Medical Review

The Medical Review Department is responsible for several functions, including post-procedural review of claims for manually priced procedures and review of designated procedures and diagnoses which require medical documentation to ensure compliance with Medicaid policy.

Expediting Correct Payment

Listed below are suggestions for facilitating correct payment:

- All attachments should be clear, legible, and easy-to-read copies.
- All operative reports should be dated correctly.
- Specific, appropriate diagnosis codes should be used.
- Requested documentation should be submitted as soon as possible so that correct payment can be determined quickly. Requested documentation should be attached behind a copy of the original claim form, as there is no mechanism to match incoming medical records with previously submitted claims.
- All procedures performed under the same anesthesia session should be billed on the same CMS-1500 claim form using correct modifiers and attaching all pertinent documents with the claim.
- Assistant surgeons should always append an -80 modifier on each claim line. Assistant surgeons are not required to use the -51 modifier for secondary procedures.
- All reports (i.e. operative, history and physical, etc.) must be submitted as one-sided for accurate imaging.

Billing Information

Bilateral Procedures

A -50 modifier indicates that a bilateral procedure was performed. Providers should submit the appropriate *Current Procedural Terminology* (CPT) code on one claim line, append modifier -50, and place a "1" in the "units" column of the claim form.

The bilateral modifier may only be appended to the CPT code if the procedure can be surgically performed bilaterally. The -50 modifier is not to be added if the CPT definition reads "unilateral or bilateral".

Reimbursement for bilateral procedures is 150% of the fee on file, or the billed charge, whichever is lower.

Multiple Surgical Reductions

Multiple surgery reduction is the general industry term applied to the practice of paying decreasing pay percentages for multiple surgeries performed during the same surgical session. When more than one surgical procedure is submitted for a patient on the same date of service, the 51 modifier should be appended to the secondary code(s). Certain procedure codes are exempt from this process due to their status as "add-on" or "modifier 51 exempt" codes as defined in CPT.

ClaimCheck allows the system to add or remove the -51 modifier (Multiple Procedures) from the claim, regardless of whether it was applied to the appropriate procedure(s), and then process the claim accordingly. Providers may see the specific ClaimCheck edits when the system identifies such cases.

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.

Multiple Modifiers

Multiple modifiers may be appended to a procedure code when appropriate. Billing multiple surgical procedures and bilateral procedures during the same surgical session should follow Medicaid policy for each type of modifier.

Bilateral secondary procedures should be billed with modifiers 50/51 and if appropriate, will be reimbursed at 75% of the Medicaid allowable fee or 75% of the billed charges, whichever is lowest.

Saline Infusion Sonohysterography or Hysterosalpingography

Claims for catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography must be submitted hardcopy with attachments indicating the purpose for and the radiological interpretation of the procedure.

Reimbursement for this procedure is limited to the assessment of fallopian tube occlusion or ligation following a sterilization procedure.

To meet payment requirements for anesthesia during a hysterosalpingogram, the above criteria must be met.

Louisiana Medicaid does not reimburse for the diagnosis and/or treatment of infertility.

Fetal Non-stress Test

Fetal non-stress test is payable only in the following instances:

- Post-date/post-maturity pregnancies (after 41 weeks gestation)
- The treating physician has reason to suspect potential fetal problems in a "normal" pregnancy. If so, the diagnosis should reflect this.
- High-risk pregnancies, including but not limited to diabetic patient, toxemia, pre-eclampsia, eclampsia, multiple gestation, and previous intrauterine fetal death.

If the place of service is either inpatient or outpatient hospital, or the billing physician is rendering the "interpretation" only in his/her office, only the professional component modifier should be used.

NOTE: See the Obstetrics section for additional information.

Unlisted Procedures

Claims submitted for unlisted procedure codes are subject to review. Providers should not bill unlisted procedure codes when standard codes exist which describe the service. If a CPT code exists describing the service, the claim will be denied. Operative reports or documentation justifying the procedure should be submitted hardcopy each time an unlisted procedure code is billed. The reports should accurately describe the unlisted procedure. Underlining such portions of the report that describe the services performed will expedite the medical review process.

Reduction Mammaplasty

Reduction mammaplasty must be considered medically necessary. The patient must suffer from severe, intractable, debilitating symptoms not amenable to other therapeutic efforts to relieve distress such as proper supportive appliances, weight reduction, and/or general physical conditioning. The recipient must have exceedingly large breasts in relation to body size, posing a threat to her health.

The recipient must meet the following weight and height criteria before the provider is to submit a request for evaluation and consideration for reduction mammoplasty services. The patient's

total weight shall not exceed twenty percent of the weight limit established by the following formula.

Height	Pounds
5 feet	100
Each additional inch over 5 ft.	5

For example: A request for reduction mammoplasty services shall not be submitted for consideration for a recipient who is 5 feet tall and who weighs more than 120 pounds (100 pounds plus 20%). A person who is 5 feet one inch tall shall weigh no more than 126 pounds (105 pounds plus 20%) to be considered. A recipient who is 5 feet, 5 inches tall shall weigh no more than 150 pounds (125 pounds plus 20%) to be considered.

Prior Authorization

When the qualifying condition stated above is met, providers may then submit a request for prior authorization for reduction mammoplasty upon which the determination of medical necessity will be made.

The following documentation must accompany the request for the prior authorization of reduction mammoplasty services:

- Posterior photo view of the shoulder straps area,
- Frontal photo of chest with face blocked;
- Lateral photo of chest and;
- Number of grams of breast tissue to be removed from each breast.

Payment Requirements

The pathology report and the Request for Prior Authorization (PA-01 Form) or the PA approval letter must be attached to the claim submitted for payment to the fiscal intermediary. The CMS-1500 claim form cannot be electronically transmitted. The claim will be denied payment if the above requirements are not attached to the claim.

When medically necessary, Louisiana Medicaid reimburses the removal of breast implants.