



PROFESSIONAL SERVICES PROVIDER MANUAL

Chapter Five of the Medicaid Services Manual

Issued February 1, 2012

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**

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CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.0: OVERVIEW****PAGE(S) 1****OVERVIEW**

Professional services are provided by, but are not limited to, physicians, nurse practitioners, certified registered nurse anesthetists, 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. 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 recipients must be enrolled with Louisiana Medicaid and accept the Medicaid payment as payment in full for Medicaid covered services.

Louisiana Medicaid offers support via the internet and telephone. Professional service providers should refer to Appendix A of this chapter for various reference contacts and tools.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****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:

- A physician has found, and so certifies in his/her own handwriting, that on the basis of his/her professional judgment, the life of the pregnant woman would be endangered if the fetus was carried to term.
- The certification statement, which must contain the name and address of the recipient, 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

- In the case of terminating a pregnancy due to rape or incest the following requirements must be met:
 - The Medicaid recipient shall report the act of rape or incest to a law enforcement official unless the treating physician certifies in writing that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the rape or incest.
 - The report of the act of rape or incest to a law enforcement official or the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest must be submitted to the Bureau of Health Services Financing along with the treating physician's claim for reimbursement for performing an abortion.
 - The Medicaid recipient shall certify that the pregnancy is the result of rape or incest and this certification shall be witnessed by the treating physician.
 - The "Office of Public Health 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 "Office of Public Health Certification of Informed Consent-Abortion" form to their claim form. (See Appendix B for information on obtaining a copy of this form)

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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 physician consultants for payment consideration.

Threatened, Incomplete or Missed Abortion

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

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

- Sonogram report showing no fetal heart tones,
- History indicating passage of fetus at home, en route, or in the emergency room,
- Pathology report showing degenerating products of conception, or
- Pelvic exam report describing stage of cervical dilation.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5****Affordable Care Act – Primary Care Services Enhanced Reimbursement**

The Affordable Care Act (ACA) requires Medicaid to reimburse specified primary care services at an enhanced rate when those services are rendered by or under the supervision of designated physicians during calendar years 2013 and 2014. Specified services are limited to:

- Evaluation and management, and
- Vaccine administration.

NOTE: Specified services are published on the ACA Enhanced Reimbursement fee schedules. (See Appendix A for information on accessing the fee schedule)

Provider Eligibility

Eligible providers are limited to designated physicians and physician assistants (PAs) or advanced practice registered nurses (APRNs) under the supervision of a designated physician as follows.

Physicians

Medical doctors or doctors of osteopathy must meet the federal requirements of a designated physician by attesting to a specialty or subspecialty designation within:

- Family medicine,
- General internal medicine, or
- Pediatric medicine.

The specialty or subspecialty designation must be supported by:

- Board certification by one of the following:
 - American Board of Medical Specialists (ABMS),
 - American Board of Physician Specialties (ABPS), or
 - American Osteopathic Association (AOA)

OR

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- Furnishing specified evaluation and management and vaccine administration services that equal at least 60 percent of total Medicaid codes paid, including those for individuals enrolled in a Bayou Health plan, during the most recently completed calendar year, or for newly eligible physicians the prior month.

NOTE: Codes paid will be measured in service units, not payment amounts.

A completed “Medicaid Primary Care Services Designated Physician Form” must be submitted to the fiscal intermediary (FI) for each eligible physician regardless of group affiliation. Eligibility is based on each individual physician meeting federal requirements. Forms may be submitted at any time, and there is no deadline for form submission. (See Appendix A for information on accessing this form)

NOTE: Physicians who contract with a Bayou Health plan and who are not separately enrolled as a Medicaid provider must submit their completed “Medicaid Primary Care Services Designated Physician Form” directly to the contracted Bayou Health plan(s) instead of the FI. The contracted Bayou Health plan(s) should be contacted for submission requirements.

Physician Assistants

PAs must meet federal requirements for physician supervision. The physician must assume professional responsibility and legal liability for services provided.

NOTE: This precludes “arms-length” arrangements or collaborative agreements with physicians for purposes of establishing a relationship that leads to higher payment of the non-physician practitioner services.

Advanced Practice Registered Nurses

APRNs must meet federal requirements for physician supervision. The physician must assume professional responsibility and legal liability for services provided.

NOTE: This precludes “arms-length” arrangements or collaborative agreements with physicians for purposes of establishing a relationship that leads to higher payment of the non-physician practitioner services.

APRNs must submit a completed “Medicaid Primary Care Services Advanced Practice Registered Nurse Form” to the FI. (See Appendix A for information on accessing this form.)

NOTE: APRNs who contract with a Bayou Health plan and who are not separately enrolled as a Medicaid provider must submit their completed “Medicaid Primary Care Services Advanced

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Practice Registered Nurse Form” directly to the contracted Bayou Health plan(s) instead of the FI. The contracted Bayou Health plan(s) should be contacted for submission requirements.

Effective Date for Enhanced Reimbursement**Physicians**

A physician's effective date for enhanced reimbursement is based on the date a complete and correct “Medicaid Primary Care Services Designated Physician Form” is received by the FI. Incomplete or incorrect forms will be returned to the provider. The FI will mail a letter confirming receipt of the form which is used in establishing the effective date for enhanced reimbursement.

Receipt of Complete and Correct Form	Effective Date for Enhanced Reimbursement
By December 31, 2013	Eligible for enhanced reimbursement of eligible services rendered on or after January 1, 2013
After December 31, 2013	Eligible for enhanced reimbursement of eligible services rendered on or after the date the form is received.

Physicians must immediately notify the FI if they no longer meet requirements for enhanced reimbursement. The termination date will be the date the provider notifies the FI of ineligibility. The FI will send the provider confirmation of ineligibility that established the termination date for enhanced reimbursement.

Physician Assistants

A PA's effective date for enhanced reimbursement is the effective date for the supervising physician that is identified in the “Referring Provider” field on the claim form.

Advanced Practice Registered Nurses

The effective date for enhanced reimbursement for an APRN who has a “Medicaid Primary Care Services Advanced Practice Registered Nurse Form” on file with the FI is the effective date for the supervising physician that is identified in the “Referring Provider” field of the claim form. Incomplete or incorrect forms will be returned to the provider. The FI will mail a letter confirming receipt of the form.

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Receipt of Complete and Correct Form	Effective Date for Enhanced Reimbursement
By May 30, 2014	Eligible for enhanced reimbursement of eligible primary care services rendered on or after January 1, 2013 (<i>supervising physician must also be eligible on date of service</i>)
After May 30, 2014	Eligible for enhanced reimbursement of eligible services rendered on or after the date the form is received (<i>supervising physician must also be eligible on date of service</i>).

APRNs must immediately notify the FI if they no longer meet requirements for enhanced reimbursement.

Physicians must immediately notify the FI if they or the APRNs they supervise no longer meet requirements for enhanced reimbursement. The termination date will be the date the FI is notified of ineligibility. The FI will send the provider confirmation of ineligibility that established the termination date for enhanced reimbursement.

Claims Related Information

Claims for specified services rendered by a PA or APRN under the supervision of a designated physician must have the supervising physician's "Medicaid Primary Care Services Designated Physician Form" on file effective the date of service.

NOTE: An APRN must also have a "Medicaid Primary Care Services Advanced Practice Registered Nurse Form" on file effective the date of service.

Eligible services rendered by a PA or APRN must be

- Be billed by a physician group,
- Identify the PA or APRN as the Rendering Provider, and
- Include the supervising physician's National Provider Identifier (NPI) in the "Referring Provider" field on the claim form.
- Field 17b on the CMS 1500 form (paper)
- NM1 segment with NPI as part of the segment on v5010 837P (Electronic claims). The NM1 segment may be billed at either the Claim level 2310A or the Line level 2420F

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Services will not be eligible for the enhanced reimbursement when:

- Billed by an APRN practicing independently or in a nurse managed clinic,
- Billed on an encounter basis, including but not limited to Federally Qualified Health Centers and Rural Health Clinics,
- Rendered by or under the supervision of a physician who does not meet the federal requirements of a designated physician,
- Rendered by or under the supervision of physicians who do not have the required “Medicaid Primary Care Services Designated Physician Form” on file effective for the date of service, or
- Rendered by an APRN who does not have the required “Medicaid Primary Care Services Advanced Practice Registered Nurse Form” on file effective for the date of service.

ACA enhanced reimbursement rates reflect Medicare **site of service adjustments**. (See Appendix H for additional information regarding place of service codes)

NOTE: A statistically valid sample of the “Medicaid Primary Care Services Designated Physician Form” and “Medicaid Primary Care Services Advanced Practice Registered Nurse Form” will be reviewed at least annually. If it is determined that a provider did not qualify for the enhanced rate for any reason, Medicaid will recoup any difference between the Medicaid rate and the enhanced rate paid for the service.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3****Acute Hospital Pre-Certification**

McKesson's InterQual CareEnhance Review Manager Enterprise ® (CERMe) and the Thomson Reuters Length of Stay Data are used in determining current medical practice standards in the appropriateness of inpatient admissions and continued inpatient stays.

InterQual criteria clinical content is a synthesis of evidence-based standards of care, current practices, and consensus from licensed specialists and/or primary care physicians. The criteria identifies the most appropriate level of care during the initial admission, validates the need for continued stay, directs care to the appropriate level of care (if needed), and is based on patient specific information.

Acute inpatient extension requests are reviewed utilizing the most recent criteria guidelines and length of stay data available at any given time.

Claims for physician inpatient services are edited to assure the inpatient hospitalization has been pre-certified/approved. When there is no approved pre-certification on file, the inpatient physician services claim will deny.

For further information related to submitting physician charges when hospital stays are not pre-certified, refer to "Physician Billing When Pre-Certification Is Not Authorized" in this section. For assistance with claims related to this topic, providers should contact the fiscal intermediary's Provider Relations Unit. (See Appendix A for contact information)

Medical Necessity

Admissions are not dependent solely upon the basis of the length of time the recipient actually spends in the hospital. Louisiana Medicaid allows reimbursement up to 30 medically necessary hours for a recipient to be in an outpatient status. This time frame is for the physician to observe the recipient and to determine the need for further treatment, admission to an inpatient status or for discharge.

The decision to admit a recipient is a complex medical judgment which can be made only after the physician has considered a number of factors. A recipient should not be "deemed" inpatient once outpatient services exceed 24 hours. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for recipients who are expected to need hospital care for 24 hours or more, and treat other recipients on an outpatient basis. Physicians who are responsible for a recipient's care at the hospital are likewise responsible for deciding whether the recipient should be admitted as an inpatient.

Upon the physician order in the medical record for inpatient status, the hospital should register a recipient using a "Request for Hospital Pre-Admission Certification and LOS Assignment" (PC-

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F01) form for the inpatient stay when there is medical necessity per InterQual criteria. (See Appendix B for information on how to access this form)

OB Care and Delivery

Louisiana Medicaid complies with the federal Newborn Protection Act. Any days greater than the federal mandates are subject to medical necessity and retrospective review.

Precert Inquiry Application

Precert Inquiry is a web-based tool giving providers the ability to check and track the status of Medicaid inpatient hospital pre-certifications online. The Precert Inquiry tool is available to all Medicaid enrolled physician providers through the Louisiana Medicaid website. (See Appendix A for information on accessing user manual and website)

Physician Billing When Pre-Certification Is Not Authorized

A provider may bill the Medicaid recipient when the recipient presents to the hospital as a private-pay patient and does not inform the hospital of his/her Medicaid coverage.

The recipient cannot be billed when a pre-certification request is denied because medical necessity is not met. If medical necessity had been met, then the recipient would have received pre-certification. Since pre-certification was not received, the provider should not have admitted the recipient. This same logic is applicable to extensions. If it is not medically necessary for the recipient to be in the hospital, then discharge would be in order.

Providers shall not bill recipients simply because the pre-certification request was not timely. When a hospital's pre-certification request (initial or extension request) is denied due to the request not being submitted timely, or if the hospital fails to request initial pre-certification, the physician can request Medicaid payment for those services, but the claim must be submitted hard-copy to the fiscal intermediary's Provider Relations Unit and must include the following:

- An admit summary,
- A discharge summary, and
- A cover letter requesting pre-certification override.

NOTE: See Appendix A for contact information.

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These hard copy claims may deny if they contain errors. Overriding the pre-certification requirement does not negate Medicaid policy regarding claim completion. Providers should ensure claims submitted for pre-certification overrides are correctly completed.

Retrospective Eligibility Pre-Certification

A retrospective eligibility pre-certification review may be considered filed timely if the request is submitted within a year from the date the eligibility decision was added to the recipient's eligibility file. If the retrospective review is received within a year of the eligibility decision and the date of service is already over one year old, the normal timely filing restriction may be overridden. Inquiries related to this condition should be addressed to the fiscal intermediary's Provider Relations Unit. (See Appendix A for contact information)

Outpatient Surgery Performed on an Inpatient Basis

Outpatient surgeries performed on an inpatient basis require prior authorization if the surgery is performed within the first two days of a hospital stay. The hospital's Utilization Review Department must complete a "Request for Hospitalization for Outpatient Procedures: Day of Admit or Day After Admit" (PCF-02) form and submit it to the fiscal intermediary's Pre-certification Department requesting the procedure be added to the pre-certification file. Clinical documentation on the PCF-02 form must indicate why the outpatient procedure was performed as an inpatient. (See Appendix A for contact information and Appendix B for information on accessing this form)

If the surgery is performed on or after the third day of a hospital stay, no prior authorization is required.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Adjunct Services**

Louisiana Medicaid's adjunct services policy is intended to facilitate recipient access to services during non-typical hours primarily to reduce the inappropriate use of the hospital emergency department. The reimbursement for the adjunct codes is intended to assist with coverage of the additional administrative costs associated with staffing during these times. The intent is not for providers to alter their existing business hours for the purpose of maximizing reimbursement.

The Louisiana Medicaid Program provides reimbursement for select adjunct services. These *Current Procedural Terminology* (CPT) adjunct 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 emergency departments during the hours of:

- Monday through Friday between 5 p.m. and 8 a.m.(when outside of regular office hours),
- Weekends (12 a.m. Saturday through midnight on Sunday), or
- State/Governor proclaimed legal holidays (12 a.m. through midnight).

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

- If the existing office hours are Monday through Friday from 8 a.m. to 5 p.m., and the physician treats the recipient in the office at 7 p.m., then the provider may report the appropriate basic service (E/M visit code) **and** adjunct code.
- If the existing office hours are Monday through Friday from 8:30 a.m. to 6:30 p.m., and the physician treats the recipient in the office at 6 p.m., then the provider may not report the adjunct code.
- If a recipient is seen in the office on Saturday during existing office hours, then the provider may report the appropriate basic service (E/M visit code) **and** adjunct 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

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

Reimbursement

The reimbursement for adjunct services is based on the following current CPT codes:

- 99050 (Services...at times other than regularly scheduled office hours...) or
- 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 evaluation and management 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 and Federally Qualified Health Center providers should refer to policies in the manual specific to these providers.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Advanced Practice Registered Nurses: Clinical Nurse Specialists, Certified Nurse Practitioners, and Certified Nurse Midwives**

An advanced practice registered nurse (APRN) must hold a current, unencumbered and valid license from the Louisiana Board of Nursing to participate in Louisiana Medicaid. A nurse licensed as an APRN includes a:

- Clinical Nurse Specialist (CNS)
- Certified Nurse Practitioner (CNP)
- Certified Nurse Midwife (CNM)

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

Services provided by advanced practice registered nurses shall count toward all applicable limitations specified for physician services.

Billing Information

CNS/CNP/CNMs must obtain an individual Medicaid provider number.

CNS/CNP/CNMs **not** linked to a physician group must place their individual provider number 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 CNS/CNP/CNMs must obtain a group provider number and link the individual CNS/CNP/CNM provider number to the group number. Physician groups must notify, in writing, the fiscal intermediary's Provider Enrollment Unit of such employment or contract(s) when CNS/CNP/CNMs are added/removed from the group.

- Services provided by a CNS/CNP/CNM **must be identified** by entering the provider number of the CNS/CNP/CNM 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.
- CNS/CNP/CNMs 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.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****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.

Immunizations and Early and Periodic Screening, Diagnosis and Treatment medical, vision, and hearing screens are reimbursed at 100% of the physician fee on file. All other payable procedures are reimbursed at 80% of the physician fee on file.

Qualified CNS/CNP/CNMs who perform as first assistant in surgery should use the "AS" modifier to identify these services.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Allergy Testing**

Allergy Testing describes the performance and evaluation of selective cutaneous and mucous membrane tests in correlation with the history, physical examination, and other observations of the recipients.

Testing for Allergies

Only children and adults who have symptoms that suggest they have an allergic disease should be tested for allergies. Allergy symptoms can include:

- Respiratory symptoms: itchy eyes, nose, or throat, nasal congestion, runny nose, watery eyes, chest congestion or wheezing,
- Skin symptoms: hives, generalized itchiness or atopic dermatitis, and
- Other symptoms: anaphylaxis (severe life-threatening allergic reactions) or abdominal symptoms (cramping, diarrhea) that consistently follow particular foods or stinging insect reactions (other than large local swelling at the sting site).

Allergen Immunotherapy

Allergen immunotherapy is a vaccination program that increases immunity to allergens that trigger allergy symptoms. Allergen immunotherapy involves administering increasing amounts of an allergen to a recipient over a period of time. The method of administration and dosage administered should be included in the recipient's record. Indications for immunotherapy are determined by appropriate diagnostic procedures and clinical judgment.

Allergen Immunotherapy Treatment

Allergen immunotherapy is only recommended for allergic asthma, allergic rhinitis and conjunctivitis, and stinging insect allergy. Immunotherapy for food allergies is not recommended. Decisions to initiate immunotherapy should be based on severity of allergy symptoms, other possible treatment options, and cost of treatment options.

Five years of age is the youngest recommended age to begin immunotherapy. There is no upper age limit for receiving immunotherapy. However, before initiating immunotherapy in an older person, consideration must be given to other common medical conditions that could make immunotherapy more risky.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Allergy Testing and Allergen Immunotherapy Billing**

When billing 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 number of allergy tests performed should be judicious and dependent upon the history, physical findings, and clinical judgment of the provider. All recipients should not necessarily receive the same test or number of tests.

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

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****Ambulatory Surgical Centers (Non-Hospital)**

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

Ambulatory surgical centers 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's Health Standards Section.

ASCs are reimbursed a flat fee per occurrence that includes all charges by the facility for the care of the recipient while the recipient 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 "Ambulatory Surgical Centers ASC (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 Ambulatory Surgical Center provider manual. (See Appendix A for information on how to access this manual)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 10****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 to be used to bill for surgical anesthesia procedures.

- Reimbursement for surgical anesthesia procedures will be based on formulas utilizing base units, time units (1 unit = 15 min) and a conversion factor as identified in the Anesthesia Fee Schedule. Budget reductions will apply when applicable.
- The Anesthesia Fee Schedule is located on the Louisiana Medicaid website www.lamedicaid.com under the Fee Schedule link.
- Minutes **must** be reported on anesthesia claims.

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

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

Modifier	Servicing Provider	Surgical Anesthesia Service
AA	Anesthesiologist	Anesthesia services performed personally 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
QZ	CRNA	CRNA service without medical direction* by an anesthesiologist

*See Medical Direction section for further explanation.

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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

Medical Direction

Medical direction is defined as:

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

Only anesthesiologists will be 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 Obstetric section of the (CPT) manual are to be used to bill for maternity-related anesthesia services by anesthesiologists and CRNA's.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 10**

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 shall be a flat fee, except for general anesthesia for vaginal delivery.

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

Modifier	Servicing Provider	Service Performed
AA	Anesthesiologist	Anesthesia services performed personally 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	<p>Monitored anesthesia care service</p> <p>The QS modifier is a secondary modifier only, and must be paired with the appropriate anesthesia provider modifier (either the anesthesiologist or the CRNA).</p> <p>The QS modifier indicates that the provider did not introduce the epidural for anesthesia, but did monitor the recipient after catheter placement.</p>

*See Medical Direction section for further explanation.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 10****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 add-on code.

An add-on code in and of itself is not a full service and typically cannot be reimbursed separately to different providers. The exception is when 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

- Reimbursement for maternity-related procedures, other than general anesthesia for vaginal delivery, will be a flat fee.
- 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
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

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Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
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
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

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Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
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

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 10****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, will be 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 C-section delivery.

Anesthesiologists and CRNAs must attach the following forms for reimbursement:

- For a sterilization procedure – Form OMB No. 0937-0166, “Consent to Sterilization”
- For a hysterectomy – Form 96-A, “Acknowledgement of Receipt of Hysterectomy Information”

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- and post-sedation clinical evaluation of the recipient.

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

Moderate sedation is restricted to recipients 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 recipients 21 years of age or older).

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

- Assessment of the recipient (not included in intra-service time);
- Establishment of intravenous (IV) access and fluids to maintain patency, when performed;
- Administration of agent(s);
- Maintenance of sedation;

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- Monitoring of oxygen saturation, heart rate and blood pressure; and
- 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 when the second physician provides moderate sedation in the facility setting (e.g., hospital, outpatient hospital, ambulatory surgical center, 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 that which occurs during delivery or surgery, are covered by the Professional Services Program for this purpose only.

Epidurals given to alleviate chronic, intractable pain are not covered.

If a recipient requests treatment for chronic intractable pain, the provider may submit a claim for the initial office visit. Subsequent services that are provided for the treatment or management of this chronic pain are not covered and are billable to the recipient. Claims paid inappropriately are subject to recoupment.

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.

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- **Anesthesia Time**

Anesthesia time begins when the provider begins to prepare the recipient 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 to be billed in this manner are tubal ligations and hysterectomies.

Claims which **require a hard copy** claim and special instructions include:

- **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.
- **Claims for multiple but separate operative services performed on the same recipient on the same date of service.**

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 Provider Relations Unit.

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- Anesthesia for vaginal procedures; hysteroscopy; and/or hysterosalpingogram (HSG).

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

The attached documentation must indicate:

- Medical necessity for anesthesia (diagnosis of mental retardation, hysteria, and/or musculoskeletal deformities that would cause procedural difficulty),
- That the HSG meets the criteria for that procedure (Refer to the Medical Review section).

- Vaginal Delivery – Complete Anesthesia Service by Delivering Physician

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.

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

A new claim must be submitted to the fiscal intermediary's Provider Relations Unit with a cover letter explaining the situation which seemed to have caused the original claim denial.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****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 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.

Advanced practice registered nurses, certified nurse midwives, 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.

CHAPTER 15: PROFESSIONAL SERVICES**SECTION 15.1: COVERED SERVICES****PAGE(S) 1****Audiology Services**

Audiology services are defined as diagnostic, preventive, or corrective services for individuals with speech, hearing, and 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 currently approved for the reimbursement of audiology services to physicians and in accordance with the current regulations of the Professional Services Program.

Restrictions

Recipients must have a written authorization from their primary care physician for the audiologist's services. This includes recipients referred to the audiologist by the Head Start Program.

Audiologist Employed by Hospitals

Audiologists who are salaried employees of hospitals cannot bill Medicaid for their professional services rendered at that hospital because 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 recipient per 180 days. (See Appendix C for a list of these codes)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Bariatric Surgery**

Louisiana Medicaid covers bariatric or weight loss surgery as an option only after a comprehensive and sustained program of diet and exercise with or without pharmacologic measures has been unsuccessful over time.

Bariatric surgery may consist of open or laparoscopic procedures that revise the gastro-intestinal anatomy to restrict the size of the stomach and/or reduce absorption of nutrients.

Prior Authorization

Surgeons who perform bariatric surgery must obtain prior authorization through the fiscal intermediary's Prior Authorization (PA) Unit. The PA request shall include a thorough multidisciplinary evaluation within the previous 12 months.

NOTE: A physician letter documenting recipient qualifications and medical necessity must accompany the PA request and must include confirmatory evidence of co-morbid condition(s). Photographs must be submitted with the request for consideration of bariatric surgery.

Eligibility Criteria

All of the following criteria must be met by candidates for bariatric surgery:

- Be a minimum of 16 years of age,
- Have a documented weight in the morbidly obese range as defined by a body mass index greater than 40,
- Have at least three failed efforts at medical therapy and is experiencing the complications of extreme obesity,
- Have current obesity-related medical conditions which are classified as being very high risk for morbidity and mortality,
- Not have a major psychiatric diagnosis as the cause of the obesity or which will act as a deterrent to successful treatment as evidenced by the results of a psycho-social evaluation,
- Not be currently abusing alcohol or other substances, and

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2**

- Be capable of complying with the modified food intake regimen and follow-up program which will come after surgery.

Exceptions will not be authorized for recipients who fail to meet all of the above criteria.

Lipectomy or Panniculectomy Subsequent to Bariatric Surgery

A surgical lipectomy will be considered for approval if:

- It is determined to be medically necessary,
- Is being performed to correct an illness which was caused or aggravated by the pannus,
- Documentation supports that the recipient has at least one of the following indications:
 - Intertriginous infections with documented evidence of serious problems with infection control,
 - The apron of the panniculus interferes with ambulation, or
 - The panniculus is causing prolapsed of a ventral hernia.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5****Breast Reconstruction Post Mastectomy**

Effective with dates of service October 1, 2016 and forward, Louisiana Medicaid considers reconstructive breast surgery medically necessary after a mastectomy or a lumpectomy that results in a significant deformity (i.e., mastectomy or lumpectomy for treatment of breast cancer). Reconstruction of the affected/diseased breast and the contralateral unaffected breast to achieve symmetry is considered medically necessary.

Breast reconstruction is covered for recipients who have a mastectomy with a diagnosis of breast cancer. Mastectomy includes:

- Partial (lumpectomy, tylectomy, quadrantectomy and segmentectomy);
- Simple;
- Modified radical; and
- Radical.

Breast reconstruction surgery is often considered after a mastectomy to correct deformity or reestablish symmetry caused by previous surgery and/or the effects of therapeutic treatments. Reconstruction procedures may involve multiple techniques and stages to recreate the breast mound through the use of prosthetic implants, tissue flaps or autologous tissue transfers, as well as nipple/areola reconstruction.

The following services are covered:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, including nipple tattooing;
- Prosthesis (Implanted and/or external); and
- Treatment of physical complications of the mastectomy.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5****Clinical Guidelines and Criteria**

Louisiana Medicaid bases its determination of medical necessity for breast reconstruction on a combination of clinical data and the presence of indicators that would affect the relative risks and benefits of the procedure, including post-operative recovery. These include, but are not limited to, the following:

- A comprehensive medical history and physical exam has been conducted by a physician to evaluate the need for breast reconstruction surgery;
- The breast reconstruction surgery is intended to correct, restore or improve anatomical and/or functional impairments that result from therapeutic interventions (i.e., radiation) or disease of the breast;
- A surgical treatment plan that outlines the type of techniques and stages of the procedure(s) that will be performed has been developed; and
- The proposed surgery follows a mastectomy that has been performed to remove a malignant neoplasm or carcinoma in situ of the breast.

Covered Procedures

The following procedures for breast reconstruction following mastectomy or lumpectomy will be covered if prior authorized:

- Breast reconstruction procedures performed on the diseased/affected breast (i.e., breast on which the mastectomy/lumpectomy was performed), including:
 - Areolar and nipple reconstruction;
 - Areolar and nipple tattooing;
 - Autologous fat transplant (i.e., lipoinjection, lipofilling, lipomodeling);
 - Breast implant removal and subsequent re-implantation;
 - Capsulectomy;

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- Capsulotomy;
- Implantation of tissue expander;
- Implantation of U.S. Food and Drug Administration (FDA)-approved internal breast prosthesis;
- Oncoplastic reconstruction;
- Reconstructive surgical revisions; and
- Tissue/muscle reconstruction procedures (e.g., flaps), including, but not limited to, the following :
 - Deep inferior epigastric perforator (DIEP) flap;
 - Latissimus dorsi (LD) myocutaneous flap;
 - Ruben's flap;
 - Superficial inferior epigastric perforator/artery (SIEP/SIEA) flap ;
 - Superior or inferior gluteal free flap;
 - Transverse rectus abdominus myocutaneous (TRAM) flap; and
 - Transverse upper gracilis (TUG) flap.
- Breast reconstruction procedures performed on the non-diseased, unaffected, contralateral breast, in order to produce a symmetrical appearance, including:
 - Areolar and nipple reconstruction;
 - Areolar and nipple tattooing;
 - Augmentation mammoplasty;

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5**

- Augmentation with implantation of FDA-approved internal breast prosthesis when the unaffected breast is smaller than the smallest available internal prosthesis ;
- Autologous fat transplant (i.e., lipoinjection, lipofilling, lipomodeling);
- Breast implant removal and subsequent reimplantation when performed to produce a symmetrical appearance;
- Breast reduction by mammoplasty or mastopexy;
- Capsulectomy;
- Capsulotomy; and
- Reconstructive surgery revisions to produce a symmetrical appearance.

Reconstruction of the contralateral unaffected breast to achieve symmetry, including tattooing to correct color defects of the skin is limited to clients with a documented history of a breast reconstruction performed within the past 12 months. The breast reconstruction must have been performed while the recipient was eligible for Louisiana Medicaid.

Prior Authorization

Breast reconstruction post mastectomy of the affected/diseased breast, and the contralateral unaffected breast to achieve symmetry must be prior approved by the fiscal intermediary's Prior Authorization Unit (PAU) or the managed care organization (MCO).

Prior authorization (PA) requests to the fiscal intermediary's PAU should include the following:

- PA request form;
- Documentation of medical necessity, to include all of the following:
 - The primary diagnosis name and ICD-CM codes for the condition requiring reconstruction;
 - The secondary diagnosis name(s) and ICD-CM code(s) pertinent to comorbid condition(s);

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5**

- The most recent medical evaluation, including a summary of the medical history and last physical exam;
- Laboratory and pathology reports pertinent to a diagnosis of malignant neoplasm or carcinoma in situ of the breast;
- Risk factors or comorbid conditions;
- Surgical treatment plan, including a description of the type of tissue flaps and/or prosthetic implant(s) to be used. Where the procedure requires an implant, the implant must be FDA-approved; and
- Other pertinent clinical information that may be requested.

Clinical information must be submitted by the surgeon involved in the recipient's care.

The documentation required for PA requests to the MCO shall be determined by the MCO. Managed care organizations will utilize the criteria they deem appropriate for breast reconstruction based upon the clinical information submitted by the surgeon involved in the recipient's care.

Reimbursement

Breast reconstruction surgery is reimbursed for the *Current Procedural Terminology* (CPT) codes currently approved for the reimbursement of reconstructive breast surgery services to physicians and in accordance with the current regulations of the Professional Services Program. Information regarding the fee schedule to be used for breast reconstructive surgery services can be obtained on Louisiana Medicaid website following the links under "Fee Schedule," "Professional Services Fee Schedule".

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****Chiropractic Services**

Chiropractic manipulative treatment may be covered for Medicaid recipients up to 21 years of age when medically necessary and provided as a result of a medical referral from the recipient's primary care physician. Referrals from other providers will not be accepted.

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) code for the service provided. Healthcare Common Procedure Coding System (HCPCS) modifier "AT" may be used to designate acute treatment.

Claims for chiropractic services pertain 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 provider or primary care provider **and** documentation substantiating the medical necessity of the services. The documentation should include, but is not limited to the following:

- Diagnosis and chief complaint,
- Relevant history,
- Subjective and objective diagnostic examination findings,
- Acuity and severity of the recipient's condition,
- Results of x-ray, lab and other diagnostic tests,
- Number of treatment sessions necessary to correct or alleviate the recipient's symptoms or problem,
- The level of care (relief, therapeutic, rehabilitative, supportive) planned,
- Procedures performed and results,
- Response to therapy, and
- Progress notes and recipient disposition.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 7****Cochlear Implant**

Louisiana Medicaid allows reimbursement of prior authorized unilateral or bilateral cochlear implants when deemed medically necessary for the treatment of profound-to-total bilateral sensorineural hearing loss. Recipients should be considered for a bilateral cochlear implantation when it has been determined that a unilateral cochlear implant with a hearing aid in the contralateral ear will not result in a binaural benefit. Only recipients one through twenty years of age who meet the medical and social criteria included below shall qualify for implantation.

Medical and Social Criteria

The following general criteria apply to all candidates:

- Have a profound bilateral sensorineural hearing loss with pure tone average of 1000, 2000, and 4000Hz of 90dB HL or greater;
- Be a child age one year or older who is profoundly deaf or be a post linguistically deafened adult through the age of twenty years;
- Receive no significant benefit from hearing aids as validated by the cochlear implant team;
- Have a high motivation to be part of the hearing community as validated by the cochlear implant team;
- Have appropriate expectations;
- Have had radiologic studies that demonstrate no intracranial anomalies or malformations which contraindicate implantation of the receiver- stimulator or the electrode array;
- Have no medical contraindication for the undergoing implant surgery or post-implant rehabilitation; and
- Show that the recipient and his/her family are well-motivated, have appropriate post-implant expectations and are prepared and willing to participate and cooperate in the pre and post implant assessment and rehabilitation programs recommended by the implant team and in conjunction with the Food and Drug Administration (FDA) guidelines.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 7****Age-Specific Criteria****Children – 1 Year through 9 Years**

In addition to the documentation that candidates meet the above listed general criteria, the requestor shall provide documentation that the recipient:

- Has a profound-to-total bilateral sensorineural hearing loss which is a pure tone average of 1,000, 2,000, and 4,000Hz of 90dB HL or greater;
- Had appropriate tests administered and no significant benefit from a hearing aid was obtained in the best aided conditions measured by age appropriate speech perception materials; and
- Had no responses obtained to Auditory Brainstem Response, otoacoustic emission testing, or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation.

Children – 10 Years through 17 Years

In addition to the documentation that candidates meet the above listed general criteria, the requestor shall provide documentation that the recipient:

- Has a profound-to-total bilateral sensorineural hearing loss which is a pure tone average of 1,000, 2,000, and 4,000Hz of 90dB HL or greater;
- Had appropriate tests administered and no significant benefit from a hearing aid was obtained in the best aided condition as measured by age and language appropriate speech perception materials;
- Had no responses obtained to Auditory Brainstem Response, otoacoustic emission testing, or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation;
- Has received consistent exposure to effective auditory or phonological stimulation in conjunction with the oral method of education and auditory training;
- Utilizes spoken language as the primary mode of communication through one of the following: an oral/aural (re) habilitation program or total communications educational program with significant oral/aural; and

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 7**

- Has at least six months experience with a hearing aid or vibrotactile device except in the case of meningitis (in which case the six month period will be reduced to three months).

Adults – 18 Years through 20 Years

In addition to the documentation that candidates meet general criteria, the requestor shall provide documentation that the recipient:

- Is post linguistically deafened with severe to profound bilateral sensorineural hearing loss which is pure tone average of 1000, 2000, and 4000 Hz of 90dB HL or greater;
- Has obtained no significant benefit from a hearing aid obtained in the best aided condition for speech/sentence recognition material;
- Had no responses obtained to Auditory Brainstem Response, otoacoustic emission testing, or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation;
- Has received consistent exposure to effective auditory or phonological stimulation or auditory communication;
- Utilizes spoken language as his primary mode of communication through either an oral/aural (re)habilitation program or a total communications educational program with significant oral/aural training; and
- Has at least 6 months experience with hearing aids or vibrotactile device except in the case of meningitis in which case 3 months experience will be required.

NOTE: For the child who is multi-handicapped, Louisiana Medicaid utilizes criteria appropriate for the child's age.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 7****Prior Authorization**

A prior authorization (PA) request must be submitted by the implant team with results of all pre-operative testing (audiogram, tympanogram, acoustic reflexes, auditory brainstem response, otoacoustic emission, speech and language evaluation, social/psychological evaluation, medical evaluation and other pertinent testing/evaluations) to the fiscal intermediary's PA Unit. (See Prior Authorization section for additional information)

The implant team is a multidisciplinary team comprised with a minimum of the following members:

- Physician/otologist;
- Audiologist;
- Speech/language pathologist;
- Psychiatrist; and
- Educator of the deaf (with experience in oral/auditory instruction).

Ongoing speech, language and hearing therapy services for cochlear implant recipients require prior authorization. (See Billing for Subsequent Speech, Language, and Hearing Therapy section)

Covered Expenses

The following expenses related to the maintenance of each cochlear device will be covered if prior authorized:

- All costs for upgrades and repairs to the component parts of the device; and
- All costs for cords and batteries.

Non-covered Expenses

The following items are the **responsibility of the recipient or his/her family or caregiver(s)**:

- Service contracts and/or extended warranties; and
- Insurance to protect against loss and theft.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 7****Billing for the Device(s)**

Reimbursement will be made to the hospital for both the device 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)

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

Billing for the Implantation

The cochlear device implantation must also be prior authorized.

The surgeon shall submit a Request for Prior Authorization (PA-01 Form) as part of the implant team's packet to the fiscal intermediary's PA Unit requesting approval to perform the surgery.

After approval and implantation, electronic or CMS 1500 claim submission of the appropriate billing 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 physicians' fee maximum is found on the Provider Fee Schedule. (See Appendix A for information on how to access the fee schedule) The assistant surgeon's claim form 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.

Billing for the Preoperative Speech and Language Evaluation

The preoperative speech and language evaluation must be prior authorized. The audiologist shall submit a PA-01 Form requesting approval as part of the implant team's packet. After approval has been given and services provided, the audiologist shall bill the appropriate procedure code for the evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status on a CMS-1500 claim form or electronically to receive reimbursement for the evaluation. This service is reimbursable for cochlear implant candidates although the individual may not subsequently receive an implant.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 7****Billing for the Postoperative Rehabilitative Costs**

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

Billing for Subsequent Speech, Language, and Hearing Therapy

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

Billing for Speech Processor Repairs, Batteries, Headset Cords, Etc.

All durable medical equipment associated with the maintenance of each cochlear device such as the speech processor and/or microphone repairs, headset cords, headset replacements and batteries must be prior authorized and must be made on the PA-01 Form to the fiscal intermediary's PA Unit as identified in Appendix A.

Louisiana Medicaid anticipates, on the average, processors need repairing every 2.5 years and that headset cords need to be replaced from 2-4 times per year. Batteries require replacement every 10-12 months.

When billing hard copy, providers should submit the applicable Healthcare Common Procedure Coding System (HCPCS) code on a CMS-1500 claim form with the letters "DME" written in red on the top of the form. The PA number must be written in Item 23 in order for payment to be made.

Replacement of the External Speech Processor

The Louisiana Medicaid Program will consider replacing the external speech processor only if one of the following occurs:

- The recipient loses his/her processor;
- The processor is stolen; or
- The processor was irreparably damaged.

An upgrade to the speech processor because of cosmetic or technological advances in the hardware shall not qualify as a reason for replacement.

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PA for replacement of the external speech processor must be obtained when/if replacement becomes necessary.

The multidisciplinary team shall initiate a new request for approval and shall submit the following information with its request for replacement:

- A copy of the PA initial approval letter for the implant; and
- Documentation explaining the reason a new processor is needed.

Billing for Replacement of the External Speech Processor

The claim for this component must be billed by submitting the appropriate HCPCS code on a CMS-1500 claim form with the letters “DME” written in red on the top. The PA number must be written in Item 23.

Billing for Re-performance of the Implantation Surgery

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

Documentation explaining the reason the initial implant surgery has to be repeated and the request for re-performance should be submitted simultaneously to the PA Unit 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 *Current Procedural Terminology* (CPT) code(s) for this service.

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Concurrent Care - Inpatient

Inpatient concurrent care is the provision of services by more than one physician to the same recipient on the same day. Concurrent care services are necessary when a recipient's condition and or diagnosis (es) require the services of more than one physician to assure the recipient receives the appropriate standard of treatment. In all cases, concurrent care must be medically necessary, unduplicative, and reasonable.

In order to qualify for concurrent care, the recipient must:

- Have a condition(s) or a diagnosis(es) which requires the services of a physician(s) whose specialty/subspecialty is different from that of the primary care physician in the majority of cases, and
- Have a condition of such severity and/or complexity that the medical community would consider the rendering of concurrent care to be reasonable and warranted and upheld by peer review.

Recipients 21 years of age and older are allowed up to three medically necessary inpatient hospital service visits per day from providers of different specialties/subspecialties. Reimbursement is allowed for only one provider per specialty/subspecialty with a maximum of three paid visits per day per recipient for all providers.

General guidelines:

- Concurrent care for simple outpatient surgical procedures and uncomplicated diagnoses is not covered.
- The recipient's hospital record must be available for review, should it be necessary to substantiate the need for concurrent care.
- If the surgeon's role is assumed by a provider, the global surgery period policy (GSP) and pre and post-op editing supersedes this policy.
- Providers should bill the appropriate subsequent hospital care code when rendering these services in the hospital settings. Only one service from the current CPT listing of 'initial hospital care' procedure code range can be reimbursed per **inpatient stay** to the "admitting" provider. For initial inpatient encounters by physicians other than the admitting physician, subsequent hospital care codes or inpatient consultation codes, if appropriate, are to be used.

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- Only one inpatient hospital care service or inpatient consultation is allowed per day by each concurrent care provider as described above. If a recipient must be seen by the same provider more than once daily, the level of code billed for that date should reflect all the services rendered that day.
- Hospital discharge services are included in the three inpatient visit limit per day. An attending provider cannot be reimbursed for an inpatient service and a hospital discharge service on the same date of service. Only one provider shall be reimbursed for the hospital discharge service per inpatient stay.

NOTE: Concurrent care policy does not apply to state-funded foster children.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****Consultations**

A consultation is a type of evaluation and management (E/M) service provided by a physician at the request of another physician to either recommend care for a specific condition or to determine whether to accept responsibility for ongoing management of the recipient's entire care or the care of a specific condition.

Providers should refer to Section 5.1 – Concurrent Care – Inpatient in for applicable policy.

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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 recipient and date of service.

Critical care services are a physician's direct delivery of medical care for a critically ill or critically injured recipient. 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 recipient's condition.

The duration of critical care services is based on the physician's documentation in the recipient'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 physician must devote full attention to the recipient, and therefore, cannot provide services to any other patient during the same period of time. The time may be spent at the recipient's immediate bedside or elsewhere on the unit, as long as the physician is immediately available to the recipient.

If the minimum total time requirement is not satisfied, then another appropriate evaluation and management (E/M) code should 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 recipient who is not critically ill but is in the critical care area should be reported using other appropriate E/M codes.

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.

Should nationally approved changes occur to CPT codes at a future date that relate to critical care services, providers are to follow the most accurate coding available for the particular date of service, unless directed otherwise.

Claims for critical care services are to be submitted hard copy. These claims pend for medical review and must have notes attached indicating the necessity for critical care. If notes are not submitted or the submitted notes do not substantiate medical necessity, the claim may deny. If critical care is not justified, the provider may bill an appropriate E/M service that represents the services provided.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 6****Diabetes Education Management Training**

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

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

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

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

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

Provider Qualifications

Providers of DSMT services must be:

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

Providers must be enrolled 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 of the required criteria. **DSMT is not a separately recognized provider type**; therefore, Louisiana Medicaid will not enroll a person or entity for the sole purpose of performing DSMT.

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

Accreditation

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

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

Services provided by a program without accreditation 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.

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

All DSMT programs must adhere to the National Standards for Diabetes Self-Management Education.

Coverage Requirements

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

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

- A **maximum** of 10 hours of initial training (1 hour of individual and 9 hours of group sessions) are allowed during the first 12 month period beginning with the initial training date
- A **maximum** of 2 hours of individual sessions are allowed for each subsequent year

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

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

Recipients enrolled in BAYOU HEALTH will receive DSMT through their health plan.

Medicaid Recipients Not Eligible for DSMT

The following recipients are not eligible for DSMT:

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

Initial DSMT

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 recipient 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 2-20 recipients.

Follow-Up DSMT

After receiving 10 hours of initial training, a recipient is eligible to receive a maximum of two hours of follow-up training each year, if ordered by the primary care provider.

Follow-up training is based on a **12-month calendar year following completion of the initial training**. If a recipient completes 10 hours of initial training, the recipient would be eligible for two hours of follow-up training for the next **calendar year**. If all 10 hours of initial training are not used within the first calendar year, then the recipient has 12 months to complete the initial training prior to follow up training.

- Example #1:

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

- Example #2:

A recipient receives his first training in February 2011 and exhausts all 10 hours of initial training by November 2011. He would be eligible for two hours of subsequent training beginning January 2012. If the recipient completes the two

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subsequent hours of training by May 2012, then he is not eligible for additional training until January 2013.

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

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

Provider Responsibilities

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

- **The recipient meets one of the following requirements:**
 - Is a newly diagnosed diabetic, gestational diabetic, pregnant with a history of diabetes, or has received no previous diabetes education,
 - Demonstrates poor glycemic control ($A1c > 7$),
 - Has documentation of an acute episode of severe hypoglycemia hyperglycemia occurring in the past 12 months, or
 - Has received a diagnosis of a complication, a diagnosis of a co-morbidity, or prescription for new equipment such as an insulin pump.
- **The provider maintains the following documentation requirements:**
 - A copy of the order for DSMT from the recipient's primary care provider
 - A comprehensive plan of care documented in the medical record
 - Start and stop time of services
 - Clinical notes, documenting recipient progress
 - Original and ongoing pertinent lab work
 - Individual education plan
 - Assessment of the individual's education needs
 - Evaluation of achievement of self-management goals
 - Proof of correspondence with the ordering provider regarding the recipient's progress
 - All other pertinent documentation

Recipient records, facility accreditation, and proof of staff licensure, certification, and educational requirements must be kept readily available to be furnished, as requested, to

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

Reimbursement

Reimbursement for DSMT services is a flat fee based on the 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 should be billed for DSMT services:

- G0108 – Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109 – Diabetes self-management training services, group session (2 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 allowed to be billed with HR942.

Reimbursable DSMT services for FQHCs/RHCs are included in the all inclusive encounter; therefore, separate encounters for these services are not allowed and the delivery of DSMT services alone does not constitute an encounter visit.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 8****Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**

Medicaid recipients under 21 years of age are entitled to receive **all medically necessary health care, diagnostic services, treatment and other measures covered by Medicaid to correct or improve physical or mental conditions**. Services may include those not covered by Medicaid for recipients over the age of 21.

Screening

Medicaid recipients are eligible for checkups which are referred to as "EPSDT screens". Recipient screening includes medical, vision, hearing and dental screenings.

Medical Screening

Components of the EPSDT medical screenings include the following:

- A comprehensive health and developmental history (including assessment of both physical and mental health and development),
- A comprehensive unclothed physical exam or assessment,
- Appropriate immunizations according to age and health history (unless medically contraindicated or parents/guardians refuse at the time),
- Laboratory tests (including appropriate neonatal, iron deficiency anemia, and blood lead screening), and
- Health education (including anticipatory guidance).

NOTE: All components, including specimen collection, must be provided on-site during the same medical screening visit.

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.

Neonatal/Newborn Screenings

Newborn screening (via heel stick) includes testing for 28 conditions recommended by the American College of Medical Genetics (ACMG). Louisiana Revised Statute 40:1299.1-3 requires hospitals with delivery units to screen all newborns before discharge regardless of the

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newborn's length of stay at the hospital. The Louisiana Administrative Code Title 48, Part V, Subpart 19, 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 the Office of Public Health (OPH) Genetics 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 should 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 28 specified conditions, and a private laboratory is used, the provider must immediately notify the Louisiana OPH Genetics Disease Program.

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 medical screening and must include the history of any:

- Eye disorders of the child or the child's family,
- Systemic diseases of the child or the child's family which involves the eyes or affects vision,
- Behavior on the part of the child that may indicate the presence or risk of eye problems, and
- Medical treatment for any eye condition.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 8****Objective Vision Screening**

Objective vision screenings may be performed by trained office staff under the supervision of a licensed Medicaid physician, physician assistant, registered nurse, or optometrist. The interpretive conference to discuss findings from the screenings must be performed by a licensed physician, physician assistant, or registered nurse.

Objective vision screenings begin at age three. The objective vision screening must include tests of:

- Visual acuity (Snellen Test or Allen Cards for preschoolers and equivalent tests such as Titmus, HOTV or Good Light, or Keystone Telebinocular for older children),
- Color perception (must be performed at least once after the child reaches the age of six using polychromatic plates by Ishihara, Stilling, or Hardy-Rand-Ritter), and
- Muscle balance (including convergence, eye alignment, tracking, and a cover-uncover test).

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 medical screening and must include the history of:

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

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 8****Objective Hearing Screening**

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

Objective hearing screenings begin at age four. The objective hearing screening must test at 1000, 2000, and 4000 Hz at 20 decibels for each ear using the puretone audiometer, Welsh Allyn audioscope, or other approved instrument.

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)

Immunizations

Appropriate immunizations (unless medically contraindicated or the parents/guardians refuse) are a federally required medical screening component, and failure to comply with or properly document the immunization requirement constitutes an incomplete screening and is subject to recoupment of the total medical screening fee. The current Childhood Immunization Schedule recommended by Advisory Committee on Immunizations Practices (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP), which is updated yearly, should be followed. Providers are responsible for obtaining current copies of the schedule.

Laboratory

Age-appropriate laboratory tests are required at selected age intervals. Specimen collection must be performed in-house at the medical screening visit. A child cannot be sent to an outside laboratory to have blood drawn. Documented laboratory procedures provided less than six months prior to the medical screening should not be repeated unless medically necessary. **Iron deficiency anemia screening when required is included in the medical screening fee and CANNOT be billed separately.**

Providers should not bill Medicaid for lab services not performed in their own office.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 8****Screening Periodicity Policy**

Screening services should be provided according to the periodicity schedule. (See Appendix A for information on obtaining the periodicity schedule) Initial screenings must be scheduled within the following time limits:

- Newborns – immediately
- Children one month to three years of age – within 45 days
- Children three to six years of age – within 60 days
- Children six to 21 years of age – within 120 days

Periodicity Restrictions

Screenings must be performed on time at the ages shown on the periodicity schedule. A screening that is due when the child is six months old must be performed after the child has reached the age of six months, but before the seven-month birthday. A screening scheduled for three years of age must be performed between the child's third and fourth birthdays.

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. Claims submitted for periodic screenings performed at an inappropriate time will not be paid.

Off-Schedule Screenings

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. However, all screenings on children who are under two years of age must be at least 30 days apart, and those on children age two through six years of age must be at least six months apart.

A medically necessary preventive/well-child screening performed that does not meet this minimum number of calendar days/months between screenings should be billed as an interperiodic screening.

Interperiodic Screenings

Interperiodic screenings may be performed if medically necessary. The parent/guardian or any medical provider or qualified health, developmental, or education professional that comes into contact with the child outside the formal health care system may request the interperiodic screening.

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An interperiodic screening can only be billed if the recipient has received an age-appropriate medical screening. If the medical screening has not been performed, then the provider should bill an age-appropriate medical screening.

An interperiodic screening includes a complete unclothed exam or assessment, health and history update, measurements, immunizations, health education and other age-appropriate procedures.

An interperiodic screening 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 periodic screening.

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 in the recipient's records:

- Who requested the interperiodic screening,
- Why the screening was requested (the concern, symptoms or condition that led to the request), and
- 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 should be billed separately. **A well diagnosis is not required.**

Diagnosis and Treatment

Screening services are performed to assure that health problems are found, diagnosed, and treated early before becoming more serious and treatment more costly. 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, or hearing 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.

An infant or toddler who meets or may meet the medical or biological eligibility criteria for Early Steps (infant and toddler early intervention services) must be referred to the local System

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Point of Entry (SPOE) within two working days of the screening. (See Appendix A for contact information for the Early Steps 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.

Providing or Referring Recipients for Services

Providers detecting a health or mental health problem in a screening must either provide the services indicated or refer the recipient 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 recipients receive the necessary services within 60 days of the screening.

Providers who refer the recipient for care should make the necessary referrals at the time of screening. Referrals should not be limited to those services covered by Medicaid. Providers should 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 should forward the necessary medical information and request a report of the exam results or services provided by the “referred-to” provider. This information should be maintained in the recipient’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 recipients six months through five years of age. Providers eligible for reimbursement of this service include physicians, physician assistants and nurse practitioners 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)

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

- Appropriate dental providers,
- Physicians,
- Physician assistants,
- Nurse practitioners,
- Registered nurses, or
- Licensed practical nurses.

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)

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).

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3****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:

- Physicians,
- Nurse practitioners,
- Certified nurse-midwives,
- Dentists, and
- 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:

- Services are rendered to the required number of recipients based on the Medicaid recipient volume threshold, and
- 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 recipient volume threshold of 30 percent. This threshold shall be calculated as a ratio where the numerator is the total number of Medicaid recipient encounters with needy individuals treated in any 90-day period in the previous calendar year and the denominator is all recipient encounters over the same period of time.

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Needy individuals shall include:

- Medicaid recipients,
- Children's Health Insurance Program recipients,
- Patients furnished uncompensated care by the provider, and
- 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 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 setting.

Registration

Professional practitioners choosing to participate in the Louisiana Medicaid EHR incentive payment program must first register with CMS and then begin 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 which professional practitioners find necessary 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 state fiscal year (SFY) 2011 and ends in SFY 2021. The last state fiscal year a Medicaid provider can begin the program is SFY 2016.

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Payments are based on a calendar year and may total up to \$63,750 over six years of participation. A provider would have 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 recipient 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 his/her services in a hospital setting. This includes services furnished on an inpatient or outpatient basis and in an emergency room 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 Provider Enrollment Unit. (See Appendix A for contact information)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****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.

The fiscal intermediary's Provider Relations Unit should be contacted for direct inquiries regarding the performance or billing of ESRD services. (See Appendix A for contact information)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3****Exclusions and Limitations**

Physicians and all other professionals must abide by the professional guidelines set forth by their certifying and licensing agencies in addition to complying with Louisiana Medicaid regulations.

In general, services that are not approved by the Food and Drug Administration or services that are experimental, investigational, or cosmetic are excluded from Medicaid coverage and will be deemed not medically necessary.

The following includes a non-exhaustive list of services excluded or limited by Louisiana Medicaid, which often generate clarifying inquiries from participating providers:

- **Aborted Surgical Procedures**

Medicaid will not pay professional, operating room, or anesthesia charges for an aborted surgical procedure, regardless of the reason.

- **Billing for Services Not Provided/Not Documented**

Providers shall not bill Medicaid or the recipient 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.

- **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 recipient. Reimbursement will not be provided when the following “never events” occur:

- The wrong surgical procedure is performed on a recipient;
- The surgical or invasive procedures are performed on the wrong body part; or
- The surgical or invasive procedures are performed on the wrong recipient.

- **Billing for 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.

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- **Billing and Reimbursement for Federally Qualified Health Centers and Rural Health Centers**

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are reimbursed for Medicaid covered services under an all-inclusive Prospective Payment System (PPS) as specified under Section 1902(bb) of the Social Security Act.

Payments specified at the PPS rates are all inclusive of professional charges and must be billed by the facilities' provider ID and Tax Identification Number (TIN).

NOTE: Professional services performed in an FQHC or RHC will be subject to recoupment if billed under a physician/practitioner's individual Medicaid number.

- **Infertility**

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.

- **“New Patient” Evaluation and Management Codes**

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 or another physician of the same specialty, 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)

- **Pain Management**

Louisiana Medicaid covers the epidural injection of an anesthetic substance for the prevention or control of acute pain such as that which occurs during delivery or surgery. Billing of these procedures subsequently for pain management, pain control, or any other reason is not covered. Medicaid does not cover spinal injections to alleviate chronic, intractable pain.

Louisiana Medicaid does not cover any services for chronic pain management.

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- **Outpatient Visit Service**

Louisiana Medicaid covers outpatient visit service when the service is medically necessary and has no limit. Recipients under 21 years of age are not subject to program limitations.

Professional services provided in emergency rooms, outpatient hospital clinics, physician's offices, Federally Qualified Health Centers (FQHC's) and Rural Health Centers (RHC's) are not subject to visit limits when medically necessary. All visits and services provided must be medically necessary but do not require prior authorization for reimbursement. Nursing home and skilled nursing facility visits should be billed with the appropriate place of service and not as inpatient hospitals.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****Eye Care and Vision Services**

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

- Vision services,
- Eyeglasses and contact lens, and
- Required prior authorization.

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

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Family Planning Waiver (TAKE CHARGE)

Louisiana Medicaid operates a limited benefits family planning waiver program called TAKE CHARGE. The TAKE CHARGE Waiver targets females between the ages of 19 – 44 who do not meet regular Medicaid criteria but have family incomes up to 200% of the federal poverty level (FPL).

Recipient Eligibility

TAKE CHARGE Waiver recipients **DO NOT** have regular Medicaid benefits. Only the following limited benefits are available to recipients of the TAKE CHARGE Waiver:

- Yearly physical examinations and necessary re-visits,
- Family planning laboratory tests,
- Family planning prescriptions and supplies (such as birth control pills, condoms, intrauterine devices (IUDs), diaphragms, etc.), and
- Some voluntary sterilization procedures.

A **limit of four** visits per calendar year (including initial visit and re-visits) for physical examinations or necessary re-visits as it relates to family planning and birth control has been established on services rendered by a physician, nurse practitioner, or physician assistant.

NOTE: It is important that providers **verify eligibility and coverage limitations** for TAKE CHARGE Waiver services **on the date of service** on all Medicaid recipients through the Medicaid Eligibility Verification System or the Recipient Eligibility Verification System. (See Appendix A for information on how to access these verification systems)

If a recipient becomes eligible for regular Medicaid benefits and enrolls in Medicaid during or after enrolling in the TAKE CHARGE Waiver, the number of annual visits utilized in the TAKE CHARGE Waiver will not be counted against the number of annual Medicaid visits.

Participating Providers

Any of the following enrolled Medicaid provider(s) whose scope of practice permits the delivery of family planning services is eligible to provide covered services through the TAKE CHARGE Waiver:

- Physicians,

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- Rural Health Clinics,
- Hospitals,
- Federally Qualified Health Centers,
- American Indians “638” Clinics,
- Pharmacies,
- Family Planning Clinics,
- Nurse Practitioners, and
- Physician Assistants.

Diagnosis Procedure/Revenue Codes

The primary purpose of the visit must be family planning for the provider to receive reimbursement. Claims for TAKE CHARGE Waiver recipients must have a primary diagnosis code from the approved V25 family planning series. The codes approved for use under this waiver are available in Chapter 21 of the Medicaid Services Manual, Family Planning Waiver (TAKE CHARGE). (See Appendix A for information on how to access this manual chapter)

Pharmaceutical Policy for TAKE CHARGE

The family planning waiver outpatient pharmacy benefits include the following:

- Birth control pills,
- Condoms,
- IUDs, and
- Diaphragms and spermicide as covered in the Medicaid program.

NOTE: Refer to Chapter 21 of the Medicaid Services Manual, Family Planning Waiver (TAKE CHARGE) for specific information related to this program.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5****Genetic Testing for Breast and Ovarian Cancer**

BRCA1 and BRCA2 are human genes that produce tumor suppressor proteins. Louisiana Medicaid considers genetic testing for BRCA1 and BRCA2 mutations in cancer-affected individuals and cancer-unaffected individuals to be medically necessary if the recipient meets the following published criteria. Prior authorization is required through the fiscal intermediary's Prior Authorization Unit (PAU).

Eligibility Criteria**Patients with Cancer Diagnosis**

Genetic testing for BRCA1 and BRCA2 mutations in cancer-affected individuals may be medically necessary under any of the following circumstances:

- Individual from a family with a known BRCA1/BRCA2 mutation;
- Personal history of breast cancer and ≥ 1 of the following:
 - Diagnosed age ≤ 45 years;
 - Two primary breast cancers when the first breast cancer diagnosis occurred age ≤ 50 years;
 - Diagnosed age ≤ 50 years AND: ≥ 1 1st-, 2nd-, or 3rd-degree relative with breast cancer at any age;
 - Unknown or limited family history;
 - Diagnosed age ≤ 60 years with a triple negative (ER-, PR-, HER2-) breast cancer;
 - Diagnosed any age AND ≥ 1 1st-, 2nd-, or 3rd-degree relative with breast cancer diagnosed ≤ 50 years;
 - Diagnosed any age AND ≥ 2 1st-, 2nd-, or 3rd-degree relatives with breast cancer at any age;

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- Diagnosed any age AND ≥ 1 1st-, 2nd-, or 3rd-degree relative with epithelial ovarian/fallopian tube/primary peritoneal cancer;
- Diagnosed any age AND ≥ 2 1st-, 2nd-, or 3rd-degree relatives with pancreatic cancer or prostate cancer at any age;
- 1st-, 2nd-, or 3rd-degree male relative with breast cancer; or
- Ethnicity associated with deleterious founder mutations (e.g., Ashkenazi Jewish);
- Personal history of epithelial ovarian/fallopian tube/primary peritoneal cancer;
- Personal history of male breast cancer; or
- Personal history of pancreatic cancer or prostate cancer at any age AND ≥ 2 1st-, 2nd-, or 3rd-degree relatives with any of the following at any age. For pancreatic cancer, if Ashkenazi Jewish ancestry, only one additional affected relative is needed.
 - Breast cancer;
 - Ovarian/fallopian tube/primary peritoneal cancer; or
 - Pancreatic or prostate cancer.

Patients without cancer (Testing unaffected individuals)

Genetic testing for BRCA1 and BRCA2 mutations of cancer-unaffected individuals may be considered medically necessary under any of the following circumstances:

- Individual from a family with a known BRCA1/BRCA2 mutation;
- 1st- or 2nd-degree blood relative meeting any criterion listed above for patients with cancer; or
- 3rd-degree blood relative with breast cancer and/or ovarian/fallopian tube/primary peritoneal cancer AND ≥ 2 1st-, 2nd-, or 3rd-degree relatives with breast cancer.

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For the purpose of familial assessment, 1st-, 2nd-, and 3rd-degree relatives are blood relatives on the same side of the family (maternal or paternal):

- 1st-degree relatives are parents, siblings, and children;
- 2nd-degree relatives are grandparents, aunts, uncles, nieces, nephews, grandchildren, and half siblings; or
- 3rd-degree relatives are great-grandparents, great-aunts, great-uncles, great grandchildren and first cousins.

For the purpose of familial assessment, prostate cancer is defined as Gleason score ≥ 7 . Testing for Ashkenazi Jewish or other founder mutation(s) should be performed first (see guidelines: High risk ethnic groups).

NOTE: Generally, genetic testing for a particular disease should 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).

When Genetic Testing for Breast and Ovarian Cancer is not covered

Unless the above criteria is met, genetic testing either for those affected by breast, ovarian, fallopian tube, or primary peritoneal cancer or for unaffected individuals, including those with a family history of pancreatic cancer, is considered ‘investigational’.

Genetic testing in minors for BRCA1 and BRCA2 mutations is considered investigational.

High-risk ethnic groups

Testing in eligible individuals who belong to ethnic populations in which there are well-characterized founder mutations should begin with tests specifically for these mutations. For example, founder mutations account for approximately three quarters of the BRCA mutations found in Ashkenazi Jewish populations. When the testing for founder mutations is negative, comprehensive mutation analysis should then be performed.

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In unaffected family members of potential BRCA mutation families, most test results will be negative and uninformative. Therefore, it is strongly recommended that an affected family member be tested first whenever possible to adequately interpret the test. Should a BRCA mutation be found in an affected family member(s), DNA from the unaffected family member can be tested specifically for the same mutation of the affected family member without having to sequence the entire gene. Interpreting the test results for an unaffected family member without knowing the genetic status of the family may be possible in the case of a positive result for an established disease-associated mutation, but leads to difficulties in interpreting negative test results (uninformative negative) or mutations of uncertain significance because the possibility of a causative BRCA mutation is not ruled out.

Prostate cancer

Recipients with BRCA mutations have an increased risk of prostate cancer, and patients with known BRCA mutations may therefore consider more aggressive screening approaches for prostate cancer. However, the presence of prostate cancer in an individual, or in a family, is not itself felt to be sufficient justification for BRCA testing.

Prior Authorization

BRAC1 and BRCA2 testing must be prior approved by the fiscal intermediary's PAU or the managed care organization (MCO). Prior authorization (PA) requests should include the following:

- PA request form;
- Documentation of medical necessity; and
- Other pertinent clinical information that may be requested.

Clinical information must be submitted by the provider involved in the recipient's care.

The documentation required for PA requests to the MCO shall be determined by the MCO. Managed care organizations will utilize the criteria they deem appropriate for BRCA1 and BRCA2 testing based upon the clinical information submitted by the provider involved in the recipient's care.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5****Reimbursement**

BRAC1 and BRCA2 testing are reimbursed for *Current Procedural Terminology* (CPT) codes currently approved for cancer-affected individuals and cancer- unaffected individuals. Information regarding the fee Schedule to be used for BRCA1 and BRCA2 testing can be obtained on the [Louisiana Medicaid website](#) following the links under “Fee Schedule,” “Professional Services Fee Schedule,” “Laboratory and Radiology”.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****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:

- Major procedures with a 90-day global surgery period.
- Minor procedures with a 10-day global surgery period.
- 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.

Providers may view the National Physician Fee Schedule and the specific global surgery period for each procedure code on the CMS website. (See Appendix A for website information)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 4****Gynecology**

Gynecologic services include:

- Contraceptive implants
- Intrauterine contraceptive system
- Pap smears
- Pelvic examinations
- Hysterectomies, and
- Screening mammographies

Limitations may apply and services provisions must conform to the policy detailed below.

Contraceptive Implants

Louisiana Medicaid reimburses for the insertion and removal of the Etonogestrel implant.

Clinically trained providers must obtain the contraceptive implant (one per recipient per three years) from a specialty pharmacy authorized by the manufacturer.

NOTE: The physician will not be reimbursed by Medicaid for the implant as the implant is reimbursed as a pharmacy benefit.

Provider claims for the insertion, removal, or removal with reinsertion of the implant are to be submitted using the appropriate *Current Procedural Terminology* (CPT) codes and diagnosis codes (V25.5, V25.43, or V45.52) or the equivalent. If nationally approved changes occur to diagnosis or CPT codes relating to this implant, providers are to use the most accurate coding available for the particular date of service.

Claims submitted for this contraceptive implant and its insertion in excess of the manufacturer's recommended guidelines are subject to review and action by Louisiana Medicaid.

Documentation in the physician's recipient record is to include evidence of appropriate recipient education regarding this long-acting contraceptive, as detailed in the prescribing literature.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 4****Intrauterine Contraceptive System**

Louisiana Medicaid reimburses for the insertion and the Levonorgestrel releasing intrauterine system (20 mcg/day) implant. Providers are to submit the appropriate insertion and implant procedure codes.

Federal statutes require provider filing of the National Drug Code (NDC) on claims for physician administered drugs, as is the case for the Levonorgestrel releasing intrauterine system.

Pap Smears

Collection of the pap smear specimen is included in the reimbursement of the evaluation and management service.

Cytopathologic vaginal smears (Pap smears) may be billed only if the provider billing the service has the necessary laboratory equipment to perform the test in their office.

Pelvic Examinations

Routine pelvic examinations are included in the reimbursement for the evaluation and management service. Therefore, routine pelvic examinations should not be billed as separate procedures.

Pelvic examinations under anesthesia (procedure code 57410) may be medically necessary for certain populations and must be prior authorized. The recipient's medical record must indicate the medical justification for the pelvic examination under anesthesia.

Hysterectomy

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

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

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

- The person securing authorization to perform the hysterectomy has informed the individual and her representative (if any), both orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing, and
- The individual or her 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,” BHSF Form 96-A).

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

Consent for Hysterectomy

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

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

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

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

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

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

Exceptions

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

- The individual was already sterile before the hysterectomy, and the physician who performed the hysterectomy certifies in his own writing that the individual was already sterile at the time of the hysterectomy and states the cause of sterility.
- The individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible, and the physician certifies in his own writing that the hysterectomy was performed under these conditions and includes in his narrative a description of the nature of the emergency.
- The individual was retroactively certified for Medicaid benefits, and the physician who performed the hysterectomy certifies in his own writing that the individual was informed before the operation that the hysterectomy would make her 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 in writing that the hysterectomy was performed under one of those conditions and that the recipient was informed, in advance, of the reproductive consequences of having a hysterectomy.

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

Screening Mammography

Louisiana Medicaid allows payment for one screening mammogram (either film or digital) per calendar year for females at least 40 years of age. Providers should perform the most clinically appropriate method (film or digital) specific to the recipient.

Abortions (See Obstetrics Section)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Hospice**

Hospice care is an alternative treatment based on the recognition of impending death and requires a change from curative treatment to palliative care for the terminally ill recipient and support for the family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, hospice care shall focus on maintaining the terminally ill recipient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

A recipient must be terminally ill in order to receive Louisiana Medicaid funded hospice care. A recipient shall be considered terminally ill when the medical prognosis and life expectancy is six months or less, if the illness runs its normal course.

Election of Hospice Services

An election statement must be filed with a particular hospice provider for the recipient who meets the eligibility requirements of hospice services. The election must be filed by the recipient or by a person authorized by law to consent to medical treatment for the recipient.

Payment of Medical Services Related to the Terminal Illness

Once a recipient elects to receive hospice services, the hospice agency is responsible for either providing or paying for all covered services related to the recipient's terminal illness.

For the duration of hospice care, the recipient waives all rights to Medicaid payments for:

- Hospice care provided by a hospice agency other than the hospice agency designated by the recipient or a person authorized by law to consent to medical treatment for the recipient.
- Any Medicaid services related to the terminal condition for which hospice care was elected OR for a related condition OR Medicaid services that are equivalent to hospice care, except for services provided by:
 - the designated hospice,
 - another hospice under arrangements made by the designated hospice, or
 - the recipient's attending physician if that physician IS NOT an employee of the designated hospice or receiving compensation from the hospice for those services.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Payment for Medical Services Not Related to the Terminal Illness**

Any claim for services submitted by a provider other than the elected hospice agency will be denied if the claim does not have attached justification that the service was medically necessary and WAS NOT related to the terminal condition for which hospice care was elected. If documentation is attached to the claim, the claim will pend for medical review. Documentation may include:

- A statement/letter from the physician confirming the service was not related to the recipient's terminal illness, or
- Documentation of the procedure and diagnosis illustrating why the service was not related to the recipient's terminal illness.

If the information does not justify that the service was medically necessary and unrelated to the terminal condition for which hospice care was elected, the claim will be denied. If review of the claim and attachments justifies the claim for a covered service not related to the terminal condition for which hospice care was elected, the claim will be released for claims processing.

NOTE: If prior authorization or precertification is required for any covered Medicaid service not related to the treatment of the terminal condition, that prior authorization/precertification is required and must be obtained just as in any other case.

Once a claim from a non-hospice provider is denied by the Medical Review staff, resubmitted for reconsideration and denied a second time, the only recourse for appeal of the decision is through the official appeals process. The appeal request must include an explanation of the reason for the request, the claim(s) in question, and supporting documentation. (See Appendix A for information on where to file appeals)

NOTE: Claims for prescription drugs will not be denied but will be subject to post-payment review.

Revocation of Hospice Services

The recipient or his/her representative may revoke the election of hospice care at any time during an election period. The recipient's or the authorized representative's signature is required whenever a recipient revokes hospice.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3****Hyperbaric Oxygen Therapy**

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

Covered Conditions

Reimbursement for HBO therapy is limited to what is administered in a chamber and is also limited to the following conditions:

- Acute carbon monoxide intoxication,
- Decompression illness,
- Gas embolism,
- Gas gangrene,
- Acute traumatic peripheral ischemia. HBO 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,
- Crush injuries and suturing of severed limbs. HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened,
- Progressive necrotizing infections (necrotizing fasciitis),
- Acute peripheral arterial insufficiency,
- Preparation and preservation of compromised skin grafts (not for primary management of wounds),
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management,
- Osteoradionecrosis as an adjunct to conventional treatment,
- Soft tissue radionecrosis as an adjunct to conventional treatment,
- Cyanide poisoning, and

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3**

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

Non-covered Conditions

No reimbursement shall be made for HBO in the treatment of the following conditions:

- Cutaneous, decubitus, and stasis ulcers,
- Chronic peripheral vascular insufficiency,
- Anaerobic septicemia and infection other than clostridial,
- Skin burns (thermal),
- Senility,
- Myocardial infarction,
- Cardiogenic shock,
- Sickle cell anemia,
- Acute thermal and chemical pulmonary damage, i.e. smoke inhalation with pulmonary insufficiency,
- Acute or chronic cerebral vascular insufficiency,
- Hepatic necrosis,
- Aerobic septicemia,
- Nonvascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, Korsakoff's syndrome),
- Tetanus,
- Systemic aerobic infection,

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3**

- Organ transplantation, or
- Organ storage.

Topical Application of Oxygen

This method of administering oxygen does not meet the definition of HBO therapy; therefore, no Louisiana Medicaid reimbursement may be made for the topical application of oxygen.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5****Immunizations****Vaccine Codes**

Providers should refer to the Immunization Fee Schedules to determine covered vaccines and any restriction to the use of the vaccine codes. (See Appendix A for information on how to access the Immunization Fee Schedules)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Immunizations

Combination vaccines are encouraged in order to maximize the opportunity to immunize and to reduce the number of injections a child receives in one day. Louisiana Medicaid does not reimburse providers for a single-antigen vaccine and its administration if a combined-antigen vaccine is medically appropriate and the combined vaccine is approved by the Secretary of the United States Department of Health and Human Services.

Immunization Administration Coding

Providers should refer to the *Current Procedural Terminology* (CPT) code description to determine the appropriate code for the administration of a vaccine.

Reimbursement

Medicaid immunization administration rates cannot exceed the maximum regional charge as determined by the Centers for Medicare and Medicaid Services (CMS). The CMS determined rate is utilized where applicable. Reimbursement rates can be found on the Immunization Fee Schedules located on the Louisiana Medicaid website. (See Appendix A for information on how to access the fee schedule)

Providers must indicate the CPT code for the specific vaccine in addition to the appropriate administration CPT code(s) in order to receive reimbursement for the administration of appropriate immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) in the current immunization schedule. The listing of the vaccine on the claim form is required for federal reporting purposes.

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

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Providers should submit claims with their usual and customary charge for the vaccine for recipients 19 through 20 years of age. These claims will be reimbursed at the fee on file or the billed charges, whichever is lower.

Billing For a Single Administration

Providers should bill CPT immunization administration code(s) (Immunization administration - first injection/first administration/one vaccine) when administering one immunization. The next line on the claim must contain the specific CPT code for the vaccine, with \$0.00 in the "billed charges" column.

Billing for Multiple Administrations

When administering more than one immunization, providers should bill as described for billing for a single administration. The appropriate procedure code(s) (Immunization administration - each additional injection/administration/vaccine) should be listed with the appropriate number of units for the additional vaccines placed in the "units" column. The specific vaccines should then be listed on subsequent lines. The number of specific vaccines listed after CPT codes should match the number of units listed in the "units" column.

Hard Copy Claim Filing for Greater Than Four Immunizations

Providers should 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 should follow the instructions for billing for a single administration. A second CMS-1500 claim form should be used to bill the remaining immunizations as described for billing for multiple administrations.

Coverage of Vaccines for Recipients Age 19 through 20 Years

Providers should submit claims reporting the appropriate immunization administration CPT code along with the specific CPT code and their usual and customary charge for the vaccine administered to recipients 19 through 20 years of age. The claims will be reimbursed at the fee on file or the billed charge, whichever is lower for the vaccine and administration.

Pediatric Flu Vaccine: Special Situations

If a Medicaid provider does not have VFC pediatric influenza vaccine on hand to vaccinate a **high priority VFC Medicaid eligible child**, the provider should not turn away, refer or reschedule the recipient for a later date if vaccine is available from private stock. The provider should use pediatric influenza vaccine from private stock and replace the dose(s) used from private stock with dose(s) from VFC stock when VFC vaccine becomes available.

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If a Medicaid provider does not have VFC pediatric influenza vaccine on hand to vaccinate a **non-high priority or non-high risk** VFC Medicaid eligible recipient, the recipient can:

- Wait for the VFC influenza vaccine to be obtained, or
- If the recipient chooses not to wait for the VFC influenza vaccine to be obtained, and the provider has private stock of the vaccine on hand, only the administration of this vaccine will be reimbursed by Medicaid.

NOTE: If the provider intends to charge the recipient for the vaccine, then prior to the injection the provider should inform the recipient/guardian that the actual vaccine does not come from the VFC program and the recipient will be responsible for the cost of the vaccine. In these situations the provider should obtain signed documentation that the recipient is responsible for payment of the vaccine only.

Louisiana Medicaid utilizes the weekly Remittance Advices and the *Louisiana Medicaid Provider Update* to provide current information regarding availability of vaccines through the VFC program.

Providers should contact the Louisiana Office of Public Health VFC Program for vaccine availability information. (See Appendix A for contact information)

Adult Immunizations

Louisiana Medicaid provides coverage for certain immunizations administered by enrolled Medicaid providers to adult recipients, age 21 or older. Adult immunizations shall be covered for the following diseases:

- Influenza,
- Pneumonia, and
- Human papillomavirus (HPV).

The following immunization guidelines shall be followed:

- Recommendations from the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practice (ACIP) for these vaccines as identified in the current *Recommended Adult Immunization Schedule*. Providers are responsible for obtaining current copies of the schedule as the schedule is updated frequently. (See Appendix A for web address)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5**

- Usual and customary charges shall be used for the billed charges for all claim lines. Louisiana Medicaid reimburses the vaccine administration as well as the specific vaccine(s), as identified in this policy. A fee schedule for Adult Immunizations is available on the Louisiana Medicaid website. (See Appendix A for web address)
- Federally qualified health centers (FQHCs) and rural health clinics (RHCs) should enter the appropriate immunization administration procedure code(s) as well as the vaccine procedure code(s) as encounter detail lines when submitting claims for these services. When billing an FQHC or RHC encounter, minimum requirements as identified in FQHC or RHC program policy must be met.

Billing a Single/First Administration

Providers should bill the appropriate CPT immunization administration code for the first vaccine administration. The next line on the claim must contain the specific CPT code for the vaccine administered.

Only one initial administration CPT code is allowable on the same date of service for the same recipient.

NOTE: Providers should refer to the CPT manual and the Immunization Fee Schedule for appropriate administration codes.

Billing Multiple Administrations

When administering more than one immunization on the same date of service to the same recipient, providers shall bill as described for billing a single/first administration. The appropriate procedure code(s) for additional immunization administrations should then be listed with the appropriate number of units for the additional vaccine(s). The specific CPT code(s) for the additional vaccine(s) administered should be listed on subsequent line(s) following the appropriate administration code. The number of specific vaccines listed after each immunization administration code should match the number of units listed for each administration code.

NOTE: Providers should refer to the CPT manual and the Immunization Fee Schedule for appropriate administration codes.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5****Appropriate Use of CPT Evaluation/Management Codes with Immunization Administrations**

If a significant, separately identifiable medically necessary evaluation/management (E/M) service is performed on the same date of service, an appropriate E/M procedure code may be reported in addition to the vaccine and immunization administration codes. The separately identifiable service must be reflected in the medical record documentation.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****“Incident To” Services**

“Incident to” a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness. “Incident to” services include those provided by aides or nurses, but exclude those provided by an advanced practice registered nurse (APRN) and physician assistant (PA). The physician, under whose provider number a service is billed, must perform or be involved with a portion of the service billed.

Physician involvement may take the form of personal participation in the service or may consist of direct personal supervision coupled with review and approval of the service notes at a future point in time. Direct personal supervision by the physician must be provided when the billed service is performed by auxiliary personnel. Direct personal supervision in an office means the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the service is performed.

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 office suite, the service does **not** meet the requirements of Medicaid “incident to” billing. Instead, the service must be billed using the provider number of the APRN or PA as the rendering provider and must meet the specific coverage requirements of the APRN’s or PA’s scope of practice.

Provider Alert

It would be 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, and/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.

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Injectable Medications

Certain physician administered injections may be covered by the Medicaid Professional Services Program when medically necessary. Providers should refer to the Professional Services Fee Schedule for the most current reimbursement information and coverage details regarding injectable medications. (See Appendix A for information on how to access the fee schedule)

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

The information listed below contains **general guidelines**. Medicaid strongly encourages providers to seek guidance from the Professional Services Fee Schedule for coverage and/or limitations and reimbursement information.

NOTE: 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.

Physicians may write prescriptions for injectable medications covered by the Louisiana Medicaid pharmacy program and have the Medicaid recipient/family member/responsible party bring the prescription to a Medicaid enrolled pharmacy to be filled.

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 could be billed by the provider if a higher level visit had not been submitted for that recipient on that date.

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 charge for administering the injection.

Antibiotic Injections for Recipients under the Age of 21

- For injectable antibiotics supplied and administered by the physician, providers are to use the specific HCPCS code for the antibiotic given.
- When the dosage administered has no HCPCS code assigned, providers must calculate the appropriate number of units to enter in Item 24G of the CMS 1500 claim form or the appropriate loop in the electronic 837P. (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

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administered. Attempts to maximize reimbursement are subject to recoupment and additional sanctions.

17-Alpha Hydroxyprogesterone Caproate

17-alpha hydroxyprogesterone caproate (17P) is reimbursable when substantiated by an appropriate diagnosis and all of the following criteria are met:

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

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5****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:

- Meningitis,
- Encephalitis,
- Dystonia,
- Multiple sclerosis,
- Spastic hemiplegia,
- Infantile cerebral palsy,
- Other specified paralytic syndromes,
- Acute, but ill-defined, cerebrovascular disease,
- Closed fracture of the base of skull,
- Open fracture of base of skull,
- Closed skull fracture,
- Fracture of vertebral column with spinal cord injury,
- Intracranial injury of other and unspecified nature, or
- Spinal cord injury without evidence of spinal bone injury.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5****Criteria for Recipient 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:

- **Inclusive Criteria for Candidates with Spasticity of Cerebral Origin:**
 - There is severe spasticity of cerebral origin with no more than mild athetosis,
 - The injury is older than one year,
 - There has been a drop in Ashworth scale of 1 or more,
 - Spasticity of cerebral origin is resistant to conservative management, or
 - The candidate has a positive response to test dose of ITB.
- **Inclusive Criteria for Candidates with Spasticity of Spinal Cord Origin:**
 - Spasticity of spinal cord origin that is resistant to oral antispasmodics or side effects unacceptable in effective doses,
 - There has been a drop in Ashworth scale of 2 or more, or
 - The candidate has a positive response to test dose of intrathecal baclofen.

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

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

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 5****Exclusive Criteria for Candidates**

Consideration shall not be made if the candidate:

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

Prior Authorization

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 which evaluates the recipient. The multidisciplinary team shall be comprised of the following:

- A neurosurgeon and/or an orthopedic surgeon,
- A physiatrist and/or a neurologist,
- The recipient's attending physician,
- A nurse,

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- A social worker, and
- Allied professionals (physical therapists, occupational therapist, etc.)

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

The multidisciplinary team 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 PA Unit:

- A recent history with documentation of assessments in the following areas:
 - Medical and physical,
 - Neurological,
 - Functional, and
 - Psychosocial.
- Ashworth scores for pre and post administration of the ITB test dose(s).
- Documentation of any other findings regarding the recipient'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 Prior Authorization (PA-01 Form) to the fiscal intermediary's PA Unit as part of the multidisciplinary team's packet. The surgeon must use his/her 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 prior authorization number included in item 23, if billing hard copy. Assistant surgeons, anesthesiologists and non-anesthesiologists-directed Certified Registered Nurse Anesthetists (CRNAs) may receive

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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 prior authorization for it by submitting a PA-01 Form to the fiscal intermediary's PA Unit. The PA-01 Form should be submitted as part of the multidisciplinary team's packet. Hospitals will not be given a PA number for the pump until a prior authorization 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 fiscal intermediary 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 recipient.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 4****Laboratory and Radiology Services**

Only the policy regarding the performance of laboratory and radiology procedures in a physician's office is provided in this chapter.

Physicians may bill for laboratory and radiology services covered by Louisiana Medicaid only if a properly completed OFS Form 24 is included in their Medicaid enrollment file. This form must list all radiology and laboratory equipment and the capabilities of such equipment. Any time an equipment change occurs within the office, a new OFS Form 24 must be completed and sent to the fiscal intermediary's Provider Enrollment Unit. The new information must be on file prior to billing for the services rendered by such equipment. (See Appendix A for the Provider Enrollment Unit's contact information and Appendix B for a copy of the OFS Form 24)

Providers are not to bill Louisiana Medicaid for the full service of radiological/laboratory services that are not performed in their own offices. Tests which are sent to other facilities for processing are not to be billed to Louisiana Medicaid.

Clinical Laboratory Improvement Amendments (CLIA) Certification

CLIA claim edits are applied to all claims for lab services that require CLIA certification. Those claims that do not meet the required criteria will deny.

Claims are edited to ensure payment is not made to:

- Providers who do not have a CLIA certificate;
- Providers rendering services outside the effective dates of the CLIA certificate; and
- Providers submitting 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 Provider Enrollment Unit. (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's (CMS's) Online Survey, Certification and Reporting (OSCAR) process and are sent to Louisiana Medicaid without further provider involvement.

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Providers with regular accreditation, partial accreditation, or registration certificate types are allowed by CLIA to bill for all lab codes. Providers **should not** include their CLIA certification number on claim forms.

Providers with waiver or provider-performed microscopy (PPM) certificate types may be paid for only those waiver and/or PPM codes approved for billing by CMS.

Providers with waiver or provider-performed microscopy (PPM) certificate wishing to bill for codes outside their restricted certificate types shall obtain the appropriate certificate through the Louisiana Medicaid's Health Standards Section.

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

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

Providers are notified of additions and deletions to the CLIA file through the Louisiana Medicaid *Provider Update* and remittance advice messages.

CLIA information can also be obtained using the CLIA link on the Louisiana Medicaid website. (See Appendix A for web address)

Specimen Collection

Physicians collecting specimens during the course 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 service.

Positron Emission Tomography Scans for Oncologic Conditions

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

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Combination Studies PET/Computed Tomography (CT)

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

Prior Authorization

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

- Completed PA request form;
- Documentation of medical necessity includes all of the following:
 - The primary diagnosis name and International Classification of Diseases (ICD) code(s) for the condition requiring PET imaging;
 - All secondary diagnosis name(s) and ICD code(s) pertinent to comorbid condition(s);
 - The most recent medical evaluation, including a summary of the medical history and the last physical exam (clinical information must be submitted by the recipient's treating oncologist);
 - Laboratory and pathology reports pertinent to a diagnosis of malignant neoplasm or carcinoma;
 - Risk factors or comorbid conditions;
 - The patient's treatment plan, including a description of the type and dates of any anti-tumor therapy; and
 - Any additional clinical information that supports the coverage criteria and that is requested by the Prior Authorization Unit.

Billing for Radiology and Laboratory Procedures

Providers must use the most appropriate Healthcare Common Procedure Coding System (HCPCS)/*Current Procedural Terminology* (CPT) code representing the service performed when submitting claims to Louisiana Medicaid. Guidelines indicated in the pertinent CPT manual shall be followed when billing for these services unless otherwise specifically directed in writing by Louisiana Medicaid.

It is the intent of Louisiana Medicaid that no more than the full service for a procedure be reimbursed. **Physicians may not bill for both the professional component and the full service for the same patient for the same service when billing for radiology or laboratory procedures.**

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The physician must own or lease (and have on the premises) the equipment necessary to perform the “technical” aspect of the service when billing Louisiana Medicaid for full service. Payment for full service encompasses both the use of the equipment and the physician’s professional services.

Certain procedures are a combination of a physician component and a technical component. When the physician 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.

Prenatal Lab Panels

The obstetric panel code is payable only once per pregnancy.

A complete urinalysis is payable only once per pregnancy per recipient per billing provider unless substantiated by a diagnosis such as those currently found in the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) category of “Other Diseases of Urinary System” or “Infections of the genitourinary tract in pregnancy”. All lab work must be substantiated by appropriate diagnosis code.

Reimbursement for Laboratory Procedures

Reimbursement for clinical laboratory procedures shall not exceed 100% of the current year’s Medicare allowable. Reimbursement shall be the lower of billed charges or the fee on file, minus the amount that any third party coverage would pay.

Reimbursement for Radiology Services

Reimbursement for radiology services shall be the lower of billed charges or the fee on file, minus the amount that any third party coverage would pay. (See Appendix A for information on how to access the fee schedule)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 4****Medical Review**

The Medical Review Department is responsible for several functions, including 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:

- All attachments should be clear, legible, and easy-to-read copies.
- All operative reports should be dated correctly.
- Specific, appropriate diagnosis codes should be used.
- Requested documentation should be submitted 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.
- All procedures performed under the same anesthesia session should be billed on the same CMS-1500 claim form using correct modifiers and attaching all pertinent documents with the claim.
- 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.
- All reports (i.e. operative, history and physical, etc.) must be submitted 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.

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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% of the fee on file, or the billed charge, whichever is lower.

Multiple Surgical Reductions

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.

ClaimCheck allows the 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 ClaimCheck edits when the system identifies such cases.

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

Multiple Modifiers

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% of the Medicaid allowable fee or 75% of the billed charges, whichever is lowest.

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 hardcopy with 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.

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

Louisiana Medicaid does not reimburse for the diagnosis and/or treatment of infertility.

Fetal Non-stress Test

Fetal non-stress test is payable only in the following instances:

- Post-date/post-maturity pregnancies (after 41 weeks gestation)
- The treating physician has reason to suspect potential fetal problems in a “normal” pregnancy. If so, the diagnosis should reflect this.
- High-risk pregnancies, including but not limited to diabetic patient, toxemia, pre-eclampsia, eclampsia, multiple gestation, and previous intrauterine fetal death.

If the place of service is either inpatient or outpatient hospital, or the billing physician is rendering the “interpretation” only in his/her office, only the professional component modifier should be used.

NOTE: See the Obstetrics section for additional information.

Unlisted Procedures

Claims submitted for unlisted procedure codes are subject to review. Providers should not bill unlisted procedure codes when standard 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 billed. 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.

Reduction Mammoplasty

Reduction mammoplasty must be considered medically necessary. The patient must suffer from severe, intractable, debilitating symptoms not amenable to other therapeutic efforts to relieve distress such as proper supportive appliances, weight reduction, and/or general physical conditioning. The recipient must have exceedingly large breasts in relation to body size, posing a threat to her health.

The recipient must meet the following weight and height criteria before the provider is to submit a request for evaluation and consideration for reduction mammoplasty services. The patient's

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total weight shall not exceed twenty percent of the weight limit established by the following formula.

Height	Pounds
5 feet	100
Each additional inch over 5 ft.	5

For example: A request for reduction mammoplasty services shall not be submitted for consideration for a recipient who is 5 feet tall and who weighs more than 120 pounds (100 pounds plus 20%). A person who is 5 feet one inch tall shall weigh no more than 126 pounds (105 pounds plus 20%) to be considered. A recipient who is 5 feet, 5 inches tall shall weigh no more than 150 pounds (125 pounds plus 20%) to be considered.

Prior Authorization

When the qualifying condition stated above is met, providers may then submit a request for prior authorization for reduction mammoplasty upon which the determination of medical necessity will be made.

The following documentation must accompany the request for the prior authorization of reduction mammoplasty services:

- Posterior photo view of the shoulder straps area;
- Frontal photo of chest with face blocked;
- Lateral photo of chest and;
- Number of grams of breast tissue to be removed from each breast.

Payment Requirements

The pathology report and the Request for Prior Authorization (PA-01 Form) or the PA approval letter must be attached to the claim submitted for payment to the fiscal intermediary. The CMS-1500 claim form cannot be electronically transmitted. The claim will be denied payment if the above requirements are not attached to the claim.

When medically necessary, Louisiana Medicaid reimburses the removal of breast implants.

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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 lab codes	Attach supporting documentation which clearly describes the extent of the service	125% of the fee on file or billed charges whichever is lower
24 Unrelated evaluation and management service by the same physician during the post-op period			Lower of billed charges or fee on file

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Modifier	Use/Example	Special Billing Instructions	Reimbursement
25 Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service	EPSDT medical screening performed on same date of service and suspected condition identified and referred in-house	<p>When a suspected condition identified during a screening visit and diagnosed/treated by the screening provider during the same visit, only lower level E&M appended with modifier 25 allowable; otherwise claim will deny</p> <p>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.</p>	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 x-ray procedures performed by another provider)		Lower of billed charges or 40% of the fee on file
<p>NOTE: Louisiana Medicaid does not reimburse technical component on straight Medicaid claims. Reimbursement is not allowed for both the professional component and full service on the same procedure.</p>			

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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 codes description, RT/LT or -50 shall not be used.	Lower of billed charges or 150% 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% of the fee on file for primary/ 50% 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% of the fee on file
53 Discontinued Procedure	Only for use by Free Standing Birthing Centers (FSBC's) when the recipient is transferred prior to delivery		50% of the FSBC's facility fee or billed charges, whichever is lower

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Modifier	Use/Example	Special Billing Instructions	Reimbursement
54 Surgical Care Only	Surgical procedure performed by physician when another physician provides pre- and/or postoperative management		Lower of billed charges or 70% of the fee on file
55 Postoperative Management Only	Postoperative management only when another physician has performed the surgical procedure		Lower of billed charges or 20% of the fee on file
56 Preoperative Management Only	Preoperative management only when another physician has performed the surgical procedure		Lower of billed charges or 10% 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 Evaluation and management service resulting in the initial decision to perform the surgery			Lower of billed charges or fee on file

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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% 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% 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% 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.			

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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% of the full service physician fee on file.
AS* First Assistant in Surgery: Qualified Phys. Assistant, Nurse Practitioner, Certified Nurse Midwives or Clinical Nurse Specialist			Lower of billed charges or 80% 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 service 98940, 98941		Lower of billed charges or fee on file
GT Telemedicine	Services provided via interactive audio and video telecommunications system	Modifier should be appended to all services provided via telemedicine and be documented in the clinical record at both sites.	Lower of billed charges or 100% of the fee on file

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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% 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% of the fee on file
TH Prenatal Visits	Required to indicate E&M pre-natal services rendered in the MD office. This will also exempt the service from the adult evaluation and management visit limit.		Lower of billed charges or fee for prenatal services
QW Laboratory	Required when billing certain laboratory codes (refer to Laboratory Section of packet)		Lower of billed charges or fee on file

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 8****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 LT (Left side)/RT (Right side) 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	LT*	Left side
E2	Lower left, eyelid	RT*	Right side
E3	Upper right, eyelid	LC	Left circumflex, coronary artery
E4	Lower right, eyelid	RC	Right coronary artery
FA	Left hand, thumb	LD	Left anterior descending coronary artery
F1	Left hand, second digit	TA	Left foot, great toe
F2	Left hand, third digit	T1	Left foot, second digit
F3	Left hand, fourth digit	T2	Left foot, third digit
F4	Left hand, fifth digit	T3	Left foot, fourth digit
F5	Right hand, thumb	T4	Left foot, fifth digit
F6	Right hand, second digit	T5	Right foot, great toe
F7	Right hand, third digit	T6	Right foot, second digit
F8	Right hand, fourth digit	T7	Right foot, third digit
F9	Right hand, fifth 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.**

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Newborn Care and Discharge**

Physician providers billing for initial newborn care should use the appropriate procedure codes for history and examination of normal newborn when the service provided meets the criteria for the initial examination rendered. This procedure is limited to one per lifetime of the recipient.

The procedure code for subsequent hospital care, normal newborn, per day should be billed for each day of normal newborn care rendered subsequent to the date of birth other than the discharge date. Louisiana Medicaid limits this procedure to three per lifetime of the recipient.

Discharge Services

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

When newborns are admitted and discharged from the hospital or birthing room on the same date, use the appropriate code for services rendered within the first 24 hours of the child's life.

Routine Circumcision

Routine circumcision is a non-covered service and billable to the recipient's responsible party. All medically necessary circumcisions continue to be a covered benefit.

Newborn Pre-certification

When normal newborn care procedure codes are billed within the initial two or four days of the mother's approved pre-certification, providers can submit claims without a newborn pre-certification.

However, if the newborn is admitted to the Neonatal Intensive Care Unit (NICU), a pre-certification must be obtained with the baby's Medicaid number. After the pre-certification has been obtained, the physician's claims for these services should be submitted through regular claims processing channels.

If the newborn is not admitted to the NICU, but requires services other than normal newborn care and it is within the initial 2 or 4 days of the mother's approved pre-certification, no pre-certification is required. Claims for these services must be submitted hard copy with appropriate documentation to substantiate the medical necessity for the billing of codes other than normal newborn care. These hard copy claims and documentation must be submitted to the fiscal intermediary's Provider Relations Unit with a cover letter requesting a pre-certification override. (See Appendix A for mailing address.)

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If the newborn is not admitted to the NICU but requires services after the initial two or four days of the mother's pre-certification, a pre-certification must be obtained with the newborn's Medicaid ID number. After the pre-certification has been obtained, claims should be submitted using the provider's normal process.

NOTE: The mother's pre-certification number should never be placed on the newborn's claim.

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Obstetrics

All prenatal outpatient visit evaluation and management (E&M) codes must be modified with TH in order to process correctly. The modifier must be placed in the first position after the *Current Procedural Terminology* (CPT) code.

The TH modifier is not required for observation or inpatient hospital physician services.

Initial Prenatal Visit(s)

Louisiana Medicaid allows two initial prenatal visits per pregnancy (270 days). These two visits cannot be performed by the same attending provider.

Louisiana Medicaid considers the recipient a ‘new patient’ for each pregnancy whether or not the recipient is a new or established patient to the provider/practice. The appropriate level E&M CPT procedure code from the range of codes for new patient “Office or Other Outpatient Services” shall be billed for the initial prenatal visit with the TH modifier. A pregnancy-related diagnosis code must also be used on the claim form as either the primary or secondary diagnosis.

Reimbursement for the initial prenatal visit, **which must be modified with TH**, includes, but is not limited to the following:

- 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. Also, see the ultrasound policy below.);
- Identification of patient at risk for complications including those with prior preterm birth;
- Health and nutrition counseling; and
- Routine dipstick urinalysis.

If the pregnancy is not verified, or if the pregnancy test is negative, the service can only be billed at the appropriate level E&M service 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 in the “Office or Other Outpatient Services” may be billed for the subsequent prenatal visit(s). The E&M CPT code for each of these visits **must be modified with –TH**.

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

- The obstetrical (OB) examination,
- Routine fetal monitoring (excluding fetal non-stress testing),
- Diagnosis and treatment of conditions both related and unrelated to the pregnancy, and
- Routine dipstick urinalysis.

Treatment for conditions such as minor vaginal problems and routine primary care issues, including infections, sinusitis, etc., is considered an essential part of maternal care during pregnancy.

Delivery Codes

The most appropriate “delivery only” CPT code should be billed. Delivery codes inclusive of the antepartum care and/or postpartum visit are not covered.

In cases of multiple births (twins, triplets, etc.), providers must submit claims hardcopy. The diagnosis code must indicate a multiple birth and delivery records should be attached. A -22 modifier for unusual circumstances should 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 should bill 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.

Postpartum Care Visit

The postpartum care CPT code (which should NOT be modified with –TH) should 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:

- Physical examination,
- Body mass index (BMI) assessment and blood pressure check,

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- Routine dipstick urinalysis,
- Follow up plan for women with gestational diabetes,
- Family planning counseling,
- Breast feeding support including referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), if needed,
- Screening for postpartum depression and intimate partner violence, and
- Other counseling and or services associated with releasing a patient from obstetrical care.

Laboratory Services

One laboratory “Obstetric Panel” is reimbursable per pregnancy. See current CPT manual for the appropriate procedure code for the “Obstetric Panel”.

A complete urinalysis is reimbursable only once per pregnancy (270 days) per billing provider unless medically necessary and the primary diagnosis for the additional urinalysis supports a disease or infection of the genitourinary (GU) tract.

Ultrasounds

Two medically necessary ultrasounds shall be allowed per pregnancy (270 days). This includes OB ultrasounds performed by all providers regardless of place of treatment. Obstetrical providers shall utilize the obstetrical ultrasound section of CPT.

Louisiana Medicaid anticipates that two medically necessary ultrasounds will have been performed by the end of the second trimester of the pregnancy, one for determination of gestational age and one for survey of fetal anatomy. Providers are cautioned not to maximize reimbursement by performing more than the medically necessary number of ultrasounds per pregnancy. Abuse of the ultrasound limit to maximize reimbursement is subject to review and possible recoupment and/or sanctions.

Payment for additional ultrasounds may be considered when medically necessary and must be submitted with the appropriate documentation. Documentation should include evidence of an existing condition or documentation to rule out an expected abnormality.

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If the two ultrasound limit has been exceeded 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.

The recipient's obstetrical provider should forward the information supporting the medical need for additional ultrasounds to the radiologist when recipients are sent to an outpatient facility for the ultrasound.

Reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists. (These are not included in the two per pregnancy limit described previously for the attending OB provider.)

Injections

Refer to the "Injectable Medications" section for more information on 17 Alpha Hydroxyprogesterone Caproate (17-P) and the billing of other injectable medications.

Fetal Testing**Fetal Oxytocin Stress Test**

A fetal oxytocin stress test is payable in an office setting to those professionals who have provided written verification to the fiscal intermediary's Provider Enrollment Unit of their capacity to perform the procedure in their office.

- The full service is payable to physicians only when the service is performed in the office setting. The full service is not payable to physicians if the place of service is in an inpatient or outpatient hospital.
- The "professional component only" aspect of this code is payable to all physicians, regardless of the place of service.

Fetal Non-stress Test

Fetal non-stress test is payable only in the following instances:

- Post-date/post-maturity pregnancies (after 41 weeks gestation).
- The treating physician has reason to suspect potential fetal problems in a "normal" pregnancy. If so, the diagnosis should reflect this.

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- High-risk pregnancies, including but not limited to diabetic patient, toxemia, pre-eclampsia, eclampsia, multiple gestation, and previous intrauterine fetal death. The diagnosis should reflect high risk.

In addition, if the place of service is either in an inpatient or outpatient hospital, or the billing physician is rendering the “interpretation only” in his/her office, only the professional component (modifier-26) should be used.

NOTE: See the Medical Review section for additional information.

Fetal Biophysical Profile

Fetal biophysical profiles are reimbursable, but claims must be substantiated by at least two of the three criteria listed below:

- Gestation period is at least 28 weeks,
- Pregnancy must be high-risk, if so, the diagnosis should reflect high risk, or
- Uteroplacental insufficiency must be suspected in a normal pregnancy.

Hospital Observation Care

Louisiana Medicaid considers “Initial Observation Care” a part of the E&M services provided to recipients designated as “observation status” in a hospital. The key components of the codes used to report physician encounter(s) are defined in CPT’s “Evaluation and Management Services Guidelines”. These guidelines indicate that professional services include those face-to-face and/or bedside services rendered by the physician and reported by the appropriate CPT code. In order to submit claims to the Louisiana Medicaid program for hospital observation care, the service provided by the physician must include face-to-face and/or bedside care.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Oral and Maxillofacial Surgery**

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

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

Pre-Certification

Should anticipated hospitalization for oral and maxillofacial surgery exceed 24 hours, providers should refer to the Pre-Certification Policy in this manual or the Acute Pre-Cert policy found on the Louisiana Medicaid website. (See Appendix A for information on accessing this website)

The surgeon must request approval when it is medically necessary to perform a procedure as an inpatient when the procedure has been designated by the Medicaid Program as an outpatient procedure. Providers should refer to the Acute Pre-Cert policy found on the Louisiana Medicaid website.

Non-Covered Services

The following are not covered services:

- Tooth extractions for recipients age 21 and older, and
- 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.

Additional Information

For information regarding the Medicaid Dental Program policy and procedures, providers should refer to the Louisiana Medicaid website for the following information:

- Dental Services Manual chapter,
- Dental Provider Training Packets,
- Policy updates contained in other provider resources such as the:

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- Medicaid remittance advices (RA), and
- Louisiana Medicaid *Provider Update*.

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

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

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

The Prior Authorization Request for Transplant (TP-01 FORM), rather than the Request for Prior Authorization (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 fiscal intermediary's PA Unit. (See Appendix B for information on accessing the TP – 01 FORM).

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

- Attach a copy of the approval letter to their Request for Hospital Pre-Admission Certification and LOS Assignment PCF 01 form when requesting precertification for the inpatient admission, and
- 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 recipient receives an organ transplant, all charges incurred in the transplant are to be billed under the Medicaid recipient's name and Medicaid ID number. This includes all procedures involved in the harvest of the organ from the donor. Donor search costs are included in the recipient's inpatient bill and will not be paid on an outpatient basis.

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

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 deny with error code 078 (Resubmit claim with operative/pathology/history/picture to establish medical necessity).

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****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.

The Professional Services Fee Schedule should be used to verify coverage for specific chemotherapeutic agents and services. (See Appendix A for information on accessing the Professional Services Fee Schedule).

Requests for consideration of coverage of additional chemotherapeutic agents should be submitted in writing. (See Appendix A for information on where to submit written requests)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Papanicolaou Testing for Cervical Cancer**

Papanicolaou testing (also called a Pap test) is a screening procedure for cervical cancer. The Pap test detects the presence of precancerous or cancerous cells on the cervix, the opening of the uterus. Louisiana Medicaid supports The American Congress of Obstetricians and Gynecologists guidelines (ACOG) regarding Pap tests. It is not considered medically necessary to screen women younger than 21 years of age if they do not meet eligibility criteria. Therefore, effective with dates of service January 1, 2017 and forward, Medicaid will not routinely reimburse testing done on women under 21 years of age.

Eligibility Criteria

Medicaid considers cervical cancer screening medically necessary for recipients under 21 years of age if they meet the following criteria:

- Were exposed to diethylstilbestrol before birth;
- Have human immunodeficiency virus;
- Have a weakened immune system;
- Have a history of cervical cancer; or
- Meet other criteria subsequently published by ACOG.

Outside of these ACOG guidelines, Louisiana Medicaid will cover repeat Pap test for recipients under the age of 21 that were being treated for abnormal cervical cancer screening test prior to January 1, 2017.

Providers of recipients who meet any of the criteria above must submit hard copy supporting documentation to the fiscal intermediary. Required documentation includes but is not limited to:

- Initial abnormal Pap test result and subsequent abnormal Pap test results;
- History and Physical; and
- Procedure note.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Reimbursement**

Collection of cytopathologic vaginal test (Pap test) specimens are included in the reimbursement of the Evaluation and Management 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 recipients 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.

Providers of these services must submit hard copy supporting documentation to the fiscal intermediary to have the age restriction bypassed for a specific clinical situation.

Claims filed with hard copy supporting documentation to the fiscal intermediary will pend to Medical Review for confirmation of the conditions that are considered medically necessary.

- If the hard copy documentation is not present, the claim for the test will be denied.
- If the hard copy supporting documentation is present and meets the clinical criteria, the claim will be allowed to continue normal processing.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****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 recipient 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 patient 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 is to 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 CPT.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****Pharmacy Services**

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

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****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 billed 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 80% of the professional services fee schedule and 100% of the fee for immunizations and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical, vision, and hearing screenings.

Billing Information

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

- Physician assistant services are billed on the CMS 1500 or 837P claim forms.
- Attending services provided by the physician assistant must be identified by entering the specific physician assistant provider number in the attending block on the claim form. The group number must be entered in the billing provider block.
- 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 Provider Enrollment Unit of such employment or contracts when physician assistants are added or removed from the group. (See Appendix A for information on how to contact the Provider Enrollment Unit)
- Qualified physician assistants who perform as assistant at surgery should use the "AS" modifier to identify these services.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2**

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 subject to recoupment.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3****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:

- Licensed by the state of Louisiana,
- Enrolled as a Louisiana Medicaid provider, and
- 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:
 - has been designated by the bureau as an essential provider, and
 - 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 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:

- Determining the amount that private commercial insurance companies paid for commercial claims submitted by the state-owned or operated practice plan or entity, and
- Dividing that amount by the respective charges for these payers.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3**

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 and certified registered nurse anesthetists) 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 recipients. To qualify for the supplemental payment, the physician or professional service practitioner must be:

- Licensed by the state of Louisiana,
- Enrolled as a Louisiana Medicaid provider, and
- 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

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3**

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.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****Podiatry**

A listing of procedures payable by Louisiana Medicaid to podiatrists can be found in Appendix G. 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.

If there is a service that is within the scope of practice for podiatry that is not on the list of reimbursable services, a request for consideration may be submitted in writing to Louisiana Medicaid. (See Appendix A for contact information)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****Preventive Medicine Evaluation and Management Services (Adult)**

Louisiana Medicaid reimburses preventive medicine services for adults, aged 21 years and older. Providers are to use the appropriate Preventive Medicine Services “New Patient” or “Established Patient” *Current Procedural Terminology* (CPT) code based on the age of the recipient when submitting claims for the services.

One preventive medicine service will be reimbursed per recipient per calendar year. The information gathered during the preventive medicine visit is to be forwarded to any requesting provider in order to communicate findings and prevent duplicative services.

Preventive medicine services CPT codes are comprehensive in nature and should reflect age and gender specific services. Separately reported screening procedures performed by the physician, or referrals for those services, should be based on nationally recognized standards of care/best practices (e.g., screening mammography, prostate cancer screening, etc.).

The medical record documentation must include, but is not limited to:

- Physical examination;
- Medical and social history review;
- Counseling/anticipatory guidance/risk factor reduction intervention; and
- Screening test(s) and results.

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 Evaluation and Management (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 CPT code 99212 is reimbursable.

Payments to providers are subject to post payment review and recovery of overpayments.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 4****Prior Authorization**

Certain Medicaid services/procedures require prior authorization from the fiscal intermediary's (FI) Prior Authorization (PA) Unit. The physician who is to perform the procedure that requires PA must submit the prior authorization 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 PA Unit. (See Appendix A for information on how to access the Professional Services Fee Schedule and how to contact the PA Unit)

Routine Prior Authorization Requests

When requesting prior authorization for a procedure/service, providers must:

- Complete a Request for Prior Authorization (PA-01 Form),
- Attach all documentation to warrant medical necessity, and
- Send the information to the PA Unit by fax, electronic prior authorization (e-PA) or mail. (See Appendix A for PA Unit address and contact information and Appendix B for PA-01 Form information)

The provider and recipient 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 recipient becomes retroactively eligible for Medicaid, post authorization may be obtained for those procedures that would normally require prior authorization. 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 recipient will receive written notification of the reason(s) for denial. The provider may resubmit a request for reconsideration by:

- 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,

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 4**

- Attaching to the request all original documentation and any additional information which confirms medical necessity, and
- Sending the information to the PA Unit.

Electronic Prior Authorization (e-PA)

Electronic prior authorization is a web application providing a secure web-based tool for providers to submit and review the status of routine prior authorization 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 PA Unit)

E-PA is restricted to the following provider types:

- 01 – Inpatient
- 05 – Rehabilitation
- 06 – Home Health
- 09 – Durable Medical Equipment (DME)
- 14 – EPSDT Personal Care Service
- 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 recipient. Emergency requests may also be submitted for services required for a hospital discharge.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 4**

Emergency requests are made through the PA Unit for any of the Medicaid services requiring prior authorization. The provider must contact the PA Unit immediately by telephone and provide the following information in order for the request to be considered under the emergency PA procedures:

- The beneficiary's name, age, and 13-digit identification number,
- The treating physician's name,
- The diagnosis,
- The time period of need for the item or service,
- A complete description of the item(s) or service(s) requested,
- The reason that the request is a medical emergency, and
- The cost of the item (only applies to Durable Medical Equipment).

The PA Unit will make a decision and contact the provider by telephone within two working days of the date the completed request is received. The PA Unit will then follow up with written confirmation of the decision.

NOTE: It is always the responsibility of the provider to verify recipient eligibility. **The PA Unit only approves the existence of medical necessity**, not recipient 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 prior authorization from the PA Unit before they can be performed and reimbursed.

Clarification on whether or not a code requires PA can be obtained by referring to the Professional Services fee schedule. (See Appendix A for information on accessing the fee schedule)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 4**

Authorization for a surgical procedure to be performed in an inpatient setting will be valid for 90 days from the approval date unless the recipient becomes ineligible for Medicaid benefits prior to that time. **Providers must validate the recipient's eligibility for the date of service.**

Providers should note that obtaining prior authorization 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, assistant surgeon services. Obtaining prior authorization 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.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****Professional Fee Schedule**

The Professional Services fee schedule is maintained on the Louisiana Medicaid website. Providers should review the website regularly for fee schedule additions, deletions and updates. A 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 messages and the *Provider Update*.

Providers may contact the fiscal intermediary's Provider Relations Unit to determine a reimbursement rate or other information for a covered procedure code not listed on the published fee schedule. (See Appendix A for contact information)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****Psychiatric Services**

Louisiana Medicaid reimburses professional service providers for select *Current Procedural Terminology* (CPT) codes as outlined in the CPT manual related to psychiatric services delivered in the office or other outpatient facility setting. Covered services are listed on the Professional Services fee schedule accessed on the Medicaid website.

Psychological testing is covered once per recipient per year per attending provider. Providers shall bill all applicable units of service related to the testing on a single date of service and not divide the units into multiple dates of service or claim lines.

Federally qualified health centers (FQHCs) and rural health clinics (RHCs) who provide mental health services shall enter the appropriate psychiatric procedure codes as encounter detail lines when submitting claims for these services.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****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 6 months to 72 months must have children screened in compliance with Louisiana Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (requirements and in accordance to practices consistent with current Centers for Disease Control and Prevention guidelines, which include the following specifications:

- Administer a risk assessment questionnaire at every well child visit,
- 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
- Use a venous blood sample to confirm results when finger stick samples indicate blood lead levels $\geq 15\text{ug/dl}$.

Mandatory Case Reporting by Health Care Providers

Medical providers must report a lead case to the Office of Public Health's Childhood Lead Poisoning Prevention Program by fax **within 24 working hours**. A lead case is indicated by a blood lead test result of $>15\text{ug/dl}$ (micrograms per deciliter). The original lead case reporting form shall be mailed 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)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****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.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****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)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Same-Day Outpatient Visits****Recipients under Age 21**

Same-day outpatient visits may be considered for payment for recipients under age 21 when justified if:

- The physician needs to check on the progress of an unstable recipient treated earlier in the day,
- An emergency situation necessitates a second visit on the same day as the first, or
- 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 recipient.

Two same-day outpatient visits per specialty per recipient are allowed; however, the second same-day outpatient visit is payable for only the lower level Evaluation and Management (E/M) codes. The recipient'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, Diagnosis and Treatment (EPSDT) screening has been paid, only the lower level E/M codes are payable for the same recipient, 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:

- The diagnosis is simple,
- The condition requires non-complex care, or
- The recipient is a child in state-funded foster care (aid category 15).

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Recipients Age 21 and Over**

If a preventive medicine E/M service has been paid, only lower level E/M is reimbursable for the same recipient, 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)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3****Sterilizations**

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

- The individual is at least 21 years of age at the time the consent is obtained.
- The individual is not a mentally incompetent individual,
- The individual has voluntarily given informed consent in accordance with all federal requirements, and
- 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 he or she 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 forms (HHS 687 available in English and HHS 687-1 available in Spanish) from the Health and Human Services website. (See Appendix B for information on obtaining and completing these forms)

The consent form must be signed and dated by:

- The individual to be sterilized,
- The interpreter, if one was provided,
- The person who obtained the consent, and
- The physician performing the sterilization procedure.

NOTE: If the physician who performed the sterilization procedure is the one who obtained the consent, he/she must sign both statements.

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Consent Forms and Name Changes

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

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 can be corrected, but **only by the person over whose signature they appear:**

- “Consent to Sterilization,”
- “Interpreter’s Statement,”
- “Statement of Person Obtaining Consent,” and
- “Physician’s Statement”.

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

To make an allowable correction to the form, the individual making the correction should 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 recipient can correct the date to the right of her signature. The same applies to the interpreter, to the person obtaining consent, and to the doctor. The corrections of the recipient, the interpreter, and the person obtaining consent must be made **before** the claim is submitted.

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

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3**

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

Consent forms will be considered invalid if:

- Errors have been made in correctable sections, but have not been corrected,
- Errors have been made in blanks that cannot be corrected, or
- The consent form shows evidence of erasures, “write-overs,” or use of correction fluid.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3****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 recipient on an occasional reciprocal basis. A physician can have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

The recipient'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:

- The regular physician is unavailable to provide the services.
- The substitute physician does not provide the services to Medicaid recipients 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 recipients of the regular physician, and ends with the last day on which the substitute physician provides these services to the recipients before the regular physician returns to work. This period continues without interruption on days on which 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 his/her own Medicaid provider number.

- 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.
- 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

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3**

representatives upon request. All Medicaid related records must be maintained in a systematic and orderly manner and be retained for a period of five 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 his/her 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 can submit a claim and receive payment for covered services of a locum tenens physician who is not an employee of the regular physician if:

- The regular physician is unavailable to provide the services.
- The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis.
- The substitute physician does not provide the services to Medicaid recipients 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 recipients of the regular physician, and ends with the last day on which the substitute physician provides these services to the recipients before the regular physician returns to work. This period continues without interruption on days on which 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.

- The regular physician identifies the services as substitute physician services by entering HCPCS modifier -Q6 after the procedure code on the claim.
- 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

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 3**

representatives upon request. All Medicaid related records must be maintained in a systematic and orderly manner and be retained for a period of five years.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****Telemedicine**

Telemedicine is the use of medical information exchanges from one site to another via electronic communications to improve a recipient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the recipient at the originating site, and the physician or practitioner at the distant site.

Distant site means the site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

Originating site means the location of the Medicaid recipient at the time the services being furnished via a telecommunications system occurs.

Reimbursement

Louisiana Medicaid only reimburses the distant site provider for services provided via telemedicine.

NOTE: The distant site provider must be enrolled as a Louisiana Medicaid provider to receive reimbursement for covered services rendered to Louisiana Medicaid recipients.

Billing

Medicaid covered services provided using telemedicine must be identified on claims submissions by appending the modifier "GT" (via interactive audio and video telecommunications system) to the applicable procedure code. The recipient's clinical record at both the originating and distant sites should reflect that the service was provided through the use of telemedicine.

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 1****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 recipient's medical and health expenses as Medicaid, by law, is intended to be the payer of last resort.

Providers must determine if recipients are covered by other third parties. If a recipient 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)

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2****Vaccines for Children and Louisiana Immunization Network for Kids****Vaccines for Children**

Section 1928 of the Social Security Act provides for vaccines for children (VFC) to improve vaccine availability nationwide by providing vaccines free of charge to VFC-eligible children through public and private providers.

The goal of VFC is to ensure that no VFC-eligible child contracts a vaccine preventable disease because of his/her parent's inability to pay for the vaccine or its administration.

Persons eligible for VFC are between the ages of birth through 18 years of age and who meet one of the following criteria:

- American Indian or Alaskan native
- Medicaid eligible
- Uninsured
- Underinsured

Underinsured individuals are individuals who have health insurance, but the health insurance does not cover vaccines or has limited vaccine coverage. Underinsured children are eligible to receive vaccines only at federally qualified health centers or rural health clinics.

Providers can obtain a VFC enrollment packet by calling the Office of Public Health's (OPH) Immunization Section. (See Appendix A for contact information)

NOTE: All Medicaid enrolled providers that provide Early and Periodic Screening, Diagnosis and Treatment (EPSDT) well child preventative screenings must be enrolled in the VFC program and utilize VFC vaccines for recipients aged birth through 18 years of age.

Louisiana Immunization Network for Kids Statewide (LINKS)

Louisiana Immunization Network for Kids Statewide (LINKS) is a computer-based system designed to track immunization records for providers and their patients by:

- Consolidating immunization information among all health care providers,
- Assuring adequate immunization coverage levels, and

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 2**

- Avoiding duplicative immunizations.

LINKS can be accessed through the OPH website. (See Appendix A for contact information)

LINKS assists providers by offering:

- Immediate records for new patients,
- Decrease office staff time retrieving immunization records,
- Avoid missed opportunities to administer needed vaccines, and
- Fewer missed appointments (if the “reminder cards and letter” option is used).

LINKS assists patients by offering:

- Easy access to records needed for school and child care,
- Automatic reminders to help children’s immunizations remain on schedule, and
- Reduced cost (and discomfort to child) of unnecessary immunizations.

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

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 4****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 recipient meets the published criteria, and the recipient has a diagnosis of medically intractable epilepsy.

Criteria for Recipient Selection

The following criteria are used to determine recipient eligibility and approval of the VNS:

- Partial epilepsy confirmed and classified according to the International League Against Epilepsy (ILAE) classification. The recipient may also have associated generalized seizures, such as tonic, tonic-clonic, or atonic. The VNS may have efficacy in primary generalized epilepsy as well.
- 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.
- Seizures refractory to medical anti-epilepsy treatment, with adequately documented trials of appropriate standard and newer anti-epilepsy drugs or documentation of recipient's inability to tolerate these medications.
- Recipient has undergone surgical evaluation and is considered not to be an optimal candidate for epilepsy surgery.
- Recipient is experiencing at least four to six identifiable partial onset seizures each month. Recipient 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 recipient.
- Recipient 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.
- 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).

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 4****Exclusion Criteria**

Regardless of the criteria for recipient selection, **authorization for VNS implantation shall not be given if the recipient has one or more of the following criteria:**

- Psychogenic seizures or other non-epileptic seizures,
- Insufficient body mass to support the implanted system,
- Systemic or localized infections that could infect the implanted system, or
- 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 recipient 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 recipient evaluation has been completed but prior to stimulator implantation.

This request to initiate implantation shall come from the multi-disciplinary team that evaluates the recipient. The multi-disciplinary team should be comprised of the following:

- A surgeon who has been trained and is familiar with the carotid sheath,
- A psychiatrist or neurologist,
- The recipient's attending physician,
- A nurse,
- A social worker, and
- Allied health professionals (physical therapist, occupational therapist, etc.).

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 4**

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 multi-disciplinary team:

- A recent history with documentation of assessments in the following areas:
 - Medical and physical including a history of prior drug experience
 - Neurological information about seizure type and epilepsy syndrome diagnosis, and the results of electroencephalogram (EEG) and/or video EEG monitoring
 - Functional and psychosocial assessment
 - Result of evaluation of epilepsy surgery
- Documentation of any other findings about the recipient's condition which would be of interest to or would assist the Medical Review team in making a decision regarding the medical necessity for recipient implantation.

Billing for the Cost of the Vagus Nerve Stimulator

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 on a CMS-1500 claim form with the words "DME" written in red on the top of the form. The claim will pend to the fiscal intermediary'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 Prior Authorization Request (PA-01 Form) to the PA Unit as part of the multi-disciplinary team's packet. The surgeon must use his/her individual, rather than group, provider number on the PA-01 Form. The provider shall bill for the implantation of the generator by

CHAPTER 5: PROFESSIONAL SERVICES**SECTION 5.1: COVERED SERVICES****PAGE(S) 4**

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 recipient 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:

- Recipient response – the status of seizure control, i.e. frequency and severity of seizures,
- Current VNS program settings, i.e., current output, pulse width, duty cycle, and signal frequency,
- Frequency of medications and dose schedule,
- Documentation of adverse effects such as swallowing problems, hoarseness, coughing and neck tightness,
- Magnet setting, and
- 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.

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX A: CONTACT INFORMATION****PAGE(S) 5****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 this website.

Type of Assistance	Link Where Information is Found
Provider Fee Schedules	“Fee Schedules”
Preferred Drug List/Prior Authorization List	“Pharmacy * Prescribing Providers”
Electronic prior authorization	“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”
Access the Pre-cert Inquiry application	“Provider Login”
Access the Pre-Cert Inquiry application manual	“Forms/Files/User Manuals” and then Under the “User Manuals” link
Periodicity Schedule	“Training/Policy Updates” Then “Provider Training Packets/Policy Updates” then “2013 Policy Updates” then “Professional Services Program”
Access the “Medicaid Primary Care Services Designated Physician Form” or the “Medicaid Primary Care Services Advanced Practice Registered Nurse Form”	“Provider Enrollment”, then “Forms to Update Existing Provider Information”

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX A: CONTACT INFORMATION****PAGE(S) 5****Molina Medicaid Solutions**

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

Type of Assistance	Contact
Where to send a completed BHSF 158-A Physician Outpatient Visit Extension Form	Molina Medicaid Solutions P. O. Box 14919 Baton Rouge, LA 70898-4919
Where to send a hardcopy claim when approval has been received for outpatient visit extension	Molina Medicaid Solutions P. O. Box 91024 Baton Rouge, LA 70821
Who to contact for consideration of coverage of additional chemotherapeutic agents	Molina Medicaid Solutions -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	Molina Medicaid Solutions -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	Molina Medicaid Solutions 1-877-598-8753
Pre-Certification Department	Molina Medicaid Solutions - Pre Certification P. O. Box 14849 Baton Rouge, LA 70809-4849 Phone: 1-800-877-0666, Fax: 1-800-717-4329
Prior Authorization Unit	Molina Medicaid Solutions – Prior Authorization P. O. Box 14919 Baton Rouge, LA 70898-4919 Phone: 1-800-807-1320 (Home Health/EPSDT) Phone: 1-866-263-6534 (Dental) Phone: 1-800-488-6334 (DME & All Other)

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX A: CONTACT INFORMATION****PAGE(S) 5****Molina Medicaid Solutions (continued)**

Type of Assistance	Contact
Provider Enrollment Unit	Molina Medicaid Solutions – Provider Enrollment P.O. Box 80159 Baton Rouge, LA 70898 Phone: 225-216-6370, Fax: 225-216-6392
Provider Relations Unit	Molina Medicaid Solutions -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

The Office of Public Health can be contacted for the following assistance:

Type of Assistance	Contact
Obtain a copy of the “Office of Public Health Certification of Informed Consent-Abortion”	Office of Public Health (504) 568-5330
Obtain an enrollment packet for <ul style="list-style-type: none"> • Vaccines for Children (VFC) • Louisiana Immunization Network for Kids Statewide (LINKS) 	Office of Public Health (504) 838-5300
Obtain information about vaccine availability	
Access LINKS	https://linksweb.oph.dhh.louisiana.gov
Information about the Louisiana Childhood Lead Poisoning Prevention Program	http://www.dhh.louisiana.gov/offices/page.asp?ID=263&Detail=6296
Obtain neonatal screening results	Genetic Diseases Program (504) 568-8248 or http://new.dhh.louisiana.gov/index.cfm/page/470

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX A: CONTACT INFORMATION****PAGE(S) 5****Pharmacy**

Pharmacy information can be obtained from the following:

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	Bureau of Health Services Financing Pharmacy Benefits Management Section (225) 342-9768

EarlySteps

EarlySteps information can be obtained from the following:

Type of Assistance	Contact
Information about the EarlySteps program	http://new.dhh.louisiana.gov/index.cfm/page/139/n/139

Clinical Laboratory Improvement Amendments (CLIA)

Type of Assistance	Web Address
Information about CLIA	http://new.dhh.louisiana.gov/index.cfm/directory/detail/705

Centers for Disease Control and Prevention (CDC)

The CDC can be contacted for the following assistance:

Type of Assistance	Office to Contact
Access the <i>Recommended Adult Immunization Schedule</i> from the 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

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX A: CONTACT INFORMATION****PAGE(S) 5****Louisiana Medicare**

Type of Assistance	Web Address
Information about Louisiana Medicare	www.lamedicare.com

National Physician Fee Schedule

Type of Assistance	Web Address
Access the National Physician Fee Schedule.	http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

Appeals

Type of Assistance	Contact
To file an appeal	Division of Administrative Law - 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
Access the <i>Smiles for Life</i> training module	http://smilesforlifeoralhealth.talariainc.com/buildcontent.aspx?pagekey=62949&lastpagekey=62959&userkey=11410424&sessionkey=2184058&tut=55&customerkey=84&custsitegroupkey=0

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX B: FORMS****PAGE(S) 9**

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 in this appendix.

The following forms are available at www.lamedicaid.com under the “Forms/Files/User Manuals” link:

- **Acknowledgement of Receipt of Hysterectomy Information** (BHSF Form 96-A)
- **Physician Outpatient Visit Extension Form** (BHSF Form 158-A)
- **Request for Prior Authorization** (PA-01 Form)
- **Prior Authorization Request for Transplant** (TP-01 FORM)
- **Referral for Pregnancy Related Dental Services** (BHSF Form 9-M)
- **Request for Prescription Prior Authorization** (Form RXPA01)

The following forms are available at <http://www.lamedicaid.com/provweb1/Forms/PCforms.htm>

- **Request for Hospital Pre-Admission Certification and LOS Assignment** (PCF 01)
- **Request for Hospitalization for Outpatient Procedures: Day of Admit or Day After Admit** (PCF-02)

Instructions and a copy of the **Department of Health and Hospitals Office of Public Health Certification of Informed Consent-Abortion** form are available at:

http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/CC_NPAppendices/AppendixNAbortionCertificationofInformedConsent.pdf

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX B: FORMS****PAGE(S) 9**

The **Consent for Sterilization** forms, Form HHS-687 (English) and Form HHS-687-1 (Spanish), are available at:

http://www.hhs.gov/opa/order-publications/#pub_sterilization-pubs

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 recipient’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 the 37th week of 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.

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APPENDIX B: FORMS

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Form Approved: OMB No. 0937-0166
Expiration date: 10/31/2015

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) _____ When I first asked

Doctor or Clinic

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) _____. The discomforts, risks

Specify Type of Operation

and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

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

I am at least 21 years of age and was born on: (3) _____ Date

I, (4) _____, hereby consent of my own free will to be sterilized by (5) _____ Doctor or Clinic

by a method called (6) _____. My Specify Type of Operation

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) _____ (8) _____

Signature

Date

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)

Ethnicity:

- Hispanic or Latino American Indian or Alaska Native
- Not Hispanic or Latino 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) _____ (11) _____

Interpreter's Signature

Date

HHS-687 (05/10)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) _____ signed the

Name of Individual

consent form, I explained to him/her the nature of sterilization operation (13) _____, the fact that it is

Specify Type of Operation

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) _____ (15) _____

Signature of Person Obtaining Consent

Date

(16) _____ Facility

(17) _____ Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

(18) _____ on (19) _____

Name of Individual

Date of Sterilization

I explained to him/her the nature of the sterilization operation (20) _____, the fact that it is

Specify Type of Operation

intended to be a final and irreversible procedure and the discomforts, 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 thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the 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) _____ (23) _____

Physician's Signature

Date

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX B: FORMS****PAGE(S) 9****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)

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.)

- Y N 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)

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX B: FORMS****PAGE(S) 9****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: 10/31/2015

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 When I first asked
Doctor or Clinic

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. The discomforts, risks
Specify Type of Operation

and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

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

I am at least 21 years of age and was born on: (3) 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. My
Specify Type of Operation

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 (8) 06/12/2012
Signature *Date*

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)

Ethnicity: Hispanic or Latino American Asian Black or Native Hawaiian or Other Pacific Islander 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 Gomez (11) 06/12/2012
Interpreter's Signature *Date*

HHS-687 (05/10)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) Judy Marshall signed the
Name of Individual

consent form, I explained to him/her the nature of sterilization operation

(13) Tubal Ligation, the fact that it is

Specify Type of Operation

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, RN (15) 06/12/2012
Signature of Person Obtaining Consent *Date*

(16) Woman's OB/GYN Group
Facility

(17) 433 10th Street Pine, LA 70776
Address

■ CONSENT ■

Shortl MUST MATCH
(18) _____
Name of Individual

on (19) 07/17/12
Date of Sterilization

I explained to him/her the nature of the sterilization operation

(20) Tubal Ligation, the fact that it is

Specify Type of Operation

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 c

abdominal surgery where the sterilization is performed after the date of the individual's signature on the consent form. In these cases, the second paragraph below must be used graph which is not used.)

(1) At least thirty days have passed between the date of signature on this consent form and the date 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: (21) _____

Individual's expected date of delivery: (21) _____

Emergency abdominal surgery (describe circumstances): _____

SIGN AFTER**SURGERY****COMPLETE**

(22) Thatch Strong, M.D. (23) 07/17/2012
Physician's Signature *Date*

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX B: FORMS****PAGE(S) 9****Sterilization Consent Form Example – Consent obtained at Least 30 Days prior to Sterilization with Interpreter's Statement**

Form Approved: OMB No. 0937-0166
Expiration date: 10/31/2015

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 When I first asked
Doctor or Clinic

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. The discomforts, risks

Specify Type of Operation

and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

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

I am at least 21 years of age and was born on: **(3) 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** My

Specify Type of Operation

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 **(8) 06/12/2012**

Signature *Date*

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:

- Hispanic or Latino American Indian or Alaska Native
- Not Hispanic or Latino 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 Gomez **(11) 06/12/2012**

Interpreter's Signature *Date*

HHS-687 (05/10)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before **(12) Judy Marshall** signed the
Name of Individual consent form, I explained to him/her the nature of sterilization operation

(13) Tubal Ligation, the fact that it is

Specify Type of Operation

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, RN **(15) 06/12/2012**

Signature of Person Obtaining Consent *Date*

(16) Woman'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 on **(19) 07/17/12**

Name of Individual *Date of Sterilization*

I explained to him/her the nature of the sterilization operation

(20) Tubal Ligation, the fact that it is

Specify Type of Operation

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 thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the 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) Thatch Strong, M.D. **(23) 07/17/2012**

Physician's Signature *Date*

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX B: FORMS****PAGE(S) 9****Sterilization Consent Form Example – Consent obtained Less Than 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: 10/31/2015

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 When I first asked Doctor or Clinic

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. The discomforts, risks

and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

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

I am at least 21 years of age and was born on: (3) 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. My Specify Type of Operation

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 (8) 06/12/2012 Signature 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):

CROSS OUT

PARAGRAPH

ider

NOT USED AND

COMPLETE AS

ne in: also

APPLICABLE

■ INTERPRETER

If an interpreter is provided to me, I have translated the information to be sterilized by the individual to be sterilized by the read him/her the consent form 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 (05/10)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) Judy Marshall signed the Name of individual consent form, I explained to him/her the nature of sterilization operation (13) Tubal Ligation. the fact that it is Specify Type of Operation 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, RN (15) 06/12/2012 Signature of Person Obtaining Consent Date

(16) Woman's OB/GYN Group Facility

(17) 433 10th Street, Pine, LA 70776 Address

■ ATTENTION ■

MUST MATCH Name of individual Date of sterilization

I explained to him/her the nature of the sterilization operation

(20) Tubal Ligation. the fact that it is Specify Type of Operation 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. 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 these cases, the second paragraph below must be used. (Graph which is not used.)

(1) At least thirty days have passed between the date signature on this consent form and the date the procedure performed.

(2) The sterilization was performed less than 30 days hours after the date of the individual's signature on the consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery Individual's expected date of delivery (21) 08/01/2012

Emergency abdominal surgery (describe circumstances)

(22) Thatch Strong, M.D. (23) 07/08/2012 Physician's Signature Date

SIGN AFTER SURGERY COMPLETED

CHAPTER 5: PROFESSIONAL SERVICES

APPENDIX B: FORMS

PAGE(S) 9

Form Approved: OMB No. 0937-0166
Expiration date: 10/31/2015

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. When I first asked

Doctor or Clinic

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. The discomforts, risks

Specify Type of Operation

and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

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

I am at least 21 years of age and was born on: (3) 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. My

Specify Type of Operation

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 (8) 06/12/2012
Signature *Date*

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)

- Ethnicity:
 Hispanic or Latino American Indian or Alaska Native
 Not Hispanic or Latino 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) (11)
Interpreter's Signature *Date*

HHS-687 (05/10)

■ 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, RN (15) 06/12/2012
Signature of Person Obtaining Consent *Date*

(16) Woman'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 (19) 07/01/2012
Name of Individual *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.

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.)

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

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the 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) 08/01/2012
 Emergency abdominal surgery (describe circumstances): _____

(22) Thatch Strong, M.D. (23) 07/08/2012
Physician's Signature *Date*

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX B: FORMS****PAGE(S) 9**

La. OFS Form 24
Revised 1/86
IV
1/82 issue usable

Diagnostic and/or Laboratory Equipment

Name:
Provider Number:

Address:
Pay to Number:

Diagnostic and/or Laboratory Test Equipment

Make	Model	Serial #	Capabilities

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX C: RESTRICTED AUDIOLOGY CODES****PAGE(S) 1****RESTRICTED AUDIOLOGY CODES**

Payment for the following audiology codes is restricted to one per recipient per 180 days:

92552	92571
92553	92572
92555	92575
92556	92576
92557	92577
92563	92579
92564	92582
92565	92583
92567	92584
92568	92585
92569	

LOUISIANA MEDICAID PROGRAM

ISSUED: **04/13/18**

REPLACED: **02/01/12**

CHAPTER 5: PROFESSIONAL SERVICES

APPENDIX D: RESERVED

PAGE(S) 1

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX E – CLAIMS FILING****PAGE(S) 16**

CLAIMS FILING

Hard copy billing of professional services are billed on the paper CMS-1500 (02/12) claim form or 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:

Molina Medicaid Solutions
P.O. Box 91020
Baton Rouge, LA 70821

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers, or
- 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 EDI Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and
- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX E – CLAIMS FILING****PAGE(S) 16****CMS 1500 (02/12) INSTRUCTIONS FOR PROFESSIONAL SERVICES**

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's I.D. Number	<p>Required – Enter the recipient's 13-digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REV\$.</p> <p>NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.</p>	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date	Situational – Enter the recipient's date of birth 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).	
	Sex	Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
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 NUCC USE		

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX E – CLAIMS FILING****PAGE(S) 16**

Locator #	Description	Instructions	Alerts
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	<p>Situational – If recipient has no other insurance coverage, leave blank.</p> <p>If there is other commercial insurance coverage, the Louisiana assigned 6-digit TPL carrier code is required in this block. The carrier code is indicated on the Medicaid Eligibility Verification (MEVS) response as the Network Provider Identification Number.</p> <p>Make sure the EOB or EOBS from other insurance(s) are attached to the claim.</p>	<p>ONLY the 6-digit code should be entered for commercial and Medicare HMO's in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.</p> <p>NOTE: DO NOT ENTER A 6-DIGIT CODE FOR TRADITIONAL MEDICARE</p>
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.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth 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.	

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX E – CLAIMS FILING****PAGE(S) 16**

Locator #	Description	Instructions	Alerts
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	<p>Situational – Complete if applicable. In the following circumstances, entering the name of the appropriate physician is required:</p> <ul style="list-style-type: none"> • If ACA services are delivered by a PA or APRN, the name of the supervising ACA certified physician is required in this field • If services are performed by a CRNA, enter the name of the directing physician • If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name. • If the services are performed by an independent laboratory, enter the name of the referring physician. 	
17a	Unlabeled	Situational – Complete if applicable. ACA Services delivered by a PA or APRN require the identification of the supervising ACA certified physician.	
17b	NPI	Situational – Complete if applicable. ACA Services delivered by a PA or APRN require the identification of the supervising ACA certified physician.	

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX E – CLAIMS FILING****PAGE(S) 16**

Locator #	Description	Instructions	Alerts
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	
21	ICD Indicator Diagnosis or Nature of Illness or Injury	<p>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.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p> <p>Required -- Enter the most current ICD diagnosis code.</p> <p>NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable</p> <p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15. Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page (www.lamedicaid.com)</p>

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX E – CLAIMS FILING****PAGE(S) 16**

Locator #	Description	Instructions	Alerts
22	Resubmission Code	<p>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.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u></p> <p>01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>Voids</u></p> <p>10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	<p>Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).</p> <p>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 internal control number.</p>
23	Prior Authorization (PA) Number	<p>Situational – Complete if appropriate or leave blank. If the services being billed must be prior authorized, the PA number is required to be entered.</p>	

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX E – CLAIMS FILING****PAGE(S) 16**

Locator #	Description	Instructions	Alerts
24	Supplemental Information	<p>Situational - Applies to the detail lines for drugs and biologicals only.</p> <p>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.</p> <p><u>Claims for these drugs shall include the NDC from the label of the product administered.</u></p> <p>To report additional information related to 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.</p> <p>Providers should then leave one space and then enter the appropriate Unit Qualifier (see below) and the actual units administered in NDC UNITS.</p> <p>Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.</p> <p>The following qualifiers shall be used when reporting NDC units:</p> <ul style="list-style-type: none"> • F2=International Unit • ML=Milliliter • GR=Gram • UN=Unit 	<p>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.</p> <p>This information must be entered in addition to the procedure code(s).</p> <p>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.</p>
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure billed.</p> <p>Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.</p>	
24B	Place of Service	Required -- Enter the appropriate place of service code for the services rendered.	

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX E – CLAIMS FILING****PAGE(S) 16**

Locator #	Description	Instructions	Alerts
24C	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	Amount Charged	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	EPSDT Family Plan	Situational – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Situational – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is required. Entering the Rendering Provider's NPI in the non-shaded portion of the block is optional.	
25	Federal Tax I.D. Number	Optional.	
26	Patient's Account No.	Situational – Enter the provider specific identifier assigned to the recipient. 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.	

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX E – CLAIMS FILING****PAGE(S) 16**

Locator #	Description	Instructions	Alerts
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	<p>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.</p> <p>If TPL does not apply to the claim, leave blank.</p> <p>Do not report Medicare payments in this field.</p>	
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.	
32a	NPI	Optional.	
32b	Unlabeled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	Required -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	The 7-digit Medicaid Provider Number must appear on paper claims.

Sample forms are on the following pages

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CHAPTER 5: PROFESSIONAL SERVICES

APPENDIX E – CLAIMS FILING

PAGE(S) 16

**SAMPLE PROFESSIONAL CLAIM FORM WITH ICD-9 DIAGNOSIS CODE
(DATES BEFORE 10/1/15)**



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

HCA

PICA

CARRIER →

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE											
EXAMPLE OF ICD-9											
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											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE MM DD YY QUAL				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 71b. NPI _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				20. OUTSIDE LAB? \$ CHARGES YES NO			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9 A. <u>V250.1</u> 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 EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. H. FEE PER UNIT I. ID QUAL J. RENDERING PROVIDER ID. #											
1 03 02 14 03 02 14 11 99213 A 80 00 1 NPI 1236549875 2 N400703680101 UN150.00 DEPO-ROVERA INJ A 50 00 150 NPI 1236549875 3 _____ NPI _____ 4 _____ NPI _____ 5 _____ NPI _____ 6 _____ NPI _____											
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? X YES NO			
\$ 130 00								\$ 130 00 \$ \$			
28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE \$ 130 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 Always Open 500 Main St Any Town, LA 70000											
33. BILLING PROVIDER INFO & PH# (225) 555-4957 a. 1326547895 b. 1987654											
SIGNED John Doe, MD DATE 3/9/14 a. b.											

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APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CHAPTER 5: PROFESSIONAL SERVICES

APPENDIX E – CLAIMS FILING

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**SAMPLE PROFESSIONAL CLAIM FORM WITH ICD-10 DIAGNOSIS CODE
(DATES ON OR AFTER 10/1/15)**



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SAMPLE											
EXAMPLE OF ICD 10											
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 15. OTHER DATE MM DD YY											
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____											
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LAB? \$ CHARGES YES NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: O											
A. Z30.42 B. _____ C. _____ D. _____											
E. _____ F. _____ G. _____ H. _____											
I. _____ J. _____ K. _____ L. _____											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS E. MODIFIER F. DIAGNOSIS POINTERS											
1 10 01 15 10 01 15 12 99213 A 80.00 1 NPI 1236549875											
2 N400703680101 UN150.00 DEPO-ROVERA INJ 10 01 15 10 01 15 12 J1050 A 50.00 150 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 self claims, see back) YES NO			28. TOTAL CHARGE \$ 130.00 29. AMOUNT PAID \$ 130.00 30. BALANCE DUE \$ 130.00	
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# (225) 555-4957 Always Open 500 Main St. Any Town, LA 70000			a. 1326547895 b. 1987654	
SIGNED John Doe, MD DATE a. b.											

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CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX E – CLAIMS FILING**

PAGE(S) 16**ADJUSTING/VOIDING CLAIMS**

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can 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 Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided, thus:

- 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.
- 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 Identification Number and the Recipient/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They 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 Remittance Advice 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.

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX E – CLAIMS FILING****PAGE(S) 16**

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 Remittance Advice.

Sample forms are on the following pages.

CHAPTER 5: PROFESSIONAL SERVICES

APPENDIX E – CLAIMS FILING

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SAMPLE PROFESSIONAL CLAIM FORM ADJUSTMENT WITH ICD-9 DIAGNOSIS CODE (DATES BEFORE 10/1/15)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

				PICA			CARRIER	
1. MEDICARE (Medicare #) X (Medicaid #) (ID#DoD#)		TRICARE (Member ID#)		CHAMP VA (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) LOU, JANNIE		3. PATIENT'S BIRTH DATE MM DD YY 06 19 85		SEX M F X		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 _____ ()				ZIP CODE _____ ()		TELEPHONE (Include Area Code) _____ ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable		11. INSURED'S POLICY GROUP OR FECA NUMBER a. EMPLOYMENT? (Current or Previous) YES NO				
		b. AUTO ACCIDENT? YES NO		a. INSURED'S DATE OF BIRTH MM DD YY M F				
		c. OTHER MEDICAL? YES NO		b. OTHER CLAIM ID (Designated by NUCC)				
		d. INSURANCE PLAN NAME OR PROGRAM NAME 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.		c. INSURANCE PLAN NAME OR PROGRAM NAME				
SIGNED _____ DATE _____				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 71b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY 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 9 A. V250.1 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. RESUBMISSION CODE A 99		ORIGINAL REF. NO 4090145678600				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSC E. MODIFIER F. \$ CHARGES G. DAYS OR UNITS H. EPSSOT Family Plan I. ID. # J. RENDERING PROVIDER ID. # 1 03 02 14 03 02 14 11 99213 A 80 00 1 NPI 1236549875 2 _____ NPI _____ 3 _____ NPI _____ 4 _____ NPI _____ 5 _____ NPI _____ 6 _____ NPI _____		23. PRIOR AUTHORIZATION NUMBER		1236549875				
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? X YES NO (For govt. claims, see back)		28. TOTAL CHARGE \$ 80 00 29. AMOUNT PAID \$ _____ 30. BALANCE DUE \$ _____				
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 John Doe, MD DATE 3/9/14		32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____		33. BILLING PROVIDER INFO & PH# (225) 555-4957 Always Open 500 Main St Any Town, LA 70000 a. 1326547895 b. 1987654				

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PATIENT AND INSURED INFORMATION ↑

PHYSICIAN OR SUPPLIER INFORMATION ↓

CHAPTER 5: PROFESSIONAL SERVICES

APPENDIX E – CLAIMS FILING

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SAMPLE PROFESSIONAL CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/1/15)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

CARRIER →

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER 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) 1234567890123			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE			3. PATIENT'S BIRTH DATE MM DD YY 06 19 85		SEX M F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) CITY ZIP CODE			6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other		7. INSURED'S ADDRESS (No., Street) CITY ZIP CODE					
8. RESERVED FOR NUCC USE TELEPHONE (Include Area Code) ()			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL code if applicable		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO					
			b. AUTO ACCIDENT? YES NO		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M F					
			c. OTHER FACILITY? YES NO		b. OTHER CLAIM ID (Designated by NUCC)					
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE 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		c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL			15. OTHER DATE MM DD YY QUAL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 71b. NPI _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES YES NO					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0 A. Z30.42 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. RESUBMISSION CODE ORIGINAL REF. NO. A 02 5299198798700					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY Place of Service EMG			B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS Modifier		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. PAYOR PER UNIT	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 15 10 01 15 12		99213		A	80 00	1		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 gov't claim, see back) YES NO		28. TOTAL CHARGE \$ 80 00	29. AMOUNT PAID \$	30. BALANCE DUE \$ 80 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.) SIGNED John Doe, MD DATE			32. SERVICE FACILITY LOCATION INFORMATION Always Open 500 Main St. Any Town, LA 70000		33. BILLING PROVIDER INFO & PH# (225) 555-4957					
			a. _____	b. _____	a. 1326547895	b. 1987654				

CHAPTER 5: PROFESSIONAL SERVICES

APPENDIX E – CLAIMS FILING

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SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA												CARRIER			
1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP BENEFITS PLAN		FECA EXCLUDING (ID#)		OTHER (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
<input type="checkbox"/> (Medicare)		<input type="checkbox"/> (Medicaid)		<input type="checkbox"/> (ID#DoD#)		<input type="checkbox"/> (Member ID#)		<input type="checkbox"/> (ID#)		<input type="checkbox"/> (ID#)		<input type="checkbox"/> (ID#)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY						SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)			
CITY			STATE			CITY			STATE						
ZIP CODE		TELEPHONE (Include Area Code) ()				ZIP CODE		TELEPHONE (Include Area Code) ()							
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE						d. INSURANCE PLAN NAME OR PROGRAM NAME						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? <input type="checkbox"/> YES <input type="checkbox"/> 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													
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															
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. _____				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMR		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. MODIFIER		F. \$ CHARGES		G. DAYS OR UNITS		H. I. J. I. RENDERING PROVIDER ID. # NPI			
1															
2												NPI			
3												NPI			
4												NPI			
5												NPI			
6												NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. a. NPI b. _____		27. ACCEPT ASSIGNMENT? (For govt. claims, see below) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rwd 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.)		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()											
SIGNED		DATE													

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX F: GLOSSARY AND ACRONYMS****PAGE(S) 10**

GLOSSARY AND ACRONYMS

The following is a list of abbreviations, acronyms and definitions used in this manual chapter.

Glossary

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.

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.

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

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.

Children's Health Insurance Program (CHIP) Phase IV – An expansion of Louisiana's State Child Health Insurance Program 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.

Co-payment – A fixed dollar amount paid by a Medicaid enrollee at the time of receiving a covered service from a participating provider.

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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.

Department of Health and Hospitals (DHH) – 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 DHH.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering all state Medicaid programs as well as other public health programs.

Dual Eligible – Individuals entitled to Medicare and full or partial Medicaid benefits.

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 Medicaid Eligibility Verification System (eMEVS) – Louisiana Medicaid’s electronic system for direct access to Medicaid eligibility information for enrolled providers.

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 his/her 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, Diagnosis, 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.

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Federally Qualified Health Center (FQHC) – An entity receiving a grant under Section 330 of the Public Health Service Act; is receiving funding from such grant under a contract with the recipients 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 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 DHH to operate the federally approved Medicaid Management Information System (MMIS). The fiscal intermediary 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.

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 the Department of Health and Human Services whose mission is to improve access to healthcare services for the uninsured, isolated, or medically vulnerable through leadership and financial support.

Lock-In – An educational program administered by the Medicaid pharmacy program staff which restricts certain Medicaid enrollees to a specific physician and/or pharmacy.

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 federal poverty level (FPL).

Medicaid – A federal-state financed medical assistance entitlement program provided under an approved State Plan authorized under Title XIX of the Social Security Act.

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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 recipients.

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, 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.

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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.

Prior Authorization (PA) – Management tool used to determine if treatments/services are medically necessary and appropriate for the patient.

Provider Enrollment (PE) – Another term for enrollment of providers.

Recipient – Enrollee having received Medicaid services and paid claims rendered to the enrolled provider.

Recipient Eligibility Verification System (REVS) – Louisiana Medicaid's automated telephonic voice response system for verifying Medicaid eligibility.

Secretary – The secretary of the Department of Health and Hospitals or any official to whom (s)he has delegated the pertinent authority.

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 – 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.

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.

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX F: GLOSSARY AND ACRONYMS****PAGE(S) 10****Acronyms****17-P** – 17 Alpha Hydroxyprogesterone Caproate**AADE** – American Association of Diabetes Educators**ADA** – American Diabetes Association**ADA** – American Dental Association**APRN** – Advance Practice Registered Nurse**ASC** – Ambulatory Surgical Center**ASMBS** – American Society for Metabolic and Bariatric Surgery**CCN** – Coordinated Care Network**CDE** – Certified Diabetes Educator**CDI** – Clinical Data Inquiry**CERMe** – Care Enhance Review Manager Enterprise**CEUs** – Continuing Education Units**CFR** – Code of Federal Regulations**CHAMP** – Child Health and Maternity Program**CHIP** – Children's Health Insurance Program**CLIA** – Clinical Laboratory Improvement Amendment**CNM** – Certified Nurse Midwife**CNP** – Certified Nurse Practitioner**CNS** – Clinical Nurse Specialist**CPT** – Current Procedural Terminology

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CRNA – Certified Registered Nurse Anesthetist

DD – Developmentally Disabled

DME – Durable Medical Equipment

DSMT – Diabetes Self Management Training

E/M – Evaluation and Management

E&M – Evaluation and Management

EDI – Electronic Data Interchange

EFT – Electronic Funds Transfer

EHR – Electronic Health Records

EPSDT – Early and Periodic Screening, Diagnosis and Treatment

ESRD – End Stage Renal Disease

FMAP – Federal Medical Assistance Percentages

FPL – Federal Poverty Level

HCBS – Home and Community Based Services

HCPCS – Healthcare Common Procedure Coding System

HHA – Home Health Agency

HIPAA – Health Insurance Portability and Accountability Act

HMO – Health Maintenance Organization

ICF/DD – Intermediate Care Facility/Developmentally Disabled

IEP – Individualized Education Plan

IFSP – Individualized Family Service Plan

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IHS – Indian Health Service

ITB – Intrathecal Baclofen

LINKS – Louisiana Immunization Network for Kids Statewide

LPN – Licensed Practical Nurse

LTC – Long Term Care

MCH – Maternal Child Health

MED REV – Medical Review

MST – Multi-Systemic Therapy

MVA – Medical Vendor Administration

MVP – Medical Vendor Program

NCBDE – National Certification Board for Diabetes Educators

NDC – National Drug Code

NOW – New Opportunities Waiver

OBRA – Omnibus Budget Reconciliation Act of 1993

OFS – Office of Family Support

OPH – Office of Public Health

OSCAR – Online Survey, Certification and Reporting

OT – Occupational Therapy

PA – Physician Assistant

PACE – Program of All Inclusive Care for the Elderly

PAU – Prior Authorization Unit

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PCCM – Primary Care Case Management

PCP – Primary Care Provider

PCS – Personal Care Services

PDL – Preferred Drug List

PEU – Provider Enrollment Unit

PPM – Provider Performed Microscopy

POC – Plan of Care

PSR – Provider Specialty Restriction

PT – Physical Therapy

REVS – Recipient Eligibility Verification System

RHC – Rural Health Clinic

RN – Registered Nurse

RFSR – Request for Services Registry

RUM – Radiology Utilization Management

SCHIP – State Children's Health Insurance Program

SL – Service Limits

SRI – Statistical Resources, Inc.

SSA – Social Security Administration

ST – Speech Therapy

TCM – Targeted Case Management

TOS – Type of Service

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TPL – Third Party Liability

TS – Type of Service

UCC – Uncompensated Care Costs

VFC – Vaccines for Children

VNS – Vagus Nerve Stimulator

WIC – Women, Infants and Children

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX G: PODIATRY CODES****PAGE(S) 1****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.)

CHAPTER 5: PROFESSIONAL SERVICES**APPENDIX H: ACA ENHANCED REIMBURSEMENT****PAGE(S) 2**

**AFFORDABLE CARE ACT ENHANCED REIMBURSEMENT
PLACE OF SERVICE CODES**

The following table provides a crosswalk from the Health Insurance Portability and Accountability Act (HIPAA) Place of Service Codes to the Affordable Care Act (ACA) enhanced reimbursement rate. Place of service codes applicable to a facility setting will be paid Type of Service 54 rates. Place of service codes applicable to a non-facility setting will be paid Type of Service 55 rates.

HIPAA PLACE OF SERVICE CODES		
Code	Short Description	N/NF
01	Pharmacy	NF
03	School	NF
04	Homeless Shelter	NF
09	Prison/Correctional Facility	NF
11	Office	NF
12	Home	NF
13	Assisted Living Facility	NF
14	Group Home	NF
15	Mobile Unit	NF
16	Temporary Lodging	NF
17	Walk-in Retail Health Clinic	NF
20	Urgent Care Facility	NF
21	Inpatient Hospital	F
22	Outpatient Hospital	F
23	Emergency Room - Hospital	F
24	Ambulatory Surgical Center	F

F = Facility. NF = Non-Facility. Codes 10, 63, 64 are unassigned

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Code	Short Description	N/NF
25	Birthing Center	NF
26	Military Treatment Center	F
31	Skilled Nursing Facility	F
32	Nursing Facility	NF
33	Custodial Care Facility	NF
34	Hospice	F
41	Ambulance - Land	F
42	Ambulance - Air or Water	F
49	Independent Clinic	NF
50	FQHC	Not Applicable
51	Inpatient Psychiatric Facility	F
52	Psychiatric Facility - Partial Hospitalization	F
53	Community Mental Health Center	F
54	Intermediate Care Facility/Developmentally Disabled	NF
55	Residential Substance Abuse Treatment Facility	NF
56	Psychiatric Residential Treatment Center	F
57	Non-Resident Substance Abuse Treatment Facility	NF
60	Mass Immunization Center	NF
61	Comprehensive Inpatient Rehab Facility	F
62	Comprehensive Outpatient Rehab Facility	NF
65	End-Stage Renal Disease Treatment Facility	NF
71	State or Local Public Health Clinic	NF
72	Rural Health Clinic	Not Applicable
81	Independent Laboratory	NF

F = Facility. NF = Non-Facility. Codes 10, 63, 64 are unassigned