HOSPITAL PROCESS AND PROCEDURES MANUAL FOR PRECERTIFICATION
Length of Stay

Version **3**

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

Molina

ABOUT THIS DOCUMENT

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

This document does not present general Medicaid policy such as standards for participation, recipient eligibility and ID cards, and third party liability. The Basic Medicaid Information Training packet may be obtained by going to the Louisiana Medicaid website (www.lamedicaid.com) and downloading the Basic Medicaid Information packet, found under the **Training** link or by clicking on the yellow **Acute Precert** button.

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PROJECT INFORMATION

Document Title	Louisiana Medicaid Management Information System (LMMIS) – Precertification Process and Procedures		
Author	Technical Communications Group, Molina Medical Solutions, LMMIS QA		
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Date	**Description of Change**	**LIFT**	**By**
September 2009	Initial draft		T. Tate
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September 20, 2010	Updated the instructions on the attached PCF04 in the Appendix. Updated pages 5, 6, 9, 13, 15, 17, 22, 23 and 25. Repaginated. Bumped up to Word 2007 (docx).		R. Sheehan
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1.0 Introduction

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

The major functions/procedures of the Hospital PreCertification/Length of Stay process are:

- Registration and length of stay (LOS) assignment for all acute care and rehabilitation hospitals admissions.
- Pre-admission certification and LOS assignment for admissions to long term acute care hospitals, private distinct part psychiatric/substance abuse units in acute care general hospitals and free-standing psychiatric hospitals.
- Reviews are conducted by nurses and physicians. Physicians are available to discuss any denied stay with the hospital designated physician.
- Hospitals submit all requests, including required forms and limited documentation when requested, via fax to the fiscal intermediary, Molina.
- Hospitals are notified by written notification of approval, rejection and denial of requests.
- A reconsideration process is available for denied requests as well as a formal appeal process through DHH.
- Timely updating of clinical criteria and length of stay data bases occurs annually.
- Medical documentation submitted by the provider on required forms is utilized when the Molina Precert reviewer inputs data into the system to make a decision.
- All initial requests are assigned a designated Precertification case number to enhance access and communication between the provider and Molina Precertification personnel.

The types of requests for inpatient hospital stays include:

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

2.0 Acute Care Adult or Pediatric Hospital Stays

2.1 Acute Care: Adult or Pediatric Admissions Process

- Acute Care admissions include the following levels of care: General, Burn, ICU, PICU, CCU and NICU (additional information on NICU and low-birth weight babies is in Section 2.8).
- Initial requests whether approved, rejected or denied are assigned a Precertification case number.
- Medicaid recipients should be registered for admission by completing the Form PCF01 and faxing to Molina. No requests prior to the admission date are accepted for acute care facilities.
- All initial admission requests must be submitted within 24 hours of admit except for weekends or Molina Holidays. In these instances, submit the next business day.
- Approved, denied, or rejected case decisions will be faxed to the facility within the required 24 hours from the date and time of receipt in precert.
- The hospital should only register a patient and submit a PCF01 **if** there is medical necessity present for an inpatient admission, **if** the case meets InterQual Criteria and **if** there is a physician order for inpatient status.
- Initial LOS for acute care is assigned according to the current Thomson-Reuters Recommended LOS Southern Region average. The assignment will be set at age appropriate All Stays of the 50th percentile of the ICD-9 primary and/or admitting diagnosis code submitted.

2.2 Acute Care: Adult or Pediatric Extension Process

- Acute Care extensions include the following levels of care: General, Burn, ICU, PICU, CCU and NICU (additional information on NICU and low-birth weight babies is in Sections 2.8).
- Request for an extension must be submitted via fax no later than the expected discharge date. If the discharge date is a weekend or Molina holiday, the extension request may be submitted on the next business day. The “expected discharge date” is shown on the provider notification received after each approved request.
- Forms PCF-01and PCF-02 must be submitted for each acute care extension request. There are to be no attachments to the PCF02 unless requested by the nurse reviewer with a limit of no more than two additional pages of documentation. All pertinent information must be included on the form itself or on the accepted forms by the Provider Link system.
- Extension LOS requests will be reviewed by a nurse to determine if the stay meets InterQual® criteria based on the patient information submitted on the Form PCF-02 for the appropriate Level of Care.
- Extension LOS for Acute Care is assigned according to the current Thomson-Reuters recommended LOS Southern Region average. The first extension assignment will be set at the age appropriate ALL Stays up to the 75th percentile of the ICD-9 diagnosis code submitted. Subsequent extensions will be assigned a LOS up to 5 days for a general level of care and up to 7 days for the named levels of care. All approvals are based on criteria being met.

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

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

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

2.3 Rejections of Acute Care Precertification Requests

- All initial Precert requests that are REJECTED (no assignment of stay given) should be returned to Precert as an **Initial Resubmittal**. The PCF01 must be used for the **Resubmittal Request**. The resubmitted PCF01 must include the Case Number assigned on the initial Precert request.

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

2.4 Denials of Acute Care Precertification Requests

- Only a physician can issue medical necessity denials. All Precerted days must meet current InterQual criteria for inpatient admit and LOS.

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

- The hospital Provider has three options following a Denial.
    1. Submit written Reconsideration. Must be submitted the next business day following the Denial.
    2. Request a scheduled Physician to Physician Telephone Conference.
    3. Submit to DHH for Appeal through the Administrative Court. The Provider must schedule the appeal through DHH within 30 days of the first denial date.

- A written **Reconsideration** is submitted to Precert within one business day of the Denial Notification faxed by Molina. For denial of an initial admission, the PCF01 must be used for the Reconsideration request and must include the Case number assigned on the initial Precertification request.

- For denial after an extension request, the PCF02 must be used for the Reconsideration request.

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

- The reconsideration documentation will be reviewed by a Precert Physician. If an InterQual criterion is met; a LOS will be approved. The Provider will then submit routine extension requests if patient remains inpatient. If InterQual is NOT met, the reconsideration will be denied.

- Following a Denial of a Reconsideration request, the Provider has two remaining options:

    1. Schedule Physician to Physician conference through Molina Precert. Telephone # 800-877-0666.
    2. Submit to DHH for Appeal through the Administrative Court. The Provider must schedule the appeal through DHH within 30 days of the first denial date.

- The Physician to Physician Conference is an opportunity for the Facility Physician to discuss a denied case with a Precert Physician. The Hospital may “designate” a Physician from their facility to participate in the conference.

    - The Hospital will contact the telephone representative in Precert. She will fax to the Hospital, a schedule of conference date and time availability. The Hospital will contact their Physician for his/her availability. The Hospital will then contact the Precert telephone representative to set up the conference day and time based on the availability of the participating Physicians.

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

    - The Department allows a Hospital up to two appointment cancellations per Precert denied case. If the conference is cancelled after two (2) appointments, the Hospital will need to submit to DHH Appeal for further action on the denial.

2.5 Outpatient Status vs Inpatient Status

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

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

- The hospital should **ONLY** register a patient and submit a PCF01 if there is **MEDICAL NECESSITY** present for an inpatient admission, if the case meets InterQual Criteria and if there is a physician order for inpatient status.

- All claims submitted are subject to post payment review by program integrity.

2.5.1 Outpatient Status Changing to Inpatient Status

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

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

- If situations where the patient is outpatient on hospital day 1 and converts to inpatient after hours on hospital day 2, the PCF01 must submitted the next business day. The hospital should indicate on the PCF01 by the admit date that hospital day 1 was an outpatient day. This will prevent denials for timely submission.

- The outpatient admit day becomes the inpatient "Admit day" for this type of case.

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

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

NOTE: Molina reserves the right to request a copy of the inpatient order.

2.5.2 Outpatient Ambulatory Surgeries

- Certain surgical procedures are covered by the Medicaid Program only when performed outpatient unless otherwise authorized. A list of these procedures is provided in Appendix G.

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

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

2.6 Outpatient Procedures Performed on Day of Admission or Day After Admission

- In certain circumstances, patients may require inpatient admission for surgical procedures normally covered by the Medicaid Program only when performed outpatient as referenced in Section 2.5.2.

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

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

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

- The PCF02 information supports the medical necessity for the procedure being performed inpatient. If the PCF01 is received without the PCF02, the request will be rejected.

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

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

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

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

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

2.7 Precertification of Newborns

Newborn Initial Admissions

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

- Healthy babies, born to **NON MEDICAID ELIGIBLE** mothers **can** be precerted. You must submit a **completed** PCF01 with all "zeros" for the 13 digit Medicaid ID number.
- In the "description" area on the PCF01 you must state "Mom not Medicaid Eligible" and include the mother's Social Security number.

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

    - V3000 will be used for baby "delivered vaginally."
    - V3001 will be used for baby "delivered by C Section.

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

- Ill newborns (with Medicaid eligible mothers) who remain after the mother's discharge date and are NOT admitted to NICU are precerted with the Mother's discharge date as the ill newborn's admit date on form pcf01.

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

    - Fully completed PCF01 checked as an UPDATE.

    - This will include the 13 digit Medicaid ID number, the baby's name BEFORE the Medicaid ID number was assigned, the Baby's name NOW associated with the ID Number and the PROVIDER'S SIGNATURE. Molina staff member is changing the name designation on the case and therefore must have signed authorization.

Newborn Extension Request

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

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

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

2.8 Precertification for NICU Levels of Care

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

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

- Initial NICU Admissions for Short Gestation and Low Birth Weight (less than 2500 gms)

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

- Initial NICU Admissions for Other Than Short Gestation and Low Birth Weight

    - Initial length of stay for NICU is assigned referencing the ICD-9 primary and/or admitting diagnosis code submitted by the hospital, and
    - Current Thomson-Reuters 50th percentile of the Southern Region and/or Louisiana customized length of stay.
    - PCF01 will be required for initial admissions to NICU for diagnosis other than low birth weight/short gestation.

- Extension requests for NICU for Short Gestation and Low Birth Weight (less than 2500 gms)
    - Fully completed PCF04 will be required for all extension requests.
    - Extension LOS assignment will be based on the Louisiana Medicaid defined Length of Stay.
    - Current InterQual Intensity of Service (IS) criteria will be used for review of all extension requests for continued stay.
    - The birth weight or short gestation ICD-9 diagnosis code used on the Initial admission should **ALWAYS** be the first extension ICD-9 code entered in Diagnosis block 1 on the PCF04 for all subsequent extension requests.
    - Include additional diagnosis codes affecting intensity of service and supporting the continued stay.

- Extensions Other Than Short Gestation and Low Birth Weight.

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

2.9 Precertification for OB Care and Delivery

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

    - 3 days are authorized for vaginal deliveries if the admission date is equal to the date of delivery.
    - 4 days are authorized for vaginal deliveries if the delivery occurs the day after admission.
    - 5 days are authorized for C-Sections if the admission date is equal to the date of delivery.
    - 6 days are authorized for C-sections if the delivery date occurs the day after admission.

Note: The 2 days approved for a vaginal delivery and 4 days approved for a cesarean section are in accordance with federal guidelines pertaining to the Newborn Protection Act. Days beyond the 2 and 4 days that are approved in accordance with the Newborn Protection Act via the precertification edit are to account for admissions or deliveries late in the evening. Any days approved via the claims processing edit that are greater than the 2 and 4 days mandated by federal guidelines may be subject to medical necessity review retrospectively. Facility specific length of stay reports are generated monthly to compare delivery LOS data pre and post implementation of this policy. Medical necessity should guide the physician decision making process related to discharge and patients should be kept in the hospital for <u>medical necessity only</u>.

- Complete PCF01 and PCF02 with clinical information supporting stays beyond these periods of time.

- The PCF02 should include clinical information supporting stays beyond the periods of time listed above.

- The PCF01 and PCF02 must be submitted on the expected discharge date. If the expected discharge date falls on a weekend or Molina holiday then submit the PCF01 and PCF02 the next business day following the expected discharge date.

- If an ambulatory surgical procedure is performed on the first or second day of the inpatient stay for a delivery, precertification is required. Refer to Appendix G for the list of ambulatory surgical procedures---sterilization procedures are included on this list as they are considered outpatient procedures.

- If a sterilization procedure is performed following the delivery (and not on the first or second day) and the inpatient stay does not exceed the number of days considered automatically approved (refer to information in the first bulleted item above), there is no need to request Precertification because of the sterilization.

- When billing for the sterilization/delivery all required forms **must** be attached and correctly completed.

Vaginal Delivery Precertification Example:

- If the vaginal delivery day is equal to the admission date to the hospital then the patient must discharge home by day 4 of the hospitalization in order to be excluded from precert. If the mother does not discharge home on the 4th day of her hospitalization then the PCF01 & PCF02 must be submitted on the 4th day of hospitalization. The 4th day is the expected discharge day. If the 4th day falls on a weekend then the PCF01 & PCF02 are due on the next business day.

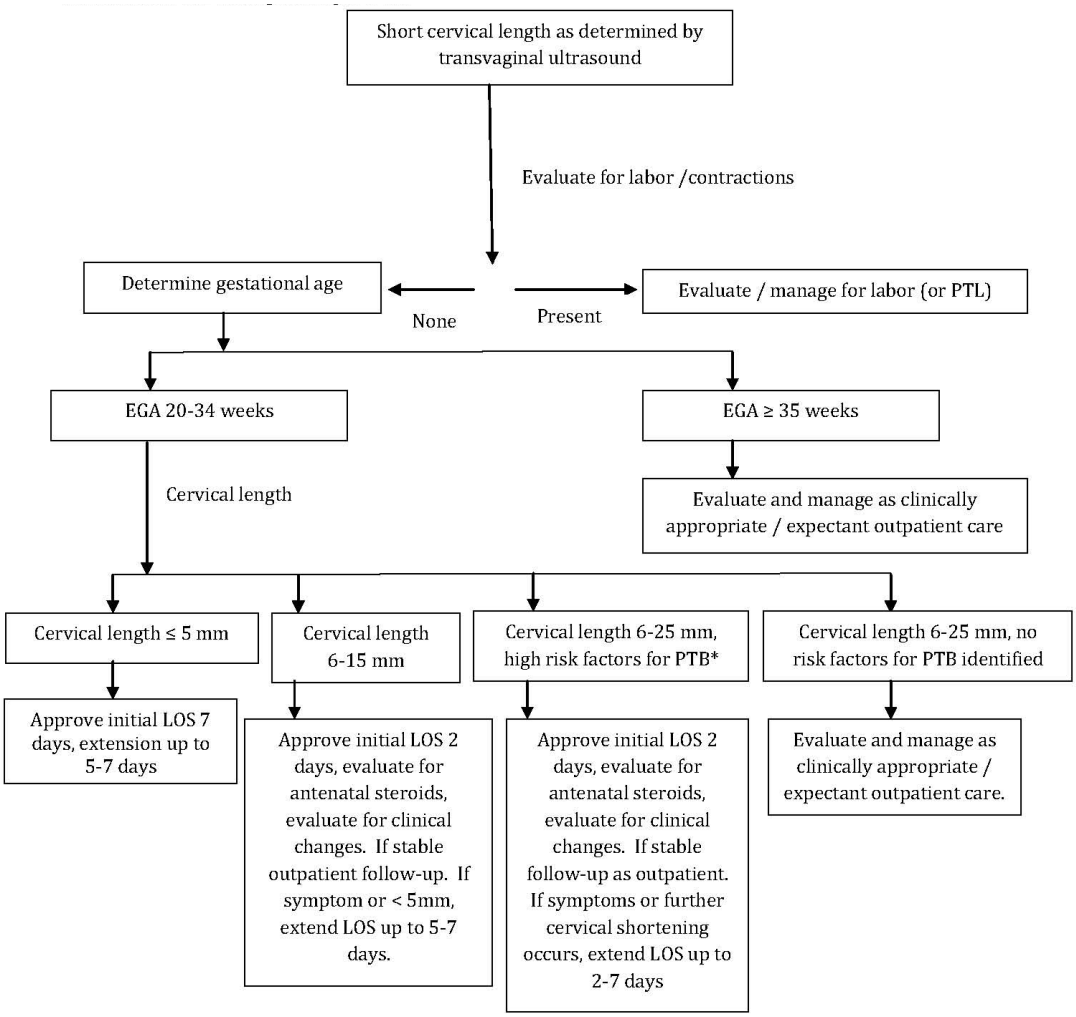
C-Section Precertification Example:

- If the C-Section delivery date is the day after the admission date to the hospital then the patient must discharge home by day 7 of the hospitalization in order to be excluded from precert. If the mother does not discharge home on day 7 then precert is required. Submit a PCF01 & PCF02 on day 7 of the hospitalization. Day 7 is the expected discharge date. If the 7th day falls on a weekend then the PCF01 & PCF02 are due on the next business day.

2.10 Short Cervical Length Guidelines

Short Cervical Length in Pregnancy

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



*Risk factors include, but not limited to, multiple gestation, prior preterm birth / labor, incompetent cervix, FFN status.

3.0 Rehabilitation Admission/Level of Care

3.1 Rehabilitation Admissions

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

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

3.2 Rehabilitation Extension

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

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

    - All of the following medical data must accompany the Rehab extension request:
        a. PCF01
        b. PCF03
        c. Established criteria
        d. Multidiscipline staffing report

    - The first extension approval for Rehab is given up to 14 days. Subsequent extensions are up to 7 days.

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

3.3 Process for rejected extensions for Acute Care and Rehabilitation:

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

3.4 Process for denied extensions for Acute Care and Rehabilitation:

- The provider has 24 hours to request a written reconsideration by submitting the requested supporting medical documentation and a Form PCF02 for the denied days.
- If the request is denied, the provider may contact the Molina Pre-certification Department to set up physician-to-physician conference.
- There is no reconsideration process for requests denied for lack of a timely submittal.
- If the request and the physician-to-physician review have been denied, providers may file an official appeal with DHH at the address below:

Department of Administrative Law/HH Section
P. O. Box 4189
Baton Rouge, Louisiana 70821

Note: Additional information can be found on the Precert notification letter or refer to Section 10.0 for additional information on the appeals process.

4.0 Long-Term Acute Care (LTAC) Hospital Stays

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

- All of the following medical data must accompany the preadmission/admission request for Long-Term Acute Care:
    - Form PCF01 **and**
    - Established criteria **and**

    Either Discharge summary from transferring hospital **or**
    Form PCF06

- Long-Term Acute Care will be assigned an initial LOS of up to 14 days.

4.1 Long-Term Acute Care (LTAC) Extension

- All of the following medical data must accompany the extension request for Long-Term Acute Care to determine if the stay meets criteria:
    - Form PCF01 **and**
    - Established criteria **and**
    - Form PCF06

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

- The first extension approval for Long-Term Acute Care is given for up to 14 days. Subsequent extension is up to 7 days.

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

5.0 Psychiatric/Substance Abuse (SAU) Hospitals Stays

5.1 Psychiatric/Substance Abuse (SAU) Admissions

- All of the following medical data must accompany the admission request for Psych/Substance Abuse:

    a. Form PCF01 **and**
    b. Appropriate criteria (psych/substance abuse) **and**
    c. **Certificate of Need for Recipients under 21 years and**
    d. Form PCF05 or all of the following:

        1. a, b, c, **and**
        2. Psychiatric physician evaluation (if available) **and**
        3. Initial assessment by registered nurse or licensed mental health professional **and**
        4. Psychiatric physician admit orders

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

NOTE: **In compliance with CMS regulations, Certificate of Need (CON) must be signed by the independent admit team unless it is documented as an emergency psychiatric admission. Emergency admissions supported by appropriate documentation may have the CON signed by the hospital interdisciplinary team.**

5.2 Psychiatric/Substance Abuse Extension

- All of the following medical data must accompany the extension request for Psych/Substance Abuse:

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

- The first extension approval is assigned according to the current Thomson-Reuters recommended LOS Southern Region average. The assignment will be set up at the age appropriate ALL Stays up to the 75th percentile of the ICD-9 diagnosis code submitted. Subsequent extensions are up to 3 days.

6.0 Late Requests for Initial Stay Due to Conflicting Medicaid Eligibility Verification System (MEVS) Response

Late submissions of an initial pre-certification case due to an incorrect response from a MEVS inquiry will be given consideration if a good faith effort is verified with the actual printout from the MEVS system that was accessed within one business day of the admission. Such cases, along with supporting documentation, should be submitted to Molina Pre-certification Department.

6.1 Retrospective Review Based on Patient Retroactive Eligibility

- Only one situation is recognized for retrospective review based on patient eligibility. This occurs when positive determination of Medicaid eligibility cannot be made during the admission period. This refers to the State's determination of eligibility.
- If a patient's stay exceeded the recommended LOS, an extension should be requested concurrently with the admission LOS review. All retrospective LOS must be supported by criteria. Approval of the request will follow the procedures required for the type of admission/extended stay being requested.
- The patient's discharge date must be indicated on the PCF01.
- If the approved LOS days are less than actual days of stay, only the number of approved LOS days will appear on the provider notification.
- Cases denied will follow same denial and appeal procedures described in Section 10.0.

6.2 Retrospective Review Based on Provider Retroactive Eligibility

- If an in-state hospital is enrolled as a Louisiana Medicaid provider with a retroactive begin date of eligibility; the hospital may request retroactive review for Medicaid patient stays during the retroactive period.
    - If the patient has been discharged, the request should be for the entire stay and must be supported by criteria.
    - If the approved LOS days are less than the actual days of stay, only the approved LOS will appear on the provider notification.
- Cases denied will follow same denial and appeal procedures described in Section 10.0.

7.0 Pre-certification Requirements for Recipients with Both Medicare and Medicaid

Coverage	Pre-certification Required?
Medicare Part A only – benefits not exhausted	No
Medicare Part A only – benefits exhausted	Yes –Form PCF-01 and Medicare EOMB (Explanation of Medical Benefits) to verify days are exhausted. EOMB should show the first date of Medicare exhausted benefits for denied days. (See Section 8.0)
Medicare Part B only	Yes
Medicare Parts A and B - Part A Benefits not exhausted	No
Medicare Parts A and B - Part A Benefits exhausted	Yes –Form PCF-01 and Medicare must submit EOMB (Explanation of Medical Benefits) to verify days are exhausted. EOMB should show the first date of Medicare exhausted benefits for denied days. (See Section 8.0.)
Medicare Replacement Plans	No

*****Remember that the provider has only 60 days from the notification date on the Medicare EOMB to submit a precert request. *****

8.0 Submission of Hospital "Common Working File" (CWF) Screens for Pre-certification Documentation of Medicare Part A Benefits Exhausted

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

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

In situations when a hospital is denied an extension request based on timely submittal of the medical information requested by Molina, and the patient is still in the hospital, the Department of Health and Hospitals allows hospitals to request to re-open the pre-certification case under a new pre-certification number when the hospital submits current documentation to be reviewed as long as the patient continues to be an inpatient.

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

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

If you have questions about the process described, please call the Pre-Cert Department at 1-800-877-0666. The hospital will be assigned a new pre-certification number, with the admit date being the date that Molina receives the current request. The days that were denied may be appealed through the DHH appeal process using the pre-certification number under which the days were denied.

10.0 Hospital Precertification Reconsideration/Appeal Process

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

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

If the Molina physician upholds the denial and the facility still feels that a valid need exists to admit or extend the stay of a patient, then a formal appeal may be initiated through Division of Administrative Law.

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

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

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

This information must be sent to:

(For regular mail) Division of Administrative Law/HH Section P. O. Box 4189 Baton Rouge, LA 70821	(For certified mail or Federal Express *only*) Office of Secretary Division of Administrative Law/HH Section 654 Main Street Baton Rouge, LA 70802

11.0 Precertification Department General Information

Molina Working Hours and Holidays

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

Molina holidays are as follows:

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

Molina Pre-certification Fax Information

Pre-certification Fax Numbers
(800) 717-4329
(800) 348-5658

(225) 216-6219 – **Do NOT use unless requested by a Precert staff member.**

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

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

- Often information is difficult to read. This may be the result of copier quality or writing legibility. Please be as clear as possible.

- Colored pages DO NOT fax well.

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

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

The second unique feature of the Pre-certification fax server is its written reports, generated each hour, documenting failed faxes. (These are faxes Pre-certification is sending to providers).

This allows Pre-certification staff to refax information listed as having failed. If groups of faxes sent to the same facility continue to fail in transmission, the Pre-certification staff contacts that facility to alert its staff to potential problems with the provider's fax machine. Every 24 hours, Pre-certification receives a written log of all faxes sent—those received by the providers as well as those which failed and were re-sent.

If, despite these features, providers have an ongoing fax problem with either sending data to or receiving data from Pre-certification, providers are encouraged to contact Molina Pre-certification Department who will assist in identifying the problem and in advising of its solution.

- Every fax to the Precert Department should have a cover page.
- On your fax cover letters, you must identify the total number of pages submitted in that particular fax. This enables you to know if all the pages you intended to fax did go through.
- Check your fax transmittal receipt to verify that all pages were sent successfully.
- If your fax transmittal shows that some pages did not go through, please refax the entire submission.

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

Precertification Turnaround Times

Maximum response time begins when all necessary information is received in the Precert Department.

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

Psych and Substance Abuse	
Initial LOS	24 Hours
Extension	24 Hours
Pre-certification	24 Hours
Retro Review	21 Days

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

Long-Term Acute Care	
Initial LOS	24 Hours
Extension	24 Hours
Pre-certification	24 Hours
Retro Review	21 Days

Precertification Reference Guides

The following reference guides will be used as criteria:

Most current McKesson InterQual® Level of Care Criteria
- Acute Care Adult
- Acute Care Pediatric

Most current McKesson InterQual® Level of Care Criteria
- Procedures Volume I Adult

- Procedures Volume II Adult
- Procedures – Pediatric

Most recent data from Thomson-Reuters recommended LOS Southern Region Average.

These manuals may be obtained by contacting the InterQual® and Thomson-Reuters offices:

McKesson Health Solutions, LLC
www.mckesson.com
InterQual® Support 800-274-8374
cesupport@mckesson.com

275 Grove Street
Suite 1-110
Newton, MA 02466-2273
USA

Tel: 617-273-2800
Fax: 617-273-3777

Thomson Reuters
777 East Eisenhower Parkway
Ann Arbor, MI 48108
(508) 842-0656 – phone
(866) 314-2572 – fax
(877) 843-6796 – help line

Molina Precertification Contact Information

Molina Pre-certification Telephone Number
Pre-certification: (800) 877-0666

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

Molina
Molina Louisiana Medicaid
Attn. Pre-certification Department
8591 United Plaza Blvd.
Suite 300
Baton Rouge, Louisiana 70809

Precertification Reminders

- Please list an extension diagnosis for each extension request. This extension diagnosis should be the attending physician's diagnosis at the time of the extension request and may or may not be the same as the admitting and/or primary diagnosis.

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

- Write the description of the ICD-9 codes submitted.

- Include start and stop dates for medication, and date all lab values and vital signs. Per Interqual Criteria: “All PRN medication must be noted by the number of times administered and by what route.”

- Transcribe the requested physician progress notes if they are not legible. Do not send additional documentation unless specifically requested for acute inpatient stays.

- Do not fax copies of photographs since they copy very poorly. Instead, please submit description or mail pictures of wounds/decubiti.

- In compliance with HCFA regulations, Certificate of Need (CON) must be signed, as introduced in the CMS (Combined Medicare/Medicaid Service) required form, (refer to page XX), by the independent admit team unless this can be documented as an emergency psychiatric admission. Emergency admissions supported by appropriate documentation may have the CON signed by the hospital interdisciplinary team.

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

12.0 What Providers Can Do To Help The Process

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

- The notification letter to the provider will contain the status of the request and, using 3-digit codes; will inform the provider of any additional information needed. Providers need to respond by sending the requested information on the appropriate required Forms (PCFO1, PCFO2, PCF04 for acute inpatient and non general level of care) or by writing an explanation of why the information is not available.

- Read over what is being sent to Molina. Often providers send conflicting documentation among disciplines. These cases are reviewed based on the preponderance of information.

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

Molina Pre-certification staff always requires current, up-to-date information on medications and therapies supporting the criteria. Lack of current or time-sensitive information usually results in an unfavorable decision. Only that information pertinent to the request from the last request is required. Do not resubmit information previously submitted unless requested. Information must be on mandatory forms required.

13.0 Pre-certification Glossary

Approved: Admission and/or extension is approved.

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

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

Resubmittal: Hospitals may send additional documentation/information for requests that have been **rejected**. If rejected, then provider is **resubmitting** the request, not a reconsideration. A Resubmittal must be submitted within 48 hours (two business days) form the date faxed from Precert.

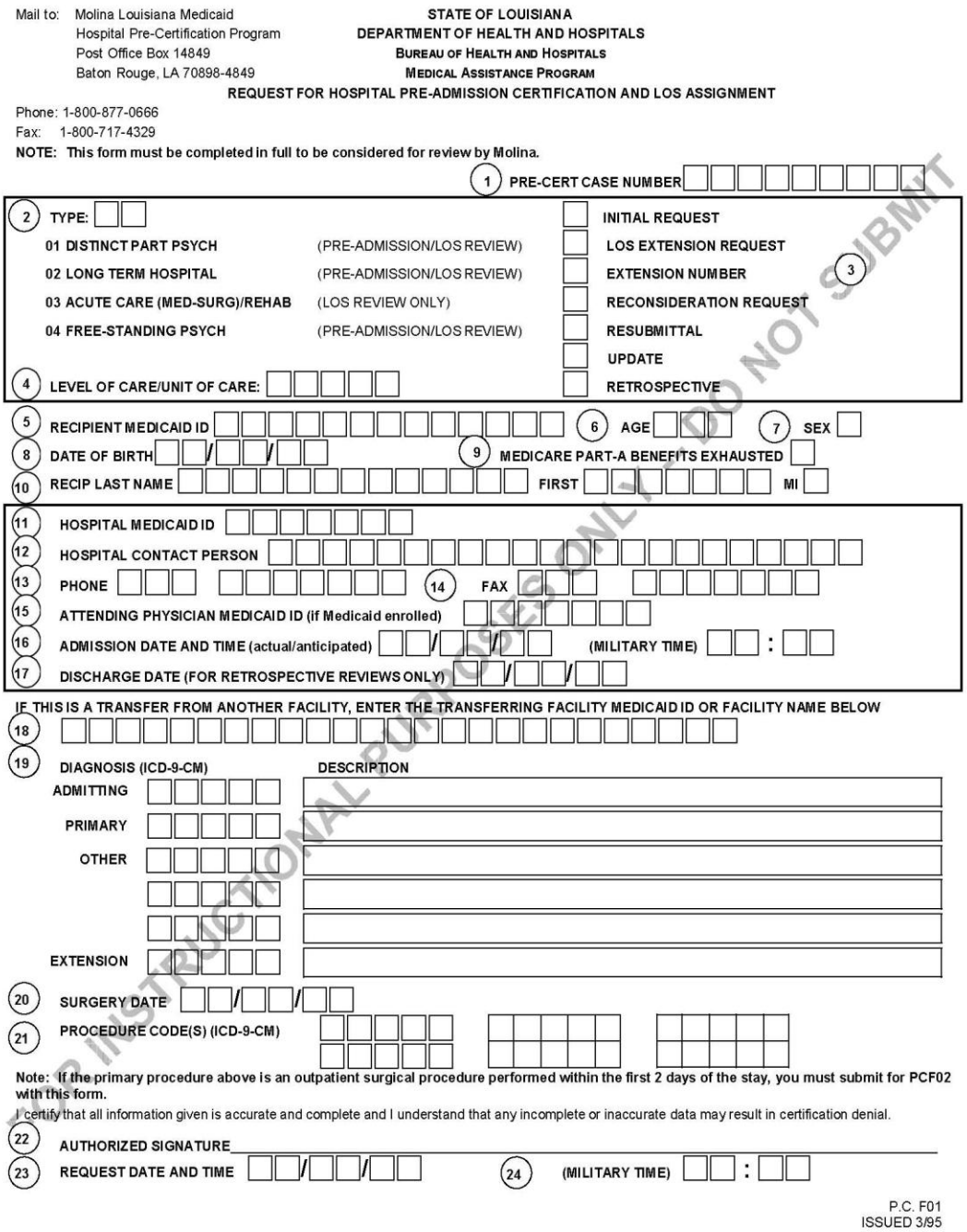
Reconsideration: Hospitals may request reconsideration of cases **denied** for lack of medical necessity. A reconsideration must be submitted with in 24 hours from the date faxed from Precert, except for weekends or Molina holidays. In these instances, submit by the next business day.

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

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

14.0 APPENDICES

Appendix A - PCF01 with instructions



Mail to: Molina Louisiana Medicaid
Hospital Pre-Certification Program
Post Office Box 14849
Baton Rouge, LA 70898-4849

Phone: 1-800-877-0666
Fax: 1-800-717-4329

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH AND HOSPITALS
MEDICAL ASSISTANCE PROGRAM

REQUEST FOR HOSPITAL PRE-ADMISSION CERTIFICATION AND LOS ASSIGNMENT

NOTE: This form must be completed in full to be considered for review by Molina.

1 PRE-CERT CASE NUMBER

2 TYPE:
- 01 DISTINCT PART PSYCH (PRE-ADMISSION/LOS REVIEW)
- 02 LONG TERM HOSPITAL (PRE-ADMISSION/LOS REVIEW)
- 03 ACUTE CARE (MED-SURG)/REHAB (LOS REVIEW ONLY)
- 04 FREE-STANDING PSYCH (PRE-ADMISSION/LOS REVIEW)

- INITIAL REQUEST
- LOS EXTENSION REQUEST
- EXTENSION NUMBER 3
- RECONSIDERATION REQUEST
- RESUBMITTAL
- UPDATE
- RETROSPECTIVE

4 LEVEL OF CARE/UNIT OF CARE:

5 RECIPIENT MEDICAID ID 6 AGE 7 SEX

8 DATE OF BIRTH 9 MEDICARE PART-A BENEFITS EXHAUSTED

10 RECIP LAST NAME FIRST MI

11 HOSPITAL MEDICAID ID

12 HOSPITAL CONTACT PERSON

13 PHONE 14 FAX

15 ATTENDING PHYSICIAN MEDICAID ID (if Medicaid enrolled)

16 ADMISSION DATE AND TIME (actual/anticipated) (MILITARY TIME)

17 DISCHARGE DATE (FOR RETROSPECTIVE REVIEWS ONLY)

IF THIS IS A TRANSFER FROM ANOTHER FACILITY, ENTER THE TRANSFERRING FACILITY MEDICAID ID OR FACILITY NAME BELOW

18

19 DIAGNOSIS (ICD-9-CM) DESCRIPTION

ADMITTING
PRIMARY
OTHER
EXTENSION

20 SURGERY DATE

21 PROCEDURE CODE(S) (ICD-9-CM)

Note: If the primary procedure above is an outpatient surgical procedure performed within the first 2 days of the stay, you must submit for PCF02 with this form.

I certify that all information given is accurate and complete and I understand that any incomplete or inaccurate data may result in certification denial.

22 AUTHORIZED SIGNATURE

23 REQUEST DATE AND TIME 24 (MILITARY TIME)

P.C. F01
ISSUED 3/95

FOR INSTRUCTIONAL PURPOSES ONLY - DO NOT SUBMIT

INSTRUCTIONS FOR COMPLETING THE PRE-CERT REQUEST FORM P.C.F01
Please note that ALL FIELDS ARE REQUIRED. Incomplete forms will result in a REQUEST REJECTION.

1. Enter the case number when requesting extension of days, or reconsideration. Leave this field blank when requesting an initial admission review.

2. Enter the type of facility requesting admission approval and LOS assignment.

3. Check the appropriate box to indicate the type of review requested. If extension request, please indicate extension number. Reconsideration to be checked for cases denied for medical necessity. For resubmittals, follow instructions as documented on rejection letter. **Update is used for adding recipient Medicaid ID number for newborns and/or outpatient procedures performed on an in-patient basis if it is primary or only procedure preformed within the first two days of the hospital stay.** It is not necessary to update other procedures. Retrospective is for recipients discharged from hospital when positive determination of Medicaid eligibility could not be made during admission process.

4. Enter one of the following LEVEL-OF-CARE or UNIT-OF-CARE CODES:

BURN	Burn Unit	**PICU**	Pediatric Intensive Care Unit
CCU	Coronary Care Unit	**PSYCH**	Psychiatric Unit
GEN	General Unit	**REHAB**	Rehabilitation Unit
ICU	Intensive Care Unit	**SAU**	Substance Abuse Unit
NICU	Neonatal Intensive Care Unit	**TU**	Telemetry Unit
OU	Observation Unit	**LT**	Long Term

5. Enter the 13-digit recipient's Medicaid number.

6. Enter the recipient's age on date of admit. If recipient is less than 1 year old, enter zeros in this field.

7. Enter the recipient sex. M=male F=female

8. Enter the recipient date of birth MM/DD/YY.

9. Enter a "Y" in this field if the recipient is eligible for Medicare Part-A and benefits have expired. If used, a Medicare EOMB or other appropriate documentation must be attached to this form.

10. Enter the recipient's last name, first name, and middle initial.

11. Enter the seven-digit Hospital Medicaid number.

12. Enter the name of the person to be contacted for information pertaining to this case.

13. Enter the phone number for the contact on this case.

14. Enter the fax number where data should be faxed, if desired.

15. Enter the admitting/attending physician Medicaid number of the primary care physician. If the physician is not enrolled in the Medicaid program, leave blank.

16. Enter the admission date MM/DD/YY. If the actual date is not know, enter the anticipated admit date. Enter the admission time (in military format).

17. Enter the date of discharge for retrospective review cases only, where the recipient has already been discharged.

18. If the recipient is being transferred from another facility, or a separate unit in the same facility, enter the transferring facility's Medicaid ID number (if Medicaid enrolled). If not enrolled in Medicaid, enter that facility's name. If not a transfer, leave blank.

19. For an initial admission, enter the ADMITTING (most likely the initial diagnosis; may be problem oriented), PRIMARY (more specific or final disposition based on hospital diagnostic testing), and OTHER diagnosis ICD-9-CM codes and descriptions that pertain to the recipient's condition. **You must enter at least the admitting and/or the primary diagnosis. For extension requests, you must enter an extension diagnosis.**

20. Enter the date of surgery if applicable to this case (required for organ transplants and outpatient surgery performed on an inpatient basis).

21. Enter the procedure(s) ICD-9-CM codes associated with this case (required for organ transplants and outpatient surgery performed on an inpatient basis, for which you must also submit for PCF02).

22. **Authorized signature is required. Requests will not be accepted if not signed.**

23. Enter the date this request is submitted to UNISYS.

24. Enter the time of day (military time format) this request is submitted to Molina.

Appendix B - PCF02 with instructions

INSTRUCTIONS FOR COMPLETING THE REQUEST FOR INPATIENT ACUTE CARE OR HOSPITALIZATION FOR OUTPATIENT PROCEDURES FORM P.C.F02

Please note that ALL FIELDS ARE REQUIRED. Incomplete forms will result in a REQUEST REJECTION.

1. Enter one of the following LEVEL-OF-CARE CODES:

BURN	Burn Unit Unit	**PICU**	Pediatric Intensive Care
CCU	Coronary Care Unit	**PSYCH**	Psychiatric Unit
GEN	General Unit	**REHAB**	Rehabilitation Unit
ICU	Intensive Care Unit	**SAU**	Substance Abuse Unit
NICU	Neonatal Intensive Care Unit	**TU**	Telemetry Unit
OU	Observation Unit	**LT**	Long Term

2. Enter the case number when requesting extension of days, or reconsideration. Leave this field blank when requesting an initial admission review.

3. Enter the 13-digit recipient's Medicaid number.

4. Enter the recipient's last name, first name, and middle initial.

5. Enter the 7-digit Louisiana Medicaid Provider ID number.

6. Enter the ICD-9-CM diagnosis code or codes that justify or require the extension of hospitalization. Be sure to include the code description.

7. Enter the surgical procedure(s) ICD-9-CM codes associated with this case.

8. Enter the dates that correspond with the surgical procedures codes entered in 7 (MM/DD/YY).

9. Check the box which most accurately describes this request type: Admission, Update, Hospital Extension, Resubmittal, Reconsideration, or Outpatient Procedure.

GUIDELINES FOR MEDICAL DOCUMENTATION

10. In the space provided, describe the severity illness and the presenting history. Specify when the symptoms and findings developed, worsened, or improved, including time and date.

11. Describe the intensity of services during the last 24 hours. In the space provided, put the number of physician evaluations that have occurred per day. In the next space, list type and rate of ALL IV fluids, T.P.N., etc. with start and discontinue dates. In the next space, list all medications with dosage, route, and frequency, especially those related to current ICD-9-CM diagnosis code. In the next space, list the labs, X-Rays, imaging studies, and invasive procedures, with date(s) and frequency that relate to the extension request. In the final space provided, list all treatment(s), including type, frequency, dates, etc. Include neuro checks frequency, and start and stop dates.

12. In the space provided, write any additional comments that help to justify continued hospitalization stay, including the status of discharge planning.

13. In the spaces provided, write the name, phone number, and fax number of the main contact person for this request.

14. In the spaces provided, write the title of the primary hospital reviewer, the reviewer's signature, and the date of the request.

STATE OF LOUISIANA DHH – BHSF
MEDICAL ASSISTANCE PROGRAM

Request for Inpatient Acute Care: Admit to ICU, Extension, Reconsideration or Resubmittal or Update
Request for Hospitalization for Outpatient Procedures: Day of Admit or Day After Admit
Please Print or Type

LEVEL OF CARE (1) | PRE-CERT CASE # (2)

RECIPIENT ID NUMBER (3) | RECIPIENT LAST NAME FIRST MI (4) | PROVIDER NUMBER (5)

EXTENSION OF HOSPITALIZATION ICD-9-CM diagnosis code with description to maximum specificity. (6)	SURGICAL PROCEDURE (3 to 4 digits) (ICD-9-CM hospital procedure code) (7)	SURGERY DATE (8)	REQUEST TYPE (9)
1 ☐☐☐.☐☐ _____	1 ☐☐☐☐	1.___/___/___	Admission ☐
2 ☐☐☐.☐☐ _____	2 ☐☐☐☐	2.___/___/___	Update ☐
3 ☐☐☐.☐☐ _____	3 ☐☐☐☐	3.___/___/___	Hospital Extension ☐
4 ☐☐☐.☐☐ _____	4 ☐☐☐☐	4.___/___/___	Resubmittal ☐
			Reconsideration ☐
			Outpatient Procedure ☐

(10)

GUIDELINES FOR MEDICAL DOCUMENTATION

The medical information submitted shall be from written documentation in the patient's medical record.

Please complete pertinent medical information related to the request type.

I. SEVERITY OF ILLNESS:

Presenting History: Pertinent clinical and physical examination findings as related to admission / extension request. (**Please specify when the symptoms and findings developed, worsened, or improved, including time and date.)** _____

_____

_____

Abnormal Vital Signs , weight, I&O, CR monitor , pulse ox &/or apnea monitor**. If febrile, temp, date & time**_____

Cultures: List dates and results: Due date of any cultures pending?_____

_____

II. INTENSITY OF SERVICES DURING LAST 24 HOURS: (Physician evaluations _____ per day) (11)

IV (List type and rate. Include ALL IV fluids, T.P.N., etc. - start and discontinue dates.)_____

_____

Medications (List with dosage, **route,** and **frequency,** especially those related to current ICD-9-CM diagnosis code.)_____

_____

Labs, X-Rays, imaging studies, and invasive procedures (date(s) and frequency (related to extension request).____

_____

Treatment(s) (type, frequency, dates, etc.) Include neuro checks frequency, start and stop_____

_____

_____

III. ADDITIONAL COMMENTS justifying continued hospitalization stay including STATUS of discharge planning.

(12)

Hospital Contact Person: _____ Phone: _____ Fax: _____

(13)

I declare the foregoing recipient's medical information is true and correct.

Hospital Primary Reviewer Title: (14) _____ _____ Date of Request: _____

Signature

Revised 11/11/09 PCF-02

Appendix C - PCF03 with instructions

INSTRUCTION FOR FORM PCF03: REQUEST FOR REHAB EXTENSION

NOTE: Fields 1 – 5 MUST be filled in and you must attach a completed P.C. F01.

Any incomplete form WILL BE REJECTED

1. Enter the assigned Pre-Certification Case Number.
2. Enter the 13-digit recipient Medicaid identification number.
3. Enter the recipient's last name, first name, and middle initial.
4. Enter the seven-digit hospital Medicaid number.
5. Enter the extension ICD-9-CM diagnosis code. **An extension diagnosis code is required. Also, the description of the diagnosis is required.**
6. If this is a reconsideration request, check this box.
7. Enter the appropriate outpatient surgical procedure codes, if applicable.
8. Enter the anticipated or actual date of surgery (if applicable).
9. Indicate the number of physician evaluations performed per 24 hours.

10 – 25. Use these fields to complete pertinent medical information regarding the recipient. If additional information is necessary, up to two pages may be submitted.

26. **An authorized signature is required. Requests will not be accepted if not signed.**

27. Enter the date this request is submitted to Molina.

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

Please Print or Type

PAGE 1 of 2

PRE-CERT CASE # (1)

RECIPIENT ID NUMBER (2)	RECIPIENT LAST NAME (3) FIRST MI	PROVIDER NUMBER (4)

ICD-9-CM EXTENSION DIAGNOSIS AND DESCRIPTION (5)	CHECK HERE IF THIS REQUEST IS FOR A RECONSIDERATION (6) ☐	SURGICAL PROCEDURE ICD-9 (Hospital) (7) 1 2 3	SURGERY DATE (8) ____/____/____

SUGGESTED GUIDELINES FOR MEDICAL DOCUMENTATION

1) **Physician evaluations** (9) _____ times per 24 hours.

2) **Last multidisciplinary staffing date** (10) _____

3) **Past medical history** (Pertinent to extension diagnosis):

(11)

4) **Physical exam findings** (Pertinent to extension diagnosis):

(12)

5) **Vital signs** (List frequency. If febrile, list date and time. If cultures done, list date and result):

(13)

6) **IV** (List type and rate. Include ALL IV fluids and T.P.N.). Include type of access (peripheral, central):

(14)

7) **Medications** (List with dosage, route, and frequency, especially those relating to extension diagnosis):

(15)

8) **Labs, X-Rays, and Procedures** (List those pertinent to extension diagnosis):

(16)

9) **Decubitus ulcers?** Yes _____ No _____ If yes, list #, stage, and location. List applicable treatment(s) (dsqs, whirlpool, hyperbarics, etc.)

(17)

P.C. F03 Issued 3/95

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

PAGE 2 of 2

PRE-CERT CASE #

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

(18)

11) **Pulmonary:** Is patient on ventilator? Yes _____ No _____

Is patient weanable? Yes _____ No _____ If yes, tell how this is being accomplished. If no, explain why.

(19)

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

12) **Nutritional Status:** A) Mode of nutrition: _____TPN, _____NGT, _____GT/JT, or _____Oral.

(20) B) Diet type: _____

13) **Physical Therapy** (Please summarize):

(21)

14) **Occupational Therapy** (Please summarize):

(22)

15) **Speech Therapy** (Please summarize):

(23)

16) **Summary of medical necessity for hospitalization:**

(24)

17) **Discharge planning** and/or estimated discharge date:

(25)

(26)

PROVIDER SIGNATURE: _____ (27) **DATE OF REQUEST**_____

Up to two additional pages may be attached if necessary.

P.C. F03 Issued 3/95

Appendix D - PCF04 with instructions

INSTRUCTIONS FOR COMPLETING THE NEONATAL/NEWBORN LEVEL OF CARE REQUEST

FORM P.C.F04
Please note that ALL FIELDS ARE REQUIRED. Incomplete forms will result in a REQUEST REJECTION.

1. Enter the case number when requesting extension of days, or reconsideration. Leave this field blank when requesting an initial admission review.

2. Enter the 13-digit recipient's Medicaid number.

3. Enter the recipient's last name, first name, and middle initial.

4. Enter the 7-digit Louisiana Medicaid Provider ID number.

5. Enter the ICD-9-CM diagnosis code or codes that justify or require the neonatal/newborn level of care. Be sure to include the code description.

6. Check the box which most accurately describes this request type: Initial, Extension, Resubmittal, Reconsideration, or Update.

7. Check the box which most accurately corresponds with the Level of Care requested: Newborn Nursery Level 1, Special Care Nursery Level II, Transitional Care Nursery, or Neonatal ICU Nursery Level III.

8. Enter the date and time of the clinical and physical exam findings to follow.

9. In the spaces provided, enter the birth weight in grams, the current weight in grams, and the corrected gestational age.

10. In the spaces provided, describe the trend of weight gain per week. Space is also provided for any other clinical observations that may be pertinent to the case.

11. Using the provided check boxes, indicate the frequency with which vital signs have been taken: Less than hourly, Hourly, Every 2 hours, Every 4 hours, or List Abnormal. If you check List Abnormal, please list the abnormal frequency.

12. Check the box which most accurately describes the care environment: Radiant Warmer, Isolette, or Open Crib.

13. In the space provided, enter the liters of oxygen administered. Check the appropriate box to indicate how the oxygen has been administered: Nasal Cannula, Ventilator, CPAP, Jet Vent, or Oxyhood. In the space provided, indicate the percentage of the oxygen administered.

14. Use the check boxes to indicate the frequency of monitoring of Apnea/bradycardia episodes in a 24 hour period: Numerous (>10), Occasional (3-10), Infrequent (<3) or None. Use the next set of check boxes to indicate the type of monitoring of Cardiorespiratory: Continuous, Apnea monitoring, or No monitoring.

15. In the space provided, enter the clinical findings pertinent to the diagnosis, such as Vital Signs, Labs, X-rays, imaging studies, IDG, or invasive procedures.

16. Use the check boxes to indicate Cardio/Respiratory treatment: Pulse Ox, IPPB, Nebulizer, ECMO, or OTHER.

17. In the space provided, list all types of Intravenous Fluids/TPN.

18. Use the check boxes and spaces provided to indicate Oral Feedings: Continuous OG, OG ever _____ hours, or Nippling every _____ hours.

19. Use the spaces provided to indicate the ICD-9-CM hospital procedure code and description of any surgical procedures; also indicate the date in the space provided.

20. In the space provided, enter the number of phototherapy lights followed by the start and stop dates of the

therapy.

21. In the spaces provided, enter the start dates, discontinued dates, routes, frequencies, etc. of any medications.

22. In the space provided, enter the date and status of the discharge plan for this case.

23. In the spaces provided, write the name, phone number, and fax number of the main contact person for this request.

24. In the spaces provided, write the title of the primary hospital reviewer, the reviewer's signature, and the date of the request.

STATE OF LOUISIANA DHH – BHSF
MEDICAL ASSISTANCE PROGRAM
NEONATAL/NEWBORN LEVEL OF CARE REQUEST
Please Print or Type

1 PRE-CERT CASE #

2 RECIPIENT ID NUMBER | 3 RECIPIENT LAST NAME FIRST MI | 4 PROVIDER NUMBER

ICD-9-CM diagnosis code with description to maximum specificity.

1 ___.___ 5 _____
2 ___.___ _____
3 ___.___ _____
4 ___.___ _____

REQUEST TYPE

6
- Initial ☐
- Extension ☐
- Resubmittal ☐
- Reconsideration ☐
- Update ☐

LEVEL OF CARE

7
- General
  - Newborn Nursery Level 1 ☐
  - Special Care Nursery Level II ☐
  - Transitional Care Nursery ☐
- Neonatal ICU Nursery Level III ☐

MEDICAL HISTORY AND MATERNAL CONDITIONS
The medical information submitted shall be from written documentation in the patient's medical record.

CLINICAL AND PHYS EXAM FINDINGS (severity of illness) 9

Date and time _____ 8 _____ Birth weight in grams: _____ Current weight in grams: _____ Corrected gestational age: _____

Trend of weight gain per week _____ 10 _____

Other _____

Vital Signs: ☐ <hourly ☐ Hourly ☐ Every 2 hours ☐ Every 4 hours ☐ List Abnormal 11

CARE ENVIRONMENT: ☐ Radiant Warmer ☐ Isolette ☐ Open Crib 12

OXYGEN:_____liters via ☐ Nasal Cannula 13 ☐ Ventilator ☐ CPAP ☐ Jet Vent ☐ Oxyhood _____ % oxygen

MONITORING:

Apnea/bradycardia episodes (# in 24 hours) 14 ☐ Numerous (>10) ☐ Occasional (3-10) ☐ Infrequent (<3) ☐ None

Cardiorespiratory ☐ Continuous ☐ Apnea monitoring ☐ No monitoring

CLINICAL FINDINGS:

Vital Signs, Labs, X-rays, imaging studies, EKG, Invasive procedures (those pertinent to diagnosis): 15 _____

TREATMENT (intensity of services): 16

Cardio/Respiratory ☐ Pulse Ox ☐ IPPB ☐ Nebulizer

Intravenous: Fluids/TPN (List ALL types) 17 _____

Oral Feedings: 18 ☐ Continuous OG ☐ OG every _____ hours ☐ Nippl

Surgical Procedure(s): ICD-9-CM hospital procedure code & description: _____ _____ _____ Date: _____

Phototherapy (# of lights): Start/stop dates: 20 _____

MEDICATIONS (Specify route, frequency, etc.) Start dates and discontinued dates. _____

21 _____

DATE/STATUS OF DISCHARGE PLAN: 22 _____

Hospital Contact Person: _____ Phone: _____ Fax: _____

I declare the foregoing recipient's medical information is true and correct.

Provider Reviewer Signature _____ Title: _____ Date: 24 _____

Revised 09/14/10 PCF-04

Appendix E - PCF05 with instructions

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

NOTE: Fields 1 – 6 MUST be filled in

Any incomplete form WILL BE REJECTED

1. Enter the assigned Pre-Certification Case Number if this is a request other than an initial.

2. Enter the 13-digit recipient Medicaid identification number.

3. Enter the recipient's last name, first name, and middle initial.

4. Enter the seven-digit hospital Medicaid number.

5. Enter the admitting and primary (if applicable) ICD-9-CM diagnoses codes if this is an initial request. If this is an extension request, enter the extension ICD-9-CM diagnosis code. **Either an admitting or an extension diagnosis code is required. Also, the description of the diagnosis is required.**

6. Check in the appropriate box the type of request: psychiatric or substance abuse, extension or reconsideration.

7 – 15. Use these fields to complete pertinent medical information regarding the recipient for an admission request. If additional information is necessary, up to two pages may be submitted.

16 – 23. Use these fields to complete pertinent medical information regarding the recipient for an extension request. If additional information is necessary, up to two pages may be submitted.

24. **An authorized signature is required. Requests will not be accepted if not signed.**

25. Enter the date this request is submitted to Molina.

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

Please Print or Type

PAGE 1 of 2

PRE-CERT CASE # (1)

RECIPIENT ID NUMBER (2) | RECIPIENT LAST NAME (3) FIRST MI | PROVIDER NUMBER (4)

ICD-9-CM ADMISSION/EXTENSION DIAGNOSIS AND DESCRIPTION (5)

REQUEST TYPE (6)

- PSYCHIATRIC ☐
- SUBSTANCE ABUSE ☐
- EXTENSION ☐
- RECONSIDERATION ☐

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

ADMISSION CRITERIA

1) Presenting problem and course of illness: _____

(7) When did it start: _____
(Provide supporting medical documentation)

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

(8)

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

(9)

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

(10)

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

(11)

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

(12)

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

(13)

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

(14)

P.C. F05 Issued 3/95

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

PRE-CERT CASE #

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

15

EXTENSION CRITERIA

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

1) Treatment plan goals.

16

2) Methods used to address treatment plan goals.

17

3) Course of hospitalization, to date.

18

4) Patient's level of functioning on unit.

19

5) Presence of special precautions.

20

6) Is behavior on unit dangerous? Compliant?

21

7) Have medication dosages been changed recently?

22

8) How would further hospitalization benefit this patient?

23

PROVIDER SIGNATURE: 24 _____ **DATE:** 25

_____

P.C. F05 Issued

Appendix F - PCF06 with instructions

INSTRUCTIONS FOR FORM PCF06:
LONG TERM EXTENSION OR RECONSIDERATION

NOTE:
Fields 1 – 5 and field 8 MUST be filled in and you must attach a complete P.C.F01.

Any incomplete form WILL BE REJECTED.

1. Enter the assigned Pre-Certification Case Number if this is an extension or reconsideration. If this is an initial request for hospitalization for an outpatient procedure, leave this field blank.

2. Enter the 13-digit recipient Medicaid identification number.

3. Enter the recipient's last name, first name, and middle initial.

4. Enter the seven-digit hospital Medicaid number.

5. Enter the admitting and primary (if applicable) ICD-9-CM diagnoses codes if this is an initial request. If this is an extension request, enter the extension ICD-9-CM diagnosis code. **Either an admitting or an extension diagnosis code is required. Also, the description of the diagnosis is required.**

6. Enter the appropriate outpatient surgical procedure codes. The hospital should enter the appropriate ICD-9-CM surgical procedure codes.

7. Enter the anticipated or actual date of surgery (if applicable).

8. Check in the appropriate box the type of request: hospital extension or reconsideration.

9. Indicate the number of physician evaluations performed per 24 hours.

10 – 25. Use these fields to complete pertinent medical information regarding the recipient. If additional information is necessary, up to two pages may be submitted.

26. **An authorized signature is required. Requests will not be accepted if not signed.**

27. Enter the date this request is submitted to Molina.

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

Please Print or Type

PAGE 1 of 2

PRE-CERT CASE # (1)

RECIPIENT ID NUMBER (2)	RECIPIENT LAST NAME (3) FIRST MI	PROVIDER NUMBER (4)

ICD-9-CM EXTENSION DIAGNOSIS AND DESCRIPTION	SURGICAL PROCEDURE ICD-9 (Hospital)	SURGERY DATE	REQUEST TYPE
(5)	1 (6) 2 3	(7) ____/____/____	EXTENSION ☐ RECONSIDERATION ☐ (8)

SUGGESTED GUIDELINES FOR MEDICAL DOCUMENTATION

1) **Physician evaluations** (9) _____ times per 24 hours.

2) **Last multidisciplinary staffing date** (10) _____

3) **Past medical history** (Pertinent to extension diagnosis):

(11)

4) **Physical exam findings** (Pertinent to extension diagnosis):

(12)

5) **Vital signs** (List frequency. If febrile, list date and time. If cultures done, list date and result):

(13)

6) **IV** (List type and rate. Include ALL IV fluids and T.P.N.). Include type of access (peripheral, central):

(14)

7) **Medications** (List with dosage, route, and frequency, especially those relating to extension diagnosis):

(15)

8) **Labs, X-Rays, and Procedures** (List those pertinent to extension diagnosis):

(16)

9) **Decubitus ulcers?** Yes _____ No _____ If yes, list #, stage, and location. List applicable treatment(s) (dsqs, whirlpool, hyperbarics, etc.)

(17)

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

PRE-CERT CASE #

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

(18)

11) **Pulmonary:** Is patient on ventilator? Yes _____ No _____

Is patient weanable? Yes _____ No _____ If yes, tell how this is being accomplished. If no, explain why.

(19)

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

12) **Nutritional Status:** A) Mode of nutrition: _____TPN, _____NGT, _____GT/JT, or _____Oral.

(20) B) Diet type: _____

13) **Physical Therapy** (Please summarize):

(21)

14) **Occupational Therapy** (Please summarize):

(22)

15) **Speech Therapy** (Please summarize):

(23)

16) **Summary of medical necessity for hospitalization:**

(24)

17) **Discharge planning** and/or estimated discharge date:

(25)

PROVIDER SIGNATURE: (26) _____ **DATE:** (27) _____

Up to two additional pages may be attached if necessary.

P.C. F06 Issued

Appendix G - Ambulatory Surgical Procedure Codes

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

DX	DESC	SURGIND
154	OTHER OPERATIONS ON TWO OR MORE EXTRAOCU	4
1631	REMOVAL OF OCULAR CONTENTS WITH SYNCHRON	4
1639	OTHER EVISCERATION OF EYEBALL	4
1642	ENUCLEATION OF EYEBALL WITH OTHER SYNCHR	4
1649	OTHER ENUCLEATION OF EYEBALL	4
1661	SECONDARY INSERTION OF OCULAR IMPLANT	4
1662	REVISION AND REINSERTION OF OCULAR IMPLA	4
1671	REMOVAL OF OCULAR IMPLANT	4
1809	OTHER INCISION OF EXTERNAL EAR	2
1811	OTOSCOPY	1
1829	EXCISION OR DESTRUCTION OF OTHER LESION	1
1911	STAPEDECTOMY WITH INCUS REPLACEMENT	4
1919	OTHER STAPEDECTOMY	4
193	OTHER OPERATIONS ON OSSICULAR CHAIN	4
194	MYRINGOPLASTY	4
195	OTHER TYMPANOPLASTY	4
1952	TYPE II TYMPANOPLASTY	4
1953	TYPE III TYMPANOPLASTY	4

1954	TYPE IV TYMPANOPLASTY	4
1955	TYPE V TYMPANOPLASTY	4
196	REVISION OF TYMPANOPLASTY	4
2001	MYRINGOTOMY WITH INSERTION OF TUBE	4
2009	OTHER MYRINGOTOMY	1
2041	SIMPLE MASTOIDECTOMY	4
208	OPERATIONS ON EUSTACHIAN TUBE	1
2121	RHINOSCOPY	1
2122	BIOPSY OF NOSE	1
2131	LOCAL EXCISION OR DESTRUCTION OF INTRANA	2
2132	LOCAL EXCISION OR DESTRUCTION OF OTHER L	1
215	SUBMUCOUS RESECTION OF NASAL SEPTUM	4
2162	FRACTURE OF THE TURBINATES	1
2169	OTHER TURBINECTOMY	1
217	REDUCTION OF NASAL FRACTURE	1
2171	CLOSED REDUCTION OF NASAL FRACTURE	1
2183	TOTAL NASAL RECONSTRUCTION	4
2187	OTHER RHINOPLASTY	4
2188	OTHER SEPTOPLASTY	4
2199	OTHER OPERATIONS ON NOSE	1
2200	ASPIRATION AND LAVAGE OF NASAL SINUS, NO	2
2201	PUNCTURE OF NASAL SINUS FOR ASPIRATION O	2
2202	ASPIRATION OR LAVAGE OF NASAL SINUS THRO	2
2263	ETHMOIDECTOMY	3
230	FORCEPS EXTRACTION OF TOOTH	1
2301	EXTRACTION OF DECIDUOUS TOOTH	1
2309	EXTRACTION OF OTHER TOOTH	1
231	SURGICAL REMOVAL OF TOOTH	1
2311	REMOVAL OF RESIDUAL ROOT	1
2319	OTHER SURGICAL EXTRACTION OF TOOTH	1
232	RESTORATION OF TOOTH BY FILLING	1
233	RESTORATION OF TOOTH BY INLAY	1

DX	DESC	SURGIND
234	OTHER DENTAL RESTORATION	1
2341	APPLICATION OF CROWN	1
2342	INSERTION OF FIXED BRIDGE	1
2343	INSERTION OF REMOVABLE BRIDGE	1
2349	OTHER DENTAL RESTORATION	1
235	IMPLANTATION OF TOOTH	1
245	ALVEOLOPLASTY	1
2501	NEEDLE BIOPSY OF TONGUE	1
2502	OTHER BIOPSY OF TONGUE	1
2594	OTHER GLOSSOTOMY	2
270	DRAINAGE OF FACE AND FLOOR OF MOUTH	2
2741	LABIAL FRENECTOMY	4
2742	WIDE EXCISION OF LESION OF LIP	3
2743	OTHER EXCISION OF LESION OR TISSUE OF LI	1
2792	INCISION OF MOUTH, UNSPECIFIED STRUCTURE	2
280	INCISION AND DRAINAGE OF TONSIL AND PERI	2
282	TONSILLECTOMY WITHOUT ADENOIDECTOMY	4
283	TONSILLECTOMY WITH ADENOIDECTOMY	4
284	EXCISION OF TONSIL TAG	4
286	ADENOIDECTOMY WITHOUT TONSILLECTOMY	4
2911	PHARYNGOSCOPY	1
292	EXCISION OF BRANCHIAL CLEFT CYST OR VEST	2
3009	OTHER EXCISION OR DESTRUCTION OF LESION	1
313	OTHER INCISION OF LARYNX OR TRACHEA	1
3142	LARYNGOSCOPY AND OTHER TRACHEOSCOPY	1
3143	BIOPSY OF LARYNX	1
3144	BIOPSY OF TRACHEA	1
3321	BRONCHOSCOPY THROUGH ARTIFICIAL STOMA	1
3322	FIBER-OPTIC BRONCHOSCOPY	1
3323	OTHER BRONCHOSCOPY	1
3324	ENDOSCOPIC BRONCHIAL BIOPSY	1
3409	OTHER INCISION OF PLEURA	2
3797	REPL CARDIVERT / DFIB LEAD	1
3821	BIOPSY OF BLOOD VESSEL	1
3822	PERCUTANEOUS ANGIOSCOPY	4
3859	LIGATION AND STRIPPING OF LOWER LIMB VAR	4
3882	OTHER SURGICAL OCCLUSION OF OTHER VESSEL	1
3889	OTHER SURGICAL OCCLUSION OF LOWER LIMB V	4
4011	BIOPSY OF LYMPHATIC STRUCTURE	2
4021	EXCISION OF DEEP CERVICAL LYMPH NODE	2
4221	OPERATIVE ESOPHAGOSCOPY BY INCISION	1

4222	ESOPHAGOSCOPY THROUGH ARTIFICIAL STOMA	1
4223	OTHER ESOPHAGOSCOPY	1
4224	BIOPSY OF ESOPHAGUS	1
4232	LOCAL EXCISION OF OTHER LESION OR TISSUE	1
4239	OTHER DESTRUCTION OF LESION OR TISSUE OF	1
4292	DILATION OF ESOPHAGUS	1
4342	LOCAL EXCISION OF OTHER LESION OR TISSUE	1
4349	OTHER DESTRUCTION OF LESION OR TISSUE OF	1
4411	TRANSABDOMINAL GASTROSCOPY	1

DX	DESC	SURGIND
4413	OTHER GASTROSCOPY	1
4414	BRUSH BIOPSY OF STOMACH	1
4415	OTHER BIOPSY OF STOMACH	1
4493	INSERT GASTRIC BALLOON	1
4494	REMOVAL GASTRIC BALLOON	1
4513	OTHER ENDOSCOPY OF SMALL INTESTINE	1
4514	BRUSH BIOPSY OF SMALL INTESTINE	1
4524	OTHER ENDOSCOPY OF LARGE INTESTINE	1
4525	BRUSH BIOPSY OF LARGE INTESTINE	1
4526	OTHER BIOPSY OF LARGE INTESTINE	1
4532	OTHER DESTRUCTION OF LESION OF DUODENUM	1
4541	LOCAL EXCISION OF LESION OR TISSUE OF LA	1
4595	SM BOWEL-ANUS ANASTOMOS	4
4643	OTHER REVISION OF STOMA OF LARGE INTESTI	3
4823	OTHER PROCTOSIGMOIDOSCOPY	1
4824	BRUSH BIOPSY OF RECTUM	1
4825	OTHER BIOPSY OF RECTUM	1
4835	LOCAL EXCISION OF RECTAL LESION OR TISSU	1
4881	INCISION OF PERIRECTAL TISSUE	1
4901	INCISION OF PERIANAL ABSCESS	1
4912	ANAL FISTULECTOMY	2
4945	LIGATION OF HEMORRHOIDS	3
4946	EXCISION OF HEMORRHOIDS	3
4947	EVACUATION OF THROMBOSED HEMORRHOIDS	3
4949	OTHER PROCEDURES ON HEMORRHOIDS	1
4951	LEFT LATERAL ANAL SPHINCTEROTOMY	2
4952	POSTERIOR ANAL SPHINCTEROTOMY	2
4959	OTHER ANAL SPHINCTEROTOMY	2
5011	PERCUTANEOUS (NEEDLE) BIOPSY OF LIVER	2
5300	UNILATERAL REPAIR OF INGUINAL HERNIA, NO	4
5301	UNILATERAL REPAIR OF DIRECT INGUINAL HER	4
5302	UNILATERAL REPAIR OF INDIRECT INGUINAL H	4
5303	UNILATERAL REPAIR OF DIRECT INGUINAL HER	4
5304	UNILATERAL REPAIR OF INDIRECT INGUINAL H	4
5305	UNILATERAL REPAIR OF INGUINAL HERNIA WIT	4
5321	UNILATERAL REPAIR OF FEMORAL HERNIA WITH	4
5329	OTHER UNILATERAL FEMORAL HERNIORRHAPHY	4
5349	OTHER UMBILICAL HERNIORRHAPHY	4
5359	REPAIR OF OTHER HERNIA OF ANTERIOR ABDOM	4
5369	REPAIR OF OTHER HERNIA OF ANTERIOR ABDOM	4
5421	LAPAROSCOPY	4
5423	BIOPSY OF PERITONEUM	4
5425	PERITONEAL LAVAGE	3
544	EXCISION OR DESTRUCTION OF PERITONEAL TI	4
5451	LAPAROSCOPE LYSIS OF PERTIONEAL ADHES	0
5459	OTHER LYSIS OF PERITONEAL ADHESIONS	0
5634	OPEN BIOPSY OF URETER	4
5635	ILEAL CONDUCT ENDOSCOPY	3
5731	CYSTOSCOPY THROUGH ARTIFICIAL STOMA	1
5732	OTHER CYSTOSCOPY	1

DX	DESC	SURGIND
5749	OTHER TRANSURETHRAL EXCISION OR DESTRUCT	1
5791	SPHINCTEROTOMY OF BLADDER	1
5792	DILATION OF BLADDER NECK	1
581	URETHRAL MEATOTOMY	1
5821	PERINEAL URETHROSCOPY	1
5822	OTHER URETHROSCOPY	1
585	RELEASE OF URETHRAL STRICTURE	1
586	DILATION OF URETHRA	1

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

DX	DESC	SURGIND
6611	BIOPSY OF FALLOPIAN TUBE	4
6621	BILATERAL ENDOSCOPIC LIGATION AND CRUSHI	4
6622	BILATERAL ENDOSCOPIC LIGATION AND DIVISI	4
6629	OTHER BILATERAL ENDOSCOPIC DESTRUCTION	4
6631	OTHER BILATERAL LIGATION AND CRUSHING OF	4
6632	OTHER BILATERAL LIGATION AND DIVISION OF	4
6639	OTHER BILATERAL DESTRUCTION OR OCCLUSION	4
6661	EXCISION OR DESTRUCTION OF LESION OF FAL	4
6692	UNILATERAL DESTRUCTION OR OCCLUSION OF F	4
670	DILATION OF CERVICAL CANAL	3
6711	ENDOCERVICAL BIOPSY	1
6712	OTHER CERVICAL BIOPSY	1
6732	DESTRUCTION OF LESION OF CERVIX BY CAUTE	4
6733	DESTRUCTION OF LESION OF CERVIX BY CRYOS	4
6739	OTHER EXCISION OR DESTRUCTION OF LESION	4
6823	ENDOMETRIAL ABLATION	0
6901	DILATION AND CURETTAGE FOR TERMINATION O	4
6909	OTHER DILATION AND CURETTAGE OF UTERUS	3
6951	ASPIRATION CURETTAGE OF UTERUS FOR TERMI	4
6952	ASPIRATION CURETTAGE FOLLOWING DELIVERY	3
700	CULDOCENTESIS	1
7011	HYMENOTOMY	4
7014	OTHER VAGINOTOMY	3
7024	VAGINAL BIOPSY	1
7031	HYMENECTOMY	4
7033	EXCISION OR DESTRUCTION OF LESION OF VAG	2
7109	OTHER INCISION OF VULVA AND PERINEUM	2
7111	BIOPSY OF VULVA	1
7121	PERCUTANEOUS ASPIRATION OF BARTHOLIN'S G	1

7122	INCISION OF BARTHOLIN'S GLAND (CYST)	1
7123	MARSUPIALIZATION OF BARTHOLIN'S GLAND (C	1
713	OTHER LOCAL EXCISION OR DESTRUCTION OF V	1
7179	OTHER REPAIR OF VULVA AND PERINEUM	2
750	INTRA-AMNIOTIC INJECTION FOR ABORTION	4
762	LOCAL EXCISION OR DESTRUCTION OF LESION	3
7671	CLOSED REDUCTION OF MALAR AND ZYGOMATIC	2
7672	OPEN REDUCTION OF MALAR AND ZYGOMATIC FR	2
7697	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
7702	SEQUESTRECTOMY OF HUMERUS	2
7723	WEDGE OSTEOTOMY OF RADIUS AND ULNA	4
7724	WEDGE OSTEOTOMY OF CARPALS AND METACARPA	4
7728	WEDGE OSTEOTOMY OF TARSALS AND METATARSA	4
7733	OTHER DIVISION OF RADIUS AND ULNA	4
7734	OTHER DIVISION OF CARPALS AND METACARPAL	4
7738	OTHER DIVISION OF TARSALS AND METATARSAL	4
7739	OTHER DIVISION OF OTHER BONE, EXCEPT FAC	4
7752	BUNIONECTOMY WITH SOFT TISSUE CORRECTION	4
7753	OTHER BUNIONECTOMY WITH SOFT TISSUE CORR	4
7754	EXCISION OF BUNIONETTE	3
7759	OTHER BUNIONECTOMY	4

DX	DESC	SURGIND
7788	OTHER PARTIAL OSTECTOMY OF TARSALS AND M	3
7789	OTHER PARTIAL OSTECTOMY OF OTHER BONE, E	2
7838	*OTHER CHANGE IN BONE LENGTH OF TARSALS	4
7839	OTHER CHANGE IN BONE LENGTH OF OTHER BON	4
7858	INTERNAL FIXATION OF TARSALS AND METATAR	4
7861	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
7862	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
7864	REMOVAL OF INTERNAL FIXATION DEVICE FROM	4
7865	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
7866	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
7867	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
7868	REMOVAL OF INTERNAL FIXATION DEVICE FROM	2
8003	ARTHROTOMY FOR REMOVAL OF PROSTHESIS OF	4
8012	OTHER ARTHROTOMY OF ELBOW	2
8016	OTHER ARTHROTOMY OF KNEE	4
8026	ARTHROSCOPY OF KNEE	4
8043	DIVISION OF JOINT CAPSULE, LIGAMENT, OR	3
8044	DIVISION OF JOINT CAPSULE, LIGAMENT, OR	3
8048	DIVISION OF JOINT CAPSULE, LIGAMENT, OR	3
8050	IV DISC EXCS / DSTRUCT NOS	3
806	EXCISION OF SEMILUNAR CARTILAGE OF KNEE	4
8073	SYNOVECTOMY OF WRIST	4
8074	SYNOVECTOMY OF HAND AND FINGER	4
8078	SYNOVECTOMY OF FOOT AND TOE	4
8087	OTHER LOCAL EXCISION OR DESTRUCTION OF L	3
8094	OTHER EXCISION OF JOINT OF HAND AND FING	3
8116	METATARSOPHALANGEAL FUSION	4
8118	OTHER FUSION OF TOE	4
8128	INTERPHALANGEAL FUSION	4
8131	ARTHROPLASTY OF FOOT AND TOE WITH SYNTHE	4
8139	OTHER ARTHROPLASTY OF FOOT AND TOE	4
8171	ARTHROPLASTY OF HAND AND FINGER WITH SYN	4
8179	OTHER REPAIR OF HAND AND FINGER	4
8201	EXPLORATION OF TENDON SHEATH OF HAND	1
8203	BURSOTOMY OF HAND	1
8209	OTHER INCISION OF SOFT TISSUE OF HAND	2
8211	TENOTOMY OF HAND	1
8212	FASCIOTOMY OF HAND	4
8221	EXCISION OF LESION OF TENDON SHEATH OF H	3
8232	EXCISION OF TENDON OF HAND FOR GRAFT	3
8233	OTHER TENONECTOMY OF HAND	4
8235	OTHER FASCIECTOMY OF HAND	4
8251	ADVANCEMENT OF TENDON OF HAND	3
8279	PLASTIC OPERATION ON HAND WITH OTHER GRA	4
8284	REPAIR OF MALLET FINGER	3
8285	OTHER TENODESIS OF HAND	3
8286	OTHER TENOPLASTY OF HAND	3
8289	OTHER PLASTIC OPERATIONS ON HAND	4
8291	LYSIS OF ADHESIONS OF HAND	3
8301	EXPLORATION OF TENDON SHEATH	2

DX	DESC	SURGIND
8303	BURSOTOMY	2
8309	OTHER INCISION OF SOFT TISSUE	2
8314	FASCIOTOMY	4
8321	BIOPSY OF SOFT TISSUE	2
8331	EXCISION OF LESION OF TENDON SHEATH	3
8339	EXCISION OF LESION OF OTHER SOFT TISSUE	3
8341	EXCISION OF TENDON FOR GRAFT	4
8342	OTHER TENONECTOMY	4
8345	OTHER MYECTOMY	4
835	BURSECTOMY	3
8361	SUTURE OF TENDON SHEATH	3
8364	OTHER SUTURE OF TENDON	3
8387	OTHER PLASTIC OPERATIONS ON MUSCLE	3
8388	OTHER PLASTIC OPERATIONS ON TENDON	3
8391	LYSIS OF ADHESIONS OF MUSCLE, TENDON, FA	3
8411	AMPUTATION OF TOE	2
8412	AMPUTATION THROUGH FOOT	2
850	MASTOTOMY	3
8511	PERCUTANEOUS (NEEDLE) BIOPSY OF BREAST	3
8512	OTHER BIOPSY OF BREAST	3
8521	LOCAL EXCISION OF LESION OF BREAST	3
8524	EXCISION OF ECTOPIC BREAST TISSUE	3
8591	ASPIRATION OF BREAST	3
8595	INSRT BREAST TISS EXPAND	2
8596	REMOV BREAST TISS EXPAND	2
8601	ASPIRATION OF SKIN AND SUBCUTANEOUS TISS	3
8604	OTHER INCISION WITH DRAINAGE OF SKIN AND	2
8605	INCISION WITH REMOVAL OF FOREIGN BODY FR	2
8609	OTHER INCISION OF SKIN AND SUBCUTANEOUS	2
8611	BIOPSY OF SKIN AND SUBCUTANEOUS TISSUE	1
8621	EXCISION OF PILONIDAL CYST OR SINUS	3
8622	DEBRIDEMENT OF WOUND, INFECTION, OR BURN	1
8623	REMOVAL OF NAIL, NAILBED, OR NAIL FOLD	1
8627	DEBRID.NAIL,BED,FOLD	1
863	OTHER LOCAL EXCISION OR DESTRUCTION OF L	1
8660	FREE SKIN GRAFT, NOT OTHERWISE SPECIFIED	3
8662	OTHER SKIN GRAFT TO HAND	3
8686	ONYCHOPLASTY	1
8689	OTHER REPAIR AND RECONSTRUCTION OF SKIN	2
8693	INSRT SKIN TISS EXPANDER	2
8782	GAS CONTRAST HYSTEROSALPINGOGRAM	2
8783	OPAQUE DYE CONTRAST HYSTEROSALPINGOGRAM	2
8926	GYNECOLOGICAL EXAMINATION	1
9616	OTHER VAGINAL DILATION	1
9622	DILATION OF RECTUM	1
9623	DILATION OF ANAL SPHINCTER	1
9625	THERAPEUTIC DISTENTION OF BLADDER	1
9649	OTHER GENITOURINARY INSTILLATION	1
9659	OTHER IRRIGATION OF WOUND	2
9739	REMOVAL OF OTHER THERAPEUTIC DEVICE FROM	2

DX	DESC	SURGIND
9802	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1
9803	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1
9804	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1
9805	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1
9814	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1
9815	REMOVAL OF INTRALUMINAL FOREIGN BODY FRO	1
9821	REMOVAL OF SUPERFICIAL FOREIGN BODY FROM	1
9822	REMOVAL OF OTHER FOREIGN BODY WITHOUT IN	1
9827	REMOVAL OF FOREIGN BODY WITHOUT INCISION	2
9985	LOCALIZED HYPERTHERMIA	1
9986	PLACED EXT. BONE STIM	1

Appendix H - Certificate of Need

Rev 07/95
Prior Issues Obsolete

Louisiana's MEDICAID PROGRAM
Certification of Need for Psychiatric Hospitalization

Patient's Name:_____ DOB:____/____/____ SS#:_____-____-_____

Facility:_____ Provider #:_____ DOA:____/____/____

Hospital Treating Physician:_____

Type of Care:_____ (Substance or Mental Disorder)

DSM III - R Axis I Diagnosis and ICD-9 Code:_____

Primary Reason for Admission:_____

Admission

❑ Patient is currently Medicaid eligible - 13-digit Medicaid ID#:_____

❑ Patient is applying for Medicaid - Application Date:____/____/____

❑ Emergency admission (NOTE: Supporting documentation **must** be attached.)

❑ Court-ordered admission (NOTE: These admissions are subject to the listed criteria to qualify for Medicaid reimbursement.)

The patient named above **requires** care in a mental facility/program. The following requirements are met:

1. Ambulatory care resources available in the community have been tried **or** are currently inadequate to meet the treatment needs of this patient (the availability or lack of outpatient resources is not a determining factor for Medicaid reimbursement); **and**
2. Proper treatment of this patient's psychiatric condition **requires** services on an in-patient basis under the direction of a psychiatrist or a physician under the supervision of a psychiatrist; **and**
3. The services can be expected to improve this patient's condition within a **reasonable** period of time **or** prevent further regression to the extent that services will no longer be needed.

Independent Team
(Not Associated with Admitting Hospital - If Medicaid Certified)

Date____/____/____ _____(signature)

_____(name & credentials)

Date____/____/____ _____(signature)

_____(name & credentials)

Admitting Hospital Interdisciplinary Team
(If Not Medicaid Certified)

Date____/____/____ _____(signature)

_____(name & credentials)

Date____/____/____ _____(signature)

_____(name & credentials)

Date____/____/____ _____(signature)

_____(name & credentials)

(Certification by the appropriate team **cannot be made earlier** than five (5) days prior to admission. A **minimum** of two signatures are required. See Reverse for specific instructions.)

Instructions for Completion of BHSF Form 142-C

All items which apply to the patient and the facility must be legible and properly completed.

Certification of Need is a requirement of federal regulations found at 42 CFR 441.152. Specifically, the need for inpatient psychiatric services must be established and documented by a team of professional personnel, as described below. Accordingly, the form must contain the signatures and credentials of either independent or interdisciplinary team members who are knowledgeable of the circumstances necessitating admission.

The composition of the appropriate professional team is dependent upon the status of the patient's Medicaid certification at the time of admission.

Independent Team

Certification for an individual who is a Medicaid recipient at the time of admission **must** be made by an **independent** team that consists of a physician licensed to practice in Louisiana and another professional, including an RN, BCSW, MSW, Psychologist, or Licensed Professional Mental Health Counselor. Additionally, this team must have: (1) competence in the diagnosis and treatment of mental illness, preferably in child psychiatry; and (2) have knowledge of the individual's situation.

NOTE: NO member of the independent team may be employed by or have a consultant relationship with the admitting hospital.

Admitting Hospital Interdisciplinary Team

Certification for an individual who applies for Medicaid at or during admission **may** be made by the admitting hospital's **interdisciplinary** team. At a minimum, this team **must** include either (1) a Board-eligible or Board certified psychiatrist; **OR** (2) a clinical psychologist who has a doctoral degree **and** a licensed physician; **OR** (3) a licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases **and** a psychologist who has a master's degree in clinical psychology and who has been certified by the State or by the State psychological association. The team must also include (1) an RN with specialized training or one year's experience in treating mentally ill individuals; **OR** (2) a psychiatric social worker, a licensed occupational therapist with specialized training or one year's experience in treating mentally ill individuals, or a psychologist with a master's degree in clinical psychology or who has been certified by the State or the State psychological association.

To obtain pre-certification authorization for admission, submit this form with other supporting documentation to the state fiscal intermediary:

UNISYS
Attn: Pre-Certification Unit
8591 United Plaza Blvd., Suite 100
Baton Rouge, LA 70809
FAX 1+800+717-4329

Medicaid payment **will not** begin until the date of the **last** signature.