# CLAIMS RELATED INFORMATION

Hospital claims are to be billed using the Health Insurance Portability and Accountability Act (HIPAA) 837I or most current UB-04 claim form.

This section provides specific billing information for the services outlined below.

## Provider Preventable Conditions

Effective for dates of service July 1, 2012, and thereafter; Louisiana Medicaid is mandated to meet the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for Provider Preventable Conditions (PPC's). The guidance below applies to fee-for-service claims including the shared savings Bayou Health Plans. The Prepaid Bayou Health Plans are required to implement their own procedures for non-payment for the same events when applicable to their enrollees. Providers should contact the plans to obtain additional information.

Provider Preventable Conditions are defined into two separate categories:

1. Healthcare Acquired Conditions (HCAC's) and
2. Other Provider Preventable Conditions (OPPC's).

Health Care Acquired Conditions include Hospital Acquired Conditions (HAC's) as outlined below. Other Provider Preventable Conditions refer to OPPCs (surgery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient).

No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for the patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

- The identified provider preventable conditions would otherwise result in an increase in payment.
- The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.

Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

**The following diagnoses that were not present on admission are considered HCAC:**

| HCAC | Complications and Comorbidities (CC)/ Major Complications and Comorbidities (MCC) (ICD-9-CM Codes) |
|---|---|
| Foreign Object Retained After Surgery | 998.4 (CC)<br>998.7 (CC) |
| Air Embolism | 999.1 (MCC) |
| Blood Incompatibility | 999.60(CC)<br>999.61(CC)<br>999.62(CC)<br>999.63(CC)<br>999.69(CC) |
| Pressure Ulcer Stages III & IV | 707.23 (MCC)<br>707.24 (MCC) |
| Falls and Trauma:<br>• Fracture<br>• Dislocation<br>• Intracranial Injury<br>• Crushing Injury<br>• Burn<br>• Other Injuries | Codes within these ranges on the CC/MCC list:<br>800 – 829<br>830 - 839<br>850 - 854<br>925 - 929<br>940 - 949<br>991 - 994 |
| Catheter-Associated Urinary Tract Infection (UTI) | 996.64 (CC)<br>Also excludes the following from acting as a CC/MCC:<br>112.2 (CC)<br>590.10 (CC)<br>590.11 (MCC)<br>590.2 (MCC)<br>590.3 (CC)<br>590.80 (CC)<br>590.81 (CC)<br>595.0 (CC)<br>597.0 (CC)<br>599.0 (CC) |
| Vascular Catheter-Associated Infection | 999.31 (CC) |
| Manifestations of Poor Glycemic Control:<br>• Diabetic Ketoacidosis<br>• Nonketotic Hyperosmolar Coma<br>• Hypoglycemic Coma<br>• Secondary Diabetes with Ketoacidosis<br>• Secondary Diabetes with Hyperosmolarity | 250.10-250.13(MCC)<br>250.20-250.23(MCC)<br>251.0(CC)<br>249.10-249.11(MCC)<br>249.20-249.21(MCC) |
| | **Complications and Comorbidities (CC)/** |

| HCAC | Major Complications and Comorbidities (MCC) (ICD-9-CM Codes) |
|---|---|
| Surgical Site Infection, Mediastinitis, following Coronary Artery Bypass Graft (CABG) | 519.2 (MCC)<br>And one of the following procedure codes:36.10-36.19 |
| Surgical Site Infection Following Certain Orthopedic Procedures:<br>• Spine<br>• Neck<br>• Shoulder<br>• Elbow | 996.67 (CC)<br>998.59 (CC)<br><br>And one of the following procedure codes:81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85 |
| Surgical Site Infection Following Bariatric Surgery for Obesity:<br>• Laparoscopic Gastric Bypass<br>• Gastroenterostomy<br>• Laparoscopic Gastric Restrictive Surgery | *Principal Diagnosis*: 278.01<br><br>539.01 (CC)<br>539.81 (CC)<br>998.59 (CC)<br><br>And one of the following procedure codes: 44.38, 44.39, or 44.95 |
| Deep Vein Thrombosis and Pulmonary Embolism Following certain Orthopedic Procedures (with exception for pediatric and obstetric population)<br>• Total Knee Replacement<br>• Hip Replacement | 415.11 (MCC)<br>415.13 (MCC)<br>415.19 (MCC)<br>453.40-453.42 (MCC)<br><br>And one of the following procedure codes:00.85-00.87, 81.51-81.52, or 81.54 |

It will be the responsibility of the hospital to determine if the HCAC was the cause for any additional days added to the length of stay.

If there are any days that are attributable to the HCAC, these days are to be reported on the UB-04 as non-covered days utilizing the bill type of 110.

Medicaid will require the Present on Admission (POA) indicators as listed below with all reported diagnosis codes. Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered as present on admission.

**Present on Admission Reporting Options**

| Code | Definition |
|---|---|
| Y | Present at the time of inpatient admission |
| N | Not present at the time of inpatient admission |
| U | Documentation is insufficient to determine if condition is present on admission |
| W | Provider is unable to clinically determine whether condition was present on admission or not |

## Other Provider Preventable Conditions (OPPC's)

Louisiana Medicaid also will not reimburse providers for other provider preventable conditions in any setting as follows:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

If there are any days that are attributable to the OPPC, these days are to be reported on the UB-04 as non-covered days utilizing the bill type of 110.

When a provider encounters a provider preventable condition listed above, they should use the appropriate ICD-9-CM diagnosis code reported in diagnosis position 2-9.

- E876.5-Performance of wrong operation (procedure) on correct patient (existing code)
- E876.6-Performance of operation (procedure) on patient not scheduled for surgery
- E876.7-Performance of correct operation (procedure) on wrong side/body part

  Note: The above codes shall not be reported in the External Cause of Injury (E-code) field.

## Outpatient Hospital Claims

Providers are required to append one of the following applicable HCPCS modifiers to all lines related to the erroneous surgery(s)/procedure(s):

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

In summary, it is the responsibility of the provider to identify and report (through the UB-04) any PPC and not seek payment from Medicaid for any additional expenses incurred as a result of

the PPC. Provider payments may be disallowed or reduced based on a post-payment review of the medical record.

## Blood

The Medicaid Program will pay for all necessary blood while the recipient is hospitalized if other provisions to obtain blood cannot be made. However, every effort must be made to have the blood replaced. To bill for blood on the UB-04 form locator blocks 39 through 41 must be completed, and the total number of units billed must be entered in the Description of Services block.

## Hospital-Based Ambulance Services

If a recipient is transported to a hospital that owns the hospital-based ambulance (ground or air) and is admitted, the ambulance charges must be billed on the UB-04 as part of the inpatient services using revenue code 540.

## Mother/Newborn

Mother and newborn claims must be billed separately. The claim is to include only the mother's room/board and ancillary charges.

When a newborn remains hospitalized after the mother's discharge, the claim must be split billed. The first billing of the newborn claim should be for charges incurred on the dates that the mother was hospitalized. The second billing should be for the days after the mother's discharge. The newborn assumes the mother's discharge date as his/her admit date and the hospital will be required to obtain pre-certification.

## Deliveries with Non-Payable Sterilizations

Medicaid allows payment of an inpatient claim for a delivery/c-section when a non-payable sterilization is performed during the same hospital stay. When there is no valid sterilization form obtained, the procedure code for the sterilization and the diagnosis code associated with the sterilization should not be reported on the claim form, and charges related to the sterilization process should not be included on the claim form.

Providers will continue to receive their per diem for covered charges for these services. Claims for these services will not require any prior or post authorization (other than pre-certification) and may be billed via Electronic Media Claims (EMC) or on paper.

## Split-Billing

Split-billing is permitted/required by the Medicaid Program in the following circumstances.

- Hospitals must split-bill claims at the hospital's fiscal year end.
- Hospitals must split-bill claims when the hospital changes ownership.
- Hospitals must split-bill claims if the charges exceed $999,999.99.

Hospitals have discretion to split bill claims as warranted by other situations that may arise.

**Split-Billing Procedures**

Specific instructions for split-billing on the UB-04 claim form are provided below.

In the *Type of Bill* block (form locator 4), the hospital must enter code 112, 113, or 114 to indicate the specific type of facility, the bill classification, and the frequency for both the first part and the split-billing interim and any subsequent part of the split-billing interim.

In the *Patient Status* block (form locator 17), the hospital must enter a 30 to show that the recipient is "still a patient."

**NOTE:** When split-billing, the hospital should never code the first claim as a discharge.

In the *Remarks* section of the claim form, the hospital must write in the part of stay for which it is split-billing. For example, the hospital should write in "Split-billing for Part 1," if it *is* billing for Part 1.

Providers submitting a hospital claim which crosses the date for the fiscal year end, should complete the claim in two parts: (1) through the date of the fiscal year end and (2) for the first day of the new fiscal year.

## Claims Filing For Outpatient Rehabilitation Services

All outpatient hospital claims for therapy must have a prior authorization (PA) number in form locator 63.

When the revenue code listed at form locator 42 on the UB-04 is 420-424, 430-431, 434, 440-444 or 454, the correct procedure code corresponding to the revenue code must be entered in form locator 44, or the claim will be denied.

Durable medical equipment and medical supplies for the recipient must be prior authorized whether it is provided by the hospital or the DME provider.

## Billing for the Implantation of the Infusion Pump and Catheter

Implantation of the infusion pump must be prior authorized. The surgeon who implants the pump shall submit a PA-01 Form to the Prior Authorization Unit (PAU) as part of the disciplinary team's packet. The surgeon must use his/her individual, rather than the group's provider number on the PA-01. The provider shall bill for the implantation of the intraspinal catheter by using the appropriate code.

These codes are to be billed on the CMS 1500 with the PA number included in item 23. Additionally, assistant surgeons, anesthesiologists and non-anesthesiologists-directed CRNA's may receive payment for appropriate codes associated with this surgery. All billers must include the PA number issued to the requesting physician in order to be reimbursed for the services.

## Billing for the Cost of the Infusion Pump

The cost of the pump is a separate billable item. Hospitals will be reimbursed by Medicaid for their purchase of the infusion pump but must request PA for it by submitting a PA-01 to the PAU. The PA-01 should be submitted as part of the multidisciplinary team's packet. Hospitals will not be given a PA number for the pump until a PA request for the surgery has been received from the surgeon who will perform the procedure. If the surgeon's request is approved, the hospital will be given a PA number for the pump. To be reimbursed for the device the hospitals shall use HCPCS code E0783 (implantable programmable infusion pump) on a CMS 1500 claim form with the letters "DME" written in red across the top of the form.

When preparing to bill for any of these services remember these simple steps:

- When completing the PA-01 use the hospital facility number.
- When billing on the CMS-1500 include the hospital facility number in form locator #33.

## Billing For Replacement Pumps and Catheters

Replacement pumps shall be billed on a CMS 1500 claim form with the letters "DME" in red across the top. A copy of the original authorization letter should be attached for either the pump or the catheter. Use the appropriate covered codes for replacement pumps and catheter.