Exclusions and Limitations

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

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

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

- **Aborted Surgical Procedures**

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

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

  Providers shall not bill Medicaid or the recipient for a missed appointment or any other services not actually provided.

  NOTE: Services that have not been documented are considered services not rendered and are subject to recoupment.

- **Never Events**

  Medicaid will not pay for "never events" or medical procedures performed in error which are preventable and have a serious, adverse impact to the health of the Medicaid recipient. Reimbursement will not be provided when the following "never events" occur:

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

- **Billing for Services Related to Non-Covered Services**

  Louisiana Medicaid does not reimburse for services related to a non-covered service. Any payment received for non-covered and related services is subject to post-payment review and recovery.

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

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

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

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

- **Infertility**

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

- **"New Patient" Evaluation and Management Codes**

  Consistent with *Current Procedural Terminology* (CPT) guidelines, Louisiana Medicaid defines a new patient as one who has not received any professional services from the physician or another physician of the same specialty, who belongs to the same group practice, within the past three years.

  Exception: The initial pre-natal visit of each new pregnancy. (See Obstetrics policy)

- **Pain Management**

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

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

- **Outpatient Visit Service Limits**

  Medically necessary outpatient visits are limited to 12 physician/clinic visits per **calendar** 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.

  Except for prenatal visits modified with -TH, all visits performed at federally qualified health centers, rural health clinics, nursing homes, and skilled nursing facilities will be counted toward the 12 visits per calendar year for recipients over age 21. Nursing home and skilled nursing facility visits should be billed with the appropriate place of service and not as inpatient hospital.

  Visits in excess of 12 per **calendar** year for which medically necessary extensions are not approved, are considered to be a non-covered Medicaid service and are therefore billable to recipients. An extension must have been filed and denied as not medically necessary in order for the visit to be billed to the recipient.

- **Outpatient Visit Service Limits – Medicare/Medicaid Recipients**

  Recipients who are covered by Medicare and Medicaid, but who are not identified as Qualified Medicare Beneficiaries (QMBs), are subject to the same limitation on outpatient medically necessary visits as are Medicaid only recipients. Deductible and coinsurance amounts that result from visits in excess of the 12 per calendar year limit may be billed to dually eligible recipients who are not QMBs, if extensions are not approved for those excess visits. When extensions are not approved for excess visits, the visits are considered a non-covered service.

- **Outpatient Office Visit Extensions**

  In order for the Louisiana Medicaid Program to reimburse outpatient physician visits beyond the maximum allowed visits per **calendar** year, the physician must request an extension from the fiscal intermediary's Prior Authorization Unit. Only those services deemed medically necessary will be granted extensions. Services considered medically necessary must be:

  - Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunctions; and

- Those for which no equally effective, more conservative or less costly course of treatment is available or suitable for the recipient.

These services must be individualized and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, neither more or less than what the recipient requires at that specific point in time.

Although a service may be deemed medically necessary it does not automatically necessitate coverage in the Medicaid Program. Services that are experimental, non-Food and Drug Administration (FDA) approved, investigational, or cosmetic are excluded from Medicaid coverage and will be deemed "not medically necessary." The Medicaid Director, in consultation with the Medicaid Medical Director, may review and authorize services on a case-by-case basis.

All extensions of outpatient visits must be requested **AFTER** the service has been rendered. Clinical notes, recipient history, pathology reports, laboratory reports or other documents supporting the diagnosis and services performed that substantiate the diagnosis that justified the office visit are to be attached to the Physician Outpatient Visit Extension Form (BHSF 158-A). (See Appendix B for information on obtaining a copy of this form)

The physician must complete the top portion of the BHSF 158-A form including the current diagnosis code and appropriate-level *Current Procedural Terminology* (CPT) code that correlates to the diagnosis. Incomplete extension forms will be rejected. Completed forms should be submitted to the fiscal intermediary's Prior Authorization Unit where approval/disapproval will be determined. (See Appendix A for information on where to submit the completed form)

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

For **approved extensions**, the provider should submit a hardcopy claim, with an explanation cover letter and a copy of the approved BHSF 158-A form to the fiscal intermediary's Provider Relations Correspondence Unit. (See Appendix A for information on where to send the claim)