



HOSPITAL SERVICES PROVIDER MANUAL

Chapter Twenty-five of the Medicaid Services Manual

Issued July 1, 2011

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

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CHAPTER 25: HOSPITAL SERVICES

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

OVERVIEW

This chapter applies to services provided to eligible Medicaid beneficiaries in an inpatient and/or outpatient hospital setting unless otherwise stated. Hospital providers are to ensure that the services provided to Medicaid beneficiaries 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 the Louisiana Department of Health's licensing requirements.

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

PROVIDER REQUIREMENTS

Enrollment in the Louisiana Medicaid Hospital Services Program is voluntary. Participating providers must accept the Medicaid payment as payment in full for those services covered by Medicaid. The Medicaid beneficiary must not 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 beneficiary. **The provider must inform the Medicaid beneficiary 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 Louisiana Department of Health's, 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 qualifying for distinct part status must complete a separate provider enrollment packet and be assigned a separate provider number from the rest of the hospital.

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INPATIENT SERVICES

Inpatient hospital care is defined 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 following:

- Attending physician;
- An emergency room physician; or
- 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 beneficiary 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

Precertification of inpatient hospital services is no longer a requirement for Legacy/Fee-for-Service Medicaid. Each day of an inpatient stay must be medically necessary. All claims for inpatient services are subject to post payment medical necessity review and recoupment, if medical necessity is not met.

NOTE: Changes to precertification requirements are for Legacy/Fee-for-Service Medicaid beneficiaries only. Managed care organizations will continue to require precertification of inpatient hospital stays for their members.

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Inpatient Status vs. Outpatient Status

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

Medicaid will allow up to 48 hours for a beneficiary 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).

NOTE: Providers should refer to Section 25.3 – Outpatient Services for additional information.

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 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 and must be billed using the Medicaid distinct part psychiatric number. 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.

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.

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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) website (see Appendix A).

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

Sterilizations are reimbursable only if:

- The beneficiary is at least 21 years old at time the informed consent form is signed;
- The beneficiary 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
- The beneficiary 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 beneficiary 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 beneficiary will be considered informed only if all the conditions described in this section are met.

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

- The beneficiary 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 beneficiary might be otherwise entitled;
- The beneficiary is provided a description of available alternative methods of family planning and birth control. Beneficiary is informed that sterilization is considered irreversible;
- The beneficiary is provided a thorough explanation of the specific sterilization procedure to be performed;
- The beneficiary 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; and
- 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 beneficiary who is blind, deaf, or otherwise disabled.

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

The beneficiary 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 beneficiary is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the beneficiary’s state of awareness.

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The beneficiary 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 beneficiary 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.**

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 beneficiary and appropriate diagnosis code that makes the pregnancy life endangering; and

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- The beneficiary'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 beneficiary 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 beneficiary must certify in writing that the pregnancy is a result of incest or rape and the treating physician must witness the beneficiary's certification by signature;
- The certification statements must be attached to the claim and include the complete name and address of the beneficiary and appropriate diagnosis code; and
- The beneficiary'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 beneficiary 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 beneficiary's state of awareness.

Spontaneous / Missed Abortions

Must be coded with the appropriate diagnosis code and the operative report must be attached to the claim.

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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.

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 surgical procedure code that denotes the termination of an ectopic pregnancy. A sterilization procedure code cannot be used. Use of an improper surgical procedure may cause the claim to deny.

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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 beneficiary permanently incapable of reproducing.

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

- The person securing authorization to perform the hysterectomy has informed the beneficiary and her representative (if any), both orally and in writing, that the hysterectomy will make the beneficiary permanently incapable of reproducing; and
- The beneficiary 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 beneficiary on or before the date of the hysterectomy.

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The consent must include signed acknowledgement from the beneficiary 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 beneficiary'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 beneficiary'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 beneficiary's name has changed and should include the beneficiary's social security number and date of birth. This letter should be attached to all claims requiring consent upon submission for claims processing.

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

- Beneficiary 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 beneficiary'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 beneficiary was already sterile before the hysterectomy, and the physician who performed the hysterectomy certifies in writing that the beneficiary was sterile at the time of the hysterectomy and states the cause of sterility;

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- The beneficiary 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 beneficiary was retroactively certified for Medicaid benefits, and the physician who performed the hysterectomy certifies in writing that the beneficiary was informed before the operation that the hysterectomy would make her permanently incapable of reproducing. In addition, if the beneficiary 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 beneficiary 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.

Deliveries Prior to 39 Weeks

Louisiana Medicaid does not reimburse for deliveries prior to 39 weeks that are not medically necessary. In order for claims to process, the Department must validate that the delivery was not prior to 39 weeks or if prior to 39 weeks, that it was medically necessary.

Please see the link below for reporting instructions of deliveries:

http://www.lamedicaid.com/provweb1/ProviderTraining/Packets/2014ProviderTraining/Performing_OB_Delivery_Services.pdf

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.

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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 and may be billed via electronic media claims (EMC) or on paper.

Donor Human Milk

Donor human milk provided in the inpatient hospital setting is covered for certain medically vulnerable infants.

Eligibility Criteria

Donor human milk is considered medically necessary when all of the following criteria are met:

- The hospitalized infant is less than 12 months of age with one or more of the following conditions:
 - Prematurity;
 - Malabsorption syndrome;
 - Feeding intolerance;
 - Immunologic deficiency;
 - Congenital heart disease or other congenital anomalies; and
 - Other congenital or acquired condition that places the infant at high risk of developing necrotizing enterocolitis (NEC) and/or infection.
- The infant's caregiver is medically or physically unable to produce breast milk at all or in sufficient quantities, is unable to participate in breastfeeding despite optimal lactation support, or has a contraindication to breastfeeding;

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- The infant’s caregiver has received education on donor human milk, including the risks and benefits, and agrees to the provision of donor human milk to their infant; and
- The donor human milk is obtained from a milk bank accredited by, and in good standing with, the Human Milk Banking Association of North America.

Reimbursement

Reimbursement for donor human milk is made separately from the hospital payment for inpatient services. The payment for the donor human milk is equal to the fee on the Durable Medical Equipment (DME) fee schedule.

Hospitals shall bill the donor human milk using the HCPCS procedure code T2101 (1 unit per ounce) 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 hard copy claim, the claim must be submitted with the word “DME” written in bold, black print on the top of the form.

Long-Acting Reversible Contraceptives in the Inpatient Hospital Setting

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 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.

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Other Inpatient Services

Blood

The Medicaid Program will pay for all necessary blood while the beneficiary 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: Claims Related Information for specific information for billing blood.

Hospital-Based Ambulance Services

If a beneficiary 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 beneficiary is transported to the facility which owns the ambulance.

NOTE: See Section 25.8: Claims Related Information 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 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).

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

NOTE: See other discharge criteria below.

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

If non-medical circumstances arise and the beneficiary does not leave the hospital when he/she is discharged and the hospital is not reimbursed, the beneficiary 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

If the beneficiary is **readmitted to a different hospital** than the discharging hospital on the same day as discharge, 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.

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.

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.

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Trade Area

In-state acute care provider resources must be utilized prior to referring a beneficiary 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:

Louisiana Trade Area		
Arkansas Counties	Mississippi Counties	Texas Counties
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	

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Louisiana Trade Area		
Arkansas Counties	Mississippi Counties	Texas Counties
	Issaquena County	
	Warren County	

Rehabilitation Units in Acute Care Hospitals

Rehabilitation Units (Medicare designated) 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 Medicaid provider numbers are not issued for rehabilitation units.

Psychiatric Diagnosis within an Acute Care Hospital

When the beneficiary’s primary diagnosis is psychiatric, payment will be on the psychiatric per diem and not the long-term or acute care rate.

NOTE: See Appendix B for website addresses and contacts mentioned in this section.

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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 beneficiaries 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 beneficiary 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; and
- 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 beneficiary 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 beneficiary is not admitted as an inpatient.

Physicians responsible for a beneficiary's care at the hospital are responsible for deciding whether the beneficiary should be admitted as an inpatient. Physicians should use a 24 hour period as a benchmark, i.e., they should order admission for beneficiaries 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

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physician has considered a number of factors. Admissions of particular beneficiaries are not covered or non-covered solely on the basis of the length of time the beneficiary actually spends in the hospital.

Medicaid will reimburse up to 48 medically necessary hours for a beneficiary to be in an outpatient status. This time frame is for the physician to observe the beneficiary and to determine the need for further treatment, admission to an inpatient status or for discharge. If the beneficiary 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 beneficiary's medical records.

Proton Beam Therapy

The Medicaid Program no longer covers proton beam radiation therapy (PBRT) for beneficiaries 21 years of age and older.

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 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; or
- Serious dysfunction of any organ or body part.

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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 beneficiary 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. Only one revenue code 450 or 459 may be used per emergency room visit. These revenue codes must be billed with the appropriate accompanying CPT codes of 99281, 99282, 99283, 99284, 99285, and 99291. 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 beneficiary'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 beneficiaries admitted from the ER or if the beneficiary 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 beneficiaries may be reimbursed if circumstances exist that make the use of any conveyance other than an ambulance medically inadvisable for transport of the beneficiary. Such circumstances must be documented in the beneficiary's medical record.

Hospital-based ambulances can be used only to transport beneficiaries 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 beneficiary 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.

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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;
- Gas embolism;
- Gas gangrene;
- Acute traumatic peripheral ischemia;
- Crush injuries and suturing of severed limbs;
- Progressive necrotizing infections;
- Acute peripheral arterial insufficiency;

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- Preparation and preservation of compromised skin grafts;
- Chronic refractory osteomyelitis;
- Osteoradionecrosis;
- Soft tissue radionecrosis;
- Cyanide poisoning;
- Actinomycosis; and
- Diabetic wounds of the lower extremities in beneficiaries who meet the following three criteria:
 - Beneficiary has type 1 or 2 diabetes and has a lower extremity wound that is due to diabetes;
 - Beneficiary has a wound classified as Wagner grade 111 or higher; and
 - Beneficiary has failed an adequate course of standard wound therapy.

NOTE: This list may not be all-inclusive.

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.

Long-Acting Reversible Contraceptives in the Outpatient Hospital Setting

For LARCs inserted in the outpatient hospital setting, hospitals receive an additional payment for the LARC device when it is inserted during an outpatient hospital visit. Payment for the LARC device in the outpatient hospital setting is in addition to the reimbursement for the outpatient hospital claim. Providers have been instructed to bill the outpatient claim for the outpatient visit on the UB-04 and the claim for the LARC device on the CMS 1500 claim form.

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Providers inserting LARCs in the outpatient hospital setting may bill the DME revenue code of 290 with the appropriate accompanying HCPCS code for the LARC device on the UB-04. Providers should consult the DME fee schedule for covered LARCs and their reimbursement.

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; and
- 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
Evaluation of Speech Fluency	92521
Evaluation of Speech Production	92522
Speech Sound Lang Comprehension	92523
Behavioral Qualit Analysis Voice	92524
Speech/Lang/Hear Therapy – per 15 min	92507
Physical Therapy Evaluation: Low Comp	97161

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Description	HCPC
Physical Therapy Evaluation: Mod Comp	97162
Physical Therapy Evaluation: High Comp	97163
Re-Evaluation of Physical Therapy	97164
Physical therapy – per 15 min	97110
Occupational Therapy Evaluation: Low Comp	97165
Occupational Therapy Evaluation: Mod Comp	97166
Occupational Therapy Evaluation: High Comp	97167
Re-Evaluation of Occupational Therapy	97168
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 beneficiaries under the age of 21 and for up to six months for beneficiaries 21 and over.

When a beneficiary is being discharged from an inpatient acute care stay and requires outpatient rehab services immediately, a PA request should be submitted using the beneficiary’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.

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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).

"Less individual care by others" is defined as the ability of the beneficiary 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.

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.

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 website (<https://www.lamedicaid.com/provweb1/default.htm>). 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 website (<https://www.lamedicaid.com/provweb1/default.htm>).

NOTE: When more than one surgical procedure is performed on the same date of service, only the primary surgical procedure will be paid. The CPT/HCPCS code for the primary surgical procedure must be entered in Form Locator 44 on the UB-04 form.

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.

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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.

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 procedures codes must be in conjunction with an ICD-10 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).

Observation Room Charges

When applicable, hospitals should bill for treatment or observation room charges with the appropriate covered revenue code. The payable observation room services revenue code is 762. This revenue code must be billed with the appropriate accompanying CPT codes of G0378 and G0379 or the claim will deny with error code 114 (INVALID OR MISSING HCPCS). The entire outpatient visit, including observation, may not exceed 48 hours duration.

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.

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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, 99212, 99213, 99214, and 99215.

Psychiatric and Substance Abuse

Outpatient psychiatric or substance abuse treatment is not covered.

Screening Mammography

When applicable, hospitals should bill for mammography screening services with the appropriate covered revenue code. The payable screening mammography revenue code is 403. This revenue code must be billed with the appropriate accompanying CPT codes for screening mammograms.

Diabetes Self-Management Training

Diabetes self-management training (DSMT) is a collaborative process through which beneficiaries 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 beneficiaries); and
- Encouragement and support for use of self-management skills.

DSMT programs should be aimed at educating beneficiaries 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;

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- 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;
- 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 beneficiary. Beneficiaries 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.

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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).

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 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 beneficiaries 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:

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- 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; and
- 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 beneficiary 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.

Beneficiaries enrolled in a managed care organization will receive DSMT through their health plan.

Medicaid Beneficiaries Not Eligible for DSMT

The following beneficiaries are not eligible for DSMT:

- Beneficiaries residing in an inpatient hospital or other institutional setting such as a nursing care facility, or a residential care facility;
- Beneficiaries receiving hospice services; or
- Beneficiaries enrolled in a managed care organization.

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 beneficiary 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.

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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 beneficiaries.

Follow-Up DSMT

After receiving the initial training, a beneficiary 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 beneficiary completes 10 hours of initial training, the beneficiary would be eligible for two hours of follow-up training for the next **calendar year**. If all 10 hours of initial training are not used within the first calendar year, then the beneficiary has 12 months to complete the initial training prior to follow up training.

- Example #1:

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

- Example #2:

If a beneficiary receives his first training in February 2011 and exhausts all 10 hours of initial training by November 2011, the beneficiary would be eligible for two hours of subsequent training beginning January 2012. If the beneficiary 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 beneficiaries to determine if the beneficiary 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.

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Provider Responsibilities

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

- **The beneficiary 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 ($A1c > 7$);
 - 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 beneficiary's primary care provider;
 - A comprehensive plan of care documented in the medical record;
 - Start and stop time of services;
 - Clinical notes, documenting beneficiary 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 beneficiary progress; and

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- All other pertinent documentation.

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

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 Healthcare Common Procedure Coding System (HCPCS) codes should be billed for DSMT services:

- G0108-Diabetes outpatient self-management training services, individual, per 30 minutes; and
- 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 beneficiary 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.

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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:

Louisiana Trade Area		
Arkansas Counties	Mississippi Counties	Texas Counties
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	

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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.

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SECTION 25.5: RESERVED

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SECTION 25.6: PRIOR AUTHORIZATION**PAGE(S) 17**

PRIOR AUTHORIZATION

Prior Authorization (PA) of certain services is necessary from a quality assurance, and 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 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****PAGE(S) 17****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 the Healthcare Common Procedure Coding System (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
Evaluation of Speech Fluency	92521
Evaluation of Speech Production	92522
Speech Sound Lang Comprehension	92523
Behavioral Qualit Analysis Voice	92524
Speech/Lang/Hear Therapy – per 15 min	92507
Physical Therapy Evaluation: Low Comp	97161
Physical Therapy Evaluation: Mod Comp	97162
Physical Therapy Evaluation: High Comp	97163
Re-Evaluation of Physical Therapy	97164

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SECTION 25.6: PRIOR AUTHORIZATION

Description	HCPC
Physical therapy – per 15 min	97110
Occupational Therapy Evaluation: Low Comp	97165
Occupational Therapy Evaluation: Mod Comp	97166
Occupational Therapy Evaluation: High Comp	97167
Re-Evaluation of Occupational Therapy	97168
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;
- 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

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- 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.

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:

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- 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.

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 Louisiana Department of Health (LDH). 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:

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- 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;
- 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

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- 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:
 - 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 LDH 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 LDH).

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.

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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.

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

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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.

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

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- 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.

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;

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- 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;
- 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).

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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.

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.

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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).

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; or
 - 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.

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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.

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.

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

- Medical and physical;
- Neurological;
- Functional;
- Psychosocial;
- Ashworth scores taken before and after the administration of the IBT test dose(s); and
- 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?

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- 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.

Positron Emission Tomography Scans**Positron Emission Tomography Scans for Oncologic Conditions**

Positron emission tomography (PET) scans are covered services, which require prior authorization, and must be consistent with Medicaid's clinical guidelines and medical necessity criteria for oncologic indications. The medical necessity criteria can be found at [PET Scan Medical Necessity Criteria](#). The procedure must be performed within 30 days of receiving prior authorization.

Combination Studies PET/Computed Tomography (CT)

The combination of PET and CT scans into a single system (PET/CT) may be considered for oncologic indications where a PET scan is considered medically necessary and specific anatomical identification is required to guide clinical management.

Prior Authorization

The following documentation is required for prior authorization of PET scans and PET/CT combination studies for oncologic conditions:

- Completed PA request form;
- Documentation of medical necessity includes all of the following;
- The primary diagnosis name and International Classification of Diseases (ICD) code(s) for the condition requiring PET imaging;
- All secondary diagnosis name(s) and ICD code(s) pertinent to comorbid condition(s);
- The most recent medical evaluation, including a summary of the medical history and the last physical exam (clinical information must be submitted

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by the recipient's treating oncologist);

- Laboratory and pathology reports pertinent to a diagnosis of malignant neoplasm or carcinoma;
- Risk factors or comorbid conditions;
- The patient's treatment plan, including a description of the type and dates of any anti-tumor therapy; and
- Any additional clinical information that supports the coverage criteria and that is requested by the PAU.

The payable revenue codes for positron emission tomography scans are 343 and 404. These revenue codes must be billed with the appropriate accompanying CPT codes for PET scans.

Reconsiderations

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

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).

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).

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.

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.

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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;
- **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; or
- **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

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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;
- Freestanding Psychiatric Hospitals;
- Distinct Part Psychiatric (DPP) Hospitals;
- Long Term Acute Care (LTAC) Hospitals; and
- Rehabilitation Hospitals

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

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indeed had more than 1,500 Medicaid deliveries in that SFY. It is the hospital's responsibility to request qualifying status in order to be paid the well-baby per diem rate. If the hospital does not inform LDH of their change in status, they will not qualify.

The Rate Setting and Audit Section generates an annual report to determine if there are any new hospitals that may qualify. **If the Rate Setting and Audit Section cannot determine from the hospital's billing data, available at the time of the report, that it had 1,500 Medicaid deliveries, the hospital must then provide documentation satisfactory to LDH that supports the 1,500 Medicaid deliveries in that SFY.** If the hospital does not notify LDH of their change in status *and* provide sufficient information supporting the 1,500 Medicaid deliveries in the time frame specified above, the hospital will not be eligible for the well-baby per diem rate.

Medicaid eligibles do count as Medicaid deliveries, but must be billed to Medicaid, in order 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.

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,

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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.

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).

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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.

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

If the qualifying hospital's average percentage:	Tier	Additional Per Diem
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

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

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.

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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.

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 PICU 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.

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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.

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

If the qualifying hospital's average percentage	Tier	Additional Per Diem
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 Hospital received greater than .25 percent of the outlier payments for dates of service in: <ul style="list-style-type: none"> • SFY 2008, • SFY 2009, and • Calendar year 2010 	3	\$178.27

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If the qualifying hospital:	Tier	Additional Per Diem
Exceeds 0 percent but received less than .25 percent of outlier payments for dates of service in: <ul style="list-style-type: none"> • SFY 2008, • SFY 2009, and • Calendar year 2010 	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 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.

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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.

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.

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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.

NOTE: Outlier payments are not payable for transplant procedures, and services provided to beneficiaries 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;

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- 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.

To submit an outlier claim, a copy of all of the UB-04s and corresponding remittance advice (RA) for a qualifying beneficiaries entire inpatient stay (along with documentation of payment from third parties on the beneficiary'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.

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"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 beneficiaries 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;
- 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;

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- 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.

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:

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- 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 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;

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- 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 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.

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, shall continue in effect during subsequent rate periods, and shall 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

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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.

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.

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 beneficiaries who are temporarily absent from the state when:

- An emergency is caused by accident or illness;
- The health of the beneficiary would be endangered if the beneficiary undertook travel to return to Louisiana; and

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- The health of the beneficiary would be endangered if medical care were postponed until the beneficiary 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 beneficiaries 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 beneficiaries under age 21 years of age and 40 percent of billed charges for beneficiaries 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 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 beneficiary 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 beneficiaries the ages of 22 and 64 in a free-standing psychiatric hospital.

Outpatient Hospitals

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

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

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

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:

- 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.

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 **beneficiaries up to the age of three** are included in the fee schedule.

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.

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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:

Dates of Services	Percentage of Costs
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 to January 31, 2013	67.13
February 1, 2013 to December 31, 2016	66.46
January 1, 2017 to December 31, 2017	71.13
January 1, 2018 and forward	74.56

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 ratio 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.

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 beneficiaries 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: beneficiary name, dates of service, number of patient days, number of discharges, room and ancillary charges. Only statistics related to the days that the beneficiary is physically in the specialty unit are

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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 Hospitals (DSH) payments 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.

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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

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 of the Social Security Act with respect to non-payment for Provider Preventable Conditions (PPCs). The guidance below applies to the Legacy Medicaid/Fee-For-Service delivery model. Managed care organizations 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 (HCACs); and
- Other Provider Preventable Conditions (OPPCs).

Healthcare Acquired Conditions include Hospital Acquired Conditions (HACs) 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; and
- 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.

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Please see the link below for the current listing of Hospital Acquired Conditions (HACs) and associated diagnoses:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html

NOTE: Louisiana Medicaid considers HACs as identified by Medicare, other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

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.

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

NOTE: All claims with a POA indicator with a healthcare-acquired condition code will be denied payment.

Please see the link below for the current listing of diagnoses that are exempt from Present on Admission reporting requirements:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html>

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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; or
- 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-10-CM diagnosis code reported in diagnosis position 2-9:

- Y65.51-Performance of wrong operation (procedure) on correct patient (existing code);
- Y65.52-Performance of operation (procedure) on patient not scheduled for surgery;
or
- Y65.53-Performance of correct operation (procedure) on wrong side/body part.

Note: The above codes shall not be reported in the External Cause of Injury field.

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; or
- PC: Wrong Surgery on Patient.

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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 beneficiary 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 beneficiary 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.

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 and may be billed via Electronic Media Claims (EMC) or on paper.

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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; and
- 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 beneficiary is "still a patient."

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

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.

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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 beneficiary 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 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; and
- When billing on the CMS-1500 include the hospital facility number in form locator #33.

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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 beneficiary’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 beneficiary.

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.

Medicare Part A Only Claims

If the beneficiary 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 beneficiaries 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

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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; and
- “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 beneficiary 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;
- 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; and
- “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.

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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.

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APPENDIX A: FORMS AND LINKS**PAGE(S) 1**

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.

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_Rural_State.pdf

The current listing of Hospital Acquired Conditions (HACs) and associated diagnoses can be obtained by using the below hyperlink.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html

The current listing of diagnoses that are exempt from Present on Admission (POA) reporting requirements may be obtained by using the below hyperlink.

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html>

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

Instructions and a copy of the **Louisiana 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/CCNP_Appendices/AppendixNAbortionCertificationofInformedConsent.pdf

Other hospital related forms, including the Consent to Sterilization form, can be obtained from the Louisiana Medicaid web site at:

<http://www.lamedicaid.com/provweb1/Forms/forms.htm>

CHAPTER 25: HOSPITAL SERVICES**APPENDIX B: CONTACT/REFERRAL INFORMATION****PAGE(S) 4****CONTACT/REFERRAL INFORMATION****Gainwell Technologies**

The Medicaid Program's fiscal intermediary, Molina Medicaid Solutions can be contacted for assistance with the following:

TYPE OF ASSISTANCE	CONTACT INFORMATION
e-CDI technical support	Gainwell Technologies (877) 598-8753 (Toll Free)
Electronic Media Interchange (EDI) Electronic Claims testing and assistance	P.O. Box 91025 Baton Rouge, LA 70898 Phone: (225) 216-6000 Fax: (225) 216-6335
Pharmacy Point of Sale (POS)	P.O. Box 91019 Baton Rouge, LA 70821 Phone: (800) 648-0790 (Toll Free) Phone: (225) 216-6381 (Local) <i>*After hours, please call REVS</i>
Prior Authorization Unit (PAU)	Gainwell Technologies – Prior Authorization Phone: (800) 807-1320 e-PA Fax: (225) 216-6481
Provider Enrollment Unit (PEU)	Gainwell Technologies-Provider Enrollment P. O. Box 80159 Baton Rouge, LA 70898-0159 Phone: (225) 216-6370 Fax: (225) 216-6392
Provider Relations Unit (PR)	Gainwell Technologies – Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: (225) 924-5040 or (800) 473-2783 Fax: (225) 216-6334
Recipient Eligibility Verification (REVS)	Phone: (800) 766-6323 (Toll Free) Phone: (225) 216-7387 (Local)

CHAPTER 25: HOSPITAL SERVICES**APPENDIX B: CONTACT/REFERRAL INFORMATION****PAGE(S) 4****Louisiana Department of Health (LDH)**

TYPE OF ASSISTANCE	CONTACT INFORMATION
General Medicaid Information	General Hotline (888) 342-6207 (Toll Free) www.lamedicaid.com
Health Standards Section (HHS) Licensing Standards	P.O. Box 3767 Baton Rouge, LA 70821 Phone: (225) 342-0128 Fax: (225) 342-5292 http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1623
Louisiana Children's Health Insurance Program (LaCHIP)	(225) 342-0555 (Local) (877) 252-2447 (Toll Free) http://new.dhh.louisiana.gov/index.cfm/page/222
Office of Aging and Adult Services (OAAS) Waiver Assistance and Complaints	P.O. Box 2031 Baton Rouge, LA 70821 Phone: (866) 758-5035 Fax: (225) 219-0202 E-mail: MedWeb@dhh.la.gov http://dhh.louisiana.gov/index.cfm/subhome/12/n/327
Office for Citizens with Developmental Disabilities (OCDD)	628 N. Fourth Street P.O. Box 3117 Baton Rouge, LA 70821-3117 Phone: (225) 342-0095 (Local) Phone: (866) 783-5553 (Toll-free) E-mail: ocddinfo@la.gov http://new.dhh.louisiana.gov/index.cfm/subhome/11/n/8
Office of Management and Finance (Bureau of Health Services Financing) - MEDICAID	P.O. Box 91030 Baton Rouge, LA 70810-9030 http://new.dhh.louisiana.gov/index.cfm/subhome/1
Rate Setting and Audit Hospital Services	P.O. Box 91030 Baton Rouge, LA 70821 Phone: 225-342-0127 225-342-9462
Beneficiary Assistance for Authorized Services	Phone: (888) 342-6207 (Toll Free)
Recovery and Premium Assistance TPL Recovery, Trauma	P.O. Box 3588 Baton Rouge, LA 70821 Phone: (225) 342-8662 Fax: (225) 342-1376

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LDH (continued)

<p>Take Charge Plus</p>	<p>P.O. Box 91030 Baton Rouge, LA 70821 Phone: (888) 342-6207 www.MakingMedicaidBetter.com</p>
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Fraud hotline

<p>TYPE OF ASSISTANCE</p>	<p>CONTACT INFORMATION</p>
<p>To report fraud</p>	<p>Program Integrity (PI) Section P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 http://dhh.louisiana.gov/index.cfm/page/219</p>

Appeals

<p>TYPE OF ASSISTANCE</p>	<p>CONTACT INFORMATION</p>
<p>To file an appeal</p>	<p>Division of Administrative Law (DAL) - Health and Hospitals Section Post Office Box 4189 Baton Rouge, LA 70821-4189 Phone: (225) 342-0443 Fax: (225) 219-9823</p>

Other Helpful Contact Information:

<p>TYPE OF ASSISTANCE</p>	<p>CONTACT INFORMATION</p>
<p>Leblanc, Robertson, Chisholm & Associates, LLC</p>	<p>Attention: Ms. Priscilla Smith 5555 Hilton Avenue, Suite 605 Baton Rouge, LA 70808 Phone: 225 218-6242 Email: questions@cypressaudit.com</p>
<p>Office of Population Affairs (OPA) Clearinghouse</p>	<p>P.O. Box 30686 Bethesda, MD 20824-0686 Phone: 866-640-7827 Fax: 866-592-3299 E-mail: Info@OPAClearinghouse.org</p>

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TYPE OF ASSISTANCE	CONTACT INFORMATION
Thomson Reuters	777 East Eisenhower Parkway Ann Arbor, MI 48108 Phone: 508-842-0656 / Help Line: 877-843-6796 Fax: 866-314-2572