Louisiana Medicaid Hospital Precertification for Acute Care

UNISYS

On-Line Webinar

November 12-13, 2009

LOUISIANA Department of HEALTH and HOSPITALS

OVERVIEW OF TRAINING SESSION

- Summary of Changes
- Acute Care Admissions and Extensions
  - Adult or Pediatric
  - NICU
- Revised PCF-02
- Revised PCF-04
- HIPPA Privacy and Confidentiality
- PreCertification Reminders
- Contact and General Information
- General Reminders

PRECERTIFICATION CHANGES EFFECTIVE NOVEMBER 16, 2009

Effective November 16, 2009, the following changes will be made to the existing hospital PreCertification/Length of Stay process.

- Review of Inpatient extension requests for acute care hospitals will be completed by utilizing nationally recognized criteria. Clinical reviews will utilize current McKesson InterQual guidelines. These guidelines will be updated annually.
- Length of Stay assignments will be made referencing clinical information and current Thomson Reuters data for the Southern Region or Louisiana Medicaid customized data.
- Diagnosis codes must be submitted using a valid ICD-9 code to the highest specificity (this is usually a 4 or 5 digit code).
- Outpatient surgical procedures performed on an inpatient basis on day one or day two of the inpatient hospital admission will be reviewed utilizing the current McKesson Procedures Guidelines and patient specific medical information.
- The PreCertification form 01 (PCF-01) will continue to be required for initial admissions and may be requested for certain extension requests. The PreCertification form 02 (PCF-02) and the PreCertification form 04 (PCF-04) have been revised to obtain comprehensive patient specific information pertinent to the extension request. The revised versions are required beginning November 16, 2009. If requested by the PreCertification Unit, two additional pages of documentation may be submitted with the PCF-02 or PCF-04.

These changes apply to the following acute inpatient hospital levels of care: acute General, NICU, ICU, PICU, CCU, TU and BURN unit. This does not include Rehabilitation, Long Term Acute Care, Psychiatric (Free Standing and DPP units) or Substance Abuse.

ACUTE CARE ADMISSION LENGTH OF STAY

Acute Care: Adult or Pediatric Admissions

Effective November 16, 2009

- Acute admissions affected include the following levels of care:
  - General, Burn, ICU, PICU, TU and CCU
- Initial LOS for acute care 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

ACUTE CARE ADMISSION LENGTH OF STAY

Acute Care: NICU Admissions

Short gestation and low birth weight (less than 2500 grams)

- Effective November 16, 2009 length of stay assignment will be based on revisions to the Louisiana Medicaid defined length of stay.
- The admission ICD-9 diagnosis code should be reported as the specific low birth weight or short gestational age.
- Effective December 21, 2009 PCF-01 **and** PCF-04 will be required for precertification admissions.

Admissions other than short gestation and low birth weight

- Effective November 16, 2009, initial LOS for acute care 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.
- Effective December 21, 2009 PCF-01 **and** PCF-04 will be required for precertification admissions.

ACUTE CARE EXTENSION LENGTH OF STAY REQUEST

Acute Care: Adult or Pediatric Extensions

Effective November 16, 2009

- Acute extensions affected include the following levels of care:
  - General, Burn, ICU, PICU, TU, and CCU
- First extension LOS request is assigned referencing the ICD-9 extension diagnosis code submitted by the hospital and,
- Up to current Thomson-Reuters 75th percentile of the Southern Region
- Current InterQual Intensity of Service (IS) criteria will be used for review of all extension requests for continued stay.
- PCF-01 and revised PCF-02 is required.
- All pertinent information must be included on the form itself and reflect the current patient intensity of service. There are to be no attachments to the PCF-02 unless requested by the nurse reviewer.
- When the patient is moved to a more intensive Level of Care the nurse reviewer will utilize InterQual Severity of Illness and Intensity of Service criteria for review.

ACUTE CARE EXTENSION LENGTH OF STAY REQUEST

Acute Care: NICU Extensions

Short gestation and low birth weight (less than 2500 grams)

- Extension LOS assignment will be based on revisions to 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.
- Forms PCF-01 **and** revised PCF-04 will be required for extensions.
- The birth weight or short gestation ICD-9 diagnosis code used on admission should be the first extension ICD-9 reported on the PCF04.
- Include additional diagnosis codes affecting intensity of service and supporting the continued stay.

Extensions other than short gestation and low birth weight

- Extension LOS assignment 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.
- Revised PCF-04 will be required for extensions.

OUTPATIENT PROCEDURES PERFORMED ON DAY OF ADMISSION OR DAY AFTER ADMISSION

Outpatient surgical procedures performed on an inpatient basis on day one or day two of the inpatient hospital admission will be reviewed utilizing the current McKesson Procedures Guidelines and patient specific medical information.

Revised Forms PCF-02 and PCF-04

- Providers are required to begin using these forms effective November 16, 2009.
- A review of the revised forms follows.

PCF-02

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		PRE-CERT CASE #
RECIPIENT ID NUMBER	RECIPIENT LAST NAME FIRST MI	PROVIDER NUMBER

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

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)

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.

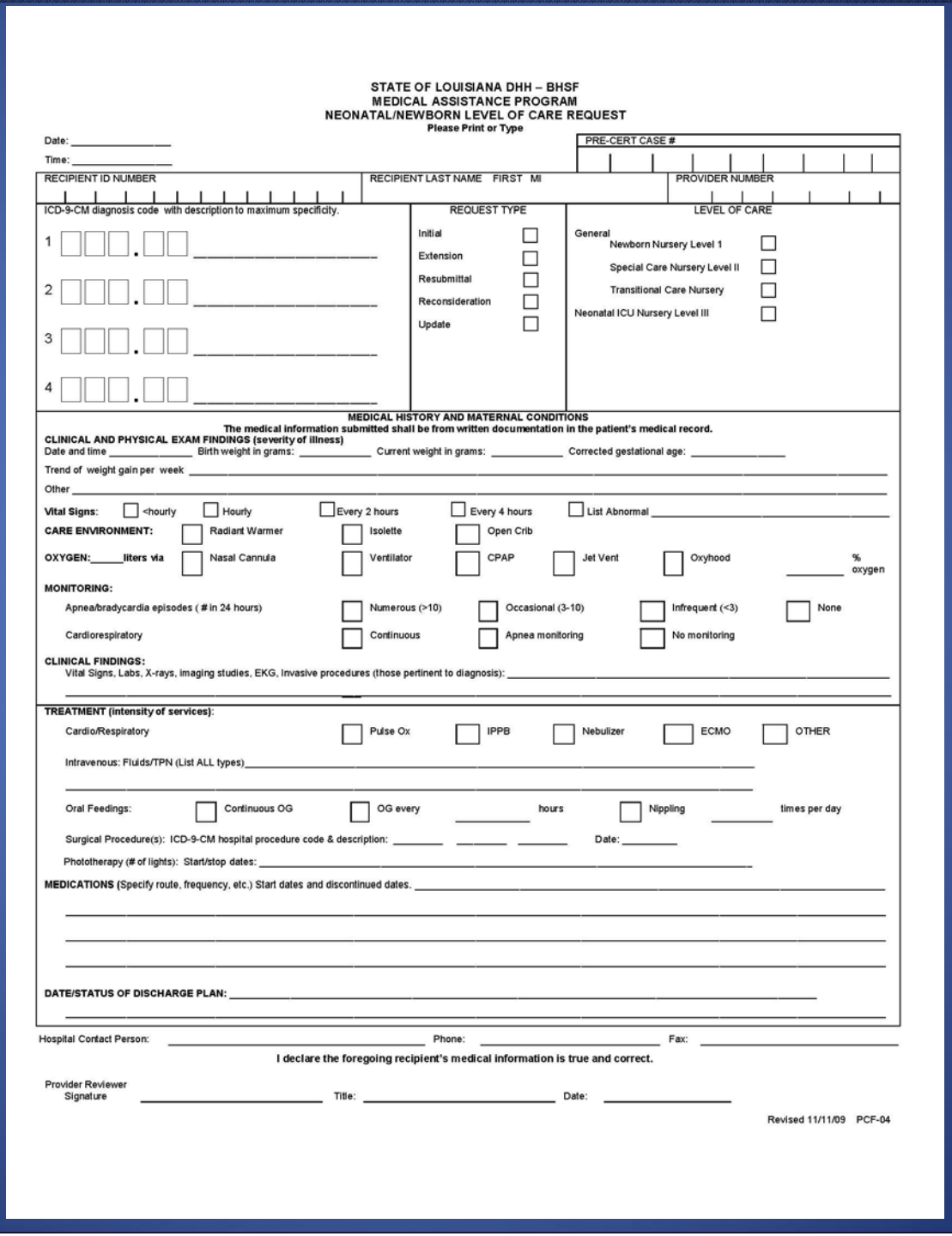
Hospital Contact Person: _____ Phone: _____ Fax: _____

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

Hospital Primary Reviewer
Title: _____ _____ Date of Request: _____
Signature

Revised 11/11/09 PCF-02

PCF-04



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

Date: _____
Time: _____

PRE-CERT CASE #

RECIPIENT ID NUMBER | RECIPIENT LAST NAME FIRST MI | PROVIDER NUMBER

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

1 ☐☐☐.☐☐ _____
2 ☐☐☐.☐☐ _____
3 ☐☐☐.☐☐ _____
4 ☐☐☐.☐☐ _____

REQUEST TYPE
- Initial ☐
- Extension ☐
- Resubmittal ☐
- Reconsideration ☐
- Update ☐

LEVEL OF CARE
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 PHYSICAL EXAM FINDINGS (severity of illness)
Date and time _____ Birth weight in grams: _____ Current weight in grams: _____ Corrected gestational age: _____
Trend of weight gain per week _____
Other _____

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

CARE ENVIRONMENT: ☐ Radiant Warmer ☐ Isolette ☐ Open Crib

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

MONITORING:
Apnea/bradycardia episodes (# in 24 hours) ☐ 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): _____

TREATMENT (intensity of services):
Cardio/Respiratory ☐ Pulse Ox ☐ IPPB ☐ Nebulizer ☐ ECMO ☐ OTHER

Intravenous: Fluids/TPN (List ALL types) _____

Oral Feedings: ☐ Continuous OG ☐ OG every _____ hours ☐ Nippling _____ times per day

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

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

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

DATE/STATUS OF DISCHARGE PLAN: _____

Hospital Contact Person: _____ Phone: _____ Fax: _____

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

Provider Reviewer Signature _____ Title: _____ Date: _____

Revised 11/11/09 PCF-04

HIPPA PRIVACY AND CONFIDENTIALITY STATEMENT

Privacy, Confidentiality and Protection of Records: A provider shall comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as established by the Centers for Medicare and Medicaid Services (CMS).

The privacy rule applies to any covered entity that maintains or transmits PHI in any form: electronic, oral, written, faxed, etc. Providers and their employees must not directly or indirectly disclose or knowingly permit the disclosure of any Protected Health Information (PHI) concerning recipients to any unauthorized person/entity.

PHI shall only be released (1) by the recipient's written, informed consent for release of information; (2) for treatment, payment or health care operations (TPO) with consent; or (3) by court order. The provider must safeguard the confidentiality of PHI which may identify the recipient, and a system must be maintained that provides for the security of all records.

PRE-CERTIFICATION REMINDERS

- Please list an extension diagnosis for each extension request.
- Providers are required to use a valid ICD-9 code that is coded to the highest specificity. This is usually a 5 or 4 digit code. Include a brief description of the ICD-9 code(s) submitted.
- Include start and discontinued dates for medication, and date all lab values and vital signs.
- 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.

CONTACT INFORMATION

- Pre-certification Fax Numbers

  (800) 717-4329

  (800) 348-5658

- Mailing Address

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

GENERAL REMINDERS

- Frequently Asked Questions (FAQ) Posted on Web
- Provider Notices Posted on Web
  www.lamedicaid.com
- Fax any questions to Unisys Precertification Department Attn: Sandy Whitcomb Fax number (225)216-6219

Questions
&
Answers

As you exit from the presentation, please wait to take the short survey before disconnecting from the web site.