LOUISIANA DEPARTMENT OF HEALTH

PROFESSIONAL SERVICES

Chapter Five of the Medicaid Services Manual

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

State of Louisiana
Bureau of Health Services Financing

PROFESSIONAL SERVICES

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OVERVIEW

Professional services are provided by, but are not limited to, physicians, advanced practice registered nurses (RNs), certified registered nurse anesthetists (CRNAs), physician assistants, audiologists, optometrists and other health care professionals. These services are provided within the licensed individual's scope of practice, as defined by Louisiana law and are provided by, or under the personal direction and supervision of, a State Board licensed individual as authorized under Louisiana law.

This chapter is designed to offer the provider a description of Medicaid benefits in the professional services program and the policies relating to those benefits.

Some professional services may be subject to service limitations or prior authorization (PA). These specific limitations, or prior authorization requirements, are detailed in the topic-specific policy.

Participation in Medicaid is voluntary. Licensed professionals seeking reimbursement for services provided to Medicaid beneficiaries must be enrolled with Louisiana Medicaid and accept the Medicaid payment as payment in full for Medicaid covered services. Services reimbursed by Medicaid may be subject to post-payment review and recoupment of any overpayments.

The Medicaid Services Manual contains information about Medicaid fee-for-service (FFS) benefits. This manual chapter provides the minimum service requirements for the Professional Services Program. Providers must comply with the service coverage requirements outlined in this policy. For information concerning managed care benefits, providers should refer to the comprehensive provider manual maintained by each managed care organization (MCO).

LEGAL DISCLAIMER

The Louisiana Department of Health (LDH) strives to make the information in this manual as accurate, complete, reliable and as timely as possible. Providers are responsible to ensure services are delivered in accordance with the version of this manual in effect on the date of service.

LDH, its employees, agents, or others will not be liable or responsible for any claim, loss, injury, liability, or damages related to use of or reliance upon this information.

Abortion

Induced Abortion

The use of public funds to provide induced abortion services must meet applicable state and federal laws.

Medicaid payment for induced abortion is restricted to those that meet the following criteria:

1. A physician has found, and so certifies in their own handwriting, that on the basis of their professional judgment, the life of the pregnant beneficiary would be endangered if the fetus was carried to term;

2. The certification statement, must contain the name and address of the beneficiary, and must be attached to the claim form. The diagnosis or medical condition which makes the pregnancy life endangering must be specified on the claim; or

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

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

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

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

    d. The "Office of Public Health (OPH) Certification of Informed Consent-Abortion" form shall be witnessed by the treating physician.

In order for Medicaid reimbursement to be made for an induced abortion, providers must attach a copy of the "OPH Certification of Informed Consent-Abortion" form to their claim form. (See Appendix B for information on obtaining a copy of this form).

Claims associated with an induced abortion, including those of the attending physician, hospital, assistant surgeon, and anesthesiologist must be accompanied by a copy of the attending physician's written statement of medical necessity; therefore**, only hard-copy claims** will be reviewed by the fiscal intermediary (FI) physician consultants for payment consideration.

Threatened, Incomplete or Missed Abortion

Claims for threatened, incomplete, or missed abortion must include the beneficiary history and complete documentation of treatment.

Supporting documentation that will substantiate payment may include, but is not limited to, one or more of the following:

1. Sonogram report showing no fetal heart tones;
2. History indicating passage of fetus at home, en route, or in the emergency room (ER);
3. Pathology report showing degenerating products of conception; or
4. Pelvic exam report describing stage of cervical dilation.

Advanced Practice Registered Nurses: Clinical Nurse Specialists, Certified Nurse Practitioners, and Certified Nurse Midwives

Advanced practice registered nurses (APRNs) must hold a current, unencumbered and valid license from the Louisiana Board of Nursing to participate in Louisiana Medicaid. Nurses licensed as APRNs include:

1. Clinical Nurse Specialists (CNSs);
2. Certified Nurse Practitioners (CNPs); and
3. Certified Nurse Midwifes (CNMs).

APRNs shall comply with their scope of practice as authorized by Louisiana state law and regulations.

Billing Information

APRNs must obtain an individual Medicaid provider number.

APRNs **not** linked to a physician group must place their individual provider numbers in block 33B on the CMS-1500 claim form, or the appropriate loop and segment of the 837P as the billing provider.

Physicians who employ or contract with APRNs must obtain group provider numbers and link the individual APRN provider number to the group number. Physician groups must notify, in writing, the fiscal intermediary's (FI's) Provider Enrollment Unit (PEU) of such employment or contract(s) when APRNs are added/removed from the group.

Services provided by an APRN **must be identified** by entering the provider number of the APRN in block 24J and the group number in block 33B on the CMS-1500 claim form as well as the appropriate loop and segment for the 837P.

APRNs employed or under contract to a group or facility may not bill individually for the same services for which reimbursement is made to the group or facility.

Reimbursement

Unless otherwise excluded by the Medicaid program, coverage of services will be determined by individual licensure, scope of practice, and terms of the physician collaborative agreement. Collaborative agreements must be available for review upon request by authorized representatives of the Medicaid program.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) medical, vision and hearing preventive services, immunizations, physician-administered medications, and long-acting reversible contraceptives (LARCs) are reimbursed at 100 percent of the physician fee on file. All other payable procedures are reimbursed at 80 percent of the physician fee on file.

Qualified APRNs who perform as first assistant in surgery should use the "AS" modifier to identify these services.

After Hours Care on Evenings, Weekends, and Holidays

Louisiana Medicaid's after hours care policy is intended to facilitate beneficiary access to services during non-typical hours, primarily to reduce the inappropriate use of the hospital emergency department (ED). Reimbursement for the evening, weekend, and holiday procedure codes is intended to assist with coverage of the additional administrative costs associated with staffing outside of non-typical hours.

The *Current Procedural Terminology* (CPT) evening, weekend, and holiday codes are reimbursed in addition to the reimbursement for most outpatient evaluation and management (E/M) services, when the services are rendered in settings other than hospital EDs during the hours of:

1. Monday through Friday between 5 P.M. and 8 A.M. (when outside of regular office hours);

2. Weekends (12 A.M. Saturday through midnight on Sunday); or

3. State/Governor proclaimed legal holidays (12 A.M. through midnight).

Only one of the evening, weekend, and holiday codes may be submitted by a billing provider per day per beneficiary. Providers should select the evening, weekend, and holiday procedure codes that most accurately reflect the situation on a particular date. These codes are never reported alone, but in addition to another code or codes describing the service related to that beneficiary's visit or encounter. The following examples illustrate the appropriate use of evening, weekend, and holiday procedure codes based on the situation described:

1. If the existing office hours are Monday through Friday from 8 A.M. to 5 P.M., and the physician treats the beneficiary in the office at 7 P.M., the provider may report the appropriate basic service (E/M visit code) and evening, weekend, and holiday code.

2. If the existing office hours are Monday through Friday from 8:30 A.M. to 6:30 P.M., and the physician treats the beneficiary in the office at 6 P.M., the provider may not report the evening, weekend, and holiday code.

3. If a beneficiary is seen in the office on Saturday during existing office hours, the provider may report the appropriate basic service (E/M visit code) and evening, weekend, and holiday code.

Documentation in the medical record relative to this reimbursement must include the time the services were rendered. Should there be a post payment review of claims, providers may also be

asked to submit documentation regarding the existing office hours during the timeframe being reviewed.

Reimbursement

The reimbursement for evening, weekend, and holiday services is based on the following current CPT codes or their successors:

1. 99050 (Services…at times other than regularly scheduled office hours…); or

2. 99051 (Services …at regularly scheduled evening, weekend, or holiday hours…).

When used, these procedure codes must be submitted with the code(s) for the associated E/M services on that date.

Providers should refer to the fee schedule on the Medicaid website for reimbursement information relative to these codes. (See Appendix A for information on how to access the fee schedule).

Providers are instructed to bill usual and customary charges.

NOTE: Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) providers should refer to policies in the manual specific to these providers.

Allergy Testing and Immunotherapy

Louisiana Medicaid covers allergy testing and allergen immunotherapy relating to hypersensitivity disorders manifested by generalized systemic reactions as well as by localized reactions in any organ system of the body. Covered allergy services include:

1. In vitro specific immunoglobulin E (IgE) tests;
2. Intracutaneous (intradermal) skin tests;
3. Percutaneous skin tests;
4. Ingestion challenge testing; and
5. Allergen immunotherapy.

Allergy Testing

Allergy testing is only covered for beneficiaries who have symptoms of allergic disease, such as respiratory symptoms, skin symptoms, or other symptoms that consistently follow a particular exposure, not including local reactions after an insect sting or bite.

The number of allergy tests performed must be judicious and dependent upon the history, physical findings, and clinical judgment of the provider (i.e., all beneficiaries should not necessarily receive the same test or number of tests).

Allergen Immunotherapy

Allergen immunotherapy is covered:

1. Up to 180 doses every calendar year, per beneficiary, for supervision of preparation and provision of antigens other than those related to stinging or biting insects;
2. Up to 52 doses every calendar year, per beneficiary, for supervision of preparation and provision of antigens related to stinging or biting insects; and
3. When medically necessary, if doses exceed the above quantities.

Reimbursement

When submitting claims for allergy testing and allergen immunotherapy, providers are to use the most appropriate and inclusive *Current Procedural Terminology* (CPT) codes that describe the services provided. Unless otherwise listed, Louisiana Medicaid uses the definitions and criteria found in the CPT manual.

The procedure codes used for allergen immunotherapy include the necessary professional services associated with this therapy, including monitoring of the injection site and post-injection observation of the beneficiary for adverse reactions. Office visit codes may be billed in addition to immunotherapy only if other significant identifiable services are provided at that time.

Ambulatory Surgical Centers (Non-Hospital)

An ambulatory surgical center (ASC) is a freestanding facility, separate from a hospital, which meets the needs of eligible beneficiaries for outpatient surgery, usually on a single day basis.

An ASC must be licensed and certified by Louisiana's licensing and certification agency, and shall continuously meet Louisiana Medicaid standards as determined by the Bureau of Health Services Financing (BHSF), Health Standards Section (HSS).

ASCs are reimbursed a flat fee per occurrence that includes all charges by the facility for the care of the beneficiary while the beneficiary is in the center. The costs of contract physicians are included in the flat fee rate.

Payment does not include the private fees of physicians, dentists, anesthesiologists, radiologists, or osteopaths. These services are billed by the physician or other provider on the CMS-1500 claim form.

ASC claims should be completed on the CMS-1500 claim form or electronically on the 837P. Only one line item is allowed per claim form. Louisiana Medicaid allows only one procedure code to be reimbursed per outpatient surgical session.

Reimbursement

ASCs are reimbursed a flat fee per occurrence based on reasonable charges not to exceed the Medicare maximum. Reimbursement is in accordance with four payment groups as specified on the "ASCs (Non-Hospital) Fee Schedule." (See Appendix A for information on how to access this fee schedule).

Chronic pain management is not a covered service. Funds reimbursed for this purpose are subject to recoupment.

NOTE: For additional information regarding ASCs, refer to the ASC section of the provider manual. (See Appendix A for information on how to access this manual).

Anesthesia Services

Surgical Anesthesia

Surgical anesthesia services may be provided by an anesthesiologist or certified registered nurse anesthetist (CRNA).

Procedure codes in the 'Anesthesia' section of the *Current Procedural Terminology* (CPT) manual are used to bill for surgical anesthesia procedures.

1. Reimbursement for surgical anesthesia procedures are based on formulas utilizing base units, time units (one unit = 15 min) and a conversion factor as identified in the anesthesia fee schedule. Budget reductions will apply when applicable;

2. General anesthesia services for dental procedures are reimbursed an additional $20 per time unit. To receive the additional reimbursement, modifier 23 must be appended to the anesthesia CPT code 00170, in addition to the appropriate anesthesia modifiers;

3. The anesthesia fee schedule is located on the Louisiana Medicaid website at www.lamedicaid.com, under the fee schedule link; and

4. Minutes **must** be reported on anesthesia claims.

A **surgeon** who performs a non-obstetrical (OB) surgical procedure will not be reimbursed for the administration of anesthesia for the procedure.

The following modifiers are used to bill for **surgical anesthesia** services:

Modifier	Servicing Provider	Surgical Anesthesia Service
AA	Anesthesiologist	Anesthesia services performed by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction* of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX	CRNA	CRNA service with direction* by an anesthesiologist

Modifier	Servicing Provider	Surgical Anesthesia Service
QZ	CRNA	CRNA service without medical direction* by an anesthesiologist
23	Anesthesiologist/CRNA	Unusual Anesthesia (for anesthesia procedure code 00170 only)

*See Medical Direction section for further explanation.

The following are acceptable uses of modifiers:

Modifiers which can stand alone	AA and QZ
Modifiers which need a partner	QK, QX and QY
Valid combinations	QK and QX or QY and QX
Modifier 23 (CPT code 00170 only)	In addition to modifiers above

Medical Direction

Medical direction includes:

1. Performing a pre-anesthetic examination and evaluation;
2. Prescribing the anesthesia plan;
3. Participating personally in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensuring that any procedures in the anesthesia plan that the anesthesiologist or CRNA does not perform are rendered by a qualified individual;
5. Monitoring the course of anesthesia administration at frequent intervals;
6. Remaining physically present and available for immediate diagnosis and treatment of emergencies; and
7. Providing the indicated post-anesthesia care.

Only anesthesiologists are reimbursed for medical direction.

Maternity-Related Anesthesia

Maternity-related anesthesia services may be provided by anesthesiologists, CRNAs or the delivering physician. Refer to the anesthesia fee schedule on the Medicaid website, www.lamedicaid.com for reimbursement information.

Procedure codes in the 'Anesthesia OB' section of the CPT manual are used to bill for maternity-related anesthesia services provided by anesthesiologists and CRNAs.

The delivering physician must use CPT codes in the 'Surgery Maternity Care and Delivery' section of the CPT manual to bill for maternity-related anesthesia services.

Reimbursement for these services is a flat fee, except for general anesthesia for vaginal delivery.

The following modifiers are used when billing for maternity-related anesthesia services:

Modifier	Servicing Provider	Service Performed
AA	Anesthesiologist	Anesthesia services performed directly by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction* of two, three, or four concurrent anesthesia procedures
QX	CRNA	CRNA service with medical direction* by an anesthesiologist
QZ	CRNA	CRNA service without medical direction* by an anesthesiologist
47	Delivering Physician	Anesthesia provided by delivering physician
52	Delivering Physician or Anesthesiologist	Reduced services
QS	Anesthesiologist or CRNA	Monitored anesthesia care service The QS modifier is a secondary modifier only, and must be paired with the appropriate anesthesia provider modifier (either the anesthesiologist or the CRNA). The QS modifier indicates that the provider **did not introduce** the epidural for anesthesia, but **did monitor** the beneficiary after catheter placement.

*See Medical Direction section for further explanation.

Add-on Codes for Maternity-Related Anesthesia

When an add-on code is used to fully define a maternity-related anesthesia service, the date of delivery must be the date of service for both the primary and the add-on code.

An add-on code is not a full service and cannot be reimbursed separately to different providers unless more than one provider performs services over the duration of labor and delivery.

A group practice frequently includes anesthesiologists and/or CRNA providers. One member may provide the pre-anesthesia examination/evaluation, and another may fulfill other criteria. The medical record must indicate the services provided and must identify the provider who rendered the service.

Billing for Maternity-Related Anesthesia

1. Reimbursement for maternity-related procedures, other than general anesthesia for vaginal delivery, is a flat fee; and

2. Minutes **must** be reported on all maternity-related anesthesia claims.

The following chart must be followed when billing for **maternity-related anesthesia**:

Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
Vaginal Delivery General Anesthesia	01960	Valid Modifier	Formula	Anesthesiologist performs complete service, or direction of the CRNA
				CRNA performs complete service with or without direction by Anesthesiologist

Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
Epidural for Vaginal Delivery	01967	AA, QY or QK for MD QX or QZ for CRNA	Flat Fee	See modifier list for maternity-related services
Cesarean Delivery only (epidural or general)	01961	AA, QY or QK for MD QX or QZ for CRNA	Flat Fee	See modifier list for maternity-related services
Cesarean Delivery after Epidural, for planned vaginal delivery	01967 + 01968	AA, QY or QK for MD QX or QZ for CRNA	Flat Fee plus add-on	See modifier list for maternity-related services
Cesarean Hysterectomy after Epidural and Cesarean Delivery	01967 + 01969	AA, QY or QK for MD QX or QZ for CRNA	Flat Fee plus add-on	See modifier list for maternity-related services
Epidural – Vaginal Delivery	59409 59612	47	Fee for delivery plus additional reimbursement for anesthesia	Delivering physician provides the **entire** service for vaginal delivery
Epidural – Vaginal Delivery	59409 59612	47 and 52	Fee for delivery plus additional reimbursement for anesthesia	Introduction only by the delivering physician
Epidural – Vaginal Delivery	01967	AA and 52	Flat Fee	Introduction only by anesthesiologist

Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
Epidural – Vaginal Delivery	01967	AA and QS for MD QZ and QS or QX and QS for CRNA	Flat Fee	Monitoring by anesthesiologist or CRNA
Cesarean Delivery	59514 59620	47 and 52	Fee for delivery plus additional reimbursement for anesthesia	Introduction only by the delivering physician
Cesarean Delivery – after Epidural	01961	AA and 52	Flat Fee	Introduction only by the anesthesiologist
Cesarean Delivery-following Epidural for planned vaginal delivery	01967 + 01968	AA and 52	Flat Fee plus add-on	Introduction only by the anesthesiologist
Cesarean Delivery – after Epidural	01961	AA and QS for MD QZ and QS or QX and QS for CRNA	Flat Fee	Monitoring by the anesthesiologist or CRNA
Cesarean Delivery-following Epidural for planned vaginal delivery	01967 + 01968	AA and QS for MD QZ and QS or QX and QS for CRNA	Flat Fee plus add-on	Monitoring by the anesthesiologist or CRNA

Anesthesia for Tubal Ligation or Hysterectomy

Anesthesia reimbursement for tubal ligations and hysterectomies is formula-based, with the exception of anesthesia for cesarean hysterectomy (CPT code 01969).

The reimbursement for CPT codes 01967 and 01969, when billed together, is a flat fee. CPT code 01968 is implied in CPT code 01969 and should not be placed on the claim form if a cesarean hysterectomy was performed after cesarean delivery.

The primary surgeon is required to complete the forms listed below for reimbursement of services for sterilizations and hysterectomies. The primary surgeon shall share the forms with all ancillary providers involved in the beneficiary's care (e.g. hospital, anesthesiologist, assistant surgeon, and/or ambulatory surgery center (ASC)).

1. Sterilization: Form OMB No. 0937-0166/HHS-687, "Consent for Sterilization"; and

2. Hysterectomy: Form 96-A, "Acknowledgement of Receipt of Hysterectomy Information."

If an ancillary provider submits a claim for sterilization or hysterectomy services without the appropriate consent form, the claim will be paid only if the primary surgeon's claim has been approved.

The ancillary provider's claim may be held for up to 30 days pending review of the primary surgeon's claim. If the primary surgeon's claim has not been approved during this timeframe, Medical Review will deny the ancillary provider's claim. If the claim is denied, ancillary providers may resubmit after allowing additional time for the primary surgeon's claim to be paid or submit the claim, in hard-copy, with the appropriate consent form.

Pediatric Moderate (Conscious) Sedation

Claims for moderate sedation should be submitted hard copy indicating the medical necessity for the procedure. Documentation should also reflect pre-sedation and post-sedation clinical evaluation of the beneficiary.

Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care.

Moderate sedation is restricted to beneficiaries from birth to age 13. Exceptions to the age restriction will be made for children who have severe developmental disabilities with documentation attached to support this condition. No claims will be considered for beneficiaries 21 years of age or older.

Moderate sedation includes the following services (which are not reported/billed separately):

1. Assessment of the beneficiary (not included in intra-service time);
2. Establishment of intravenous (IV) access and fluids to maintain patency, when performed;
3. Administration of agent(s);
4. Maintenance of sedation;
5. Monitoring of oxygen saturation, heart rate and blood pressure; and
6. Recovery (not included in intra-service time).

Intra-service time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.

Louisiana Medicaid has adopted CPT guidelines for all moderate sedation services and procedures that include moderate sedation as an inherent part of providing the procedure.

Louisiana Medicaid will reimburse a second physician, other than the health care professional performing the diagnostic or therapeutic procedure, when the second physician provides moderate sedation in the facility setting (e.g., hospital, outpatient hospital, ASC, skilled nursing facility). However, moderate sedation services performed by a second physician in the non-facility setting (e.g., physician office, freestanding imaging center) should not be reported.

Pain Management

Epidurals that are administered for the prevention or control of acute pain, such as during delivery or surgery, are covered under Professional Services for this purpose only.

Chronic Pain

Coverage for chronic, intractable pain is dependent on the clinical etiology and the type of service or treatment.

If a beneficiary requests treatment for chronic, intractable pain, depending on the underlying cause or anatomical defect, the provider may determine treatment or management to include:

1. Physical therapy (PT);
2. Occupational therapy (OT);
3. Medication therapy management (MTM);
4. Epidural steroid injection (ESI) therapy;
5. Acupuncture;
6. Chiropractic;
7. Behavioral health; and/or
8. Addiction medicine services in coordination with case management.

These include some alternative treatments and the inclusion of coverage on the Professional Services Fee Schedule to define covered treatments.

Certain Medicaid procedures or services may require prior authorization (PA). Procedure codes requiring PA can be identified on the Professional Services Fee Schedule.

NOTE: Medical necessity for ESI therapy shall be determined by the history of illness, physical examination, and concordant diagnostic imaging supporting radiculopathy, radicular pain, or neurogenic claudication due to herniation, stenosis, and/or degenerative disease protracted and severe enough to greatly impact quality of life or function.

Claims Filing

Anesthesia claims may be submitted either electronically or hard copy, using the CMS-1500 claim form.

Dental

Anesthesia for dental restoration should be billed under the appropriate CPT anesthesia code with the appropriate modifier, minutes and most specific diagnosis code.

Anesthesia Time

Anesthesia time begins when the provider begins to prepare the beneficiary for induction and ends with termination of the administration of anesthesia. Time spent in pre- and postoperative care may not be included in the total anesthesia time.

Group Practices

If the billing provider is a group practice that includes multiple anesthesiologists and/or CRNAs, one member may provide the pre-anesthesia examination/evaluation and another may fulfill other criteria. The medical record must indicate the services provided and must identify the provider who rendered the service.

Multiple Surgical Procedures

Anesthesia for multiple surgical (non-OB) procedures in the same anesthesia session must be billed on one claim line using the most appropriate anesthesia code with the total anesthesia time spent reported in item 24G on the claim form.

The only secondary procedures that are not billed in this manner are tubal ligations and hysterectomies.

The following claims **require a hard-copy** and special instructions:

1. ***Claims with a total anesthesia time of less than 10 minutes or greater than 224 minutes*.** Submit a hard copy claim with the appropriate anesthesia graph attached;

2. ***Claims for multiple but separate operative services performed on the same beneficiary on the same date of service***;

   NOTE: Submit a hard-copy claim with a cover letter explaining the circumstances and medical necessity. Attach anesthesia graphs from surgical procedures to the fiscal intermediary's (FI's) Provider Relations Unit.

3. ***Anesthesia for vaginal procedures, hysteroscopy, and/or hysterosalpingography (HSG)***;

   NOTE: Claims will pend to Medical Review and must have anesthesia record attached.

   a. The attached documentation must indicate the following:

i. Medical necessity for anesthesia (diagnosis of mental retardation, hysteria, and/or musculoskeletal deformities that would cause procedural difficulty); and

ii. HSG meets the criteria for that procedure. (Refer to the 'Medical Review' section).

4. V***aginal Delivery – Complete Anesthesia Service by Delivering Physician***; and

NOTE: The delivering physician should submit a claim for the delivery and anesthesia on a single claim line with modifier 47. The fee for the delivery plus the additional reimbursement will be paid for both services in a single payment.

5. ***Claims that deny with error codes 749 (delivery billed after hysterectomy was done) or 917 (lifetime limits for this service have been exceeded)***.

NOTE: A new claim must be submitted to the FI's Provider Relations Unit with a cover letter explaining the situation that caused the original claim denial**.**

Assistant Surgeon/Assistant at Surgery

Louisiana Medicaid will reimburse for **only one** assistant at surgery. The assistant to the surgeon should be a qualified physician. However, in those situations when a physician does not serve as the assistant, qualified, enrolled, advanced practice registered nurses (APRNs) and physician assistants may function in the role of an assistant at surgery and submit claims for their services under their Medicaid provider number.

Physicians serving as the assistant are to use the modifier "80" on the procedure code(s) representing their services.

APRNs, certified nurse midwives (CNMs), and physician assistants are to use the modifier "AS" when reporting their services as the only assistant at surgery.

NOTE: Refer to "Modifiers" for additional information on these modifiers.

The reimbursement of claims for more than one assistant at surgery is subject to recoupment.

ClaimCheck

With the implementation of ClaimCheck, Louisiana Medicaid recognizes the American College of Surgeons (ACS) as its primary source for determining assistant surgeon designations. This rationale is based on the ACS determination of these designations using clinical necessity guidelines.

ClaimCheck performs a procedure code-to-modifier validity check to determine if a procedure code is valid with an 80/AS modifier.

When ClaimCheck identifies a specific procedure code that does not require an assistant surgeon, the provider will receive the following explanation of benefits message:

"558 – Assistant Surgeon invalid for this procedure/ClaimCheck"

NOTE: See Appendix A for information on where to obtain a list of procedure codes reimbursable with the 80/AS modifiers.

Audiology Services

Audiology services are defined as diagnostic, preventive, or corrective services for individuals with speech, hearing, and/or language disorders provided by or under the direction of an audiologist. Generally, a referral must be made by a licensed physician for these services.

Reimbursement

Audiologists are reimbursed under the same methodology used to reimburse physician providers. Audiologists are reimbursed for the *Current Procedural Terminology* (CPT) codes approved for the reimbursement of audiology services to physicians and in accordance with the current regulations of the Professional Services Program.

Restrictions

Beneficiaries must have a written authorization from their primary care physician (PCP) for the audiologist's services. This includes beneficiaries referred to the audiologist by the Head Start Program.

Audiologist Employed by Hospitals

Audiologists who are salaried employees of hospitals cannot bill Medicaid for professional services rendered at that hospital, as their services are included in the hospital's per diem rate. Audiologists can enroll and bill Medicaid if they are providing services at a hospital at which there is no audiologist on staff.

Frequency

Payment for certain audiology codes is restricted to one code per beneficiary per 180 days. (See Appendix C for a list of these codes).

Bariatric Surgery

Louisiana Medicaid covers bariatric surgery, consisting of open or laparoscopic procedures that revise the gastrointestinal anatomy to restrict the size of the stomach, reduce absorption of nutrients, or both.

Eligibility Criteria

To be eligible for bariatric surgery, beneficiaries must meet the following criteria:

1. Received a preoperative evaluation within the previous 12 months that is conducted by a multidisciplinary team (MDT) including, at a minimum: a physician, nutritionist or dietician and a licensed qualified mental health professional. For beneficiaries under the age of 18, the MDT must have pediatric expertise. For all beneficiaries, the preoperative evaluation must document all of the following:

    a. A determination that previous attempt(s) at weight loss have been unsuccessful and that future attempts, other than bariatric surgery, are not likely to be successful;

    b. A determination that the beneficiary is capable of adhering to the post-surgery diet and follow-up care; and

    c. For individuals capable of becoming pregnant, counseling to avoid pregnancy preoperatively and for at least 12 months postoperatively and until weight has stabilized.

2. Beneficiaries age 18 and older must meet the following criteria:

    a. A body mass index (BMI) equal to or greater than 40 kg/m^2, or more than 100 pounds overweight; or

    b. A BMI of greater or equal to 35 kg/m^2 with one or more of the following comorbidities related to obesity:

        i. Type 2 diabetes mellitus;

        ii. Cardiovascular disease (e.g., stroke, myocardial infarction (MI), poorly controlled hypertension, systemic blood pressure (BP) greater than 140 mm Hg or diastolic BP 90 mm Hg or greater, despite pharmacotherapy);

iii. History of coronary artery disease with a surgical intervention such as coronary artery bypass or percutaneous transluminal coronary angioplasty;

iv. History of cardiomyopathy;

v. Obstructive sleep apnea (OSA) confirmed on polysomnography (PSG) with an apnea-hypopnea index (AHI) or RDI of ≥ 30; or

vi. Any other comorbidity related to obesity that is determined by the preoperative evaluation to be improved by weight loss.

c. A BMI of 30 to 34.9 kg/m^2 with type 2 diabetes mellitus if hyperglycemia is inadequately controlled despite optimal medical control by oral or injectable medications.

3. Beneficiaries age 13 through 17 years old must have:

a. A BMI equal to or greater than 40 kg/m^2 or 140% of the 95th percentile for age and sex, whichever is lower; or

b. A BMI of 35 to 39.9 kg/m^2 or 120% of the 95th percentile for age and sex, whichever is lower, with one or more comorbidities related to obesity:

i. OSA confirmed on PSG with an AHI > 5;

ii. Type 2 diabetes mellitus;

iii. Idiopathic intracranial hypertension;

iv. Nonalcoholic steatohepatitis;

v. Blount's disease;

vi. Slipped capital femoral epiphysis;

vii. Gastroesophageal reflux disease;

viii. Hypertension; or

ix. Any other comorbidity related to obesity that is determined by the preoperative evaluation to be improved by weight loss.

4. Requests for beneficiaries under the age of 13 will be reviewed for medical necessity on a case-by-case basis.

Prior Authorization

Coverage of bariatric surgery requires prior authorization (PA).

Panniculectomy Subsequent to Bariatric Surgery

Panniculectomy after bariatric surgery is considered medically necessary when all of the following criteria are met:

1. The beneficiary had bariatric surgery at least 18 months prior and the beneficiary's weight has been stable for at least six months; and

2. The pannus is at or below the level of the pubic symphysis; and

3. The pannus causes significant consequences, as indicated by at least one of the following:

    a. Cellulitis, other infections, skin ulcerations, or persistent dermatitis that has failed to respond to at least three months of non-surgical treatment; or

    b. Functional impairment such as interference with ambulation.

Breast Surgery

Mastectomy

Mastectomy or breast conserving surgery is covered when medically necessary.

Risk-reducing mastectomy to prevent cancer is considered medically necessary for beneficiaries that meet all of the following criteria:

1. A high risk of breast cancer, as defined by one or more of the following:

    a. Positive genetic mutation that is known or likely to confer a high risk of breast cancer (e.g., BRCA1 and BRCA2) where risk-reducing mastectomy is recommended by National Comprehensive Cancer Network guidelines;

    b. Significant family history, as defined by meeting the family history criteria listed under "Breast and Ovarian Cancer" within the "Genetic Testing" policy; or

    c. Prior thoracic radiation therapy at an age less than 30 years old.

2. A life expectancy greater than or equal to 10 years.

Breast Reconstruction

Reconstructive breast surgery is covered after a therapeutic intervention (e.g., mastectomy) or trauma resulting in significant loss of breast tissue.

The following services are considered medically necessary:

1. Reconstruction of the affected breast;

2. Reconstruction of the contralateral breast to produce a symmetrical appearance;

3. Prostheses (implanted, external, or both); and

4. Treatment of complications of the reconstruction.

All prosthetic implants must be approved by the Food and Drug Administration (FDA) and used in compliance with all FDA requirements at the time of the surgery.

Reduction Mammaplasty and Removal of Breast Implants

Reduction mammaplasty and removal of breast implants for the purpose of breast reconstruction are covered under the above breast reconstruction policy.

Reduction mammaplasty for purposes other than reconstruction is considered medically necessary when all of the following criteria are met:

1. Pubertal breast development is complete;

2. A diagnosis of macromastia with at least two of the following symptoms for at least a 12-week duration:

    a. Chronic breast pain;

    b. Headache;

    c. Neck, shoulder, or back pain;

    d. Shoulder grooving from bra straps;

    e. Upper extremity paresthesia due to brachial plexus compression syndrome, secondary to the weight of the breasts being transferred to the shoulder strap area;

    f. Thoracic kyphosis;

    g. Persistent skin condition such as intertrigo in the inframammary fold that is unresponsive to medical management; and/or

    h. Congenital breast deformity.

3. There is a reasonable likelihood that the symptoms are primarily due to macromastia; and

4. The amount of breast tissue to be removed is reasonably expected to alleviate the symptoms.

Removal of breast implants for purposes other than reconstruction is considered medically necessary for the following indications:

1. Visible capsular contracture causing pain (Baker Grade IV);

2. Diagnosed or suspected implant rupture;

3. Local or systemic infection;

4. Siliconoma or granuloma;

5. Implant extrusion;

6. Interference with the diagnosis or treatment of breast cancer; and

7. Breast implant-associated anaplastic large cell lymphoma.

If an indication for medically necessary removal of breast implants is present unilaterally, removal of the contralateral breast implant is also considered medically necessary when performed during the same operative session.

When the procedure is not reconstructive and is performed solely for the purpose of altering the appearance of the breast, reduction mammaplasty and removal of breast implants are considered cosmetic and not medically necessary.

Cardiovascular Services

Invasive Coronary Angiography and Percutaneous Coronary Intervention

Louisiana Medicaid covers elective invasive coronary angiography (ICA) and percutaneous coronary intervention (PCI) as treatment for cardiovascular conditions under specific circumstances.

The policy only applies to beneficiaries age 18 and older and does not apply to the following beneficiaries:

1. Beneficiaries under the age of 18;
2. Pregnant beneficiaries;
3. Cardiac transplant beneficiaries;
4. Solid organ transplant candidates; and
5. Survivors of sudden cardiac arrest.

Eligibility Criteria

Elective Invasive Coronary Angiography

Elective ICA is covered and considered medically necessary in beneficiaries with one or more of the following:

1. Congenital heart disease (CHD) that cannot be characterized by non-invasive modalities such as cardiac ultrasound, computed tomography (CT), or magnetic resonance imaging (MRI);
2. Heart failure with reduced ejection fraction for the purposes of diagnosing ischemic cardiomyopathy;
3. Hypertrophic cardiomyopathy prior to septal ablation or myomectomy;
4. Severe valvular disease or valvular disease with plans for surgery or percutaneous valve replacement;

5. Type 1 myocardial infarction (MI) within the past three months defined by detection of a rise and/or fall of cardiac troponin values with at least one value above the 99th percentile upper reference limit and with at least one of the following:

   a. Symptoms of acute myocardial ischemia;

   b. New ischemic electrocardiogram (ECG) changes;

   c. Development of pathological Q waves;

   d. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality in a pattern consistent with an ischemic etiology; and

   e. Identification of a coronary thrombus.

6. History of ventricular tachycardia requiring therapy for termination or sustained ventricular tachycardia not due to a transient reversible cause, within the past year;

7. History of ventricular fibrillation;

8. Return of angina within nine months of prior PCI;

9. Patients without chronic kidney disease who have Canadian Cardiovascular Society class I-IV classification of angina with intolerance of or failure to respond to at least two target dose anti-anginal medications (beta blocker, dihydropyridine or non-dihydropyridine calcium channel blocker, nitrates, and/or ranolazine); or

10. High risk imaging findings, characterized by one or more of the following:

    a. Severe resting left ventricular dysfunction (LVEF ≤35%) not readily explained by non-coronary causes;

    b. Resting perfusion abnormalities ≥10% of the myocardium in patients without prior history or evidence of myocardial infarction;

    c. Stress ECG findings including ≥2 mm of ST-segment depression at low workload or persisting into recovery, exercise-induced ST-segment elevation, or exercise-induced ventricular tachycardia/ventricular fibrillation;

    d. Severe stress-induced left ventricular dysfunction (peak exercise LVEF <45% or drop in LVEF with stress ≥10%);

e. Stress-induced perfusion abnormalities affecting ≥10% myocardium or stress segmental scores indicating multiple vascular territories with abnormalities;

f. Stress-induced left ventricular dilation;

g. Inducible wall motion abnormality (involving >2 segments or two coronary beds);

h. Wall motion abnormality developing at low dose of dobutamine (≥10 mg/kg/min) or at a low heart rate (<120 beats/min); or

i. Left main stenosis (≥50% stenosis) on coronary CT angiography.

ICA for non-acute, stable coronary artery disease is not considered medically necessary, including for patients with stable angina who are not interested in revascularization or who are not candidates for PCI or coronary artery bypass graft surgery.

Elective PCI

Elective PCI for angina with stable coronary artery disease is considered medically necessary in beneficiaries without chronic kidney disease who have Canadian Cardiovascular Society class I-IV classification of angina with intolerance of or failure to respond to at least two target dose anti-anginal medications (beta blocker, dihydropyridine or non-dihydropyridine calcium channel blocker, nitrates, and/or ranolazine).

Elective PCI for other cardiac conditions is considered medically necessary in beneficiaries with one or more of the following:

1. Heart failure with reduced ejection fraction for the purposes of treating ischemic cardiomyopathy;

2. Left main stenosis ≥ 50% as determined on prior cardiac catheterization or coronary CT angiography, if the patient has documentation indicating they were declined for a coronary artery bypass graft surgery; or

3. Type 1 myocardial infarction within the past three months as defined by detection of a rise and/or fall of cardiac troponin values with at least one value above the 99th percentile upper reference limit and with at least one of the following:

   a. Symptoms of acute myocardial ischemia;

b. New ischemic electrocardiogram changes;

c. Development of pathological Q waves;

d. Imaging evidence of new loss of viable myocardium, or new regional wall motion abnormality in a pattern consistent with an ischemic etiology; and

e. Identification of a coronary thrombus.

Elective PCI for non-acute, stable coronary artery disease is not considered medically necessary in all other patient populations, including if the patient is unwilling to adhere with recommended medical therapy, or if the patient is unlikely to benefit from the proposed procedure (e.g. life expectancy less than six months due to a terminal illness).

Endovascular Revascularization for Peripheral Artery Disease

Endovascular revascularization procedures (stents, angioplasty, and atherectomy) for the lower extremity are covered and considered medically necessary for the following conditions:

1. Acute limb ischemia; and

2. Chronic limb-threatening ischemia, defined as the presence of any of the following:

   a. Ischemic pain at rest;

   b. Gangrene; or

   c. Lower limb ulceration greater than two weeks duration.

Endovascular revascularization procedures are also covered and considered medically necessary in beneficiaries with peripheral artery disease who have symptoms of intermittent claudication and meet all of the following criteria:

1. Significant peripheral artery disease of the lower extremity as indicated by at least one of the following:

   a. Moderate to severe ischemic peripheral artery disease with ankle-brachial index (ABI) ≤ 0.69; or

b. Stenosis in the aortoiliac artery, femoropopliteal artery, or both arteries, with a severity of stenosis greater than or equal to 70% by imaging studies.

2. Claudication symptoms that impair the ability to work or perform activities of daily living (ADL); and no improvement of symptoms despite all of the following treatments:

a. Documented participation in a medically supervised or directed exercise program for at least 12 weeks. Individuals fully unable to perform exercise therapy may qualify for revascularization only if the procedure is expected to provide long-term functional benefits despite the limitations that precluded exercise therapy;

b. At least six months of optimal pharmacologic therapy including all of the below agents, unless contraindicated or discontinued due to adverse effects:

i. Antiplatelet therapy with aspirin, clopidogrel, or both;

ii. Statin therapy;

iii. Cilostazol; and

iv. Antihypertensives to a goal systolic blood pressure (BP) ≤ 140 mmHg and diastolic BP ≤ 90 mmHg.

c. At least one documented attempt at smoking cessation, if applicable, consisting of pharmacotherapy, unless contraindicated, and behavioral counseling, or referral to a smoking cessation program that offers both pharmacotherapy and counseling.

Endovascular revascularization procedures for the lower extremity are not covered and considered not medically necessary in the following circumstances:

1. Claudication due to isolated infrapopliteal artery disease (anterior tibial, posterior tibial or peroneal) including patients with coronary artery disease, diabetes mellitus, or both;

2. To prevent the progression of claudication to chronic limb-threatening ischemia in a beneficiary who does not otherwise meet medical necessity criteria;

3. Beneficiary is asymptomatic; and/or

4. Treatment of a nonviable limb.

Peripheral Arterial Disease Rehabilitation for Symptomatic Peripheral Arterial Disease

Peripheral arterial disease rehabilitation, also known as supervised exercise therapy, involves the use of intermittent exercise training for the purpose of reducing intermittent claudication symptoms.

Louisiana Medicaid covers and considers medically necessary up to 36 sessions of peripheral arterial disease rehabilitation annually. Delivery of these sessions three times per week over a 12-week period is recommended, but not required. Providers must adhere to the Current Procedural Terminology (CPT) guidance on the time per session, exercise activities permitted, and the qualifications of the supervising provider.

Chiropractic Services

Chiropractic manipulative treatment may be covered for Medicaid beneficiaries up to 21 years of age when medically necessary and provided as a result of a medical referral from the beneficiary's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) medical screening primary care physician (PCP).

Billing Information

Only chiropractic manipulation of up to four spinal regions will be approved for reimbursement. Chiropractors are to bill for these services using the most current and appropriate *Current Procedural Terminology* (CPT) codes for the services provided. Healthcare Common Procedure Coding System (HCPCS) modifier "AT" may be used to designate acute treatment.

Claims for chiropractic services pend to Medical Review and must be submitted hardcopy. The claim is to be accompanied by a written, dated, and signed referral statement from the EPSDT medical screening PCP **and** documentation substantiating the medical necessity of the services. The documentation should include, but is not limited to, the following:

1. Diagnosis and chief complaint;
2. Relevant history;
3. Subjective and objective diagnostic examination findings;
4. Acuity and severity of the beneficiary's condition;
5. Results of x-ray, laboratory and other diagnostic tests;
6. Number of treatment sessions necessary to correct or alleviate the beneficiary's symptoms or problem;
7. The level of care (LOC) (relief, therapeutic, rehabilitative, supportive) planned;
8. Procedures performed and results;
9. Response to therapy; and
10. Progress notes and beneficiary disposition.

Cognitive Assessment and Care Plan Services

Cognitive assessment and care plan services are covered for eligible beneficiaries' ages 21 and older exhibiting signs or symptoms of cognitive impairment, such as Alzheimer's disease or dementia. The service must be medically necessary and documented in the patient's medical record.

Reimbursement is limited to two services per beneficiary per calendar year.

Cochlear Implant

Louisiana Medicaid covers unilateral or bilateral cochlear implants when deemed medically necessary for the treatment of severe-to-profound, bilateral, sensorineural hearing loss in beneficiaries under 21 years of age. Any implant must be used in accordance with Food and Drug Administration (FDA) guidelines.

Eligibility Criteria

A multidisciplinary implant team is to collaborate on determining eligibility and providing care and is to include, at minimum:

1. A fellowship-trained pediatric otolaryngologist or fellowship-trained otologist;
2. An audiologist; and
3. A speech-language pathologist.

An audiological evaluation must find:

1. Severe-to-profound hearing loss determined through the use of an age-appropriate combination of behavioral and physiological measures; and
2. Limited or no functional benefit achieved after a sufficient trial of hearing aid amplification.

A medical evaluation must include:

1. Medical history;
2. Physical examination verifying the candidate has intact tympanic membrane(s), is free of active ear disease, and has no contraindication for surgery under general anesthesia;
3. Verification of receipt of all recommended immunizations;
4. Verification of accessible cochlear anatomy that is suitable to implantation, as confirmed by imaging studies (computed tomography (CT) and/or magnetic resonance imagery (MRI)), when necessary; and
5. Verification of auditory nerve integrity, as confirmed by electrical promontory stimulation, when necessary.

For bilateral cochlear implants, an audiologic and medical evaluation must determine that a unilateral cochlear implant plus hearing aid in the contralateral ear will not result in binaural benefit for the beneficiary.

Non-audiological evaluations must include:

1. Speech and language evaluation to determine beneficiary's level of communicative ability; and

2. Psychological and/or social work evaluation, as needed.

Pre-operative counseling must be provided to the beneficiary, if age appropriate, and the beneficiary's caregiver must provide:

1. Information on implant components and function, including:

    a. Risks;

    b. Limitations;

    c. Potential benefits of implantation;

    d. The surgical procedure; and

    e. Postoperative follow-up schedule.

2. Appropriate post-implant expectations, including being prepared and willing to participate in pre- and post- implant assessment and rehabilitation programs; and

3. Information about alternative communication methods to cochlear implants.

Prior Authorization and Reimbursement

All aspects of cochlear implant care (preoperative evaluation, implantation, implants, repairs, supplies, therapy) must be prior authorized, as specified below.

Preoperative Evaluation

The preoperative evaluation must be prior authorized through the submission of a PA-01 Form requesting approval as part of the implant team's packet. After approval has been given and services provided, the appropriate team member shall bill the appropriate procedure code for the

evaluation of speech, language, voice, communication, auditory processing and/or audiologic/aural rehabilitation on a CMS-1500 claim form, or electronically, to receive reimbursement for the evaluation. This service is reimbursable for cochlear implant candidates although the beneficiary may not subsequently receive an implant.

Implants, Equipment, Repairs, and Replacements

At the time of surgery, reimbursement will be made to the hospital for both the implant and the per diem. Refer to Chapter 25, Hospital Services, for specific information. (See Appendix A for information on how to access other manual chapters).

For information on coverage of other necessary equipment, repairs, and replacements, please refer to Chapter 18, Durable Medical Equipment (DME).

NOTE: Reimbursement for each implant will not be authorized until the surgical procedure has been approved.

Implantation Procedure

The cochlear implant surgery must be prior authorized. The surgeon shall submit a Request for Prior Authorization (PA) (PA-01 Form) as part of the implant team's packet to the fiscal intermediary's (FI's) Prior Authorization Unit (PAU) requesting approval to perform the surgery. The PA must include documentation of supporting audiological, medical, and non-audiological evaluations, and documentation of pre-operative counseling.

After approval and surgery, electronic or CMS-1500 claim submission of the appropriate procedure codes are billable by the surgeon and the assistant surgeon. This procedure shall not be billed as either team surgery or co-surgery. The surgeon's claim form must have the PA number written in Item 23 (if billing hard copy). (See Appendix B for information on obtaining a PA-01 Form).

The assistant surgeon's claim, if applicable, will pend to the Medical Review Unit and will be paid only if the surgeon's request for implantation has been approved.

The anesthesiologist's claim form does not require a PA number.

Postoperative Rehabilitative Costs

Only the audiologist will be reimbursed for the aural rehabilitation of the cochlear implant beneficiary after cochlear implant surgery. These procedures shall be billed electronically or on the CMS-1500 claim form and do not require PA.

Subsequent Speech, Language, and Hearing Therapy

Subsequent speech, language, and hearing therapy services for cochlear implant beneficiaries must be prior authorized. The request for PA should be submitted to the FI's PAU on the PA-01 Form. (See Appendix B for information on accessing these forms).

Re-performance of the Implantation Surgery

Re-performance of cochlear implant surgery because of infection, extrusion, or other reasons must be prior authorized.

Documentation explaining the reason the initial cochlear implant surgery must be repeated and the request for re-performance should be submitted simultaneously to the PAU for review.

The PA number approving the re-performance must be on the claim form for reimbursement to be received.

Post-Operative Programming

Reimbursement is made for cochlear implant post-operative programming and diagnostic analysis services. Providers are to use the appropriate procedure code(s) for this service.

Community Health Workers

Louisiana Medicaid covers services rendered to Medicaid beneficiaries by qualified community health workers (CHWs) meeting the criteria and policy outlined below.

Community Health Worker Qualifications

A qualified CHW is someone who:

1. Has completed state-recognized training curricula approved by the Louisiana CHW Workforce Board; or

2. Has a minimum of 3,000 hours of documented work experience as a CHW.

Providers who employ CHWs are responsible for verifying and maintaining documentation that qualification criteria are met.

Eligibility Criteria

To be eligible to receive CHW services, a beneficiary must have one or more of the following:

1. Diagnosis of one or more chronic health (including behavioral health) conditions;

2. Suspected or documented unmet health-related social need; or

3. Pregnancy.

Covered Services

The following are covered services that can be provided by CHWs:

1. Health promotion and coaching. This can include assessment and screening for health-related social needs, setting goals and creating an action plan, on-site observation of beneficiaries' living situations and providing information and/or coaching in an individual or group setting;

2. Care planning with the beneficiary and their healthcare team. This should occur as part of a person-centered approach to improve health by meeting a beneficiary's situational health needs and health-related social needs, including time-limited episodes of instability and ongoing secondary and tertiary prevention; and

3. Health system navigation and resource coordination services. This can include helping to engage, re-engage, or ensure patient follow-up in primary care, routine preventive care, adherence to treatment plans and/or self-management of chronic conditions.

Services must be ordered by a physician, advanced practice registered nurse (APRN), or physician assistant with an established clinical relationship with the beneficiary. The order for CHW services may be a patient-specific order, or a standing order. A standing order is valid for CHW services if the beneficiary has an established clinical relationship with the clinic setting that is supervised by the supervising provider issuing the order, and employs the CHW, or contracts with an entity employing the CHW, providing the service. Services must be rendered under this supervising provider's general supervision, defined as being under the supervising provider's overall direction and control, but not requiring the provider's presence during the performance of the CHW services.

There is no restriction as to the site of service, which may include, but is not limited to: a health care facility, clinic setting, community setting or the beneficiary's home. Delivery of the service through a synchronous audio/video telehealth modality is also permissible.

Use of the current procedural terminology (CPT) procedure codes in the 'Education and Training for Patient Self-Management' section are the only billable services that may be provided by CHWs. CPT guidance must be followed.

Coverage Limitations

The following services are not covered:

1. Insurance enrollment and insurance navigator assistance;

2. Case management;

3. Direct provision of transportation for a beneficiary to and from services; and

4. Direct patient care outside the level of training an individual has attained.

Services will only be reimbursed up to two hours per day and ten hours per month per beneficiary.

Reimbursement

CHW services are reimbursed "incident to" the supervising physician, APRN, or physician assistant.

A CHW who provides services to more than one beneficiary at a time must document in the clinical record and bill appropriately using the approved codes associated with the number of people receiving the service simultaneously. This is limited to eight unique beneficiaries per session.

Concurrent Care - Inpatient

Inpatient concurrent care is the provision of services by more than one provider to the same beneficiary on the same day. Concurrent care is only covered when a beneficiary's condition requires the care of more than one provider and the services rendered by each individual provider are medically necessary and not duplicative.

Providers from different specialties/subspecialties, whether from the same group or a different group, shall be reimbursed separately for concurrent care.

Each provider from a different specialty/subspecialty can be reimbursed for one initial hospital visit per admission. In addition, each provider from a different specialty/subspecialty can be reimbursed for a maximum of one subsequent hospital visit per day. In all cases, services rendered must meet Current Procedural Terminology (CPT) guidelines and be medically necessary to be eligible for reimbursement.

Within the same specialty/subspecialty, only one provider can be reimbursed for one initial hospital visit per admission and, subsequently, only one provider can be reimbursed for a maximum of one subsequent hospital visit per day.

Only the provider responsible for discharging the beneficiary shall be reimbursed for hospital discharge services on the discharge day.

The global surgery period policy, and pre- and post-operative procedure code edits, supersede this policy when applicable.

Critical Care Services

Louisiana Medicaid covers critical care services as defined by the *Current Procedural Terminology* (CPT) Manual. Providers must follow the direction and criteria in the CPT Manual as applicable for the age of the beneficiary and date of service.

Critical care services are a provider's direct delivery of medical care for a critically ill or critically injured beneficiary. It involves decision making of high complexity to assess, manipulate and support vital organ system function(s) to treat single or multiple vital organ failure and/or to prevent further life threatening deterioration of the beneficiary condition.

The duration of critical care services is based on the provider's documentation in the beneficiary's record of the total time spent in evaluating, managing and providing the care, as well as time spent in documenting such activities. During this time the provider must devote full attention to the beneficiary, and therefore, cannot provide services to any other patient during the same period of time. The time may be spent at the beneficiary's immediate bedside or elsewhere on the unit, as long as the provider is immediately available to the beneficiary.

If the minimum total time requirement is not satisfied, then another appropriate evaluation and management (E/M) code must be reported.

Critical care services are usually, but not always, provided in the critical care or emergency care setting. However, the service is reimbursable in other settings as long as the level of care is appropriate and meets the criteria as defined. Services for a beneficiary who is not critically ill but, is in the critical care area, must be reported using other appropriate E/M codes.

Claims Related Information

Professional service providers submitting claims for critical care services, which include adult, pediatric, and neonatal critical care, should refer to the CPT Manual for direction and the most current description of procedures and services included in the Critical Care Services codes. These services are not to be reported separately. Services paid to providers that are included in the payment for critical care as defined by the CPT Manual are subject to post payment review and recovery of overpayments.

Diabetes Self-Management Training

Diabetes self-management training (DSMT) is an evidence-based and 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 services, at a minimum, must include the following:

1. Instructions for blood glucose self-monitoring;
2. Education regarding diet and exercise;
3. Individualized insulin treatment plan (for insulin dependent beneficiaries); and
4. Encouragement and support for use of self-management skills.

DSMT must be aimed at educating beneficiaries on the following topics to promote successful self-management:

1. Diabetes overview, including current treatment options and disease process;
2. Diet and nutritional needs;
3. Increasing activity and exercise;
4. Medication management, including instructions for self-administering injectable medications (as applicable);
5. Management of hyperglycemia and hypoglycemia;
6. Blood glucose monitoring and utilization of results;
7. Prevention, detection, and treatment of acute and chronic complications associated with diabetes (including discussions on foot care, skin care, etc.);
8. Reducing risk factors, incorporating new healthy behaviors into daily life, and setting goals to promote successful outcomes;
9. Importance of preconception care and management during pregnancy;
10. Managing stress regarding adjustments being made in daily life; and
11. Importance of family and social support.

All educational material must be pertinent and age appropriate for each beneficiary. Parents or legal guardians can participate in DSMT rendered to their child, but all claims for these services must be submitted under the child's Medicaid number.

Provider Qualifications

Providers of DSMT services must be:

1. Enrolled as a Louisiana Medicaid provider;
2. Employed by an enrolled Louisiana Medicaid provider; or
3. Contracted to provide services by an enrolled Louisiana Medicaid provider.

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

Louisiana Medicaid does not enroll dieticians, registered nurses (RNs), or pharmacists as providers of service. If a dietician, RN, or a pharmacist provides DSMT services to an eligible beneficiary, the group/billing identification (ID) number must be entered in block 24J on the CMS-1500 claim form.

Accreditation

Providers of DSMT services must be accredited by one of the following national accreditation organizations:

1. American Diabetes Association (ADA);
2. American Association of Diabetes Educators (AADE); or
3. Indian Health Service (IHS).

Services provided by providers without accreditation from 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 (FI).

At a minimum, providers of DSMT services must include at least one registered dietician, RN, or 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 of staff members as requested by Louisiana Medicaid or its FI.

All DSMT services 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 been diagnosed with Type I, Type II, or gestational diabetes mellitus and who have an order from a provider involved in the management their diabetes, such as a primary care provider (PCP) or obstetrician.

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

1. 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.

2. 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 ordering provider and copies must be retained in the medical record.

Medicaid Beneficiaries Not Eligible for Diabetes Self-Management Training

The following beneficiaries are not eligible for DSMT:

1. Beneficiaries residing in an inpatient hospital or other institutional setting such as an nursing care facility or a residential care facility; or

2. Beneficiaries receiving hospice services.

Initial Diabetes Self-Management Training

Initial DSMT may begin after receiving the initial order. DSMT 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.

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 lasting less than 30 minutes.

Group sessions may be provided in any combination of 30-minute increments. Sessions less than 30 minutes are not covered. Each group session must contain between two and 20 beneficiaries.

Follow-Up Diabetes Self-Management Training

After receiving 10 hours of initial training, a beneficiary is eligible to receive a maximum of two hours of follow-up training each year, if ordered. Additional training for beneficiaries under the age of 21 is covered if determined to be medically necessary and documented in the record.

Follow-up training is based on a **12-month calendar year following completion of the 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.

Examples include the following:

1. Example #1: A beneficiary receives their first training in April and completes the initial 10 hours by April of the next year. The beneficiary would be eligible for two hours of subsequent training beginning in May, since that would be the 13th month. If the beneficiary completes the two hours of subsequent training in November of that same year, then additional training cannot begin until January (the next calendar year); and

2. Example #2: A beneficiary receives their first training in February and exhausts all 10 hours of initial training by November. The beneficiary would be eligible for two hours of subsequent training beginning in January. If the beneficiary completes the two subsequent hours of training by May, then additional training cannot begin until January of the following year.

Providers are expected 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 the providers of service.

Provider Responsibilities

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

1. **The beneficiary meets one of the following requirements:**

    a. Is a newly diagnosed diabetic, gestational diabetic, pregnant with a history of diabetes, or has received no previous diabetes education;

    b. Demonstrates poor glycemic control (A1c>7);

    c. Has documentation of an acute episode of severe hypoglycemia or hyperglycemia occurring in the past 12 months; or

    d. Has received a diagnosis of a complication, a diagnosis of a co-morbidity, or prescription for new equipment such as an insulin pump.

2. **The provider maintains the following documentation requirements:**

    a. A copy of the order for DSMT from the beneficiary's ordering provider;

    b. A comprehensive plan of care (POC) documented in the medical record;

    c. Start and stop time of services;

    d. Clinical notes, documenting beneficiary progress;

    e. Original and ongoing pertinent laboratory work;

    f. Individual education plan (IEP);

    g. Assessment of the individual's education needs;

    h. Evaluation of achievement of self-management goals;

i. Proof of correspondence with the ordering provider regarding the beneficiary's progress; and

j. 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 Louisiana Medicaid, its authorized representatives, or the state Attorney General's Medicaid Fraud Control Unit.

Reimbursement

Reimbursement for DSMT services is a flat fee based on the Louisiana Medicaid Professional Services Program fee schedule, minus the amount which any third party coverage would pay. The following Healthcare Common Procedure Coding System (HCPCS) codes or their successors are used to bill DSMT services:

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

2. 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 are the only HCPCS codes currently allowed to be billed with HR942.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a comprehensive benefit for individuals under the age of 21 years old.

Beneficiaries under 21 years of age receive all medically necessary health care, screening, diagnostic services, treatment, and other measures covered under federal Medicaid statutes and regulations to correct or improve physical or mental conditions. Services may include those not otherwise covered by Louisiana Medicaid for beneficiaries age 21 and older, unless prohibited or excluded.

Screening

Medicaid beneficiaries are eligible for well child visits, which are referred to as "EPSDT preventive screenings." EPSDT preventive screening includes medical, vision, hearing, dental, developmental, and perinatal depression screenings.

Periodic Screening

Screening services are provided according to the "Recommendations for Preventive Pediatric Health Care" promulgated by the American Academy of Pediatrics (AAP)/Bright Futures with three exceptions:

1. This policy only applies to Medicaid beneficiaries under the age of 21. (The AAP/Bright Futures periodicity schedule provides guidance for patients through age 21);

2. Perinatal depression screening is a recommended, but not required, component of the EPSDT preventive screening; and

3. There are stricter requirements for lead assessment and blood lead screening in keeping with the Louisiana Office of Public Health (OPH) recommendations.

Screenings performed on children under two years of age must be performed at least 30 days apart. Screenings performed after the child's second birthday must be at least six months apart.

If a child misses a regular periodic screening, that child may be screened off-schedule in order to bring the child up to date at the earliest possible time.

Interperiodic Screening

Interperiodic screenings may be performed if medically necessary. The parent/guardian, any medical provider, or any qualified health, developmental, or education professional that comes into contact with the child outside the formal health care system may request the interperiodic screening. These screenings can only be billed if the beneficiary has received an age-appropriate preventive screening. If the preventive screening has not been performed, the provider is to bill an age-appropriate preventive screening.

These screenings may be performed and billed for a required Head Start physical or school sports physical, but must include all of the components required in the EPSDT preventive screening, which includes a complete unclothed exam or assessment, health and history update, measurements, immunizations, health education and other age-appropriate procedures.

There is no limit on the frequency or number of medically necessary interperiodic screenings, or on the proximity to previous screenings; therefore, it is essential that providers document the following information in the beneficiary's records:

1. The individual that requested the interperiodic screening;

2. Why the screening was requested (the concern, symptoms or condition that led to the request); and

3. The outcome of the screening (any diagnosis and/or referral resulting from the screening).

Documentation must indicate that all components of the screening were completed. Medically necessary laboratory, radiology, or other procedures may also be performed and are to be billed separately. A well diagnosis is not required.

Preventive Medical Screening

The EPSDT preventive medical screening includes the following components:

1. A comprehensive health and developmental history (including assessment of physical and mental health and development);

2. A comprehensive unclothed physical exam or assessment;

3. Appropriate immunizations according to age and health history (unless medically contraindicated or parents/guardians refuse at the time);

4. Laboratory tests* (including age-appropriate screenings for newborns, iron deficiency anemia, blood lead levels, dyslipidemia, and sexually transmitted infections); and

5. Health education (including anticipatory guidance).

The services are available both on a regular basis, and whenever additional health treatment or services are needed. EPSDT screens may identify problems needing other health treatment or additional services.

If an abnormality or problem is encountered and treatment is significant enough to require an additional evaluation and management (E/M) service on the same date, by the same provider, no additional E/M of a level higher than Current Procedural Terminology (CPT) code 99212 is reimbursable.

The physician, advanced practice registered nurse (APRN), or physician assistant listed as the rendering provider must be present and involved during a preventive visit. Any care provided by a registered nurse or other ancillary staff in a provider's office is subject to Medicaid's 'Incident to' policy and must only be providing services within the scope of their license or certification.

*The blood lead levels and iron deficiency anemia components of the preventive medical screening must be provided on-site on the same date of service as the screening visit. See "Blood Lead Screening and Testing" policy section in the following pages.

Neonatal/Newborn Screening for Genetic Disorders

Newborn screening (via heel stick) includes testing for certain specified conditions recommended by the American College of Medical Genetics (ACMG). Louisiana Revised Statute requires hospitals with delivery units to screen all newborns before discharge, regardless of the newborn's length of stay at the hospital. The Louisiana Administrative Code (LAC) Title 48, Part V, Subpart 18, Chapter 63 provides the requirements related to newborn screenings.

Providers are responsible for obtaining the results of the initial neonatal screening by contacting the hospital of birth, the health unit in the parish of the mother's residence, or through OPH Genetic Diseases Program's web-based Secure Remote Viewer (SRV). (See Appendix A for contact information).

If screening results are not available, or if newborns are screened prior to 24 hours of age, newborns must have another newborn screen. The newborn infant must be rescreened at the first medical visit after birth, preferably between one and two weeks of age, but no later than the third week of life.

Initial or repeat neonatal screening results must be documented in the medical record for all children less than six months of age. Children over six months of age do not need to be screened unless it is medically indicated. When a positive result is identified from any of the conditions, and a private laboratory is used, the provider must immediately notify the Louisiana OPH Genetic Disease Program.

Preventive Vision Screening

The purpose of the vision screening is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malfunctions, eye diseases, strabismus, amblyopia, refractive errors, and color blindness.

Subjective Vision Screening

The subjective vision screening is part of the comprehensive history and physical exam or assessment component of the EPSDT preventive medical screening and must include the history of any:

1. Eye disorders of the child or the child's family;

2. Systemic diseases of the child or the child's family which involves the eyes or affects vision;

3. Behavior on the part of the child that may indicate the presence or risk of eye problems; and

4. Medical treatment for any eye condition.

Objective Vision Screening Component

The objective vision screening component may be performed by trained office staff under the supervision of a licensed physician, APRN, physician assistant, registered nurse (RN), or optometrist. The interpretive conference to discuss findings from the screenings must be performed by a licensed physician, APRN, physician assistant, or RN.

Vision screening services are to be provided according to the AAP/Bright Futures recommendations.

Preventive Hearing Screening

The purpose of the hearing screening is to detect central auditory problems, sensorineural hearing loss, conductive hearing impairments, congenital abnormalities, or a history of conditions which may increase the risk of potential hearing loss.

Subjective Hearing Screening

The subjective hearing screening is part of the comprehensive history and physical exam or assessment component of the EPSDT preventive medical screening and must include the history of:

1. The child's response to voices and other auditory stimuli;
2. Delayed speech development;
3. Chronic or current otitis media; and
4. Other health problems that place the child at risk for hearing loss or impairment.

Objective Hearing Screening Component

The objective hearing screening component may be performed by trained office staff under the supervision of a licensed audiologist or speech pathologist, physician, APRN, physician assistant, or RN. The interpretive conference to discuss findings from the screenings must be performed by a licensed physician, APRN, physician assistant, or RN.

Hearing screening services are to be provided according to the AAP/Bright Futures recommendations.

Dental Screening

Refer to Medicaid Manual Chapter 16 – Dental Program for information pertaining to EPSDT dental screenings. (See Appendix A for information on how to access this manual).

Developmental Screening

Developmental and autism screenings administered during EPSDT preventive visits in accordance with the AAP/Bright Futures periodicity schedule are covered services. Louisiana Medicaid also covers developmental and autism screenings performed by primary care providers (PCPs) when administered at intervals outside EPSDT preventive visits if they are medically indicated for a beneficiary at-risk for, or with a suspected, developmental abnormality.

To receive reimbursement, providers must use age-appropriate, caregiver-completed, and validated screening tools as described by the AAP/Bright Futures.

If a beneficiary screens positive on a developmental or autism screen, the provider must give appropriate developmental health recommendations, refer the beneficiary for additional evaluation, or both, as clinically appropriate. Providers must document the screening tool(s) used, the result of the screen, and any action taken, if needed, in the beneficiary's medical record.

Developmental screening and autism screening are currently reimbursed using the same procedure code. Providers may only receive reimbursement for one developmental screen and one autism screen per date of service. To receive reimbursement for both services performed on the same day, providers may submit claims for two units of the relevant procedure code.

Perinatal Depression Screening

Perinatal depression screening administered to a beneficiary's caregiver in accordance with AAP/Bright Futures periodicity schedule is covered. The screening may be administered from birth to one year during an EPSDT preventive visit, interperiodic visit, or office visit. This service is a recommended, but not required, component of well-child care.

Perinatal depression screening must employ one of the following validated screening tools:

1. Edinburg Postnatal Depression Scale (EPDS);

2. Patient Health Questionnaire 9 (PHQ-9); or

3. Patient Health Questionnaire 2 (PHQ-2) and, if positive, a full PHQ-9.

Documentation must include the tool used, the results, and any follow-up actions taken. If a beneficiary's caregiver screens positive, the provider must refer the caregiver to available resources, such as their primary care provider, obstetrician, or mental health professionals, and document the recommendations provided. If screening indicates possible suicidality, concern for the safety of the caregiver or beneficiary, or another psychiatric emergency, then referral to emergency mental health services is required.

Though the screening is administered to the caregiver, reimbursement for this service is under the child's Medicaid coverage. If two or more children under age one present for care on the same day (e.g., twins or other siblings both under age one), the provider must submit the claim under only one of the children. When performed on the same day as developmental screening, autism screening, or both, providers are to append modifier -59 to claims for perinatal depression screening.

Blood Lead Screening and Testing

Based on surveillance data gathered by the State Childhood Lead Poisoning Prevention Program, and review by the state health officer and representatives from medical schools in the state, all parishes in Louisiana are identified as high risk for lead poisoning. Medical providers who provide routine primary care services to children ages six months to 72 months must have children screened in compliance with the following requirements and in accordance to practices consistent with current Centers for Disease Control and Prevention (CDC) guidelines, which include the following specifications:

1. Perform a risk assessment at every well child visit;

2. Use a blood test to screen all children at ages 12 months and 24 months, or any age older than 24 months and up to 72 months if they have not been previously screened; and

3. Use a venous blood sample to confirm results when finger stick samples indicate blood lead levels ≥3.5ug/dl.

Mandatory Case Reporting by Health Care Providers

Medical providers must report a lead case to OPH's Childhood Lead Poisoning Prevention Program **within 24 business hours**. A lead case is indicated by a venous blood lead test result of ≥3.5ug/dl. Providers must confirm current blood lead level for reportable lead cases with OPH as this value is subject to change.

Immunizations

Appropriate immunizations (unless medically contraindicated or the parents/guardians refuse) are a federally required EPSDT preventive medical screening component, and failure to comply with or properly document the immunization requirement constitutes an incomplete medical screening and is subject to recoupment of the total preventive medical screening fee. It is the responsibility of the screening provider to administer age-appropriate immunizations.

The current Childhood Immunization Schedule recommended by Advisory Committee on Immunizations Practices (ACIP), AAP, and American Academy of Family Physicians (AAFP), which is updated yearly, must be followed. Providers are responsible for obtaining current copies of the schedule.

NOTE: Refer to the *Immunizations and, Vaccines for Children* and *Louisiana Immunization Network for Kids* policies in this manual for additional information.

Laboratory

Age-appropriate laboratory tests are required at selected age intervals. Specimen collection must be performed in-house at the preventive medical screening visit. Laboratory procedures provided less than six months prior to the preventive screening are not to be repeated unless medically necessary. When required as part of the preventive medical screening, iron deficiency anemia and blood lead testing are included in the reimbursement for the medical screening and must not be billed separately.

Diagnosis and Treatment

Screening services are performed to assure that health problems are found, diagnosed, and treated early before becoming more serious and additional treatment is necessary. Providers are responsible for identifying any general suspected conditions and reporting the presence, nature, and status of the suspected conditions.

Diagnosis

When a medical, vision, hearing, or developmental screening indicates the need for further diagnosis or evaluation of a child's health, the child must receive a complete diagnostic evaluation within 60 days of the screening or sooner as medically necessary.

An infant or toddler who meets or may meet the medical or biological eligibility criteria for EarlySteps (infant and toddler early intervention services) must be referred to the local System Point of Entry (SPOE) within two working days of the screening. (See Appendix A for contact information for the EarlySteps program).

Initial Treatment

Medically necessary health care, initial treatment, or other measures needed to correct or ameliorate physical or mental illnesses or conditions discovered in a medical, vision, or hearing screening must be initiated within 60 days of the screening or sooner if medically necessary.

Providing or Referring Beneficiaries for Services

Providers detecting a health or mental health problem in a screening must either provide the services indicated or refer the beneficiary for care without delay. Providers who perform the diagnostic and/or initial treatment services should do so at the screening appointment when possible, but must ensure that beneficiaries receive the necessary services within 60 days of the screening or sooner if medically necessary.

Providers who refer the beneficiary for care must make the necessary referrals at the time of screening. Referrals are not limited to those services covered by Medicaid. Providers must attempt to locate other providers who furnish services at little or no cost and inform parents/guardians of costs associated with services that Medicaid does not cover. Providers must forward the necessary medical information and request a report of the exam results or services provided by the "referred-to" provider. This information must be maintained in the beneficiary's record.

Providers must follow up and document the record that the child kept the appointment and received services. If the child did not keep the appointment, the provider must make at least two good faith efforts to re-schedule the appointment. The provider must have a process in place to document these efforts.

Dental Treatment

Fluoride Varnish Application

Fluoride varnish applications are covered by Louisiana Medicaid when provided in a physician office setting once every six months for beneficiaries six months through five years of age. Providers eligible for reimbursement of this service include physicians, physician assistants and nurse practitioners (NPs) who have reviewed the fluoride varnish *Smiles for Life* training module and successfully completed the post assessment. Physicians are responsible to provide and document training to their participating staff to ensure competency in fluoride varnish applications. (See Appendix A for information on accessing the training module).

Fluoride varnish applications may only be applied by the following disciplines:

1. Appropriate dental providers;
2. Physicians;
3. Physician assistants;
4. APRNs;
5. RNs;
6. Licensed practical nurses (LPNs); or
7. Certified Medical Assistants.

NOTE: Refer to Medicaid Manual Chapter 16 – Dental Program for information pertaining to EPSDT Fluoride Varnish Application. (See Appendix A for information on how to access this manual chapter).

EarlySteps Program

The EarlySteps Program provides services to families with infants and toddlers aged birth to three years who have a medical condition likely to result in a developmental delay, or who have developmental delays. (See Appendix A for the web address to obtain additional information about EarlySteps).

Electronic Health Records Incentive Payments

Louisiana Medicaid operates an electronic health record (EHR) incentive payment program to provide payments to eligible professional practitioners who adopt, implement or upgrade certified EHR technology.

The following professional practitioners may qualify to receive Louisiana Medicaid incentive payments:

1. Physicians;
2. Nurse practitioners (NPs);
3. Certified nurse-midwives (CNMs);
4. Dentists; and
5. Physician assistants directing a federally qualified health center (FQHC) or rural health clinic (RHC).

Eligible providers shall meet the appropriate meaningful use requirements for certified EHR systems as established by the Centers for Medicare and Medicaid Services (CMS).

Payments shall be distributed through a web-based Medicaid EHR incentive payment system.

Qualifying Criteria for Professional Practitioners

Professional practitioners shall qualify for Medicaid incentive payments when:

1. Services are rendered to the required number of beneficiaries based on the Medicaid beneficiary volume threshold; and
2. Meaningful use requirements are met for EHR systems, based on the participation year of the program.

Professional practitioners shall be required to meet the minimum Medicaid beneficiary volume threshold of 30 percent. This threshold shall be calculated as a ratio where the numerator is the total number of Medicaid beneficiary encounters with needy individuals treated in any 90-day period in the previous calendar year and the denominator is all beneficiary encounters over the same period of time.

Needy individuals shall include the following:

1. Medicaid beneficiaries;

2. Children's Health Insurance Program (CHIP) beneficiaries;

3. Patients furnished uncompensated care by the provider; and

4. Patients furnished services at no cost or on a sliding scale.

During the first year of program participation, the meaningful use requirements for an eligible provider are to adopt, implement, and upgrade a certified EHR system. In subsequent years' participation, providers must meet the meaningful use requirements defined by CMS at the stage that is in place at that time.

Eligible practitioners may receive incentive payments from the Medicaid program or from the Medicare program. Payments cannot be received from both entities simultaneously. After the initial program selection, eligible practitioners shall be allowed to change their selection only once during state fiscal year (SFY) 2012 through SFY 2014.

Medicaid EHR incentive payments shall not be available to hospital-based providers who furnish 90 percent or more of their services in a hospital setting. This includes services furnished on an inpatient or outpatient basis and in an emergency room (ER) setting.

Registration

Professional practitioners choosing to participate in the Louisiana Medicaid EHR incentive payment program must first register with CMS, before beginning the Louisiana Medicaid EHR registration using the EHR Incentives link on the Louisiana Medicaid website. (See Appendix A for information on how to access this website).

The Louisiana Medicaid website EHR link provides current Medicaid information and additional non-Medicaid links necessary for professional practitioners to fully incorporate the provisions of the American Recovery and Reinvestment Act of 2009 related to EHR.

Payments

Incentive payments to eligible practitioners began in SFY 2011 and ended in SFY 2021. The last SFY a Medicaid provider could begin the program was SFY 2016.

Payments are based on a calendar year and may total up to $63,750 over six years of participation. A provider would have had to initiate the program by SFY 2016 to receive the maximum total payment amount.

NOTE: Medicaid enrolled pediatricians with more than 20 percent, but less than 30 percent Medicaid beneficiary volume will receive two-thirds of the maximum amount.

EHR incentive payments shall not be available to a hospital-based provider who furnishes 90 percent or more of their services in a hospital setting. This includes services furnished on an inpatient or outpatient basis and in an ER setting.

EHR incentive payments are made to eligible professional practitioners based on the information in the filed payment attestation. If the information in the payment attestation matches the payee field and the account number on the Louisiana Medicaid provider enrollment file, payment will be made by electronic funds transfer (EFT). If the information does not match, a paper check will be issued based on the payee information in the filed payment attestation.

The Provider Enrollment file must be maintained with the correct payee name, address and account numbers. Providers are responsible for reporting all changes to the fiscal intermediary's (FI's) Provider Enrollment Unit. (See Appendix A for contact information).

End Stage Renal Disease

Services provided in an outpatient end stage renal disease (ESRD) facility are covered under the ESRD program. Providers should refer to the Medicaid Manual Chapter 17 for specific information relating to ESRD services. (See Appendix A for information on accessing this manual chapter).

Professional service providers submitting claims for dialysis services should refer to the *Current Procedural Terminology* (CPT) Manual for direction, allowances and the most current description of procedures and services for those service codes.

For direct inquiries regarding the performance or billing of ESRD services, contact the fiscal intermediary's (FI's) Provider Relations Unit. (See Appendix A for contact information).

Eye Care and Vision Services

Providers shall refer to Chapter 46 – Vision (Eyewear) Services of the Medicaid Manual for Louisiana Medicaid policy related to:

1. Vision services;

2. Eyeglasses and contact lens; and

3. Required prior authorization (PA).

NOTE: See Appendix A for information on accessing the Vision (Eyewear) Services manual.

Genetic Counseling and Testing

Genetic Counseling

Counseling is required before and after all genetic testing. Counseling, at a minimum, must consist of the following and be documented in the beneficiary's medical record:

1. Obtaining a structured family genetic history;

2. Genetic risk assessment; and

3. Counseling of the beneficiary and family about diagnosis, prognosis, and treatment.

When performed by licensed genetic counselors, services are reimbursed using the procedure code specific to genetic counseling. Reimbursement for this service is "incident to" the services of a supervising physician and is limited to no more than 90 minutes on a single day of service.

When performed by providers other than licensed genetic counselors, an applicable evaluation and management code must be used.

Breast and Ovarian Cancer

Louisiana Medicaid considers genetic testing for BRCA1 and BRCA2 mutations in cancer-affected individuals and cancer-unaffected individuals to be medically necessary if the beneficiary meets the criteria listed below.

Eligibility Criteria

Individuals meeting one or more of the below criteria are considered eligible:

1. Individuals with any blood relative with a known BRCA1/BRCA2 mutation;

2. Individuals meeting the criteria below but with previous limited testing (e.g., single gene and/or absent deletion duplication analysis) interested in pursuing multi-gene testing;

3. Individuals with a personal history of cancer, defined as one or more of the following:

    a. Breast cancer and one or more of the following:

i. Diagnosed age ≤45 years;

ii. Diagnosed at age 45—50 years with:

1. Unknown or limited family history; or

2. A second breast cancer diagnosed at any age; or

3. ≥1 close blood relative* with breast, ovarian, pancreatic, or high-grade (Gleason score ≥7) or intraductal prostate cancer at any age.

iii. Diagnosed at age ≤60 years with triple negative (ER–, PR–, HER2) breast cancer;

iv. Diagnosed at any age with:

1. Ashkenazi Jewish ancestry; or

2. ≥1 close blood relative* with breast cancer at age ≤50 years, or ovarian, pancreatic, or metastatic or intraductal prostate cancer at any age; or

3. ≥3 total diagnoses of breast cancer in patient and/or close blood relatives*.

v. Diagnosed at any age with male breast cancer; or

vi. Epithelial ovarian cancer (including fallopian tube cancer or peritoneal cancer) at any age.

b. Exocrine pancreatic cancer at any age;

c. Metastatic or intraductal prostate cancer at any age;

d. High-grade (Gleason score ≥7) prostate cancer at any age with:

i. Ashkenazi Jewish ancestry;

ii. ≥1 close blood relative* with breast cancer at age ≤50 years, or ovarian, pancreatic, or metastatic or intraductal prostate cancer at any age; or

iii. ≥2 close blood relatives* with breast or prostate cancer (any grade) at any age.

e. A mutation identified on tumor genomic testing that has clinical implications if also identified in the germline; or

f. To aid in systemic therapy decision-making, such as for HER2-negative metastatic breast cancer.

4. Individuals with a family history of cancer, including unaffected individuals, defined as one or more of the following:

a. An affected or unaffected individual with a first- or second-degree blood relative meeting any of the criterion listed above (except individuals who meet criteria only for systemic therapy decision-making); or

b. An affected or unaffected individual who otherwise does not meet criteria above but also has a probability >5% of a BRCA1/2 pathogenic variant based on prior probability models (eg, Tyer-Cuzick, BRCAPro, Pennll).

*For the purpose of familial assessment, close blood relatives include first-, second-, and third-degree relatives on the same side of the family (maternal or paternal):

1. First-degree relatives are parents, siblings, and children;

2. Second-degree relatives are grandparents, aunts, uncles, nieces, nephews, grandchildren, and half siblings; and

3. Third-degree relatives are great-grandparents, great-aunts, great-uncles, great grandchildren and first cousins.

Familial Adenomatous Polyposis

Louisiana Medicaid considers genetic testing for adenomatous polyposis coli (APC) gene mutations to diagnose familial adenomatous polyposis (FAP) to be medically necessary if the beneficiary meets the following criteria.

Eligibility Criteria

1. Personal history of ≥ 20 cumulative adenomas; or

2. Known deleterious APC mutation in first-degree family member.

Lynch Syndrome

Louisiana Medicaid considers genetic testing for Lynch syndrome to be medically necessary when a beneficiary meets the following criteria:

1. Amsterdam II criteria;

2. Revised Bethesda Guidelines; or

3. Estimated risk ≥ 5 percent based on predictive models (MMRpro, PREMM5, or MMRpredict).

Amsterdam II Criteria

There must be at least three relatives with a Lynch syndrome associated cancer (cancer of the colorectal, endometrium, small bowel, ureter or renal pelvis). All of the following criteria should be present:

1. One must be a first-degree relative to the other two;

2. Two or more successive generations must be affected;

3. One or more must be diagnosed before 50 years of age;

4. Familial adenomatous polyposis should be excluded in the colorectal cancer; and

5. Tumors must be verified by pathological examination.

Revised Bethesda Guidelines

One or more criterion must be met:

1. Colorectal or uterine cancer diagnosed in a patient who is less than 50 years of age;

2. Presence of synchronous (coexisting), metachronous (previous or recurring) colorectal cancer, or other Lynch syndrome associated tumors**;

3. Colorectal cancer with the MSI-H *** histology **** diagnosed in a patient who is less than 60 years of age;

4. Colorectal cancer diagnosed in one or more first-degree relatives with a Lynch syndrome related tumor, with one of the cancers being diagnosed under 50 years of age; and/or

5. Colorectal cancer diagnosed in two or more first- or second-degree relatives with Lynch syndrome related tumors, regardless of age.

**Hereditary nonpolyposis colorectal cancer (HNPCC)-related tumors include colorectal, endometrial, stomach, ovarian, pancreas, ureter and renal pelvis, biliary tract, and brain (usually glioblastoma as seen in Turcot syndrome) tumors, sebaceous gland adenomas and keratoacanthomas in Muir-Torre syndrome, and carcinoma of the small bowel.

***MSI-H - microsatellite instability–high in tumors refers to changes in two or more of the five National Cancer Institute-recommended panels of microsatellite markers.

****MSI-H histology refers to the presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern.

Prior Authorization

Genetic testing must be prior approved by the fiscal intermediary's (FI's) Prior Authorization Unit (PAU) or the managed care organization (MCO).

Genetic testing for a particular disease should generally be performed once per lifetime; however, there are rare instances in which testing may be performed more than once in a lifetime (e.g., previous testing methodology is inaccurate or a new discovery has added significant relevant mutations for a disease).

Global Surgery Period (Pre/Post-Operative Editing)

Louisiana Medicaid performs pre/post-operative editing on evaluation and management (E/M) services reported with surgical procedures during their associated pre/post-operative periods using the McKesson ClaimCheck claims editing product. This editing is generally based on values designated in the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule.

ClaimCheck references the CMS National Physician Fee Schedule where CMS categorizes most significant *Current Procedural Terminology* (CPT) surgical procedures in one of three categories, based on complexity:

1. Major procedures with a 90-day global surgery period;

2. Minor procedures with a 10-day global surgery period; or

3. Minor procedures with a 0-day global surgery period.

ClaimCheck editing will deny those E/M services that are reported with surgical procedures during their associated pre/post-operative periods. Claims that have been inappropriately paid for E/M services prior to the submission of the claim for the surgical procedure will be voided when the surgical claim is submitted.

Gynecology

Gynecologic services include:

1. Pelvic examinations;
2. Papanicolaou testing (Pap Test) for cervical cancer;
3. Screening mammography;
4. Contraceptive implants;
5. Intrauterine contraceptive system;
6. Saline infusion sonohysterography or hysterosalpingography;
7. Hysterectomies; and
8. Sterilizations.

Pelvic Examinations

Routine pelvic examinations are included in the reimbursement for the evaluation and management (E/M) service; therefore, routine pelvic examinations are not billed as separate procedures.

Pelvic examinations under anesthesia may be medically necessary for certain populations and must be prior authorized. The beneficiary's medical record must indicate the medical justification for the pelvic examination under anesthesia.

Papanicolaou Testing for Cervical Cancer

Pap testing is a screening procedure for cervical cancer. The Pap test detects the presence of precancerous or cancerous cells on the cervix. In alignment with American College of Obstetricians and Gynecologists (ACOG) guidelines, it is not considered medically necessary to screen beneficiaries younger than 21 years of age if they do not meet eligibility criteria; therefore, Medicaid will not routinely reimburse testing for beneficiaries under 21 years of age.

Eligibility Criteria

Medicaid considers cervical cancer screening (including repeat screening) medically necessary for beneficiaries under 21 years of age, if they meet the following criteria:

1. Were exposed to diethylstilbestrol before birth;
2. Have Human Immunodeficiency Virus (HIV);
3. Have a weakened immune system;
4. Have a history of cervical cancer or abnormal cervical cancer screening test; or
5. Meet other criteria subsequently published by ACOG.

Providers must submit hard copy supporting documentation of medical necessity to the fiscal intermediary (FI). Required documentation includes but is not limited to:

1. Initial abnormal Pap test result and subsequent abnormal Pap test results;
2. History and physical; and
3. Procedure note.

Reimbursement

Collection of Pap test specimens is included in the reimbursement of the E/M service.

A claim for a Pap test may be submitted only if the provider submitting the claim has the necessary laboratory equipment to perform the test in their office or facility.

For those beneficiaries under the age of 21, it is the responsibility of the treating provider to submit the required documentation needed for billing to the laboratory provider.

For specific clinical situations, providers of these services must submit hard copy supporting documentation to the FI to have the age restriction bypassed.

Claims filed with hard copy supporting documentation to the FI will pend to medical review for confirmation of the conditions that are considered medically necessary.

The following claims processing conditions will also apply:

1. The absence of hard copy supporting documentation will result in the denial of the claim; and

2. The claim will proceed with regular processing if the physical supporting documents are available and align with the clinical criteria.

Screening Mammography

Louisiana Medicaid allows payment for one-screening mammogram (either film or digital) per calendar year for beneficiaries meeting one of more of the following criteria:

1. Any woman age 30 or older with hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation;

2. Provider recommendation for any woman 35 years of age or older with a predicted lifetime risk greater than 20 percent;

3. Any woman who is 35 through 39 years of age; or

   NOTE: Only one baseline mammogram is allowable between this age range for beneficiaries not meeting other criteria.

4. Any woman who is 40 years of age or older.

Providers should perform the most clinically appropriate method (film or digital) specific to the beneficiary.

Under the following instances Louisiana Medicaid may also reimburse for an annual magnetic resonance imaging (MRI):

1. Women at least 25 years of age with hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation;

2. Provider recommendation for any woman 35 years of age or older with a predicted lifetime risk greater than 20 percent;

3. Any woman 40 or older, with increased breast density (C and D density), if recommended by their physician;

4. Women with a prior history of breast cancer below 50 years of age; or

5. Women with a prior history of breast cancer at any age and dense breast (C and D density).

NOTE: A breast ultrasound is the initial preferred modality, followed by MRI if found to be inconclusive, in this instance.

Contraceptive Implants

Louisiana Medicaid reimburses the insertion and removal of all Food and Drug Administration (FDA)-approved contraceptive implants.

Intrauterine Contraceptive Systems

Louisiana Medicaid reimburses the insertion and removal of all FDA-approved intrauterine contraceptive systems.

Saline Infusion Sonohysterography or Hysterosalpingography

Claims for catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography must be submitted with hardcopy and attachments indicating the purpose for, and the radiological interpretation of, the procedure.

Reimbursement for this procedure is limited to the assessment of fallopian tube occlusion or ligation following a sterilization procedure.

To meet payment requirements for anesthesia during a hysterosalpingogram, the above criteria must be met.

Hysterectomy

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

1. If the hysterectomy is performed solely for the purpose of terminating reproductive capability; or

2. 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 individual permanently incapable of reproducing.

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

1. The person securing authorization to perform the hysterectomy has informed the individual and their representative (if any), both orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing; and

2. The individual or their representative (if any) has signed a written acknowledgement of receipt of that information. (See Appendix B for information on obtaining a copy of the "Acknowledgement of Receipt of Hysterectomy Information," Bureau of Health Services Financing (BHSF) Form 96-A).

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

Informed Consent for Hysterectomy

The hysterectomy consent form must be signed and dated by the beneficiary on or before the date of the hysterectomy, and include signed acknowledgement the beneficiary has been informed the hysterectomy will result in permanent loss of reproductive ability.

The primary surgeon's claim requires hard-copy submission with a valid consent form and the primary surgeon is expected to share copies of the completed consent forms to facilitate ancillary provider billing for hysterectomy services. Ancillary providers include the assistant surgeon, anesthesiologist, hospital, and/or ambulatory surgical center (ASC).

If an ancillary provider submits a claim for hysterectomy services without the appropriate consent form, the claim will be paid only if the primary surgeon's claim has been approved.

The ancillary provider's claim may be held for up to 30 days pending review of the primary surgeon's claim. If the primary surgeon's claim has not been approved during this timeframe, Medical Review will deny the ancillary provider's claim. If the claim is denied, ancillary providers may resubmit after allowing additional time for the primary surgeon's claim to be paid or submit the claim hard-copy with the appropriate consent form.

When submitting claims for services that require a hysterectomy consent form, the name on the Medicaid file for the date of service on which the form was signed, must 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 must be:

1. Signed by the physician;

2. State that the beneficiary's name has changed;

3. Include the beneficiary's social security number (SSN) and date of birth (DOB); and

4. Be attached to all claims requiring consent upon submission for claims processing.

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

1. Beneficiary is unable to sign and must indicate "x" on the signature line; or

2. 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 deny.

Exceptions

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

1. Individual was sterile before the hysterectomy, the physician who performed the hysterectomy certifies in writing that the individual was sterile at the time of the hysterectomy, and states the cause of sterility;

2. Individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible, the physician certifies that the hysterectomy was performed under these conditions, and includes a description of the nature of the emergency; and/or

3. Individual was retroactively certified for Medicaid benefits and the physician who performed the hysterectomy certifies that the individual was informed before the operation that the hysterectomy would make the patient permanently incapable of reproducing. In addition, if the individual was certified retroactively for benefits and the hysterectomy was performed under one of the two other conditions listed above, the physician must certify that the hysterectomy was performed under one of those 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.

Sterilizations

In accordance with federal regulations, Medicaid payment for sterilization requires:

1. Individual is at least 21 years of age at the time the consent is obtained;

2. Individual is not mentally incompetent;

3. Individual has voluntarily given informed consent in accordance with all federal requirements; and

4. At least 30 days, but no more than 180 days, have passed between the date of the informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Sterilization Consent Form Requirements

Providers must use the current sterilization consent form (OMB No. 0937-0166/HHS-687) available in English and Spanish from the Health and Human Services, Office of Population Affairs website. (See Appendix B for information on obtaining and completing these forms).

The consent form must be signed and dated by:

1. Individual to be sterilized;

2. Interpreter, if one was provided;

3. Person who obtained the consent; and

4. Physician performing the sterilization procedure.

   NOTE: If the physician who performed the sterilization procedure is also the physician who obtained the consent, that physician must sign both statements.

The primary surgeon's claim requires hard-copy submission with a valid consent form and the primary surgeon is expected to share copies of the completed consent forms to facilitate ancillary

provider billing for sterilization services. Ancillary providers include the assistant surgeon, anesthesiologist, hospital, and/or ASC.

If an ancillary provider submits a claim for sterilization services without the appropriate consent form, the claim will be paid only if the primary surgeon's claim has been approved.

The ancillary provider's claim may be held for up to 30 days pending review of the primary surgeon's claim. If the primary surgeon's claim has not been approved during this timeframe, Medical Review will deny the ancillary provider's claim. If the claim is denied, ancillary providers may resubmit after allowing additional time for the primary surgeon's claim to be paid or submit the claim hard-copy with the appropriate consent form.

Consent Forms and Name Changes

When submitting claims for services that require a sterilization consent form, the name on the Medicaid file for the date of service in which the form was signed must 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 must be:

1. Signed by the physician;
2. State that the beneficiary's name has changed;
3. Include the beneficiary's SSN and DOB; and
4. Be attached to all claims requiring consent upon submission for claims processing.

Correcting the Sterilization Consent Form

The informed consent must be obtained and documented prior to the performance of the sterilization.

Errors in the following sections may be corrected, but only by the person over whose signature they appear:

1. "Consent to Sterilization";
2. "Interpreter's Statement";
3. "Statement of Person Obtaining Consent"; and
4. "Physician's Statement".

If either the beneficiary, the interpreter, or the person obtaining consent returns to the office to make a correction to the relevant portion of the consent form, the medical record must reflect that person's presence in the office on the day of the correction.

To make an allowable correction to the form, the person making the correction must line through the mistake once, write the corrected information above or to the side of the mistake, and initial and date the correction. Erasures, "write-overs," or use of correction fluid in making corrections, are unacceptable.

Only the beneficiary may correct the date of signature. The same applies to the interpreter, to the person obtaining consent, and to the physician. Corrections by the beneficiary, the interpreter, and the person obtaining consent must be made before the claim is submitted.

The date of the sterilization may be corrected either before or after submission by the physician over whose signature it appears; however, the operative report must support the corrected date.

An invalid consent form will result in denial of all claims associated with the sterilization.

Consent forms will be considered invalid if:

1. Errors have been made in correctable sections, but have not been corrected;

2. Errors have been made in blanks that cannot be corrected; or

3. The consent form shows evidence of erasures, "write-overs," or use of correction fluid.

Hospice

Louisiana Medicaid covers hospice care for qualifying beneficiaries of all ages who elect this treatment, and covers life-prolonging care for beneficiaries under 21 years of age who elect the concurrent care model of hospice. See Chapter 24 Hospice Provider manual for all information pertaining to hospice care at:
https://www.lamedicaid.com/provweb1/providermanuals/manuals/Hospice/Hospice.pdf

Hyperbaric Oxygen Therapy

Hyperbaric oxygen therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

Covered Conditions

Reimbursement for hyperbaric oxygen therapy is limited to treatments administered in a hyperbaric oxygen therapy chamber. Hyperbaric oxygen therapy is covered for the following conditions, if deemed medically necessary:

1. Acute carbon monoxide intoxication;

2. Decompression illness;

3. Gas embolism;

4. Gas gangrene;

5. Acute traumatic peripheral ischemia. Hyperbaric oxygen therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;

6. Crush injuries and suturing of severed limbs. Hyperbaric oxygen therapy would be an adjunctive treatment when loss of function, limb, or life is threatened;

7. Progressive necrotizing infections (necrotizing fasciitis);

8. Acute peripheral arterial insufficiency;

9. Preparation and preservation of compromised skin grafts (not for primary management of wounds);

10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management;

11. Osteoradionecrosis as an adjunct to conventional treatment;

12. Soft tissue radionecrosis as an adjunct to conventional treatment;

13. Cyanide poisoning;

14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment; and

15. Diabetic wounds of the lower extremities when the wound is classified as Wagner grade three or higher and an adequate course of standard wound therapy was not sufficient to lead to healing.

Immunizations

Louisiana Medicaid covers immunizations for all beneficiaries in accordance with the schedule established by the Advisory Committee on Immunization Practices (ACIP). For beneficiaries under the age of 21 years old, immunizations are given in conjunction with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Preventive Services (*well child*) visits or when other appropriate opportunities exist.

Vaccines for Children

Section 1928 of the Social Security Act provides for vaccines for children (VFC) free of charge to enrolled public and private health care providers for eligible children. Persons eligible for VFC are between the ages of birth through 18 years and meet one of the following criteria:

1. American Indian or Alaskan native, as defined by the Indian Health Services Act;
2. Medicaid eligible;
3. Uninsured; or
4. Underinsured.

Underinsured individuals are those whose health insurance plan does not cover vaccines or has limited vaccine coverage. Underinsured children are eligible to receive vaccines only at Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), or Office of Public Health (OPH) Parish Health Units.

All Medicaid enrolled providers that provide EPSDT well child preventive services, must be enrolled in the VFC program and utilize VFC vaccines for beneficiaries between the ages of birth through 18 years.

Providers can obtain a VFC enrollment packet by calling the OPH Immunization Section. (See Appendix A for contact information).

Louisiana Immunization Network for Kids Statewide (LINKS)

Louisiana Immunization Network for Kids Statewide (LINKS) is a secure, internet-based registry designed to track immunization records for providers and their patients. LINKS can be accessed through the OPH website. (See Appendix A for contact information).

Providers can obtain a LINKS enrollment packet or learn more about LINKS by calling the Louisiana Department of Health (LDH), OPH Immunization Program. (See Appendix A for contact information).

Combination Vaccines

A vaccine component refers to all the antigens (including multivalent antigens and antigen serotypes) in a vaccine that prevent disease(s) caused by one organism. Combination vaccines are those that contain more than one component. Combination vaccines are encouraged to maximize the opportunity to immunize and to reduce the number of injections that a child receives in a single visit. Louisiana Medicaid does not reimburse providers for administration of multiple single-component vaccines if a combination vaccine is medically appropriate and the combination vaccine is approved by the United States Food and Drug Administration (FDA).

Immunization Administration Coding

Louisiana Medicaid defines the administration of a vaccine as the delivery of a single component vaccine or combination vaccine via a single route, such as one injection, nasal spray, or oral dose. Providers must indicate the Current Procedural Terminology (CPT) code for the specific vaccine in addition to the appropriate administration CPT code(s) to receive reimbursement for the administration of appropriate immunizations. Providers are to refer to the *CPT* code description and immunization fee schedules to determine the appropriate codes.

Reimbursement

Vaccines from the VFC program are available at no cost to the provider and are required to be used for Medicaid beneficiaries who are from **birth through 18 years of age**. Therefore, CPT codes for vaccines available from the VFC program will be paid at zero ($0) for a beneficiary from birth through 18 years of age.

Providers must submit claims with their usual and customary charges for the vaccines for beneficiaries from 19 through 20 years of age, and for all beneficiaries aged 21 years of age and older. These claims will be reimbursed at the fee on file or the billed charges, whichever is lower.

Reimbursement rates can be found on the immunization fee schedules located on the Louisiana Medicaid website at https://www.lamedicaid.com/Provweb1/fee_schedules/feeschedulesindex.htm.

Billing for Single Vaccine Administration

Providers must submit the appropriate CPT immunization administration code when administering one immunization. In addition, the CPT code for the vaccine must be included on the same claim.

Billing for Multiple Administrations

When administering more than one immunization on a single date of service, providers are to bill as described for a single administration. In addition, the appropriate procedure code(s) (Immunization administration -each additional injection/administration/vaccine) is to be listed with the appropriate number of units for the additional vaccines placed in the "units" column. The specific vaccines are to be listed on subsequent lines. The number of vaccines listed must match the number of units listed in the "units" column.

Hard Copy Claim Filing for Greater Than Four Immunizations

Providers must bill on two CMS-1500 claim forms when billing hard copy claims for more than four immunizations and the six-line claim form limit is exceeded. The first claim must follow the instructions for billing for a single administration. A second CMS-1500 claim form can be used to bill the remaining immunizations as described for billing for multiple administrations.

Coverage of Vaccines for Young Adult (Ages 19 through 20) and Adult (21+)

For beneficiaries aged 19 years and older, providers are to submit claims using the appropriate immunization administration CPT code along with the specific vaccine CPT code and include their usual and customary billed amounts. Providers will be reimbursed for the vaccine and the administration based on the fee on file or the billed charges, whichever is lower.

"Incident To" Services

"Incident to" services means services or supplies that are furnished as an integral, although incidental, part of a supervising provider's professional services. For physicians, "incident to" services include those provided by auxiliary personnel (e.g., medical assistants, licensed practical nurses, registered nurses, etc.), but exclude those provided by an advanced practice registered nurse (APRN) and physician assistant (PA). For APRNs and PAs, "incident to" services also include those provided by auxiliary personnel. For all "incident to" services, auxiliary personnel must only operate within the scope of practice of their license or certification.

Provider supervision must consist of either personal participation in the service or direct supervision coupled with review and approval of the service notes. Direct supervision is defined as the provider being present in the facility, though not necessarily present in the room where the service is being rendered, and immediately available to provide assistance and direction throughout the time the service is performed. For Office of Public Health (OPH) clinics and services provided, providers must furnish general supervision, defined as under the supervising provider's overall direction and control, but the provider's presence is not required in the facility during the performance of the service.

When an APRN or PA provides all parts of the service independent of a supervising or collaborating physician's involvement, even if a physician signs off on the service or is present in the facility, the service does not meet the requirements of "incident to" services. Instead, claims for such services must be submitted using the APRN or PA as the rendering provider.

It is inappropriate for a physician to submit claims for services provided by an APRN or PA with the physician listed as the rendering provider when the physician is only supervising, reviewing, or "signing off" on the APRN's or PA's records. Services billed in this manner are subject to post-payment review, recoupment, and additional sanctions as deemed appropriate by Louisiana Medicaid.

Intrathecal Baclofen Therapy

Louisiana Medicaid allows reimbursement for the surgical implantation of a programmable infusion pump for the delivery of intrathecal baclofen (ITB) therapy for individuals four years of age and older who meet medical necessity for the treatment of severe spasticity of the spinal cord or of cerebral origin. This procedure and treatment regimen **must be prior authorized**.

Hospitals may obtain pre-certification for the inpatient stay by following the inpatient hospital precertification process.

The following diagnoses are considered appropriate for ITB treatment and infusion pump implantation:

1. Meningitis;
2. Encephalitis;
3. Dystonia;
4. Multiple sclerosis;
5. Spastic hemiplegia;
6. Infantile cerebral palsy;
7. Other specified paralytic syndromes;
8. Acute, but ill-defined, cerebrovascular disease;
9. Closed fracture of the base of skull;
10. Open fracture of base of skull;
11. Closed skull fracture;
12. Fracture of vertebral column with spinal cord injury;
13. Intracranial injury of other and unspecified nature; or
14. Spinal cord injury without evidence of spinal bone injury.

Criteria for Beneficiary Selection

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

1. **Inclusive Criteria for Candidates with Spasticity of Cerebral Origin**

    a. There is severe spasticity of cerebral origin with no more than mild athetosis;

    b. The injury is older than one year;

    c. There has been a drop in Ashworth scale of one or more;

    d. Spasticity of cerebral origin is resistant to conservative management; and/or

    e. The candidate has a positive response to test dose of ITB.

2. **Inclusive Criteria for Candidates with Spasticity of Spinal Cord Origin**

    a. There is Spasticity of spinal cord origin that is resistant to oral antispasmodics or side effects unacceptable in effective doses;

    b. There has been a drop in Ashworth scale of two or more; and/or

    c. The candidate has a positive response to test dose of ITB.

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

1. Have a history of autonomic dysreflexia;

2. Suffer from psychotic disorders;

3. Have other implanted devices; or

4. Utilize spasticity to increase function such as posture, balance, and locomotion.

Exclusive Criteria for Candidates

Consideration shall not be made if the candidate:

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

Reimbursement is available for the cost of the outpatient bolus injections given to candidates for the ITB infusion treatment even if the beneficiary fails the screening trial procedure. Physicians may bill for these injections by submitting the appropriate Healthcare Common Procedure Coding System (HCPCS) code for each date on which an injection was given. These screening trial injections do not require prior authorization (PA).

Prior Authorization

PA 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 multidisciplinary team (MDT), which evaluates the beneficiary. The MDT shall be comprised of the following:

1. A neurosurgeon and/or an orthopedic surgeon;
2. A physiatrist and/or a neurologist;
3. The beneficiary's attending physician;
4. A nurse;

5. A social worker; and

6. 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 a nationally recognized ITB product supplier with expertise in ITB.

The MDT shall evaluate the candidate after the screening trial procedure has been completed but prior to the pump implantation.

The following documentation must be submitted to the fiscal intermediary's (FI's) Prior Authorization Unit (PAU):

1. A recent history with documentation of assessments in the following areas:

   a. Medical and physical;

   b. Neurological;

   c. Functional; and

   d. Psychosocial.

2. Ashworth scores for pre and post administration of the ITB test dose(s); and

3. Documentation of any other findings regarding the beneficiary's condition, which would assist in determining medical necessity for ITB, i.e., a videotape of the trial dosage.

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 must submit a Request for PA (PA-01 Form) to the FI's PAU as part of the MDT's packet. The surgeon must use their individual, rather than group, provider number on the PA-01 Form. The provider may bill for the implantation of the intraspinal catheter.

The appropriate codes are to be billed on the CMS-1500 claim form with the PA number included in item 23, if billing hard copy. Assistant surgeons, anesthesiologists and non-anesthesiologists-directed Certified Registered Nurse Anesthetists (CRNAs) 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 Form to the FI's PAU. The PA-01 Form should be submitted as part of the MDT'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 considered for reimbursement for the device, the hospital must use the appropriate HCPCS code and submit the claim to the FI on a CMS-1500 claim form with the letters "DME" written in red across the top of the form, if billing hard copy. However, providers are encouraged to bill electronically.

Billing for Replacement Pumps and Catheters

Replacement pumps and/or catheters must be billed on a CMS-1500 claim form with the letters "DME" in red across the top. A copy of the original authorization letter must be attached to the claim.

Billing for Reservoir Refills and Pump Maintenance

Only physicians with specialties in anesthesiology, neurology, neurosurgery, or physical medicine rehabilitation may be reimbursed for the filling of the reservoir and the maintenance of the pump.

If outpatient surgery is performed on an inpatient basis, the policy outlined in that section of this manual shall apply. Please refer to that policy before admitting the beneficiary.

Laboratory and Radiology Services

This policy only applies to the performance of laboratory and radiology procedures in a provider's office (i.e., other than a hospital or independent laboratory).

Provider Requirements

Providers may only receive reimbursement for laboratory and radiology services that they personally perform or supervise.

Clinical Laboratory Improvement Amendments Certification

Providers must include a valid Clinical Laboratory Improvement Amendments (CLIA) certification number on all claims submitted for laboratory services, including CLIA waived tests.

CLIA claim edits are applied to all claims for laboratory services. Claims are edited to ensure payment is not made to providers who:

1. Do not have a CLIA certificate;

2. Render services outside the effective dates of the CLIA certificate; and

3. Submit claims for services not covered by their CLIA certificate.

Louisiana Medicaid maintains a current provider CLIA file. Providers must submit a copy of the CLIA certification to the fiscal intermediary's (FI's) Provider Enrollment Unit (PEU). (See Appendix A for contact information).

Once the CLIA certification has been added to the file, certification updates are made automatically via the Centers for Medicare and Medicaid Services (CMS) Online Survey, Certification and Reporting (OSCAR) process and are sent to Louisiana Medicaid without further provider involvement.

Providers with regular accreditation, partial accreditation, or registration certificate types are allowed by CLIA to submit claims for all laboratory procedure codes. Providers with waiver or provider-performed microscopy (PPM) certificate types will only be reimbursed for certain laboratory procedure codes in connection with those certificate types, as approved by CMS.

To submit claims for laboratory procedure codes outside of their restricted certificate types, providers with waiver or PPM certificates must obtain the appropriate certificate through the Louisiana Department of Health (LDH), Health Standards Section (HSS).

Claim payments are only made for dates of service falling within the particular certification dates governing those services.

Providers must add the QW modifier to the procedure code for all CLIA waived tests.

CLIA information can be obtained at: https://ldh.la.gov/page/3766

Covered Services

Medicaid covers medically necessary laboratory and radiology services needed to diagnose and appropriately treat a specific condition, illness, or injury. Screening laboratory and radiology services are only considered medically necessary if recommended as Grade A or B by the United States Preventive Services Taskforce, specified in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, or as otherwise specified in Medicaid policy.

For laboratory services, when multiple laboratory tests are conducted simultaneously, for example as part of a profile, battery, or panel, each individual test must be medically necessary for the profile, battery, or panel to be considered medically necessary.

Specimen Collection

Providers collecting specimens as part of an evaluation and management service and forwarding them to an outside laboratory are not separately reimbursed for collection of the specimen. The collection of the specimen is considered incidental to the evaluation and management (E/M) service.

Drug Testing

Louisiana Medicaid covers presumptive and definitive drug testing under the following parameters:

1. Presumptive drug testing is limited to 24 total tests per member per calendar year. Providers are to consider the methodology used when selecting the appropriate procedure code for the presumptive testing;

2. Definitive drug testing is limited to 12 total tests per member per calendar year. Testing more than 14 definitive drug classes per day is not medically necessary. Definitive drug testing is limited to individuals with an unexpected positive or unexpected negative finding on presumptive drug testing, or if there is a clinical reason to detect a specific substance or metabolite that would be inadequately detected through presumptive drug testing;

3. No more than one presumptive and one definitive drug test will be reimbursed per day per beneficiary, from the same or different provider; and

4. Universal drug testing (screening) in a primary care setting is not covered. Drug testing without signs or symptoms of substance use, or without current controlled substance treatment, is not covered.

These services may be subject to post payment review. Non-compliance with written policy may result in recoupment and additional sanctions, as deemed appropriate by Louisiana Medicaid.

Positron Emission Tomography

Positron emission tomography (PET), with or without computed tomography (CT), is covered when medically necessary. For oncologic conditions, coverage is in accordance with National Comprehensive Cancer Network guidelines.

Proprietary Laboratory Analyses

Proprietary Laboratory Analyses (PLA) testing is covered when used for the particular "brand" respiratory panel kit as stated within the Current Procedural Terminology (CPT) codebook. PLA codes must be used with the specific device or kit. *"Services should not be reported with any other CPT code and other CPT codes should not be used to report services that may be reported with that specific PLA code."*

The expectation is that the procedure codes are billed in accordance with CPT guidelines.

Reimbursement for Laboratory and Radiology Procedures

Reimbursement is made at the lower of the billed charges or the fee on file, minus the amount that any third-party coverage would pay. For laboratory services, reimbursement shall not exceed 100 percent of the current year's Medicare allowable.

Providers shall not submit claims for both the professional component and the full service for the same patient for the same laboratory or radiology service on the same date of service.

To receive reimbursement for the full service, the provider must own or lease, and have on the premises, the necessary equipment. Reimbursement for the full service encompasses both the use of the equipment and the provider's professional service.

Certain procedures are a combination of a professional component and a technical component. When the professional component is reported separately, providers may bill the procedure code with the appropriate modifier to denote only the professional component. Louisiana Medicaid does not reimburse for the technical component separately.

Medical Review

The Medical Review Department is responsible for several functions. These include post-procedural review of claims for manually priced procedures and review of designated procedures and diagnoses which require medical documentation to ensure compliance with Medicaid policy.

Expediting Correct Payment

Listed below are suggestions for facilitating correct payment:

1. All attachments should be clear, legible, and easy-to-read;

2. All operative reports should be dated correctly;

3. Use of specific, appropriate diagnosis codes;

4. Submit requested documentation as soon as possible so that correct payment can be determined quickly. Requested documentation should be attached behind a copy of the original claim form, as there is no mechanism to match incoming medical records with previously submitted claims;

5. Bill all procedures performed under the same anesthesia session on the same CMS-1500 claim form using correct modifiers and attaching all pertinent documents with the claim;

6. Assistant surgeons should always append an -80 modifier on each claim line. Assistant surgeons are not required to use the -51 modifier for secondary procedures; and

7. Submit all reports (i.e. operative, history and physical, etc.) as one-sided for accurate imaging.

Billing Information

Bilateral Procedures

A -50 modifier indicates that a bilateral procedure was performed. Providers should submit the appropriate *Current Procedural Terminology* (CPT) code on one claim line, append modifier -50, and place a "1" in the "units" column of the claim form.

The bilateral modifier may only be appended to the CPT code if the procedure can be surgically performed bilaterally. The -50 modifier is not to be added if the CPT definition reads "unilateral or bilateral".

Reimbursement for bilateral procedures is 150 percent of the fee on file, or the billed charge, whichever is lower.

Multiple Surgical Reductions Reimbursement

Multiple surgery reduction is the general industry term applied to the practice of paying decreasing pay percentages for multiple surgeries performed during the same surgical session. When more than one surgical procedure is submitted for a patient on the same date of service, the 51 modifier should be appended to the secondary code(s). Certain procedure codes are exempt from this process due to their status as "add-on" or "modifier 51 exempt" codes as defined in CPT.

Claim Check allows the claims processing system to add or remove the -51 modifier (multiple procedures) from the claim, regardless of whether it was applied to the appropriate procedure(s), and then process the claim accordingly. Providers may see the specific Claim Check edits when the system identifies such cases.

The primary procedure will be paid at 100 percent of either the Medicaid allowable fee or the billed charge, whichever is lower. All other procedures will be paid at 50 percent of the Medicaid allowable fee, or 50 percent of the billed charge, whichever is less.

Bilateral Secondary Surgical Procedures

Multiple modifiers may be appended to a procedure code when appropriate. Billing multiple surgical procedures and bilateral procedures during the same surgical session should follow Medicaid policy for each type of modifier.

Bilateral secondary procedures should be billed with modifiers 50/51 and if appropriate, will be reimbursed at 75 percent of the Medicaid allowable fee or 75 percent of the billed charges, whichever is lowest.

Unlisted Procedures

Claims submitted for unlisted procedure codes are subject to review. Providers should not use unlisted procedure codes when standard CPT codes exist, which describe the service. If a CPT code exists describing the service, the claim will be denied. Operative reports or documentation justifying the procedure should be submitted hardcopy each time an unlisted procedure code is submitted. The reports should accurately describe the unlisted procedure. Underlining such portions of the report that describe the services performed will expedite the medical review process.

Modifiers

Claims for dually eligible Medicare and Medicaid enrollees must be submitted to Medicaid with the same modifiers used for the Medicare adjudication. The modifiers in the table in this section indicate modifiers that impact reimbursement or policy.

A modifier provides the means to report or indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. Modifiers enable providers to apply payment policy established by Louisiana Medicaid.

Providers should refer to the most recent *Current Procedural Terminology* (CPT) manual for procedure codes exempt from certain modifier usage. Not all acceptable modifiers result in action by the claims processing system.

NOTE: Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program.

Modifier Table

Modifier	Use/Example	Special Billing Instructions	Reimbursement
22 **Unusual Service**	Service provided is greater than that which is usually required (e.g., delivery of twins); not to be used with visits or laboratory codes	Attach supporting documentation which clearly describes the extent of the service	125 percent of the fee on file or billed charges whichever is lower
24 **Unrelated evaluation and management (E/M) service by the same physician during the post-op period**			Lower of billed charges or fee on file

Modifier	Use/Example	Special Billing Instructions	Reimbursement
25 Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service	Early and Periodic Screening, Diagnostic and Treatment (EPSDT) medical screening performed on same date of service and suspected condition identified and referred in-house	When a suspected condition identified during a screening visit and diagnosed/treated by the screening provider during the same visit, only a lower level E/M appended with modifier 25 is allowed; otherwise claim will deny Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program	Lower of billed charges or fee on file
26 Professional Component	Professional portion only of a procedure that typically consists of both a professional and a technical component (e.g., interpretation of laboratory or radiology procedures performed by another provider)		Lower of billed charges or 40 percent of the fee on file
NOTE: Louisiana Medicaid does not reimburse technical component (TC modifier) on straight Medicaid claims. Reimbursement is not allowed for both the professional component and full service on the same procedure.			

Modifier	Use/Example	Special Billing Instructions	Reimbursement
50 Bilateral Procedure (See site-specific modifier policy)	Procedure was performed bilaterally during the same operative session	When "bilateral" is part of the procedure code's description, RT/LT or -50 shall not be used.	Lower of billed charges or 150 percent of the fee on file
51 Multiple Procedures	More than one procedure was performed during the same operative session	Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program	Lower of billed charges or 100 percent of the fee on file for primary/50 percent of the fee on file for all others
NOTE: When the -51 modifier has or has not been applied to the appropriate procedure(s), the claims processing system will add or remove the modifier as appropriate and process the claim accordingly. When more than one surgical procedure is performed on a date of service, the modifier -51 must be appended appropriately to the secondary or subsequent procedure(s). With few exceptions, the primary procedure is the most clinically intensive procedure, usually with the highest relative value.			
52 Reduced Services	Service or procedure is reduced at the physician's election	Attach supporting documentation	Lower of billed charges or 75 percent of the fee on file
53 Discontinued Procedure	Only for use by Free-Standing Birthing Centers (FSBC's) when the beneficiary is transferred prior to delivery		50 percent of the FSBC's facility fee or billed charges, whichever is lower

Modifier	Use/Example	Special Billing Instructions	Reimbursement
54 Surgical Care Only	Surgical procedure performed by physician when another physician provides pre- and/or post-operative management		Lower of billed charges or 70 percent of the fee on file
55 Postoperative Management Only	Post-operative management only when another physician has performed the surgical procedure		Lower of billed charges or 20 percent of the fee on file
56 Preoperative Management Only	Pre-operative management only when another physician has performed the surgical procedure		Lower of billed charges or 10 percent of the fee on file
NOTE: If full service payment is made for a procedure (i.e., the procedure is billed and paid with no modifier), additional payment will not be made for the same procedure for surgical care only, post-operative care only, or preoperative care only. In order for all providers to be paid in the case when modifiers -54, -55, and -56 would be used, each provider must use the appropriate modifier to indicate the service performed. Claims that are incorrectly billed and paid must be adjusted using the correct modifier in order to allow payment of other claims billed with the correct modifier.			
57 E/M service resulting in the initial decision to perform the surgery			Lower of billed charges or fee on file

Modifier	Use/Example	Special Billing Instructions	Reimbursement
59 Distinct procedural services performed; separate from other services rendered on the same day by the same provider		Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program	Lower of billed charges or fee on file
62 Two Surgeons	Performance of procedure requiring the skills of two surgeons	Attach supporting documentation which clearly indicates the name of each surgeon and the procedures performed by each	Lower of billed charges or 80 percent of the fee on file
63 Infants less than 4 kg	Indicates a procedure performed on an infant less than 4 kg	Attach supporting documentation if multiple modifiers are used (i.e. 51 and 63)	Lower of billed charges or 125 percent of the fee on file
66 Surgical Team	Performance of highly complex procedure requiring the concomitant services of several physicians (e.g., organ transplant)	Attach supporting documentation which clearly indicates the name of each surgeon and the procedures performed by each	Lower of billed charges or 80 percent of the fee on file

NOTE: In order for correct payment to be made in the case of two surgeons or a surgical team, all providers involved must bill correctly using appropriate modifiers. If full service payment is made for a procedure (i.e., the procedure is billed and paid with no modifier), additional payment will not be made for the same procedure for two surgeons or surgical team. Payment will not be made for any procedure billed for both full service (no modifier) and for two surgeons or surgical team. If even one of the surgeons involved bills with no modifier and is paid, no additional payment will be made to any other surgeon for the same procedure. Claims which are incorrectly billed with no modifier and are paid must be adjusted using the correct modifier in order to allow payment of other claims billed with the correct modifier.

Modifier	Use/Example	Special Billing Instructions	Reimbursement
79 Unrelated procedure or service by the same physician during the postoperative period			Lower of billed charges or fee on file
80* Assistant Surgeon			Lower of billed charges or MD's – 20 percent of the full service physician fee on file.
95 Telemedicine/Telehealth	Services provided via a telecommunications system, see the Telemedicine/Telehealth section	Modifier shall be appended to claims for all services provided via telemedicine/telehealth	Lower of billed charges or 100 percent of the fee on file
AS* First Assistant in Surgery: Qualified Physician Assistant, Nurse Practitioner (NP), Certified Nurse Midwives (CNMs) or Clinical Nurse Specialist (CNS)			Lower of billed charges or 80 percent of MD's 'Assistant Surgeon' fee
NOTE: *The list of codes acceptable with the 80/AS modifier is posted on the Louisiana Medicaid website. (See Appendix A for information on how to access this information).			
AT Acute Treatment	Chiropractors use this modifier when reporting chiropractic manipulative treatment		Lower of billed charges or fee on file

Modifier	Use/Example	Special Billing Instructions	Reimbursement
Q5 Reciprocal Billing Arrangement	Services provided by a substitute physician on an occasional reciprocal basis not over a continuous period of longer than 60 days. Does not apply to substitution within the same group	The regular physician submits the claim and receives payment for the substitute. The record must identify each service provided by the substitute	Lower of billed charges or 100 percent of the fee on file
Q6 Locum Tenens	Services provided by a substitute physician retained to take over a regular physician's practice for reasons such as illness, pregnancy, vacation, or continuing education. The substitute is an independent contractor typically paid on a per diem or fee-for-time basis and does not provide services over a period of longer than 60 days	The regular physician submits claims and receives payment for the substitute. The record must identify each service provided by the substitute	Lower of billed charges or 100 percent of the fee on file
TH Prenatal Services	Required to indicate pre-natal services		Lower of billed charges or fee for prenatal services
QW Laboratory	Required when billing certain laboratory codes		Lower of billed charges or fee on file

Site-Specific Modifiers

Unless specifically indicated otherwise in CPT, providers should use site-specific modifiers to accurately document the anatomic site where procedures are performed when appropriate for the clinical situation. Site specific modifiers left side (LT)/right side (RT) should not be used in lieu of modifier -50 (bilateral procedure).

When billing a site-specific modifier, in addition to other modifiers for an applicable procedure code, the site-specific modifier should be reported in the first position on the claim.

List of Site-Specific Modifiers

E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
LT*	Left side
RT*	Right side
LC	Left circumflex, coronary artery
RC	Right coronary artery
LD	Left anterior descending coronary artery
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit

***NOTE:** When “bilateral” is part of the procedure code description, RT/LT or -50 shall not be used.

Newborn Care and Discharge

The appropriate *Current Procedural Terminology* (CPT) codes for the initial care of the normal newborn may be submitted when the service provided meets the criteria as defined by CPT. This procedure code is limited to once per lifetime of the beneficiary.

The CPT code for subsequent care of the normal newborn may be submitted for each day care is rendered subsequent to the date of birth (DOB), other than the discharge date. Louisiana Medicaid covers up to three normal newborn subsequent care days.

Discharge Services

When the date of discharge is subsequent to the admission date, the provider shall submit claims for newborn hospital discharge services using the appropriate CPT code for discharge day management.

When newborns are admitted and discharged on the same date, the provider shall use the appropriate code for these services.

Routine Circumcision

In fee-for-service (FFS) Medicaid, routine newborn circumcision is a non-covered service and is billable to the beneficiary's responsible party. The provider shall inform the responsible party that the service is not covered by Medicaid before performing the service.

For newborns covered by a managed care organization (MCO), routine circumcision is covered as a value-added benefit.

All medically necessary circumcisions are a covered benefit for all beneficiaries.

Newborn Screenings

Newborn screening (via heel stick) includes testing for certain specified conditions recommended by the American College of Medical Genetics. Louisiana Revised Statute (La. RS) 40:1081.1 and 1081.2 requires hospitals with delivery units to screen all newborns before discharge, regardless of the newborn's length of stay at the hospital. Louisiana Administrative Code (LAC) Title 48, Part V, Subpart 18, Chapter 63, provides the requirements related to newborn screenings.

Obstetrics

All prenatal outpatient visit evaluation and management (E/M) procedure codes must contain the TH modifier. The TH modifier is not required for observation or inpatient hospital physician services.

Initial Prenatal Visit(s)

Louisiana Medicaid provided reimbursement for up to two initial prenatal visits per pregnancy (270 days). These two visits cannot be performed by the same attending provider.

Louisiana Medicaid considers the beneficiary a 'new patient' for each pregnancy whether or not the beneficiary is a new or established patient to the provider/practice. The appropriate level E/M *Current Procedural Terminology* (CPT) procedure code shall be billed for the initial prenatal visit with the TH modifier.

Reimbursement for the initial prenatal visit, must be modified with TH and shall include, but is not limited to, the following:

1. Estimation of gestational age by ultrasound or firm last menstrual period. If the ultrasound is performed during the initial visit, it may be billed separately. See the ultrasound policy later in this section;

2. Identification of patient at risk for complications including those with prior preterm birth;

3. Health and nutrition counseling; and

4. Routine dipstick urinalysis.

If the pregnancy is not verified, or if the pregnancy test is negative, the service may only be submitted with the appropriate level E/M without the TH modifier.

Follow-Up Prenatal Visits

The appropriate level E/M CPT code from the range of procedure codes used for an established patient may be submitted for the subsequent prenatal visit(s). The E/M CPT code for each of these visits must be modified with the TH modifier**.**

The reimbursement for this service shall include, but is not limited to:

1. The obstetrical (OB) examination;

2. Routine fetal monitoring (excluding fetal non-stress testing);

3. Diagnosis and treatment of conditions both related and unrelated to the pregnancy; and

4. Routine dipstick urinalysis.

Delivery Codes

The most appropriate "delivery only" CPT code shall be submitted. Delivery codes inclusive of the antepartum care and/or postpartum visit are not covered except in cases related to third-party liability.

In cases of multiple births (twins, triplets, etc.), providers must submit claims hardcopy. The diagnosis code must indicate a multiple birth and delivery records must be attached. A modifier-22 for unusual circumstances is to be used with the most appropriate CPT code for a vaginal or cesarean section (C-section) delivery when the method of delivery is the **same** for all births.

If the multiple gestation results in a C-section delivery **and** a vaginal delivery, the provider must use the most appropriate "delivery only" CPT code for the C-section delivery and also bill the most appropriate vaginal "delivery only" procedure code with modifier-51 appended.

When a long-acting reversible contraceptive (LARC) is inserted, immediately postpartum and prior to discharge, reimbursement shall be made separately for the insertion procedure and the LARC.

Postpartum Care Visit

The postpartum care CPT code (which is not modified with –TH) may be billed for the postpartum care visit when performed. Reimbursement is allowed for one postpartum visit per 270 days.

The reimbursement for the postpartum care visit includes, but is not limited to:

1. Physical examination;

2. Body mass index (BMI) assessment and blood pressure check;

3. Routine dipstick urinalysis;

4. Follow up plan for women with gestational diabetes;

5. Family planning counseling;

6. Breast feeding support including referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), if needed;

7. Screening for postpartum depression and intimate partner violence; and

8. Other counseling and or services associated with releasing a patient from OB care.

Doula Services

Louisiana Medicaid covers services rendered to Medicaid beneficiaries by qualified doulas meeting the criteria and policy outlined below.

Louisiana Medicaid provides coverage for the following core doula services:

1. Up to five prenatal visits, each lasting up to 90 minutes;

2. Up to three postpartum visits, each lasting up to 90 minutes; and

3. Attendance and support during labor and delivery, including cesarean births.

In addition, the following supportive doula services are covered:

1. Continuous support during labor and immediately following childbirth;

2. Prenatal and postpartum education and support;

3. Breastfeeding and lactation assistance;

4. Parenting education and guidance; and

5. Support services following pregnancy loss.

Doula Qualifications

Doula services offer continuous, non-clinical support to individuals and families throughout pregnancy, labor and delivery, and the postpartum period. This support includes emotional, physical, and informational assistance to help individuals navigate the childbirth experience and promote positive maternal and infant health outcomes.

A qualified doula is an individual who:

1. Has been trained to provide physical, emotional, and educational support, but not medical or midwifery care, to pregnant and birthing women and their families;

2. Has approved registration with the Louisiana Doula Registry Board; and

3. Has been enrolled as a Louisiana Medicaid provider.

Reimbursement

Reimbursement for doula services shall be a flat fee based on the applicable CPT or healthcare common procedure coding system (HCPCS) codes and must be supported by appropriate documentation. (See below for applicable procedure codes).

Code	Description	Maximum Units
99404	Pre/Postnatal Nurse Advocacy Visit	As medically necessary
*S9445	Prenatal/Postpartum Visit	
99199	Attendance at Labor and Delivery	1 per pregnancy
*S9442	Birthing Class	
*S9443	Lactation Class	
*S9444	Parenting Class	

*These visits to be utilized in any combination for the total eight allowable visits (not factoring in the delivery).

Providers should refer to the Professional Services fee schedule on the Medicaid website for reimbursement information relative to these codes.

Prenatal Laboratory and Ultrasound Services

Prenatal Laboratory Panels

The OB panel test as defined by CPT shall only be reimbursed once per pregnancy.

A complete urinalysis is reimbursable only once per pregnancy (270 days) per billing provider unless medically necessary, for example, to diagnose a disease or infection of the genitourinary tract.

Non-Invasive Prenatal Testing

Non-Invasive Prenatal Testing (NIPT) is a genetic test which uses maternal blood that contains cell-free fetal deoxyribonucleic acid (DNA) from the placenta. NIPT is completed during the pre-natal period of pregnancy to screen for the presence of some common fetal chromosomal abnormalities. Common types of chromosomal abnormalities (aneuploidies and microdeletions) in fetuses include:

1. Trisomy 21 (Down syndrome);
2. Trisomy 18 (Edwards syndrome); and
3. Trisomy 13 (Patau syndrome).

NIPT is considered medically necessary once per pregnancy for pregnant women over the age of 35, and for women of all ages who meet one or more of the following high-risk criteria:

1. Abnormal first trimester screen, quad screen or integrated screen;
2. Abnormal fetal ultrasound scan indicating increased risk of aneuploidy;
3. Prior family history of aneuploidy in first degree relative for either parent;
4. Previous history of pregnancy with aneuploidy; and
5. Known Robertsonian translocation in either parent involving chromosomes 13 or 21.

NOTE: First degree relative is defined as a person's parent, children, or sibling.

NIPT is **NOT** covered for women with multiple gestations.

Ultrasounds

Three OB ultrasounds shall be reimbursed per pregnancy (270 days) when medically necessary and performed by providers other than maternal fetal medicine specialists when:

1. An OB ultrasound is performed for an individual with multiple gestations, leading to more than one procedure code being submitted, this shall only be counted as one OB ultrasound; and
2. OB ultrasounds performed in inpatient hospital, emergency department (ED), and labor and delivery triage settings are excluded from this count.

Payment for additional ultrasounds may be considered when medically necessary and must be submitted with the appropriate documentation. Documentation must include evidence of an existing condition or indicate that the ultrasound is necessary to rule out a suspected abnormality.

If more than three ultrasounds must be performed due to multiple pregnancies (failed or completed) within 270 days, providers must submit a hardcopy claim and attach documentation with each submission for these subsequent ultrasounds indicating a previous pregnancy within 270 days.

When a beneficiary is sent to an outpatient facility for the ultrasound, the OB provider must forward the information supporting the medical need for additional ultrasounds to the radiologist.

For maternal fetal medicine specialists, there shall be no prior authorization (PA) or medical review required for reimbursement of OB ultrasounds. In addition, reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists. In all cases, OB ultrasounds must be medically necessary to be eligible for reimbursement.

17-Alpha Hydroxyprogesterone Caproate

Medicaid covers 17-alpha hydroxyprogesterone caproate (17-P) without the requirement of PA when substantiated by an appropriate diagnosis and all of the following criteria are met:

1. Pregnant woman with a history of pre-term delivery before 37 weeks gestation;
2. No symptoms of pre-term in the current pregnancy;
3. Current singleton pregnancy; and
4. Treatment initiation between 16 weeks 0 days and 23 weeks 6 days gestation.

Fetal Testing

Fetal Non-Stress Test

Fetal non-stress tests are covered and considered medically necessary when one of the following is met:

1. The pregnancy is post-date/post-maturity (after 41 weeks gestation);
2. The treating provider suspects fetal problems in an otherwise normal pregnancy; or

3. The pregnancy is high risk, including but not limited to diabetes mellitus, pre-eclampsia, eclampsia, multiple gestations, and previous intrauterine fetal death.

Fetal Biophysical Profile

Fetal biophysical profiles are covered and considered medically necessary when at least two of the following are met:

1. Gestation period is at least 28 weeks;

2. Pregnancy must be high risk, as determined by the provider; or

3. Uteroplacental insufficiency is suspected in a normal pregnancy.

Tobacco Cessation Counseling During Pregnancy

Tobacco cessation counseling is covered for pregnant beneficiaries when provided by the beneficiary's primary care provider (PCP) or OB provider. Tobacco cessation counseling may be provided by other appropriate healthcare professionals upon referral from the member's PCP or OB provider, but all care must be coordinated.

During the prenatal period through 12 months postpartum, beneficiaries may receive up to four tobacco cessation counseling sessions per quit attempt, up to two quit attempts per calendar year, for a maximum of eight counseling sessions per calendar year. These limits may be exceeded if deemed medically necessary.

Reimbursement for tobacco cessation counseling shall be a flat fee based on the applicable CPT code and must be supported by appropriate documentation. The -TH modifier is required when submitting claims for tobacco cessation counseling within the prenatal period, but is not to be used for services in the postpartum period.

If tobacco cessation counseling is provided as a significant and separately identifiable service on the same day as an E/M visit, and is supported by clinical documentation, a modifier to indicate a separate service may be used when applicable.

Oral and Maxillofacial Surgery

Only medically necessary oral and maxillofacial medical procedures are reimbursed when required in the treatment of injury, malformation, or disease related to the head and neck.

Enrolled dental providers are limited to those surgical services billed through the Professional Services Program.

Non-Covered Services

The following services are **NOT** covered:

1. Tooth extractions for beneficiaries age 21 and older; and

2. Procedures performed for cosmetic purposes.

Services described with a Current Dental Terminology procedure code such as extractions, periodontal treatment, and fillings are not reimbursable under this program. Providers should refer to Chapter 16 – Dental Services of the *Medicaid Services Manual* for additional information on dental program requirements.

Organ Transplants

Transplants (other than bone marrow and stem cell) must be performed in a hospital that is a Medicare approved transplant center for that procedure. These transplants must be prior authorized by the fiscal intermediary's (FI's) Prior Authorization Unit (PAU) before the performance of the surgery. This policy applies to **all Louisiana Medicaid** enrolled hospitals including out-of-state hospitals and hospitals located in the trade area performing organ transplants.

When the beneficiary has other private insurance and has received approval for the transplant by that company, prior authorization (PA) is required by Louisiana Medicaid as a second insurer only.

NOTE: PA is **not** required if the beneficiary has both Medicare and Medicaid and the transplant is covered and reimbursed by Medicare as primary.

Post authorization is required for any Louisiana Medicaid beneficiary granted retroactive eligibility.

The PA Request for Transplant (TP-01 FORM), rather than the Request for PA (PA-01 Form), must be used by all hospital transplant coordinators when requesting approval for transplant procedures. The completed form, along with supporting documentation warranting medical necessity, must be attached and sent to the FI's PAU. (See Appendix B for information on accessing the TP – 01 FORM).

Once the transplant is approved, the hospital and beneficiary will receive written notification. The hospital must:

1. Attach a copy of the approval letter to their Request for Hospital Pre-Admission Certification and Length of Stay (LOS) Assignment /Precertification Form (PCF) 01 form when requesting precertification for the inpatient admission; and

2. Make a copy of the approval letter for other providers as **all providers involved in the transplant** must have a copy of the approval letter to attach with the dated operative report to each claim submitted for payment.

NOTE: See Appendix B for information on accessing the PCF 01 form.

Billing Reminders

When a Louisiana Medicaid beneficiary receives an organ transplant, all charges incurred in the transplant are to be billed under the Medicaid beneficiary's name and Medicaid identification (ID) number. This includes all procedures involved in the harvest of the organ from the donor. Donor search costs are included in the beneficiary's inpatient bill and will not be paid on an outpatient

basis.

NOTE: Medicaid does not pay for harvesting of organs when a Louisiana Medicaid beneficiary is the donor of an organ to a non-Medicaid beneficiary.

When billing, it is necessary to submit the claim hard copy and attach a copy of the authorization letter and appropriate documentation, which includes a dated operative report. If appropriate documentation is not attached, the claim will be denied with error code 078. (Resubmit claim with operative/pathology/history/picture to establish medical necessity).

Outpatient Chemotherapy

Outpatient chemotherapy is covered by Louisiana Medicaid. Providers are to use the appropriate chemotherapy administration procedure code in addition to the "J-code" for the chemotherapeutic agent. If a significant, separately identifiable evaluation and management (E/M) service is performed, the appropriate E/M procedure code may also be reported.

Providers may verify coverage of specific chemotherapeutic agents and services by referring to the Professional Services fee schedule.

Papanicolaou Testing for Cervical Cancer

Information on Papanicolaou testing (Pap Test) for cervical cancer can be referenced by visiting Section 5.1 - Covered Services - Gynecology of this manual chapter or by clicking the following link: 5.1 Gynecology.

Pediatric Critical Care Transport

Louisiana Medicaid reimburses for the physical attendance and direct face-to-face care by a physician during the inter-facility transport of a critically ill or injured beneficiary 24 months of age or younger. Providers are to use the most current and appropriate *Current Procedural Terminology* (CPT) code for this service. When submitting claims, providers are expected to adhere to the descriptions pertaining to the services and the time involved in the face-to-face care of the beneficiary given in the CPT manual. Services that are included in the reimbursement for these procedure codes when performed during the transport should not be billed separately.

Documentation in the medical record should include when care begins and ends as described in the CPT guidelines. The condition or injury that necessitates the transport must also meet the definition of critical illness or injury as detailed in the CPT guidelines.

Pharmacy Services

Providers should refer to the Louisiana Medicaid Pharmacy Benefits Management Services (PBMS) Manual, Chapter 37, for detailed information on pharmacy services and policy. (See Appendix A for information on accessing this manual).

Physician Administered Drugs

Certain physician administered drugs are covered by the Professional Services Program when medically necessary. The information below contains general guidelines, and providers may refer to the Professional Services Fee Schedule for current fee-for-service (FFS) reimbursement coverage information. (See Appendix A for information on how to access the fee schedule.) For reimbursement and coverage information for managed care organization (MCO) enrollees, providers must refer to the provider manuals maintained by each MCO.

NOTE: For information on immunizations and chemotherapy, see specific policy included in this manual.

Federal statute requires the use of the National Drug Code (NDC) on claims for physician administered drugs. The NDC number and the Healthcare Common Procedure Code System (HCPCS) code for drug products are required on both the electronic 837P claim and the CMS-1500 claim form. When any portion of a single dose vial is used, providers may bill for the complete vial. Providers are expected to procure medication most closely matching dosages typically administered. Attempts to maximize reimbursement are subject to recoupment and additional sanctions.

If physician administered medications are dispensed by a pharmacy, the dispensed medication may then be brought to the physician's office for injection. A low-level office visit (procedure code 99211) for the administration of the injection, may be billed by the provider if a higher level evaluation and management (E/M) visit had not been submitted for that beneficiary on that date by the rendering provider.

If the injection is administered during the course of a more complex office visit, the appropriate code for the visit should be billed, and there would not be a separate reimbursement for administering the injection.

Physician Assistants

Louisiana Medicaid enrolls and issues individual Medicaid provider numbers to physician assistants. All claims for services provided by the physician assistant must identify the physician assistant as the attending provider.

Unless otherwise excluded by Louisiana Medicaid, the services covered shall be determined by individual licensure, scope of practice, and supervising physician delegation. The supervising physician must be an enrolled Medicaid provider. Clinical practice guidelines and protocols shall be available for review upon request by authorized representatives of Louisiana Medicaid.

A separate claim shall not be submitted for physician assistant services when the physician assistant is employed by, or under contract with, a Medicaid enrolled provider whose reimbursement is based on cost reports which include the cost of the physician assistant's salary.

The reimbursement for services rendered by a physician assistant shall be 100 percent of the fee for physician administered medications, long-acting reversible contraceptives (LARCs), immunizations, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) medical, vision, and hearing screenings, and 80 percent of the professional services fee schedule for all other services.

Billing Information

Providers are to note the following billing instructions and enrollment requirements regarding physician assistant services:

1. Physician assistant services are billed on the CMS-1500 or 837P claim forms;

2. Services provided by the physician assistant must be identified by entering the specific physician assistant provider number in the attending provider block on the claim form. The group number must be entered in the billing provider block;

3. Physicians who employ or contract with physician assistants must obtain a group provider number and link the physician assistant's individual provider number to the group number. Physician groups must notify the fiscal intermediary's (FI's) Provider Enrollment Unit (PEU) of such employment or contracts when physician assistants are added or removed from the group; and

4. Qualified physician assistants who perform as assistant at surgery must use the "AS" modifier to identify these services.

NOTE: Services rendered by the physician assistant billed and paid by Medicaid using a physician's number as the attending provider are subject to post payment review and recovery.

Assistant at Surgery

Louisiana Medicaid will reimburse for only one assistant at surgery. The assistant to the surgeon should be a qualified physician. In those situations when a physician does not serve as the assistant, a qualified, enrolled, physician assistant or advanced practice registered nurse (APRN) may function in the role of an assistant at surgery and may submit claims for their services under their Medicaid provider number.

The reimbursement of claims for more than one assistant at surgery is not covered and subject to recoupment.

Physician Supplemental Payments

These provisions may be contingent upon the approval from the Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Qualifying Criteria – State Owned or Operated Professional Services Practices

Physicians and other eligible professional service practitioners may qualify for supplemental payments if they are:

1. Licensed by the state of Louisiana;

2. Enrolled as a Louisiana Medicaid provider; and

3. Employed by a state-owned or operated entity, such as a state-operated hospital or other state entity, including a state academic health system, which:

    a. Has been designated by the bureau as an essential provider; and

    b. Has furnished satisfactory data to Louisiana Medicaid regarding the commercial insurance payments made to its employed physicians and other professional service practitioners.

The supplemental payment to each qualifying physician or other eligible professional services practitioner in the practice plan will equal the difference between the Medicaid payments otherwise made to these qualifying providers for professional services and the average amount that would have been paid at the equivalent community rate defined as the average amount that would have been paid by commercial insurers for the same services.

The supplemental payments shall be calculated by applying a conversion factor to actual charges for claims paid during a quarter for Medicaid services provided by the state-owned or operated practice plan providers. The commercial payments and respective charges shall be obtained for the state fiscal year (SFY) preceding the reimbursement year. If this data is not provided satisfactorily to Louisiana Medicaid, the default conversion factor shall equal "1". This conversion factor shall be established annually for qualifying physicians/practitioners by:

1. Determining the amount that private commercial insurance companies paid for commercial claims submitted by the state-owned or operated practice plan or entity; and

2. Dividing that amount by the respective charges for these payers.

The actual charges for paid Medicaid services shall be multiplied by the conversion factor to determine the maximum allowable Medicaid reimbursement. For eligible non-physician practitioners, the maximum allowable Medicaid reimbursement shall be limited to 80 percent of this amount.

The actual base Medicaid payments to the qualifying physicians/practitioners employed by a state-owned or operated entity shall then be subtracted from the maximum Medicaid reimbursable amount to determine the supplemental payment amount.

The supplemental payment for services provided by the qualifying state-owned or operated physician practice plan will be implemented through a quarterly supplemental payment to providers, based on specific Medicaid paid claim data.

Qualifying Criteria – Non-State Owned or Operated Professional Services Practices with Tulane School of Medicine

Physicians and other professional service practitioners (physician assistants, certified registered nurse practitioners (CRNPs) and certified registered nurse anesthetists (CRNAs)) who are employed by, or under contract with, a non-state owned or operated governmental entity, such as a non-state owned or operated public hospital, may qualify for supplemental payments for services rendered to Medicaid beneficiaries. To qualify for the supplemental payment, the physician or professional service practitioner must be:

1. Licensed by the state of Louisiana;

2. Enrolled as a Louisiana Medicaid provider; and

3. Identified as a physician or other professional service practitioner that is employed by, or under contract to provide services for, Tulane University School of Medicine.

The supplemental payment will be determined in a manner to bring payments for these services up to the community rate level defined as the rates paid by commercial payers for the same service.

The non-state governmental entity shall periodically furnish satisfactory data for calculating the community rate as requested by Louisiana Medicaid.

Supplemental payments shall be made on a quarterly basis. The supplemental payment amount shall be determined by establishing a Medicare to community rate conversion factor for the physician or physician practice plan. For each Medicaid claim paid during the quarter, a Medicare payment amount will be calculated and the Medicare to community rate conversion factor will be applied to the result. Medicaid payments made for the claims paid during the quarter will then be subtracted from this amount to establish the supplemental payment amount for that quarter. To

allow claims to be captured in the computations, calculations and payments will be made the quarter following the actual quarter of service provision.

The Medicare to community rate conversion factor shall be recalculated periodically as determined by Louisiana Medicaid.

Podiatry

A listing of procedures payable by Louisiana Medicaid to podiatrists can be found on the Professional Services Fee Schedule. These procedures fall within the scope of practice for podiatrists as defined by the Louisiana Podiatry Practice Act and may be billed to the Louisiana Medicaid Program by any currently licensed podiatrist who is enrolled as a Medicaid provider.

Preventive Services (Adult)

Louisiana Medicaid covers all United States Preventive Services Task Force Grade A and B preventive services for adults, aged 21 years and older without restrictions or prior authorization (PA). In addition, one preventive medicine evaluation/management (E/M) service for adults' age 21 years and older is covered per calendar year.

When submitting claims for preventive medicine E/M services, providers must use the appropriate "new patient" or "established patient" procedure code based on the age of the beneficiary on the date of service. Preventive medicine E/M services are comprehensive in nature and must reflect age and gender specific services.

The medical record documentation must include, but is not limited to:

1. Physical examination;
2. Medical and social history review;
3. Counseling/anticipatory guidance/risk factor reduction intervention; and
4. Screening test(s) and results.

In addition, one preventive gynecological examination per calendar year for beneficiaries aged 21 and over is covered, when performed by a primary care provider (PCP) or gynecologist. This is to allow beneficiaries to receive both the necessary primary care and gynecological components of their annual preventive screening visits. The visit must include:

1. Examination;
2. Sexually Transmitted Infection (STI) screening and counseling;
3. Breast and pelvic examination;
4. Pap smear, if appropriate; and
5. Contraceptive methods and counseling, as age appropriate.

If an abnormality or pre-existing problem is encountered and treatment is significant enough to require additional work to perform the key components of a problem-oriented E/M service on the same date of service by the provider performing the preventive medicine service visit, no additional office visit of a higher level than Current Procedural Terminology (CPT) code 99212 is reimbursable.

Payments to providers are subject to post payment review and recovery of overpayments.

Prior Authorization

Certain Medicaid services/procedures require prior authorization (PA) from the fiscal intermediary's (FI) Prior Authorization Unit (PAU). The physician who is to perform the procedure that requires PA must submit the PA request.

Current Procedural Terminology (CPT) codes requiring PA are identified on the Professional Services Fee Schedule. Clarification on whether or not a code requires PA can be obtained by contacting the PAU. (See Appendix A for information on how to access the Professional Services Fee Schedule and how to contact the PAU).

Routine Prior Authorization Requests

When requesting PA for a procedure/service, providers must:

1. Complete a Request for PA (PA-01 Form);

2. Attach all documentation to warrant medical necessity; and

3. Send the information to the PAU by fax, electronic prior authorization (e-PA) or mail. (See Appendix A for PAU address and contact information and Appendix B for PA-01 Form information).

The provider and beneficiary will receive written notification of the PA decision and will receive a PA number, if one has been assigned. The PA number must be entered in item 23 of the CMS-1500 claim form or the appropriate loop of the 837P for all claims associated with the procedure.

Post Authorization

When a beneficiary becomes retroactively eligible for Medicaid, post authorization may be obtained for those procedures that would normally require PA. Such requests must be submitted within six months from the date of Medicaid certification of retroactive eligibility.

Reconsiderations

If the PA request is not approved, the provider and beneficiary will receive written notification of the reason(s) for denial. The provider may resubmit a request for reconsideration by:

1. Writing the word "Reconsideration" across the top of the denial letter, and writing the reason for the request of reconsideration at the bottom of the letter;

2. Attaching to the request all original documentation and any additional information which confirms medical necessity; and

3. Sending the information to the PAU.

Electronic Prior Authorization

e-PA is a web application providing a secure web-based tool for providers to submit and review the status of routine PA requests. Providers must have access to a computer and/or fax machine to be able to utilize e-PA for their PA requests. (See Appendix A for information on how to access e-PA or contact the PAU).

E-PA is restricted to the following provider types:

1. 05 – Rehabilitation;

2. 06 – Home Health;

3. 07 – Air Ambulance Services;

4. 09 – Durable Medical Equipment (DME);

5. 14 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Personal Care Service (PCS);

6. 16 – Pediatric Day Health Care (PDHC) Services;

7. 18- Home Health Skilled Nursing and Home Health Aide Services for over 21 years of age;

8. 88 – Hospice Services; and

9. 99 – Other.

Reconsideration requests can be submitted using e-PA as long as the original request was submitted through e-PA.

Emergency Requests for Prior Authorization

NOTE: Emergency requests cannot be submitted via e-PA.

Louisiana Medicaid has provisions and procedures in place for emergency situations. A request is considered an emergency if a delay in obtaining the medical service, equipment, appliance or supplies would be life-threatening for the beneficiary. Emergency requests may also be submitted for services required for a hospital discharge.

Emergency requests are made through the PAU for any of the Medicaid services requiring PA. The provider must contact the PAU immediately by telephone and provide the following information in order for the request to be considered under the emergency PA procedures:

1. The beneficiary's name, age, and 13-digit identification (ID) number;
2. The treating physician's name;
3. The diagnosis;
4. The time period of need for the item or service;
5. A complete description of the item(s) or service(s) requested;
6. The reason that the request is a medical emergency; and
7. The cost of the item (only applies to DME).

The PAU will make a decision and contact the provider by telephone within two working days of the date the completed request is received. The PAU will then follow up with written confirmation of the decision.

NOTE: It is always the responsibility of the provider to verify beneficiary eligibility. The PAU only approves the existence of medical necessity, not beneficiary eligibility.

Emergency requests for PA of services that are not truly emergencies will be denied as such, and the provider must resubmit the request as a routine request.

Prior Authorization of Surgical Procedures

Many surgical codes do not require PA if the procedure is performed in an outpatient setting.

In an inpatient setting, certain surgical procedures always require PA before they can be performed and reimbursed.

Authorization for a surgical procedure to be performed in an inpatient setting will be valid for 90 days from the approval date unless the beneficiary becomes ineligible for Medicaid benefits prior to that time. Providers must validate the beneficiary's eligibility for the date of service.

Providers should note that obtaining PA for a surgical procedure does not replace, or in any way affect, valid claims editing or other policy requirements which may apply to surgical claims (e.g., timely filing requirements, sterilization consent requirements, and assistant surgeon services). Obtaining PA ensures only the proposed procedure has been reviewed for medical necessity.

To expedite the review process, providers should attach the appropriate medical documentation that substantiates the need for the service being provided in an inpatient setting. Documentation of extenuating circumstances should be included with the request, if applicable.

Professional Services Fee Schedule

The Professional Services fee schedule is maintained on the Louisiana Medicaid website (www.lamedicaid.com) using the fee schedules link. Providers should review the website regularly for fee schedule additions, deletions and updates. The legend can be found on the first page of the published fee schedule that explains the information contained on the schedule. (See Appendix A for information on accessing the fee schedule).

Louisiana Medicaid also notifies providers of significant fee schedule changes through remittance advice (RA) messages and the *Provider Update*. Providers may contact the fiscal intermediary's (FI's) Provider Relations Department for questions related to the fee schedule.

Prohibited and Non-Covered Services

Physicians and all other professionals must abide by the scope of practice set forth by their licensing or certifying agencies in addition to complying with Louisiana Medicaid regulations and policies.

The following includes a non-exhaustive list of services excluded or limited by Louisiana Medicaid, which often generate clarifying inquiries from participating providers:

1. **Services that are not medically necessary:**

   Louisiana Medicaid does not reimburse for services that are not medically necessary including services that are not approved by the Food and Drug Administration (FDA), experimental or investigational services, and cosmetic services;

2. **Aborted surgical procedures:**

   Medicaid will not pay professional, operating room, or anesthesia charges for an aborted surgical procedure, regardless of the reason;

3. **Services not provided or not documented:**

   Providers shall not bill Medicaid or the beneficiary for a missed appointment or any other services not actually provided;

NOTE: Services that have not been documented are considered services not rendered and are subject to recoupment.

4. **Never events:**

   Medicaid will not pay for "never events" or medical procedures performed in error that are preventable and have a serious, adverse impact to the health of the Medicaid beneficiary. Reimbursement will not be provided when the following "never events" occur:

   a. The wrong surgical procedure is performed on a beneficiary;

   b. The surgical or invasive procedures are performed on the wrong body part; or

c. The surgical or invasive procedures are performed on the wrong beneficiary.

5. **Services related to non-covered services:**

Louisiana Medicaid does not reimburse for services related to a non-covered service. Any payment received for non-covered and related services is subject to post-payment review and recovery;

6. **Infertility services:**

Louisiana Medicaid does not pay for services relating to the diagnosis or correction of infertility, including sterilization reversal procedures. This policy extends to any surgical, laboratory, or radiological service when the primary purpose is to diagnose infertility or to enhance reproductive capacity; and

7. **"New patient" evaluation and management visits with an established provider:**

Consistent with *Current Procedural Terminology* (CPT) guidelines, Louisiana Medicaid defines a new patient as one who has not received any professional services from the physician/provider or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

Exception: The initial pre-natal visit of each new pregnancy. (See Obstetrics policy).

Psychiatric Services

Louisiana Medicaid reimburses professional service providers for psychiatric services delivered in the office, or other outpatient facility settings. Providers are to select the most appropriate *Current Procedural Terminology* (CPT) codes for psychiatric services rendered as outlined in the CPT manual. Covered services are listed on the Professional Services fee schedule, which can be accessed on the Medicaid website. Behavioral health providers should also refer to the Specialized Behavioral Health fee schedule for information on covered services.

Public Health Surveillance Mandates

Based on surveillance data gathered by the State Childhood Lead Poisoning Prevention Program and review by the state health officer and representatives from medical schools in the state, all parishes in Louisiana are identified as high risk for lead poisoning.

Medical providers who provide routine primary care services to children ages six months to 72 months must have children screened in compliance with Louisiana Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements and in accordance to practices consistent with current Centers for Disease Control and Prevention (CDC) guidelines, which include the following specifications:

1. Administer a risk assessment questionnaire at every well child visit;

2. Use a blood test to screen all children at ages 12 months and 24 months or at any time from ages 36 months to 72 months, if they have not been previously screened; and

3. Use a venous blood sample to confirm results when finger stick samples indicate blood lead levels ≥3.5ug/dl.

Mandatory Case Reporting by Health Care Providers

Medical providers must report a lead case to the Office of Public Health's (OPH's) Childhood Lead Poisoning Prevention Program by fax **within 24 working hours**. A lead case is indicated by a venous blood lead test result of >3.5ug/dl (micrograms per deciliter). The original lead case reporting form shall be mailed or faxed within five business days. (See Appendix A for contact information).

Reporting Requirements of Blood Lead Levels by Laboratories and by Health Care Providers Performing Office-Based Blood Lead Analyses for Public Health Surveillance

All results of blood lead testing of children less than 72 months of age, regardless of the blood lead level, must be reported to the Louisiana Childhood Lead Poisoning Prevention Program by electronic transmission. (See Appendix A for contact information).

Radiation Treatment Management

Louisiana Medicaid provides reimbursement for radiation treatment management when claims are submitted using the appropriate *Current Procedural Terminology* (CPT) code, currently procedure code 77427 (Radiation treatment management; 5 treatments). This CPT code represents units of five fractions or treatment sessions regardless of the actual time period in which the services are furnished. Reimbursement reflects payment for the entire service; therefore, the "units of service" submitted must be "1". Providers should refer to the most current CPT manual for further guidance.

Billing Information

Radiation treatment management must be billed with "1" in the "units" field using a single date of service. The single date of service must be the last date of the treatment sessions. Spanning the dates of service for this procedure code and/or billing for more than one unit will result in a denied claim.

Radiopharmaceutical Diagnostic Imaging Agents

Louisiana Medicaid provides reimbursement for the radiopharmaceutical imaging agents required for covered and appropriate diagnostic procedures. Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) code for the agent used. Providers can find the imaging agents currently payable on the Professional Services Fee Schedule. (See Appendix A for information on how to access the fee schedule).

Claims for radiopharmaceutical diagnostic imaging agents will only be reimbursed when billed with the appropriate medically necessary radiological procedure. The imaging agent is not to be paid unless the appropriate radiological procedure is also paid on the same date of service.

In the event providers utilize a diagnostic imaging agent not currently on the Louisiana Medicaid procedure file, providers may submit a written payment consideration request to Medicaid. (See Appendix A for contact information).

Routine Care Provided to Beneficiaries Participating in Clinical Trials

Louisiana Medicaid covers any item or service provided to a beneficiary participating in a qualifying clinical trial to the extent that the item or service would otherwise be covered for the beneficiary when not participating in the qualifying clinical trial. This includes including any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation.

Qualifying Clinical Trial

A qualifying clinical trial is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition that meets any of the following criteria:

1. The study or investigation is approved, conducted, or supported (which may include funding) by one or more of the following:

    a. The National Institutes of Health (NIH);

    b. The Centers for Disease Control and Prevention (CDC);

    c. The Agency for Healthcare Research and Quality (AHRQ);

    d. The Centers for Medicare & Medicaid Services (CMS);

    e. A cooperative group or center of any of the entities described in sub clauses (I) through (IV) or the Department of Defense or the Department of Veterans Affairs (DVA);

    f. A qualified non-governmental research entity identified in the guidelines issued by NIH for center support grants; or

    g. The study or investigation is approved or funded by one or more of the following and has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by NIH which assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:

        i. The DVA;

        ii. The Department of Defense; and/or

iii. The Department of Energy.

2. The clinical trial is conducted pursuant to an investigational new drug exemption under section 335(i) of Title 21 or an exemption for a biological product undergoing investigation under section 262(a)(3) of this title; and

3. The clinical trial is a drug trial that is exempt from having such an investigational new drug application.

Coverage determinations shall be:

1. Expedited and completed within 72 hours;

2. Made without limitation on the geographic location or network affiliation of the health care provider treating such individual or the principal investigator of the qualifying clinical trial;

3. Based on attestation regarding the appropriateness of the qualifying clinical trial by the health care provider and principal investigator using the following form and kept on file by the provider: https://www.medicaid.gov/resources-for-states/downloads/medicaid-attest-form.docx; and

4. Completed without any requirement of submission of the protocols of the qualifying clinical trial, or any other documentation that may be proprietary or determined by the U.S. Department of Health and Human Services (HHS) Secretary to be burdensome to provide.

Coverage Limitations

Louisiana Medicaid does not cover any of the following:

1. The investigational item or service that is the subject of the qualifying clinical trial;

2. Any service provided to the individual solely to satisfy data collection and analysis needs for the qualifying clinical trial and is not used in the direct clinical management of the individual; and

3. Services not otherwise covered by Louisiana Medicaid.

Same-Day Outpatient Visits

Beneficiaries under Age 21

Same-day outpatient visits may be considered for payment for beneficiaries under age 21 when justified if one of the following criteria is met:

1. The physician needs to check on the progress of an unstable beneficiary treated earlier in the day;

2. An emergency situation necessitates a second visit on the same day as the first; or

3. Any other occasion arises in which a second visit within a 24-hour period is necessary to ensure the provision of medically necessary care to the beneficiary.

Two same-day outpatient visits per specialty per beneficiary are allowed; however, the second same-day outpatient visit is payable for only the lower level Evaluation and Management (E/M) codes. The beneficiary's medical record must be available for review and must substantiate the need for the second same-day visit. Louisiana Medicaid accepts nationally recognized modifiers to identify significant, separately identifiable services on the same date. Improper use of modifiers solely to maximize reimbursement will be subject to administrative sanction.

If an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening has been paid, only the lower level E/M codes are payable for the same beneficiary, on the same date of service and by the same attending provider. In these circumstances, when it is clinically appropriate, providers may use the correct modifier to allow both services to be paid. A same day follow up office visit for the purpose of fitting eyeglasses is allowed, but no higher level office visit than the lowest level E/M code is reimbursable for the fitting. Correct modifier usage may be required.

Exclusions

Same-day outpatient visit policy does not apply when:

1. The diagnosis is simple;

2. The condition requires non-complex care; or

3. The beneficiary is a child in state-funded foster care (aid category 15).

Beneficiaries Age 21 and Over

If a preventive medicine E/M service has been paid, only lower level E/M is reimbursable for the same beneficiary, on the same date of service, and by the same attending provider. (See Preventive Medicine Evaluation and Management Services (Adults) and Modifiers for additional information).

Sinus Procedures

Balloon ostial dilation and functional endoscopic sinus surgery are considered medically necessary for the treatment of chronic rhinosinusitis when all of the following criteria are met:

1. Uncomplicated chronic rhinosinusitis limited to the paranasal sinuses without the involvement of adjacent neurological, soft tissue, or bony structures that has persisted for at least 12 weeks with at least two of the following sinonasal symptoms:
    a. Facial pain/pressure;
    b. Hyposmia/anosmia;
    c. Nasal obstruction; and/or
    d. Mucopurulent nasal discharge.
2. Sinonasal symptoms are persistent after maximal medical therapy has been attempted, as defined by all of the following, either sequentially or overlapping:
    a. Saline nasal irrigation for at least six weeks;
    b. Nasal corticosteroids for at least six weeks;
    c. Approved biologics, if applicable, for at least six weeks;
    d. A complete course of antibiotic therapy when an acute bacterial infection is suspected; and
    e. Treatment of concomitant allergic rhinitis, if present.
3. Objective evidence of sinonasal inflammation as determined by one of the following:
    a. Nasal endoscopy; or
    b. Computed tomography (CT).

Coverage Limitations

Balloon ostial dilation and functional endoscopic sinus surgery are not covered and not considered medically necessary in the following situations:

1. Presence of sinonasal symptoms but no objective evidence of sinonasal disease by nasal endoscopy or CT;

2. For the treatment of obstructive sleep apnea and/or snoring when the above criteria are not met;

3. For the treatment of headaches when the above criteria are not met; and

4. For balloon ostial dilation only, when sinonasal polyps are present.

Reimbursement for sinus procedures is subject to post-payment review and recoupment in the event of non-compliance with this coverage policy.

Skin Substitutes for Chronic Diabetic Lower Extremity Ulcers

Louisiana Medicaid covers skin substitutes and considers them to be medically necessary for the treatment of partial and full-thickness diabetic lower extremity ulcers when the beneficiary meets all of the following criteria:

1. Presence of a lower extremity ulcer that:
    a. Is at least 1.0 square centimeter (cm) in size;
    b. Has persisted for at least four weeks;
    c. Has not demonstrated measurable signs of healing, defined as a decrease in surface area and depth or a decreased amount of exudate and necrotic tissue, with comprehensive therapy including all of the following:
        i. Application of dressings to maintain a moist wound environment;
        ii. Debridement of necrotic tissue, if present; and
        iii. Offloading of weight.
    d. A diagnosis of type one or type two diabetes mellitus;
    e. A glycated hemoglobin (HbA1c) level of ≤ 9% within the last 90 days or a documented plan to improve HbA1c to 9% or below as soon as possible;
    f. Evidence of adequate circulation to the affected extremity, as indicated by one or more of the following:
        i. Ankle-brachial index (ABI) of at least 0.7;
        ii. Toe-brachial index (TBI) of at least 0.5;
        iii. Dorsum transcutaneous oxygen test (TcPO2) >= 30 mm Hg; and
        iv. Triphasic or biphasic Doppler arterial waveforms at the ankle of the affected leg.
    g. No evidence of untreated wound infection or underlying bone infection; and

h. Ulcer does not extend to tendon, muscle, joint capsule, or bone or exhibit exposed sinus tracts unless the product indication for use allows application to such ulcers.

The beneficiary must not have any of the following:

1. Active Charcot deformity or major structural abnormalities of the foot, when the ulcer is on the foot;

2. Active and untreated autoimmune connective tissue disease;

3. Known or suspected malignancy of the ulcer;

4. Beneficiary is receiving radiation therapy or chemotherapy; and

5. Re-treatment of the same ulcer within one year.

Coverage Limitations

The following coverage limitations apply:

1. Coverage is limited to a maximum of 10 treatments within a 12-week period;

2. If there is no measurable decrease in surface area or depth after five applications, then further applications are not covered;

3. For all ulcers, a comprehensive treatment plan must be documented, including at least all of the following:

   a. Offloading of weight;

   b. Smoking cessation counseling and/or medications, if applicable;

   c. Edema control;

   d. Improvement in diabetes control and nutritional status; and

   e. Identification and treatment of other comorbidities that may affect wound healing such as ongoing monitoring for infection.

4. While providers may change products used for the diabetic lower extremity ulcers, simultaneous use of more than one product for the diabetic lower extremity ulcers is not covered; and

5. Hyperbaric oxygen therapy is not covered when used at the same time as skin substitute treatment.

Prior Authorization

Skin substitutes require prior authorization (PA) and submitted medical documentation must demonstrate that the beneficiary meets all of the aforementioned requirements.

NOTE: If there is no measurable decrease in surface area, or depth, after five applications, then further applications are not covered even when prior authorized.

Substitute Physician Billing

Louisiana Medicaid allows both the reciprocal billing arrangement and the locum tenens arrangement when Medicaid enrolled providers utilize substitute physician services. Services shall comply with policy, and paid claims are subject to post-payment review.

Reciprocal Billing Arrangement

A reciprocal billing arrangement occurs when a regular physician or group has a substitute physician provide covered services to a Medicaid beneficiary on an occasional reciprocal basis. A physician can have reciprocal arrangements with more than one physician. The arrangements are not required to be in writing.

The beneficiary's regular physician may submit the claim and receive payment for covered services which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if:

1. The regular physician is unavailable to provide the services;

2. The substitute physician does not provide the services to Medicaid beneficiaries over a continuous period of longer than 60 days;

   NOTE: A continuous period of covered services begins with the first day on which the substitute physician provides covered services to Medicaid beneficiaries of the regular physician, and ends with the last day on which the substitute physician provides these services to the beneficiaries before the regular physician returns to work. This period continues without interruption on days no covered services are provided on behalf of the regular physician. A new period of covered services can begin after the regular physician has returned to work. If the regular physician does not come back after the 60 days, the substitute physician must bill for the services under their own Medicaid provider number.

3. The regular physician identifies the services as substitute physician services by entering the Healthcare Common Procedure Coding System (HCPCS) modifier -Q5 after the procedure code on the claim. By entering the -Q5 modifier, the regular physician (or billing group) is certifying that the services billed are covered services furnished by the substitute physician for which the regular physician is entitled to submit Medicaid claims; and

4. The regular physician must keep, on file, a record of each service provided by the substitute physician and make the record available to Louisiana Medicaid or its

representatives upon request. All Medicaid related records must be maintained in a systematic and orderly manner and be retained for a period of six years.

This situation **does not apply** to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who actually performed the service must be identified.

Locum Tenens Arrangement

A locum tenens arrangement occurs when a substitute physician is retained to take over a regular physician's professional practice for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician generally has no practice of their own. The regular physician usually pays the substitute physician a fixed amount per diem, with the substitute physician being an independent contractor rather than an employee.

The regular physician may submit a claim and receive payment for covered services of a locum tenens physician who is not an employee of the regular physician if:

1. The regular physician is unavailable to provide the services;

2. The regular physician pays the locum tenens for their services on a per diem or similar fee-for-time basis;

3. The substitute physician does not provide the services to Medicaid beneficiaries over a continuous period of longer than 60 days;

   NOTE: A continuous period of covered services begins with the first day on which the substitute physician provides covered services to Medicaid beneficiaries of the regular physician, and ends with the last day on which the substitute physician provides these services to the beneficiaries before the regular physician returns to work. This period continues without interruption on days no covered services are provided on behalf of the regular physician. A new period of covered services can begin after the regular physician has returned to work. If the regular physician does not come back after the 60 days, a new 60-day period can begin with a different locum tenens doctor.

4. The regular physician identifies the services as substitute physician services by entering HCPCS modifier **-**Q6 after the procedure code on the claim; and

5. The regular physician must keep on file a record of each service provided by the substitute physician and make the record available to Louisiana Medicaid or its

representatives upon request. All Medicaid related records must be maintained in a systematic and orderly manner and be retained for a period of six years.

Take Charge Plus

Take Charge Plus is a limited benefit program available to males and females of child-bearing age, offering family planning and family planning related services to eligible individuals, including treatment for sexually transmitted infections (STI) and non-emergency medical transportation (NEMT) to family planning appointments.

Eligible individuals must not have previously had a medical procedure that would prevent pregnancy, such as hysterectomy, tubal ligation, or vasectomy, and must have household income at or below 138 percent of the Federal Poverty Level (FPL).

It is the responsibility of the provider to ensure beneficiaries receiving Take Charge Plus related services meet the above referenced criteria in relation to child-bearing age and non-sterilization.

Providers should refer to Chapter 48 – Take Charge Plus - Family Planning Services (FPS) of the Medicaid Services Manual for specific information and policy related to these services.

Telemedicine/Telehealth

Telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a physician or other licensed practitioner and a beneficiary are not in the same location.

The telecommunications system shall include, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the beneficiary at the originating site and the physician or other licensed practitioner at the distant site. The telecommunications system must be secure, ensure patient confidentiality, and be compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Originating site means the location of the Medicaid beneficiary at the time the services are provided. There is no restriction on the originating site and it can include, but is not limited to, a healthcare facility, school, or the beneficiary's home.

Distant site means the site at which the physician or other licensed practitioner is located at the time the services are provided.

When otherwise covered, services located in the Telemedicine appendix of the Current Procedural Terminology (CPT) manual, or its successor, may be reimbursed when provided by telemedicine/telehealth. In addition, other specified services may be reimbursed when provided by telemedicine/telehealth and these services are explicitly noted in this manual. Physicians and other licensed practitioners must continue to adhere to all existing clinical policy for all services rendered. Providing services through telemedicine/telehealth does not remove or add any medical necessity requirements.

Reimbursement

Louisiana Medicaid only reimburses the distant site provider for services provided via telemedicine/telehealth. Reimbursement for services provided by telemedicine/telehealth is at the same level as services provided in person.

The beneficiary's clinical record must include documentation that the service was provided through the use of telemedicine/telehealth.

NOTE: The distant site provider must be enrolled as a Louisiana Medicaid provider to receive reimbursement for covered services rendered to Louisiana Medicaid beneficiaries.

Billing

Medicaid covered services provided using telemedicine must be identified on claim submissions by appending the modifier "95" to the applicable procedure code and indicating the correct place of service, either place of service 02 (other than home) or 10 (home). Both the correct place of service and the -95 modifier must be present on the claim to receive reimbursement.

Third-Party Liability

Third-party liability (TPL) refers to those payment resources available from both private and public health insurance and from other liable sources, such as liability and casualty insurance, which can be applied toward the beneficiary's medical and health expenses as Medicaid, by law, is intended to be the payer of last resort.

Providers must determine if beneficiaries are covered by other third-parties. If a beneficiary has other medical benefits, providers must bill all other third-parties prior to billing Medicaid. Additional information about TPL can be found in Chapter 1, General Information and Administration, of the Louisiana Medicaid Manual. (See Appendix A for information on accessing this manual).

Tobacco Cessation Counseling Services

Tobacco cessation counseling services are covered for Medicaid beneficiaries who use tobacco products or who are being treated for tobacco use when provided by, or under the supervision of, the beneficiary's primary care provider (PCP) or other appropriate healthcare professionals.

Beneficiaries may receive up to four tobacco cessation counseling sessions per quit attempt, up to two quit attempts per calendar year, for a maximum of eight counseling sessions per calendar year. These limits may be exceeded if deemed medically necessary.

Provider Qualifications

The entity rendering tobacco cessation counseling services must be an enrolled Medicaid provider.

Health care professionals who may provide tobacco cessation counseling include physicians, advanced practice registered nurses (APRNs), and physicians' assistants, as well as mental health providers (MHPs) who are licensed to practice independently. Other professional or paraprofessional healthcare practitioners must have completed training in the provision of tobacco cessation counseling and must provide services under the supervision of a licensed practitioner.

Reimbursement

Reimbursement for tobacco cessation counseling shall be a flat fee based on the appropriate Health Care Procedure Coding Scheme (HCPCS) code and must be supported by appropriate documentation.

Vaccines for Children and Louisiana Immunization Network for Kids

Information on Vaccines for Children (VFC) and Louisiana Immunization Network for Kids (LINKS) can be referenced by visiting Section 5.1 - Immunization of this manual chapter or by clicking the following link: Section 5.1: Immunization.

Vagus Nerve Stimulators

Consideration shall be given for Medicaid reimbursement for implantation of the vagus nerve stimulator (VNS) if the treatment is considered medically necessary, the beneficiary meets the published criteria, and the beneficiary has a diagnosis of medically intractable epilepsy.

Criteria for Beneficiary Selection

The following criteria are used to determine beneficiary eligibility and approval of the VNS:

1. Partial epilepsy confirmed and classified according to the International League Against Epilepsy (ILAE) classification. The beneficiary may also have associated generalized seizures, such as tonic, tonic-clonic, or atonic. The VNS may have efficacy in primary generalized epilepsy as well;

2. Age 12 years or older, although case by case consideration may be given to younger children who meet all other criteria and have sufficient body mass to support the implanted system;

3. Seizures refractory to medical anti-epilepsy treatment, with adequately documented trials of appropriate standard and newer anti-epilepsy drugs or documentation of beneficiary's inability to tolerate these medications;

4. Beneficiary has undergone surgical evaluation and is considered not to be an optimal candidate for epilepsy surgery;

5. Beneficiary is experiencing at least four to six identifiable partial onset seizures each month. Beneficiary must have had a diagnosis of intractable epilepsy for at least two years. The two-year period may be waived if waiting would be seriously harmful to the beneficiary;

6. Beneficiary must have undergone quality of life (QOL) measurements. The choice of instruments used for the QOL measurements must assess quantifiable measures of daily life in addition to the occurrence of seizures; and

7. In the expert opinion of the treating physician, there must be reason to believe that QOL will improve as a result of implantation of the VNS. This improvement should occur in addition to the benefit of seizure frequency reduction. The treating physician must document this opinion clearly in the request for prior authorization (PA).

Exclusion Criteria

Regardless of the criteria for beneficiary selection, **authorization for VNS implantation shall not be given if the beneficiary has one or more of the following criteria**:

1. Psychogenic seizures or other non-epileptic seizures;
2. Insufficient body mass to support the implanted system;
3. Systemic or localized infections that could infect the implanted system; or
4. A progressive disorder contraindicated to VNS implantation, e.g., malignant brain neoplasm, Rasmussen's encephalitis, Landau-Kleffner syndrome and progressive metabolic and degenerative disorders.

Place of Service Restriction

Surgery to implant the VNS is restricted to an outpatient hospital, unless medically contraindicated. If it is medically necessary for the beneficiary to be hospitalized, the hospital must obtain pre-certification for the stay as well as obtain PA to perform the surgery and purchase the device.

Prior Authorization

PA for implantation of the VNS shall be requested after the beneficiary evaluation has been completed but prior to stimulator implantation.

This request to initiate implantation shall come from the multi-disciplinary team (MDT) that evaluates the beneficiary. The MDT shall be comprised of the following:

1. Surgeon who has been trained and is familiar with the carotid sheath;
2. Psychiatrist or neurologist;
3. Beneficiary's attending physician;
4. Nurse;
5. Social worker; and
6. Allied health professionals (physical therapist, occupational therapist, etc.).

These professionals shall have expertise in the evaluation, management, and treatment of epilepsy and have undergone VNS implantation training by a nationally recognized product supplier with expertise in VNS.

The following documentation shall be labeled and submitted in one package by the MDT:

1. A recent history with documentation of assessments in the following areas:
    a. Medical and physical including a history of prior drug experience;
    b. Neurological information about seizure type and epilepsy syndrome diagnosis, and the results of electroencephalogram (EEG) and/or video EEG monitoring;
    c. Functional and psychosocial assessment; and
    d. Result of evaluation of epilepsy surgery.
2. Documentation of any other findings about the beneficiary's condition which would be of interest to or would assist the Medical Review team in making a decision regarding the medical necessity for beneficiary implantation.

Billing for the Cost of the VNS

The VNS is reimbursable by Louisiana Medicaid; however, reimbursement of the device is dependent upon approval of the surgeon to perform the procedure. Hospitals should confirm the surgeon has received an authorization for the procedure prior to submitting the claim. Hospitals shall submit the appropriate Healthcare Common Procedure Coding System (HCPCS) code for the VNS generator and VNS leads, to the fiscal intermediary (FI) on a CMS-1500 claim form with the words "Durable Medical Equipment (DME)" written in red on the top of the form. The claim will pend to the FI's Medical Review Department for review of the surgeon's approved PA request. If the surgeon's request is 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).

Billing for Implantation of the VNS

Implantation of the VNS must be prior authorized. The surgeon who implants the VNS shall submit a PA Request (PA-01 Form) to the Prior Authorization Unit (PAU) as part of the MDT's packet. The surgeon must use their individual, rather than group, provider number on the PA-01 Form. The provider shall bill for the implantation of the generator by submitting the appropriate *Current Procedural Terminology* (CPT) procedure codes on a CMS-1500 form, and the PA

number given to the surgeon must be written in Item 23 when submitting a hard copy claims; however, providers are encouraged to bill electronically.

Programming

Programming of the VNS stimulator must be performed by the surgeon who performed the implant procedure or by a licensed neurologist.

Programming subsequent to the first three times may be subject to post-authorization review for medical necessity prior to payment of the claim.

Authorization for payment will only be considered when there is documented clinical evidence indicating the beneficiary has experienced seizures since the previous programming attempts.

Payment for the programming procedure will be authorized when it is performed as an attempt to reduce or prevent future episodes of seizures.

After the third programming service, providers must submit hardcopy claims to the Provider Relations Unit with documentation attached supporting the medical necessity of the procedure. Payment will not be made on claims billed electronically or claims lacking the required documentation. The required documentation includes:

1. Beneficiary response – the status of seizure control, i.e. frequency and severity of seizures;

2. Current VNS program settings, i.e., current output, pulse width, duty cycle, and signal frequency;

3. Frequency of medications and dose schedule;

4. Documentation of adverse effects such as swallowing problems, hoarseness, coughing and neck tightness;

5. Magnet setting; and

6. Reasons for reprogramming.

Subsequent Implants/Battery Replacement

Battery replacement and subsequent implants require PA. In order to be considered, the request must contain documentation demonstrating the benefits of the original VNS transplant.

CONTACT INFORMATION

Louisiana Medicaid Website

The Louisiana Medicaid website can be accessed at www.lamedicaid.com. Refer to the table below for the specific link to information that is found on the website.

Type of Assistance	Link Where Information is Found
Provider Fee Schedules	"Fee Schedules"
Preferred Drug List (PDL)/Prior Authorization (PA) List	"Pharmacy * Prescribing Providers"
Electronic Prior Authorization (e-PA)	"Forms/Files/User Manuals" and then under the "User Manuals" link
List of acceptable procedure codes reimbursable with 80/AS modifiers	"ClaimCheck"
Medicaid Provider Manuals	"Provider Manuals"
Vaccine Codes	"Fee Schedules" then "Immunization Fee Schedules Page" links
Information about Electronic Medicaid Eligibility Verification System (eMEVS)	"Forms/Files/User Manuals" link
Access the Electronic Clinical Drug Inquiry (e-CDI) application	"Provider Login"
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Periodicity Schedule	"Training/Policy Updates" Then "Provider Training Packets/Policy Updates" then "2018 Provider Training/Policy Updates" then "Professional Services Program 2018"

Gainwell Technologies

Louisiana Medicaid's fiscal intermediary (FI), Gainwell Technologies, may be contacted for assistance with the following:

Type of Assistance	Contact
Who to contact for consideration of coverage of additional chemotherapeutic agents.	Gainwell Technologies - Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: 225-924-5040 or 1-800-473-2783 Fax: 225-216-6334
Who to contact when a service is not on the list of reimbursable services.	Gainwell Technologies - Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: 225-924-5040 or 1-800-473-2783 Fax: 225-216-6334
e-CDI technical support	Gainwell Technologies 1-877-598-8753
Prior Authorization Unit (PAU)	Gainwell Technologies – PAU E-PA Fax: 225-216-6481
LDH Medicaid Dental PAU Dental PA **ONLY**	P.O. Box 91030 Baton Rouge, LA 70821-9030 Phone: (225) 384-0460 (Local) Fax: (225)389-8013
Provider Enrollment Unit (PEU)	Gainwell Technologies – PEU P.O. Box 80159 Baton Rouge, LA 70898 Phone: 225-216-6370, Fax: 225-216-6392
Provider Relations Unit	Gainwell Technologies - Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: 225-924-5040 or 1-800-473-2783 Fax: 225-216-6334
Recipient Eligibility Verification System (REVS)	Phone: 800-766-6323 Phone: 225-216-7387

Office of Public Health

Type of Assistance	Contact
Obtain a copy of the "Office of Public Health (OPH) Certification of Informed Consent-Abortion"	Office of Public Health (504) 568-5330
Obtain an enrollment packet for 1. Vaccines for Children (VFC) 2. Louisiana Immunization Network for Kids Statewide (LINKS) Obtain information about vaccine availability	Office of Public Health (504) 838-5300
Access LINKS	https://linksweb.oph.dhh.louisiana.gov
For reporting and information about the Louisiana Childhood Lead Poisoning Prevention Program	Phone: (888)293-7020 Fax: (225)242-0496 https://ldh.la.gov/lead-poisoning-prevention
Obtain neonatal screening results	Genetic Diseases Program (504) 568-8248 or http://new.dhh.louisiana.gov/index.cfm/page/470

Pharmacy

Type of Assistance	Contact
Pharmacy PA Unit	University of Louisiana – Monroe College of Pharmacy 1800 Bienville Dr. Monroe, LA 71201-3765 Phone: 1-866-730-4357 Fax: 1-866-797-2329 (Do not send a cover sheet with the facsimile)
Pharmacy Benefits Management Section (PBMS)	Bureau of Health Services Financing (BHSF) PBMS (800) 437-9101

EarlySteps

Type of Assistance	Contact
Information about the EarlySteps program	http://new.dhh.louisiana.gov/index.cfm/page/139/n/139

Clinical Laboratory Improvement Amendments

Type of Assistance	Web Address
Information about Clinical Laboratory Improvement Amendments (CLIA)	http://new.dhh.louisiana.gov/index.cfm/directory/detail/705

Centers for Disease Control and Prevention

Type of Assistance	Office to Contact
Access the *Recommended Adult Immunization Schedule* from the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practice.	www.cdc.gov/vaccines under 'Immunization Schedules'
Guidelines about the CDC requirements for lead poisoning	http://www.cdc.gov/nceh/lead

Louisiana Medicare

Type of Assistance	Web Address
Information about Louisiana Medicare	https://medicare.com/state/louisiana-medicare/

National Physician Fee Schedule

Type of Assistance	Web Address
Access the National Physician Fee Schedule	https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx

Appeals

Type of Assistance	Contact
To file an appeal	Division of Administrative Law (DAL) - Health and Hospitals Section P. O. Box 4189 Baton Rouge, LA 70821-4189 Phone: (225) 342-0443, Fax: (225) 219-9823

Fluoride Varnish

Type of Assistance	Web Address
Accessing the *Smiles for Life* Caries Risk Assessment, Fluoride Varnish, and Counseling Module	Smiles for Life: Caries Risk Assessment, Fluoride Varnish and Counseling

FORMS

This appendix includes information about the forms that are referenced in the Professional Services manual chapter, and where they can be obtained.

A copy of the **Diagnostic and/or Laboratory Equipment** (La OFS Form 24) can be found at the following link:

Microsoft Word - PT20 Group Packet 3.9.18 (lamedicaid.com)

The following forms are available at www.lamedicaid.com under the "Forms/Files/User Manuals" link:

1. **Acknowledgement of Receipt of Hysterectomy Information** (Bureau of Health Services Financing (BHSF) Form 96-A);

2. **Request for Prior Authorization (PA)** (PA-01 Form); and

3. **PA Request for Transplant** (TP-01 FORM).

The following forms are available at https://www.lamedicaid.com/Provweb1/Forms/PCforms.htm:

1. **Request for Hospital Pre-Admission Certification and Length of Stay (LOS) Assignment** (PCF-01); and

2. **Request for Inpatient Acute Care** (PCF-02).

Instructions and a copy of the **Louisiana Department of Health (LDH) Office of Public Health (OPH) Certification of Informed Consent-Abortion** form are available at: http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/CCNPAppendices/AppendixNAbortionCertificationofInformedConsent.pdf

The **Consent for Sterilization** forms, Form HHS-687 (English) and Form HHS-687-1 (Spanish), are available at: Consent for Sterilization: Form HHS-687 (English) and Consent for Sterilization: Form HHS-687-1 (Spanish).

Completed examples of accepted Consent for Sterilization, Form HHS-687 (English) can be found on the following pages.

The examples illustrate a correctly completed sterilization form, without an interpreter and with an interpreter, for a sterilization that was done less than 30 days after the consent was obtained.

"Premature delivery" is confirmed with a "check mark"; the expected date of delivery is included and is equal to or greater than 30 days after the date of the beneficiary's signature.

In order to facilitate correct submission of the sterilization consent when a premature delivery occurs, the following clarification is provided. "Prematurity" is defined as the state of an infant born prior to 37 weeks gestation. Physicians should use this definition in the completion of the sterilization consent when premature delivery is a factor."

The consent was (and must be) obtained at least 72 hours before sterilization was performed.

Physicians and clinics are reminded to obtain valid, legible consent forms.

Copies must be shared with any provider billing for sterilization services, including the assistant surgeon, hospital, and anesthesiologist.

Form Approved: OMB No. 0937-0166
Expiration date: 7/31/2025

CONSENT FOR STERILIZATION

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

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from (1) _____ (*Doctor or Clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

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

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

I understand that I will be sterilized by an operation known as a (2) _____ (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: (3) _____ (*Date*)

I, (4) _____, hereby consent of my own free will to be sterilized by (5) _____ (*Doctor or Clinic*) by a method called (6) _____ (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

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

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (*Signature*) (8) _____ (*Date*)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

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

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (*Interpreter's Signature*) (11) _____ (*Date*)

HHS-687 (07/2025)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation (13) _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

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

(14) _____ (*Signature of Person Obtaining Consent*) (15) _____ (*Date*)

(16) _____ (*Facility*)

(17) _____ (*Address*)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon (18) _____ (*Name of Individual*) on (19) _____ (*Date of Sterilization*)

I explained to him/her the nature of the sterilization operation (20) _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

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

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

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

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: (21) _____
- ☐ Emergency abdominal surgery *(describe circumstances)*:

_____

_____

(22) _____ (*Physician's Signature*) (23) _____ (*Date*)

Checklist for Sterilization Form
(See previous page for number items on form)

CONSENT TO STERILIZATION

Y	N	Are all blanks filled in and legible?
Y	N	Is the patient's signature present? (Line 7)
Y	N	Is the date of the signature present? (Line 8)
Y	N	Was the patient at least 21 years old on the date the consent form was signed? (Line 3)
Y	N	Is race and ethnicity section filled out (not mandatory)?

INTERPRETER'S STATEMENT (if applicable)

Y	N	Are all blanks filled in and legible?
Y	N	Is the interpreter's signature present? (Line 10)
Y	N	Is the date of the signature the same as the date of the patient's signature? (Line 11 same as Line 8?)

STATEMENT OF PERSON OBTAINING CONSENT

Y	N	Are all blanks filled in and legible?
Y	N	Is the signature of the person obtaining consent and date of signature present? (Lines 14 and 15)
Y	N	Is the date of the signature the same as the date of the patient's signature? (Lines 8 and 15)

PHYSICIAN'S STATEMENT

Y	N	Are all blanks filled in and legible?
Y	N	Is the physician signature and date present? (Lines 22 and 23)
Y	N	Have at least 30 days, but no more than 180 days, passed between the date of the patient's signature and the date the surgery was done? (Lines 8 and 19)
Y	N	**NOTE:** "When counting, do not count the date of the patient's signature as one day (for example, if the patient signed on January 1, 30 days will have passed after January 31).
		If 30 days have not passed, does one of the following conditions exist? • Premature delivery (or early delivery) • Emergency abdominal surgery
Y	N	If premature delivery, is the individual's expected date of delivery at least 30 days after the date of informed consent? (Lines 8 and 21)
Y	N	Is the individual's expected delivery date documented? (Line 21)
Y	N	In the case of premature delivery or emergency abdominal surgery, was the sterilization performed more than 72 hours after the date of individual's signature on the consent form? (Lines 8 and 19)
Y	N	In the emergency abdominal surgery, are the circumstances described on the physician's statement on the consent form?
Y	N	Was the physician statement signed on or after the sterilization operation date? (Lines 19, 22 and 23)

Sterilization Consent Form Example – Consent obtained at Least 30 Days prior to Sterilization with Interpreter's Statement

Must be group or individual who gave information about sterilization procedure

Form Approved: OMB No. 0937-0166
Expiration date: 7/31/2025

CONSENT FOR STERILIZATION

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

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from (1) Woman's OB/GYN Group (*Doctor or Clinic*). When I first asked G for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

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

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

I understand that I will be sterilized by an operation known as a (2) Tubal Ligation (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: (3) 12/06/90 (*Date*)

I, (4) Judy Marshall, hereby consent of my own free will to be sterilized by (5) Dr. Thatch Strong (*Doctor or Clinic*) by a method called (6) Tubal Ligation (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

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

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) Judy Marshall (*Signature*) (8) 06/12/2024 (*Date*)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African Al
- ☐ Native Hawaiian o
- ☐ White

MUST MATCH

■ INTERPRETER'S STATEMENT ■

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

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) Spanish language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) Gloria Adams (*Interpreter's Signature*) (11) 06/12/2024 (*Date*)

HHS-687 (07/2025)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) Judy Marshall (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation (13) Tubal Ligation (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

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

(14) Sue Thomas, R.N. (*Signature of Person Obtaining Consent*) (15) 06/12/2024 (*Date*)

(16) Women's OB/GYN Group (*Facility*)

(17) 433 10th Street, Pine, LA 70776 (*Address*)

■ STATEMENT ■

MUST MATCH

Shortly before the operation upon (18) Judy Marshall (*Name of Individual*) on (19) 07/17/2024 (*Date of Sterilization*) I explained to him/her the nature of the sterilization operation (20) Tubal Ligation (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I coun... at alternative methods of birth cor... I explained that sterilization is di...

AT LEAST 30 DAYS

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

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

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

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: (21) 08/01/2024
- ☐ Emergency abdominal surgery *(describe circumstances)*:

(22) Thatch Strong, M.D. (*Physician's Signature*) (23) 07/17/2024 (*Date*)

SIGN AFTER SURGERY COMPLETE

Sterilization Consent Form Example – Consent obtained at Least 30 Days prior to Sterilization without Interpreter's Statement

Must be group or individual who gave information about sterilization procedure

Form Approved: OMB No. 0937-0166
Expiration date: 7/31/2025

CONSENT FOR STERILIZATION

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

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from (1) Woman's OB/GYN Group (*Doctor or Clinic*). When I first asked G for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

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

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

I understand that I will be sterilized by an operation known as a (2) Tubal Ligation (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: (3) 12/06/90 (*Date*)

I, (4) Judy Marshall, hereby consent of my own free will to be sterilized by (5) Dr. Thatch Strong (*Doctor or Clinic*) by a method called (6) Tubal Ligation (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

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

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) *Judy Marshall* (*Signature*) (8) 06/12/2024 (*Date*)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designatic*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (ma
- ☐ Ameri
- ☐ Asian
- ☐ Black
- ☐ Native
- ☐ White

CROSS OUT PARAGRAPH NOT USED AND COMPLETED APPLICABLE

■ INTERPRETER'S

If an interpreter is provided to assist

I have translated the information a e individual to be sterilized by the perso also read him/her the consent form in (9) Spanish language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) *Gloria Adams* (*Interpreter's Signature*) (11) 06/12/2024 (*Date*)

HHS-687 (07/2025)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) Judy Marshall (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation (13) Tubal Ligation (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

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

(14) Sue Thomas, R.N. (*Signature of Person Obtaining Consent*) (15) 06/12/2024 (*Date*)

(16) Women's OB/GYN Group (*Facility*)

(17) 433 10th Street, Pine, LA 70776 (*Address*)

MUST MATCH

AN'S STATEMENT ■

sterilization operation upon (18) Judy Marshall (*Name of Individual*) on (19) 07/17/2024 (*Date of Sterilization*).

I explained to him/her the nature of the sterilization operation (20) Tubal Ligation (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and bene

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

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

~~(1) At least 30 days have passed between the date of the indi signature on this consent form and the date the sterilizatic performed.~~

(2) This sterilization was performed less than 30 days but more th hours after the date of the individual's signature on this conse because of the following circumstances (check applicable box an information requested):

★ Premature delivery
Individual's expected date of delivery: (21) 08/01/2024

☐ Emergency abdominal surgery *(describe circumstances)*:

SIGN AFTER SURGERY COMPLETED

(22) *Thatch Strong, M.D.* (*Physician's Signature*) (23) 07/17/2024 (*Date*)

Form Approved: OMB No. 0937-0166
Expiration date: 7/31/2025

CONSENT FOR STERILIZATION

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

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from (1) Woman's OB/GYN Group (*Doctor or Clinic*). When I first asked G for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

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

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

I understand that I will be sterilized by an operation known as a (2) Tubal Ligation (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: (3) 12/06/90 (*Date*)

I, (4) Judy Marshall, hereby consent of my own free will to be sterilized by (5) Dr. Thatch Strong (*Doctor or Clinic*) by a method called (6) Tubal Ligation (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

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

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) *Judy Marshall* (*Signature*) (8) 06/12/2024 (*Date*)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

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

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) Spanish language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) *Gloria Adams* (*Interpreter's Signature*) (11) 06/12/2024 (*Date*)

HHS-687 (07/2025)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) Judy Marshall (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation (13) Tubal Ligation (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

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

(14) *Sue Thomas, R.N.* (*Signature of Person Obtaining Consent*) (15) 06/12/2024 (*Date*)

(16) Women's OB/GYN Group (*Facility*)

(17) 433 10th Street, Pine, LA 70776 (*Address*)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon (18) Judy Marshall (*Name of Individual*) on (19) 07/17/2024 (*Date of Sterilization*) I explained to him/her the nature of the sterilization operation (20) Tubal Ligation (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

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

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

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

~~(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.~~

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☒ Premature delivery
  Individual's expected date of delivery: (21) 08/01/2024
- ☐ Emergency abdominal surgery *(describe circumstances)*:

(22) *Thatch Strong, M.D.* (*Physician's Signature*) (23) 07/17/2024 (*Date*)

RESTRICTED AUDIOLOGY CODES

Payment for the following audiology codes is restricted to one per beneficiary, per 180 days:

92552	**92571**
92553	**92572**
92555	**92575**
92556	**92576**
92557	**92577**
92563	**92579**
92564	**92582**
92565	**92583**
92567	**92584**
92568	**92585**
92569	

CLAIMS RELATED INFORMATION

Hard copy billing of professional services are billed on the paper CMS-1500 (02/12) claim form or billed electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required, situational** or **optional**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

Services may be billed using:

1. The rendering provider's individual provider number as the billing provider number for independently practicing providers; or

2. The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

NOTE: Electronic claims submission is the preferred method for billing. (See the Electronic Data Interchange (EDI) Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "Health Insurance Portability and Accountability Act (HIPAA) Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide).

This appendix includes the following:

1. Instructions for completing the CMS-1500 claim form and samples of completed CMS-1500 claim forms; and

2. Instructions for adjusting/voiding a claim and samples of adjusted CMS-1500 claim forms.

CMS-1500 (02/12) INSTRUCTIONS FOR PROFESSIONAL SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid number).	
1a	Insured's Identification (ID) Number	**Required** – Enter the beneficiary's 13-digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through the Medicaid Eligibility Verification System (MEVS), electronic Medicaid Eligibility Verification System (eMEVS), or Recipient Eligibility Verification System (REVS). **NOTE:** The beneficiaries' 13-digit Medicaid ID number must be used to bill claims. The card control number (CCN) number from the plastic ID card is **NOT** acceptable. The ID number must match the beneficiary's name in block two.	
2	Patient's Name	**Required** – Enter the beneficiary's last name, first name, middle initial (MI).	
3	Patient's Birth Date of Birth (DOB) Sex	**Situational** – Enter the beneficiary's DOB using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the beneficiary.	
4	Insured's Name	**Situational** – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the beneficiary's permanent address.	

Locator #	Description	Instructions	Alerts
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	RESERVED FOR NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) USE	**Leave Blank.**	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Situational** – If beneficiary has no other insurance coverage, leave blank. If there is other commercial insurance coverage, the Louisiana assigned six-digit third-party liability (TPL) carrier code is **required** in this block. The carrier code is indicated on MEVS response as the Network Provider ID Number. Make sure the explanation of benefits (EOB) or EOBs from other insurance(s) are attached to the claim.	**ONLY the six-digit code should be entered for commercial and Medicare Health Maintenance Organization's (HMO's) in this field.** **DO NOT enter dashes, hyphens, or the word TPL in the field.** **NOTE: DO NOT ENTER A SIX-DIGIT CODE FOR TRADITIONAL MEDICARE**
9b	RESERVED FOR NUCC USE	**Leave Blank.**	
9c	RESERVED FOR NUCC USE	**Leave Blank**.	
9d	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.	
11	Insured's Policy Group or Federal Employees' Compensation Act (FECA) Number	**Situational** – Complete if appropriate or leave blank.	
11a	Insured's DOB Sex	**Situational** – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	**Leave Blank**.	
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	**Situational** – Complete if appropriate or leave blank.	
13	Insured's or Authorized Person's Signature (Payment)	**Situational** – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness/ Injury / Pregnancy	**Optional.**	
15	OTHER DATE	**Leave Blank.**	
16	Dates Patient Unable to Work in Current Occupation	**Optional.**	

17	Name of Referring Provider or Other Source	**Situational** – Complete if applicable. 1. In the following circumstances, entering the name, National Provider Identifier (NPI) and credentials of the appropriate physician or non-physician practitioner and appropriate qualifier is required: If services are performed at the request of an ordering or referring practitioner: Enter the applicable qualifier to the left of the vertical, dotted line to identify the practitioner being reported is either 1. DK= Ordering Provider or 2. DN= Referring Provider 2. Enter the name (First Name, MI, Last Name) followed by the credential of the physician or non-physician practitioner who ordered or referred the service(s) or supply(ies) on the claim. Examples of services requiring Ordering Provider (DK qualifier) 1. Services performed by an independent laboratory; 2. Diagnostic testing; 3. Services performed by a pediatric day health care (PDHC) clinic; and 4. Services are for durable medical equipment (DME). Examples of services requiring Referring Provider: 1. If the beneficiary is a lock-in beneficiary and has been referred to the billing provider for services, enter the lock-in physician's name; 2. If the beneficiary was referred to the billing provider for chiropractic services; and 3. If Affordable Care Act (ACA) services are delivered by a physician assistant or advanced practice registered nurse (APRN),	**For LA Medicaid "Other Source" is defined as the ordering provider or referring provider.**

Locator #	Description	Instructions	Alerts
		the name of the supervising ACA certified physician is required in this field.	
17a	Other ID Number	**Situational** – Complete if applicable. If 17 is completed, 17A is **Required.**	**Enter the seven-digit Medicaid ID Number here.**
17b	NPI	**Situational** – Complete if applicable. If 17 is completed, 17B is **Required.**	**The 10-digit NPI Number is required when 17 or 17A is complete**
18	Hospitalization Dates Related to Current Services	**Optional.**	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	**Leave Blank.**	
20	Outside Lab? $Charges	**Optional.**	
21	ICD Indicator Diagnosis or Nature of Illness or Injury	**Required** -- Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 0 ICD-10-CM **Required** -- Enter the most current ICD diagnosis code. NOTE: ICD-10 external cause of injury diagnosis codes V, W, X and Y will be accepted as non-primary diagnosis codes.	**The most specific diagnosis codes must be used. General codes are not acceptable**

Locator #	Description	Instructions	Alerts
22	Resubmission Code and/or Original Reference Number	**Situational** – If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Reference Number" portion of this field. Appropriate reason codes follow: <u>Adjustments</u> 01 = TPL Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other	**To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different ICN.**
23	Prior Authorization (PA) Number	**Situational** – Complete if appropriate or leave blank. If the services being billed must be prior authorized, the PA number is **required** to be entered.	

Locator #	Description	Instructions	Alerts
24	Supplemental Information	Situational - Applies to the detail lines for drugs and biologicals only. In addition to the procedure code, the **National Drug Code (NDC)** is required by the Deficit Reduction Act of 2005 for **physician-administered drugs** and **shall be entered** in the **shaded** section of 24A through 24G. **Claims for these drugs shall include the National Drug Code (NDC) from the label of the product administered.** To report additional information related to Healthcare Common Procedure Coding System (HCPCS) codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the **Qualifier N4** followed by the **11-digit NDC**. Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC. Providers should then leave one space and then enter the appropriate **Unit Qualifier** (see below) and the **actual units administered in NDC UNITS**. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space. The following qualifiers shall be used when reporting NDC units: 1. F2=International Unit 2. ML=Milliliter 3. GR=Gram 4. UN=Unit	**Physicians and other provider types who administer drugs and biologicals must enter drug-related information in the SHADED section of 24A-24G of the appropriate detail lines only.** **This information must be entered in addition to the procedure code(s).** **Please refer to the NDC Q&A information posted on lamedicaid.com for more details concerning NDC units versus service units and entry of NDC numbers with less than 11 digits.**
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure billed. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.	

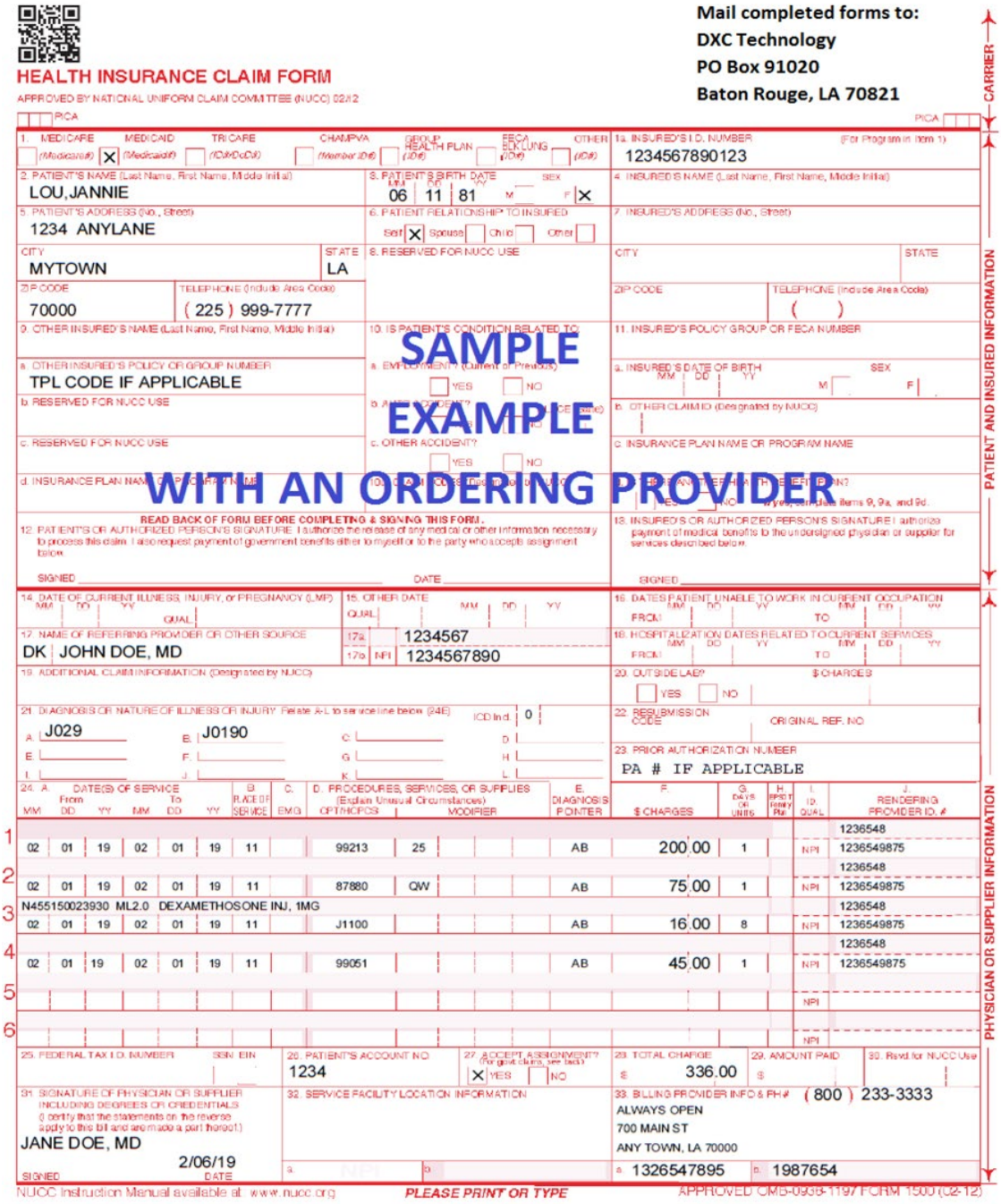
Locator #	Description	Instructions	Alerts
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	
24C	Electromyography (EMG)	**Situational** – Complete if appropriate or leave blank.	
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s). If a modifier(s) is required, enter the appropriate modifier in the correct field.	
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A”, “B”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	Charges	**Required** -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D	**Please refer to the NDC Q&A information posted on lamedicaid.com for more details concerning NDC units versus service units.**
24H	Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Family Plan	**Situational** – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	ID Qualifier	**Optional.** If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider ID Number	**Situational** – If appropriate, entering the Rendering Provider’s seven-digit Medicaid Provider Number in the shaded portion of the block is **required**.	**Both the seven-digit Medicaid provider number and the 10-digit NPI numbers are required when entering a**

Locator #	Description	Instructions	Alerts
		Entering the Rendering Provider's NPI in the non-shaded portion of the block is **required** if the shaded portion is complete.	**rendering provider.** **Rendering =Attending**
25	Federal Tax ID Number	**Optional.**	
26	Patient's Account Number	**Situational** – Enter the provider specific identifier assigned to the beneficiary. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	**Optional.** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Situational** – If TPL applies and block 9A is completed, enter the amount paid by primary payor. Enter '0' if the third-party did not pay. If TPL does not apply to the claim, leave blank. **Do not report Medicare payments in this field.**	**Do not report Medicare or Medicare Replacement plan payments in this field.**
30	Reserved for NUCC use	**Leave Blank.**	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Optional** – The practitioner or the practitioner's authorized representative's original signature is no longer required. **Required** -- Enter the date of the signature.	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
32a	NPI	**Optional.**	
32b	Other ID Number	**Situational –** Complete if appropriate or leave blank.	
33	Billing Provider Information and Phone Number	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	**Required –** Enter the billing provider's 10-digit NPI number**.**	**The 10-digit NPI Number must appear on paper claims.**
33b	Other ID Number	**Required** – Enter the billing provider's seven-digit Medicaid ID number. **ID Qualifier - Optional.** If possible, leave blank for Louisiana Medicaid billing.	**The seven-digit Medicaid Provider Number must appear on paper claims.**

Sample forms are on the following pages

SAMPLE PROFESSIONAL CLAIM FORM



Mail completed forms to:
DXC Technology
PO Box 91020
Baton Rouge, LA 70821

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) [X] MEDICAID (Medicaid#) TRICARE (ID/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789O123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LOU, JANNIE
3. PATIENT'S BIRTH DATE MM DD YY: 06 11 81 SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):
5. PATIENT'S ADDRESS (No., Street): 1234 ANYLANE
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street):
CITY: MYTOWN STATE: LA
8. RESERVED FOR NUCC USE
CITY: STATE:
ZIP CODE: 70000 TELEPHONE (Include Area Code): (225) 999-7777
ZIP CODE: TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER:
a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL CODE IF APPLICABLE
a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]
a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC):
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES [ ] NO [ ]
c. INSURANCE PLAN NAME OR PROGRAM NAME:
d. INSURANCE PLAN NAME OR PROGRAM NAME:
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: DATE:
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL:
15. OTHER DATE QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK JOHN DOE, MD
17a. 1234567
17b. NPI 1234567890
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0
A. J029 B. J0190 C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: PA # IF APPLICABLE

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 02 01 19	02 01 19	11		99213	25	AB	200.00	1		NPI	1236548 1236549875
2 02 01 19	02 01 19	11		87880	QW	AB	75.00	1		NPI	1236548 1236549875
3 N455150023930 ML2.0 DEXAMETHOSONE INJ, 1MG 02 01 19	02 01 19	11		J1100		AB	16.00	8		NPI	1236548 1236549875
4 02 01 19	02 01 19	11		99051		AB	45.00	1		NPI	1236548 1236549875
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN:
26. PATIENT'S ACCOUNT NO.: 1234
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 336.00
29. AMOUNT PAID: $
30. Rsvd. for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JANE DOE, MD
SIGNED 2/06/19 DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # (800) 233-3333
ALWAYS OPEN
700 MAIN ST
ANY TOWN, LA 70000
a. 1326547895 b. 1987654

NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE
EXAMPLE
WITH AN ORDERING PROVIDER

ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim may be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line may be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim**.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the RA, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved ICN can be adjusted or voided, thus:

1. If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim; or

2. If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider ID Number and the Beneficiary/Patient ID Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. Those claims must be voided and corrected claims submitted.**

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the RA under ***Adjustment or Voided Claim***. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the RA.

Sample forms are on the following pages.

SAMPLE PROFESSIONAL CLAIM FORM ADJUSTMENT

Mail completed forms to:
Gainwell Technologies
PO Box 91020
Baton Rouge, LA 70821

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#) X	TRICARE (ID/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
							1234567890123		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
LOU, JANNIE			06 11 81	M F X					
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
1234 ANYLANE			Self X Spouse Child Other						
CITY		STATE	8. RESERVED FOR NUCC USE				CITY		STATE
MYTOWN		LA							
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE	TELEPHONE (Include Area Code)	
70000	(225) 999-7777							( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX	
TPL CODE IF APPLICABLE			YES NO					M F	
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)		
			YES NO						
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES NO						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
							YES NO If yes, complete items 9, 9a, and 9d.		

SAMPLE
EXAMPLE
WITH AN ORDERING PROVIDER

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 1234567	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
DK JOHN DOE, MD	17b. NPI 1234567890		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0		22. RESUBMISSION CODE A 02	ORIGINAL REF. NO. 9038012345602
A. J029 B. J0190 C. D.		23. PRIOR AUTHORIZATION NUMBER	
E. F. G. H. I. J. K. L.		PA # IF APPLICABLE	

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 02 01 19	02 01 19	11		87880	QW	AB	50 00	1			1236548
										NPI	1236549875
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

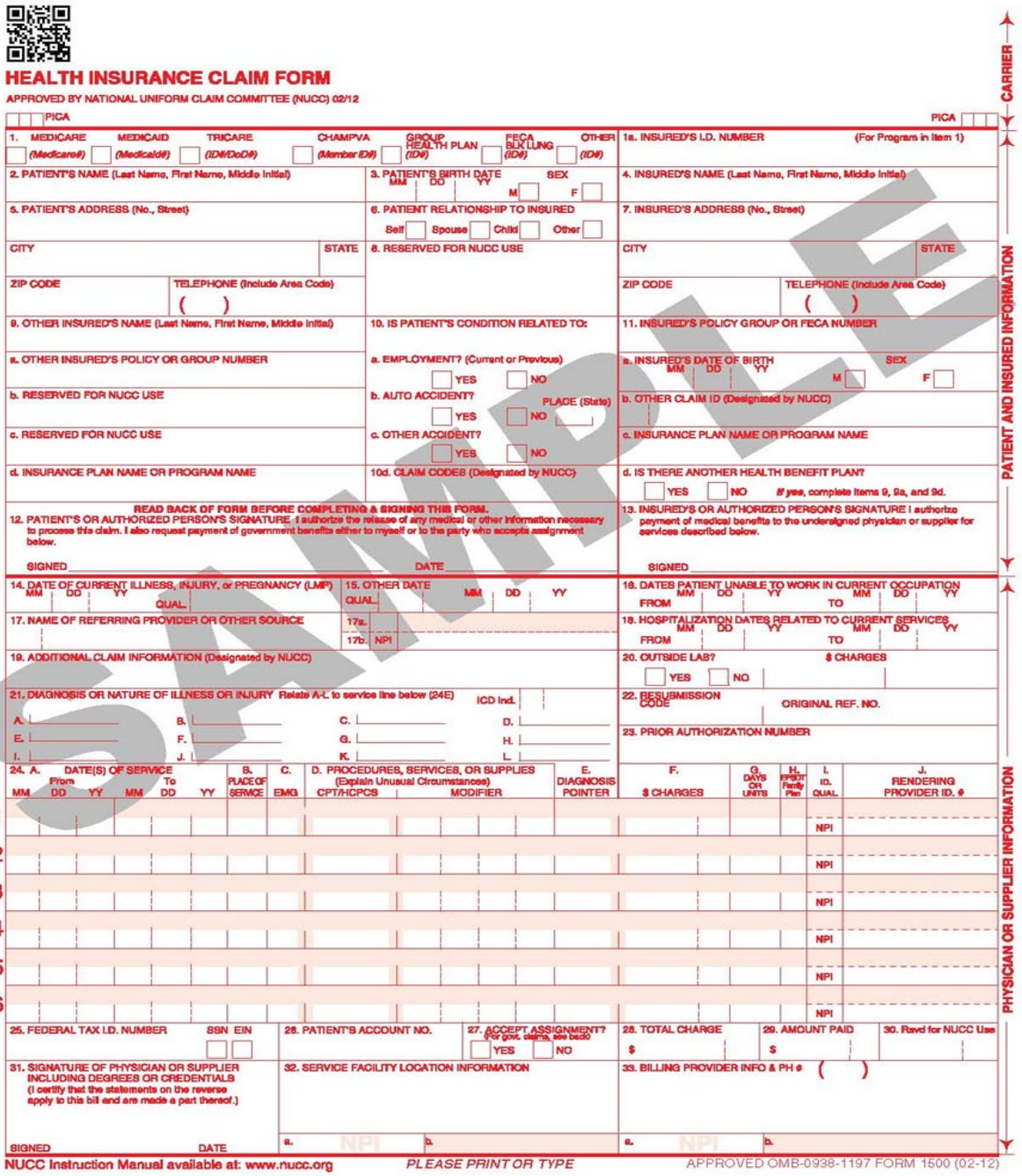
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd. for NUCC Use
	1234	X YES NO	$ 50.00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (800) 233-3333
JANE DOE, MD 2/28/19 SIGNED DATE	a. NPI b.	ALWAYS OPEN 700 MAIN ST ANY TOWN, LA 70000 a. 1326547895 b. 1987654

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

GLOSSARY AND ACRONYMS

The following is a list of abbreviations, acronyms and definitions used in this manual chapter.

17 Alpha Hydroxyprogesterone Caproate (17-P) – A synthetic progestin used to help prevent recurrent preterm birth in singleton pregnant women with a history of a previous singleton spontaneous preterm delivery.

638 Clinic – An Indian Health Service provider serving the Native American population with preventive, diagnostic, therapeutic, rehabilitative or palliative medical care.

Adjunct Services – Services provided by the Medicaid provider at times other than regularly scheduled office hours or at regularly scheduled evening, weekend or, state legal holidays in addition to basic service.

Advanced Practice Registered Nurse (APRN) – A registered nurse (RN) with advanced education, training, and licensure who provides a wide range of patient care services, including diagnosing illnesses, prescribing medications, and managing care plans.

Ambulatory Surgical Center (ASC) – A free-standing facility, separate from a hospital, which meets the needs of eligible patients for minor surgery on a one-day basis. ASCs are reimbursed a flat fee per occurrence.

American Association of Diabetes Educators (AADE) – Now known as the Association of Diabetes Care & Education Specialists (ADCES), a professional organization dedicated to advancing the quality of diabetes care and education for health care professionals and people affected by diabetes.

American Dental Association – A U.S.-based organization founded in 1859 that serves as the leading national advocate for the dental profession and public oral health.

American Diabetes Association – A non-profit organization dedicated to fighting diabetes through research and providing resources for people with diabetes, as well as setting evidence-based clinical guidelines through their published Standards of Care in Diabetes.

American Society for Metabolic and Bariatric Surgery (ASMBS) – A non-profit medical organization dedicated to metabolic and bariatric surgery, and obesity-related diseases and conditions.

Beneficiary – Enrollee having received Medicaid services and paid claims rendered to the enrolled provider.

Bureau of Health Services Financing (BHSF) – The bureau within the Department of Health and Hospitals (DHHS) responsible for the administration of the Louisiana Medicaid Program.

Care Enhance Review Manager Enterprise (CERMe) – A software that integrates evidence-based InterQual® Criteria into the healthcare utilization review process, enabling organizations to automate and streamline the evaluation of patient care, improve reviewer consistency, and facilitate data retrieval and aggregated reporting to ensure appropriate, cost-effective, and high-quality care delivery.

Centers for Medicare and Medicaid Services (CMS) – The federal agency in DHHS charged with overseeing and approving states' implementation and administration of the Medicaid and Medicare programs.

Certified Diabetes Educator (CDE) – A qualified healthcare professional who helps individuals with diabetes understand, manage, and live with their condition.

Certified Nurse Midwife (CNM) – A RN who has completed graduate-level training and obtained a national certification to provide advanced, patient-centered care to women, including reproductive and gynecological care, prenatal, labor and delivery, postpartum, and newborn care.

Certified Nurse Practitioner (CNP) – A RN who has completed advanced graduate-level education and passed a national certification exam in a specific patient population specialty.

Certified Registered Nurse Anesthetist (CRNA) – An APRN who provides anesthesia and related care for patients undergoing surgical, obstetrical, and other medical procedures.

Child Health and Maternity Program (CHAMP) – Refers to various initiatives, like the federal Title V MCH Services Block Grant and state programs, aimed at improving the health of mothers, infants, and children, especially those with low incomes or special health needs.

Children's Health Insurance Program (CHIP) Phase IV – An expansion of Louisiana's State CHIP that provides prenatal care services, from conception to birth, for low income uninsured mothers who are not otherwise eligible for other Medicaid programs.

ClaimCheck – A commercial claims editing tool utilized by Louisiana Medicaid which evaluates billing information and coding accuracy based on national coding standards during the claims processing cycle.

Clear Claim Connection – A web-based reference tool that enables providers with access to the editing rules and clinical rationale for ClaimCheck processing.

Clinical Data Inquiry (CDI) – A daily updated on-line inquiry providing a complete history of a Medicaid enrollee's paid claims for a specified time period.

Clinical Laboratory Improvement Amendments (CLIA) of 1988 – A federal law that establishes quality standards for all laboratory testing performed on human specimens to ensure the accuracy, reliability, and timeliness of patient test results.

Clinical Nurse Specialist (CNS) – An APRN with advanced education and clinical expertise in a specific nursing specialty, such as a patient population, disease, or setting.

Code of Federal Regulations (CRF) - The codification of the general and permanent regulations promulgated by the executive departments and agencies of the federal government of the United States. The CFR is divided into 50 titles that represent broad areas subject to federal regulation.

Continuing Education Units (CEUs) – A measure used in continuing education programs to assist the professional to maintain their license in their profession.

Coordinated Care Network (CCN) – A health care system providing quality, cost-effective care, with two models: Shared Savings and Prepaid.

Co-Payment – A fixed dollar amount paid by a Medicaid enrollee at the time of receiving a covered service from a participating provider.

Current Procedural Terminology (CPT) – A systematic listing of codes and descriptions that classify medical services and procedures.

Deficit Reduction Act of 2005 (DRA) – The federal law enacted in February 2006 aimed to reduce the rate of federal and state Medicaid spending growth through a new flexibility on Medicaid premiums, cost sharing and benefits, along with tighter controls on asset transfers in order to qualify for Medicaid long-term care (LTC).

Department of Health and Human Services (DHHS) – The federal agency responsible for administering all state Medicaid programs as well as other public health programs.

Diabetes Self-Management Training (DSMT) – Provides the knowledge, skills, and support for people with diabetes to actively manage their condition by focusing on self-care behaviors like monitoring, healthy eating, physical activity, medication use, problem-solving, and healthy coping, aiming to improve clinical outcomes and quality of life.

Dual Eligible – Individuals entitled to Medicare and full or partial Medicaid benefits.

Durable Medical Equipment (DME) – Medical equipment that can withstand repeated use, serves a medical purpose, is typically only useful due to a medical condition or injury, and is appropriate for use in the home.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – A federally mandated cluster of preventive health, diagnosis, and treatment services for Medicaid eligible children age 0-21.

EarlySteps – Louisiana's early intervention system for children with developmental disabilities.

Electronic Clinical Documentation Improvement (eCDI) – Louisiana Medicaid's electronic clinical data inquiry providing paid claims history for specified Medicaid enrollees for a selected time period.

Electronic Data Interchange (EDI) – A technology that facilitates the automated, computer-to-computer exchange of standardized business documents and data between different organizations or trading partners.

Electronic Funds Transfer (EFT) – A method of transferring money from one bank account to another electronically, without the need for physical checks or cash.

Electronic Health Records (EHR) – A comprehensive, digital collection of a patient's health information—including diagnoses, medications, allergies, immunizations, and test results—that is stored, managed, and accessed by authorized healthcare providers to provide real-time, patient-centered care.

Electronic Medicaid Eligibility Verification System (eMEVS) – Louisiana Medicaid's electronic system for direct access to Medicaid eligibility information for enrolled providers.

End Stage Renal Disease – The final, irreversible stage of chronic kidney disease (CKD) where the kidneys have lost their ability to filter waste and excess fluid from the blood, leading to permanent kidney failure.

Enrollee – A person meeting Medicaid eligibility, applied and approved by the Medicaid program to receive benefits regardless of whether services are actually received and/or claims paid on their behalf.

Enrollment – The act of registering into the computerized system for payment of eligible services under the Medical Assistance Program. Enrollment includes the execution of the provider agreement and assignment of the provider number used for payment. This is also referred to as provider enrollment.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – A program established by the federal government in 1967 to provide low-income children with comprehensive health care.

Federal Financial Participation (FFP) – The federal government's share of Louisiana's Medicaid payments made to enrolled providers for services rendered to Medicaid enrollees.

Federal Medical Assistance Percentage (FMAP) – The percentage rate used to determine the matching funds rate allocated annually by the federal government for the operation of the state Medicaid program.

Federal Poverty Level (FPL) – Defines poverty in the U.S. for administrative purposes, with DHHS issuing Federal Poverty Guidelines (FPG) annually to determine eligibility for federal programs like Supplemental Nutrition Assistance Program (SNAP), Head Start, and Medicaid.

Federally Qualified Health Center (FQHC) – An entity receiving a grant under Section 330 of the Public Health Service (PHS) Act; is receiving funding from such grant under a contract with the beneficiaries of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act; is not receiving a grant under Section 330 of the PHS Act but determined by the Secretary of DHHS to meet the requirements for receiving a grant based on the recommendation of the Health Resources Services Administration (HRSA); is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Fiscal Intermediary (FI) – The fiscal agent contracted by LDH to operate the federally approved Medicaid Management Information System (MMIS). The FI processes Medicaid claims for services provided under the Medicaid Program and issues appropriate payment and provides assistance to providers.

Global Surgery Period (GSP) – This concept refers to those services that are paid as part of the reimbursement for surgical procedures. This can include both pre-operative and post-operative services.

Healthcare Common Procedure Coding System (HCPCS) – A collection of standardized alphanumeric codes used by healthcare providers to bill for services, procedures, supplies, and products to Medicare, Medicaid, and private health insurance programs.

Health Insurance Portability and Accountability Act (HIPAA) – A U.S. federal law passed in 1996 that provides data privacy and security provisions for safeguarding medical information. It primarily establishes national standards for the electronic transaction of health care information,

mandates the protection of protected health information (PHI), and includes provisions for maintaining health insurance coverage and reducing health care fraud.

Health Maintenance Organization (HMO) – A type of managed care health insurance plan that provides health services for a fixed, prepaid fee, typically offering lower monthly premiums and out-of-pocket costs.

Health Professional Shortage Area – An urban or rural area, population group, or public or nonprofit private medical facility which the Secretary of DHHS determines has a shortage of health professionals.

Health Resources Services Administration (HRSA) – An office within DHHS whose mission is to improve access to healthcare services for the uninsured, isolated, or medically vulnerable through leadership and financial support.

Home and Community-Based Services (HCBS) – A range of optional, person-centered services that support individuals with disabilities, chronic illnesses, or aging needs to live in their homes and communities instead of institutional settings.

Home Health Agency (HHA) – An organization that provides medical and therapeutic services, like skilled nursing, physical therapy (PT), and aide services, in a patient's own residence rather than a traditional healthcare facility.

Indian Health Service (HIS) – The federal agency within DHHS responsible for providing health services to approximately 2.6 million members of 574 federally recognized American Indian and Alaska Native (AI/AN) tribes. Established to fulfill the federal government's trust responsibility to Native Americans, the IHS aims to improve the physical, mental, social, and spiritual health of AI/AN communities through preventive, curative, and rehabilitative care.

Individualized Education Plan (IEP) – A legally binding, written plan that ensures students with disabilities receive specialized instruction and related services to meet their unique needs in a free and appropriate public education (FAPE). Mandated by the Individuals with Disabilities Education Act (IDEA), the IEP serves as a "roadmap" outlining academic, social, and behavioral goals, as well as the accommodations, services, and progress-monitoring strategies required for a student to thrive and make progress in school.

Individualized Family Services Plan (IFSP) – A written plan created for infants and toddlers (ages birth to three) with developmental delays or disabilities, and their families, under IDEA Part C. It outlines early intervention services, establishes goals for the child and family, and determines how progress will be monitored and services provided in the child's natural environment. The IFSP is a team-developed, family-centered document that is reviewed and updated regularly, with parents as key members of the decision-making team.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – Any 24-hour residential facility, whether public or private, that provides services to individuals that meet the criteria to reside in that facility.

Intrathecal Baclofen (ITB) – A muscle relaxant medication delivered directly into the cerebrospinal fluid of the spinal cord to treat severe muscle spasticity, muscle tightness, and spasms caused by central nervous system conditions like spinal cord injury or cerebral palsy.

Licensed Practical Nurse (LPN) - A licensed healthcare professional who provides routine nursing care to patients under the supervision of a RN or physician.

Lock-In – An educational program administered by the Medicaid pharmacy program staff which restricts certain Medicaid enrollees to a specific physician and/or pharmacy.

Long-Term Care (LTC) – A broad spectrum of medical and personal services provided over an extended period for individuals who, due to chronic illness or disability, cannot perform daily tasks independently.

Long Term-Personal Care Services (LT-PCS) – An optional Medicaid State Plan service which assists with activities of daily living (ADL) and instrumental activities of daily living (IADL) as an alternative to institutional care to qualified Medicaid beneficiaries who are age 21 or older, and meet specific program requirements.

Louisiana Children's Health Insurance Program (LaCHIP) – A Medicaid expansion population covering children less than 19 years of age without health insurance and income up to 200% of the federal poverty level (FPL).

LaCHIP Affordable Plan – A stand-alone eligibility group providing Medicaid coverage for children under the age of 19 not covered by health insurance with income below 250% of the FPL.

Louisiana Department of Health (LDH) – The state agency responsible for administering the Medicaid program and other health related services including public health, behavioral health and developmental disabilities. In this manual, the use of the word "department" means LDH.

Louisiana Immunization Network for Kids Statewide (LINKS) - Louisiana's centralized, statewide immunization information system (IIS) and registry, which collects, stores, and allows access to immunization records for residents.

Maternal and Child Health (MCH) – The interrelated health and well-being of mothers, their children, and their families, focusing on preventative care, education, and access to quality services to reduce disparities and ensure healthy outcomes from before conception through infancy and adolescence.

Medicaid – A federal-state financed medical assistance entitlement program provided under an approved State Plan authorized under Title XIX of the Social Security Act.

Medicaid Eligibility Verification System (MEVS) – Louisiana Medicaid's electronic eligibility verification system accessed through a switch vendor.

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

Medical Vendor Administration (MVA) – The appropriated entity responsible for the administration of Louisiana's Medicaid program.

Medical Vendor Program (MVP) – That portion of Medicaid expenditures directly related to payments for services rendered to enrollees.

Medically Necessary – Those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

Medically Needy Program (MNP) – A Medicaid eligibility group with limited Medicaid benefits for those individuals with income and resources insufficient to meet medical needs during a specific time period.

Medically Underserved Area – Areas designated by HRSA as having too few primary care providers (PCPs), high infant mortality, high poverty and/or high elderly population.

Medically Underserved Population – Areas designated by HRSA as having high infant mortality, high poverty, and/or high elderly population.

Medicare – The Social Security Act Title XVIII that provides the health insurance program for the aged and disabled.

Medicare Part A – The hospital insurance portion of Medicare.

Medicare Part B – The supplementary insurance portion of Medicare that covers medically-necessary physician and outpatient care.

Medicare Part C – The managed care portion of Medicare.

Medicare Part D – The prescription drug portion of Medicare.

Multi-Systemic Therapy (MST) - An intensive, family and community-based intervention for juveniles with serious antisocial behavior, aiming to reduce criminal activity and out-of-home placements by empowering caregivers to address the multiple risk factors across the youth's family, school, peers, and community systems. This evidence-based program utilizes a scientific approach to identify and address the underlying causes of delinquent behavior within the young person's natural environment, creating sustainable positive change by aligning these systems.

National Correct Coding Initiative (NCCI) – The federally mandated editing methodologies applied to Medicaid claims filed on or after October 1, 2010 that are used to prevent improper payments when incorrect code combinations are reported.

National Drug Code (NDC) – A unique, 10-digit identifier for human drug products in the United States, assigned to each labeler (manufacturer), drug product, and commercial package size.

New Opportunities Waiver (NOW) – A 1915(c) waiver program designed to provide HCBS to beneficiaries who otherwise would require the LOC of an ICF/IID.

Occupational Therapy (OT) – A form of therapy for those recuperating from physical or mental illness that encourages rehabilitation through the performance of activities required in daily life.

Office for Citizens with Developmental Disabilities (OCDD) – The office in LDH responsible for services to individuals with developmental disabilities.

Office of Aging and Adult Services (OAAS) – The office within LDH responsible for the management and oversight of certain Medicaid home and community-based services (HCBS), waiver programs, State Plan programs including long-term – personal care services (LT-PCS), APS for adults ages 18 through 59, and other programs that offer services and supports to the elderly and adults with disabilities.

Office of Public Health (OPH) – A government agency dedicated to protecting and promoting the health of communities and populations through science-based policies, education, disease prevention, and health equity efforts.

Omnibus Budget Reconciliation Act (OBRA) – A series of congressional acts that combine various budget and substantive provisions to reconcile the federal budget.

Online Survey, Certification and Reporting (OSCAR) – Refers to the Medicare/Medicaid system for inspecting and certifying healthcare providers, which collects data from on-site surveys and provider self-reports into the formerly known OSCAR system and the current CASPER/QIES database for reporting to CMS.

Personal Care Services (PCS) – Provide hands-on assistance or cueing for individuals unable to perform daily tasks themselves, primarily focusing on ADL, such as bathing, dressing, and eating, and IADL, including light housework, meal preparation, and transportation.

Physical Therapy (PT) – The treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise rather than by drugs or surgery.

Physician Assistant – A nationally certified and state-licensed medical professional who provides a wide range of healthcare services, including conducting physical exams, diagnosing and treating illnesses, ordering and interpreting tests, developing treatment plans, and assisting in surgery, all under the supervision of a physician.

Plan of Care (POC) – A written person-centered plan developed by the beneficiary, their authorized representative and support coordinator based on assessment results. The plan specifies services to be accessed and coordinated by the support coordinator on the beneficiary's behalf and includes long-range goals, assignment of responsibility, and time frames for completion or review by the support coordinator.

Prior Authorization (PA) – Management tool used to determine if treatments/services are medically necessary and appropriate for the patient.

Program of All-Inclusive Care for the Elderly (PACE) – A capitated, managed care program under the Medicaid State Plan that coordinates and provides all needed preventative, primary health, acute and LTC services for enrolled beneficiaries.

Provider Enrollment (PE) – Another term for enrollment of providers.

Recipient Eligibility Verification System (REVS) – Louisiana Medicaid's automated telephonic voice response system for verifying Medicaid eligibility.

Registered Nurse (RN) – An individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

Rural Health Clinic (RHC) – An outpatient primary care clinic seeking or possessing certification by the Health Care Financing Administration (HCFA) as a RHC and licensed by the department, which provides diagnosis and treatment to the public by a qualified mid-level practitioner and a licensed physician. The clinic must be located in a medically underserved area that is not urbanized as defined by the U.S. Bureau of Census.

Secretary – The secretary of DHHS or any official to whom they have delegated the pertinent authority.

Speech Therapy – Also known as speech and language pathology or logopedics, is a healthcare and academic discipline concerning the evaluation, treatment, and prevention of communication disorders, including expressive and mixed receptive-expressive language disorders, voice disorders, speech sound disorders, speech disfluency, pragmatic language impairments, and social communication difficulties, as well as swallowing disorders across the lifespan.

State Fiscal Year (SFY) – The state's 12-month budget appropriation time period beginning July 1 and continuing through June 30 of the next calendar year.

State Plan – The formal agreement between Louisiana and CMS regarding the policies and payment methodologies governing the administration of the Medicaid program. FFP is not available for any service/payment not approved by CMS.

Supplemental Security Income (SSI) – A federal cash assistance program for low-income aged, blind or disabled individuals established by Title XVI of the Social Security Act.

Take Charge – Louisiana Medicaid's family planning waiver.

Temporary Assistance for Needy Families (TANF) – Monthly cash assistance program for impoverished families with children under the age of 18.

Third-Party Liability (TPL) – The legal responsibility of one entity (the first party, or insured) to compensate a second entity (often their insurer) and a third entity (the victim) for harm or damages caused by the first party's actions or negligence.

Title V – Section of the Social Security Act establishing the Maternal and Child Health Services Block Grant.

Title XIX – Section of the Social Security Act authorizing state Medicaid services, populations and programs.

Trade Areas – Designated areas in the states of Texas, Arkansas, and Mississippi where a Louisiana Medicaid enrollee typically seeks medical care.

Vagus Nerve Stimulator (VNS) - An implantable medical device, similar to a cardiac pacemaker that uses electrical impulses to treat epilepsy and chronic, treatment-resistant depression.

PODIATRY CODES

Enrolled podiatrists may submit claims for covered services using procedure codes that are published on the Professional Services Fee Schedule and fall within the podiatrist's scope of practice as defined by the Louisiana Podiatry Practice Act. (See Appendix A for contact information).