PROFESSIONAL SERVICES TRAINING

Medicaid Issues for 2004
(Fall Issue)

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

UNISYS

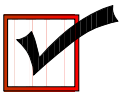
ABOUT THIS DOCUMENT

This document has been produced at the direction of the Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF), the agency that establishes all policy regarding Louisiana Medicaid. DHH contracts with a fiscal intermediary, currently Unisys Corporation, 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 training packet has been developed for presentation at the Fall 2004 Louisiana Medicaid Provider Training workshops. Each year these workshops are held to inform providers of recent changes that affect Louisiana Medicaid billing and reimbursement. In addition, established policies and procedures that prompt significant provider inquiry or billing difficulty may be clarified by workshop presenters. The emphasis of the workshops is on policy and procedures that affect Medicaid billing.

This packet does not present general Medicaid policy such as standards for participation, recipient eligibility and ID cards, and third party liability. Such information is presented only in the Basic Medicaid Information Training packet. This packet may be obtained by attending the Basic Medicaid Information workshop; by requesting a copy from Unisys Provider Relations; or by downloading it from the Louisiana MEDICAID website, www.lamedicaid.com.

Providers should use this packet in conjunction with the Physician Services Manual.



FOR YOUR INFORMATION! SPECIAL MEDICAID BENEFITS FOR CHILDREN AND YOUTH

I. MR/DD WAIVER WAITING LIST

The MR/DD Waiver Program provides services in the home, instead of institutional care, to persons who are mentally retarded or have other developmental disabilities. Each person admitted to the Waiver Program occupies a "slot." Slots are filled on a first-come, first-served basis. Services provided under the MR/DD Waiver are different from those provided to Medicaid recipients who do not have a Waiver slot. Some of the services that are only available through the Waiver are: *Respite Services; Substitute Family Care Services; Supervised Independent Living and Habilitation/Supported Employment*. There is currently a Waiting List for waiver slots.

TO ADD YOUR NAME TO THE WAITING LIST FOR MR/DD WAIVER SERVICES, CALL THIS TOLL-FREE NUMBER: 1-800-660-0488.

II. BENEFITS FOR CHILDREN AND YOUTH ON THE MR/DD WAIVER WAITING LIST

CASE MANAGEMENT

If you are a Medicaid recipient under the age of 21 and have been on the MR/DD Waiver Waiting list at any time since October 20, 1997, you may be eligible to receive case management *NOW*.

YOU NO LONGER NEED TO WAIT FOR THIS SERVICE. A case manager works with you to develop a comprehensive list of all needed services (such as medical care, therapies, personal care services, equipment, social services, and educational services), then assists you in obtaining them.

TO ADD YOUR NAME TO THE WAITING LIST FOR MR/DD WAIVER SERVICES, CALL THIS TOLL-FREE NUMBER: 1-800-660-0488.

Notice P-17
Revised November 1, 2000
*****DISCLAIMER: This information is currently being updated and some content may be incorrect or incomplete. If you are unable to get assistance using the telephone numbers listed under the specific programs, you may contact Medicaid Program Operations at 225-342-5774.**

III. BENEFITS AVAILABLE TO ALL CHILDREN AND YOUTH UNDER THE AGE OF 21

THE FOLLOWING SERVICES ARE AVAILABLE NOW. YOU DO NOT NEED TO WAIT FOR A WAIVER SLOT TO OBTAIN THEM.

EPSDT/KIDMED EXAMS AND CHECKUPS

Medicaid recipients under the age of 21 are eligible for checkups ("EPSDT screens"). These checkups include a health history, physical exam, immunizations, vision and hearing checks, and dental services. They are available both on a regular basis, and whenever additional health treatment or services are needed.

TO OBTAIN AN EPSDT SCREEN OR DENTAL SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

EPSDT screens may help to find problems which need other health treatment or additional services. **Children under 21 are entitled to receive all necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. This includes a wide range of services not normally covered by Medicaid for recipients over the age of 21.** Some of these additional services are very similar to services provided under the MR/DD Waiver Program. There is no waiting list for these Medicaid services.

PERSONAL CARE SERVICES

Personal care services are provided by attendants to persons who are unable to care for themselves. These services assist in bathing, dressing, feeding, and other non-medical activities of daily living. PCS services *do not* include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters. The Medicaid *Home Health* program or *Extended Home Health* program covers those medical services. PCS services must be ordered by a physician. Once ordered by a physician, the PCS service provider must request approval for the service from Medicaid.
FOR ASSISTANCE IN APPLYING FOR THIS SERVICE AND LOCATING A PCS SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

EXTENDED HOME HEALTH SERVICES

Children and youth may be eligible to receive *Skilled Nursing Services* and *Aide Visits* in the home. These can exceed the normal hours of service and types of service available for adults. These services are provided by a Home Health Agency and must be provided in the home. This service must also be ordered by a physician. Once ordered by a physician, the home health agency must request approval for the service from Medicaid.
FOR ASSISTANCE IN APPLYING FOR THIS SERVICE AND LOCATING A HOME HEALTH SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY , AND AUDIOLOGY SERVICES

If a child or youth wants *Rehabilitation Services* such as *Physical, Occupational, or Speech Therapy, or Audiology Services* outside of or in addition to those being provided in the school, these services can be provided by Medicaid at hospitals on an outpatient basis, or, in the home from Rehabilitation Centers or under the *Home Health* program. These services must also be ordered by a physician. Once ordered by a physician, the service provider must request approval for the service from Medicaid.

FOR ASSISTANCE IN APPLYING FOR THESES SERVICES AND LOCATING A SERVICE PROVIDER CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

SERVICES IN SCHOOLS OR EARLY INTERVENTION CENTERS

Children and youth can also obtain *Physical, Occupational, and Speech Therapy, Audiology Services, and Psychological Evaluations and Treatment* through early intervention centers (for ages 0-2) or through their schools (For ages 3-21). Medicaid covers these services if the services are a part of the IFSP or IEP. These services may also be provided in the home.

FOR INFORMATION ON RECEIVING THESE THERAPIES CONTACT YOUR EARLY INTERVENTION CENTER OR SCHOOL OR CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

MEDICAL EQUIPMENT AND SUPPLIES

Children and youth can obtain any medically necessary medical supplies, equipment and appliances needed to correct, improve, or assist in dealing with physical or mental conditions. *Medical Equipment and Supplies* must be ordered by a physician. Once ordered by a physician, the supplier of the equipment or supplies must request approval for them from Medicaid.

FOR ASSISTANCE IN APPLYING FOR MEDICAL EQUIPMENT AND SUPPLIES AND LOCATING MEDICAL EQUIPMENT PROVIDERS CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

MENTAL HEALTH REHABILITATION SERVICES

Children or youth with mental illness may receive *Mental Health Rehabilitation Services*. These services include: clinical and medical management; individual and parent/family intervention; supportive and group counseling; individual and group psychosocial skills training; behavior intervention plan development and service integration. *MENTAL HEALTH REHABILITATION SERVICES MUST BE APPROVED BY THE LOCAL OFFICE OF MENTAL HEALTH*.

FOR ASSISTANCE IN APPLYING FOR MENTAL HEALTH REHABILITATION SERVICES CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

TRANSPORTATION

Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours before the scheduled appointment.

TO ARRANGE MEDICAID TRANSPORTATION CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

Notice P-17
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OTHER MEDICAID COVERED SERVICES

° Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers
° Ambulatory Surgery Services
° Certified Family and Pediatric Nurse Practitioner Services
° Chiropractic Services
° Developmental and Behavioral Clinic Services
° Diagnostic Services-laboratory and X-ray
° Early Intervention Services
° Emergency Ambulance Services
° Family Planning Services
° Hospital Services-inpatient and outpatient
° Nursing Facility Services
° Nurse Midwifery Services
° Podiatry Services
° Prenatal Care Services
° Prescription and Pharmacy Services
° Health Services
° Sexually Transmitted Disease Screening

MEDICAID RECIPIENTS UNDER THE AGE OF 21 ARE ENTITLED TO RECEIVE THE ABOVE SERVICES AND ANY OTHER NECESSARY HEALTH CARE, DIAGNOSTIC SERVICE, TREATMENT AND OTHER MEASURES COVERED BY MEDICAID TO CORRECT OR IMPROVE A PHYSICAL OR MENTAL CONDITION. This may include services not specifically listed above. These services must be ordered by a physician and sent to Medicaid by the provider of the service for approval.

If you need a service that is not listed above call KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).

If you do not RECEIVE the help YOU need ask for the referral assistance coordinator.

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NOTICE TO ALL PROVIDERS

Pursuant to Chisholm v. Cerise DHH is required to inform both recipients and providers of certain services covered by Medicaid. The following two pages contain notices that are sent by DHH to some Medicaid recipients notifying them of the availability of services for EPSDT recipients (recipients under age 21). These notices are being included in this training packet so that providers will be informed and can help outreach and educate the Medicaid population. Please keep this information readily available so that you may provide it to recipients when necessary.

DHH reminds providers of the following services available for all recipients under age 21:

- Children under age 21 are entitled to receive all necessary health care, diagnostic services, and treatment and other measures covered by Medicaid to correct or improve physical or mental conditions. **This includes a wide range of services not normally covered by Medicaid for recipients over the age of 21.**

- Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

- Transportation to and from medical appointments, if needed, is provided by Medicaid. These medical appointments do not have to be with Medicaid providers for the transportation to be covered. Arrangements for non-emergency transportation must be made at least 48 hours before the scheduled appointment. **TO ARRANGE MEDICAID TRANSPORTATION CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544).**

Recipients may also CALL KIDMED (TOLL FREE) at 1-877-455-9955 (or TTY 1-877-544-9544) for referral assistance with all services, not just transportation

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Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

*Doctor's Visits
*Hospital (inpatient and outpatient) Services
*Lab and X-ray Tests
*Family Planning
*Home Health Care
*Dental Care
*Rehabilitation Services
*Prescription Drugs
*Medical Equipment, Appliances and Supplies (DME)
*Case Management
*Speech and Language Evaluations and Therapies
*Occupational Therapy
*Physical Therapy
*Psychological Evaluations and Therapy
*Psychological and Behavior Services
*Podiatry Services
*Optometrist Services
*Hospice Services
*Extended Skilled Nurse Services
*Residential Institutional Care or Home and Community Based (Waiver) Services
*Medical, Dental, Vision and Hearing Screenings, both Periodic and Interperiodic
*Immunizations
*Eyeglasses
*Hearing Aids
*Psychiatric Hospital Care
*Personal Care Services
*Audiological Services
*Necessary Transportation: Ambulance Transportation, Non-ambulance Transportation
*Appointment Scheduling Assistance
*Substance Abuse Clinic Services
*Chiropractic Services
*Prenatal Care
*Certified Nurse Midwives
*Certified Nurse Practitioners
*Mental Health Rehabilitation
*Mental Health Clinic Services

and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

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If you are a Medicaid recipient, under age 21, and are on the waiting list for the MR/DD waiver, you may be eligible for case management services. To access these services, you must contact your Regional Office for Citizens with Developmental Disabilities office.

You may access other services by calling KIDMED at (toll-free) 1-877-455-9955. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

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Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, KIDMED can assist you or your medical provider with information as to which services must be pre-approved.

Whenever health treatment or additional services are needed, you may obtain an appointment for a screening visit by contacting KIDMED. Such screening visits also can be recommended by any health, developmental, or educational professional. To schedule a screening visit, contact KIDMED at (toll-free) 1-800-259-4444 (or 928-9683, if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, (toll-free) 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone else call KIDMED and the appropriate assistance can be provided.

Louisiana Medicaid encourages you to contact the KIDMED office and obtain a KIDMED provider so that you may be better served.

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ELECTRONIC DATA INTERCHANGE TRANSITION

It is very important for providers billing electronically to take the necessary steps to ensure that their claims are submitted using the HIPAA mandated 837 specifications. The following information will assist your Software Vendor, Billing Agent or Clearinghouse (VBC) to submit HIPAA approved 837 transactions to Louisiana Medicaid.

The following table contains the current DHH implementation schedule for transition to HIPAA compliant electronic submissions by the applicable Medicaid Programs. Affected providers will be required to bill Louisiana Medicaid using the compliant 837 format by the implementation date stated below. **Additionally, in the near future claims submitted using the proprietary specifications will be held for 21 days. Please watch for further information that will be forthcoming about this change.**

PROGRAM	IMPLEMENTATION DATE
Ambulance Transportation	January 1, 2005
DME	January 1, 2005
Dental	January 1, 2005
Hemodialysis	November 1, 2004
Hospice	November 1, 2004
Hospital Inpatient/Outpatient	November 1, 2004
KIDMED	TBD
Personal Care Services (PCS)	TBD
Professional: Ambulatory Surgical Centers EPSDT Health Services Independent Lab & X-ray Mental Health Clinics Mental Health Rehabilitation Centers Physician Services (including physicians, optometrists, podiatrists, audiologists, psychologists, chiropractors, APRNs) Rehabilitation Centers Vision	To Be Phased In Beginning April 1, 2005 (Further information concerning dates of phases and programs will be forthcoming.)
Rural Health Clinics/Federally Qualified Health Centers	TBD
Waiver (all)	TBD

NOTE 1: Long Term Care/LTC (Nursing Facilities, ICF-MR Facilities, Hospice Room and Board, Adult Day Health Care Facilities) MUST ultimately transition to either 837 electronic billing or UB-92 paper billing. The final implementation date for this transition is to be determined.

NOTE 2: Non-Emergency Medical Transportation and Case Management Providers are excluded from HIPAA and will continue to submit electronic claims with the Louisiana Medicaid Proprietary Transactions.

If you are not currently submitting the HIPAA compliant 837 transactions, Louisiana Medicaid strongly recommends that you contact your VBC to determine if they can meet your needs as a Louisiana Medicaid provider. If your VBC has not started testing, you may go to the www.lamedicaid.com/hipaa to view the VBC list and select a VBC that is approved for your program. This list is updated monthly by the EDI group. **YOU MUST BE TRANSITIONED TO THE 837 HIPAA COMPLIANT FORMAT BY THE APPLICABLE DATES IN ORDER TO CONTINUE TO SUBMIT CLAIMS ELECTRONICALLY.**

The list includes contact information, the types of X12N HIPAA 837 transactions supported, and a status of "Enrolled", "Testing", "Parallel", or "Approved". The final "Approved" status means a provider can submit HIPAA EDI 837 transactions THROUGH the approved VBC to Louisiana Medicaid.

Louisiana Medicaid encourages all providers to use the VBC list to shop for a VBC that best suits their needs and budget. The features, functions, and costs vary significantly between VBCs. *Find the one that is right for you.*

Providers can also monitor the list to see how their VBC is progressing toward production approval.

HIPAA Desk Testing Service Enrollment

The first step towards HIPAA readiness is to have the VBC complete the HIPAA Testing Enrollment Form located at www.lamedicaid.com/hipaa. All VBCs MUST complete the required testing before any electronic claims may be submitted for providers. Therefore, the VBC must contact the LA Medicaid HIPAA EDI Group to enroll. (Providers who develop their own electronic means of submitting claims to LA Medicaid are considered the VBC).

VBCs can also get an enrollment form by e-mailing the HIPAA EDI group at *hipaaedi@unisys.com or by calling (225) 237-3318. The VBC must complete the form and return it by e-mail to Louisiana Medicaid. A HIPAA EDI representative will issue the VBC login information for our testing service.

Throughout the implementation of HIPAA requirements, Louisiana Medicaid has offered intense support. One of the support systems offered to the VBCs is HIPAADesk.com, which is a completely automated testing site for validation of X12 syntax. While the HIPAADesk.com is available for any VBC's use to validate X12 transactions, Louisiana Medicaid has furnished additional resources within this site. **The enhanced Louisiana-specific service will be offered through January 31, 2005 only.** After that, it will be the responsibility of the VBC to validate X12 syntax before testing with Louisiana Medicaid. Validation of X12 syntax does not validate 837 transactions for submission to Louisiana Medicaid. Additional testing is required.

With the exception of Long Term Care providers, individual providers using software that has been approved for a VBC do not need to test individually. Once a VBC is approved for production, this approval is also applied to those providers using the approved software.

In the Louisiana-specific section of HIPAADesk.com all Companion Guides for the 837I, 837P, 837D, and 278 transactions are available for download. **Our testing service through HIPAADesk.com is available 24 hours a day, 7 days a week and will maintain those hours through the end of January 2005.**

HIPAA-Compliant 837 Transaction Testing Service

Testing of 837 transactions involves two levels: validation of 837 transaction syntax and parallel testing of claims submitted in proprietary and HIPAA-compliant formats. Once the VBC has contacted Louisiana Medicaid and the enrollment process is complete, login information will be furnished to the identified testers on the enrollment form.

The testing service is a secure web based application that requires an internet connection and a web browser. The testing service contains all necessary information for a VBC to test for compliance with Louisiana Medicaid. Companion Guides for the 837I, 837P, 837D, and 278 transactions and other necessary and useful documentation are available for download from within the HIPAADesk.com testing service.

Each 837 testing program includes several tasks that must be performed successfully to complete EDI Desk.com testing. Upon completion of EDI testing, the VBC will begin MMIS Parallel Testing. The testing service is comprehensive and evaluates SNIP 1-7 types of testing.

MMIS Parallel Testing

Please refer to the section on Connectivity with the Payer/Communications in the Louisiana Medicaid General Companion Guide for instructions on how to gain access to our test Bulletin Board System (BBS). This guide is also available for download from within HIPAADesk.com.

Parallel testing will compare a current proprietary electronic claim file with a parallel HIPAA EDI file both utilizing the same source data. Generally, the current proprietary and HIPAA EDI file should adjudicate the same.

NOTE: For those submitters who did not previously send proprietary electronic Medicaid claims, such as TAD billers, the parallel testing process will be slightly different. Instead of sending a copy of an EDI file to the BBS, you will e-mail 25 Internal Control Numbers (ICNs) from paper-billed claims from your last remittance advice to your HIPAA EDI QA parallel testing support person. If there weren't 25 ICNs on your last remittance advice, e-mail all the ICNs on your most recent weeks remittance advice and that is acceptable. If a tester does not have an assigned support person, contact the HIPAA EDI Test Team at *hipaaedi@unisys.com or call (225) 237-3318.

These claims will be compared to the HIPAA file sent to the test BBS, which was generated from the same data.

ANESTHESIA SERVICES

The following anesthesia billing and reimbursement guidelines are effective with dates of service October 1, 2003.

Surgical Anesthesia

CPT procedure codes in the range 00100 through 01999 shall be used to bill for surgical anesthesia procedures.

- Reimbursement for surgical anesthesia procedures will be based on formulas utilizing base units, time units (1= 15 min) and a conversion factor.

- Reimbursement for conscious sedation procedures and maternity-related procedures other than general anesthesia for vaginal delivery will be flat fee.

- Minutes must be reported on all anesthesia claims except where policy states otherwise.

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

- AA - Anesthesia services performed personally by anesthesiologist.
- QK - Medical direction of 2, 3, or 4 concurrent anesthesia procedures by anesthesiologist.
- QX - CRNA service with medical direction by a physician. This physician is an anesthesiologist.
- QY - Medical direction of one CRNA by an anesthesiologist.
- QZ - CRNA service without medical direction. Not medically directed for Medicaid means that someone other than an anesthesiologist (probably the surgeon) supervised the CRNA.

    - Modifiers which can stand alone: AA and QZ.

    - Modifiers which need a partner: QK, QX and QY.

    - Legitimate combinations: QK and QX
QY and QX

- Reimbursement will not be made for the direction of five or more anesthesia procedures being performed concurrently UNLESS the patient is a Medicare/Medicaid beneficiary.

- **Only anesthesiologists will be reimbursed for medical direction.**

Reimbursement Formulas for Surgical Anesthesia

The formulas for determining payment for surgical procedures requiring anesthesia are as follows:

- Anesthesia performed personally by the anesthesiologist (AA)
  Base units plus time units times conversion factor = X - 20% = fee.

- Medical direction of 2, 3 or 4 concurrent anesthesia procedures by anesthesiologist (QK)
  Base units plus time units times conversion factor = X - 50% = Y - 20% = fee.

- CRNA service with medical direction by a physician (QX)
  Base units plus time units times conversion factor = X - 50% = Y - 20% = fee.

- Medical direction of one CRNA by an anesthesiologist (QY)
  Same as for QK.

- Anesthesia performed by the CRNA without medical direction (QZ)
  Same formula as for AA.

- In billing for anesthesia for second and third degree burn excision or debridement with or without skin grafting, report the total anesthesia time with code 01952 and report the appropriate number of units of body surface area with code 01953.

    - Reimbursement for code 01952 will be as follows: Base units of 01952 plus time units for 01952 and 01953 (1 = 15 minutes) times conversion factor ($16.41) = X - 20% = fee.
    - Reimbursement for code 01953 will be: One base unit for each unit of 01953 times the conversion factor ($16.41) = X - 20% = fee. For 01953 only, report units instead of time in Item 24G.

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

- Anesthesia for arteriograms, cardiac catheterizations, CT scans, angioplasties and MRIs should be billed with the appropriate code from the *Radiological Procedures* sub-heading in the Anesthesia section of CPT.

- Anesthesia for dental restoration should be billed under CPT anesthesia code 00170 with the appropriate modifier, minutes and most specific diagnosis code. Reimbursement is formula-based, with no additional payment being made for a biopsy. A provider does not have to perform a biopsy to bill this code.

Maternity-Related Anesthesia

CPT codes in the range 01960 through 01969 shall be used by anesthesiologists and CRNAs to bill for maternity-related anesthesia services. The delivering physician should use CPT codes in the *Maternity Care and Delivery* section of CPT to bill for maternity-related anesthesia services. Reimbursement for these services shall be flat fee except for general anesthesia for vaginal delivery.

The modifiers to be used for maternity-related anesthesia are as follows:

- Anesthesia services performed personally by the anesthesiologist (AA).
- CRNA service without medical direction (QZ).
- Medical direction of 2, 3 or 4 concurrent anesthesia procedures by anesthesiologist (QK).
- CRNA service with medical direction by a physician who is an anesthesiologist (QX).
- Medical direction of one CRNA by an anesthesiologist (QY).
- Anesthesia by surgeon [to be used by the delivering physician] (47).
- Reduced services [to be used by the delivering physician or the anesthesiologist] (52).
- Monitored anesthesia service [to be used by the anesthesiologist or CRNA] (QS).

Billing Add-on codes: When an add-on code is used to fully define the anesthesia service provided, the date of delivery should be the date of service for both the primary and add-on code.

REMINDER: Maternity-related services are exempt from the CommunityCARE referral process.

Billing for Maternity Related Anesthesia

Use the following chart when:

Anesthesiologist performs complete service, or just supervision of CRNA;
OR
CRNA performs complete service with or without supervision by anesthesiologist.

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
Vaginal Delivery General Anesthesia	01960	Valid Modifier	Record Minutes	Formula
Epidural for Vaginal Delivery	01967	AA or QZ	Record Minutes	$324.00
		QK or QY		$162.00
		QX		$162.00
Cesarean Delivery, only (epidural or general)	01961	AA or QZ	Record Minutes	$403.76
		QK or QY		$201.88
		QX		$201.88
Cesarean Delivery after Epidural, for planned vaginal delivery	01967 + 01968	AA or QZ	Record Minutes	$324.00 $79.76
		QK or QY		$162.00 $39.88
		QX		$162.00 $39.88
Cesarean Hysterectomy after Epidural and Cesarean Delivery	01967 + 01969	AA or QZ	Record Minutes	$324.00 $79.76
		QK or QY		$162.00 $39.88
		QX		$162.00 $39.88

Use the following chart when**:**

The delivering physician provides the **entire** anesthesia service for a vaginal delivery. The most appropriate code from codes 59410, 59610, 59612 and 59614 should be billed.

Vaginal Delivery

Complete Anesthesia Service by Delivering Physician

TYPE OF ANESTHESIA	CPT CODE	MODIFIER	TIME	ADDITIONAL REIMBURSEMENT
Epidural	59410, 59610, 59612 or 59614	47	Record minutes	$325.08

NOTE: Delivering physician should bill delivery and anesthesia on a single claim line. Reimbursement for both services will be made in a single payment.

Use the following charts when the anesthesia service for **vaginal** delivery is shared by:

The delivering physician and the anesthesiologist/CRNA
OR
The anesthesiologist and CRNA

Vaginal Delivery

Introduction Only, by Delivering Physician

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	ADDITIONAL REIMBURSEMENT
Epidural	59410, 59610, 59612 or 59614	47and 52	Record minutes	$178.02

Vaginal Delivery

Introduction Only, by An Anesthesiologist

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
Epidural	01967	AA and 52	Record minutes	$178.20

Vaginal Delivery

Monitoring by Anesthesiologist or CRNA

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
Epidural	01967	AA and QS or QZ and QS Or QX and QS	Record minutes	$145.80

Use the following charts when the anesthesia service for **cesarean** delivery is shared by:

The delivering physician and the anesthesiologist/CRNA
OR
The anesthesiologist and CRNA

Cesarean Delivery
Introduction Only, by Delivering Physician

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	ADDITIONAL REIMBURSEMENT
Most appropriate	59515, 59618, 59620 or 59622	47 and 52	Record minutes	$217.80

Cesarean Delivery
Introduction Only, by Anesthesiologist

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
C Delivery after Epidural	01961	AA and 52	Record Minutes	$213.99
C Delivery following epidural for planned vaginal delivery	01967 +01968	AA and 52	Record minutes	$178.20 $35.89

Cesarean Delivery
Monitoring by Anesthesiologist or CRNA

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
C Delivery after Epidural	01961	AA and QS Or QZ and QS Or QX and QS	Record minutes	$189.77
C Delivery following epidural for planned vaginal delivery	01967 +01968	AA and QS Or QX and QS	Record minutes	$145.80 $43.87
C Delivery following epidural for planned vaginal delivery	01967 +01968	QZ and QS or QX and QS	Record minutes	$145.80 $43.86

Anesthesia for Tubal Ligations and Hysterectomies

Anesthesia reimbursement for tubal ligations and hysterectomies is formula-based with the exception of anesthesia for Cesarean hysterectomy (code 01969) following administration of an epidural and Cesarean delivery.

- The reimbursement for code 01967 and code 01969 when billed together will be a flat sum of $403.75. Code 01968 is implied in code 01969 and should not be placed on the claim form if a Cesarean hysterectomy has to be performed after C-section delivery.
- Anesthesiologists and CRNAs must attach Form 96, *Consent to Sterilization*, to their claims for reimbursement for sterilizations, and Form 96-A, *Acknowledgement of Hysterectomy Information*, to their claims for reimbursement for hysterectomies.

Pediatric Conscious Sedation

CPT codes 99141 and 99142 are specific to the reporting of conscious sedation when it is administered by the physician who is also performing the procedure. These claims do not require modifiers and/or minutes.

- Codes 99141 and 99142 are restricted to recipients birth to 13 years of age. Exceptions to the age restriction will be made for children who are severely developmentally disabled. Under no circumstances will claims be honored for recipients twenty-one years of age or older.
- Reimbursement will be driven by the number in the Units column (Item 24 G) on the claim form.
- The reimbursement of 1 unit is $45.00
- The reimbursement for 2 units is $67.50
- Claims for conscious sedation should be submitted hard copy with supporting documentation attached. Documentation should explain the necessity for conscious sedation and are sent to Medical Review.

Pain Management

Epidurals given for the prevention or control of acute pain, such as that suffered due to delivery or surgery, are covered by the Physicians' Program but only for the day of delivery or surgery. Epidurals given to alleviate chronic, intractable pain, such as that occurring due to an old back injury, degenerative joint disease, cancer or polymyalgia rheumatica, are not covered.

If a recipient requests treatment for a chronic, intractable pain problem, the provider may bill for the initial office visit but shall not bill for any subsequent services provided for the treatment or management of the pain. Funds reimbursed for this purpose shall be recouped.

Additional Anesthesia Information

- CRNA's must place the name of their supervising doctor in Item 17 of the CMS 1500 claim form.

- Anesthesia for multiple surgical procedures in the **same anesthesia session** must be billed on one claim line using the most appropriate anesthesia code with the total anesthesia time spent reported in Item 24 G on the claim form. These claims must be submitted hard copy with the anesthesia graph or report attached to the claim.

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

- Anesthesia claims with a total anesthesia time greater than 224 minutes must be submitted hard copy with the anesthesia graph attached.

- Anesthesia claims for two separate operative services occurring on the same recipient on the same date of service will be reviewed by medical review. These claims must be submitted hard copy with the anesthesia graphs and operative notes.

- Anesthesia time begins when the provider begins to prepare the patient for induction and ends with the termination of the administration of anesthesia.

- Time spent in pre- or postoperative care may not be included in the total anesthesia time.

Personal Medical Direction

- The anesthesiologist must be physically present in the operating suite to bill for direction of concurrent anesthesia procedures.

- He/she must provide personal medical direction as defined by:

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

- The anesthesiologist may bill for the direction of up to four concurrent anesthesia procedures for straight Medicaid recipients.

- If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation and another may fulfill the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. The medical record must indicate, however, the services were furnished by physicians and must identify the physicians who rendered them. A single claim must be submitted showing one group physician as the performing physician for all the services rendered. In other words, split billing of these services will not be allowed.

AUDIOLOGY SERVICES

Payable Codes to Audiologists

SERVICE DESCRIPTION	CODE
Spontaneous Nystagmus; w/record	92541
Positional Nystagmus; w/record	92542
Caloric Vestibular Test; w/record	92543
Optokinetic Nystagmus; w/record	92544
Oscillating Tracking; w/record	92545
Use of Vertical Electrodes	92547
Screening; Pure Tone; Air Only	92551
Pure Tone Audiometry; Air Only	92552
Pure Tone Audiometry; Air and Bone	92553
Speech Audiometry Threshold	92555
Speech Audiometry, Threshold, with speech recognition	92556
Comprehensive Audiometry	92557
Tone Decay Test	92563
Short Increment Sensitivity Index	92564
Stenger Test; Pure Tone	92565
Tympanometry	92567
Acoustic Reflex Testing	92568
Acoustic Reflex Decay Test	92569
Filtered Speech Test	92571
Staggered Spondaic Word Test	92572
Sensorineural Acuity Level Test	92575
Synthetic Sentence ID Test	92576
Stenger Test; Speech	92577
Visual Reinforcement Audiometry (VRA)	92579
Conditioning Play Audiometry	92582
Select Picture Audiometry	92583
Electrochleography	92584
Auditory Evoked Potentials; Comprehensive	92585
Auditory Evoked Potentials; Limited	92586 *
Evoked Otoacoustic Emissions; Limited	92587
Evoked Otoacoustic Emissions; Comprehensive	92588
Hearing Aid Exam/Selection; Monaural	92590
Hearing Aid Exam/Selection; Binaural	92591
Hearing Aid Check; Monaural	92592
Hearing Aid Check; Binaural	92593
Electroacoustic Evaluation Hearing Aid; Monaural	92594
Electroacoustic Evaluation Hearing Aid; Binaural	92595

* Please note that this code is effective for dates of service October 1, 2003 and after. Code Z9916 is to be submitted for dates of service prior to October 1, 2003.

Restrictions

Payment for the following codes is restricted to one **each** per recipient per 180 days

92552	92553	92555	92556	92557	92563	92564
92565	92567	92568	92569	92571	92572	92575
92576	92577	92579	92582	92583	92584	92585

Audiologists Employed by Hospitals

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

CHIROPRACTIC SERVICES

Chiropractic services are covered only for recipients up to the age of 21 years when medically necessary and provided as a result of a medical referral from an EPSDT medical screening provider (KIDMED) or the recipient's primary care physician.

All claims for chiropractic services must be submitted hardcopy. These claims will be sent to medical review and should be accompanied with documentation substantiating medical necessity. This documentation should include:

- Diagnosis and chief complaint
- Relevant history
- Subjective and objective diagnostic examination findings
- Response to therapy
- Progress notes and patient disposition
- Procedures performed and results

CLINICAL NURSE SPECIALISTS/CERTIFIED NURSE PRACTITIONERS

Billing Information

- Clinical Nurse Specialists (CNS) and Certified Nurse Practitioners (CNP) must obtain individual Medicaid provider numbers.

- CNS/CNP services are billed on the CMS-1500 form**.**

    - The name of the CNS/CNP's directing physician must be entered in block 17 of this form.
    - CNS/CNP's not linked to a physician group must place their individual provider number in block 33 of the form as the billing provider.

- Physicians who employ or contract with CNS/CNP's must obtain a group provider number and link the individual provider number of the CNS/CNP to the group number. Physician groups must notify Provider Enrollment of such employment or contract(s) when CNS/CNP's are added/removed from the group.

    - Services provided by a CNS/CNP must be identified by entering the provider number of the CNS/CNP in block 24K and the group number in block 33 of the form.
    - CNS/CNP's employed or under contract to a group or facility may not bill individually for the same services for which reimbursement is made to the group or facility.

Reimbursement

Services that are reimbursable to CNS/CNP's can be found in Appendix C. Immunizations are reimbursed at 100% of the fee on file. All other payable procedures are reimbursed at 80% of the fee on file.

If there is a service that is within the scope of practice for CNS/CNP's that is not on the list of reimbursable services, a request for consideration of additional procedures may be submitted in writing to Medicaid at the following address:

DHH Program Operations
Physicians' Program Manager
P.O. Box 91030
Baton Rouge, LA 70821

Please Note: A list of codes payable to Certified Nurse Midwives can be found in Appendix D.

CommunityCARE

Program Description

CommunityCARE is operated in Louisiana under a freedom of choice waiver granted by the Centers for Medicare and Medicaid Services (CMS). It is a system of comprehensive health care based on a primary care case management (PCCM) model. CommunityCARE links Medicaid eligibles with a primary care physician (PCP) that serves as their medical home.

Recipients

Participation in the CommunityCARE program is mandatory for most Medicaid recipients. Currently, seventy-five to eighty percent of all Medicaid recipients are linked to a primary care provider. Recipients not linked to a CommunityCARE PCP may continue to receive services without a referral/authorization just as they did before CommunityCARE. Those recipient types that are **EXEMPT** from participation in CommunityCARE, and will not be linked to a PCP, are listed below. (This list is subject to change.)

- Residents of long term care nursing facilities, psychiatric facilities, or intermediate care facilities for the mentally retarded (ICF/MR) such as state developmental centers and group homes
- Recipients who are 65 years or older
- Recipients with Medicare benefits, including dual eligibles
- Foster children or children receiving adoption assistance
- Office of Youth Development recipients (children in State custody)
- Recipients in the Medicaid 'Lock In' program
- Recipients who have other primary insurance with physician benefits, including HMO's
- Recipients who have an eligibility period of less than 3 months
- Recipients with retroactive eligibility (for the retroactive eligibility period only as CommunityCARE linkages may not be retroactive)
- BHSF case-by-case approved "Medically High Risk" exemptions
- Recipients enrolled in Hospice
- Native American Indians residing in parish of reservation (currently Jefferson Davis, St. Mary, LaSalle, and Avoyelles Parishes)

CommunityCARE recipients are identified under the CommunityCARE segment of REVS, MEVS, and the online verification system through the Unisys website – www.lamedicaid.com. This segment gives the name and telephone number of the linked PCP.

Primary Care Physician

As part of the case management responsibility, the PCP is obligated to ensure that referrals/authorizations for medically necessary healthcare services which they can not/do not provide are furnished promptly and without compromise to quality of care. The PCP cannot unreasonably withhold them **OR** require that the requesting provider complete them**. Any referral/authorization requests must be responded to, either approved or denied, within 10 business days**. The need for a PCP referral/authorization does not replace other Medicaid policies that are in existence. For example, if the service requires prior authorization, the provider must still obtain prior authorization **in addition to** obtaining the referral/authorization from the PCP.

The Medicaid covered services, which do not require a referral/authorization from the CommunityCARE PCP, are **"exempt."** The current list of exempt services is as follows:

- Chiropractic service upon KIDMED referral (ages 0-21)
- Dental services for children, ages 0-21 (billed on the ADA claim form)
- Dental services for pregnant women, ages 21-59 (billed on the ADA claim form)
- Dentures for adults
- The three higher level (CPT 99283, 99284, 99285) emergency room visits and associated physician services. (NOTE: The two lower level Emergency room visits (CPT 99281, 99282) and associated physician services do not require prior authorization, but do require POST authorization). Refer to "Emergency Services" in the CommunityCARE Handbook.
- Inpatient Care that has been pre-certed (this also applies to public hospitals even though they aren't required to obtain pre-certification for inpatient stays) and related hospital, physician and ancillary services
- EPSDT Health Services – Rehabilitative type services such as occupational, physical and speech/language therapy delivered to EPSDT recipients through schools or early intervention centers or the EarlySteps program

  Note: A REFERRAL/AUTHORIZATION from the PCP IS REQUIRED for "Children's Special Health Services" clinics (Handicapped Children's Services) operated by The Office of Public Health.
- Family planning services
- Prenatal/Obstetrical Services
- Services provided through the Home and Community Based Waiver programs.
- Targeted case management
- Mental Health Clinic services (State facilities)
- Mental Health Rehabilitation services
- Neonatology services while in the hospital
- Ophthalmologist and Optometrist services
- Pharmacy
- Inpatient Psychiatric services (distinct part and freestanding psychiatric hospital)
- Psychiatrists Services
- Transportation services
- Hemodialysis
- Hospice services
- Specific lab and radiology codes

Non-PCP Providers and Exempt Services

Any provider, other than the recipient's PCP, must obtain a referral/authorization from the recipient's PCP in order to receive payment for services rendered. Any provider who provides a non-exempt, non-emergent (routine) service for a CommunityCARE enrollee, without obtaining the appropriate referral/authorization prior to the service being provided risks non-payment by Medicaid.

When a patient is being discharged from the hospital it is the responsibility of the discharging physician/hospital discharge planner to coordinate with the patient's PCP to obtain the appropriate referral/authorization for any follow-up services the patient may need after discharge (i.e. Durable Medical Equipment (DME) or home health). Neither the home health nor DME provider can receive reimbursement from Medicaid without the appropriate PCP referral/authorization. **The DME and home health provider must have the referral/authorization in hand prior to rendering the services.**

General Assistance – all numbers are available Mon-Fri, 8am-5pm

Providers:

Unisys - (800) 473-2783 or (225) 924-5040 - CommunityCARE Program policy, procedures, and problems, complaints concerning CommunityCARE

ACS - (800) 609-3888 - PCP assignment for CommunityCARE recipients, inquiries related to monitoring, certification

ACS - (877) 455-9955 - referral assistance

Recipients:

ACS - (800) 259-4444

CONCURRENT CARE

Concurrent Care (Under age 21 Only)

Concurrent care is defined as the provision of services by more than one physician to the same patient on the same day. Louisiana Medicaid does not pay for concurrent care for recipients age 21 and older. Concurrent care is reimbursed for recipients under the age of 21 only.

In order to qualify for concurrent care, a patient must have a condition(s) or a diagnosis(es) which requires the services of a physician(s) whose specialty, in the majority of cases, is different from that of the primary care physician. Additionally, the patient's condition(s) or diagnosis(es) must be of such severity and/or complexity that the medical community would consider the rendering of concurrent care to be reasonable and warranted. It must be expected that the request by the primary care physician for the provision of concurrent care services would be upheld by peer review. In all cases, concurrent care must be medically necessary, unduplicative, and reasonable. All claims are subject to post-payment review.

Concurrent Care

- Concurrent care for simple outpatient surgical procedures and uncomplicated diagnoses is not covered.
- Concurrent care policy does not apply to state-funded foster children.
- Concurrent care of patients in the intensive care areas of the hospital is allowed.
- Concurrent care by more than one provider of the same specialty will be sent to medical review prior to reimbursement. In these cases, a request for, and a review of, the medical documentation will occur before the decision to authorize payment is made.
- Providers may bill only one hospital visit per day per recipient, even if the patient must be seen more than once daily. The level of code billed for that date should reflect all the services rendered that day.
- Hospital discharge day management codes should be billed on the date of discharge. Each concurrent care provider will be reimbursed for the services on the date of discharge, as long as his specialty is different from those of the other concurrent care providers.
- The patient's hospital records must be available for review, should it be necessary to substantiate the need for concurrent care.

Consultants and Concurrent Care

A consultant may become a concurrent care provider on a case if his/her services after the consultation are necessitated by the condition of the patient, and meet the reasonableness test for standard of care. The consultant may bill for the initial consultation, but not for additional consultations, as he/she cannot be both a consultant and a concurrent care provider on the same case. Subsequent care after the initial consultation should be submitted as the appropriate level hospital inpatient service.

If, after consultation, the surgeon's role is assumed by the consultant, the consultant may bill for neither additional consultations nor follow-up care, as the global surgery period policy (GSP) supersedes this policy.

SAME-DAY OUTPATIENT VISITS

Same-Day Outpatient Visits (Under age 21 only)

- Same-day outpatient visit policy does not apply to state-funded foster children (aid category 15).

- Same-day outpatient visits are not covered if the patient's diagnosis is simple, or if the condition requires non-complex care.

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

    - the physician needs to check on the progress of an unstable patient treated earlier in the day;

    - an emergency situation necessitates a second visit on the same day as the first; or

    - any other occasion arises in which a second visit within a 24-hour period is necessary to ensure the provision of medically necessary care to the recipient.

- Two same-day outpatient visits per specialty per recipient are allowed.

    - In billing for the second same-day outpatient visit, no higher level visit than 99212 should be billed. CPT codes 99211 and 99212 may be billed twice on the same day, or in combination.

- The patient's medical record must be available for review and must substantiate the need for the second same-day visit.

- An outpatient visit and critical care services may be billed on the same day for the recipient.

- An emergency department visit and critical care services may be billed on the same day for the recipient.

- If a KIDMED screening has been paid, no higher level office visit than 99212 is payable for the same recipient, same date of service and same attending provider.

- A same day follow up office visit for the purpose of fitting eyeglasses is allowed, but no higher level office visit than 99211 should be billed for the fitting.

CONSULTATIONS

Note: Much of the confusion in reporting consultative services begins with terms used to describe the service requested. The terms "consultation" and "referral" may be mistakenly interchanged. These terms are not synonymous. Careful documentation of the services requested and provided will alleviate much of this confusion.

When a physician refers a patient to another physician it should not automatically be considered a consultation. **A consultation would be appropriate if the service provided meets the criteria described below**. Referral of a patient to another physician without a documented written request for a consultation should be reported using office or hospital care codes.

Louisiana Medicaid reimburses for a consultation, in either a hospital or office setting when:

- The service is performed by a physician other than the attending/primary care physician.
- The consultation is performed at the request of the attending/primary care physician, i.e., the 'requesting physician'. This physician's request for the consultation, as well as the need for the consultation, must be documented in the patient's medical record.
- Consultations should not be requested unless they are medically necessary, unduplicative, reasonable, and needed for adequate diagnosis and/or treatment. The patient's medical records must be available for review, and the documentation therein must substantiate the need for the consultation. Consultations for patients with simple diagnoses or who require non-complex care are not covered.
- The physician consultant may initiate diagnostic services.
- The consulting physician renders an opinion and/or gives advice to the requesting physician regarding the evaluation and/or management of a patient. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician.
- Both physicians' records should be reflective of the request for, and the results of the consultation.
- Confirmatory consultations are not covered.
- All claims are subject to post-payment review.

Billing for Consultations

The following criteria should be used to determine if a consultation code may be billed:

- If the consulting physician is to perform any indicated surgery, a consultation MAY NOT be billed. The appropriate level evaluation and management code may be billed if it does not conflict with global surgery policy. The GSP takes priority over consultation policy for recipients regardless of their age.

- If, by the end of the service, the consulting physician determines and documents in the patient's record that the patient does not warrant further treatment by the consultant, the consultation code should be billed. If the patient returns at a later date for treatment, subsequent visits should be billed using the appropriate level evaluation and management service codes.

- **If, by the end of the consultation, the consulting physician knows or suspects that the patient will have to return for treatment, the appropriate level evaluation and management code should be billed rather than the consultation code*.** The patient's record should document the fact that the consulting physician expects to treat the patient again.

Recipients Age 21 or Older

One consultation may be billed in conjunction with diagnostic procedures, **if it meets the definition of a consultation as previously described**. Follow-up consultations for recipients who are age 21 or older are not covered by Louisiana Medicaid.

Recipients under Age 21

Outpatient Consultations

- Outpatient consultation policy does not apply to state-funded foster children (aid category 15).

- Three office consultations per recipient per specialty per 180 days are allowed. (The consultant should be a specialist who is asked by the requesting physician to advise him on the management of a particular aspect of the recipient's care on three different occasions within a six month period.) If a fourth consultation is needed, reimbursement will be made only after the documentation has been reviewed and medical necessity of the additional consultations is approved by Medical Review.

- A consultation by a provider of the same specialty as that of the requesting physician will be allowed when circumstances are of an emergent nature as supported by diagnosis; and the requesting physician needs immediate consultation regarding the patient's condition. In this circumstance, no higher consultation code than 99244 should be billed. These claims will be sent to Medical Review and a review of the documentation will be made before reimbursement is authorized.

- The consulting physician may always bill for the initial consultation, **if it meets the definition of a consultation as previously described**. However, if the consultant subsequently assumes responsibility for some or all of the patient's care after the initial consultation, he/she must bill evaluation and management codes for established patients. If a provider bills an evaluation and management code for the initial visit, the provider cannot then bill a consultation code for subsequent visits.

- Claims for consultations should indicate the name of the requesting provider, which should be different from that of the consulting physician.

- The consulting physician should not have served as the primary care or concurrent care provider within the 180 days prior to performing the consultation.

Inpatient Consultations

- Inpatient consultation policy does not apply to state-funded foster children.

- One initial and two follow-up consultations are allowed per recipient per specialty per 45 days. If a third follow-up consultation is needed, reimbursement will be made only after the documentation has been reviewed and medical necessity of the additional consultation is approved by Medical Review.

- A consultation by a provider of the same specialty as that of the requesting physician will be allowed when circumstances are of an emergent nature as supported by diagnosis; and the requesting physician needs immediate consultation regarding the patient's condition. In this circumstance, no higher consultation code than 99252 should be billed. These claims will be sent to Medical Review and a review of the documentation will be made before reimbursement is authorized.

- Only one same-specialty consultation will be allowed every 365 days.

- The consulting physician may always bill for his initial consultation*, **if it meets the definition of a consultation as previously described.** However, if the consultant subsequently assumes responsibility for some or all of the patient's care after the initial consultation, he/she must bill subsequent hospital care codes for established patients for his daily visit services. If a provider bills a hospital visit code for his initial visit, the provider cannot then bill a consultation code for subsequent visits.

- Claims for consultations should indicate the name of the requesting physician, which should be different from that of the consulting physician. The consulting physician should not have served as the primary care or concurrent care provider within 730 days prior to performing the consultation.

*This is dependent upon the age of the recipient.

EXCLUSIONS AND LIMITATIONS

The following is not an exhaustive list of procedures or services excluded or limited by Louisiana Medicaid. Included are items that have generated questions from providers.

Billing for Services Not Provided

Providers may not bill Medicaid or the recipient for a missed appointment or any other services not actually provided. Additionally, services not documented are considered services not rendered and are subject to recoupment.

Aborted Procedures

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

Infertility

Louisiana Medicaid does not pay for services relating to the diagnosis or correction of infertility problems, including sterilization reversal procedures. This policy extends to any surgical, laboratory, or radiological service when the primary purpose is to diagnosis infertility or to enhance reproductive capacity. Claims for these services will be denied.

Surgical Assistant Clarification

Services rendered by a non-physician surgical assistant are not covered by the Medicaid Program.

New Patient Codes

Louisiana Medicaid will pay no more than **one new** patient code per two-year period to the same group practice, regardless of specialty, except when identifying the initial pre-natal visit of each new pregnancy.

Outpatient Visit Service Limits

Medically necessary outpatient visits are limited to 12 physician/clinic visits per state fiscal year for eligible recipients age 21 or older. Recipients under the age of 21 are not subject to program limitations, other than the limitation of medical necessity.

With the exception of obstetrical visits, all visits performed at Federally Qualified Health Centers, Rural Health Clinics, Nursing Homes, and Skilled Nursing Facilities will be counted toward the total of 12 for patients over age 21. Nursing home and skilled nursing facility visits should be billed with the appropriate place of service – not as inpatient hospital.

Visits in excess of 12 per state fiscal year, which are not approved via an extension, are considered not to be covered Medicaid services and are billable to recipients.

Outpatient Visit Service Limits – Medicare/Medicaid Recipients

Recipients who are covered by Medicare and Medicaid but who are not QMBs are subject to the same limitation on outpatient medically necessary visits as are Medicaid only recipients. Deductible and coinsurance amounts resulting from visits in excess of the 12 per fiscal year may be billed to dually eligible recipients who are not QMBs if extensions are not approved for those excess visits, as the visits are considered not to be Medicaid-covered.

Outpatient Office Visit Extensions

In order for the Louisiana Medicaid Program to reimburse outpatient physician visits beyond the maximum allowed visits per state fiscal year, the physician must request an extension from the Unisys Prior Authorization Unit. Extensions will be granted only for emergencies, life-threatening conditions, and life-sustaining treatments.

Providers need to attach documentation to the 158-A Extension Form substantiating the diagnosis justifying the office visit; therefore, all extensions of outpatient visits must be requested AFTER the service has already been rendered. The attached documentation may be clinical notes, patient history, pathology or laboratory reports or whatever else can support the diagnosis and services performed.

The ICD-9-CM diagnosis code and the appropriate-level CPT code correlating to the diagnosis must also be entered on the 158-A Extension Form. Incomplete extension forms will be rejected.

Unisys has extension forms available upon request at the address below. The physician should complete the top portion of the Form 158-A and submit it to Unisys, where approval/disapproval will be determined. Providers should send the 158-A form for approval to the following address:

Unisys
Prior Authorization Unit
P.O. Box 14919
Baton Rouge, LA 70898-4919

Once a decision has been made, Unisys will return the extension form to the provider.

For **approved extensions**, the provider should submit a hardcopy claim, with a cover letter of explanation, and a copy of the approved 158-A form to Provider Relations, at the following address:

Unisys
Provider Relations Correspondence Unit
P.O. Box 91024
Baton Rouge, LA 70821

A facsimile of the 158-A form is on the following page.

BHSF Form 158-A
Rev. 07/94
Prior Issues Usable

UNISYS for
Louisiana's **Medicaid Program**
P. O. Box 14919
Baton Rouge, LA 70898-4919

PHYSICIAN OUTPATIENT VISIT EXTENSION FORM

(Instructions for completion are on the reverse side of this form.)

I. TREATING PHYSICIAN - Complete this Section:

_____
Date

Approval of additional **EMERGENCY** or **LIFE-SUSTAINING** physician outpatient visits is being requested for:

_____ _____ _____
Patient's Name DOB Sex

_____ _____
Medicaid Identification Number Social Security Number

Provide a specific DIAGNOSIS CODE for each **EMERGENCY** or **LIFE-SUSTAINING** visit extension request.
Attach documentation of nature of emergency (Pathology report, clinical notes, etc.)

1. _____ (Date of Visit) _____/_____ (Diagnosis / Treatment)
2. _____ (Date of Visit) _____/_____ (Diagnosis / Treatment)
3. _____ (Date of Visit) _____/_____ (Diagnosis / Treatment)
4. _____ (Date of Visit) _____/_____ (Diagnosis / Treatment)
5. _____ (Date of Visit) _____/_____ (Diagnosis / Treatment)
6. _____ (Date of Visit) _____/_____ (Diagnosis / Treatment)
7. _____ (Date of Visit) _____/_____ (Diagnosis / Treatment)
8. _____ (Date of Visit) _____/_____ (Diagnosis / Treatment)
9. _____ (Date of Visit) _____/_____ (Diagnosis / Treatment)
10. _____ (Date of Visit) _____/_____ (Diagnosis / Treatment)
11. _____ (Date of Visit) _____/_____ (Diagnosis / Treatment)

Physician's Name, Address & Vendor No:

_____
Signature of Treating Physician

II. UNISYS - Prior Authorization Unit Use Only

❑ Extension of physician outpatient visits is approved for _____ (Date of Visit), _____ (Date of Visit),
_____ (Date of Visit), _____ (Date of Visit), _____ (Date of Visit), _____ (Date of Visit), _____ (Date of Visit),
_____ (Date of Visit), _____ (Date of Visit), _____ (Date of Visit), _____ (Date of Visit)

❑ Extension(s) not approved for _____ (Date(s) of Visit(s))

because _____

_____ _____
Date Signature of Reviewing Physician

PHYSICIAN COPY

FREE STANDING AMBULATORY SURGICAL CENTERS

- Ambulatory surgery centers are reimbursed a flat fee per occurrence, based on reasonable charges (not to exceed Medicare's maximum).
- The flat fee reimbursement is for facility charges only.
- Only one procedure code may be billed per outpatient surgical session.
- There should be only one line item per claim form.
- Pain Management is not a covered service. Billing for supplies or facility charges for the treatment of pain management is against Medicaid policy and payments received should be voided.
- Reimbursement is determined by the surgical grouping under which the procedure is listed:

Group 1	$220.39
Group 2	$262.36
Group 3	$282.40
Group 4	$320.56

- Procedures not listed in one of the four groupings are reimbursed at $300.00.
- A current listing of the groupings can be found in Appendix A.

GLOBAL SURGERY PERIOD

Louisiana Medicaid's global surgery (GSP) policy was implemented to establish a time period associated with the reimbursement and performance of certain surgeries and inpatient or outpatient visits.

Louisiana Medicaid's Global Surgery Period policy is not the same as Medicare's policy.

Medicaid does not pay for the day before, the day of, and the assigned GSP after surgery. Louisiana Medicaid assigns a GSP 1, 10, or 90 days. If you look at the Professional Fee Schedule, the Global Surgery Period can be found in column 11.

If a procedure has a GSP of "1", the provider cannot bill for an evaluation and management service (E/M) the day before or the day of the procedure.

If a procedure has a GSP of "10", the provider cannot bill for an E/M service the day before, the day of, or 10 days following the procedure.

If a procedure has a GSP of "90", the provider cannot bill for an E/M service the day before, the day of, or 90 days following the procedure.

Error code **690** (payment included in surgery fee) results when an E/M service is denied for a date of service within the GSP of the surgery or procedure that has been paid.

Error code **691** (visit paid in GSP; void visit, rebill surgery) results when a surgery or procedure is denied because an E/M service has been paid for a date of service within the GSP of the surgery or procedure. The paid claim for the E/M service must be voided before the claim for the surgery or procedure can be considered for payment.

E/M services should be billed separately only if the diagnosis and service rendered are unrelated to the diagnosis of the GSP procedure. If a visit is to be billed for a date of service within the GSP for unrelated diagnosis, it should be filed on a claim form separate from that of the GSP surgery or procedure.

GYNECOLOGICAL SERVICES

Hysterectomies

Federal regulations governing payment of hysterectomies under Medicaid (Title XIX) prohibit payment for a hysterectomy under the following circumstances:

- If the hysterectomy is performed solely for the purpose of terminating reproductive capability

OR

- If there was more than one purpose for performing the hysterectomy, but the procedure would not have been performed except for the purpose of rendering the individual permanently incapable of reproducing.

In addition, according to Louisiana Medicaid Program guidelines, if a hysterectomy is performed, payment can be made only if the patient is informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing and only if she has signed a written acknowledgment of receipt of this information.

This regulation applies to all hysterectomy procedures, regardless of the woman's age, fertility, or reason for the surgery.

BHSF Form 96-A

To obtain consent for hysterectomies, providers should use the Form 96-A, which may be obtained from BHSF.

The Form 96-A must be signed and dated by the recipient on or before the date of the hysterectomy, and it must be attached to the physician's hard copy claim when submitted for processing. In addition, the physician should share the consent form with all providers involved in that patient's care, (such as attending physician, hospital, anesthesiologist, and assistant surgeon) as each of these claims must also have a valid consent form attached.

It is not necessary to have someone witness the recipient signing the BHSF 96-A form, unless the recipient meets one of the following criteria:

- Recipient is unable to sign their name and must indicate "x" on signature line;
- There is a diagnosis on the claim that indicates mental incapacity.

If a witness does sign the BHSF 96A form, the date they indicate **MUST** match the date that the recipient signed it. The witness must both sign and date the form. If the dates do not match, or the witness does not sign and date the form, all claims that are related to the hysterectomy will deny. This means that not only will the physician claim deny, but also the anesthesiologist, hospital, and any other provider billing for this service.

Exceptions

Obtaining a Form 96-A consent is unnecessary only in the following circumstances:

- The individual was already sterile before the hysterectomy, and the physician who performed the hysterectomy **certifies in his own writing that the individual was already sterile at the time of the hysterectomy and states the cause of sterility.**

- The individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible, and the physician **certifies in his own writing that the hysterectomy was performed under these conditions and includes in his narrative a description of the nature of the emergency.**

- The individual was retroactively certified for Medicaid benefits, and the physician who performed the hysterectomy **certifies in his own writing that the individual was informed before the operation that the hysterectomy would make her permanently incapable of reproducing**. In addition, if the individual was certified retroactively for benefits, and the hysterectomy was performed under one of the two other conditions listed above, the physician must **certify in writing that the hysterectomy was performed under one of those conditions and that the patient was informed, in advance, of the reproductive consequences of having a hysterectomy**.

In any of the above events, the written certification from the physician **must** be attached to the hard copy of the claim in order for the claim to be considered for payment.

Sample BHSF Form 96-A

A sample of BHSF Form 96-A follows on the next page.

BHSF Form 96-A
Revised 07/94
Prior Issues Usable

Medicaid Program
Acknowledgement of Receipt of Hysterectomy Information

Recipient Name: _____
ID No.: _____
Physician Name: _____
Provider No.: _____

Payment by Louisiana's **Medicaid Program cannot** be authorized for the performance of **any** hysterectomy committed **solely** for the purpose of rendering an individual permanently incapable of reproducing or where, if there is more than one purpose for the procedure, the hysterectomy **would not** be performed but for the purpose of rendering the individual permanently incapable of reproducing.

Medicaid payment for a medically indicated hysterectomy can be authorized **only** if:
(1) the individual and her representative*, if any, are informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing; **and**,
(2) the individual and her representative*, if any, have signed a written acknowledgement of receipt of that information. The written acknowledgement **must** be signed and dated prior to the operation and **must** be attached to the claim form which is submitted for payment.

* A representative is that person who has the legal authority to act for an individual. For purposes of this acknowledgement, a representative shall be defined as either the curator of an interdicted woman or the tutor or parent of an unmarried minor. A minor emancipated by marriage is deemed capable of acting for herself in the matter.

I hereby acknowledge that I have been informed orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom the procedure is performed permanently incapable of bearing children.

_____ _____
Signature of Recipient Date

_____ _____
Signature of Representative, if any Date

Physician's Copy

Sterilizations

In accordance with Federal requirements, Medicaid payments for sterilization of a mentally competent individual aged 21 or older requires that:

- The individual is at least 21 years old at the time that consent was obtained;
- The individual is not a mentally incompetent individual;
- The individual has voluntarily given informed consent in accordance with all federal requirements;
- At least 30 days, but no more then 180 days, have passed between the date of the informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Sterilization Form With Consent Signed Less Than 30 Days

An individual may consent to be sterilized at the time of emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization.

The consent form must contain the signatures of the following individuals:

- The individual to be sterilized;
- The interpreter, if one was provided;
- The person who obtained the consent; and
- The physician who performed the sterilization procedure.
  (If the physician who performs the sterilization procedure is the one who obtained the consent, he/she must sign **both** statements.)

Consent Forms and Name Changes

When billing for services that require a BHSF Form 96 or Form 96A, the name on the Medicaid file for the date of service in which the forms were signed should be the same as the name signed at the time consent was obtained. If the patient's name changes before the claim is processed for payment, the provider must attach a letter from the physician's office from which the consent was obtained. The letter should be signed by the physician and should state that the patient's name has changed and should include the patient's social security number and date of birth. This letter should be attached to all claims requiring consent upon submission for claims processing.

Requests for BHSF Form 96 and Form 96-A

Sterilization and hysterectomy consent forms may be obtained by calling (225) 342-1304 or by sending a written request to:

BHSF Program Operations
ATTN: Physicians' Program Manager
P.O. Box 91030
Baton Rouge, LA 70821

Sample BHSF Form 96

Two examples of completed BHSF Forms 96 and instructions for making corrections can be found on the next three pages. The new form (Revised 06/00) is shown first, followed by the older version (Revised 01/92). Both versions are currently accepted by Louisiana Medicaid. The sections and examples are numbered on both examples. The instructions for correcting the forms refer to the numbers in order to explain corrections that can be made.

One example illustrates a correctly completed form for sterilization completed less than 30 days after the consent was obtained. In this case, "premature delivery" is checked and the expected date of delivery is indicated in blank 21 on the old 96 Form **(Revised 01/92)** and blank 19 on the **new 96 Form (Revised 06/00**)**.** Note that the expected date of delivery was at least 30 days after the date of the recipient's signature. In addition, at least 72 hours passed after consent was obtained and before sterilization was performed.

Must be group or individual who gave information about sterilization procedure.

BHSF Fo •
Rev. 06/00
Prior Issue Usable

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (1) Woman's OBGYN Group (Doctor or Clinic) When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving federal funds, such as FITAP or Medicaid, that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I **DO NOT** WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and have chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (2) tubal ligation. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time.

I am at least 21 years of age and was born on (3) 3/14/74 (Month/Day/Year).

I, (4) Mary Smith, hereby consent of my own free will to be sterilized by (5) Dr. John Cutter (Doctor)

by a method called (6) tubal ligation. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: *Representatives of the Department of Health and Hospitals; employees of programs or projects funded by that Department but only for determining if Federal laws were observed.*

I have received a copy of this form.

I (7) *Mary Smith* (Signature) (8) 6/2/04 (Date: Month/Day/Year)

You are asked to supply the following information, but it is not required: *Race and Ethnicity designation, please check.*

- ☐ American Indian or Alaska Native
- ☐ Black (not of Hispanic origin)
- ☐ Asian or Pacific Islander
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

II (10) (Interpreter Signature) (11) (Date: Month/Day/Year)

STATEMENT OF PERSON OBTAINING CONSENT

Before (12) Mary Smith (Name of Individual) signed the consent form, I explained to him/her the nature of the sterilization operation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control which are temporary are available. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

III (13) *Sue Andrews, RN* (Signature of Person Obtaining Consent) (14) 6/2/04 (Date: Month/Day/Year)

(15) Woman's OBGYN Group 433 10th St., Pine, LA 70001 (Name of Facility and Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (16) Mary Smith (Name of Individual to be Sterilized) on (17) 6/30/04 (Date: Month/Day/Year), I explained to him/her the nature of the sterilization operation, (18) tubal ligation (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control which are temporary are available. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily asked to be sterilized and appeared to understand the nature and consequence of the procedure.

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. (Cross out the paragraph which is not used.)

(3) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(4) This sterilization was performed less than 30 days, but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (Check the appropriate box and fill in the requested information):

(19) ☑ Premature delivery ☑ Individual's expected date of delivery: 8/1/04

☐ Emergency abdominal surgery:

(Describe circumstances):

IV (20) *John Cutter, MD* (Physician's Signature) (21) 7/6/04 (Date: Month/Day/Year)

SIGNATURE DATE MUST BE AT LEAST 30 DAYS

COMPLETE IF < 30 DAYS

SIGN AFTER SURGERY COMPLETE

Must be group or individual who gave information about sterilization procedure

BHSF Form 96
Rev. 01/92
Prior Issue Usable

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

I ■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from (1) Womans OB/GYN Group. When I first asked for
(doctor or clinic)
the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D. C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE.** I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (2) tubal ligation. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

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

I am at least 21 years of age and was born on (3) 12/06/74
Month Day Year

I, (4) Mary Smith, hereby consent of my own free will to be sterilized by (5) Dr. T.A. Jones
(doctor)

by a method called (6) tubal ligation. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Hospitals

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) Mary Smith *Signature* Date: (8) 08/10/04 *Month Day Year*

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

II ■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) *Interpreter* (11) *Date*

III ■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) Mary Smith *name of individual* signed the consent form, I explained to him/her the nature of the sterilization operation (13) tubal ligation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control which are temporary are available. I expalined that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(14) Sue Andrews, R.N. *Signature of person obtaining consent* (15) 08/10/04 *Date*

(16) Womans OB/GYN Group *Facility*

(17) 433 3rd St., Pine, LA 70776 *Address*

IV ■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon (18) Mary Smith *Name of individual to be sterilized* on (19) 08/20/04 *Date of sterilization*, I explained to him/her the nature of the *operation* sterilization operation (20) tubal ligation *specify type of operation*, the fact that it is intended to be a final and irreversible procedure, all the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control which are temporary are available. I expalined that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the Paragraph which is not used.)

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

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (Check applicable box and fill in information requested):

- ☑ Premature delivery
- ☑ Individual's expected date of delivery: 09/15/04
- ☐ Emergency abdominal surgery:

(describe circumstances):

(22) Dr. T. A. James *Physician*

Date (23) 10/1/04

MUST MATCH

AT LEAST 30 DAYS

COMPLETE

SIGN AFTER SURGERY COMPLETE

PATIENT'S COPY

Correcting the BHSF Form 96

The only blanks on the form that cannot be changed after the form has been submitted are blanks 7, 8, 10, 11, 14, 15 **(old 96 Form – Revised 01/92)** and 7, 8, 10, 11, 13, 14 **(new 96 Form – Revised 06/00).**

Errors in sections I, II, III, and IV can be corrected, but **only by the person over whose signature they appear.**

In addition, if the recipient, the interpreter, or the person obtaining consent returns to the office to make a correction to his portion of the consent form, the medical record must reflect his presence in the office on the day of the correction.

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

Only the recipient can correct the date to the right of her signature. The same applies to the interpreter, to the person obtaining consent, and to the doctor. The corrections of the recipient, the interpreter, and the person obtaining consent must be made **before** the claim is submitted.

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

In addition, providers must remember that ***informed consent*** must be obtained and documented **prior to** the performance of the sterilization, not afterward. Therefore, corrections to blanks 7, 8, 10, 11, 14, 15 **(old 96 Form – Revised 01/92)** and 7, 8, 10, 11, 13, 14 **(new 96 Form – 06/00)** may not be made subsequent to the performance of the procedure.

Physicians and clinics are reminded to obtain valid, legible consent forms. Copies must be shared with any provider billing for sterilization services, including the assistant surgeon, hospital, and anesthesiologist. An invalid consent form will result in denial of all claims associated with the sterilization. Consent forms will be considered invalid if errors have been made in correctable sections but have not been corrected, if errors have been made in blanks that cannot be corrected, or if the consent form shows evidence of erasures, "write overs", or use of correction fluid.

Abortions

Induced Abortions

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

A physician has found, and so certifies in **their own handwriting**, that on the basis of his/her professional judgment, the life of the pregnant woman would be endangered if the fetus were carried to term. The certification statement either must be on the claim form sent to Unisys or attached to the claim. If attached, the certification must contain the name and address of the patient. The diagnosis or medical condition which makes the pregnancy life endangering must be specified on the claim.

OR

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

A. The Medicaid recipient shall report the act of rape or incest to a law enforcement official unless the treating physician certifies in writing that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the rape or incest.
B. The Medicaid recipient shall certify that the pregnancy is the result of rape or incest and this certification shall be witnessed by the treating physician.
C. The report of the act of rape or incest to a law enforcement official or the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest must be submitted to the Bureau of Health Services Financing along with the treating physician's claim for reimbursement for performing an abortion.
D. In review, when submitting a claim for reimbursement of an abortion due to rape or incest, the claim form must have attached a law enforcement report or the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest AND a signed statement from the Medicaid recipient certifying that the pregnancy is the result of rape or incest. The OPH Informed Consent form shall be witnessed by the treating physician.

Effective with date of service September 25, 1995, in order for Medicaid reimbursement to be made for an abortion, providers must attach a copy of the OPH Informed Consent form to their claim form for an abortion. Copies of the OPH Informed Consent form can be requested from the Office of Public Health at (504) 568-5330. A blank copy of the form is shown on the following page.

Claims associated with an abortion, including those of the attending physician, hospital, assistant surgeon, and anesthesiologist must be accompanied by a copy of the attending physician's written statement of medical necessity. Therefore, **only hard-copy claims will be reviewed and considered for payment**. All hard-copy abortion claims will be reviewed by the Fiscal Intermediary physician consultants.

To be completed by the Provider:
Name, address of facility:

_____

_____

_____

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF PUBLIC HEALTH
CERTIFICATION OF INFORMED CONSENT-ABORTION

Please initial each section to indicate the information was provided.

SECTION I. The following information was presented to me, orally and in person, at least 24 hours prior to the abortion by _____, who is (check one): ___the physician who is to perform the abortion, ___ a referring physician.

- The name of the physician who will perform the abortion.
- A description of the proposed abortion method, medical risks, and alternatives to the abortion.
- The probable gestational age of the unborn child at the time the abortion is to be performed and,
- If the unborn child is viable or has reached the gestational age of 24 weeks and the abortion may be otherwise lawfully performed under existing law, that:

  1. The unborn child may be able to survive outside the womb
  2. The woman has the right to request the physician to use the method of abortion that is most likely to preserve the life of the unborn child.
  3. If the unborn child is born alive, that attending physicians have the legal obligation to take all reasonable steps necessary to maintain the life and health of the child.

- The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed.
- The medical risks associated with carrying the child to term.
- Any need for anti-RH immune globulin therapy, if RH negative, the likely consequences of refusing such therapy; and a good faith estimate of the cost of the therapy.

Initials:
_____

SECTION II. The following information was presented to me, orally and in person, at least 24 hours prior to the abortion by _____, who is (check one): the physician who is to perform the abortion, ___a referring physician, ___a qualified agent of the physician (Psychologist, Licensed Social Worker, Licensed Professional Counselor, Registered Nurse, Physician).

- That medical assistance benefits may be available for prenatal care, childbirth, and neonatal care. More detailed information on the availability of such assistance is contained in the directory.
- That the pamphlet describes the unborn child and contains a directory of agencies that offer abortion alternatives.
- That the father of the unborn child is liable to assist in the support of the child, even if he has offered to pay for the abortion. In the case of rape this information may be omitted.
- That I am free to withhold or withdraw my consent to the abortion at any time before or during the abortion without affecting my right to future care or treatment and without the loss of any state or federally funded benefits to which I might otherwise be entitled.

Initials:
_____

SECTION III. The following printed materials were provided to me by _____, who is (check one): ___the physician who is to perform the abortion, ___a referring physician,___ a qualified agent of the physician (Psychologist, Licensed Social Worker, Licensed Professional Counselor, Registered Nurse, Physician).

- The pamphlet titled "Abortion: Making A Decision" and the directory of agencies that offer abortion alternatives. [If you are unable to read, they shall be read to you.]

The pamphlet and directory were provided to me on:

Date:_____ Time:_____ A.M. or P.M. (Circle one)

Initials:
_____

PHS 16-IC 9/95

Threatened, Incomplete, or Missed Abortions

For the threatened abortion, please submit patient history, sonogram reports, documentation of treatment, and discharge summary. The sonogram report must indicate that there were no fetal heart tones or that the mom was in active labor and that her cervix had fully dilated without any medical intervention. In other words, that labor had begun **on its own accord**.

Incomplete or missed abortion claims must be submitted hardcopy with appropriate documentation.

This documentation should include:

1) sonogram report showing no fetal heart tones;

2) history showing passage of fetus at home, in an ambulance, or in the emergency room;

3) pathology report showing degenerating products of conception; or

4) operative report indicating products of conception in the vagina.

All reports are not needed. These are examples of the information needed to provide enough documentation to properly review the claim and substantiate payment.

HOSPICE

Overview

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

A recipient must be terminally ill in order to receive Medicaid hospice care. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

Payment of Medical Services Related to the Terminal Illness

Once a recipient elects to receive hospice services**, the hospice agency is responsible for <u>either providing or paying for</u> all covered services related to the treatment of the recipient's terminal illness.**

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

- Hospice care provided by a hospice other than the hospice designated by the individual recipient or a person authorized by law to consent to medical treatment for the recipient.
- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected OR a related condition OR that are equivalent to hospice care, except for services provided by: (1) the designated hospice; (2) another hospice under arrangements made by the designated hospice; or (3) the individual's attending physician if that physician IS NOT an employee of the designated hospice or receiving compensation from the hospice for those services.

Payment for Medical Services Not Related to the Terminal Illness

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

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

If the information does not justify that the service was medically necessary and not related to the terminal condition for which hospice care was elected, the claim will be denied. If review of the claim and attachments justify that the claim is for a covered service not related to the terminal condition for which hospice care was elected, the claim will be released for payment. *Please note, if prior authorization or pre-certification is required for any covered Medicaid services not related to the treatment of the terminal condition, that prior authorization/pre-certification is required and must be obtained just as in any other case.*

NOTE: Claims for prescription drugs and home and community based waiver services will not be denied but will be subject to post-payment review.

INJECTIONS

For all payable injection codes, please refer to the “J Code” listing that can be found in Appendix B at the end of this document.

Changes to Payable Injections Policy

Antibiotic injections for recipients under age 21:

- Effective with date of service October 15, 2004, CPT code 90782 will be placed in non-pay status.

- Providers should use CPT code 90788 for the reimbursement of injectable antibiotics supplied and administered by the physician.

LABORATORY SERVICES

Specimen Collection

Physicians who collect specimens and forward them to an outside laboratory may not bill for collection of the specimen or performance of the test. Only the provider who has performed the test (i.e., the outside laboratory) may bill for the test. The collection of the specimen is included in the office visit fee.

CLIA Certification

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

Claims are edited to ensure payment is not made to:

- providers who do not have a CLIA certificate
- providers submitting claims for services rendered outside the effective dates of the CLIA certificate
- providers submitting claims for services not covered by their CLIA certificate

Louisiana Medicaid maintains a current provider CLIA file. Therefore, providers do not have to include their CLIA certification number on claim forms. In fact, the CLIA certificate number should not be entered on the claim form for Medicaid services.

Providers must submit a copy of the CLIA certification to Unisys Provider Enrollment initially to have the certification added to the provider file. Once the CLIA certification has been added to the file, certification updates are done automatically via CMS's file updating process (OSCAR) and are sent to Medicaid without provider involvement.

Providers with regular accreditation, partial accreditation, or registration certificate types are allowed by CLIA to bill for all lab codes.

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

Providers with waiver or provider-performed microscopy (PPM) certificates wishing to bill for codes outside their restricted certificate types should obtain the appropriate certificate through Health Standards. If the certificate type is upgraded, claims can be paid only for dates of service that fall within the upgraded certification dates.

The following page includes a listing of payable codes **as of July 30, 2004** for each restricted CLIA certificate type.

These listings are frequently updated.

Providers are notified of additions and deletions to the CLIA file through Provider Updates and Remittance Advice messages.

CLIA Waiver Certificate (Type 2) Payable Codes

80061	82570	83718	86588
80101	82679	83986	86618
81002	82947	84460	86701
81003	82950	84478	87072
81007	82951	84703	87077
81025	89252	84830	87210
82010	82962	84999	87449
82044	82985	85013	87804
82055	83001	85014	87880
82120	83002	85018	87899
82270	83026	85610	89300
82274	83036	85651	
82465	83518	86308	
82523	83605	86318	

CLIA Provider-Performed Microscopy (Type 4) Payable Codes

80061	82465	83605	86294
80101	82523	83718	86308
81000	82570	83986	86318
81003	82679	84460	86588
81007	82947	84478	86618
81025	82950	84703	87072
82010	82951	84830	87077
82044	82952	84999	87210
82055	82962	85013	87449
82120	82985	85014	87804
82270	83001-83002	85018	87880
82273	83026	85610	89190
82274	83036	85651	89300

QW Modifiers

The following lab procedure codes require a QW modifier:

80061	82570	83718	87072
80101	82679	83986	87076
81000	82947	84460	87077
81003	82950	84478	87210
81007	82951	84703	87339
82010	82952	84999	87449
82044	92962	85014	87804
82055	82985	85018	87880
82120	83001	85610	87899
82273	83002	86308	89300
82274	83036	86318	
82465	83518	86618	
82523	83605	86683	

MEDICAL REVIEW

The Unisys Medical Review Department is responsible for several functions, including reviewing claims for all manually priced procedures and designated procedures and diagnoses which require medical documentation to ensure compliance with Medicaid policy.

Federal and Louisiana Medicaid guidelines for certain types of gynecological procedures (including abortions, hysterectomies, and sterilizations) are very stringent. Consequently, a number of gynecological procedures are reviewed to ensure that the procedures billed are actually those performed and that non-covered services are not being billed as covered services. In addition, Medical Review also reviews claims submitted for multiple surgical procedures and bilateral procedures.

Expediting Correct Payment

Listed below are suggestions for facilitating correct payment:

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

2. Correctly date all operative reports.

3. Use specific, appropriate diagnosis codes.

4. Submit requested documentation as soon as possible so that correct payment can be quickly determined. When submitting requested documentation, attach it behind a copy of the original claim form, as Unisys has no mechanism to match incoming medical records with previously submitted claims.

5. Refrain from submitting two or more identical CMS-1500 forms at the same time. Bill all procedures performed under the same anesthesia session on the same CMS-1500 form. Use correct modifiers and attach all pertinent documents with the claim.

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

7. All reports (i.e. operative, history and physical, etc.) must be submitted as one sided for accurate imaging.

Bilateral Procedures

Providers should submit bilateral procedures on one claim line, append modifier 50, and place a “1” in the units column. These claims must be submitted hard copy with operative reports attached. Attaching operative notes to all surgery claims will expedite review and prevent a denial requesting operative notes.

Multiple Surgical Procedures

When more than one surgical procedure is submitted for a recipient on the same date of service, the claim is always evaluated by the Medical Review Unit, regardless of the method or timing of claim submittal.

When submitting multiple surgical procedures while under the same anesthesia session, providers should bill the major procedure with no modifier and append a -51 modifier on all other procedures, including add-on procedure codes.

Add-on codes must be modified with a -51 modifier and cannot be billed as primary procedures. If an add-on code is paid as a primary procedure, the code which should have been the primary procedure will deny with error edit 563 (adjust add-on code with -51 modifier) and will not be paid until the add-on code has been adjusted with a -51 modifier.

If no primary procedure has been designated by the provider, the claim will be priced as follows:

1. When multiple procedures are performed under the same anesthesia session and a modifier -51 is not appended to any of the billed procedures, the system will pay the procedure with the lowest numerical CPT code as major and all others will pend for review. If at the time of review it is determined that a procedure different from the one the system paid is actually the major procedure, the procedure determined to be the major will deny with error code 560. Denial code 560 tells the provider that the paid procedure must be adjusted with modifier -51 appended. The major procedure should not be resubmitted until the adjustment has been completed. Proper use of the modifier -51 will prevent this improper payment and need for adjustment.

2. When being reviewed by medical review, the procedure with the highest billed charge will be deemed the primary procedure. If more than one procedure has the same highest billed amount, the primary procedure will be determined based on the nature of the procedures.

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

4. Any procedure performed bilaterally and as a secondary procedure will be paid at 75% of the Medicaid allowable fee or 75% of the billed charge, whichever is less.

Multiple Modifiers

Multiple modifiers may be appended to a procedure code when appropriate. Billing both multiple surgical procedures and bilateral procedures during the same surgical session should follow the rules for each type of modifier: bilateral procedures should be billed with modifier -50; the principal procedure should be billed without the -51 modifier and secondary procedures should have the modifier -51 appended.

Gastrointestinal Surgery for Clinically Severe Obesity With Co-Morbid Conditions

Recipient Qualifications

To qualify for gastric restrictive surgery or gastric bypass, a recipient shall:

- Be at least 16 years of age;
- Have a documented weight in the morbidly obese range as defined by a body mass index greater than 40;
- Have at least three failed efforts at non-surgical methods of weight reduction;
- Have current obesity-related medical conditions which are classified as being very high risk for morbidity and mortality;
- Not be currently abusing alcohol or other substances;
- Be capable of complying with the modified food intake regimen and follow-up program which will come after surgery.

The surgeon who will be performing the surgical procedure must obtain **prior authorization** through the PA Unit. A letter documenting recipient qualifications and medical necessity from the recipient's physician must be submitted with the PA request for surgery. Documentation submitted with the prior authorization request shall include confirmatory evidence of co-morbid condition(s).

Keloid Policy

Providers will not be reimbursed for the removal of keloids if removal is/was for cosmetic reasons. The initial diagnostic visit is excluded from this policy. Such claims must be submitted hardcopy with a copy of the patient's chart notes documenting the visit and an accompanying statement from the physician indicating that the visit was the **initial** visit during which the problem was diagnosed. (Follow-up visits for keloid removal are not payable.)

Auditory System Procedures to Be Included In Tympanostomy

The following auditory system procedures are included in the performance of tympanostomy (CPT code 69436):

Code 69200 - Removal foreign body from external canal; without general anesthesia
Code 69205 - Removal foreign body from external auditory canal; with general anesthesia
Code 69210 - Removal impacted cerumen separate procedure; one or both ears
Code 69401 - Eustachian tube inflation, transnasal; without catheterization

Providers will receive payment for code 69436 only, even though the other four procedures may have been performed on the same recipient on the same date. Conversely, a payment for code 69200 for a particular recipient on a particular date of service will result in denials of claims for codes 69205, 69210, 69401, and 69436.

Spirometry

Spirometry (CPT code 94010) is a comprehensive code that includes respiratory flow volume loop (CPT code 94375). When spirometry is billed, respiratory flow volume loop may not be billed on the same date of service by the same provider or group for the same recipient. Bronchospasm evaluation (CPT code 94060) is a comprehensive code that includes spirometry and respiratory flow volume loop (CPT code 94010 and 94375). Therefore, when a bronchospasm evaluation is billed, neither spirometry nor respiratory flow volume loop may be billed on the same date of service by the same provider or group for the same recipient.

Unlisted Procedures

Claims submitted for unlisted procedure codes are subject to review, and should be submitted hardcopy with operative reports attached. The operative reports should accurately describe the unlisted procedure; underlining such portions of the report that describes the services performed will expedite the medical review process. If a CPT code exists that describes the service that was billed as an unlisted procedure code, the claim will be denied.

MODIFIERS

Providers often question which modifiers are acceptable for their patients. For recipients with Medicare and Medicaid, providers should submit the claim to Medicaid with the same modifiers used for Medicare. For recipients without Medicare coverage, only the following modifiers are acceptable. Please be sure to refer to the following chart to ascertain whether the modifier is an acceptable one for Louisiana Medicaid.

Modifier	Use/Example	Special Billing Instructions	Reimbursement
22 – Unusual Service	Service provided is greater than that which is usually required (e.g., delivery of twins); not to be used with visit or lab codes	Attach supporting documentation which clearly describes the extent of the service	125% of the fee on file
26 – Professional Component	Professional portion only of a procedure that typically consists of both a professional and a technical component (e.g., interpretation of laboratory or x-ray procedures performed by another provider)		40% of the fee on file
Note: Louisiana Medicaid does not reimburse technical component only on straight Medicaid claims. Reimbursement is not allowed for both the professional component and full service on the same procedure.			
50 – Bilateral Procedure	Procedure was performed bilaterally during the same operative session	Attach supporting documentation; bill on a single line with 1 unit	150% of the fee on file
51 – Multiple Procedures	More than one procedure was performed during the same operative session	Attach supporting documentation; use the modifier on all procedures except the primary one	100% of the fee on file for primary; 50% of the fee on file for all others
52 – Reduced Services	Service or procedure is reduced at the physician's election	Attach supporting documentation	75% of the fee on file
54 – Surgical Care Only	Surgical procedure performed by physician when another physician provides pre- and/or postoperative management		70% of the fee on file
55 – Postoperative Management Only	Postoperative management only when another physician has performed the surgical procedure		20% of the fee on file

Modifier	Use/Example	Special Billing Instructions	Reimbursement
56 – Preoperative Management Only	Preoperative management only when another physician has performed the surgical procedure		10% of the fee on file
Note: If full service payment is made for a procedure (i.e., the procedure is billed and paid with no modifier), additional payment will not be made for the same procedure for surgical care only, post-operative care only, or preoperative care only. In order for all providers to be paid in the case when modifiers 54, 55, and 56 would be used, each provider must use the appropriate modifier to indicate the service performed. Claims that are incorrectly billed and paid must be adjusted using the correct modifier in order to allow payment of other claims billed with the correct modifier.			
62 – Two Surgeons	Performance of procedure requiring the skills of two surgeons	Attach supporting documentation which clearly indicates the name of each surgeon and the procedures performed by each	80% of the fee on file
63 – Infants less than 4 kg	Indicates a procedure performed on an infant less than 4 kg	Attach supporting documentation	125% of the fee on file
66 – Surgical Team	Performance of highly complex procedure requiring the concomitant services of several physicians (e.g., organ transplant)	Attach supporting documentation which clearly indicates the name of each surgeon and the procedures performed by each	80% of the fee on file
In order for correct payment to be made in the case of two surgeons or a surgical team, all providers involved must bill correctly using appropriate modifiers. If full service payment is made for a procedure (i.e., the procedure is billed and paid with no modifier), additional payment will not be made for the same procedure for two surgeons or surgical team. Payment will not be made for any procedure billed for both full service (no modifier) and for two surgeons or surgical team. If even one of the surgeons involved bills with no modifier and is paid, no additional payment will be made to any other surgeon for the same procedure. Claims which are incorrectly billed with no modifier and are paid must be adjusted using the correct modifier in order to allow payment of other claims billed with the correct modifier.			
80 – Assistant Surgeon	Services of a physician surgical assistant	May be used only by licensed physicians enrolled in Louisiana Medicaid	20% of the fee on file
Q5 – Informal Reciprocal Arrangement	Services provided pursuant to a substitute physician arrangement for up to 14 continuous days (informal reciprocal arrangement)	The absent physician bills for the services performed, and the patient's chart must document who performed the services	100% of the fee on file
Q6 – Locum Tenens	Services provided pursuant to a substitute physician arrangement for 90 continuous days or longer (locum tenens arrangement)	The absent physician bills for the services performed, and the patient's chart must document who performed the services	100% of the fee on file
Note: The -Q5 and -Q6 modifiers are to be used only for informal reciprocal arrangements or locum tenens arrangements. Physicians in a partnership or practicing independently who provide "on call" services for each other so that each can have some time away from work cannot be said to have these arrangements and so should not use the -Q5 and -Q6 modifiers. This includes obstetricians who are on call for one another and may deliver the baby of another physician's patient.			

TH – Prenatal Visits	Required to indicate E&M pre-natal services rendered in the MD office		Normal fee for prenatal services (exempts the recipient from the 12 visit limit)
QW - Laboratory	Required when billing certain laboratory codes (refer to Laboratory Section of packet)		Fee on file (use of the –QW does not increase or decrease reimbursement**)**

NEWBORN CARE AND DISCHARGE

Physician providers billing for initial newborn care should use code 99431 (history and examination of normal newborn infant, initiation of diagnostic and treatment programs, and preparation of hospital records) for the initial examination rendered. Code 99431 is limited to one per lifetime of the recipient.

Procedure code 99433 (subsequent hospital care, each day; newborn services) should be billed for each day of normal newborn care subsequent to the date of birth other than the discharge date. Code 99433 is limited to 3 per lifetime of the recipient.

Discharge Services

- When the date of discharge is subsequent to the admit date, submit claims using the appropriate Hospital Discharge Services code from CPT.
- When newborns are admitted and discharged from the hospital or birthing room on the same date, use code 99435. This code is used for services within the first 24 hours of the child's life.

Request for Newborn Medicaid ID Numbers, BHSF Form 152N

An electronic process to obtain BHSF Form 152N (Request for Newborn Medicaid ID Number) is available to hospitals statewide. Each hospital has a unique ID and password for the purpose of logging in and submitting the forms electronically. The forms are received daily from participating hospitals statewide. .

Newborn Pre-certification

If newborn care procedure codes 99431, and/or 99433, and/or a discharge code of 99238 are billed within the initial 2 or 4 days of the mother's approved pre-cert, providers can submit claims as they normally would.

If the newborn is admitted to NICU, a pre-cert must be obtained with the baby's Medicaid number. After the pre-cert has been obtained, the physician's claims for these services should be submitted through regular claims processing channels.

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

If the newborn is not admitted to NICU but requires services after the initial 2 or 4 days of the mother's pre-cert, a pre-cert must be obtained with the baby's number. After the pre-cert has been obtained, claims should be submitted through regular claims processing channels.

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

OBSTETRICAL SERVICES

All prenatal visit codes must be modified with -TH in order to process correctly and the modifier must be placed in the first position after the CPT code.

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

Initial Prenatal Visit(s)

Recipients shall be allowed two initial prenatal visits per pregnancy (270 days). These two visits cannot be performed by the same provider.

The appropriate CPT code from the 99201 through 99205 section of *Office or Other Outpatient Services* range of codes shall be billed for this service, as each pregnancy will be considered a new pregnancy whether or not the recipient is a new patient to the provider. Additionally, a pregnancy-related diagnosis code must be used on the claim form as either the primary or secondary diagnosis.

Reimbursement for the initial prenatal visit, **which must be modified with -TH**, includes a routine dipstick urinalysis (CPT code 81002 or 81003), the examination, preparation of records, and health/dietetic counseling.

One OB panel code is payable per pregnancy.

If the pregnancy is not verified or if the pregnancy test is negative, the appropriate level evaluation and management code from the 99201-99215 range of codes should be billed **WITHOUT** the -TH modifier.

Follow-Up Prenatal Visits

The appropriate CPT code from the range of 99211-99215 section of *Office or Other Outpatient Services* range of codes shall be billed for each follow-up prenatal office visit. The code for each of these visits **MUST BE MODIFIED WITH –TH.**

The reimbursement for this service shall include payment for routine dipstick urinalysis, the exam, routine fetal monitoring (excluding fetal non-stress testing-CPT code 59025), and diagnosis and treatment of conditions both related and unrelated to the pregnancy.

Delivery Codes

The most appropriate CPT code should be billed for deliveries.

In cases of multiple births (twins, triplets, etc.), providers must submit claims hardcopy. The diagnosis code must indicate a multiple birth and delivery records should be attached. A -22 modifier for unusual circumstances should be used with the most appropriate CPT code for a vaginal or C-Section delivery when the method of delivery is the same for all births. If the multiple gestation results in a C-Section delivery and a vaginal delivery, the provider should bill the most appropriate CPT code for the C-Section delivery without a modifier and should also bill the most appropriate CPT code for the vaginal delivery and append modifier -51.

Postpartum Care Visit

CPT code 59430, which does not need to be modified, shall be billed for the postpartum care visit. The reimbursement for this service shall include all the services (examination, routine dipstick urinalysis, weight and blood pressure checks, etc.) normally associated with releasing a patient from OB care.

Each recipient is allowed one postpartum visit. Payment for a second medically indicated postpartum visit can be requested by submission of Form 158A.

Laboratory Services

One OB panel code is payable per pregnancy.

A complete urinalysis (CPT code 81000 or 81001) is payable only once per pregnancy per recipient per billing provider unless the primary diagnosis code for subsequent billings is within the 590-599 (Other Disease of Urinary System) diagnosis range or 646.6.

All lab work must be substantiated by appropriate diagnosis codes, e.g. urinalysis should be substantiated by a diagnosis of U.T.I.

Ultrasounds

Three ultrasounds shall be allowed per pregnancy. Payment for additional ultrasounds may be considered when medically necessary and must be submitted with the appropriate documentation. This documentation should include evidence of an existing condition or documentation to rule out a suspected abnormality.

Reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists.

Providers should bill the most appropriate CPT code for the service rendered.

Expanded Dental Services for Pregnant Women

Program Information

Effective November 1, 2003, Medicaid has implemented an adult dental program for pregnant women, entitled the "Expanded Dental Services for Pregnant Women Program". This program provides coverage for certain designated dental services for Medicaid eligible pregnant women ages 21 through 59 years in order to address their periodontal needs during pregnancy.

The BHSF Form 9-M is the referral form that is used to verify pregnancy for the Expanded Dental Services for Pregnant Women (EDSPW) Program. This referral form also provides additional important information from the physician to the dentist. The form must be signed by the medical professional providing pregnancy care, and must be kept in the patient's dental record.

The patient is required to obtain the original completed BHSF Form 9-M from the medical professional providing her pregnancy care and give it to the dentist prior to receiving dental services. This form is necessary for the dental provider to be reimbursed. If you have a patient that will benefit from this service, please complete the form for the patient to give to their dental provider.

The BHSF Form 9-M was revised with an issue date of 12/03. Effective April 2004, the BHSF Form 9-M with the issue date of 12/03 became the only version accepted by Medicaid. A copy of the revised BHSF Form 9-M (Referral For Pregnancy Related Dental Services) with an issue date of 12/03 can be found on the following page. Blank forms may be photocopied for distribution as needed. Additional copies of this form may also be obtained from the LA Medicaid website (http://www.lamedicaid.com) or from Unisys Provider Relations by calling (800) 473-2783 or (225) 924-5040.

BHSF Form 9-M
Issued 12/03

Medicaid Program

Referral For Pregnancy Related Dental Services

(Must Be Completed By The Medical Professional Providing Pregnancy Care)

Part I: All Items Must Be Complete

Name of Patient: _____

Street Address: _____ **City:** _____ **Zip Code:** _____

Medicaid Recipient ID #: _____

Estimated Date of Delivery (MM/DD/YYYY): _____

Part II: Check (☑) All Conditions That Apply

❑ **Bleeding Gums** ❑ **Pain associated with teeth or gums**
❑ **Swollen, puffy gums** ❑ **Bad breath odor that does not go away with normal brushing** ❑ **Loose teeth**
❑ **Spaces between the teeth that were not there before**
❑ **Teeth with obvious decay** ❑ **Inability to chew or swallow properly**
❑ **Teeth that appear longer** ❑ **Tender gums that bleed when brushing**

Are there any medical or perinatal complications that the dentist should be aware of prior to the delivery of dental services? ❑ **YES** ❑ **NO** **If** yes**, please describe below:**

_____

_____

Is pre-medication or other medication required prior to dental treatment? ❑ **YES** ❑ **NO**
(If yes**, please attach a photocopy of the prescription.)**

Part III: Check (☑) Any Services That Are Contraindicated

❑ **Local Anesthetic** ❑ **Restoration(s)**
❑ **Radiograph(s)** ❑ **Gum Treatment – Ultrasonic Cleaning and/or Scaling Below the Gum Line**
❑ **Teeth Cleaning** ❑ **Extraction(s)**

Part IV: Please include other comments and/or recommendations below:

_____

_____

I have confirmed the pregnancy with diagnostic testing for the above-named patient.

_____	_____	(___) _____	_____
Medical Professional Signature (Required)	**Provider Type & License #**	**Office Telephone #**	**Date**

To locate a Medicaid enrolled dentist, you may contact the Medicaid Referral Assistance Hotline toll-free at 1-877-455-9955.

ORAL AND MAXILLOFACIAL SURGERY PROGRAM

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

Non-Covered Services

- Tooth extractions for recipients age 21 and older except for those covered in the Expanded Dental Services for Pregnant Women Program
- Procedures performed for cosmetic purposes

Enrolled dental providers are limited in the types of surgical services that may be billed through the Professional Services Program. Please refer to the 2004 Dental Services Provider Training Packet for additional information regarding Dental program policy and billing procedures.

ORGAN TRANSPLANT SERVICES

When a Louisiana Medicaid recipient receives an organ transplant, all charges incurred in the transplant are to be billed under the Medicaid recipient's name and Medicaid ID number. This includes all procedures involved in the harvest of the organ from the donor. However, Medicaid does not pay for harvesting of organs when a Louisiana Medicaid recipient is the donor of an organ to a non-Medicaid recipient.

All claims for organ transplants must be submitted hard copy with a copy of the approved authorization letter and a dated operative report. Examples of the transplant form (TP-01) and the transplant approval letter follow.

Prior Authorization Request For Transplant Procedure(s)

Louisiana Department of Health and Hospitals
Bureau of Health Services
Medical Assistance Program

Date of Request : ____/____/____ _____ Original Request _____ Re-Evaluation Request

1) Patient's Name _____ 2) Date of Birth: __/_____/_____

3) Patient's Medicaid Identification Number(13-digits): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

4) Type of Transplant : _____ 5) Primary Diagnosis :_____

6) Secondary Diagnosis: _____ 7) Procedure Description :_____

8) Prognosis (with and without transplant, specifying morbidity, mortality, life expectancy and any other considerations: _____

9) Patient's history of present illness is attached and includes the following: _____Yes _____No
__Pertinent social history, clinical findings, consults, and key test results (representing the patient's current status).

10) Copy of Transplant Selection Committee's Notes and/or Minutes is attached and signed by a Transplant Committee Physician and includes the following information: _____Yes _____No
__Listing of Committee members present (Name & Title) , their discussions including any psychosocial concerns, e.g., e.g., drug or alcohol abuse, on patient suitability, quality of life, and compliance.

11) Do Urgent or Emergency conditions exist? _____Yes _____No (If Yes, please attach explanation).

NOTE: For each item above, please attach additional information to support your request for transplant(s).

Emergency Requests can be submitted by faxing all documentation to:

UNISYS PRIOR AUTHORIZATION DEPARTMENT (EMERGENCY TRANSPLANT REQUEST) AT (225)-929-6803

I certify that the requested transplant is not investigational or experimental and is regarded as standard therapy by the medical community. This transplant program is in compliance with DHH Medicaid transplant registration and approval requirements for organ or tissue. Our transplant program will notify you if there are pertinent changes between approval and actual date of transplant that could necessitate reconsideration of th request. We are submitting or preparing to submit scientific documentation for recent applicable transplant developments.

12)_____ 13) _____
(Physician Name and Title , Please Print) (Physician Signature and Title)

14)_____ 15)_____
(Transplant Coordinator or Contact Person) (Telephone Number / Fax Number)

16)Site Where Transplant is to be Performed (Hospital Name & Address) _____

_____

_____

TP-01 FORM, Issued 04/97

Mail to: Unisys / La. Medicaid , Prior Authorization Dept., P.O. Box 14919, Baton Rouge, La. 70898-4919

Telephone Number for Unisys Prior Authorization Dept. (800) 488-6334 or (225) 928-5263

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

August 25, 2004

Reference:
ID#:
SS#:

Dear Ms.

This is to confirm that a kidney/pancreas transplant has been approved for to be done at Coverage is authorized for the evaluation, transplant and follow-up care.

The approval for this procedure is contingent upon your acceptance of Medicaid payment as payment in full and that you are a Louisiana Medicaid enrolled provider. To be reimbursed for services rendered, all providers must comply with timely filing guidelines set by the Louisiana Medicaid Program. Also, the client must be eligible for Medicaid on dates of services in order to receive reimbursement from Medicaid. If you have any questions regarding the reimbursement rate, you may cal 2-21

Please attach a copy of this letter to your claim form as your authorization when billing Unisys Corporation for this service and share this letter with all other providers associated with this transplant.

You have the right to appeal this decision. If you wish to do so, please write to the Department of Health and Hospitals, Bureau of Appeals, P. O. Box 4183, Baton Rouge, LA 70821-4183 within thirty (30) days of receipt of this letter.

Sincerely,

Darlene White

for Ben A. Bearden
Director

BAB/SG/sgw

cc: D. Gough
J. Womack
S. Guarino
P. Misner w/attachments

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING
1201 CAPITOL ACCESS ROAD • P. O. BOX 91030 • BATON ROUGE, LOUISIANA 70821-9030
PHONE # 225/342-5774 • FAX # 225/342-3893

PHARMACY SERVICES

Prior Authorization

The prescribing provider must request prior authorization for non-preferred drugs from the University of Louisiana – Monroe. Prior authorizations requests can be obtained by phone, fax, or mail, as listed below.

Contact information for the Pharmacy Prior Authorization department:

Phone: (866) 730-4357 (8 a.m. to 6 p.m., Monday through Saturday)
FAX: (866) 797-2329

University of Louisiana – Monroe
School of Pharmacy
1401 Royal Avenue
Monroe, LA 71201

The following page includes a copy of the "Request for Prescription Prior Authorization" form, as can be found on the LAMedicaid.com website under "Rx PA Fax Form".

Preferred Drug List (PDL)

The most current PDL is dated October 1, 2004, and can be found on the LAMedicaid.com website.

Monthly Prescription Service Limit

An eight-prescription limit per recipient per calendar month has been implemented in the LA Medicaid Pharmacy Program.

The following federally mandated recipient groups are exempt from the eight-prescription monthly limitation:

- Persons under the age of twenty-one (21) years
- Persons living in long term care facilities such as nursing homes and ICF-MR facilities
- Pregnant women

If it is deemed medically necessary for the recipient to receive more than eight prescriptions in any given month, the provider must write "medically necessary" and the ICD-9-CM diagnosis on the script.

Fax or Mail this form to:
LA Medicaid Rx PA Operations
ULM College of Pharmacy
1401 Royal Avenue
Monroe, LA 71201
Fax: 866-RX PA FAX
(866-797-2329)

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program

REQUEST FOR PRESCRIPTION PRIOR AUTHORIZATION

Form RXPA01
Issue Date: 3/1/2002

Voice Phone:
866-730-4357

Please type or print legibly (fields followed with an asterisk * are required, all other fields are requested).

Date of Request:*	Number of Fax Pages (including cover page):*
Practitioner Information	**Patient Information**
Name:*	Name (last, first):*
LA Medicaid Prescribing Provider Number:*	LA Medicaid CCN or Recipient Number:*
LA Medicaid Billing Provider Number:	Date of Birth:*
Call-Back Phone Number (include area code):*	
Fax Number (include area code):	Projected Duration:*
Requested Drug Information	
Drug Name:*	Drug Strength:
Diagnosis Code (ICD-9-CM):	Diagnosis Description:*

Please answer the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred product(s)? ☐ YES ☐ NO

2. Does the patient have a condition that prevents the use of the preferred product(s)? ☐ YES ☐ NO
   If YES, list the condition(s) in the box below:

3. Is there a potential drug interaction between another medication and the preferred product(s)? ☐ YES ☐ NO
   If YES, list the interaction(s) in the box below:

4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐ YES ☐ NO
   If YES, list the side effects in the box below:

Practitioner Signature:*

(If a signature stamp is used, then the prescribing practitioner must initial the signature)

PHYSICIAN ASSISTANTS

Physician assistants (PAs) are not recognized as an independent provider type. Therefore, their services must be billed under the provider number of the supervising physician.

Please Note: Modifier 80 – "Assistant Surgeon" may be used only by a licensed physician. **Medicaid does not reimburse PAs who serve as assistant surgeons. Medicaid will reimburse covered assistant surgeon fees when the service is performed by a physician.** The recipient cannot be billed for assistant surgeon fees when the service is performed by a PA.

PODIATRY

A listing of procedures payable by Louisiana Medicaid can be found in appendix E. These procedures fall within the scope of practice for podiatrists as defined by the Louisiana Podiatry Practice Act and may be billed to the Louisiana Medicaid Program by any currently licensed podiatrist who is enrolled as a Medicaid provider.

If there is a service that is within the scope of practice for podiatrists that is not on the list of reimbursable services a request for consideration may be submitted in writing to Louisiana Medicaid at the following address:

DHH Program Operations
Physicians' Program Manager
PO Box 91030
Baton Rouge, LA 70821

PRE-CERTIFICATION POLICY

Billing Recipients When Pre-Certification Is Denied

DHH has received inquiries regarding the billing of recipients if a request for pre-certification of an inpatient stay is denied OR if an extension is denied following approval of the initial per-certification.

If a request for pre-certification is denied because medical necessity is not met, the recipient cannot be billed. If the case had met medical necessity, it would have been pre-certified; thus, if it was not medically necessary for the recipient to be in the hospital, the provider should never have admitted the patient. This same logic applies to the extensions - if it is not medically necessary for the patient to be in the hospital, then discharge would be in order.

Also, providers should not bill recipients simply because they were late in submitting their pre-certification information.

One situation in which a provider could bill the recipient is when the recipient presents himself to the hospital as a private-pay patient, not informing the hospital of his Medicaid coverage.

When a hospital's pre-certification request (initial request or extension request) is denied due to timely submittal, or if the hospital fails to request initial pre-certification, the physician can get their services paid, but the claim must be special handled. Providers should send their claim, along with an admit and discharge summary and a cover letter requesting a pre-certification override, to the following address:

Unisys Provider Relations Correspondence Unit
P.O. Box 91024
Baton Rouge, LA 70821

Providers should note that claims that are special handled may still deny if they contain errors. Overriding the pre-certification requirement does not negate Medicaid policy regarding claim completion. Providers should ensure that claims submitted for pre-certification overrides are correctly completed.

Submitting Physician Charges - Days Not Pre-Certified

SITUATION	PHYSICIAN VISITS COVERED	PHYSICIAN PROCEDURE
Hospital did not request pre-certification because it does not accept Medicaid*	YES	Physician submits claim with admit and discharge summary to the Correspondence Unit.
Hospital did not request pre-certification on the recipient in question, even though the hospital accepts Medicaid*	YES	Physician submits claim with admit and discharge summary to the Correspondence Unit.
Hospital did not request pre-certification timely on the recipient in question, even though the hospital accepts Medicaid*	YES	Physician submits claim with admit and discharge summary to the Correspondence Unit.
Hospital obtained pre-certification; however, the days billed by the physician were within the same hospital stay but not approved under the pre-certification*	YES	If the days in question were never applied for by the hospital, the physician can submit the claim with the admit and discharge summary to the Correspondence Unit. Cannot bill the recipient**
Hospital requested pre-certification, but it was denied because it did not meet medical necessity criteria (applicable also to extension)*	NO	Cannot bill the recipient**

***Please Note:** Hospital admission should be based on medical necessity as outlined by LA Medicaid pre-certification policy.

****Please Note:** Should the recipient choose to remain hospitalized once their stay is deemed not medically necessary the recipient should be informed that they will be responsible for charges incurred from that point on.

Providers should be aware that only the hospital may obtain approval for inpatient stays. Physicians cannot request approval for admission and need to contact the hospital's Utilization Review Department with questions concerning approval status. The attending physician will receive a copy of the pre-certification letters **IF** the hospital indicated the attending physician's Medicaid ID number on the PCF01 form.

Retrospective Eligibility Pre-Certification

For true retrospective eligibility pre-certification reviews, the pre-certification may be considered filed timely if the request is submitted within a year from the date that the eligibility decision was added to the recipients eligibility file. If the retrospective review is received within a year of the eligibility decision and the date of service is already over one year old, the normal timely filing restriction may be overridden.

Outpatient Surgery Performed on an Inpatient Basis

Outpatient surgeries performed on an inpatient basis require prior authorization if the surgery is done within the first two days of a hospital stay. The hospital Utilization Review department must complete a PCF02 and submit it to the Unisys Pre-certification Department to have the procedure added to the pre-certification file.

If the surgery is performed on the third or succeeding days, no prior authorization is required.

PRIOR AUTHORIZATION

Certain services/procedures **always** require prior authorization from the Unisys Prior Authorization Unit before they can be performed.

Each individual provider participating in the performance of the procedure **must submit a prior authorization request** for their services and must be assigned an **approved** prior authorization number. To obtain prior authorization for a procedure, providers must complete the PA01 form, attach any other necessary documentation, and mail the packet to the PA Unit at the following address:

Unisys Corporation
ATTN: Prior Authorization Unit
P.O. Box 14919
Baton Rouge, LA 70898-4919

Providers are notified via letter whether or not the procedure has been approved. If the procedure is not approved, a denial reason is indicated in this letter. The letter also indicates the prior authorization number assigned to the request, and this number must be entered in item 23 of the CMS 1500 form (if approved) for claims resulting from the procedure.

A blank PA01 form follows on the next page, along with instructions on how to complete the form.

Providers can obtain blank PA01 forms by accessing the www.lamedicaid.com web-site.

Post authorization may be obtained for a procedure that normally requires prior authorization if a recipient becomes retroactively eligible for Medicaid. However, such requests must be submitted within six months from the date of Medicaid certification of retroactive eligibility.

Instructions For Completing Prior Authorization Form (PA-01)

NOTE: Only the fields listed below are to be completed by the provider of service. All other fields are to be used by the Prior Authorization department at Unisys.

FIELD NO. 1 Check the appropriate block to indicate the type of prior authorization requested**.**

FIELD NO. 2 Enter recipient's 13-digit Medicaid ID number or the 16-digit CCN number.

FIELD NO. 3 Enter the recipient's Social Security number.

FIELD NO. 4 Enter the recipient's last name, first name and middle initial as it appears on their Medicaid card**.**

FIELD NO. 5 Enter the recipient's date of birth in MM/DD/YYY format (MM=month, DD=day, YYYY=year).

FIELD NO. 6 Enter the provider's 7-digit Medicaid number. If associated with a group, enter the attending provider number only.

FIELD NO. 7 Enter the beginning and ending dates of service in MM/DD/YYY format (MM=month, DD=day, YYYY=year).

FIELD NO. 8 Enter the numeric ICD9-diagnosis code (primary & secondary) and the corresponding description.

FIELD NO. 9 Enter the day the prescription, doctor's orders was written in MM/DD/YYY format (MM=month, DD=day, YYYY=year).

FIELD NO. 10 Enter the name of the recipient's attending physician prescribing the services.

FIELD NO. 11 Enter the HCPCS/procedure code.

FIELD NO. 11A Enter the corresponding modifiers (when appropriate).

FIELD NO. 11B Enter the HCPCS/procedure code's corresponding description for each procedure requested.

FIELD NO. 11C Enter the number of units requested for each individual HCPCS/procedure.

FIELD NO. 11D Enter the requested charges for each individual HCPCS/procedure when it is appropriate for the requested HCPCS/procedure.

FIELD NO. 12 Enter the location for all services rendered.

FIELD NO. 13 Enter the name, mailing address and telephone number for the provider of service.

FIELD NO. 14 Enter the name, mailing address and telephone number of the recipient's case manager, if available.

FIELD NO. 15 Provider/authorized signature is required. Your request will not be accepted if not signed. If using a stamped signature, it must be initialed by authorized personnel.

FIELD NO. 16 Date is required. Your request will not be accepted if field is not dated.

If you have any questions concerning the prior authorization process, please contact the Prior Authorization department at Unisys:

Toll-free number	**800-488-6334**
Local	**225-928-5263**
Fax	**225-929-6803**

MAIL TO:
UNISYS / LA. MEDICAID
P.O. BOX 14919
BATON ROUGE, LA. 70898-4919

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

P.A. NUMBER

FAX TO: (225) 929-6803

CONTINUATION OF SERVICES ____YES ____ NO

PRIOR AUTHORIZATION TYPE: (1)
___ 01-Outpatient Surgery Performed Inpatient Hospital
___ 05 Rehabilitation Therapy
___ 09 DME equipment & Supplies
___ 99 Outpatient Surgery Performed Inpatient (CPT Procedures) & All other specialized CPT Procedures

RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER (2)

Social Security No. (3)

RECIPIENT LAST NAME | FIRST | MI (4)

DATE OF BIRTH (5)

MEDICAID PROVIDER NUMBER (7- DIGIT) (6)

BEGIN DATE OF SERVICE (MMDDYYYY) (7)

END DATE OF SERVICE (MMDDYYYY)

P. A. NURSE AND / OR PHYSICIAN REVIEWER'S SIGNATURE: & DATE

DIAGNOSIS : (8)
PRIMARY CODE & DESCRIPTION

SECONDARY CODE & DESCRIPTION

PRESCRIPTION DATE (9) (MMDDYYYY)

STATUS CODES:
2 = APPROVED
3 = DENIED

PRESCRIBING PHYSICIAN'S NAME AND/ OR NUMBER: (10)

DESCRIPTION OF SERVICES

FOR INTERNAL USE ONLY

PROCEDURE CODE (11)	MODIFIERS (11A) Mod 1	Mod 2	Mod 3	Mod 4	DESCRIPTION (11B)	REQUESTED UNITS (11C)	REQUESTED AMOUNT (11D)	AUTHORIZED UNITS	AUTHORIZED AMOUNT	STATUS	P.A. MESSAGE/ DENIAL CODE (S	

(12)
PLACE OF TREATMENT: ____ RECIPIENT'S HOME ___ NURSING HOME ____ ICF-MR FACILITY ____ OUTPATIENT HOSPITAL / CLINIC

(13)
PROVIDER NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE _____
TELEPHONE: (___) ___ ___ FAX NUMBER: (___) ___ ___

(14) CASE MANAGER INFORMATION:
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIPCODE _____
TELEPHONE (___) ___ ___ FAX NUMBER: (___) ___ ___

(15)
PROVIDER SIGNATURE: _____

(16)
DATE OF REQUEST: _____

PA-01 FORM

VACCINES FOR CHILDREN & LOUISIANA IMMUNIZATION NETWORK FOR KIDS STATEWIDE

Vaccines for Children (VFC)

VFC is covered under Section 1928 of the Social Security Act. Implemented on October 1, 1994, it was an "unprecedented approach to improving vaccine availability nationwide by providing vaccines free of charge to VFC-eligible children through public and private providers."

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

Persons eligible for VFC vaccines are between the ages of birth through 18 who meet the following criteria:

- Eligible for Medicaid
- No insurance
- Have health insurance, but it does not offer immunization coverage and they receive their immunizations through a Federally Qualified Health Center
- Native American or Alaska native

Providers can obtain an enrollment packet by contacting the Office of Public Health's (OPH) Immunization Section at (504) 483-1900.

Louisiana Immunization Network for Kids Statewide (LINKS)

LINKS is a computer-based system designed to keep track of immunization records for providers and their patients.

The purpose of LINKS is to consolidate immunization information among health care providers to assure adequate immunization levels and to avoid unnecessary immunizations.

LINKS can be accessed through the OPH website: **www.oph.dhh.state.la.us.**

LINKS will assist providers within their medical practice by offering:

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

LINKS will assist patients by offering:

- Easy access to records needed for school and child care
- Automatic reminders to help in keeping children's immunizations on schedule
- Reduced cost (and discomfort to child) of unnecessary immunizations

Providers can obtain an enrollment packet, or learn more about LINKS by calling the Louisiana Department of Health and Hospitals, Office of Public Health Immunization Program at (504) 483-1900.

Immunizations

In order for providers to receive reimbursement for the administration of immunizations, providers must indicate the CPT code for the specific vaccine in addition to the appropriate administration CPT code(s). All vaccine CPT codes will be paid at zero ($0) because the provider obtains the vaccine from the Vaccines for Children Program at no cost. The listing of the vaccine on the claim form is required for federal reporting purposes.

Billing for a Single Administration

Providers should bill CPT code 90471 (Immunization administration…one vaccine) when administering one immunization. The next line on the claim form must contain the specific CPT code for the vaccine, with $0.00 in the "billed charges" column (see p. 75 for an example).

Billing for Multiple Administrations*

When administering more than one immunization, providers should bill as described above for the single administration. Procedure code 90472 (Immunization administration…each additional vaccine) should then be listed with the appropriate number of units for the additional vaccines placed in the "units" column. The specific vaccines should then be listed on subsequent lines. The number of specific vaccines listed should match the number of units associated with CPT code 90472. An example of this scenario is on page 76.

*Hard Copy Claim Filing for Greater than Four Administrations

When billing hard copy claims for more than four immunizations and the six-line claim form limit is exceeded, providers should bill on two CMS-1500 claim forms. The first claim should follow the instructions above for billing the single administration. A second CMS-1500 claim form should be used to bill the remaining immunizations as described above for billing multiple administrations. An example is shown on pages 77 and 78.

- **COMBINATION VACCINES ARE ENCOURAGED IN ORDER TO MAXIMIZE THE OPPORTUNITY TO IMMUNIZE AND TO REDUCE THE NUMBER OF INJECTIONS A CHILD RECEIVES IN ONE DAY.**

Flu Vaccine: Special Situations

If the flu vaccine is not available through the VFC program and Medicaid providers choose to use flu vaccine obtained elsewhere for Medicaid recipients, the **ADMINISTRATION** is reimbursable by Medicaid. If the provider intends to charge the recipient for the vaccine, the following must occur: **PRIOR** to the injection, providers **MUST INFORM** recipients that when the actual vaccine does not come from the VFC, the recipient can be responsible for the cost of the vaccine.

The following chart lists vaccines for immunization services.

BILLABLE VACCINE CODES	
Vaccine Code	Description
90476^	Adenovirus vaccine, type 4, live, for oral use
90477^	Adenovirus vaccine, type 7, live, for oral use
90581^	Anthrax vaccine, for subcutaneous use
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633*	Hepatitis A vaccine pediatric/adolescent dosage, 2-dose schedule, for intramuscular use
90634*	Hepatitis A vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use
90636	Hepatitis A and Hepatitis B vaccine (HEPA-HEPB), adult dosage, for intramuscular use
90645*	Hemophilus Influenza B vaccine (HIB), HBOC conjugate, 4-dose schedule, for intramuscular use
90646*	Hemophilus Influenza B vaccine (HIB), PRP-D conjugate, for booster use only, intramuscular use
90647*	Hemophilus Influenza B vaccine (HIB) PRP-OMP conjugate, 3-dose schedule, for intramuscular use
90648*	Hemophilus Influenza B vaccine (HIB), PRP-T conjugate, 4-dose schedule, for intramuscular use
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90657*	Influenza Virus vaccine, split virus, 6-35 months dosage, for intramuscular use
90658*	Influenza Virus vaccine, split virus, 3 years and above dosage, for intramuscular use
90660^	Influenza Virus vaccine live, for intranasal use
90665^	Lyme Disease vaccine, adult dosage, for intramuscular use
90669*	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use
90675^	Rabies vaccine, for intramuscular use
90676^	Rabies vaccine, for intradermal use
90680	Rotavirus vaccine, tetravalent, live, for oral use
90690^	Typhoid vaccine, live, oral use
90691^	Typhoid vaccine, VI capsular polysaccharide (VICPS), for intramuscular use
90692^	Typhoid vaccine, heat-and phenol-inactivated (H-P) for subcutaneous or intradermal use
90693	Typhoid vaccine, acetone-killed, dried (AKD), for subcutaneous use (US Military)
90698	Diphtheria, Tetanus Toxoids, Acellular Pertussis vaccine, Haemophilus influenza Type B, and Poliovirus vaccine, inactivated, (DT-aP-Hib-IPV) for intramuscular use
90700 *	Diphtheria, Tetanus Toxoids, and Acellular Pertussis vaccine (DTAP) for intramuscular use
90701	Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis vaccine (DTP), for intramuscular use
90702*	Diphtheria and Tetanus Toxoids (DT) absorbed for use in individuals younger than 7 years, for intramuscular use
90703	Tetanus Toxoids for trauma, for intramuscular use
90704	Mumps Virus vaccine, live, for subcutaneous use
90705	Measles Virus vaccine, live, for subcutaneous use
90706	Rubella Virus vaccine, live, for subcutaneous use
90707*	Measles, Mumps and Rubella Virus vaccine (MMR), live, for subcutaneous
90708	Measles and Rubella Virus vaccine, live, for subcutaneous use
90710	Measles, Mumps, Rubella, and Varicella vaccine (MMRV), live, for subcutaneous use

BILLABLE VACCINE CODES	
Vaccine Code	Description
90712	Poliovirus vaccine, any type(s), (OPV), live, for oral use
90713*	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use
90715	Tetanus, Diphtheria Toxoids and Acellular Pertusis vaccine (TdaP), for use in individuals 7 years or older, for intramuscular use
90716*	Varicella Virus vaccine, live, for subcutaneous use
90717	Yellow Fever vaccine, live, for subcutaneous use
90718*	Tetanus and Diphtheria Toxoids (TD) adsorbed for use in individuals 7 years or older, for intramuscular use
90719	Diphtheria Toxoid, for intramuscular use
90720	Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis vaccine and Hemophilus Influenza B vaccine (DTP-HIB), for intramuscular use
90721*	Diphtheria, Tetanus Toxoids, and Acellular Pertussis vaccine and Hemophilus Influenza B vaccine (DTAP-HIB), for intramuscular use
90723*	Diphtheria, Tetanus Toxoids, Acellular Pertussis vaccine, Hepatitis B, and Poliovirus vaccine, inactivated (DTAP-HEPB-IPV), for intramuscular use
90725	Cholera vaccine for injectable use
90727	Plague vaccine, for intramuscular or jet injection use
90732*	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90735	Japanese Encephalitis Virus vaccine, for subcutaneous use
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 3-dose schedule, for intramuscular use
90743	Hepatitis B vaccine, adolescent, 2-dose schedule, for intramuscular use
90744*	Hepatitis B vaccine, pediatric/adolescent dosage, 3-dose schedule, for intramuscular use
90746*	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 4-dose schedule, for intramuscular use
90748*	Hepatitis B and Hemophilus Influenza B vaccine (HEP-HIB), for intramuscular use

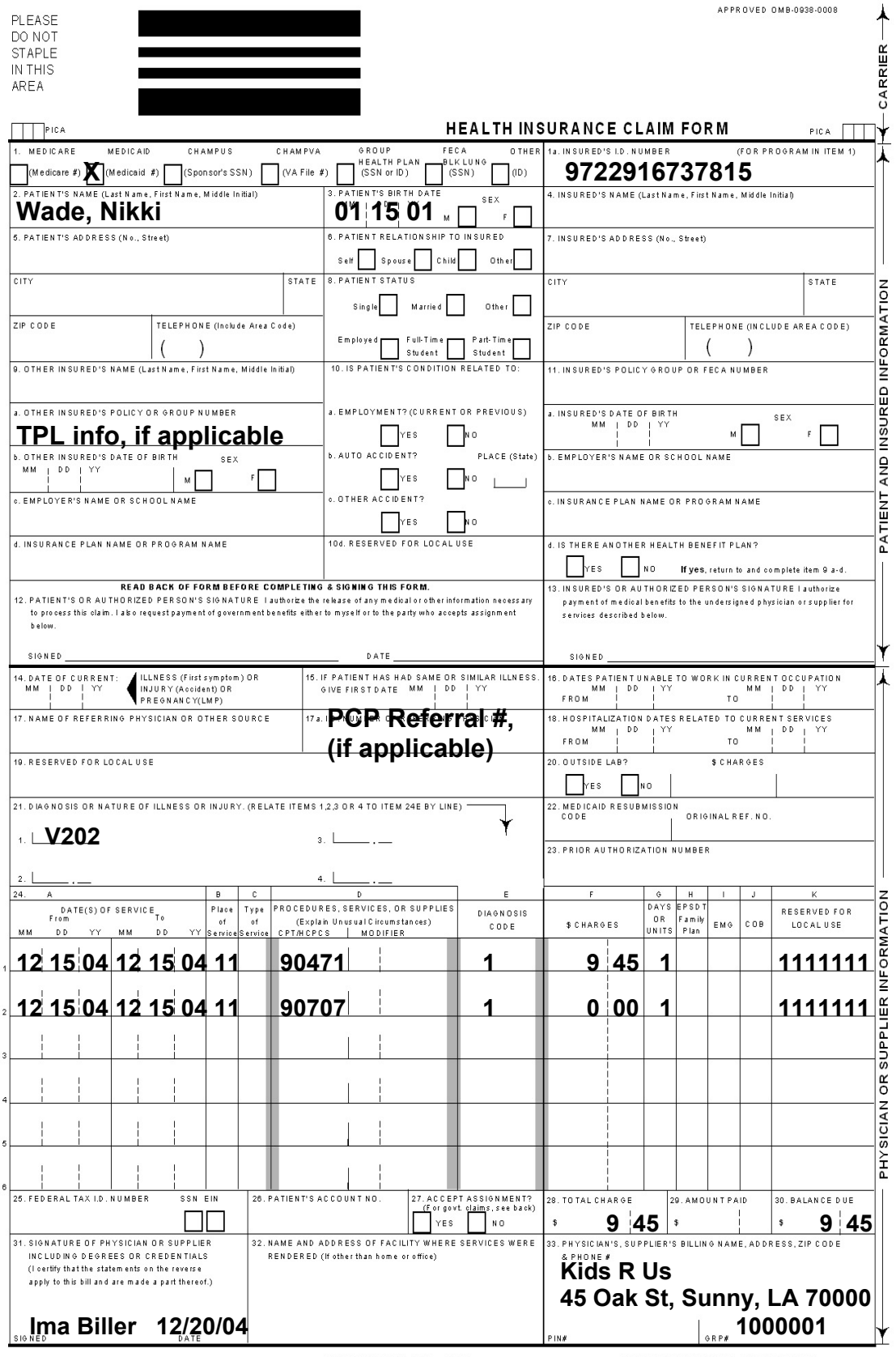
* indicates the vaccine is available from the Vaccines for Children (VFC) program
^ indicates the vaccine is payable for QMB Only and QMB Plus recipients

Reminders:

- Procedure code 90703 (Tetanus Toxoid for Trauma) will be payable at the rate of $2.42, and it is not available through the VFC program.

- If the units for 90472 are greater than the actual vaccines reported for procedure code 90472, the units will be cutback to reflect the number of vaccines codes being reported.

- If the units for 90472 are less than the actual vaccines reported for procedure code 90472, the entire claim will be approved and paid appropriately (based on the information given on the claim form).



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ( ) (Medicare #) | MEDICAID (X) (Medicaid #) | CHAMPUS ( ) (Sponsor's SSN) | CHAMPVA ( ) (VA File #) | GROUP HEALTH PLAN ( ) (SSN or ID) | FECA BLK LUNG ( ) (SSN) | OTHER ( ) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 9722916737815

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Wade, Nikki

3. PATIENT'S BIRTH DATE: 01 15 01 SEX M ( ) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single ( ) Married ( ) Other ( )

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

Employed ( ) Full-Time Student ( ) Part-Time Student ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL info, if applicable

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ( ) NO ( )

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )

b. AUTO ACCIDENT? YES ( ) NO ( ) PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ( ) NO ( )

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. [illegible] PCP Referral #, (if applicable)

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V202 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	12 15 04	12 15 04	11		90471		1	9 45	1				1111111
2	12 15 04	12 15 04	11		90707		1	0 00	1				1111111
3													
4													
5													
6													

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN ( )

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ( ) NO ( )

28. TOTAL CHARGE $ 9 45

29. AMOUNT PAID $

30. BALANCE DUE $ 9 45

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Ima Biller 12/20/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Kids R Us
45 Oak St, Sunny, LA 70000

PIN# GRP# 1000001

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID X (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **9722916737815**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Wade, Nikki**

3. PATIENT'S BIRTH DATE: **01 15 01** SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **TPL info, if applicable**

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO **If yes**, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **PCP Referral #, (if applicable)**

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **V202** 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	11 07 04	11 07 04	11		90471		1	9 45	1				1111111
2	11 07 04	11 07 04	11		90716		1	0 00	1				1111111
3	11 07 04	11 07 04	11		90472		1	28 35	3				1111111
4	11 07 04	11 07 04	11		90707		1	0 00	1				1111111
5	11 07 04	11 07 04	11		90669		1	0 00	1				1111111
6	11 07 04	11 07 04	11		90645		1	0 00	1				1111111

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 37 80

29. AMOUNT PAID $

30. BALANCE DUE $ 37 80

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Ima Biller 11/10/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Kids R Us
45 Oak St, Sunny, LA 70000

PIN# GRP# **1000001**

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FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

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PICA

HEALTH INSURANCE CLAIM FORM

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1. MEDICARE ( ) (Medicare #) | MEDICAID (X) (Medicaid #) | CHAMPUS ( ) (Sponsor's SSN) | CHAMPVA ( ) (VA File #) | GROUP HEALTH PLAN ( ) (SSN or ID) | FECA BLK LUNG ( ) (SSN) | OTHER ( ) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **5187376192279**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Harris, Dakota**

3. PATIENT'S BIRTH DATE: **08 02 01** SEX M ( ) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single ( ) Married ( ) Other ( )

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

Employed ( ) Full-Time Student ( ) Part-Time Student ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **TPL info, if applicable**

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ( ) NO ( )

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ( ) F ( )

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ( ) F ( )

b. AUTO ACCIDENT? YES ( ) NO ( ) PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ( ) NO ( )

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) **If yes**, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

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1	10 31 04 | 10 31 04	11		90471		1	9 45	1				1111111
2	10 31 04 | 10 31 04	11		90713		1	0 00	1				1111111
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN ( )

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ( ) NO ( )

28. TOTAL CHARGE $ 9 45

29. AMOUNT PAID $

30. BALANCE DUE $ 9 45

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Ima Biller 11/01/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Kids R Us
45 Oak St, Sunny, LA 70000

PIN# GRP# **1000001**

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

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PLEASE DO NOT STAPLE IN THIS AREA

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6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: **TPL info, if applicable**

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO **If yes**, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **V202** 3.

2. 4.

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1	10 31 04 10 31 04	11		90472		1	38 40	4				1111111
2	10 31 04 10 31 04	11		90657		1	0 00	1				1111111
3	10 31 04 10 31 04	11		90744		1	0 00	1				1111111
4	10 31 04 10 31 04	11		90700		1	0 00	1				1111111
5	10 31 04 10 31 04	11		90716		1	0 00	1				1111111
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ 38 40

29. AMOUNT PAID $

30. BALANCE DUE $ 38 40

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Ima Biller 11/01/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Kids R Us
45 Oak St, Sunny, LA 70000

PIN# **1000001** GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

CLAIMS FILING

Professional services are billed on the CMS-1500 (formerly known as HCFA-1500) claim form. Items to be completed are either **required** or **situational. Required** information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted by the provider. **Situational** information may be required (but only in certain circumstances as detailed in the instructions below). Claims should be submitted to:

Unisys
P.O. Box 91020
Baton Rouge, LA 70821

***1. REQUIRED** Enter an "X" in the box marked Medicaid **(Medicaid #)**

***1A. REQUIRED** Enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid swipe card (MEVS), e-MEVS, or through REVS

NOTE: The recipients' 13-digit Medicaid ID number **must** be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable**.**

Note: If the 13-digit Medicaid ID number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.

***2. REQUIRED** Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as verified through MEVS, e-MEVS or REVS

3. SITUATIONAL Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS, e-MEVS or REVS, using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "X" in the appropriate box to show the sex of the recipient.

4. SITUATIONAL Complete correctly if appropriate or leave blank

5. SITUATIONAL Print the recipient's permanent address

6. SITUATIONAL Complete if appropriate or leave blank

7. SITUATIONAL Complete if appropriate or leave blank

8. SITUATIONAL Leave blank

9. SITUATIONAL Complete if appropriate or leave blank

9A. SITUATIONAL If recipient has no other coverage, leave blank. If there is other coverage, put the state assigned 6-digit TPL carrier code in this block - make sure the EOB is attached to the claim.

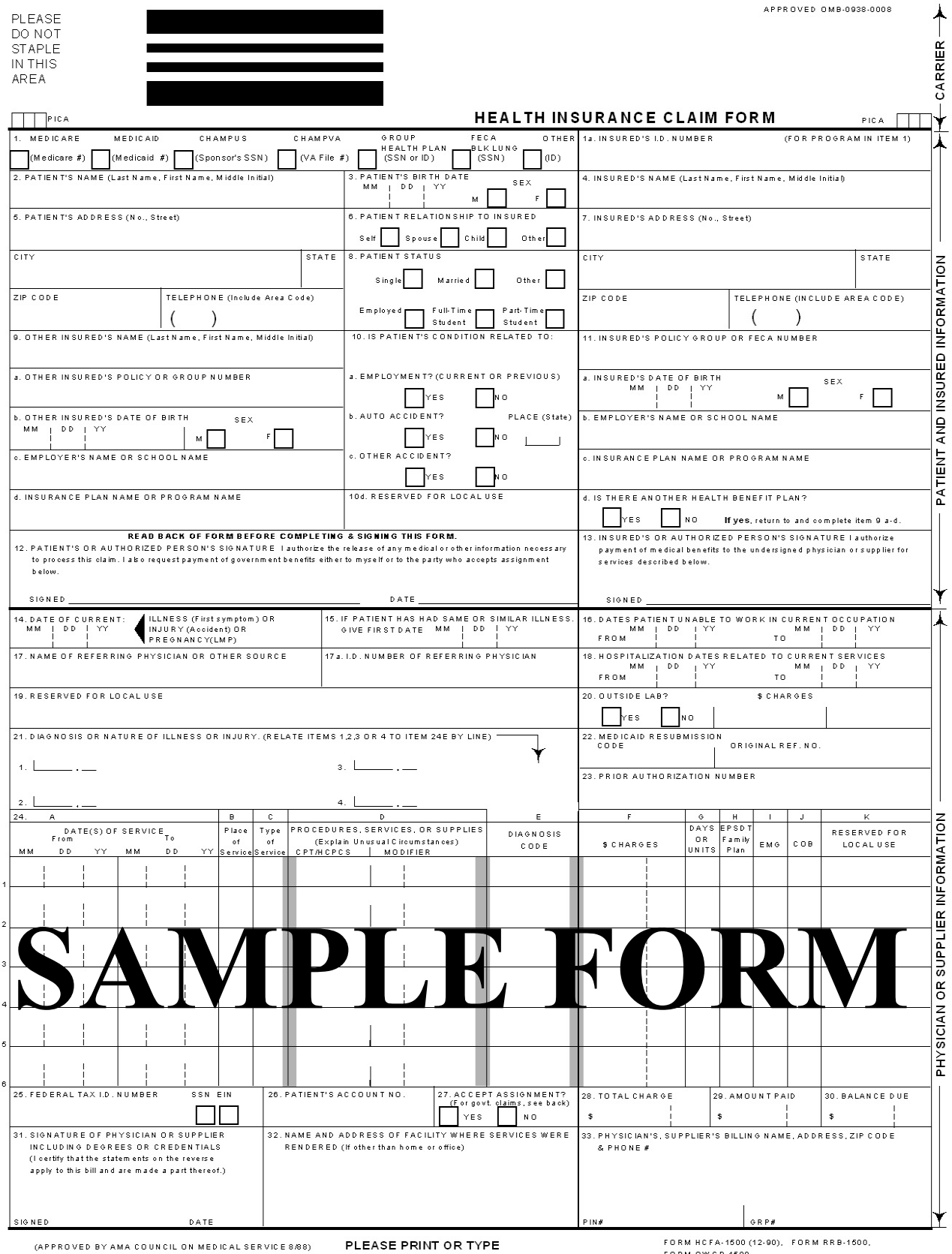
9B.	**SITUATIONAL**	Complete if appropriate or leave blank
9C.	**SITUATIONAL**	Complete if appropriate or leave blank
9D.	**SITUATIONAL**	Complete if appropriate or leave blank
10.	**SITUATIONAL**	Leave blank
11.	**SITUATIONAL**	Complete if appropriate or leave blank
11A.	**SITUATIONAL**	Complete if appropriate or leave blank
11B.	**SITUATIONAL**	Complete if appropriate or leave blank
11C.	**SITUATIONAL**	Complete if appropriate or leave blank
12.	**SITUATIONAL**	Complete if appropriate or leave blank
13.	**SITUATIONAL**	Obtain signature if appropriate or leave blank
14.	**SITUATIONAL**	Leave blank
15.	**SITUATIONAL**	Leave blank
16.	**SITUATIONAL**	Leave blank
17.	**SITUATIONAL**	If services are performed by a CRNA, enter the name of the directing physician. If services are performed by an independent laboratory, enter the name of the referring physician. If services are performed by a nurse practitioner or clinical nurse specialist, enter the name of the directing physician. If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name.
17A.	**SITUATIONAL**	If the recipient is linked to a PCP, the Primary Care Physician referral authorization number must be entered here.
18.	**SITUATIONAL**	Leave blank
19.	**SITUATIONAL**	Leave blank
20.	**SITUATIONAL**	Leave blank
***21.**	**REQUIRED**	Enter the ICD-9 numeric diagnosis code and, if desired, narrative description. Use of ICD-9-CM coding is mandatory. Standard abbreviations of narrative descriptions are accepted**.**
22.	**SITUATIONAL**	Leave blank
23.	**SITUATIONAL**	Complete if required or leave blank
***24A.**	**REQUIRED**	Enter the date of service for each procedure. Either six-digit (MMDDYY) or eight-digit (MMDDCCYY) format is acceptable.

***24B.**	**REQUIRED**	Enter the appropriate code from the approved Medicaid place of service code list.
24C.	**SITUATIONAL**	Leave blank
***24D.**	**REQUIRED**	Enter the procedure code(s) for services rendered.
***24E.**	**REQUIRED**	Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a "1", "2", etc. More than one diagnosis may be related to a procedure. Do not enter ICD-9-CM diagnosis code
***24F.**	**REQUIRED**	Enter usual and customary charges for the service rendered
***24G.**	**REQUIRED**	Enter the number of units billed for the procedure code entered on the same line in 24D
24H.	**SITUATIONAL**	Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral
24I.	**SITUATIONAL**	Leave blank
24J.	**SITUATIONAL**	Leave blank
24K.	**SITUATIONAL**	Enter the attending provider number if group number is indicated in block 33
25.	**SITUATIONAL**	Leave blank
26.	**SITUATIONAL**	Enter the provider specific information assigned to identify the patient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 16 characters**.**
27.	**SITUATIONAL**	Leave blank. Medicaid does not make payments to the recipient. Claim filing acknowledges acceptance of Medicaid assignment.
***28.**	**REQUIRED**	Total of all charges listed on the claim
29.	**SITUATIONAL**	If block 9A is completed, indicate the amount paid; if no TPL, leave blank
30.	**SITUATIONAL**	If payment has been made by a third party insurer, enter the amount due after third party payment has been subtracted from the billed charges

***31.**	**REQUIRED**	The claim form **MUST** be signed. The practitioner is not required to sign the claim form. However, the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. **If this item is left blank, or if the stamped or computer-generated signature does not have original initials, the claim will be returned unprocessed.**
	Date	Enter the date of the signature
32.	**SITUATIONAL**	Complete as appropriate or leave blank
***33.**	**REQUIRED**	Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid billing provider number must be entered in the space next to "Group (Grp) #."

Note: If no Medicaid provider number is entered, the claim will be returned to the provider for correction and re-submission.

Marked (*) items must be completed or form will be returned.



PLEASE DO NOT STAPLE IN THIS AREA

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APPROVED OMB-0938-0008

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HEALTH INSURANCE CLAIM FORM

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4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO **If yes**, return to and complete item 9 a-d.

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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

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1											
2											
3											
4											
5											
6											

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28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

ADJUSTMENT/VOID CLAIMS

Claims paid on the CMS-1500 form are adjusted or voided using the Unisys 213 adjustment/void form. These may be ordered from Unisys at no cost.

Only **one** claim line can be adjusted or voided on each adjustment/void form.

Only a **paid** claim can be adjusted or voided. Denied claims must be corrected and resubmitted—not adjusted or voided.

Electronic submitters may electronically submit adjustment/void claims.

Only the paid claim's most recently approved control number can be adjusted or voided. For example:

1. A claim is paid on the RA dated 7-15-04, ICN 4170567890123.
2. The claim is adjusted on the RA dated 8-19-04, ICN 4200590123456.
3. If the claim requires further adjustment or needs to be voided, only ICN 4200590123456 may be used.

Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.

To file an adjustment, the provider should complete the adjustment as it appears on the original claim form, changing the item that was in error to show the way the claim should have been billed. The approved adjustment will replace the approved original and will be listed under the "adjustment" column on the RA. The original payment will be taken back on the same RA in the "previously paid" column. An example of an adjustment appears on page 88.

To file a void, the provider must enter all the information from the original claim exactly as it appeared on the original claim. When the void claim is approved, it will be listed under the "void" column of the RA and a corrected claim may be submitted (if applicable).

Filing Adjustments for a Medicare/Medicaid Claim

When a provider has filed a claim with Medicare, Medicare pays, then the claim becomes a “crossover” to Medicaid for consideration of payment of the Medicare deductible or co-payment.

If, at a later date, it is determined that Medicare has overpaid or underpaid, the provider should rebill Medicare for a corrected payment. These claims may “crossover” from Blue Cross to Medicaid, but cannot be automatically processed by Medicaid (as the claim will appear to be a duplicate claim, and therefore must be denied by Medicaid).

In order for the provider to receive an adjustment, it is necessary for the provider to file a hard copy claim (Unisys Form 213) with Medicaid. These should be sent to Unisys, Attention: Crossover Adjustments, P.O. Box 91023, Baton Rouge, LA 70821, and should have a copy of the most recent Medicare explanation of benefits and the original explanation of benefits attached. In addition, the provider should write “**2X7**” at the top of the adjustment/void form to indicate the adjustment is for a Medicare/Medicaid claim.

INSTRUCTIONS FOR FILING ADJUSTMENT/VOID CLAIMS

*1. **REQUIRED ADJ/VOID**—Check the appropriate block

*2. **REQUIRED Patient's Name**

a. **Adjust**—Print the name exactly as it appears on the original claim if not adjusting this information

b. **Void**—Print the name exactly as it appears on the original claim

3. **Patient's Date of Birth**

a. **Adjust**—Print the date exactly as it appears on the original claim if not adjusting this information

b. **Void**—Print the name exactly as it appears on the original claim

*4. **REQUIRED Medicaid ID Number**—Enter the 13 digit recipient ID number

5. **Patient's Address and Telephone Number**

a. **Adjust**—Print the address exactly as it appears on the original claim

b. **Void**—Print the address exactly as it appears on the original claim

6. **Patient's Sex**

a. **Adjust**—Print this information exactly as it appears on the original claim if not adjusting this information

b. **Void**—Print this information exactly as it appears on the original claim

7. **Insured's Name**— Leave blank

8. **Patient's Relationship to Insured**—Leave blank

9. **Insured's Group No**.—Complete if appropriate or blank

10. **Other Health Insurance Coverage**—Leave blank

11. **Was Condition Related to**—Leave blank

12. **Insured's Address**—Leave blank

13. **Date of**—Leave blank

14. **Date First Consulted You for This Condition**—Leave blank

15. **Has Patient Ever had Same or Similar Symptoms**—Leave blank

16. **Date Patient Able to Return to Work**—Leave blank

17. **Dates of Total Disability-Dates of Partial Disability**—Leave blank

18. **Name of Referring Physician or Other Source**—Leave this space blank

19. **For Services Related to Hospitalization Give Hospitalization Dates**—Leave blank

20. **Name and Address of Facility Where Services Rendered (if other than home or office)**—Leave blank

21. **Was Laboratory Work Performed Outside of Office**—Leave blank

*22. **REQUIRED Diagnosis of Nature of Illness**

a. **Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information

b. **Void**—Print the information exactly as it appears on the original claim

23. **Attending Number**—Enter the attending number submitted on original claim, if any, or leave this space blank

24. **Prior Authorization #—**Enter the PA number if applicable or leave blank

*25. **REQUIRED A through F**

a. **Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information

b. **Void**—Print the information exactly as it appears on the original claim

*26. **REQUIRED Control Number**—Print the correct Control Number as shown on the Remittance Advice

*27. **REQUIRED Date of Remittance Advice that Listed Claim was Paid**—Enter MM DD YY from RA form

*28. **REQUIRED Reasons for Adjustment**—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary

*29. **REQUIRED Reasons for Void**—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary

*30. **REQUIRED Signature of Physician or Supplier**—All Adjustment/Void forms **must** be signed

*31. **REQUIRED Physician's or Supplier's Name, Address, Zip Code and Telephone Number**—Enter the requested information appropriately plus the seven (7) digit Medicaid provider number. ***The form will be returned if this information is not entered.***

32. **Patient's Account Number**—Enter the patient's provider-assigned account number.

Marked (*) items must be completed or form will be returned.

MAIL TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
3 PATIENT'S DATE OF BIRTH
4 MEDICAID ID NUMBER
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX MALE FEMALE
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES NO
B. AN AUTO ACCIDENT YES NO
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES NO CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1
2
3
23 ATTENDING NUMBER
24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE		D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $

26 CONTROL NUMBER

THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

28 REASONS FOR ADJUSTMENT

- ☐ 01 THIRD PARTY LIABILITY RECOVERY
- ☐ 02 PROVIDER CORRECTIONS
- ☐ 03 FISCAL AGENT ERROR
- ☐ 90 STATE OFFICE USE ONLY - RECOVERY
- ☐ 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

29 REASONS FOR VOID

- ☐ 10 CLAIM PAID FOR WRONG RECIPIENT
- ☐ 11 CLAIM PAID TO WRONG PROVIDER
- ☐ 99 OTHER - PLEASE EXPLAIN

30 SIGNATURE OF PHYSICIAN OR SUPPLIER
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE

32 YOUR PATIENT'S ACCOUNT NUMBER

UNISYS - 213
5/97

FISCAL AGENT COPY

MAIL TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1 ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Patrick Jason
3 PATIENT'S DATE OF BIRTH: 01/21/98
4 MEDICAID ID NUMBER: 5923450122697
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) / TELEPHONE NO.
6 PATIENT'S SEX: MALE [ ] FEMALE [ ]
7 INSURED'S NAME
8 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER: 060606
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO [ ]
B. AN AUTO ACCIDENT YES [ ] NO [ ]
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ]
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A REFERRING ID NUMBER
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO [ ] CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 V222
2
3
23 ATTENDING NUMBER: 1123987
24 PRIOR AUTHORIZATION NO.

25 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	EPSDT FAMILY PLAN	TPL $
10	16	04	10	16	04	12	99383	1	65 00	1		47.23

26 CONTROL NUMBER: 4293100000147
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 10/28/04

28 REASONS FOR ADJUSTMENT
[X] 01 THIRD PARTY LIABILITY RECOVERY — Private Insurance paid
[ ] 02 PROVIDER CORRECTIONS
[ ] 03 FISCAL AGENT ERROR
[ ] 90 STATE OFFICE USE ONLY - RECOVERY
[ ] 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

29 REASONS FOR VOID
[ ] 10 CLAIM PAID FOR WRONG RECIPIENT
[ ] 11 CLAIM PAID TO WRONG PROVIDER
[ ] 99 OTHER - PLEASE EXPLAIN

30 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Shanae O'Conner
12/1/04
32 PATIENT'S ACCOUNT NUMBER

31 PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
Kids are Terrific, LLC
Eazyday, LA 90210
1944567

FISCAL AGENT COPY

UNISYS - 213
5/97

CLAIMS PROCESSING REMINDERS

Unisys Louisiana Medicaid images and stores all Louisiana Medicaid paper claims on-line. This process allows the Unisys Provider Relations Department to respond more efficiently to claim inquiries by facilitating the retrieval and research of submitted claims.

If claims cannot be submitted electronically, prepare paper claim forms according to the following instructions to ensure appropriate and timely processing:

- Submit an original claim for whenever possible. Do not submit carbon copies under any circumstances. If you must submit a photocopy, ensure that it is legible, and not too light or too dark.

- Enter information within the appropriate boxes and align forms in your printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.

- Providers who want to draw the attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence. **DO NOT use a highlighter to draw attention to specific information.**

- Paper claims must be legible and in good condition for scanning into our document imaging system.

- **Don't forget to sign and date your claim form. Unisys will accept stamped or computer-generated signature, but they must be initialed by authorized personnel.**

- Continuous feed forms must be torn apart before submission.

- Use high quality printer ribbons or cartridges - black ink only.

- Use 10-12 point font sizes. We recommend font styles Courier 12, Arial 11, and Times New Roman 11.

- Do not use italic, bold, or underline features.

- Do not submit two-sided documents.

- Do not use a marking pen to omit claim line entries. Use a black ballpoint pen (medium point).

- **The recipient's 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic card is NOT acceptable.**

Rejected Claims

Unisys currently returns illegible claims. These claims have not been processed and are returned along with a cover letter stating what is incorrect.
The criteria for legible claims are:

(1) all claim forms are clear and in good condition,
(2) all information is readable to the normal eye,
(3) all information is centered in the appropriate block, and
(4) all essential information is complete.

Attachments

All claim attachments should be standard 81/2 x 11 sheets. Any attachments larger or smaller than this size should be copied onto standard sized paper. If it is necessary to attach documentation to a claim, the documents must be placed directly behind each claim that requires this documentation. Therefore, it may be necessary to make multiple copies of the documents if they must be placed with multiple claims.

Changes to Claim Forms

Louisiana Medicaid policy prohibits Unisys staff from changing any information on a provider's claim form. Any claims requiring changes must be made prior to submission. Please do not ask Unisys staff to make any changes on your behalf.

Data Entry

Data entry clerks do not interpret information on claim forms-data is keyed as it appears on the claim form. If the data is incorrect, or **IS NOT IN THE CORRECT LOCATION,** the claim will not process correctly.

HARD COPY REQUIREMENTS

DHH has made the decision to continue requiring hardcopy claim submissions for all existing hardcopy attachments, as indicated in the table below.

HARDCOPY CLAIM(s) & REQUIRED ATTACHMENT(s)	BILLING REQUIREMENTS
Spend Down Recipient - 110MNP Spend Down Form	Continue hardcopy billing
Third Party/Medicare Payment - EOBs (Includes Medicare adjustment claims)	Continue hardcopy billing
Failed Crossover Claims - Medicare EOB	Continue hardcopy billing
Retroactive Eligibility - copy of ID card or letter from parish office, BHSF staff	Continue hardcopy billing
Recipient Eligibility Issues - copy of MEVS printout, cover letter	Continue hardcopy billing
Timely filing - letter/other proof i.e., RA page	Continue hardcopy billing
Office Visits over limit - Form 158A for extension of office visits	Continue hardcopy billing
Bilateral procedures-operative notes	Continue hardcopy billing
Modifiers 22, 51, 52, 62, 66 - medical documentation	Continue hardcopy billing
Physician hospital visits to newborn - medical necessity, letter requesting pre-cert edit override	Continue hardcopy billing
Physician claims for inpatient visits (not newborn) when no pre-cert exists----Admit and Discharge summary	Continue hardcopy billing
All unlisted procedures - medical documentation	Continue hardcopy billing
Sterilization procedures - Form 96 Sterilization form	Continue hardcopy billing
Abortion procedures - Abortion Informed Consent Form, signed statement from recipient, treating physician statement, medical necessity	Continue hardcopy billing
Hysterectomy procedures - Form 96A Hysterectomy Form	Continue hardcopy billing
Multiple Anesthesia - graph and operative report	Continue hardcopy billing
Consultation by Physician of same specialty - medical documentation	Continue hardcopy billing
Norplant if earlier than 5 years - medical documentation	Continue hardcopy billing
Breast Reconstruction procedures - medical documentation	Continue hardcopy billing
Reduction Mammography - pathology report & approval letter, photographs	Continue hardcopy billing
Pediatric Conscious Sedation codes (99141, 99142) - medical necessity and anesthesia report	Continue hardcopy billing

HARDCOPY CLAIM(s) & REQUIRED ATTACHMENT(s)	BILLING REQUIREMENTS
Anesthesia for Arteriograms, Cardiac Catheterizations, CT Scans, Angioplasties, and MRIs (bill with appropriate anesthesia code)	Continue hardcopy billing
Codes 62310, 62311, 62318, 62319 - operative & history reports	Continue hardcopy billing
Anesthesia for Intraperitoneal procedures in lower abdomen (code 00851) - BHSF Form 96	Continue hardcopy billing
Transplants - DHH approval letter, dated operative report	Continue hardcopy billing
Infectious agent detection (code 87799) - description of test & methodology	Continue hardcopy billing
Critical Care services - medical necessity	Continue hardcopy billing
Enterolysis (code 44005) - operative report	Continue hardcopy billing
Pathology Consultations (codes 80500, 80502) - medical necessity, list of tests, test results, consult narrative	Continue hardcopy billing
Neurobehavioral testing (codes 96115, 96117) - interpretive report signed by correct specialty	Continue hardcopy billing
Incomplete Abortion - history, sonogram, discharge summary, treatment	Continue hardcopy billing
Keloid initial visit - chart notes, statement from physician	Continue hardcopy billing
Resistance Testing in HIV recipients – medical necessity of test, results of test, history of recipient	Continue hardcopy billing
Radionuclides (code 78990) - copy of invoice for the nuclide	Continue hardcopy billing
Operating Microscope (code 69990) - operative report	Continue hardcopy billing
Stereotactic Procedures - operative report, medical necessity	Continue hardcopy billing
Transmyocardial revascularization - see Provider Update, 11/99 issue	Continue hardcopy billing
Obstetrical ultrasounds >3 per pregnancy - medical necessity, dated notes	Continue hardcopy billing
Chiropractic claims for under age 21 – EPSDT/PCP medical screening referral, MD's prescription, medical necessity, medical notes	Continue hardcopy billing
Anesthesia claims for less than 10 minutes or more than 224 minutes -graph	Continue hardcopy billing

UNISYS CLAIMS FILING ADDRESSES

To expedite payment, providers should send "clean" claims directly to the appropriate Post Office Box as listed below. All Post Office Boxes are for Unisys Corporation, Baton Rouge, LA.

Type of Claim or Department	Post Office Box
The zip code for the following P.O. Boxes is 70821:	
Pharmacy (original claims and adjustment/voids)……	91019
CMS-1500, including services such as Professional, Independent Lab, Substance Abuse and Mental Health Clinic, Hemodialysis Professional Services, Chiropractic, Durable Medical Equipment, Mental Health Rehabilitation, EPSDT Health Services, Case Management, FQHC, and Rural Health Clinic (original claims and adjustment/voids)…….	91020
Inpatient and Outpatient Hospitals, Long Term Care, Hospice, Hemodialysis Facility, Freestanding Psychiatric Hospitals (original claims and adjustment/voids)……	91021
Dental, Transportation (Ambulance and Non-ambulance), Rehabilitation, Home Health (original claims and adjustment/voids)……..	91022
All Medicare Crossovers and All Medicare Adjustments and Voids…….	91023
Provider Relations…….	91024
EDI/EMC, Unisys Business, and Miscellaneous Correspondence……..	91025
The zip code for the following P.O. Boxes is 70898:	
Provider Enrollment…….	80159
Prior Authorization.....	14919
KIDMED.....	14849

EXPLANATION OF PROFESSIONAL FEE SCHEDULE

The most current version of the professional fee schedule can be found on the Louisiana Medicaid website (http//www.lamedicaid.com). The Department of Health and Hospitals has historically issued the fee schedule annually. The fee schedule will no longer be issued annually. Providers are encouraged to view the fee schedule on the website monthly for review of additions, deletions and updates. Providers will continue to be notified of significant fee schedule changes through RA messages and Provider Updates.

The following two pages include an example page from the fee schedule and the legend that is found at the end of the schedule.

Column 5 displays any age restrictions on the codes. At this time, the system cannot display months or days; therefore, providers should follow CPT coding guidelines in lieu of the fee schedule. An example of this would be CPT codes for circumcision. The code 54150 is payable from birth to age 28 days, while code 54152 is payable from age 29 days to 99 years, according to CPT guidelines. On our fee schedule, you will see that 54150 and 54152 have no age restriction.

Column 10 displays service limitations as they apply to the individual code. Any limitations guided by policy for groups/combinations of codes will not be displayed here. For example, a group of ultrasound codes for pregnancy is limited by policy to 3 per pregnancy (any combination) but not by the individual code. This limitation does not display on our fee schedule, but is explicit in policy publications.

LOUISIANA MEDICAID PROFESSIONAL SERVICES FEE SCHEDULE

COLUMN: 1	2	3	4	5 AGE MIN-MAX	6 MED REV	7 PA	8 SEX	9 PSR	10 SL	11 GSP DAY	12 BASE UNITS	13 X-OVERS	14 UVS >001
TS	CODE	DESCRIPTION	FEE										
03	92582	CONDITIONING PLAY AUDIOMETRY	45.00						X				
03	92583	SELECT PICTURE AUDIOMETRY	22.50						X				
03	92584	ELECTROCOCHLEOGRAPHY	180.00						X				
03	92585	BRAINSTEM EVOKED RESPONSE RECORDING	180.00						X				
05	92585	BRAINSTEM EVOKED RESPONSE RECORDING	72.00						X				
03	92586	AUDITOR EVOKE POTENT, LIMIT	45.00	00 20									
05	92586	AUDITOR EVOKE POTENT, LIMIT	18.00	00 20									
03	92587	EVOKED AUDITORY TEST	22.50										
05	92587	EVOKED AUDITORY TEST	9.00										
03	92588	EVOKED AUDITORY TEST	45.00										
05	92588	EVOKED AUDITORY TEST COMPREHENSIVE	18.00										
03	92590	HEARING AID EXAM/SELECTION;MONAURAL	58.50										
03	92591	HEARING AID EXAM/SELECTION;BINAURAL	58.50										
03	92592	HEARING AID CHECK; MONAURAL	22.50										
03	92593	HEARING AID CHECK; BINAURAL	45.00										
03	92594	ELECTROACOUSTIC EVAL HEAR AID;MONAUR	22.50										
03	92595	ELECTROACOUSTIC EVAL HEAR AID;BINAUR	45.00										
03	92599	UNLISTED OTORHINOLARYNGOLOGICAL PROC	59.54		X								
05	92599	UNLISTED OTORHINOLORYNGOLOGICAL PROC	MP		X								
03	92700	ENT PROCEDURE/SERVICE	MP		X					1			
03	92950	CARDIOPULMONARY RESUSCITATION	162.43							1			X
03	92960	ELECTRICAL CARDIOVERSION	100.76							1			X
03	92961	CARDIOVERSION, ELECTRIC, INT	224.58							1			
03	92970	CARDIOASSIST, INTERNAL	148.13							1			
03	92971	CARDIOASSIST, EXTERNAL	103.69							1			
03	92973	PERCUT CORONARY THROMBECTOMY	164.68										
03	92974	CATH PLACE, CARDIO BRACHYTX	190.64										
03	92978	INTRAVASCULAR US, HEART	202.10										
05	92978	INTRAVASCULAR US, HEART	80.84										
03	92979	INTRAVASCULAR US, HEART	124.83										X
05	92979	INTRAVASCULAR US, HEART	49.93										X
03	92980	INSERT INTRACORONARY STENT	922.75							1			
03	92981	INSERT INTRACORONARY STENT	286.15										X
03	92982	PTCA-SINGLE VESSEL	846.00							1			
03	92984	PERCUTANEOUS TRANSLUMINAL CORONARY A	423.00										X
02	92986	PERCUTANEOUS BALLOON VALVULOPLASTY	176.40										X
03	92986	PERCUTANEOUS BALLOON VALVULOPLASTY;	882.90							90			
02	92987	PERCUTANEOUS BALLOON VALVULOPLASTY	215.86										
03	92987	REVISION OF MITRAL VALVE	1,079.28							90			
02	92990	PERCUTAN BALLOON VALVULOPLASTY; PULM	140.40										X
03	92990	PERCUTANEOUS BALLOON VALVULOPLASTY;	703.80							90			
03	92992	ATRIAL SEPTECTOMY OR SEPTOSTOMY;	684.00							90			
02	92995	PERCUTANEOUS TRANSLUMINAL CORONARY A	179.06										
03	92995	PERCUTANEOUS TRANSLUMINAL CORONARY A	895.28							1			
03	92996	PERCUTANEOUS TRANSLUMINAL CORONARY A	210.48										X

LOUISIANA MEDICAID PROFESSIONAL SERVICES FEE SCHEDULE
LEGEND

Listed below are some aids we hope will help you understand this fee schedule. If, after reading the information below, you need further clarification of an item, please call Unisys Provider Relations at 1-800-473-2783.

COLUMN 1. TS (Type Service): Definition: Files on which codes are loaded and from which claims are paid. The file to which a claim goes for pricing is determined by, among other things, the type of provider who is billing and by the modifier appended to the procedure code.

Listed below is an explanation of the types of service found on this schedule.

01 - Anesthesia file. Anesthesia claims are priced off this file.
02 - Assistant surgery file. Assistant surgeon claims are priced off this file.
03 - Full service file; also the file from which physician, physician-owned lab and independent lab services are paid.
04 - File from which lab services billed by "sole community hospitals" are paid.
05 - Professional component file. Claims with modifier -26 are priced from this file.
07 - Full service file for CommunityCARE PCP enhanced services and other enhanced physician services based on recipient age
08 - File from which lab services billed by other hospitals are paid; also the file from which ambulatory surgery centers are paid.

COLUMNS 2, 3 and 4. CODE, DESCRIPTION and FEE: Self-explanatory. Codes with modifier TH are for prenatal obstetrical visits.

COLUMN 5. AGE MIN and MAX: Some codes have minimum or maximum age restrictions. If the recipient's age on the date of service is outside the minimum or maximum age, claims will deny. The minimum and maximum age for most codes is 00-99.

COLUMN 6. MED REV (Medical Review): Claims for some codes pend to the Medical Review Team for a review of the attachments or for manual pricing. These claims cannot be electronically billed.

COLUMN 7. PA (Prior Authorization): Some services must be prior authorized before they are rendered. If a PA request is approved, a PA number will be issued for inclusion on the claim. If a PA request is not approved, no payment for the service will be made.

COLUMN 8. SEX (Restriction): Some procedure codes can be performed on only one sex. These codes will be restricted to males or to females.

COLUMN 9. PSR (Provider Specialty Restriction): If a code has a provider specialty restriction, reimbursement for its performance will not be made to other specialists. For example, codes 62367 and 62368, two of the codes in Medicaid's intrathecal baclofen policy, are payable only to physicians with specialties in anesthesiology and neurological surgery.

COLUMN 10. SL (Services Limitation): A few codes have service limitations on them; that is, they may not be paid each time they're billed. Code 99431 is an example of a code with this limitation. It can be billed only once per lifetime.

COLUMN 11. GSP (Global Surgery Period) DAY: A number in this column tells one the number of days in a code's global surgery period. During this period (as well as the day before surgery and the day of surgery), separate reimbursement for evaluation and management visits rendered by the surgeon or assistant surgeon will not be made because the fees for their daily visits have already been included in their fee for surgery.

COLUMN 12. BASE UNITS: The base units for anesthesia codes are given in this column.

COLUMN 13. X-OVERS (Only): These codes are payable for Medicare/Medicaid recipients, only.

COLUMN 14. UVS>001: An 'X' in this column means more than one unit of service per day can be billed.

ELECTRONIC DATA INTERCHANGE (EDI)

Claims Submission

Electronic media claim submission is the preferred method of submitting Medicaid claims to Unisys. With electronic data, a provider or a third party contractor (billing agent) submits Medicaid claims to Unisys on a computer encoded magnetic tape, diskette or via telecommunications.

Each claim undergoes the editing common to all claims, e.g., verification of dates and balancing. Each type of claim has unique edits consistent with the requirements outlined in the provider manuals. All claims received via electronic data must satisfy the criteria listed in the manual for that type of claim.

Advantages of submitting claims electronically include increased cash flow, improved claim control, decrease in time for receipt of payment, automation of receivables information, improved claim reporting by observation of errors and reduction of errors through pre-editing claims information.

Certification Forms

Each reel of tape, diskette or telecommunicated file submitted for processing must be accompanied by a submission certification form signed by the authorized Medicaid provider or billing agent for each provider whose claims are billed using electronic media. The certification must be included in each tape or diskette submitted. Providers submitting by telecommunications must submit this certification within 48 hours.

Third Party Billers are required to submit a Certification Form including a list of provider(s) name(s) and Medicaid Provider numbers. Additionally, all Third Party Billers **MUST** obtain a “Professional, Pharmacy, Hospital or KIDMED Services Certification" form on which the provider has attested to the truth, accuracy and completeness of the claim information. These forms **MUST** be maintained for a period of five years. This information must be furnished to the agency, the DHH Secretary, or the Medicaid Fraud Control Unit upon request.

Required Certification forms may be obtained from lamedicaid.com under the HIPAA Information Center link. The required forms are also available in both the General EDI Companion Guide and the EDI Enrollment Packet.

For telecommunication files, the required Certification Form must be mailed to the Unisys EDI Unit within 48 hours. The form must be completed in its entirety including the following fields:

- Provider Name
- Provider Number
- Submitter Number
- Claim Count
- Total Charges of submission
- Submission Date
- Original Signature
- For **Third Party Billers/Clearinghouses** – a list of Provider Names and Numbers contained in the submission must be attached.

Failure to correctly complete the Certification Form will result in the form being returned for correction.

To contact the EDI Department at Unisys, call (225) 237-3200 and select option 2. Providers may write to Unisys EDI Department, P.O. Box 91025, Baton Rouge, LA 70821.

Electronic Data Interchange (EDI) may be submitted by magnetic tape, 5 1/4" diskette, 3 1/2" diskette, or telecommunication (modem).

Electronic Adjustments/Voids

Adjustments and voids can be submitted electronically. If your present software installation does not offer this option, please contact your software vendor to discuss adding this capability to your software.

Submission Deadlines

Regular Business Weeks

Magnetic Tape and Diskettes	4:30 P.M. each Wednesday
KIDMED Submissions (All Data)	4:30 P.M. each Wednesday
Telecommunications (Modem)	10:00 A.M. each Thursday

Thanksgiving Week

Magnetic Tape and Diskettes	4:30 P.M. Tuesday, 11/23/04
KIDMED Submissions	4:30 P.M. Tuesday, 11/23/04
Telecommunications (Modem)	10:00 A.M. Wednesday, 11/24/04

Important Reminders for EDI Submission

- Denied claims may be resubmitted electronically unless the denial code states otherwise. This includes claims that have produced a denied claim turnaround document (DTA). Claims with attachments must be submitted hardcopy.
- If errors exist on a file, the file may be rejected when submitted. Errors should be corrected and the file resubmitted for processing.
- The total amount of the submitted file must equal the amount indicated on the Unisys response file.
- **All claims submitted must meet timely filing guidelines.**

Electronic Data Interchange (EDI) General Information

- Please review the entire **General EDI Companion Guide** before completing any forms or calling the EDI Department.

- The following claim types may be submitted as approved HIPAA compliant 837 transactions:

    - Pharmacy
    - Hospital Outpatient/Inpatient
    - Physician/Professional
    - Home Health
    - Emergency Transportation
    - Adult Dental
    - Dental Screening
    - Rehabilitation
    - Crossover A/B

- The following claim types may be submitted under proprietary specifications (not as HIPAA-compliant 837 transactions):

    - Case Management services
    - Non-Ambulance Transportation

Enrollment Requirements For EDI Submission

- **Submitters wishing to submit EDI 837 transactions without using a Third Party Biller -** complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA SUBMISSION OF CLAIMS** (EDI Contract **).**

- **Submitters wishing to submit EDI 837 transactions through a Third Party Biller or Clearinghouse –** complete the **PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA SUBMISSION OF CLAIMS** (EDI Contract **) and** a Limited Power of Attorney**.**

- **Third Party Billers or Clearinghouses** (billers for multiple providers) are required to submit a completed HCFA 1513 – Disclosure of Ownership form and return it with a completed EDI Contract and a Limited Power of Attorney for their first client to Unisys Provider Enrollment.

Enrollment Requirements For 835 Electronic Remittance Advices

- All EDI billers have the option of signing up for 835 Transactions (Electronic Remittance Advice). This allows EDI billers to download their remittance advices weekly.

- 835 Transactions may not contain all information printed on the hardcopy RA, ex. blood deductible, patient account number, etc.

- To request 835 Transactions – Electronic Remittance Advice, contact Unisys EDI Department at (225) 237-3200 ext. 2.

EDI General Information

- Any number of claims can be included in production file submissions. There is no minimum number.

- EDI Testing is required for all submitters (including KIDMED) before they are approved to submit claims for production unless the testing requirement has been completed by the Vendor. LTC providers must test prior to submission to production.

- Case Management Services and Non-Ambulance Transportation submitters who file via modem MUST wait 24 hours, excluding weekends, between file submissions to allow time for processing.

PROVIDER ASSISTANCE

Many of the most commonly requested items from providers including, but not limited to, the Field Analyst listing, RA messages, Provider Updates, preferred drug listings, general Medicaid information, and program training packets are available online at www.lamedicaid.com.

Unisys Provider Relations Telephone Inquiry Unit

The telephone inquiry staff assists with inquiries such as obtaining policy and procedure/ information/clarification, ordering printed material, requesting a Field Analyst visit, etc., and may be reached by calling:

(800) 473-2783 or (225) 924-5040*
FAX: (225) 237-3334**

* Please listen to the menu options and press the appropriate key for assistance.

NOTE: Providers should access eligibility information via the Medicaid Eligibility Verification System (MEVS) or the automated Recipient Eligibility Verification System (REVS) at (800) 776-6323 or (225) 216-7387. Providers may also check eligibility by accessing the web-based application, e-MEVS, now available on the Louisiana Medicaid website. Questions regarding an eligibility response may be directed to Provider Relations.

NOTE: UNISYS cannot assist recipients. If recipients have problems, please direct them to the Parish Office or the number on their card:

RECIPIENT HELPLINE (800) 834-3333

** Provider Relations will accept faxed information regarding provider inquiries on an **approved** case by case basis. However, faxed claims **are not** acceptable for processing.

Unisys Provider Relations Correspondence Group

The Provider Relations Correspondence Unit is available to research and respond in writing to questions involving problem claims.

All requests to the Correspondence Unit should be submitted to the following address:

Unisys Provider Relations Correspondence Unit
P. O. Box 91024
Baton Rouge, LA 70821

NOTE: All correspondence sent to Provider Relations, including recipient file updates, must include a separate cover letter explaining the problem or question, a copy of the claim(s), and all pertinent documentation (e.g., copies of RA pages showing prior denials, recipient chart notes, copies of previously submitted claims, documentation verifying eligibility, etc.). **A copy of the claim form along with applicable corrections and/or attachments must accompany all resubmissions.**

Provider Relations staff does not have direct access to eligibility files. Requests to update recipient files are forwarded to the Bureau of Health Services Financing by the Correspondence Unit, so these may take additional time for final resolution.

Requests to update Third Party Liability (TPL) should be directed to:

DHH-Third Party Liability
Medicaid Recovery Unit
P.O. Box 91030
Baton Rouge, LA 70821

"Clean claims" should not be submitted to Provider Relations as this delays processing. Please submit "clean claims" to the appropriate P.O. Box. A complete list is available in this training packet under "Unisys Claims Filing Addresses".

NOTE: CLAIMS RECEIVED WITHOUT A COVER LETTER WILL BE CONSIDERED "CLEAN" CLAIMS AND WILL NOT BE RESEARCHED.

Unisys Provider Relations Field Analysts

Upon request, Provider Relations Field Analysts are available to visit and train new providers and their office staff on site. Providers are encouraged to request Analyst assistance to help resolve complicated billing/claim denial issues and to help train their staff on Medicaid billing procedures. However, since Field Analysts routinely work in the field, they are not available to answer calls regarding eligibility, routine claim denials, and requests for printed material, or other policy documentation. These calls should be directed to the Unisys Provider Relations Telephone Inquiry Unit at (800) 473-2783 or (225) 924-5040.

FIELD ANALYST	PARISHES SERVED		
Martha Craft **(225) 237-3306**	Jefferson Orleans	St. Charles Plaquemines St. Bernard	
OPEN	Bienville Bossier Caddo Claiborne East Carroll Franklin Lincoln Vicksburg, MS	Madison Morehouse Ouachita Richland Tensas Union Webster West Carroll Marshall, TX	
Mona Doucet **(225) 237-3249**	Acadia Evangeline Iberia Lafayette	St. Landry St. Martin St. Mary Vermillion	
OPEN	Allen Beauregard Calcasieu	Cameron Jeff Davis Lafourche Terrebonne	Beaumont, TX Jasper, TX
Sharon Harless **(225) 237-3267**	Avoyelles Iberville West Baton Rouge	East Feliciana West Feliciana Woodville/Centerville (MS) Pointe Coupee	
Erin McAlister **(225) 237-3201**	Ascension Assumption Livingston St. Helena St. James	St. John the Baptist St. Tammany Tangipahoa Washington McComb (MS)	
Courtney Patterson **(225) 237-3269**	East Baton Rouge		
Kathy Robertson **(225) 237-3260**	Catahoula Concordia DeSoto Grant Jackson LaSalle Natchitoches	Rapides Red River Sabine Vernon Winn Caldwell Natchez (MS)	

LOUISIANA MEDICAID WEBSITE APPLICATIONS

The newest way to obtain general and specific Medicaid information is on our Louisiana Medicaid Provider Website:

www.lamedicaid.com

This website has several applications that should be used by Louisiana Medicaid providers. These applications require that providers establish an online account for the site.

Provider Login and Password

To ensure appropriate security of recipient's patient health information (PHI) and provider's personal information, the secure area of the web site is available to providers only. It is the responsibility of each provider to become "Web Enrolled" by obtaining a login and password for this area of the site to be used with his/her provider number. Once the login and password are obtained by the provider who "owns" the provider number, that provider may permit multiple users to login using the provider number. This system allows multiple individuals to login using the same login and password OR a provider may have up to 500 individual logins and passwords established for a single provider number. The administrative account rights are established when a provider initially obtains a login and password, and should remain with the provider or designated office staff employed by the provider.

A login and password may be obtained by using the link, Provider Web Account Registration Instructions. Should you need assistance with obtaining a login and password or have questions about the technical use of the application, please contact the Unisys Technical Support Desk at 877-598-8753.

☞ Unisys has received inquiries from billing agents/vendors attempting to access this web application. DHH and CMS Security Policy restrictions will not permit Unisys to allow access of this secure application to anyone except the owner of the provider number being used for accessing the site. In cases where an outside billing agent/vendor is contracted to submit claims on behalf of a provider, any existing business partner agreement is between the provider and the billing agent/vendor. **Unisys** may not permit anyone except the provider to receive or ask for information related to a login and password to access secured information.

Web Applications

There are a number of web applications available on the Medicaid website, however, the following applications are the most commonly used:

- Medicaid Eligibility Verification System (e-MEVS) for recipient eligibility inquiries;
- Claims Status Inquiry (e-CSI) for inquiring on claims status; and
- Clinical Data Inquiry (e-CDI) for inquiring on recipient pharmacy prescriptions as well as other medical claims data

These applications are available to providers 24 hours a day, 7 days a week at no cost.

e-MEVS:

Providers can now verify eligibility, primary insurance information, and service limits for a Medicaid recipient using this web application accessed through www.lamedicaid.com. This application provides eligibility verification capability in addition to MEVS swipe card transactions and REVS. An eligibility request can be entered via the web for a single recipient and the data for that individual will be returned on a printable web page response. The application is to be used for single individual requests and cannot be used to transmit batch requests.

Since its release, the application has undergone some cosmetic and informational changes to make it more user-friendly and allow presentation of more complete, understandable information.

e-CSI:

Providers wishing to check the status of claims submitted to Louisiana Medicaid should use this application. We are required to use HIPAA compliant denial and reference codes and descriptions for this application. If the information displayed on CSI is not specific enough to determine the detailed information needed to resolve the claim inquiry, refer to the hard copy remittance advice. The date of the remittance advice is displayed in the CSI response. The hard copy remittance advice continues to carry the Louisiana specific error codes. Providers must ensure that their internal procedures include a mechanism that allows those individuals checking claims statuses to have access to remittance advices for this purpose. A LA Medicaid/HIPAA Error Code Crosswalk is available on this website by accessing the link, Forms/Files.

Once enrolled in the website, all active providers, with the exception of "prescribing only" providers, have authorization to utilize the e-CSI application.

e-CDI:

The e-CDI application provides a Medicaid recipient's essential clinical history information at the authorized practitioner's finger tips at any practice location.

The nine (9) clinical services information components are:

1. Clinical Drug Inquiry
2. Physician/EPSDT Encounters
3. Outpatient Procedures
4. Specialist Services
5. Ancillary Services
6. Lab & X-Ray Services
7. Emergency Room Services
8. Inpatient Services
9. Clinical Notes Page

This information is updated on a monthly basis, with the exception of the Clinical Drug Inquiry, which is updated on a daily basis. The Clinical Drug Inquiry component will provide clinical historical data on each Medicaid recipient for the current month, prior month, and prior four months. All other components will provide clinical historical data within a six-month period. These updates are based on Medicaid claims history. A print-friendly version of the information on each of the web pages will be accessible and suitable for the recipient's clinical chart.

The major benefits of the use of e-CDI by the practitioner will include:

1. Displays a list of all services (i.e. drugs, procedures, MD visits, etc.) by all providers that have provided services to each individual recipient.
2. Provides the practitioner rapid access to current clinical data to help him/her evaluate the need for "modifications" of an individual Medicaid recipient's health care treatment.
3. Promotes the deliberate evaluation by a practitioner to help prevent duplicate drug therapy and decreases the ordering of duplicate laboratory tests, x-ray procedures, and other services.
4. Supplies a list of all practitioner types providing health care services to each Medicaid recipient.
5. Assists the practitioner in improving therapeutic outcomes and decreasing health care costs.

Additional DHH Available Websites

www.lamedicaid.com/HIPAA: Louisiana Medicaid HIPAA Information Center

www.la-communitycare.com: DHH website – CommunityCARE (program information, provider listings, Frequently Asked Questions (FAQ)

www.la-kidmed.com: DHH website - KIDMED – (program information, provider listings, FAQ)

www.dhh.la.gov/BCSS DHH website - Bureau of Community Supports and Services

www.oph.dhh.state.la.us DHH website - EarlySteps Program

www.oph.dhh.state.la.us DHH website - LINKS

www.dhh.state.la.us/RAR DHH Rate and Audit Review (nursing home updates and cost report information, contacts, FAQ)

PHONE AND FAX NUMBERS FOR PROVIDER ASSISTANCE

Department	Toll Free Phone	Phone	Fax
REVS - Automated Eligibility Verification	(800) 776-6323	(225) 216-7387	
Provider Relations	(800) 473-2783	(225) 924-5040	(225) 237-3334
POS (Pharmacy) - Unisys	(800) 648-0790	(225) 237-3381	(225) 237-3334
Electronic Data Interchange (EDI) - Unisys		(225) 237-3200 option 2	(225) 237-3331
Prior Authorization (DME, Rehab) - Unisys	(800) 488-6334	(225) 928-5263	(225) 237-3342 or (225) 929-6803
Home Health P.A. - Unisys EPSDT PCS P.A. - Unisys	(800) 807-1320		(225) 237-3342 or (225) 929-6803
Dental P.A. **-** LSU School of Dentistry		(504) 619-8589	(504) 619-8560
Hospital Precertification **-** Unisys	(800) 877-0666		(800) 717-4329
Pharmacy Prior Authorization	(866) 730-4357		(866) 797-2329
Provider Enrollment - Unisys		(225) 237-3370	
Fraud and Abuse Hotline (for use by providers and recipients)	(800) 488-2917		
WEB Technical Support Hotline-Unisys	(877) 598-8753		

ADDITIONAL NUMBERS FOR PROVIDER ASSISTANCE

Department	Phone Number	Purpose
Regional Office – DHH	(800) 834-3333 (225) 925-7948	Providers may request verification of eligibility for presumptively eligible recipients; recipients should contact to request a new card or to discuss eligibility issues.
Eligibility Operations –BHSF	(888) 342-6207	Recipients may address eligibility questions and concerns
LaCHIP Program	(877) 252-2447	Providers or recipients may obtain information concerning the LaCHIP Program which expands Medicaid eligibility for children from birth to 19.
Office of Public Health - Vaccines for Children Program	(504) 483-1900	Providers may obtain information regarding the Vaccines for Children program, including information on how to enroll in the program.
Referral Assistance - ACS	(877) 455-9955	Providers and recipients may obtain referral assistance.
KIDMED Provider Hotline – ACS	(800) 259-8000	Providers may obtain information on KIDMED linkage, referrals, monitoring, certification, and names of agencies that provide PCS services.
KIDMED Recipient Hotline – ACS	(800) 259-4444	Recipients request enrollment in KIDMED program and obtain information on KIDMED linkage.
CommunityCARE Provider Hotline – ACS	(800) 609-3888	Providers inquire about PCP assignment for CommunityCARE recipients and about CommunityCARE monitoring/certification.
CommunityCARE Recipient Hotline – ACS	(800) 359-2122	Recipients may choose or change a PCP, inquire about CommunityCARE program policy or procedures, and express complaints concerning the CommunityCARE program.
Bureau of Community Support and Services – BCSS	(800) 660-0488 (225) 219-0200	Providers and recipients may request assistance regarding waiver services provided to waiver recipients **(does not include claim or billing problems or questions).**
EarlySteps Program - OPH	(866) 327-5978	Providers and recipients may request information on the EarlySteps Program and services offered.
LINKS	(504) 483-1900	Providers may obtain immunization information on recipients.

DHH Program Manager Requests

Questions regarding the rationale for Medicaid policy, procedure coverage and reimbursement, medical justification, written clarification of policy that is not documented, etc. should be directed in writing to the manager of your specific program:

Department of Health and Hospitals
Attn: Physicians' Program Manager
P. O. Box 91030
Baton Rouge, LA 70821

HOW DID WE DO?

In an effort to continuously improve our services, Unisys would appreciate your comments and suggestions. Please complete this survey and return it to a Unisys representative or leave it on your table. **Your opinion is important to us.**

Seminar Date:_____ Location of Seminar (City):_____

Provider Subspecialty (if applicable):_____

FACILITY	**Poor**			Excellent	
The seminar location was satisfactory	**1**	**2**	**3**	**4**	**5**
Facility provided a comfortable learning environment	**1**	**2**	**3**	**4**	**5**
SEMINAR CONTENT	**Poor**			Excellent	
Materials presented are educational and useful	**1**	**2**	**3**	**4**	**5**
Overall quality of printed material	**1**	**2**	**3**	**4**	**5**
UNISYS REPRESENTATIVE	**Poor**			Excellent	
The speakers were thorough and knowledgeable	**1**	**2**	**3**	**4**	**5**
Topics were well organized and presented	**1**	**2**	**3**	**4**	**5**
Reps provided effective response to questions	**1**	**2**	**3**	**4**	**5**
Overall meeting was helpful and informative	**1**	**2**	**3**	**4**	**5**
SESSION: Professional					

What topic was most beneficial to you?_____

Please provide constructive comments and suggestions:_____

To order written materials provided by Unisys, please call Unisys Provider Relations Telephone Inquiry Unit at **(800) 473-2783 or (225) 924-5040.**

APPENDIX A

Ambulatory Surgical Code Listing

Appendix A - Ambulatory Surgical Code Listing (reference date 10/1/04)
Group 1 - $220.39

Proc	Description	Proc	Description
11100	BIOPSY OF SINGLE LESION	11740	EVACUATE HEMATOMA UNDER NAIL
11400	EXCISE BENIGN LESION TO 0.5 CM	11760	SIMPLE RECONSTRUCTION NAIL BED
11401	EXCISE BENIGN LESION 0.6 TO 1C	11762	NAIL RECONSTRUCTION COMPLICATE
11402	EXCISE BENIGN LESION 1.1 TO 2C	21310	TREATMENT OF NASAL FRACTURE
11403	EXCISE BENIGN LESION 2.1 TO 3C	21315	DIGITAL MANIPULATION OF NASAL
11404	EXCISE BENIGN LESION 3.1 TO 4C	21337	CLOSED TREATMENT FX NASAL SEPT
11420	EXCISE BENIGN LESION TO 0.5CM	25290	TENOTOMY,OPEN,FLEX,EXTEN;SING,
11421	EXCISE BENIGN LESION 0.6 TO 1C	26020	DRAIN HAND TENDON SHEATH
11440	EXCISE BENIGN LESION TO 0.5CM	26025	DRAINAGE OF PALM BURSA
11441	EXCISE BENIGN LESION 0.6 TO 1C	26055	INCISE FINGER TENDON SHEATH
11442	EXCISE BENIGN LESION 1.1 TO 2C	26060	INCISION FINGER TENDON
11443	EXCISE BENIGN LESION 2.1 TO 3C	26450	TENOTOMY,FLEXOR,SINGLE,PALM,OP
11444	EXCISE BENIGN LESION 3.1 TO 4C	26455	TENOTOMY,FLEXOR,SINGLE,FINGER
11600	EXCISE MALIGNANCY TO 0.5CM	26460	TENOTOMY,EXTENSOR,HAND OR FING
11601	EXCISE MALIGNANCY 0.6 TO 1CM	30130	REMOVAL OF TURBINATE BONES
11602	EXCISE MALIGNANCY 1.1 TO 2CM	30140	REMOVAL OF TURBINATE BONES
11603	EXCISE MALIGNANCY 2.1 TO 3CM	31505	DIAGNOSTIC LARYNGOSCOPY
11604	EXCISE MALIGNANCY 3.1 TO 4CM	31510	LARYNGOSCOPY WITH BIOPSY
11606	EXCISE MALIGNANCY OVER 4CM	31511	REMOVE FOREIGN BODY,LARYNX
11620	EXCISE MALIGNANCY TO 0.5CM	31512	REMOVAL OF LARYNX LESION
11621	EXCISE MALIGNANCY 0.6 TO 1CM	31525	DIAGNOSTIC LARYNGOSCOPY
11622	EXCISE MALIGNANCY 1.1 TO 2CM	31530	OPERATIVE LARYNGOSCOPY
11623	EXCISE MALIGNANCY 2.1 TO 3CM	31575	LARYNGOSCOPY,FIBERSCOPIC;DIAGN
11624	EXCISE MALIGNANCY 3.1 TO 4CM	31576	LARYNGOSCOPY,FIBERSCOPIC;BIOPS
11626	EXCISE MALIGNANCY OVER 4CM	31577	LARYNGOSCOPY,FIBERSCOPIC;FOREI
11640	EXCISE MALIGNANCY TO 0.5CM	31578	LARYNGOSCOPY,FIBERSCOPIC;REMOV
11641	EXCISE MALIGNANCY 0.6 TO 1CM	31625	BRONCHOSCOPY WITH BIOPSY
11642	EXCISE MALIGNANCY 1.1 TO 2CM	37609	TEMPORAL ARTERY PROCEDURE
11643	EXCISE MALIGNANCY 2.1 TO 3CM	41100	BIOPSY OF TONGUE
11644	EXCISE MALIGNANCY 3.1 TO 4CM	41105	BIOPSY OF TONGUE
11646	EXCISE MALIGNANCY OVER 4CM	41874	REPAIR TOOTH SOCKET
11730	SIMPLE REMOVAL OF NAIL PLATE	41899	FACILITY FEE--DENTAL RESTORATI
11732	REMOVE ADDITIONAL NAIL PLATES	43200	ESOPHAGUS ENDOSCOPY

Appendix A - Ambulatory Surgical Code Listing (reference date 10/1/04)
Group 1 - $220.39

Proc	Description	Proc	Description
43202	ESOPHAGUS ENDOSCOPY,BIOPSY	52305	CYSTOSCOPY AND TREATMENT
43217	ESOPHAGUS ENDOSCOPY	52310	CYSTOSCOPY AND TREATMENT
43220	ESOPHAGUS ENDOSCOPY,DILATION	53600	DILATE URETHRA STRICTURE
43226	ESOPHAGUS/STOMACH ENDOSCOPY	53601	DILATE URETHRA STRICTURE
43228	ESOPHAGUS/STOMACH ENDOSCOPY	53605	DILATE URETHRA STRICTURE
43234	UPPER GI ENDOSCOPY SIMPLE EXAM	53620	DILATE URETHRA STRICTURE
43235	UPPER GI ENDOSCOPY,DIAGNOSIS	53621	DILATE URETHRA STRICTURE
43239	UPPER GI ENDOSCOPY,BIOPSY	53640	RELIEVE BLADDER RETENTION
43245	UPPER GI ENDOSCOPY FOR DILAT	53660	DILATION OF URETHRA
43246	UPPER GI ENDOSCOPY,TUBE PLCMNT	53661	DILATION OF URETHRA
43247	OPERATIVE UPPER GI ENDOSCOPY	53665	DILATION OF URETHRA
43251	OPERATIVE UPPER GI ENDOSCOPY	54000	SLITTING OF PREPUCE
43258	OPERATIVE UPPER GI ENDOSCOPY	54001	SLITTING OF PREPUCE
45020	DRAINAGE OF RECTAL ABSCESS	54500	BIOPSY OF TESTIS
45300	PROCTOSIGMOIDOSCOPY;DIAGNOSTIC	54505	BIOPSY OF TESTIS
45303	PROCTOSIGMOIDOSCOPY W/DILATION	55700	BIOPSY OF PROSTATE
45305	PROCTOSIGMOIDOSCOPY W/BIOPSY	56420	DRAINAGE OF VULVA ABSCESS
45307	PROCTOSIGMOIDOSCOPY;REMOVE FOR	56440	SURGERY FOR VULVA LESION
45315	PROCTOSIGMOIDOSCOPY;REMOVE MUL	57020	DRAINAGE OF PELVIC FLUID
45330	SIGMOIDOSCOPY,FLEX FIBEROPTIC	57100	BIOPSY OF VAGINA
45331	SIGMOIDOSCOPY,FLEX FIBEROPTIC	57105	BIOPSY OF VAGINA
45332	SIGMOIDOSCOPY;DIAGNOSTIC	57400	DILATION OF VAGINA
45333	SIGMOIDOSCOPY;DIAGNOSTIC	57410	PELVIC EXAMINATION
45900	REDUCTION OF RECTAL PROLAPSE	57500	BIOPSY OF CERVIX
45905	DILATION OF ANAL SPHINCTER	57505	ENDOCERVICAL CURETTAGE
45910	DILATION OF RECTAL NARROWING	65205	REMOVE FOREIGN BODY FROM EYE
52000	CYSTOSCOPY	65210	REMOVE FOREIGN BODY FROM EYE
52204	CYSTOURETHROSCOPY WITH BIOPSY	65220	REMOVE FOREIGN BODY FROM EYE
52214	CYSTOURETHROSCOPY W/FULGURATIO	65222	REMOVE FOREIGN BODY FROM EYE
52224	CYSTOURETHROSCOPY W/ FULGURATI	65260	REMOVE FOREIGN BODY FROM EYE
52260	CYSTOSCOPY & TREATMENT	65265	REMOVE FOREIGN BODY FROM EYE
52277	CYSTOSCOPY AND TREATMENT	65420	REMOVAL OF EYE LESION
52285	CYSTOSCOPY AND TREATMENT	65426	REMOVAL OF EYE LESION
52290	CYSTOSCOPY AND TREATMENT	67800	REMOVE EYELID LESION

Appendix A - Ambulatory Surgical Code Listing (reference date 10/1/04)
Group 1 - $220.39

Proc	Description	Proc	Description
67801	REMOVE EYELID LESIONS		
67805	REMOVE EYELID LESIONS		
67808	REMOVE EYELID LESION (S)		
67938	REMOVE EYELID FOREIGN BODY		
69420	INCISION OF EARDRUM		
69424	VENT TUBE REMOVAL;UNILATERAL		
91010	ESOPHAGEAL MOTILITY STUDY		
92502	OTOLARYNGOLOGIC EXAM UNDER ANE		
92511	NASOPHARYNGOSCOPY		

Appendix A - Ambulatory Surgical Code Listing (reference date 10/1/04)
Group 2 – $262.36

Proc	Description
10061	DRAIN SKIN ABSCESS COMPLICATED
10120	SIMPLE REMOVAL FOREIGN BODY
10121	COMPLICATED REMOVAL FOREIGN BO
20000	INCISION OF ABSCESS; SUPERFICI
20200	BIOPSY,MUSCLE,SUPERFICIAL
20205	BIOPSY,MUSCLE,DEEP
20206	BIOPSY,MUSCLE,PERCUTANEOUS NEE
20520	REMOVE FOREIGN BODY; SIMPLE
20680	REMOVE IMPLANT; DEEP
21355	MANIPULATE FX MALAR AREA
21360	TREAT DEPRESSED MALAR FRACTURE
21501	I & D DEEP ABSCESS OR HEMATOMA
23930	DRAINAGE OF ARM LESION
23931	DRAINAGE OF ARM BURSA
24134	REMOVE BONE LESION,SHAFT OR DI
24138	REMOVE BONE LESION/OLECRANON P
25000	TENDON SHEATH INCISION AT RADI
26010	DRAINAGE OF FINGER ABSCESS
26011	DRAINAGE OF FINGER ABSCESS
27301	I&D DEEP ABSCESS,INFECTED BURS
27603	DRAIN LOWER LEG LESION
27604	DRAIN LOWER LEG BURSA
28001	DRAINAGE OF BURSA OF FOOT
28160	PARTIAL REMOVAL OF TOE
28810	AMPUTATION TOE & METATARSAL
28820	AMPUTATION OF TOE
28825	REMOVAL OF NOSE POLYP(S)
30115	REMOVAL OF NOSE POLYP(S)
31000	IRRIGATION MAXILLARY SINUS
38500	BIOPSY/REMOVAL OF LYMPH NODE
38510	BIOPSY/REMOVAL OF LYMPH NODE
38520	BIOPSY/REMOVAL OF LYMPH NODE
38530	BIOPSY/REMOVAL OF LYMPH NODE
40500	VERMILIONECTOMY (LIP SHAVE)
40804	REMOVAL FOREIGN BODY; MOUTH
40805	REMOVAL FOREIGN BODY;MOUTH
41000	DRAINAGE OF MOUTH LESION
41005	DRAINAGE OF MOUTH LESION
41007	DRAINAGE OF MOUTH LESION
41008	DRAINAGE OF MOUTH LESION
42700	DRAINAGE OF TONSIL ABSCESS
42720	DRAINAGE OF THROAT ABSCESS
42810	EXCISION OF NECK CYST
42815	EXCISION OF NECK CYST
46060	INCISION OF RECTAL ABSCESS
46200	REMOVAL OF ANAL FISSURE
46270	REMOVAL OF ANAL FISTULA
46275	REMOVAL OF ANAL FISTULA
47000	NEEDLE BIOPSY OF LIVER
51080	DRAINAGE OF BLADDER ABSCESS
54520	REMOVAL OF TESTIS
54700	DRAINAGE OF SCROTUM
57135	REMOVE VAGINA LESION
67700	DRAINAGE OF EYELID ABSCESS
67710	INCISION OF EYELID
67880	REVISION OF EYELID
67882	REVISION OF EYELID
69000	DRAIN EXTERNAL EAR LESION
69005	DRAIN EXTERNAL EAR LESION
69020	DRAIN OUTER EAR CANAL LESION

Appendix A - Ambulatory Surgical Code Listing (reference date 10/1/04)
Group 3 – $282.40

Proc	Description	Proc	Description
11770	SIMPLE EXCISION PILONIDAL CYST	27630	REMOVAL OF TENDON LESION
11771	EXCISE PILONIDAL CYST;EXTENSIV	28080	REMOVAL OF FOOT LESION
15050	PINCH GRAFT;DEFECT UP TO 2CM	28110	PART REMOVAL OF METATARSAL
19000	PUNCTURE ASPIRATION BREAST CYS	28111	PART REMOVAL OF METATARSAL
19020	MASTOTOMY/DRAIN ABSCESS DEEP	28112	PART REMOVAL OF METATARSAL
19030	INJEC FOR MAMM DUCTOG OR GALAC	28113	PART REMOVAL OF METATARSAL
19100	BREAST BIOPSY NEEDLE	28114	REMOVAL OF METARSAL HEADS
19101	BREAST BIOPSY INCISIONAL	28200	REPAIR OF FOOT TENDON
19120	EXCISE BREAST LESIONS,1 OR MOR	28208	REPAIR OF FOOT TENDON
21040	EXCISE BENIGN CYST;MANDIBLE	28264	RELEASE OF MIDFOOT JOINT
24105	REMOVAL OF ELBOW BURSA	28270	RELEASE OT FOOT CONTRACTURE
25085	INCISION OF WRIST CAPSULE	28272	RELEASE OF TOE JOINT,EACH
25110	EXCISION,LESION OF TENDON SHEA	31002	IRRIGATION SPHENOID SINUS
25111	EXCISION GANGLION;WRIST,PRIMAR	31200	REMOVAL OF ETHMOID SINUS
25112	EXCISION GANGLION;WRIST,RECURR	40510	PARTIAL EXCISION OF LIP
25260	REP,TEND/MUSC;PRIM,SING;EACH T	40530	PARTIAL REMOVAL OF LIP
25263	REP,TEND/MUSC;SECOND,SING;EA T	44340	REVISION OF COLOSTOMY
25270	REP TEN/MUS,EXTEN,FOREARM,WRIS	46221	LIGATION OF HEMORRHOIDS
25272	REP TEN/MUS,EXTEN,FOREARM,WRIS	46320	REMOVAL OF HEMORRHOID CLOT
26160	REMOVE TENDON SHEATH LESION	52234	CYSTOURETHROSCOPY WITH FULGURA
26170	EXCISION OF TENDON PALM,FLEXOR	52235	CYSTOURETHROSCOPY WITH FULGURA
26350	FLEXOR TENDON REPAIR,PRIMARY/S	52240	CYSTOURETHROSCOPY WITH FULGURA
26390	FLEXOR TENDON EXCISE IMPLANT P	54161	CIRCUMCISION
26410	EXTENSOR TENDON REPAIR,DORSUM	55000	DRAINAGE OF HYDROCELLE
26418	EXTENSOR TENDON REPAIR,DORSUM	55040	REMOVAL OF HYDROCELLE
26432	TENDON REPAIR,DISTAL INSERT CL	55041	REMOVAL OF HYDROCELLE
26433	TENDON REPAIR,OPEN,PRIMARY/SEC	55500	REMOVAL OF HYDROCELLE
26440	TENOLYSIS,SIMPLE,FLEXOR,TENDON	57000	EXPLORATION OF VAGINA
26449	TENOLSIS,COMPLEX TENDON,HAND,F	57010	DRAINAGE OF PELVIC ABSCESS
26471	TENODESIS;FOR PROXIMAL FINGER	57800	DILATION OF CERVICAL CANAL
26474	TENODESIS,FOR DISTAL JOINT STA	57820	D & C OF RESIDUAL CERVIX
26520	RELEASE KNUCKLE CONTRACTURE	58120	DILATION AND CURETTAGE
26525	RELEASE FINGER CONTRACTURE	60200	REMOVE THYROID LESION
27345	REMOVAL OF KNEE CYST	60280	REVISE FINGER TOE NERVE

Appendix A - Ambulatory Surgical Code Listing (reference date 10/1/04)
Group 3 – $282.40

Proc	Description	Proc	Description
64704	REVISE HAND FOOT NERVE		
64708	REVISE ARM LEG NERVE		
64718	REVISE ULNAR NERVE AT ELBOW		
64719	REVISE ULNAR NERVE AT WRIST		
64721	REVISE MEDIUM NERVE AT WRIST		
64727	INTERNAL NERVE REVISION		
64774	REMOVE SKIN NERVE LESION		
64776	REMOVE DIGIT NERVE LESION		
67914	REPAIR EYELID DEFECT		
67915	REPAIR EYELID DEFECT		
67916	REPAIR EYELID DEFECT		
67917	REPAIR EYELID DEFECT		
67921	REPAIR EYELID DEFECT		
67922	REPAIR EYELID DEFECT		
67923	REPAIR EYELID DEFECT		
67924	REPAIR EYELID DEFECT		

Appendix A - Ambulatory Surgical Code Listing (reference date 10/1/04)
Group 4 – $320.56

Proc	Description	Proc	Description
19140	MASTECTOMY,GYNECOMASTIA	28072	REMOVAL OF FOOT JOINT LINING
25020	DECOMPRESSION FASCIOTOMY FLEXO	28285	REVISION OF HAMMERTOE
25023	DECOMPRESSION FASCIOTOMY FOREA	28286	REVISION OF HAMMERTOE
25116	RADICAL EXCISE BURSA,WRIST/FOR	28290	CORRECTION OF BUNION
25350	REVISION OF RADIUS;DISTAL THIR	28292	CORRECTION OF BUNION
25355	REVISION OF RADIUS;MIDDLE OR P	28293	CORRECTION OF BUNION
25360	REVISION OF ULNA	28294	CORRECTION OF BUNION
25365	REVISE RADIUS & ULNA	28298	CORRECTION OF BUNION
25442	RECONSTRUCT WRIST JOINT;DISTAL	28299	CORRECTION OF BUNION
25444	RECONSTRUCT WRIST JOINT;LUNATE	28300	INCISION OF HEEL BONE
25445	RECONSTRUCT WRIST JOINT TRAPEZ	28302	INCISION OF ANKLE BONE
25449	REVISE ARTHROPLASTY,REVDVE	28306	INCISION OF METATARSAL
26040	RELEASE PALM CONTRACTURE,CLOSE	28308	INCISION OF METATARSAL
26045	RELEASE PALM CONTRACTURE,OPEN	28310	REVISION OF BIG TOE
26130	REMOVE WRIST JOINT LINING	28312	REVISION OF TOE
26135	REVISE FINGER JOINT EACH DIGIT	28750	FUSION OF BIG TOE JOINT
26140	REVISE FINGER JOINT EACH INTE	28755	FUSION OF BIG TOE JOINT
26145	TENDON EXCISION PALM,FINGER	28760	FUSION OF BIG TOE JOINT
26420	EXTENSOR TENDON REPAIR,DORSUM	29819	ARTHROSCOPY/SURGICALLY REMOVE
26426	EXTENSOR TENDON,CENTRAL SLIP R	29820	ARTHROSCOPY-SYNOVECTOMY-PARTIA
26428	EXTENSOR TENDON,CENTRAL SLIP R	29821	ARTHROSCOPY-SYNOVECTOMY-COMPLE
26434	TENDON REPAIR,OPEN,PRIMARY/SEC	29822	ARTHROSCOPY-LIMITED DEBRIDEMEN
26530	REVISE KNUCKLE JOINT	29823	ARTHROSCOPY EXT DEBRIDEMENT
26531	REVISE KNUCKLE WITH IMPLANT	29825	ARTHROSCOPY W/LYSIS & RESECTIO
26535	REVISE FINGER JOINT	29830	ARTHROSCOPY ELBOW-DX
26536	REVISE/IMPLANT FINGER JOINT	29834	ARTHROSCOPY-ELBOW-SURGICAL
26545	RECONSTRUCT FINGER JOINT W/GRA	29835	ARTHROSCOPY SYNOVECTOMY-PARTIA
26565	CORRECT METACARPAL FLAW	29836	ARTHROSCOPY SYNOVECTOMY COMPLE
26567	CORRECT FINGER DEFORMITY	29837	ARTHROSCOPY-LIMITED DEBRIDEMEN
26860	ARTHRODESIS FINGER JOINT W/WO	29870	ARTHROSCOPY KNEE-DX
26861	EACH ADDITIONAL JOINT	29871	ARTHROSCOPY-KNEE-SURGICAL
28008	INCISION OF FOOT FASCIA	29874	ARTHROSCPOY REMOVE FOREIGN BOD
28030	REMOVAL OF FOOT NERVE	29875	ARTHROSCOPY LIMITED SYNOVECTOM
28070	REMOVAL OF FOOT JOINT LINING	29876	ARTHROSCOPY-MAJOR SYNOVECTOMY

Appendix A - Ambulatory Surgical Code Listing (reference date 10/1/04)
Group 4 – $320.56

Proc	Description	Proc	Description
29877	ARTHROSCOPY-DEBRIDEMENT	56720	INCISION OF HYMEN
29879	ARTHROSCOPY-ABRASION ARTHOPLA	57510	CAUTERIZATION OF CERVIX
29881	ARTHROSCOPY W/ MENISCECTOMY	57511	CRYOCAUTERY OF CERVIX
29882	ARTHROSCOPY W/ MENISCUS REPAIR	57513	LASER SURGERY
29884	ARTHROSCOPY W/ LYSIS ADHESIONS	58600	DIVISION OF FALLOPIAN TUBE
29887	ARTHROSCOPY-INTERNAL FIXATION	58615	OCCLUSION OF FALLOPIAN TUBES
29894	ARTHROSCOPY-ANKLE-SURGICAL	59840	THERAPEUTIC ABORTION
29895	ARTHROSCOPY-PARTIAL SYNOVECTOM	59841	ABORTION BY DILATION & EVACUAT
29897	ARTHROSCOPY-LIMITED DEBRIDEMEN	64836	REPAIR OF HAND OR FOOT NERVE
30620	RECONSTRUCTION INNER NOSE	64837	REPAIR ADDITIONAL NERVE
37700	REVISE LEG VEIN	65091	EVISCERATION EYE
37730	REMOVAL OF LEG VEINS	65093	EVISCERATION EYE WITH IMPLANT
37780	REVISION OF LEG VEIN	65101	REMOVAL OF EYE
37785	REVISION OF LEG VEIN	65103	REMOVE EYE/INSERT IMPLANT
40819	EXCISE LIP OR CHEEK FOLD	65130	INSERT OCULAR IMPLANT
42820	REMOVE TONSILS AND ADENOIDS	65135	INSERT OCULAR IMPLANT
42821	REMOVE TONSILS AND ADENOIDS	65140	ATTACH OCULAR IMPLANT
42825	REMOVAL OF TONSILS	65150	REVISE OCULAR IMPLANT
42826	REMOVAL OF TONSILS	65155	REINSERT OCULAR IMPLANT
42830	REMOVAL OF ADENOIDS	65175	REMOVAL OF OCULAR IMPLANT
42831	REMOVAL OF ADENOIDS	66500	INCISION OF IRIS
42835	REMOVAL OF ADENOIDS	66505	INCISION OF THE IRIS
42836	REMOVAL OF ADENOIDS	66600	REMOVE IRIS AND LESION
49500	REPAIR INGUINAL HERNIA	66605	REMOVAL OF IRIS
49505	REPAIR INGUINAL HERNIA	66625	REMOVAL OF IRIS
49520	REPAIR INGUINAL HERNIA	66630	REMOVAL OF IRIS
49550	REPAIR FEMORAL HERNIA	66635	REMOVAL OF IRIS
49560	REPAIR ABDOMINAL HERNIA	66830	REMOVAL OF LENS LESION
49580	REPAIR UMBILICAL HERNIA	66840	REMOVAL OF LENS MATERIAL
49590	REPAIR ABDOMINAL HERNIA	66850	REMOVAL OF LENS MATERIAL
55250	VASECTOMY UNILATERAL OR BILATE	66920	EXTRACTION OF LENS
55450	LIGATION OF VAS DEFERENS	66930	EXTRACTION OF LENS
55530	REVISE SPERMATIC CORD VEINS	66940	EXTRACTION OF LENS
56700	PARTIAL REMOVAL OF HYMEN	66983	INTRA CATARACT EXTRAC W LENS

Appendix A - Ambulatory Surgical Code Listing (reference date 10/1/04)
Group 4 – $320.56

Proc	Description	Proc	Description
66984	EXTRA CATARACT REMOVAL W LENS		
67311	REVISE EYE MUSCLE		
67312	REVISE TWO EYE MUSCLES		
67350	BIOPSY EYE MUSCLE		
69433	OFFICE TYMPANOSTOMY UNILAT		
69436	HOSPITAL TYMPANOSTOMY UNILAT		
69501	MASTOIDECTOMY		
69610	REPAIR OF EARDRUM		
69620	REPAIR OF EARDRUM		
69631	REPAIR EARDRUM STRUCTURES		
69660	REVISE MIDDLE EAR BONE		

Appendix B

J Codes

Appendix B – J Codes (reference date 9/29/04)

Proc	Description	Proc	Description
J0130	ACTEST GEL INJ	J1817	INSULIN FOR INSULIN PUMP USE
J0151	ADENOSINE INJ	J1835	INTRACONAZOLE INJ
J0170	ADRENALIN/EPINEPHRINE INJ 1ML	J1956	LEVOFLOXACIN INJ
J0275	ALPROSTADIL URETHRAL SUPPOS	J2175	MEPERDINE INJ
J0285	AMPHOTERICIN B	J2271	MORPHINE SO4 INJ 100MG
J0286	AMPHOTERICIN B LIPID COMPLEX	J2322	INJ NANDROLONE DECANOATE,UP TO
J0287	AMPHOTERICIN B LIPID COMPLEX	J2324	NESIRITIDE
J0288	AMPHO B CHOLESTERYL SULFATE	J2355	OPRELVEKIN INJ
J0289	AMPHOTERICIN B LIPOSOME INJ	J2501	PARICALCITOL
J0290	HEMODIALYSIS,AMPICILLIN INJ	J2720	HEMODIALYSIS,PROTAMINE INJ
J0395	ARBUTAMINE HCL INJ	J2788	RHO D IMMUNE GLOBULIN 50 MCG
J0475	BACLOFEN INJ 10MG	J2790	RHOGAM INJ, RHO D IMMUNE GLOBU
J0476	BACLOFEN INTRATHECAL TRIAL	J2792	RHO(D) IMMUNE GLOBULIN H, SD
J0587	BOTULINUM TOXIN TYPE B, PER UN	J2910	GOLD THERAPY INJ-ARTHRITIS
J0592	BUPRENORPHINE HYDROCHLORIDE	J2916	NA FERRIC GLUCONATE COMPLEX
J0636	INJECTION, CALCITRIOL, 0.1 MCG	J2941	SOMATROPIN INJ
J0637	CASPOFUNGIN ACETATE	J3070	HEMODIALYSIS,TALWIN INJ
J0706	CAFFEINE CITRATE INJECTION	J3120	INJ TESTOSTERONE ENANTHATE
J0710	HEMODIALYSIS,CEPADYL INJ	J3250	HEMODIALYSIS,TIGAN/PHENERGAN I
J0744	CIPROFLOXACIN IV	J3315	TRIPTORELIN PAMOATE
J1051	INJECTION MEDROXYPROGESTE ACET	J3360	HEMODIALYSIS,VALIUM INJ
J1055	DEPO-PROVERA INJ 150MG	J3370	HEMODIALYSIS,VANCOMYCIN INJ
J1056	LUNELLE MONTHLY CONTRACEPTION	J3487	ZOLEDRONIC ACID
J1094	INJ DEXAMETHASONE ACETATE	J3590	UNCLASSIFIED BIOLOGICS
J1200	DIPHENHYDRAMINE HCL INJ (BENAD	J7190	HEMOPHILIAC HEAT TREATED FACTO
J1260	DOLASETRON MESYLATE INJ 10MG	J7300	INTRAUTERINE COPPER CONTRACEPT
J1564	IMMUNE GLOBULIN 10 MG	J7302	MIRENA
J1580	HEMODIALYSIS,GARAMYCIN INJ	J7316	SODIUM HYALURONATE INJ
J1652	FONDAPARINUX SODIUM	J7317	SODIUM HYALURONATE INJECTION
J1655	TINZAPARIN SODIUM INJ	J7320	HYLAN G-F 20, 16MG FOR
J1750	IRON DEXTRAN INJ 50MG	J7342	METABOLICALLY ACTIVE TISSUE
J1756	INJECTION,IRON SUCROSE,1MG	J7513	DACLIZUMAB PARENTERAL 25MG
J1760	INFED (IRON DEXTRAN)	J7633	BUDESONIDE CONCENTRATED SOL
J1815	INSULIN INJECTION	J9000	ADRIAMYCIN INJ 10MG

Appendix B – J Codes (reference date 9/29/04)

Proc	Description	Proc	Description
J9017	ARSENIC TRIOXIDE	J9208	FOSFOMIDE, 1GM
J9040	BLEOMYCIN INJ,1 AMP	J9209	ESNA, 200MG
J9045	CARBOPLATIN INJ 50MG.	J9212	NTERFERON
J9050	CARMUSTINE, 100MG	J9217	EUPROLIDE ACETATE, DEPOT SUSP
J9060	PLATINOL INJ 10MG	J9219	EUPROLIDE ACETATE IMPLANT 65
J9070	CYTOXIN INJ 100MG	J9230	USTARGEN INJ 10MG
J9080	CYTOXIN INJ 200MG	J9250	ETHOTREXATE SOD INJ, 5 MG
J9090	CYTOXIN INJ 500MG	J9260	ETHOTREXATE SOD INJ 50MG
J9100	CYTOSAR INJ 10MG	J9265	ACLITAXEL, 30 MG
J9120	COSMEGEN INJ 0.5MG	J9280	ITOMYCIN POWDER
J9130	DTIC-DOME INJ 100MG/10ML	J9310	ITUXIMAB CANCER TREATMENT
J9140	DTIC-DOME INJ 200MG/20ML	J9320	TREPTOZOCIN, 1GM
J9151	DAUNORUBICIN CITRATE LIPOSOM	J9340	HIOTEPA, 15MG
J9160	DENILEUKIN DIFTITOX,2ML VIAL	J9350	OPOTECAN
J9170	DOCETAXEL 20 MG	J9355	RASTUZUMAB 10MG
J9181	ETOPOSIDE INJ, UP TO 10MG	J9357	ALRUBICIN, INTRAVESICAL, 200
J9182	ETOPOSIDE INJ, UP TO 100MG	J9360	ELBAN INJ,10MG/10CC
J9185	FLUDARABINE PHOSPHATE, 50 MG	J9370	NCOVIN INJ 1MG
J9190	FLOUROURACIL INJ, 500MG	J9380	NCOVIN INJ 5MG
J9201	GEDIITABINE HCL, 200MG	J9390	INORELDINE TARTRATE, 10MG,NA
J9202	OSERELIN ACETATE IMP.(ZOLADEX		
J9206	RINOTECAN, 20MG		

Appendix C

Nurse Practitioner/Clinical Nurse Specialist

Appendix C - Codes Payable to Nurse Practitioners and Clinical Nurse Specialists (reference date 9/29/04)

Proc	Description	Proc	Description
J1055	DEPO-PROVERA INJ 150MG	11975	INSERTION OR REINSERTION, IMPL
J1056	LUNELLE MONTHLY CONTRACEPTION	11976	REMOVAL WITHOUT REINSERTION, I
J7300	INTRAUTERINE COPPER CONTRACEPT	11977	REMOVAL WITH REINSERTION, IMPL
J7302	MIRENA	11981	INSERT DRUG IMPLANT DEVICE
J9000	ADRIAMYCIN INJ 10MG	12001	SIMPLE WOUND REPAIR TO 2.5CM
J9040	BLEOMYCIN INJ,1 AMP	12002	SIMPLE WOUND REPAIR 2.6 TO 7.5
J9060	PLATINOL INJ 10MG	12004	SIMPLE WOUND REPAIR 7.6 TO 12.
J9070	CYTOXIN INJ 100MG	16000	INIT TREAT 1ST DEGREE BURN
J9080	CYTOXIN INJ 200MG	16020	DRESS/DEBRID BURN SMALL,NO ANE
J9090	CYTOXIN INJ 500MG	17000	DESTROY LESION,FACE-1 LESION
J9100	CYTOSAR INJ 10MG	20610	ARTHROCENTESIS; MAJOR JOINT/ B
J9120	COSMEGEN INJ 0.5MG	31500	INSERTION OF WINDPIPE AIRWAY
J9130	DTIC-DOME INJ 100MG/10ML	31515	LARYNGOSCOPY FOR ASPIRATION
J9140	DTIC-DOME INJ 200MG/20ML	32020	TREATMENT OF COLLAPSED LUNG
J9190	FLOUROURACIL INJ, 500MG	51600	INJECTION FOR BLADDER X-RAY
J9230	MUSTARGEN INJ 10MG	51700	IRRIGATION OF BLADDER
J9250	METHOTREXATE SOD INJ, 5 MG	51725	SIMPLE CYSTOMETROGRAM
J9260	METHOTREXATE SOD INJ 50MG	51726	COMPLEX CYSTOMETROGRAM
J9280	MITOMYCIN POWDER	51741	COMPLEX UROFLOWMETRY
J9360	VELBAN INJ,10MG/10CC	51772	URETHRAL PRESSURE PROFILE STUD
J9370	ONCOVIN INJ 1MG	51784	ANAL/URINARY MUSCLE STUDY
J9380	ONCOVIN INJ 5MG	51795	VOIDING PRESSURE STUDIES (VP)
J9390	VINORELDINE TARTRATE, 10MG,NA	51797	INTRA-ABDOMINAL VOIDING PRESSU
Q0111	WET MOUNTS,PREPARATIONS OF VAG	56420	DRAINAGE OF VULVA ABSCESS
10060	DRAINAGE OF SKIN ABSCESS	56501	DESTROY VULVA LESION(S);SIMPLE
10120	SIMPLE REMOVAL FOREIGN BODY	56605	BIOPSY OF VULVA OR PERINEUM (S
10160	PUNCTURE DRAINAGE OF LESION	57160	INSERTION OF PESSARY
11040	DEBRIDE SKIN,PARTIAL THICKNESS	57170	DIAPHRAGM FITTING.WITH INSTRUC
11055	TRIM SKIN LESION	57452	EXAMINATION OF VAGINA
11056	TRIM 2 TO 4 SKIN LESIONS	57454	VAGINA EXAMINATION & BIOPSY
11100	BIOPSY OF SINGLE LESION	57505	ENDOCERVICAL CURETTAGE
11101	BIOPSY OF SKIN,EACH ADD LESION	57511	CRYOCAUTERY OF CERVIX
11720	DEBRIDE NAIL, 1-5	58100	BIOPSY OF UTERUS LINING
11721	DEBRIDE NAIL, 6 OR MORE	58300	INSERT INTRAUTERINE DEVICE
11765	WEDGE EXCISION,SKIN OF NAIL FO	58301	REMOVE INTRAUTERINE DEVICE

Appendix C - Codes Payable to Nurse Practitioners and Clinical Nurse Specialists (reference date 9/29/04)

Proc	Description
59025	FETAL NON-STRESS TEST
59430	POSTPARTUM CARE ONLY-SEPARATE
69200	CLEAR OUTER EAR CANAL
69210	REMOVE IMPACTED EAR WAX
76805	ECHO EXAM OF PELVIS
76810	ECHOGRAPHY, PREGNANT UTERUS, B
76815	ECHO EXAM FOR FETAL GROWTH
76816	ECHOGRAPHY..PG UTERUS;FOLLOW-U
76818	FETAL BIOPHYSICAL PROFILE
76830	ECHOGRAPHY, TRANSVAGINAL
76856	ECHOGRAPHY, PELVIC, REAL TIME
78990	PROVIDE DX RADIONUCLIDE(S)
81000	URINALYSIS WITH MICROSCOPY
81001	URINALYSIS, AUTO, W/SCOPE
81002	ROUTINE URINE ANALYSIS
81025	URINE PREGNANCY TEST, BY VISUA
82270	TEST FECES FOR BLOOD
82947	ASSAY BODY FLUID, GLUCOSE
82948	STICK ASSAY OF BLOOD GLUCOSE
85014	BLOOD COUNT OTHER THAN SPUN HE
85018	HEMOGLOBIN, COLORIMETRIC
85025	BLOOD COUNT;HEMO.PLAT.COUNT,AU
86403	PRECIPITIN (EG, LATEX BEAD) OR
86580	TB PATCH OR INTRADERMAL TEST
86585	TB TINE TEST
87070	CULTURE SPECIMEN, BACTERIA
87149	CULTURE TYPE, NUCLEIC ACID
87210	SMEAR, STAIN & INTERPRET
87220	TISSUE EXAMINATION FOR FUNGI
87480	CANDIDA, DNA, DIR PROBE
87490	CHYLMD TRACH, DNA, DIR PROBE
87510	GARDNER VAG, DNA, DIR PROBE
87590	N.GONORRHOEAE, DNA, DIR PROB
87880	STREP A ASSAY W/OPTIC
90471	IMMUNIZATION ADMIN, SINGLE
90472	IMMUNIZATION ADMIN, 2+
90476	ADENOVIRUS VACCINE, TYPE 4
90477	ADENOVIRUS VACCINE, TYPE 7
90581	ANTHRAX VACCINE, SC
90585	BCG TICE VACCINE, 50 MG
90586	BCG LIVE (INTRAVESICAL) PER VI
90632	HEPA VACCINE ADULT IM
90633	HEPA VACCINE PED/ADOL-2 DOSE
90634	HEPA VACCINE PED/ADOL-3 DOSE
90645	HIB VACCINE, HBOC, IM
90646	HIB VACCINE, PRP-D, IM
90647	HIB VACCINE, PRP-OMP, IM
90648	HIB VACCINE, PRP-T, IM
90657	FLU VACCINE, 6-35 MO, IM
90658	FLU VACCINE, 3 YRS, IM
90659	FLU VACCINE, WHOLE, IM
90660	FLU VACCINE, NASAL
90665	LYME DISEASE VACCINE, IM
90669	PNEUMOCOCCAL VACCINE, PED
90675	RABIES VACCINE, IM
90676	RABIES VACCINE, ID
90690	TYPHOID VACCINE, ORAL
90691	TYPHOID VACCINE, IM
90692	TYPHOID VACCINE, H-P, SC/ID
90693	TYPHOID VACCINE, AKD, SC
90700	DTAP, DIPHTH, TETANUS TOXO,PET
90701	IMMUNIZATION,DTP,ACTIVE
90702	IMMUNIZATION,DT
90703	TETANUS TOXOID FOR TRAUMA
90704	IMMUNIZATION,MUMPS
90705	IMMUNIZATION,MEASLES
90706	IMMUNIZATION,RUBELLA
90707	IMMUNIZATION,MEASLES-MUMPS-RUB
90708	IMMUNIZATION,MEASLES-RUBELLA
90709	IMMUNIZATION,MUMPS-RUBELLA
90712	IMMUNIZATION,POLIOVIRUS, LIVE,
90713	IMMUNIZATION,POLIO INJECTION

Appendix C - Codes Payable to Nurse Practitioners and Clinical Nurse Specialists (reference date 9/29/04)

Proc	Description
90716	IMMUNIZATION,VARICELLA (CHICKE
90717	IMMUNIZATION,YELLOW FEVER
90718	IMMUNIZATION,TD ABSORBED,ADULT
90719	IMMUNIZATION,DIPTHERIA TOXOID
90720	IMMUNIZATION, ACTIVE;
90721	DTAP/HIB VACCINE
90723	DTAP-HEP B-IPV VACCINE, IM
90725	IMMUNIZATION,CHOLERA VACCINE
90732	IMMUNIZATION,PNEUMOCOCCAL VAC,
90740	HEPB VACC, ILL PAT 3 DOSE IM
90743	HEP B VACC, ADOL, 2 DOSE, IM
90744	HEPATITIS B VACCINE, PED/ADOL
90746	HEPATITIS B VACCINE, OVER 20
90748	HEPATITIS B/HIB VACCINE
90749	IMMUNIZATION,UNLISTED PROCEDUR
90782	IM PROCAINE PENICILLIN/BICILLI
90783	THERAPEUTIC INJECTION OF MEDIC
90784	THERAPEUTIC INJECTION; IV
90801	DIAGNOSTIC INTERVIEW
90862	CHEMOTHERAPY MANAGEMENT PSYCH
90989	DIALYSIS TRAIN-PATIENT-COMPLET
90993	DIALYSIS TRAIN-PATIENT-NOT COM
91000	ESOPHAGEAL INTUBATION W/WASHIN
91055	GASTRIC INTUBATION W/WASHINGS
91105	GASTRIC INTUBATION, AND ASPIRA
92065	ORTHOPTIC/PLEOPTIC TRAINING
92283	COLOR VISION EXAMINATION
92551	SCREENING; PURE TONE; AIR ONLY
92552	PURE TONE AUDIOMETRY; AIR ONLY
92567	TYMPANOMETRY
92950	CARDIOPULMONARY RESUSCITATION
93000	ROUTINE ECG W/AT LEAST 12 LEAD
93005	ECG; TRACING ONLY
93010	ECG; INTERPRETATION AND REPORT
93015	CARDIOVASCULAR STRESS TEST
93040	RHYTHM ECG;1-3 LEADS W/INTERPR
93041	RHYTHM ECG; TRACING ONLY
93042	RHYTHM ECG; INTERPRET+REPORT O
93770	DETERMINATION OF VENOUS PRESSU
93965	NON-INVASIVE PHYSIOLOGIC STUDI
94010	SPIROMETRY WITH GRAPH, VITAL C
94060	BRONCHOSPASM EVALUATION
94150	VITAL CAPACITY; TOTAL
94200	MAXIMUM BREATHING CAPACITY
94640	NONPRESSURIZED INHALATION
94642	AERO INHAL PENTAMIDINE FOR PNE
94650	IPPB; INITIAL AND/OR EVALUATIO
94651	IPPB; SUBSEQUENT IT
94652	IPPB; NEWBORN INFANTS
94656	VENTILATION ASSIST & MANAGE; I
94657	VENTILATION ASSIST & MANAGE; S
94660	CONTINUOUS POSITIVE AIRWAY PRE
94662	CONTINUOUS NEGATIVE PRESSURE
94664	AEROSOL/VAPOR INHALATIONS; INI
94665	AEROSOL/VAPOR INHALATIONS; SUB
94667	MANIPULATION CHEST WALL; INITI
94668	MANIPULATION CHEST WALL; SUBSE
94760	NONINVASIVE OXIMETRY-02;SINGLE
94761	SEE 94760;MULTIPLE DETERMINATI
94762	SEE 94760;CONT.OVERNIGHT MONIT
94772	CIRCADIAN RESPIRATORY PATTERN
95004	PERCUTANEOUS TESTS (SCRATCH, P
95010	PERCUTANEOUS TESTS (SCRATCH, P
95015	INTRACUTANEOUS (INTRADERMAL) T
95024	INTRACUTANEOUS (INTRADERMAL) T
95028	INTRACUTANEOUS (INTRADERMAL) T
95044	PATCH OR APPLICATION TEST(S) (
95060	OPHTHALMIC MUCOUS MEMBRANE TES
95065	NASAL MUCOUS MEMBRANE
95115	ALLER.INJ.W/OUT EXTRACT PROV O
95117	ALLER.INJ.W/OUT EXTRACT PROV-+
95120	IMMUNOTHERAPY(RX MD)-SINGLE AN

Appendix C - Codes Payable to Nurse Practitioners and Clinical Nurse Specialists (reference date 9/29/04)

Proc	Description
95125	IMMUNOTHERAPY(RX MD)MULTIPLE A
95130	IMMUNOTHERAPY(RX MD)1 INSECT V
95131	IMMUNOTHERAPY(RX MD),2 INSECT
95132	IMMUNOTHERAPY;3 INSECT VENOMS
95133	IMMUNOTHERAPY; 4 INSCT VENOMS
95144	PROFESSIONAL SERVICES FOR THE
95145	PROV..+1 INSECT VENOM,SING DOS
95146	PROV;2 INSECT VENOMS,SING.DOSE
95147	PROV;3 INSECT VENOMS,SING.DOSE
95165	PROFESSIONAL SERVICES FOR THE
95170	MD SUPER/PROV;WHOLE BODY EXTRA
95810	POLYSOMNOGRAPHY, 4 OR MORE
95811	POLYSOMNOGRAPHY W/CPAP
95816	EEG W/RECORD AWAKE/DROWSY-STND
95819	EEG-STD/PORT; SAME FACILITY
95822	EEG; SLEEP ONLY
95824	EEG; CEREBRAL DEATH RECORDING
95827	EEG; ALL NIGHT SLEEP RECORDING
95831	TEST MUSCLE,MANUAL;EXTREMITY/T
95832	MUSCLE TESTING; MANUAL; HAND
95833	TEST MUSCLE,MANUAL;TOT BODY/NO
95834	MUSCLE TESTING; MANUAL; TOTAL
95851	RANGE OF MOTION;@ EXTREMITY,NO
95852	RANGE OF MOTION; HAND
95860	ELECTROMYOGRAPH;1 EXTREMITY&PA
95861	ELECTROMYOGRAPH;2 EXTREMITIES&
95863	ELECTROMYOGRAPH;3 EXTREMITIES&
95864	ELECTROMYOGRAPH;4 EXTREMITIES&
95867	MYOGRAPHY; CRANIAL NERVE; UNIL
95868	MYOGRAPHY; CRANIAL NERVE; BILA
95869	ELECTROMYOGRAPHY; SPECIFIC MUS
95870	MUSCLE TEST, NON-PARASPINAL
95872	ELECTROMYOGRAPHY,SING.FIBER,AN
96115	NEUROBEHAVIOR STATUS EXAM
96900	ACTINOTHERAPY
96910	PHOTOCHEMOTHERAPY; TAR AND ULT
96912	PHOTOCHEMOTHERAPY/PUVA
97016	PT-VASOPNEUMATIC DEVICES
97018	PT-PARAFFIN BATH
97032	ELECTRICAL STIMULATION,EACH 15
97033	ELECTRIC CURRENT THERAPY
97110	THERAPEUTIC PROC, ONE OR MORE,
97112	NEROMUSCULAR RED-EDUCATION,EAC
97116	GAIT TRAINING, EACH 15 MIN
97124	MASSAGE, EACH 15 MIN
97520	PROSTHETIC TRAINING; INITIAL 3
97530	THERAPEUTIC ACTIVITIES 15 MINU
97601	WOUND CARE SELECTIVE
97602	WOUND CARE NON-SELECTIVE
97703	PROSTHETIC CHECKOUT
99082	NEO-NATAL ESCORT-PER HOUR
99175	EMESIS INDUCTION WITH MEDICATI
99183	PHYSICIAN ATTENDANCE AND SUPER
99185	REGIONAL HYPOTHERMIA
99186	TOTAL BODY HYPOTHERMIA
99195	PHLEBOTOMY,THERAPEUTIC (SEPAR)
99201	OFFICE,NEW,PROBLEM, STRAIGHTFO
99202	OFFICE,NEW PT,EXPANDED,STRAIGH
99203	OFFICE,NEW PT, DETAILED, LOW C
99204	OFFICE,NEW PT, COMPREHEN, MOD
99205	OFFICE,NEW PT, COMPREHEN, HIGH
99211	OFFICE,EST PT, MINIMAL PROBLEM
99212	OFFICE,EST PT, PROBLEM,STRAITF
99213	OFFICE,EST PT, EXPANDED, LOW C
99214	OFFICE,EST PT, DETAILED, MOD C
99215	OFFICE,EST PT, COMPREHEN,HIGH
99218	INITIAL OBSERVATION CARE, PER
99219	INITIAL OBSERVATION CARE, PER
99220	INITIAL OBSERVATION CARE, PER
99221	INITIAL HOSP,COMPRE,STRTFWD,LO
99222	INITIAL HOSP,COMPRE,MOD CMPLX
99223	INITIAL HOSP,COMPRE, HIGH CMPL

Appendix C - Codes Payable to Nurse Practitioners and Clinical Nurse Specialists (reference date 9/29/04)

Proc	Description
99231	SUBSEQNT HOSP,PRBLM,STRTFWD R
99232	SBSQNT HOSP,XPANDED,MOD CMPLXT
99233	SBSQNT HOSP,DETAILED, HIGH CMP
99234	OBSERV/HOSP SAME DATE
99235	OBSERV/HOSP SAME DATE
99236	OBSERV/HOSP SAME DATE
99238	HOSPITAL DISCHARGE DAY MANAGEM
99243	OFF CNSLT,NRE PT,DTLD, LO CMPL
99244	OFF CNSLT,NRE PT,CMPHSV,MOD CM
99245	OFF CNSLT,NRE PT,CMPHSV,HI CMP
99251	INIT INPT CNSLT,NREST PT,PBLM,
99252	INIT INPT CNSLT,NRE PT,XPND,ST
99253	INIT INPT CNSLT,NRE PT,DTLD,LO
99254	INIT INPT CNSLT,NRE PT,CMPHSV,
99255	INIT INPT CNSLT,NRE PT,CMPHSV,
99261	FU INPT CNSLT,EST PT,PRBLM,STF
99262	F-U INPT CNSLT,EST PT,XPND,MOD
99263	F-U INPT CNSLT,EST PT,DTLD, HI
99281	EMER DEPT VST,PRBLM,STRTFWD
99282	EMER DEPT VST,PRBLM,LOW CMPLXT
99283	EMER DEPT VSTXXPAND,LOW CMPLST
99291	CRITICAL CARE, FIRST HOUR
99292	CRITICAL CARE, EA ADDITIONAL 3
99296	SUBSEQUENT NICU CARE, PER DAY,
99297	SUBSEQUENT NICU CARE, PER DAY,
99311	SBSQT NFC,NEW R EST PT,PBLM,ST
99312	SBSQT NFC,NREST PT,XPND PBLM M
99313	SBSQT NFC,NREST PT,DTLD,MOD/HI
99315	NURSING FAC DISCHARGE DAY
99316	NURSING FAC DISCHARGE DAY
99321	DOM R RST HM VST,PRBLM,STRTFWD
99322	DOM R RST HME VST,NEW PT,XPND,
99323	DOM R RST HM VST,DETAILED,HI C
99331	DOM R RST HM VST, EST PT,PBLM,
99332	DOM R RST HME VST,EST PT,XPND,
99333	DOM R RST HM VST,EST PT,DETLD,
99341	HOME,NEW PT, PROBLM, STRTFWD R
99342	HOME,NEW PT, EXPANDED, MOD COM
99343	HOME,NEW PT, DETAILED, HIGH CO
99344	HOME VISIT, NEW PATIENT
99345	HOME VISIT, NEW PATIENT
99347	HOME VISIT, ESTAB PATIENT
99348	HOME VISIT, ESTAB PATIENT
99349	HOME VISIT, ESTAB PATIENT
99350	HOME VISIT, ESTAB PATIENT
99360	PHYSICIAN STANDBY SERVICE, REQ
99381	INIT E&M HEALTHY INDV,NEW PT,T
99382	INIT E&M HEALTHY INDV,ERLY CHD
99383	INIT E&M HEALTHY INDV,LTE CHLD
99384	INIT E&M HEALTHY INDV,ADOLS,12
99385	INIT E&M,HEALTHY NEW PT,18-21
99391	PERDC REEVAL &MGT HLTHY INDV,I
99392	PERDC REEVAL & MGT HLTHY INDV,
99393	PERDC REEVAL & MGT,LTE CHLD 5-
99394	PERDC REEVAL & MGT, ADOLS 12-1
99395	PERDC RE-E&M,HEALTHY EST PT,18
99429	UNLISTED PREVENTIVE MEDICINE S
99431	HIST/EXAM NORMAL NEWBORN
99432	NORMAL NEWBORN CARE IN OTHER T
99433	SUBSQNT HOSP,NORML NEWBORN,P D
99435	HOSPITAL NB DISCHARGE DAY
99440	NEBORN RESUSCITATION
99499	UNLISTED EVALUATION AND MANAGE

Appendix D

Certified Nurse Midwives

Appendix D – Codes Payable to Certified Nurse Midwives (reference date 9/29/04)

Proc	Description
J7300	INTRAUTERINE COPPER CONTRACEPT
J7302	MIRENA
11975	INSERTION OR REINSERTION, IMPL
11976	REMOVAL WITHOUT REINSERTION, I
11977	REMOVAL WITH REINSERTION, IMPL
11981	INSERT DRUG IMPLANT DEVICE
51600	INJECTION FOR BLADDER X-RAY
51700	IRRIGATION OF BLADDER
51725	SIMPLE CYSTOMETROGRAM
51726	COMPLEX CYSTOMETROGRAM
51741	COMPLEX UROFLOWMETRY
51772	URETHRAL PRESSURE PROFILE STUD
51784	ANAL/URINARY MUSCLE STUDY
51795	VOIDING PRESSURE STUDIES (VP)
51797	INTRA-ABDOMINAL VOIDING PRESSU
56501	DESTROY VULVA LESION(S);SIMPLE
57061	DESTROY VAGINAL LESIONS;SIMPLE
57160	INSERTION OF PESSARY
57170	DIAPHRAGM FITTING.WITH INSTRUC
57452	EXAMINATION OF VAGINA
57505	ENDOCERVICAL CURETTAGE
57511	CRYOCAUTERY OF CERVIX
58100	BIOPSY OF UTERUS LINING
58300	INSERT INTRAUTERINE DEVICE
58301	REMOVE INTRAUTERINE DEVICE
58999	GENITAL SURGERY PROCEDURE
59020	FETAL OXYTOCIN STRESS TEST
59025	FETAL NON-STRESS TEST
59050	INTERNAL FETAL MONITORING/CONS
59300	EPISIOTOMY/VAG REP BY OTHER MD
59410	VAGINAL DELIVERY ONLY-HOSP.CAR
59414	DELIVERY OF PLACENTA FOLL DELI
59430	POSTPARTUM CARE ONLY-SEPARATE
59515	CESAREAN DELIVERY W POSTPARTUM
59610	VBAC DELIVERY
59612	VBAC DELIVERY ONLY
59614	VBAC CARE AFTER DELIVERY
59620	ATTEMPTED VBAC DELIVERY ONLY
76805	ECHO EXAM OF PELVIS
76810	ECHOGRAPHY, PREGNANT UTERUS, B
76815	ECHO EXAM FOR FETAL GROWTH
76816	ECHOGRAPHY..PG UTERUS;FOLLOW-U
76818	FETAL BIOPHYSICAL PROFILE
80050	GENERAL HEALTH SCREEN PANEL
80055	OBSTETRIC PANEL
80061	LIPID PROFILE
80090	ANTIBODY PANEL
80439	THYROTROPIN RELEASING HORMONE
80440	THYROTROPIN RELEASING HORMONE
81000	URINALYSIS WITH MICROSCOPY
81002	ROUTINE URINE ANALYSIS
81005	URINALYSIS
81007	BACTERIA SCREEN B NON-CULT TEC
81015	MICROSCOPIC EXAM OF URINE
81025	URINE PREGNANCY TEST, BY VISUA
82105	ALPHA-FETOPROTEIN;
82270	TEST FECES FOR BLOOD
82465	ASSAY SERUM CHOLESTEROL
82670	RIA ASSAY OF ESTRADIOL
82728	FERRITIN, SPECIFY METHOD
82947	ASSAY BODY FLUID, GLUCOSE
82950	GLUCOSE TEST
82951	GLUCOSE TOLERANCE TEST (GTT)
82955	ASSAY G6PD ENZYME
82962	GLUCOSE, BLOOD, BY GLUCOSE MON
83001	PITUITARY GONADOTROPIN RIA
83002	PITUITARY GONADOTROPINS RIA
83020	ASSAY HEMOGLOBIN
83718	BLOOD LIPOPROTEIN ASSAY
83719	LIPOPROTEIN,VLDL CHOLESTEROL
83721	LIPOPROTEIN, DIRECT MEASUREMEN
83896	NUCLEAR MOLECULAR DIAGNOSTICS;

Appendix D – Codes Payable to Certified Nurse Midwives (reference date 9/29/04)

Proc	Description	Proc	Description
84144	ASSAY PROGESTERONE	86674	ANTIBODY;
84146	RIA ASSAY FOR PROLACTIN	86687	HTLVI, ANTIBODY DETECTION;IMMU
84403	RIA ASSAY BLOOD TESTOSTERONE	86688	ANTIBODY;
84443	RIA ASSAY OF TS HORMONE	86689	CONFIRMATORY TEST
84479	TRIIODOTHYRONINE, RESIN UPTAKE	86694	ANTIBODY;
84702	GONADOTROPIN,CHORIONIC;QUANTIT	86695	ANTIBODY;
84703	GONADOTROPIN,CHORIONIC;QUALITA	86701	ANTIBODY;
85013	BLOOD COUNT;	86702	ANTIBODY;
85014	BLOOD COUNT OTHER THAN SPUN HE	86762	ANTIBODY;
85018	HEMOGLOBIN, COLORIMETRIC	86777	ANTIBODY;
85022	AUTOMATED HEMOGRAM	86778	ANTIBODY;
85023	BLOOD COUNT;HEMO/PLATE.COUNT,A	86781	ANTIBODY;
85024	BLOOD COUNT;HEMO/PLATE,AUTO,AU	86787	ANTIBODY;
85025	BLOOD COUNT;HEMO.PLAT.COUNT,AU	86850	ANTIBODY SCREEN, RBC, EACH SER
85031	MANUAL HEMOGRAM,COMPLETE CBC	86900	BLOOD TYPING;
85044	RETICULOCYTE COUNT	86901	BLOOD TYPING;
85045	RETICULOCYTE COUNT FLOW CYTOME	86910	BLOOD TYPING;
85362	FIBRIN DEGRADATION PRODUCTS	87070	CULTURE SPECIMEN, BACTERIA
85370	FIBRIN(OGEN) DEGRADATION (SPLI	87081	BACTERIA CULTURE SCREEN
85378	FIBRIN DEGRADATION PRODUCTS, D	87086	URINE CULTURE, COLONY COUNT
85379	FIBRIN DEGRADATION PRODUCTS, D	87088	URINE BACTERIA CULTURE
85384	FIBRINOGEN;	87110	CULTURE,CHLAMYDIA
85590	PLATELET PHASE MICROSCOPY	87164	DARK FIELD EXAMINATION
85610	PROTHROMBIN TIME	87177	OVA AND PARASITES SMEARS
85660	RBC SICKLE CELL TEST	87205	SMEAR, STAIN & INTERPRET
85670	THROMBIN TIME; PLASMA	87206	SMEAR, STAIN & INTERPRET
86317	IMMUNOASSAY/INFECTIOUS AGENT	87210	SMEAR, STAIN & INTERPRET
86403	PRECIPITIN (EG, LATEX BEAD) OR	87220	TISSUE EXAMINATION FOR FUNGI
86430	RHEUMATOID FACTOR LATEX FIXATI	87250	VIRUS INOCULATION FOR TEST
86431	RHEUMATOID FACTOR;	87252	VIRUS ID;TISSUE CULT.INOCULATI
86580	TB PATCH OR INTRADERMAL TEST	87253	VIRUS ID;TISS CULT,ADD STDY,@
86585	TB TINE TEST	88150	CYTOPATHOLOGY, PAP SMEAR
86592	SYPHILIS TEST(S),QUALITATIVE	90471	IMMUNIZATION ADMIN, SINGLE
86663	ANTIBODY;	90472	IMMUNIZATION ADMIN, 2+
86664	ANTIBODY;	90703	TETANUS TOXOID FOR TRAUMA
86665	ANTIBODY;	90706	IMMUNIZATION,RUBELLA

Appendix D – Codes Payable to Certified Nurse Midwives (reference date 9/29/04)

Proc	Description
90718	IMMUNIZATION,TD ABSORBED,ADULT
90732	IMMUNIZATION,PNEUMOCOCCAL VAC,
90746	HEPATITIS B VACCINE, OVER 20
90782	IM PROCAINE PENICILLIN/BICILLI
99201	OFFICE,NEW,PROBLEM, STRAIGHTFO
99202	OFFICE,NEW PT,EXPANDED,STRAIGH
99203	OFFICE,NEW PT, DETAILED, LOW C
99204	OFFICE,NEW PT, COMPREHEN, MOD
99205	OFFICE,NEW PT, COMPREHEN, HIGH
99211	OFFICE,EST PT, MINIMAL PROBLEM
99212	OFFICE,EST PT, PROBLEM,STRAITF
99213	OFFICE,EST PT, EXPANDED, LOW C
99214	OFFICE,EST PT, DETAILED, MOD C
99215	OFFICE,EST PT, COMPREHEN,HIGH
99218	INITIAL OBSERVATION CARE, PER
99219	INITIAL OBSERVATION CARE, PER
99220	INITIAL OBSERVATION CARE, PER
99221	INITIAL HOSP,COMPRE,STRTFWD,LO
99222	INITIAL HOSP,COMPRE,MOD CMPLX
99231	SUBSEQNT HOSP,PRBLM,STRTFWD R
99232	SBSQNT HOSP,XPANDED,MOD CMPLXT
99234	OBSERV/HOSP SAME DATE
99235	OBSERV/HOSP SAME DATE
99236	OBSERV/HOSP SAME DATE
99238	DISCHARGE DAY MANAGEM
99239	HOSPITAL DISCHARGE DAY
99241	OFF CONSULT,NRE PT,PRBLM,STRTF
99242	OFF CONSLT,NRE PT,XPND PBLM, S
99243	OFF CNSLT,NRE PT,DTLD, LO CMPL
99251	INIT INPT CNSLT,NREST PT,PBLM,
99252	INIT INPT CNSLT,NRE PT,XPND,ST
99253	INIT INPT CNSLT,NRE PT,DTLD,LO
99261	FU INPT CNSLT,EST PT,PRBLM,STF
99262	F-U INPT CNSLT,EST PT,XPND,MOD
99281	EMER DEPT VST,PRBLM,STRTFWD
99282	EMER DEPT VST,PRBLM,LOW CMPLXT
99283	EMER DEPT VSTXXPAND,LOW CMPLST
99341	HOME,NEW PT, PROBLM, STRTFWD R
99342	HOME,NEW PT, EXPANDED, MOD COM
99343	HOME,NEW PT, DETAILED, HIGH CO
99344	HOME VISIT, NEW PATIENT
99345	HOME VISIT, NEW PATIENT
99347	HOME VISIT, ESTAB PATIENT
99348	HOME VISIT, ESTAB PATIENT
99349	HOME VISIT, ESTAB PATIENT
99350	HOME VISIT, ESTAB PATIENT
99381	INIT E&M HEALTHY INDV,NEW PT,T
99384	INIT E&M HEALTHY INDV,ADOLS,12
99385	INIT E&M,HEALTHY NEW PT,18-21
99391	PERDC REEVAL &MGT HLTHY INDV,I
99394	PERDC REEVAL & MGT, ADOLS 12-1
99395	PERDC RE-E&M,HEALTHY EST PT,18
99431	HIST/EXAM NORMAL NEWBORN
99432	NORMAL NEWBORN CARE IN OTHER T
99433	SUBSQNT HOSP,NORML NEWBORN,P D
99440	NEWBORN RESUSCITATION

Appendix E

Podiatry

Appendix E – Codes Payable to Podiatrists (reference date 9/29/04)

Proc	Description	Proc	Description
A5500	DIAB SHOE FOR DENSITY INSERT	11421	EXCISE BENIGN LESION 0.6 TO 1
A5501	DIABETIC CUSTOM MOLDED SHOE	11422	EXCISE BENIGN LESION 1.1 TO 2C
A5503	DIABETIC SHOE W/ROLLER/ROCKR	11423	EXCISE BENIGN LESION 2.1 TO 3C
A5504	DIABETIC SHOE WITH WEDGE	11424	EXCISE BENIGN LESION 3.1 TO 4C
A5505	DIAB SHOE W/METATARSAL BAR	11426	EXCISE BENIGN LESION OVER 4.0
A5506	DIABETIC SHOE W/OFF SET HEEL	11620	EXCISE MALIGNANCY TO 0.5CM
A5507	MODIFICATION DIABETIC SHOE	11621	EXCISE MALIGNANCY 0.6 TO 1CM
A5508	DIABETIC DELUXE SHOE, PER SHOE	11622	EXCISE MALIGNANCY 1.1 TO 2CM
A5509	DIEBETIC SHOE DIRECT FORMED W/	11623	EXCISE MALIGNANCY 2.1 TO 3CM
A5510	DIEBETIC SHOE DIRECT FORMED PR	11624	EXCISE MALIGNANCY 3.1 TO 4CM
A5511	DIEBETIC SHOE CUSTOM MOLDED CU	11626	EXCISE MALIGNANCY OVER 4CM
G0127	TRIMMING OF DYSTROPHIC NAILS,	11720	DEBRIDE NAIL, 1-5
L1930	AFO,CUSTOM FITTED, PLASTIC	11721	DEBRIDE NAIL, 6 OR MORE
L2104	AFO,FRACTURE ORTHOSIS,TIBIAL F	11730	SIMPLE REMOVAL OF NAIL PLATE
10021	FNA W/O IMAGE	11732	REMOVE ADDITIONAL NAIL PLATES
10060	DRAINAGE OF SKIN ABSCESS	11740	EVACUATE HEMATOMA UNDER NAIL
10061	DRAIN SKIN ABSCESS COMPLICATED	11750	EXCISION NAIL & NAIL MATRIX
10120	SIMPLE REMOVAL FOREIGN BODY	11752	EXCISE NAIL,MATRIX-AMPUTATE TU
10121	COMPLICATED REMOVAL FOREIGN B	11760	SIMPLE RECONSTRUCTION NAIL BED
10140	INCISE/DRAIN SIMPLE HEMATOMA	11762	NAIL RECONSTRUCTION; COMPLICAT
10160	PUNCTURE DRAINAGE OF LESION	11900	INTRALESIONAL INJECTION; UP TO
10180	INCISE/DRAIN COMPLEX POSTOP WO	11901	INTRALESIONAL INJECTION; OVER
11000	DEBRIDE EXT ECZEM/INFECT SKN;T	12001	SIMPLE WOUND REPAIR TO 2.5CM
11001	EACH ADD 10% BODT SURF. DEBRID	12002	SIMPLE WOUND REPAIR 2.6 TO 7.5
11040	DEBRIDE SKIN,PARTIAL THICKNESS	12004	SIMPLE WOUND REPAIR 7.6 TO 12.
11041	DEBRIDE SKIN,FULL THICKNESS	12005	SIMPLE WOUND REPAIR 12.6 TO 20
11042	DEBRIDE SKIN,SUBCUTANEOUS TISS	12006	SIMPLE WOUND REPAIR 20.1 TO 30
11043	DEBRIDE;SKIN,SUBCU TISSUE AND	12007	SIMPLE WOUND REPAIR OVER 30CM
11044	DEBRIDE;SKIN,SUBC TISS,MUSCL &	12020	TREAT SUPER.DEHISCIENCE;SIMPLE
11055	TRIM SKIN LESION	12021	TREAT SUPER.DEHISCIENCE;W/PACK
11056	TRIM 2 TO 4 SKIN LESIONS	12041	LAYER CLOSURE WOUND TO 2.5CM
11057	TRIM OVER 4 SKIN LESIONS	12042	LAYER CLOSURE 2.6 TO 7.5CM
11100	BIOPSY OF SINGLE LESION	12044	LAYER CLOSURE 7.6 TO 12.5CM
11101	BIOPSY OF SKIN,EACH ADD LESION	12046	LAYER CLOSURE 20.1 TO 30CM
11200	EXCISE UP TO 15 SKIN TAGS	12047	LAYER CLOSURE WOUND OVER 30CM
11420	EXCISE BENIGN LESION TO 0.5 CM	13131	COMPLEX REPAIR 1.1 TO 2.5CM

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Proc	Description	Proc	Description
13132	COMPLEX REPAIR 2.6 TO 7.5CM	20100	EXPLORE WOUND, NECK
13160	EXT/COMP SECONDARY CLOSE/DEHIS	20101	EXPLORE WOUND, CHEST
14040	TISSUE TRANSFER; TO 10 SQ CM	20102	EXPLORE WOUND, ABDOMEN
14041	TISSUE TRANSFER; 10.1 TO 30 SQ	20103	EXPLORE WOUND, EXTREMITY
14350	FILLETED FINGER OR TOE FLAP	20150	EXCISE EPIPHYSEAL BAR
15000	PREPARE RECIPIENT GRAFT SITE	20200	BIOPSY,MUSCLE,SUPERFICIAL
15050	PINCH GRAFT; DEFECT UP TO 2CM	20205	BIOPSY,MUSCLE,DEEP
15100	SPLIT GRAFT; UP TO 100 SQ CM	20520	REMOVE FOREIGN BODY; SIMPLE
15120	SPLIT GRAFT; UP TO 100 SQ CM	20525	REMOVE FOREIGN BODY; COMPLICAT
15240	FULL THICK GRAFT TO 20 SQ CM	20526	THER INJECTION CARPAL TUNNEL
15350	APPLY ALLOGRAFT,SKIN	20550	INJECT TENDON SHEATH/LIGAMENT
15400	APPLY XENOGRAFT,SKIN	20551	INJECT TENDON ORIGIN/INSERT
15610	INTERM DELAY FLAP SCALP/LIMBS	20552	INJECT TRIGGER POINT, 1 OR 2
15620	INTERM DELAY FLAP CHIN/NECK/FE	20553	INJECT TRIGGER POINTS, > 3
15740	ISLAND PEDICLE FLAP GRAFT	20600	ARTHROCENTESIS; SMALL JOINT/ B
15750	NEUROVASCULAR PEDICLE GRAFT	20605	ARTHROCENTESIS; MED. JOINT/ BU
15860	IV AGENT/TEST BLOOD FLOW/FLAP-	20650	SKELETAL TRACTION; WIRE OR PIN
16000	INIT TREAT 1ST DEGREE BURN	20670	REMOVE IMPLANT; SUPERFICIAL
16010	DRESS/DEBRID BURN SMALL ANESTH	20680	REMOVE IMPLANT; DEEP
16015	DRESS/DEBRID BURN MED/LG ANEST	20690	APPLY ESTERNAL FIXATION SYS,ST
16020	DRESS/DEBRID BURN SMALL,NO ANE	20838	REPLANT FOOT; TOTAL AMPUTATION
16025	DRESS/DEBRID BURN MED,NO ANEST	20900	BONE GRAFT; ANY DONOR AREA, SM
16030	DRESS/DEBRID BURN LG,NO ANESTH	20902	BONE GRAFT, ANY DONOR AREA; LA
16035	ESCHAROTOMY B	20924	TENDON GRAFT; DISTANT
17000	DESTROY LESION,FACE-1 LESION	20926	TISSUE GRAFTS; OTHER
17003	DESTROY 2-14 LESIONS	20972	FREE OSTEOCUTAN FLAP..;METATAR
17004	DESTROY 15 & MORE LESIONS	20973	FREE OSTEOCUTAN FLAP..;GREAT T
17106	DESTRUCT CUT AN VASC LESIONS<1	20979	US BONE STIMULATION
17107	DESTRUCT CUT VASC LESIONS 10-5	20999	UNLISTED PROCEDURE; BONE/ MUSC
17108	DESTRUCT CUT VASC LESIONS >50	27603	DRAIN LOWER LEG LESION
17110	DESTROY FLAT WARTS,ANY METHOD,	27604	DRAIN LOWER LEG BURSA
17111	DESTRUCT LESION, 15 OR MORE	27605	INCISION OF ACHILLES TENDON
17250	CHEMICAL CAUTERY OF WOUND	27610	EXPLORE/TREAT ANKLE JOINT
17999	SKIN TISSUE PROCEDURE	27612	EXPLORATION OF ANKLE JOINT
20000	INCISION OF ABSCESS; SUPERFICI	27613	BIOPSY LOWER LEG SOFT TISSUE
20005	INCISION OF ABSCESS; DEEP	27614	BIOPSY LOWER LEG SOFT TISSUE D

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Proc	Description	Proc	Description
27615	RAD RESECT TUMOR...LEG OR ANKL	27786	TREATMENT OF ANKLE FRACTURE
27618	REMOVE LOWER LEGLES ION	27788	TREATMENT OF ANKLE FRACTURE
27619	REMOVE LOWER LEG LESION DEEP	27808	TREATMENT OF ANKLE FRACTURE
27620	BIOPSY OF ANKLE JOINT	27810	TREATMENT OF ANKLE FRACTURE
27625	REMOVE ANKLE JOINT LINING	27814	REPAIR OF ANKLE FRACTURE
27626	REMOVE ANKLE JOINT LINING	27816	TREATMENT OF ANKLE FRACTURE
27630	REMOVAL OF TENDON LESION	27818	TREATMENT OF ANKLE FRACTURE
27635	REMOVE LOWER LEG BONE LESION	27822	REPAIR OF ANKLE FRACTURE
27637	REMOVE/GRAFT LEG BONE LESION	27823	REPAIR OF ANKLE FRACTURE
27638	REMOVE/GRAFT LEG BONE LESION	27824	CLOSED TREATMENT OF FRACTURE O
27640	PARTIAL REMOVAL OF TIBIA	27825	CLOSED TREATMENT OF FRACTURE O
27641	PARTIAL REMOVAL OF FIBULA	27826	OPEN TREATMENT OF FRACTURE OF
27645	EXTENSIVE LOWER LEG SURGERY	27827	OPEN TREATMENT OF FRACTURE OF
27646	EXTENSIVE LOWER LEG SURGERY	27828	OPEN TREATMENT OF FRACTURE OF
27647	EXTENSIVE ANKLE/HEEL SURGERY	27829	OPEN TREATMENT OF DISTAL TIBIO
27648	INJECTION FOR ANKLE X-RAY	27830	TREAT LOWER LEG DISLOCATION
27650	REPAIR ACHILLES TENDON	27831	TREAT LOWER LEG DISLOCATION
27652	REPAIR/GRAFT ACHILLES TENDON	27832	REPAIR LOWER LEG DISLOCATION
27654	REPAIR OF ACHILLES TENDON	27840	TREAT ANKLE DISLOCATION
27656	REPAIR FASCIAL DEFECT OF LEG	27842	TREAT ANKLE DISLOCATION
27680	RELEASE OF LOWER LEG TENDON	27846	REPAIR ANKLE DISLOCATION
27681	TENOLYSIS....MULTIPLE, EACHS	27848	REPAIR ANKLE DISLOCATION
27685	REVISION OF LOWER LEG TENDON	27860	FIXATION OF ANKLE JOINT
27686	LENGTHEN/SHORTEN TEND;MULTIPLE	27870	FUSION OF ANKLE JOINT
27690	REVISE LOWER LEG TENDON	27871	FUSION OF TIBIOFIBULAR JOINT
27691	REVISE LOWER LEG TENDON	27888	AMPUTATION OF FOOT AT ANKLE
27692	TRANSFER/PLANT TENDN,EACH ADD	27889	AMPUTATION OF FOOT AT ANKLE
27695	REPAIR OF ANKLE LIGAMENT	27892	DECOMPRESSION FASCIOTOMY, LEG;
27696	REPAIR OF ANKLE LIGAMENTS	27893	DECOMPRESSION FASCIOTOMY, LEG;
27698	REPAIR OF ANKLE LIGAMENT	27894	DECOMPRESSION FASCIOTOMY, LEG;
27700	REVISION OF ANKLE JOINT	27899	LEG/ANKLE SURGERY PROCEDURE
27702	RECONSTRUCT ANKLE JOINT	28001	DRAINAGE OF BURSA OF FOOT
27703	ARTHROPLASTY,SECONDARY RECON.T	28002	TREATMENT OF FOOT INFECTION
27704	REMOVAL OF ANKLE IMPLANT	28003	TREATMENT OF FOOT INFECTION
27760	TREATMENT OF ANKLE FRACTURE	28005	TREAT FOOT BONE LESION
27762	TREATMENT OF ANKLE FRACTURE	28008	INCISION OF FOOT FASCIA

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Proc	Description	Proc	Description
28010	INCISION OF TOE TENDON	28119	REMOVAL OF HEEL SPUR
28011	INCISION OF TOE TENDONS	28120	PART REMOVAL OF ANKLE/HEEL
28020	EXPLORATION OF A FOOT JOINT	28122	PARTIAL REMOVAL OF FOOT BONE
28022	EXPLORATION OF A FOOT JOINT	28124	PARTIAL REMOVAL OF TOE
28024	EXPLORATION OF A TOE JOINT	28126	CONDYLECTOMY...SING. TOE, EACH
28030	REMOVAL OF FOOT NERVE	28130	REMOVAL OF ANKLE BONE
28035	DECOMPRESSION OF TIBIA NERVE	28140	REMOVAL OF METATARSAL
28043	EXCISION OF FOOT LESION	28150	PHALANGECTOMY,TOE, SINGLE, EAC
28045	EXCISION OF FOOT LESION	28153	PARTIAL REMOVAL OF TOE
28046	RAD RESECT TUMOR,SFT TISS-FOOT	28160	HEMIPHALANGECTOMY....TOE,SING.
28050	BIOPSY OF FOOT JOINT LINING	28171	RADICAL RESECTION FOR TUMOR,TA
28052	BIOPSY OF FOOT JOINT LINING	28173	RADICAL RESECTION FOR TUMOR,ME
28054	BIOPSY OF TOE JOINT LINING	28175	RADICAL RESECTION FOR TUMOR PH
28060	PARTIAL REMOVAL FOOT FASCIA	28190	REMOVAL OF FOOT FOREIGN BODY
28062	REMOVAL OF FOOT FASCIA	28192	REMOVAL OF FOOT FOREIGN BODY
28070	SYNOVECTOMY;INTERTAR/TARSOMET,	28193	REMOVAL OF FOOT FOREIGN BODY
28072	SYNOVECTOMY,METATARSOPHAL..JNT	28200	REP/SUT TEND,W/O GRAFT,EACH TE
28080	EXCISE MORTON NEUROMA,SINGLE,E	28202	REP/SUT TEND,SECOND,W/GRFT, EA
28086	EXCISE FOOT TENDON SHEATH	28208	REP/SUT TEND....EACH TENDON
28088	EXCISE FOOT TENDON SHEATH	28210	REP/SUT TEND..W/GRAFT, EACH TE
28090	REMOVAL OF FOOT LESION	28220	RELEASE OF FOOT TENDON
28092	REMOVAL OF TOE LESIONS	28222	RELEASE OF FOOT TENDONS
28100	REMOVAL OF ANKLE/HEEL LESION	28225	RELEASE OF FOOT TENDON
28102	REMOVE/GRAFT FOOT LESION	28226	RELEASE OF FOOT TENDONS
28103	REMOVE/GRAFT FOOT LESION	28230	INCISION OF FOOT TENDON(S)
28104	REMOVAL OF FOOT LESION	28232	INCISION OF TOE TENDON
28106	REMOVE/GRAFT FOOT LESION	28234	INCISION OF FOOT TENDON
28107	REMOVE/GRAFT FOOT LESION	28238	REVISION OF FOOT TENDON
28108	REMOVAL OF TOE LESIONS	28240	RELEASE OF BIG TOE
28110	PART REMOVAL OF METATARSAL	28250	REVISION OF FOOT FASCIA
28111	PART REMOVAL OF METATARSAL	28260	RELEASE OF MIDFOOT JOINT
28112	PART REMOVAL OF METATARSAL	28261	REVISION OF FOOT TENDON
28113	PART REMOVAL OF METATARSAL	28262	REVISION OF FOOT AND ANKLE
28114	REMOVAL OF METATARSAL HEADS	28264	RELEASE OF MIDFOOT JOINT
28116	REVISION OF FOOT	28270	CAPSULOTOMY...EACH JOINT
28118	PARTIAL REMOVAL OF HEEL	28272	CAPSULECTOMY...INTERPHAL.,EACH

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Proc	Description	Proc	Description
28280	FUSION OF TOES	28420	REPAIR/GRAFT HEEL FRACTURE
28285	REVISION OF HAMMERTOE	28430	TREAT CLSD TALUS FX,W/O MANIP
28286	REVISION OF HAMMERTOE	28435	TREAT CLSD TALUS FX,W/ MANIP
28288	OSTECTOMY,PARTIAL..EACH METATA	28436	TREAT CLSD TAL.FX,W/MANIP&PERC
28289	REPAIR HALLUX RIGIDUS	28445	OPEN TX,CLSD/OPEN FX,W/W/O FIX
28290	CORRECTION OF BUNION	28450	TREAT CLSD TARSAL FX;W/O MANIP
28292	CORRECTION OF BUNION	28455	TREAT CLSD TARSAL FX;W/ MANIP,
28293	CORRECTION OF BUNION	28456	OPEN TX CLSD/OPEN FX W/RED&PIN
28294	CORRECTION OF BUNION	28465	OPEN TX,CLSD/OPEN FX,W/W/O FIX
28296	CORRECTION OF BUNION	28470	TREAT CLSD METATAR FX,W/O MANI
28297	BUNION CORREDTION-LAPIDUS TYPE	28475	TREAT CLSD METATAR FX;W/ MANIP
28298	CORRECTION OF BUNION	28476	TREAT CLSD FX,W/MANIP&PINNING,
28299	CORRECTION OF BUNION	28485	OPEN TX,CLSD/OPEN FX W/W/O FIX
28300	INCISION OF HEEL BONE	28490	TREAT BIG TOE FRACTURE
28302	INCISION OF ANKLE BONE	28495	TREAT BIG TOE FRACTURE
28304	INCISION OF MIDFOOT BONES	28496	TREAT CLSD FX GREAT TOE...PINN
28305	INCISE/GRAFT MIDFOOT BONES	28505	REPAIR BIG TOE FRACTURE
28306	INCISION OF METATARSAL	28510	TREAT CLSD FX....W/O MANIP,EAC
28307	SEE 28306;1ST METATARSAL W/BON	28515	TREAT CLSD FX...W/ MANIP., EAC
28308	INCISION OF METATARSAL	28525	OPEN TX,CLSD FX..W/W/O FIX, EA
28309	INCISION OF METATARSALS	28530	TREAT CLOSED SESAMOID FRACTURE
28310	REVISION OF BIG TOE	28531	OPEN TREATMENT OF SESAMOID FRA
28312	REVISION OF TOE	28540	TREAT FOOT DISLOCATION
28313	RECONSTRUCT TOE,SOFT TISSUR ON	28545	TREAT FOOT DISLOCATION
28315	SESAMOIDECTOMY FIRST TOE	28546	TREAT FOOT DISLOCATION
28320	REPAIR OF FOOT BONES	28555	REPAIR FOOT DISLOCATION
28322	REPAIR OF METATARSALS	28570	TREAT FOOT DISLOCATION
28340	RECONSTRUCT TOE,MACRODAC;SFT T	28575	TREAT FOOT DISLOCATION
28341	SEE 28340;REQUIRING BONE RESEC	28576	PERCUTANEOUS SKELETAL FIXATION
28344	RECONSTRUCT TOE;POLYDATYLY	28585	REPAIR FOOT DISLOCATION
28345	SEE Z8344;SYNDACTYLY,W/WO GRFT	28600	TREAT FOOT DISLOCATION
28360	RECONSTRUCT CLEFT FOOT	28605	TREAT FOOT DISLOCATION
28400	TREAT CLSD CALC FX;W/O MANIP	28606	TREAT FOOT DISLOCATION
28405	TREAT CLSD CALC FX W/MANIP...R	28615	REPAIR FOOT DISLOCATION
28406	TREAT CLSD CALC FX,MANIP/FIXAT	28630	TREAT TOE DISLOCATION
28415	REPAIR OF HEEL FRACTURE	28635	TREAT TOE DISLOCATION

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Proc	Description	Proc	Description
28636	PERCUTANEOUS SKELETAL FIXATION	29580	APPLICATION OF PASTE BOOT
28645	REPAIR TOE DISLOCATION	29590	APPLICATION OF FOOT SPLINT
28660	TREAT TOE DISLOCATION	29700	REMOVAL/REVISION OF CAST
28665	TREAT TOE DISLOCATION	29705	REMOVAL/REVISION OF CAST
28666	PERCUTANEOUS SKELETAL FIXATION	29730	WINDOWING OF CAST
28675	REPAIR OF TOE DISLOCATION	29740	WEDGING OF CAST
28705	FUSION OF FOOT BONES	29750	WEDGING OF CLUBFOOT CAST
28715	FUSION OF FOOT BONES	29799	CASTING/STRAPPING PROCEDURE
28725	FUSION OF FOOT BONES	29891	ANKLE ARTHROSCOPY/SURGERY
28730	FUSION OF FOOT BONES	29892	ANKLE ARTHROSCOPY/SURGERY
28735	FUSION OF FOOT BONES	29893	SCOPE, PLANTAR FASCIOTOMY
28737	REVISION OF FOOT BONES	29894	ARTHROSCOPY, ANKLE, SURGICAL;
28740	FUSION OF FOOT BONES	29895	ARTHROSCOPY-PARTIAL SYNOVECTOM
28750	FUSION OF BIG TOE JOINT	29897	ARTHROSCOPY-LIMITED DEBRIDEMEN
28755	FUSION OF BIG TOE JOINT	29898	ARTHROSCOPY-EXT. DEBRIDEMENT
28760	FUSION OF BIG TOE JOINT	29899	ANKLE ARTHROSCOPY/SURGERY
28800	AMPUTATION OF MIDFOOT	29900	MCP JOINT ARTHROSCOPY, DX
28805	AMPUTATION THRU METATARSAL	29901	MCP JOINT ARTHROSCOPY, SURG
28810	AMPUTATION TOE & METATARSAL	29902	MCP JOINT ARTHROSCOPY, SURG
28820	AMPUTATION OF TOE	35190	REP.ACQUIRED/TRAUMA FISTULA-EX
28825	PARTIAL AMPUTATION OF TOE	35226	REPAIR BLOOD VESSEL LESION
28899	FOOT/TOES SURGERY PROCEDURE	35256	REPAIR BLOOD VESSEL LESION
29345	APPLICATION OF LONG LEG CAST	35286	REPAIR BLOOD VESSEL LESION
29355	APPLICATION OF LONG LEG CAST	36415	VENIPUNCTURE MULTIPLE PATIENTS
29358	APPLY LONG LEG CAST BRACE	64450	INJECTION FOR NERVE BLOCK
29365	APPLICATION OF LONG LEG CAST	64702	REVISE FINGER/TOE NERVE
29405	APPLY SHORT LEG CAST	64704	REVISE HAND/FOOT NERVE
29425	APPLY SHORT LEG CAST	64708	REVISE ARM/LEG NERVE
29435	APPLY SHORT LEG CAST	64722	RELIEVE PRESSURE ON NERVE(S)
29440	ADDITION OF WALKER TO CAST	64726	RELEASE FOOT/TOE NERVE
29445	APPLY RIGID LEG CAST	64774	REMOVE SKIN NERVE LESION
29450	APPLICATION OF LEG CAST	64776	REMOVE DIGIT NERVE LESION
29505	APPLICATION LONG LEG SPLINT	64778	EXCISE NEUROMA;EACH ADD DIGIT
29515	APPLICATION LOWER LEG SPLINT	64782	REMOVE LIMB NERVE LESION
29540	STRAPPING OF ANKLE	64783	EXCISE NEUROMA,HAND/FOOT,@ ADD
29550	STRAPPING OF TOES	64788	REMOVE SKIN NERVE LESION

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Proc	Description	Proc	Description
64795	BIOPSY OF NERVE	82947	ASSAY BODY FLUID, GLUCOSE
64831	REPAIR OF DIGIT NERVE	82948	STICK ASSAY OF BLOOD GLUCOSE
64832	SUTURE DIGIT NERVE;@ ADD DIGIT	83051	ASSAY PLASMA HEMOGLOBIN
64834	REPAIR OF HAND OR FOOT NERVE	84450	UV-ASSAY TRANSAMINASE (SGOT)
64837	SUTURE EACH ADD NERVE,HAND OR	84450	UV ASSAY TRANSAMINASE,SGOT
64840	REPAIR OF LEG NERVE	84550	ASSAY BLOOD URIC ACID
64890	NERVE GRAFT, HAND OR FOOT	84560	ASSAY URINE URIC ACID
64891	NERVE GRAFT, HAND OR FOOT	85002	BLEEDING TIME TEST
64892	NERVE GRAFT, ARM OR LEG	85007	DIFFERENTIAL WBC COUNT
64893	NERVE GRAFT, ARM OR LEG	85014	BLOOD COUNT OTHER THAN SPUN HE
64895	NERVE GRAFT, HAND OR FOOT	85014	HEMATOCRIT
64896	NERVE GRAFT, HAND OR FOOT	85018	HEMOGLOBIN, COLORIMETRIC
64897	NERVE GRAFT, ARM OR LEG	85021	AUTOMATED HEMOGRAM
64898	NERVE GRAFT, ARM OR LEG	85022	AUTOMATED HEMOGRAM
64901	NERVE GRAFT,@ ADD NERVE;SING.S	85031	MANUAL HEMOGRAM,COMPLETE CBC
64902	NERVE GRAFT,@ ADD NERVE;MULTI	85610	PROTHROMBIN TIME
64905	NERVE PEDICLE TRANSFER	86430	RHEUMATOID FACTOR LATEX FIXATI
64907	NERVE PEDICLE TRANSFER	87040	BLOOD CULTURE FOR BACTERIA
64999	NERVOUS SYSTEM SURGERY	87070	CULTURE SPECIMEN, BACTERIA
73600	X-RAY EXAM OF ANKLE	87081	BACTERIA CULTURE SCREEN
73600	ANKLE 2 VIEWS	87081	BACTERIA CULTURE SCREEN
73610	X-RAY EXAM OF ANKLE	87101	SKIN FUNGUS CULTURE
73610	ANKLE 4 VIEWS	87181	ANTIBIOTIC SENSITIVITY, EACH
73615	X-RAY ANKLE,ARTHROGRAPHY;SUPER	87210	SMEAR, STAIN & INTERPRET
73620	X-RAY EXAM OF FOOT	87220	TISSUE EXAMINATION FOR FUNGI
73620	FOOT 3 VIEWS	88300	SURGICAL PATHOLOGY, GROSS
73630	X-RAY EXAM OF FOOT	88302	SURGICAL PATHOLOGY, COMPLETE
73630	FOOT 3 VIEWS	88304	SURGICAL PATHOLOGY, COMPLETE
73650	X-RAY EXAM OF HEEL	88305	SURGICAL PATHOLOGY, COMPLETE
73650	HEEL 2 VIEWS	88307	SURGICAL PATHOLOGY, COMPLETE
73660	X-RAY EXAM OF TOE(S)	90782	IM PROCAINE PENICILLIN/BICILLI
73660	TOE 3 VIEWS	90784	THERAPEUTIC INJECTION; IV
76499	RADIOGRAPHIC PROCEDURE	93740	TEMPERATURE GRADIENT STUDIES
81000	URINALYSIS WITH MICROSCOPY	93922	NONINVASIVE PHYSIOLOGIC STUDIE
81002	ROUTINE URINE ANALYSIS	93923	EXTREMITY STUDY
81002	ROUTINE URINALYSIS	93924	EXTREMITY STUDY

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Proc	Description	Proc	Description
93965	NON-INVASIVE PHYSIOLOGIC STUDI	99204	OFFICE,NEW PT, COMPREHEN, MOD
93970	DUPLEX SCAN OF EXTREMITY VEINS	99204	OFC, NEW PT, COMPREHEN, MOD CO
93971	DUPLEX SCAN OF EXTREMITY VEINS	99205	OFFICE,NEW PT, COMPREHEN, HIGH
95831	TEST MUSCLE,MANUAL;EXTREMITY/T	99205	OFC, NEW PT, COMPREHEN, HIGH C
95851	RANGE OF MOTION;@ EXTREMITY,NO	99211	OFFICE,EST PT, MINIMAL PROBLEM
96900	ACTINOTHERAPY	99211	OFC, EST PATIENT, MINIMAL PROB
97001	PHYSICAL THERAPY EVALUATION	99212	OFFICE,EST PT, PROBLEM,STRAITF
97001	PHYSICAL THERAPY EVALUATION	99212	ESTAB PT, PROBLEM STRAIGHTFORW
97003	OCCUPATIONAL THERAPY EVALUATIO	99213	OFFICE,EST PT, EXPANDED, LOW C
97003	OCCUPATIONAL THERAPY EVALUATIO	99213	OFC, EST PT EXPANDED, LOW COMP
97016	PT-VASOPNEUMATIC DEVICES	99214	OFFICE,EST PT, DETAILED, MOD C
97018	PT-PARAFFIN BATH	99214	OFC, ESTAB PT DETAILED, MOD CO
97032	ELECTRICAL STIMULATION,EACH 15	99215	OFFICE,EST PT, COMPREHEN,HIGH
97032	APP OF A MOD TO ONE OR MO AREA	99215	OFC, ESTAB PT, COMPREHEN, HIGH
97033	ELECTRIC CURRENT THERAPY	99218	INITIAL OBSERVATION CARE, PER
97039	UNLISTED MODALITY	99219	INITIAL OBSERVATION CARE, PER
97110	THERAPEUTIC PROC, ONE OR MORE,	99220	INITIAL OBSERVATION CARE, PER
97110	THERAPEUTIC PROCEDURE,LOR MORE	99221	INITIAL HOSP,COMPRE,STRTFWD,LO
97112	PT-NEUROMUSCULAR REDUCTION 15M	99222	INITIAL HOSP,COMPRE,MOD CMPLX
97116	GAIT TRAINING, EACH 15 MIN	99223	INITIAL HOSP,COMPRE, HIGH CMPL
97116	PT - GAIT TRAINING - 30 MIN	99231	SUBSEQNT HOSP,PRBLM,STRTFWD R
97124	MASSAGE, EACH 15 MIN	99232	SBSQNT HOSP,XPANDED,MOD CMPLXT
97124	PT-MASSAGE 15 MIN	99233	SBSQNT HOSP,DETAILED, HIGH CMP
97139	PT-UNLISTED PROCEDUR-SPECIFY	99234	OBSERV/HOSP SAME DATE
97703	PROSTHETIC CHECKOUT	99235	OBSERV/HOSP SAME DATE
97750	PHYSICAL PERFORMANCE TEST, 15	99236	OBSERV/HOSP SAME DATE
97750	PHYSICAL PERFORMANCE TEST 15MI	99238	HOSPITAL DISCHARGE DAY MANAGEM
99082	NEO-NATAL ESCORT-PER HOUR	99241	OFF CONSULT,NRE PT,PRBLM,STRTF
99141	SEDATION, IV/IM OR INHALANT	99242	OFF CONSLT,NRE PT,XPND PBLM, S
99142	SEDATION, ORAL/RECTAL/NASAL	99243	OFF CNSLT,NRE PT,DTLD, LO CMPL
99201	OFFICE,NEW,PROBLEM, STRAIGHTFO	99244	OFF CNSLT,NRE PT,CMPHSV,MOD CM
99201	OFC, NEW PT, PROBLEM STRAIGHTF	99245	OFF CNSLT,NRE PT,CMPHSV,HI CMP
99202	OFFICE,NEW PT,EXPANDED,STRAIGH	99251	INIT INPT CNSLT,NREST PT,PBLM,
99202	OFC, NEW PT, EXPAND STRAIGHTFO	99252	INIT INPT CNSLT,NRE PT,XPND,ST
99203	OFFICE,NEW PT, DETAILED, LOW C	99253	INIT INPT CNSLT,NRE PT,DTLD,LO
99203	OFC, NEW PT, DETAILED LOW COMP	99254	INIT INPT CNSLT,NRE PT,CMPHSV,

Appendix E – Codes Payable to Podiatrists (reference date 9/29/04)

Proc	Description	Proc	Description
99255	INIT INPT CNSLT,NRE PT,CMPHSV,	99342	HOME,NEW PT, EXPANDED, MOD COM
99261	FU INPT CNSLT,EST PT,PRBLM,STF	99343	HOME,NEW PT, DETAILED, HIGH CO
99262	F-U INPT CNSLT,EST PT,XPND,MOD	99344	HOME VISIT, NEW PATIENT
99263	F-U INPT CNSLT,EST PT,DTLD, HI	99345	HOME VISIT, NEW PATIENT
99281	EMER DEPT VST,PRBLM,STRTFWD	99347	HOME VISIT, ESTAB PATIENT
99282	EMER DEPT VST,PRBLM,LOW CMPLXT	99348	HOME VISIT, ESTAB PATIENT
99283	EMER DEPT VSTXXPAND,LOW CMPLST	99349	HOME VISIT, ESTAB PATIENT
99284	EMER DEPT VST,DETAILED,MOD CMP	99350	HOME VISIT, ESTAB PATIENT
99285	EMER DEPT VST,COMPHSV,HIGH CMP	99360	PHYSICIAN STANDBY SERVICE, REQ
99311	SBSQT NFC,NEW R EST PT,PBLM,ST	99381	INIT E&M HEALTHY INDV,NEW PT,T
99312	SBSQT NFC,NREST PT,XPND PBLM M	99382	INIT E&M HEALTHY INDV,ERLY CHD
99313	SBSQT NFC,NREST PT,DTLD,MOD/HI	99383	INIT E&M HEALTHY INDV,LTE CHLD
99315	NURSING FAC DISCHARGE DAY	99384	INIT E&M HEALTHY INDV,ADOLS,12
99316	NURSING FAC DISCHARGE DAY	99385	INIT E&M,HEALTHY NEW PT,18-21
99321	DOM R RST HM VST,PRBLM,STRTFWD	99429	UNLISTED PREVENTIVE MEDICINE S
99322	DOM R RST HME VST,NEW PT,XPND,	99431	HIST/EXAM NORMAL NEWBORN
99323	DOM R RST HM VST,DETAILED,HI C	99432	NORMAL NEWBORN CARE IN OTHER T
99331	DOM R RST HM VST, EST PT,PBLM,	99433	SUBSQNT HOSP,NORML NEWBORN,P D
99332	DOM R RST HME VST,EST PT,XPND,	99435	HOSPITAL NB DISCHARGE DAY
99333	DOM R RST HM VST,EST PT,DETLD,	99440	NEBORN RESUSCITATION
99341	HOME,NEW PT, PROBLM, STRTFWD R		