new.dhh.louisiana.gov/index.cfm/page/222</a>  |
| <b>Office of Aging and Adult Services (OAAS)</b><br>Waiver Assistance and Complaints     | P.O. Box 2031<br>Baton Rouge, LA 70821<br>Phone: (866) 758-5035<br>Fax: (225) 219-0202<br>E-mail: <a href="mailto:MedWeb@dhh.la.gov">MedWeb@dhh.la.gov</a><br><a href="http://dhh.louisiana.gov/index.cfm/subhome/12/n/327">http://dhh.louisiana.gov/index.cfm/subhome/12/n/327</a>  |
| <b>Office for Citizens with Developmental Disabilities (OCDD)</b>                        | 628 N. Fourth Street<br>P.O. Box 3117<br>Baton Rouge, LA 70821-3117<br>Phone: (225) 342-0095 (Local)<br>Phone: (866) 783-5553 (Toll-free)<br>E-mail: <a href="mailto:ocddinfo@la.gov">ocddinfo@la.gov</a><br><a href="http://new.dhh.louisiana.gov/index.cfm/subhome/11/n/8">http://new.dhh.louisiana.gov/index.cfm/subhome/11/n/8</a> |
| <b>Office of Management and Finance (Bureau of Health Services Financing) - MEDICAID</b> | P.O. Box 91030<br>Baton Rouge, LA 70810-9030<br><a href="http://new.dhh.louisiana.gov/index.cfm/subhome/1">http://new.dhh.louisiana.gov/index.cfm/subhome/1</a>  |
| <b>Rate Setting and Audit</b><br>Hospital Services                                       | P.O. Box 91030<br>Baton Rouge, LA 70821<br>Phone: 225-342-0127<br>225-342-9462   |
| <b>Recipient Assistance for Authorized Services</b>                                      | Phone: (888) 342-6207 (Toll Free)  |
| <b>Recovery and Premium Assistance</b><br>TPL Recovery, Trauma                           | P.O. Box 3588<br>Baton Rouge, LA 70821<br>Phone: (225) 342-8662<br>Fax: (225) 342-1376   |

**CHAPTER 25: HOSPITAL SERVICES**

**APPENDIX B: CONTACT/REFERRAL INFORMATION PAGE(S) 4**

**DHH (continued)**

|  |   |
|--|---|
| <p><b>Take Charge Plus</b></p>                     | <p>P.O. Box 91030<br/>                 Baton Rouge, LA 70821<br/>                 Phone: (888) 342-6207<br/> <a href="http://www.MakingMedicaidBetter.com">www.MakingMedicaidBetter.com</a></p>   |
| <p><b>Take Charge (Family Planning Waiver)</b></p> | <p>P.O. Box 91278<br/>                 Baton Rouge, LA 70821<br/>                 Phone: (888) 342-6207<br/>                 Fax: (877) 523-2987<br/> <a href="mailto:medweb@la.gov">medweb@la.gov</a><br/> <a href="http://new.dhh.louisiana.gov/index.cfm/page/232">http://new.dhh.louisiana.gov/index.cfm/page/232</a></p> |

**Fraud hotline**

| <p><b>TYPE OF ASSISTANCE</b></p> | <p><b>CONTACT INFORMATION</b></p>  |
|----------------------------------|--|
| <p>To report fraud</p>           | <p>Program Integrity (PI) Section<br/>                 P.O. Box 91030<br/>                 Baton Rouge, LA 70821-9030<br/>                 Fraud and Abuse Hotline: (800) 488-2917<br/>                 Fax: (225) 219-4155<br/> <a href="http://dhh.louisiana.gov/index.cfm/page/219">http://dhh.louisiana.gov/index.cfm/page/219</a></p> |

**Appeals**

| <p><b>TYPE OF ASSISTANCE</b></p> | <p><b>CONTACT INFORMATION</b></p>   |
|----------------------------------|---|
| <p>To file an appeal</p>         | <p>Division of Administrative Law (DAL) -<br/>                 Health and Hospitals Section<br/>                 Post Office Box 4189<br/>                 Baton Rouge, LA 70821-4189<br/>                 Phone: (225) 342-0443<br/>                 Fax: (225) 219-9823</p> |

**CHAPTER 25: HOSPITAL SERVICES**

**APPENDIX B: CONTACT/REFERRAL INFORMATION PAGE(S) 4**

**Other Helpful Contact Information:**

| TYPE OF ASSISTANCE  | CONTACT INFORMATION   |
|---|---|
| Leblanc, Robertson, Chisholm & Associates, LLC                                | Attention: Ms. Priscilla Smith<br>5555 Hilton Avenue, Suite 605<br>Baton Rouge, LA 70808<br>Phone: 225 218-6242<br>Email: <a href="mailto:questions@cypressaudit.com">questions@cypressaudit.com</a>                                      |
| McKesson Health Solutions, LLC<br>InterQual Support                           | 275 Grove Street, Suite 1-110<br>Newton, MA 02466-2273<br>Phone: 800-274-8374<br>Fax: 617-273-3777<br><a href="http://www.mckesson.com">www.mckesson.com</a><br>Email: <a href="mailto:cesupport@mckesson.com">cesupport@mckesson.com</a> |
| Office of Population Affairs (OPA) Clearinghouse                              | P.O. Box 30686<br>Bethesda, MD 20824-0686<br>Phone: 866-640-7827<br>Fax: 866-592-3299<br>E-mail: <a href="mailto:Info@OPAClearinghouse.org">Info@OPAClearinghouse.org</a>   |
| Thomson Reuters   | 777 East Eisenhower Parkway<br>Ann Arbor, MI 48108<br>Phone: 508-842-0656 / Help Line: 877-843-6796<br>Fax: 866-314-2572  |
| U.S. Department of Health & Human Services<br>Sterilization and Consent Forms | <a href="#">(see below)</a>   |

**The information about Sterilization and Consent Forms is:**

Instructions and a copy of the **Department of Health and Hospitals Office of Public Health Certification of Informed Consent-Abortion** form are available at:

[http://new.dhh.louisiana.gov/assets/docs/Making\\_Medicaid\\_Better/RequestsforProposals/CCNPAppendices/AppendixNAbortionCertificationofInformedConsent.pdf](http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/CCNPAppendices/AppendixNAbortionCertificationofInformedConsent.pdf)