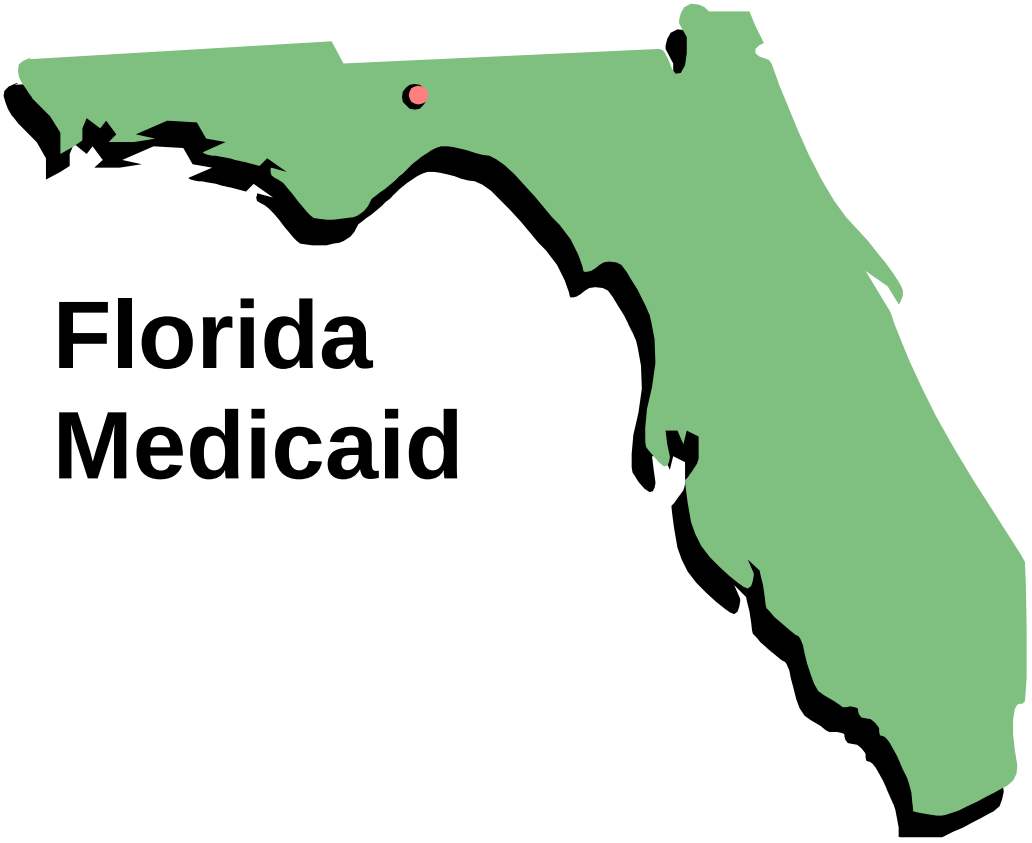

Florida Medicaid

HOSPITAL SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

December 2011

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

UPDATE LOG
HOSPITAL SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update will be issued as a completely revised handbook.

It is very important that the provider read the updated material in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update describes the change that was made.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 1-800-289-7799.

UPDATE	EFFECTIVE DATE
Revised Handbook	May 2000
Revised Pages	January 2001
Revised Pages	January 2002
Replacement Pages	March 2003
Remove Appendix C	January 2005
Revised Handbook	June 2005
Revised	December 2011

HOSPITAL SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

Table of Contents

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- *Provider General Handbook* describes the Florida Medicaid Program.
- *Coverage and Limitations Handbooks* explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- *Reimbursement Handbooks* describe how to complete and file claims for reimbursement from Medicaid.

All Florida Medicaid Handbooks may be accessed via the internet at: www.mymedicaid-florida.com/. Select *Public Information for Providers*, then *Provider Support* and then *Handbooks*.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act;
- Title 42 of the Code of Federal Regulations;
- Chapter 409, Florida Statutes; and
- Chapter 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to provide the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	The term “recipient” is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a short and regular way of displaying difficult, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Note	Note is used most frequently to refer the user to important material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an “Update” and the “Effective Date.”
How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may be: 1. Replacement handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy. 2. Revised handbook – Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.

Handbook Updates, continued

Effective Date of New Material	The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.
New Label and New Information Block	A new label and a new information block will be identified with yellow highlight to the entire section.
New Material in an Existing Information Block or Paragraph	New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence and/or paragraph affected by the change.

CHAPTER 1
HOSPITAL SERVICES
PROVIDER QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

This chapter describes the Medicaid inpatient and outpatient hospital policies and services that are covered, limited, or excluded.

Background

The federal authority governing the hospital program is Title 42, Code of Federal Regulations (CFR), Part 440.10, Inpatient Hospital Services, and Part 440.20, Outpatient Hospital Services. The state authority for licensing of hospitals is Chapter 395, Part 1, Florida Statutes, and Chapter 59, Florida Administrative Code.

In This Chapter

This chapter contains:

Purpose and Description

Purpose

The purpose of the Medicaid Hospital Services Program is to provide medically necessary inpatient and outpatient services to recipients in the hospital.

Description of Inpatient Services

Inpatient services are rendered to recipients who are admitted to a hospital and are *expected* to stay at least 24 hours and occupy a bed, even if a bed is not actually utilized because the recipient is discharged or transferred to another hospital.

A physician or dentist can render inpatient care and treatment.

Purpose and Description, continued

Description of Outpatient Services

Outpatient services are those rendered in a hospital for a specific minor surgical procedure or other treatment that is *expected* to keep recipients in the hospital less than 24 hours.

Unless severity of illness (SI) and medical necessity warrant inpatient admission, a recipient is considered an outpatient if the stay is less than 24 hours, whether or not a bed is used or the recipient remains in the hospital past midnight.

Outpatient services are preventative, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a physician or dentist.

Purpose of This Handbook

This handbook is intended for use by hospital providers. It contains Medicaid inpatient and outpatient hospital policies and regulations that impact the delivery of hospital services to eligible recipients. The handbook also provides physicians with information regarding covered, limited, and excluded hospital services.

The handbook must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, UB-04, which contains specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which contains general information about the Medicaid program.

Hospital Provider Types

Introduction

This section describes the types of hospitals that can enroll in Medicaid and render inpatient and outpatient hospital services to Medicaid recipients, and the requirements for participation in the program.

Types of Hospitals

Medicaid enrolls the following types of hospitals in the program:

- General acute care hospitals; and
- Comprehensive medical rehabilitation hospitals.

Exclusions of Institutions for Mental Diseases

Freestanding psychiatric hospitals cannot enroll in the Medicaid Hospital Services Program. These hospitals are referred to as Institutions for Mental Diseases (IMDs). An IMD is a hospital of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

Hospital Provider Types, continued

Exclusions of Institutions for Mental Diseases, continued

A critical criterion for evaluating whether a facility is primarily acute care or an IMD is to verify the admission diagnosis of each patient. If more than 50 percent of the patients have mental diseases that require inpatient treatment according to the patients' records, then the facility is an IMD, not an acute care hospital, and it cannot participate in the Medicaid Hospital Services Program.

Hospital Enrollment

Enrollment Requirements

To participate in the Medicaid program and receive payment for inpatient and outpatient hospital services, a hospital must:

- Be licensed as a general or specialty hospital under Chapter 395, Part 1, Florida Statutes. The hospital must be maintained primarily for the medical care and treatment of recipients with disorders other than mental diseases;
- Be certified or certifiable in the Medicare program;
- Provide the service in the state of Florida, except for those Alabama and Georgia hospitals that are licensed in their respective states and that routinely provide hospital services to Florida recipients;
- Not be currently under suspension from Florida's or any other state's Medicaid or Medicare program;
- Submit a projected budget or a copy of the Medicare cost report when a cost history situation allows;
- Sign an Institutional Medicaid Provider Agreement;
- Have in effect a utilization review plan, approved and monitored by the peer review organization (PRO), which provides for the review of services to Medicaid recipients in accordance with the agreement between the Medicaid and the hospital; and
- Comply with the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the American Disabilities Act of 1990.

Provider Responsibility

General Requirements

In addition to the general requirements and responsibilities that are contained in the Florida Medicaid Provider General Handbook, hospital providers are also responsible for complying with the provisions contained in this section.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes health insurance more "portable" so that workers may take their health insurance with them when they moved from one job to another, without losing health coverage. This federal legislation also requires the health care industry to adopt uniform codes and forms to streamline the processing and use of health data and claims. HIPAA also provides protection for the privacy of people's health care information and gives them greater access to that information.

HIPAA Responsibilities

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, UB-04.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 866-586-0961 or 800-289-7799, select option 3.

CHAPTER 2
HOSPITAL SERVICES
COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

This chapter describes covered services, limitations, and exclusions for inpatient and outpatient hospital services. All information applies to both inpatient and outpatient services unless specifically indicated as being one or the other.

In This Chapter

This chapter contains:

Covered Services and Limitations

Medical Necessity

Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider's service, and are:

- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Covered Services and Limitations, continued

Medical Necessity, continued

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services medically necessary or a covered service.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically necessary.

Medicaid Reimbursement

Medicaid pays a per diem (daily rate) for inpatient hospital care and treatment. The per diem covers all services and items furnished during a 24-hour period. Total payment for an inpatient claim equals the number of covered inpatient days times the per diem minus any third party payments. The per diem is selected based on the later of the following:

- The date of admission;
- The recipient's eligibility date; and
- The peer review organization's (PRO) certified FROM date.

For outpatient hospital services, Medicaid pays a line item rate. A line item rate applies one time to each covered outpatient revenue center code billed, regardless of the charges.

Reimbursement for outpatient laboratory and pathology services is the lesser of the amount charged or a technical fee. These services are identified by a 5-digit code that must accompany laboratory and pathology revenue codes 0300 through 0314.

Note: See Appendix B of this handbook for a list of covered outpatient revenue center codes and the Florida Medicaid Provider Reimbursement Schedule for a list of the 5-digit laboratory and pathology codes.

Covered Services and Limitations, continued

Abortions

Federal regulations allow payment for abortions only for specific reasons and require the physician to certify the reason for the abortion.

Medicaid reimburses for abortions for one of the following reasons:

- The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, which would place the woman in danger of death unless an abortion is performed;
- To save the life of the mother;
- When the pregnancy is the result of rape as defined in section 794.011, Florida Statutes; and
- When the pregnancy is the result of incest as defined in section 826.04, Florida Statutes.

Abortion procedures may be reimbursed for only the following diagnoses: 635.00 through 635.92. These diagnosis codes require a fifth digit for reimbursement.

The physician must record the reason for the abortion in the recipient's medical records.

Abortions: Certification Form

An Abortion Certification Form must be completed and signed by the physician who performed the abortion. The form must be submitted with the hospital and the physician claim form.

Note: See the Florida Medicaid Provider Reimbursement Handbook, UB-04, for a copy of the Abortion Certification Form and the instructions for completing the form.

Blood

A maximum of three pints of blood or the equivalent quantities of packed red blood cells are covered per recipient, per fiscal year (July through June).

Blood replacement fees are not reimbursable by Medicaid.

Cochlear Implant

Cochlear implant services provide restoration of auditory capacity to children with hearing loss that is not improved through documented use of a hearing aid.

Hospitals may be reimbursed only for implantation services. The Medicaid Hearing Services Program reimburses cochlear implant vendors for the cochlear device.

Covered Services and Limitations, continued

Covered Inpatient Days

Recipients under 21 do not have a limit on inpatient days. In the state fiscal year, which is July 1—June 30, recipients under 21 have a maximum of 365 days of inpatient services, and 366 days in a leap year.

Medicaid inpatient coverage is available via Medicaid fee-for-service for recipients under 21 who are enrolled in a Medicaid HMO and have exhausted their HMO inpatient benefits.

Recipients 21 and over have a maximum of 45 days per fiscal year.

Inpatient days due to an emergency admission may be eligible for payment beyond the 45-day cap limit if the emergency criteria in the federal Balanced Budget Act of 1997 (BBA) are met. Providers must submit the claim to Medicaid headquarters for consideration of reimbursement over the 45-day inpatient cap.

Note: See Appendix F for the BBA exceptions to the 45-day cap limit and for claim submission details.

Denials of Inpatient Stays

When inpatient services are denied by the peer review organization (PRO) or the utilization review committee (URC), any inpatient service provided that is also covered under outpatient hospital services may be billed as outpatient.

Dental Services in the Hospital

Hospitalization solely for dental treatment that is not covered under the Medicaid Dental Services Program is not reimbursable in the inpatient or outpatient hospital setting.

Medicaid will reimburse for covered dental treatment provided in the inpatient or outpatient hospital setting when one of the following conditions is met:

- The recipient's health will be so jeopardized that the procedures cannot be performed safely in the office; and
- The recipient is uncontrollable due to emotional instability or developmental disability and sedation has proven to be an ineffective intervention.

The necessity for treatment in a hospital or ambulatory surgery center must be clearly documented in the recipient's dental record.

A primary diagnosis of mental retardation is not, in and of itself, a reason to hospitalize a patient for the provision of dental services.

Covered Services and Limitations, continued

Diagnostic and Therapeutic Services	Diagnostic and therapeutic services and supplies furnished by the hospital during the inpatient stay are covered in the per diem and are not to be billed separately. In the outpatient setting, payment is made separately for each service as long as the service is covered.
Dialysis Services	Dialysis services are those provided for the artificial and mechanical removal of toxic materials and the maintenance of fluid, electrolyte, and acid-base balances in cases of impaired or absent kidney function. Dialysis services are reimbursable in an inpatient or outpatient hospital setting and freestanding dialysis centers when rendered by or under the direct supervision of a physician. A hospital must have a certified outpatient End-Stage Renal Dialysis Program in order to provide dialysis services in the outpatient setting. Inpatient renal dialysis treatments are covered for recipients undergoing short term dialysis until the kidneys recover from acute illness or for recipients with borderline renal failure who develop acute renal failure when they have an illness and require episodic dialysis. A recipient may begin dialysis as an inpatient and then progress to an outpatient status. Renal dialysis treatments performed in the outpatient hospital setting are covered for routine chronic dialysis treatments and are payable through the applicable revenue center code. For recipients who are age 21 and older, dialysis services are exempt from the outpatient $1,500 cap.
Drugs and Biologicals	Drugs and biologicals furnished by the hospital for use during the inpatient stay are included in the per diem. When furnished in the outpatient setting, they are paid for separately if there are revenue codes that identify them as covered services. The term “biologicals” refers to medicinal compounds that are prepared from living organisms and their products. They include serums, vaccines, antigens, and antitoxins.

Covered Services and Limitations, continued

Emergencies

Outpatient emergency room services, dressings, splints, oxygen, and physician ordered services and supplies medically necessary for the clinical treatment of an emergency medical condition are reimbursed based on a line item rate when the applicable revenue center code is covered. In the inpatient setting, these items and supplies are included in the per diem rate.

Florida Medicaid will reimburse one emergency room visit, per recipient, per day unless additional claims differ significantly in diagnosis or services provided. Hospitals must send such claims to the area Medicaid office for processing. The area Medicaid office staff may request medical records to support payment.

Note: The phone numbers and addresses for the area Medicaid offices are in Appendix C of the Florida Medicaid Provider General Handbook. They are also available on the AHCA website at http://ahca.myflorida.com.

Emergencies: In-state Nonparticipating Hospitals

Emergency care provided by an in-state nonparticipating hospital is reimbursable only until the recipient is sufficiently stabilized and can be moved to a participating hospital.

In-state nonparticipating hospitals are reimbursed the lesser of the amount charged or the average of per diems paid to participating hospitals in the same county.

Emergencies: Out-of-State Hospitals

Emergency services provided to Florida recipients in out-of-state hospitals are reimbursable in the following instances:

- An emergency arises from an accident or illness;
- The health of the recipient would be endangered if the care or services were postponed until he returned to Florida; and
- The health of the recipient would be endangered if he undertook travel to return to Florida.

Out-of-state nonparticipating general hospitals are reimbursed the lesser of the amount charged or the average of per diems paid to participating Florida hospitals in effect at the time the services were rendered.

Out-of-state nonparticipating teaching and specialty hospitals are reimbursed the lesser of the amount charged or the average of per diems paid to participating Florida specialty and teaching hospitals in effect at the time the services were rendered.

Covered Services and Limitations, continued

Emergencies: Medicaid for Aliens

The Medicaid Hospital Services Program reimburses for emergency services provided to aliens who meet all Medicaid eligibility requirements except for citizenship or alien status.

Eligibility can be authorized only for the duration of the emergency. Medicaid will not pay for continuous or episodic services after the emergency has been alleviated. Dialysis is considered an emergency service.

All claims must be accompanied by documentation of the emergency nature of the service, such as history and physical, emergency room report, and discharge summary. Exceptions are labor and delivery and dialysis. These services are considered emergencies and are payable without documentation when the emergency indicator is entered on the claim form.

Individuals eligible for Emergency Medicaid for Aliens are assigned the following program codes:

- MLS—Emergency Medicaid Alien, Aged or Disabled;
- MLA—Emergency Medicaid Alien, Low Income Family (LIF);
- NLS—Medically Needy, Emergency Alien, Aged or Disabled; and
- NLA—Medically Needy, Emergency Alien, Low Income Family (LIF).

These codes indicate the Medicaid coverage is only for the duration of the emergency.

Note: See the Glossary, Appendix D, in the Florida Medicaid Provider General Handbook for the definition of emergency.

Note: See the Medicaid Provider Reimbursement Handbook, UB-04, for instructions on entering an emergency indicator.

EMTALA Medical Screening Exam

The federal Emergency Medical Treatment and Labor Act (EMTALA) requires emergency rooms to conduct a medical screening exam on any patient presenting to the emergency room for medical services. The purpose of the medical screening exam is to determine if an emergency medical condition exists. If the screening determines that an emergency medical condition exists, the provider must either stabilize the condition or appropriately transfer the patient to a facility that can stabilize the condition.

Florida Medicaid will reimburse based on a line item rate for covered revenue codes.

Covered Services and Limitations, continued

Family Planning Services

Family planning services provided to Medicaid recipients of childbearing age are for the purpose of spacing children or preventing pregnancies.

Inpatient and outpatient hospital services to family planning recipients are limited to sterilization procedures and related incidental services. Claims for sterilization procedure reimbursement must be submitted with family planning diagnosis codes: V25.01 through V25.9.

Family Planning Waiver Services

The family planning waiver extends eligibility for family planning services for 24 months to postpartum women who have had a Medicaid-financed delivery, other postpartum service, or miscarriage within two years prior to the date of losing their Medicaid eligibility.

Inpatient hospital services are not covered for this group of recipients.

In the outpatient setting, the following sterilization procedures are covered: HCPCS 58600, 58615, 58670, and 58671. The sterilization procedures will be reimbursed if they are submitted with family planning diagnosis codes: V25.01 through V25.9. The lab codes listed in Appendix E are also covered in the outpatient setting if billed with a diagnosis code in one the following ranges:

- 054.0-054.9;
- 078.0-078.19;
- 079.88,079.98;
- 090.3-099.9;
- 112.0-112.9;
- 131.0-131.9; and
- 634.0-634.9.

Note: See the Florida Medicaid Provider General Handbook for additional information on Family Planning Waiver Services.

Foster Children: Out-of-State

Florida Title IV-E foster care and adoption subsidy children residing out-of-state are covered under the Medicaid program in their state of residence.

Non-Title IV-E Florida foster children living out-of-state are considered Florida residents and are covered under the Florida Medicaid program for services in out-of-state hospitals. They are not required to meet emergency criteria.

Covered Services and Limitations, continued

Hospice Recipient: Care for Conditions Unrelated to Hospice Diagnosis	When a Medicaid hospice recipient is admitted to a Medicaid-participating hospital for treatment of a condition unrelated to the diagnosis for which hospice services were elected, payment is made by Medicaid to the hospital. The hospice continues to provide routine hospice care while the recipient is hospitalized. Prior to reimbursement, the hospice must provide documentation to the area Medicaid office certifying that the condition for which the recipient is being hospitalized is unrelated to the terminal condition for which hospice was elected and is not part of the hospice plan of care. The certification must be signed and dated by the hospice medical director. The hospice claim with the hospice medical director certification must be submitted to the area Medicaid office. If the area Medicaid office determines the hospital admission is totally unrelated to the terminal diagnosis, both the hospice claim and the hospital claim will be paid.
Hospital Interns and Residents	The inpatient per diem includes the services of the physician interns and residents salaried by the hospital. These individuals may not bill Medicaid separately.
Hysterectomies	Hysterectomies are reimbursable except when they are performed for the purpose of rendering a recipient permanently sterile or incapable of reproducing. Some hysterectomy procedures must meet specific requirements before payment can be made.
Hysterectomy Reimbursement	A claim for hysterectomy reimbursement must be submitted on a paper UB-04 claim form, because either the Acknowledgement of Receipt of Hysterectomy Form or the Exception to Acknowledgement for Hysterectomy Form must be submitted with the claim.

Covered Services and Limitations, continued

Hysterectomy: Acknowledgement of Receipt of Hysterectomy Form

An Acknowledgment of Receipt of Hysterectomy Information form must be submitted with the UB-04. This form indicates that prior to the procedure the recipient or her representative was informed orally and in writing that the procedure will make her incapable of reproducing. In acknowledgment, the recipient or her representative signs the form.

Note: See the Florida Medicaid Provider Reimbursement Handbook, UB-04, for instructions on how to complete the Acknowledgment of Receipt of Hysterectomy Form.

Hysterectomy: Exception to Hysterectomy Acknowledgement Form

An Exception to Hysterectomy Acknowledgment Requirement form must be submitted with the UB-04 if any of the conditions listed below are present. The physician who performs the surgery must certify that one of the following conditions existed:

- The recipient is sterile. The cause of the sterility must be identified;
- The procedure was performed under a life-threatening situation. The doctor must describe the emergency; and
- The recipient is post menopausal.

Note: See the Florida Medicaid Provider Reimbursement Handbook, UB-04, for instructions on how to complete the Exception to Hysterectomy Acknowledgment Requirement form.

Hysterectomy: Retroactive Medicaid Eligibility

The physician who performs a hysterectomy during a period of a recipient's retroactive Medicaid eligibility must certify in writing that the recipient was informed before the operation that the hysterectomy would make her permanently incapable of reproducing or that one of the conditions listed above was met. The appropriate hysterectomy form must be submitted with the claim for payment.

Intrathecal Baclofen Therapy (ITB)

Prior authorization for Intrathecal Baclofen Therapy (ITB) must be requested from the Agency for Health Care Administration (AHCA) by the physician. The hospital must have this prior authorization form before payment for the ITB device can be made.

The physician should submit all prior authorization requests for ITB to:

Agency for Health Care Administration
ATTN: ITB Coordinator
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308

No facsimile prior authorizations are accepted.

Covered Services and Limitations, continued

Intrathecal Baclofen Therapy (ITB), continued

If Medicaid approves the device, the Medicaid ITB coordinator will fax the coversheet of the prior authorization request to the requesting provider.

Reimbursement will be made through the gross adjustment process.

Note: The physician's procedure to insert the device is covered by Medicaid and requires no prior authorization. Only the device requires prior authorization and must be requested by the physician, not the hospital.

Requesting hospital providers must provide the following documentation for reimbursement:

Medical records, including report of operation, showing the date of the surgery and that implantation of the ITB pump was performed.

A copy of the prior authorization page that was faxed by the physician.

Submit all requests for reimbursement and supporting documentation to:

Agency for Health Care Administration
ATTN: ITB Coordinator
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308

Laboratory and Pathology Services

Laboratory and pathology services are covered outpatient services for Medicaid recipients. See the Florida Medicaid Provider Reimbursement Schedule for a list of covered laboratory and pathology codes and corresponding fees. The appropriate HCPCS code from the Florida Medicaid Provider Reimbursement Schedule must accompany the lab revenue center codes (0300 through 0314) found in Appendix B of this handbook.

Note: The Florida Medicaid Provider Reimbursement Schedule is available on the Medicaid fiscal agent's website at www.mymedicaid-florida.com. Click on Provider Support, then on Fees.

Laboratory and Pathology Services: Organ and Disease Panels

There are test combinations for specific organ or disease oriented panels. When all of the individual component tests that make up a particular panel are performed, Medicaid will reimburse only for the panel, not for the individual tests.

When the components of one panel are duplicated in another panel, only one panel code must be billed. Individual tests not included in the panel may be billed separately.

Note: See Appendix C of this handbook for a list of the panels, procedure codes, and the individual tests that constitute each panel.

Covered Services and Limitations, continued

Mammography: Recommended Screening Referral

Referral for routine screening mammography is recommended by the American Cancer Society for all females age 35 and older, as follows:

- Age 35 to 39, one screening baseline mammogram;
- Age 40 and over, one screening mammogram every year.

A screening mammogram is limited to one per year.

A diagnostic mammogram that is used to evaluate or monitor an abnormal finding is allowed more than once a year.

Mammograms performed by a mobile x-ray provider are not reimbursable.

Note: See Appendix D of this handbook for the list of diagnosis codes required for the reimbursement of mammograms.

Newborn: Eligibility

A newborn child whose mother is Medicaid eligible at the time of birth and who resides with the mother is eligible for up to one year from the date of birth.

Newborn: Medicaid ID Number

A newborn without a Medicaid ID number must be referred to the local Department of Children and Families office using the Medical Assistance Referral Form, DCF-ES 2039, to request that the newborn be added to the Medicaid eligibility file. The mother's name and Medicaid ID number must be provided on the form. The newborn's eligibility will be determined by the Department of Children and Families.

If a pregnant woman has obtained a Medicaid identification number and gold card for her unborn child, the Unborn Activation Form must be completed and submitted to the Medicaid fiscal agent for activation once the child is born.

Note: See the Florida Medicaid Provider General Handbook for a sample copy of each form and instructions for completing the DCF-ES 2039.

Newborn: Concurrent Stay

When the mother is Medicaid eligible, Medicaid pays the inpatient per diem rate for concurrent days of stay for the mother and the newborn. Concurrent means that mother and baby are in the hospital for the same duration of time.

The claim is billed using the mother's name and Medicaid ID number and includes all charges for the mother and the newborn. The per diem is payment in full for both.

When the newborn is an eligible recipient and the mother is not, the claim is billed in the newborn's name and Medicaid ID number for the concurrent days. Medicaid will reimburse for nursery services only. The per diem rate is payment in full for the newborn.

Covered Services and Limitations, continued

Newborn: Nonconcurrent Stay	If the newborn stays in the hospital after the mother's discharge, this is referred to as a nonconcurrent stay and is considered a new admission. The claim is billed in the newborn's name and Medicaid ID number. When billing this type of claim, enter the entire hospitalization span (date of mother's admit through date of newborn's discharge) in Form Locator 6 of the UB-04. Also enter code 42 followed by the mother's discharge date in Form Locator 32-35 of the UB-04. Payment will be made from the mother's discharge date through the newborn's discharge date. Note: Refer to the Florida Medicaid Reimbursement Handbook, UB-04, for details on prior authorization requirements for nonconcurrent newborn claims. Refer to Chapter 1 for other billing details related to nonconcurrent newborn claims.
Nursing and Related Services	Nursing and other related services, use of hospital facilities, and medical and social services furnished by the hospital during the inpatient stay are included in the per diem. In the outpatient setting, these services are reimbursed the line item rate when they are covered services and can be identified with a covered outpatient revenue center code.
Observation Services	Observation services are those furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff. They are services that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered when provided by the order of a physician and when they are not followed by an inpatient admission. Observation services do not usually exceed one day. Some patients, however, may require a second day of observation services. Services for routine post-operative monitoring during a normal recovery period must not be billed as observation services. Medicaid reimburses up to 48 hours of observation services if the observation services are not followed by an inpatient admission. Hospitals are not expected to substitute outpatient observation services for medically appropriate inpatient admissions. Inpatients should not be discharged to outpatient observation services. Observation services must be billed one claim per observation day, in the same manner as all other outpatient services. Consecutive days of observation must be billed one claim per day.

Covered Services and Limitations, continued

Outpatient: Maximum Reimbursement and Cap Exemptions	Adult recipients, 21 years of age and older, are limited to $1,500 entitlement per fiscal year for outpatient hospital services, excluding certain medical and surgical procedures, dialysis services, and chemotherapy services. Outpatient services due to an emergency admission may be eligible for payment beyond the $1,500 cap limit, if emergency criteria in the federal Balanced Budget Act of 1997 (BBA) are met. If the emergency criteria are met, providers may submit a claim for reimbursement over the $1,500 outpatient cap. Recipients under the age of 21 have no limit on outpatient services, but services must be medically necessary as determined by a physician. Note: See Appendix B of this handbook for asterisked outpatient revenue center codes that are exempt from the $1,500 cap. Procedures in the HCPCS range 10000-69999 that are reimbursable in the outpatient setting are exempt from the $1,500 cap. Note: See Appendix F for the BBA exceptions to the 45-day cap limit and for claim submission details.
Outpatient Revenue Code Items and Services	All items and services identified by a specific outpatient revenue center code listed in Appendix B of this handbook are covered.
Outpatient Surgery	All outpatient surgical procedures are exempt from the outpatient $1,500 cap. Surgical procedures performed in the outpatient hospital setting are limited to those that: • Are commonly performed on an inpatient basis, but may be safely performing in the outpatient hospital setting; • Are not commonly performed in a physician's office, nor are they procedures that can be safely performed in a physician's office; • Do not generally exceed a total of 90 minutes operating time; • Require local or regional anesthesia, or general anesthesia of 90 minutes or less duration; and • Do not generally result in extensive blood loss, require major or prolonged involved invasion of body cavities, directly involve major blood vessels, or involve emergency or life threatening situations.

Covered Services and Limitations, continued

Out-of-State Referrals

Florida Medicaid recipients may be referred to out-of-state hospitals if the required services are not available in Florida. Prior authorization from the headquarters' Medicaid office (not the Peer Review Organization) is required for such referrals.

Note: See the Florida Medicaid Provider Reimbursement Handbook, UB-04, for more information on out-of-state prior approval requirements.

Sterilization Services

Sterilization procedures performed in the inpatient and outpatient hospital setting are for the primary purpose of rendering a recipient incapable of reproducing and are voluntary procedures reimbursable by Medicaid. The following criteria must be met:

- The recipient must be at least 21 years old at the time of signing the consent form;
- The recipient must be mentally competent and not institutionalized in a correctional, penal, or rehabilitation facility or a facility for mental diseases;
- A Florida Medicaid Sterilization Consent Form must be correctly completed at least 30 days prior to sterilization. This form is valid for 180 days from the date of recipient's signature. Consent for sterilization cannot be obtained during:
  - ⇨ Labor, childbirth, or an abortion;
  - ⇨ A period of time when the recipient is under the influence of alcohol or other agents affecting awareness; and
- When premature delivery is marked on the consent form, the expected date of delivery must be entered. There must be 30 days between the expected date of delivery and the date the consent form is signed. If premature delivery or emergency abdominal surgery occurs between 72 hours and 30 days following the consent signature, an exception is allowed.

Note: See the Florida Medicaid Provider Reimbursement Handbook, UB-04, for a sample of the Sterilization Consent Form and the instructions on how to complete it.

Covered Services and Limitations, continued

Sterilizations: Consent Form	A Sterilization Consent Form must be submitted with the UB-04. Note: See the Florida Medicaid Provider Reimbursement Handbook, UB-04, for instructions on how to complete the Sterilization Consent Form.
Sterilizations: Exceptions to Consent Form	Tubal ligations are medically necessary on an inpatient basis if performed within 48 hours following a normal delivery and performed during the same hospital stay. Otherwise tubal ligations are not reimbursable as an inpatient procedure without documentation that inpatient setting is medically warranted. A Florida Medicaid Sterilization Consent Form is not required when a sterilization procedure is performed in conjunction with a child delivery, vaginal or cesarean. All code references to a sterilization procedure must be deleted from the UB-04 claim form so the claim can be processed without a consent form.
Supplies	Supplies, appliances, and equipment furnished by the hospital during the inpatient stay are included in the per diem. When furnished in the outpatient hospital setting, these items are paid the line item rate if the services and applicable revenue center codes identifying them are specifically covered for that place of service.
Therapies: Outpatient	Physical and respiratory therapies are covered for recipients of all ages. Occupational and speech therapies are covered for recipients under 21 years of age only. These services are reimbursed the line item rate.
Ultrasounds for High Risk Pregnant Women	An initial and a maximum of three follow-up ultrasounds are covered in the outpatient hospital setting for high risk pregnant women without the need to attach documentation of medical necessity. Multiple gestations have no limit on the number of follow-up ultrasounds. One ultrasound is covered for a low risk pregnant woman per pregnancy. Note: Follow-up ultrasounds are reimbursable for recipients who have a high-risk diagnosis listed in Appendix H of this handbook.

Newborn Hearing Screenings

Description

The newborn hearing screening is for the purpose of testing all Medicaid eligible newborns for hearing impairment to alleviate the adverse effects of hearing loss on speech and language development, academic performance, and cognitive development. The screening is a test or battery of tests administered to determine the need for an in-depth hearing diagnostic evaluation.

Section 383.145, Florida Statutes, requires each licensed hospital that provides maternity and newborn care services to conduct and complete hearing screening services on newborns prior to discharge. If for a valid reason, including an initial screening failure, the screening cannot be completed before discharge, the newborn must be referred for an appointment for a hearing screening within 30 days from hospital discharge. Referral may be made to a Medicaid physician's office, to a community Medicaid hearing services provider, or to the outpatient hospital setting. Written documentation of the referral must be placed in the newborn's medical chart at the hospital.

Who Can Perform Screenings

All newborn and infant hearing screenings must be conducted by an audiologist licensed under Chapter 468, Florida Statutes, who meets the requirements of Section 1861(11)(3)(13) of the Social Security Act; a physician licensed under Chapter 458 or 459, Florida Statutes; or an individual who has completed documented training specifically for newborn hearing screenings and who is directly or indirectly supervised by a licensed physician or licensed audiologist.

Direct supervision means the licensed physician or licensed audiologist:

- Is on the premises when the services are rendered; and
- Reviews, signs, and dates the medical record.

Indirect supervision means the licensed physician or licensed audiologist:

- Has established a well defined protocol by which the supervised individual performs the services;
- Is available, so as to be physically present to provide consultation or direction in a timely fashion as required for appropriate care of the patient; and
- Reviews, signs, and dates the medical record.

Eligible Recipients

Medicaid reimburses for newborn hearing screenings for all eligible recipients from birth through 12 months of age.

Newborn Hearing Screenings, continued

Required Service Components

The required service components for infant hearing screening include at a minimum:

- Recipient's name;
- Screening method (i.e., OAE or ABR);
- Screening outcome for each ear; and
- Any risk factors related to hearing loss.

Allowable Reimbursement

Medicaid will reimburse the initial newborn hearing screening procedure as a supplement to the usual per diem.

Reimbursement for the newborn hearing screening is made through Medicaid fee for service, even if the newborn is enrolled in MediPass or a managed care plan.

Hospital providers will be reimbursed in one of two ways: a global fee or a technical component only fee. Medicaid reimburses the global fee, which comprises a technical component and a professional component, to the hospital if it is using its own equipment and medical personnel to render the newborn hearing screening. Medicaid reimburses only the technical component to the hospital when it has contracted with or has an agreement with a Medicaid hearing screening provider from the community to conduct the screening at the hospital using hospital-owned equipment.

Billing Methodology

All newborn hearing screening claims must contain revenue code 0471 and the corresponding hearing screening HCPCS procedure code.

For an inpatient concurrent stay (mother and newborn are discharged together after delivery), the newborn hearing screening is billed on the mother's inpatient delivery claim.

For a nonconcurrent stay (mother is discharged but the newborn stays in the hospital), the newborn hearing screening is billed on the newborn's inpatient claim under his own name and Medicaid ID number.

If the screening cannot be conducted during the birth inpatient stay and is performed later in the outpatient hospital setting rather than in the office of a Medicaid physician or hearing provider in the community, the hospital bills the newborn hearing screening as an outpatient service.

If a Medicaid newborn is covered by an HMO or Provider Service Network (PSN), the hospital must complete a UB-04 claim under the newborn's name and Medicaid ID number to bill only the hearing screening separately for payment under Medicaid fee for service. The HMO and PSN remain responsible for reimbursement of all other services.

Note: See Appendix G for the revenue center and HCPCS codes for billing for newborn hearing services.

Newborn Hearing Screenings, continued

Required Referrals	Any child who is diagnosed as having a permanent hearing impairment must be referred to the primary care physician for medical management, treatment, and follow-up services. In addition, in accordance with the Infants and Toddlers Program and the Individuals with Disabilities Education Act (Public Law 105-17), any child from birth to 36 months of age who is identified as having a hearing impairment that requires ongoing special hearing services must be referred within two calendar days of identification to the Children's Medical Services, Early Intervention Program serving the geographical area in which the child resides.
Refusal of Service	If the newborn's parent or legal guardian objects to a screening, the screening must not be completed. The hearing services provider must maintain a record that the hearing screening was not performed and attach a written objection that is signed by the parent or guardian.
Prior Authorization Requirements	There are no prior authorization requirements for newborn hearing screenings. Medicaid-eligible children who are enrolled in MediPass, HMOs, or PSNs do not require pre-authorization. Providers may bill Medicaid for screening services and receive the Medicaid rate of reimbursement.
Requirements for Medical Records	Appropriate written documentation of service (or referral if necessary) must be placed in the recipient's medical record within 24 hours after the provider completes the screening procedure or within 24 hours of the parent's or guardian's signed refusal of screening. The documentation must include the following: • Type of screen test administered, date of test, and tester's name; • Results; • Interpretation; • Recommendations; • Follow-up referrals for treatment, if applicable; and • Parent's or guardian's refusal of screening, if applicable.
Service Limitations	Medicaid reimburses a maximum of two newborn hearing screenings per eligible newborn using auditory brainstem response, evoked otoacoustic emissions, or appropriate technology as approved by the United States Food and Drug Administration. If the screening procedure is interrupted because of recipient status or excessive noise, then the screening procedure must continue as soon as appropriate until a pass, fail, or refer outcome is achieved. Medicaid reimburses the second screening only if the child does not pass the initial hearing screening test in each ear.

Organ and Bone Marrow Transplant Services

Description

Organ and bone marrow transplant services are performed by specialized transplant physicians in an Agency for Health Care Administration (AHCA), Medicaid-designated transplant hospital for the purpose of replacing a vital solid organ or bone marrow that is no longer functional with an organ or bone marrow from a human donor.

Guidelines for Transplantation

Organ transplantation guidelines are based on Medicare and the United Network of Organ Sharing (UNOS) criteria as adopted by the Organ Transplant Advisory Council, section 765.53, Florida Statutes.

Bone marrow transplant reimbursement guidelines are based on Rule 59B-12.001, Florida Administrative Code, as adopted by the Organ Transplant Advisory Council.

Medically Accepted Determination

Determinations for medically-accepted transplants are established within the guidelines of the AHCA Organ Transplant Advisory Council, the AHCA Bone Marrow Transplant Advisory Panel, and the Medicaid medical consultants.

Acceptance for transplant candidacy is determined by the designated transplant hospital performing the comprehensive evaluation.

Reimbursement of Medicaid-covered organ or tissue transplants is limited to those services that are determined to be reasonable, medically necessary and standard medical procedures.

Bone Marrow, Cord Blood, and Stem Cell Transplants

Medicaid considers cord blood and stem cell transplants as synonymous with bone marrow transplants. For the purposes of reimbursement under Medicaid, these transplants utilize the same illnesses, diagnoses, conditions, and disease states for which bone marrow transplant procedures are acceptable. Medicaid does review individual cases within the guidelines of the Organ Transplant Advisory Council on a case-by-case basis when medically indicated.

Organ and Bone Marrow Transplant Services, continued

Age 20 and Under	For recipients age 20 years and under, Medicaid reimburses transplants that are medically necessary and determined covered by the Medicaid medical consultant and the Organ Transplant Advisory Council. Recipients 20 years of age and under should be enrolled Children's Medical Services (CMS), a Division of the Florida Department of Health, for case management and assistance.
Age 21 and Over	For recipients age 21 and over, Medicaid reimburses kidney, heart, cornea, liver, lung, and bone marrow transplants that are medically necessary and determined covered by the Medicaid medical consultant and the Organ Transplant Advisory Council.
AHCA Designated Transplant Centers	Transplants are restricted to organ transplant programs approved by the Secretary for AHCA, based on the recommendations of the Organ Transplant Advisory Council and the Florida Medicaid Program. All transplant hospitals must request the AHCA transplant center designation by writing to the Secretary for AHCA and requesting the initial documentation criteria, standards, and preparation instructions for an on-site inspection by the Organ Transplant Advisory Council. All out-of-state transplant hospitals must have Medicare certification. Note: Contact the area Medicaid office for a list of AHCA-designated transplant centers. See Appendix C in the Florida Medicaid Provider General Handbook for a list of area Medicaid office telephone numbers. Area office telephone numbers are also available on the Internet at http://ahca.myflorida.com.
Recipients with Primary Payer Other than Medicaid	Claims for recipients with a primary payer other than Medicaid are subject to all standard third party liability policy requirements for in- or out-of-state care. Claims for recipients with a primary payer other than Medicaid are not eligible for the global reimbursement payment methodology.
In-State Evaluations and Transplants	In-state evaluations and transplants must be performed in Florida at AHCA-designated transplant centers.

Organ and Bone Marrow Transplant Services, continued

Out-of-State Evaluations and Transplants

Out-of-state transplants and evaluations must be authorized by Medicaid prior to the recipient being transferred to the out-of-state facility for care. Prior authorizations for out-of-state transplants must be initiated by the transplant physician at the AHCA-designated transplant center in Florida. They can be approved only when there is a special medical condition or a lack of a facility in Florida to perform the particular transplant.

Prior authorizations for organ transplants are valid for 365 days.

Transplants will not be authorized at any out-of-state facility unless the evaluating transplant physician at the AHCA-designated transplant center in Florida recommends that the procedure be performed out-of-state.

MediPass authorization by the primary care provider (PCP), or any other form of authorization by a primary care provider, is not considered prior authorization for out-of-state organ and bone marrow transplant services.

Note: See the Florida Medicaid Provider Reimbursement Handbook, UB-04, for general information on prior authorizations and a copy of the Florida Medicaid Prior Authorization Request Form.

Heart and Liver Transplants Recipients Age 21 and Older

Heart and liver transplant evaluations and transplant surgery for recipients age 21 and older must be prior authorized by the Medicaid medical consultant for reimbursement.

Adult heart and liver evaluations and transplants are reimbursed with a global fee.

Organ and Bone Marrow Transplant Services, continued

Adult Heart and Liver Transplant Consultation	A consultation by a heart or liver transplant specialist at an AHCA-designated heart or liver transplant center must be completed prior to the submission of the prior authorization request for the comprehensive heart or liver transplant evaluation. A copy of the consultation must be attached to the prior authorization request with documentation stating the patient qualifies for a heart or liver transplant evaluation. The initial consultation is reimbursed on a fee-for-service basis and is not included in the global reimbursement of the heart or liver transplant evaluation.
Adult Heart and Liver Transplant Evaluation	The adult heart and liver transplant comprehensive evaluation must be performed at an AHCA-designated heart or liver transplant facility. The comprehensive heart or liver transplant evaluation is determined by the AHCA-designated facility's heart or liver transplant team to determine candidacy for a transplant surgical procedure. The comprehensive heart or liver transplant evaluation may be performed in either the inpatient hospital setting, if the recipient requires hospitalization, or outpatient hospital setting. Reimbursement for the comprehensive heart or liver transplant evaluation is not available until all final results of the evaluation are made available to the Medicaid medical consultant and the recipient is either approved and listed with the United Network of Organ Sharing (UNOS) or is determined a non-candidate.
Adult Heart or Liver Transplant Surgery	If approved, accepted and listed with UNOS, the AHCA-designated center must notify Medicaid headquarters. A copy of the following documents must be forwarded to the transplant coordinator for global reimbursement to occur: • A complete copy of the comprehensive heart or liver transplant evaluation; • UNOS listing date and status; and • Completed prior authorization request for transplant surgical services.
Adult Heart or Liver Transplant Global Reimbursement	Adult heart or liver transplant services are reimbursed an all-inclusive global payment to include the facility and physician fees for the comprehensive evaluation, transplant surgery, and related follow-up care for 365 days post discharge. All non-transplant related care is separately reimbursable to the facility. Reimbursement is the per-diem rate established for that facility. All normal program limitations apply.

Organ and Bone Marrow Transplant Services, continued

Prior Authorization Process and Documentation

Requests for prior authorization must include the following documentation:

- Florida Medicaid Prior Authorization Request Form, completed and signed by a Florida transplant physician for the organ transplant specialty team, that states the type of transplant requested;
- Description of the medical condition that necessitates the transplant;
- Statement regarding the recipient's prognosis and life expectancy with and without the transplant;
- Identification of treatment alternatives considered, used, and discarded, and why;
- Documentation of a comprehensive examination, evaluation, and recommendation for a transplant by a board-certified or board-eligible specialist in the field directly related to the condition necessitating the transplant; and
- Name, address, and contact person of the requested out-of-state facility and physician.

Transplants: Out-of-State Home Health

When a recipient receives a transplant out of the state of Florida, the recipient can receive medically necessary home health services in the out-of-state setting.

The out-of-state home health services must be prior authorized by the Florida Medicaid Transplant Coordinator at the address noted above.

Where to Submit Prior Authorization Requests

Submit all prior authorization requests for transplants to:

Bureau of Medicaid Services
ATTN: Transplant Coordinator
Building 3, Mail Stop 20
2727 Mahan Drive
Tallahassee, FL 32308

No facsimile requests are accepted.

Organ and Bone Marrow Transplant Services, continued

Transplant Surgery

If the recipient is accepted for transplantation, and it is a Medicaid-covered procedure, the following additional documentation will be required, if not already provided:

- A statement from the transplant hospital and the transplant physician recommending and accepting the recipient for a transplant and the results of their evaluation;
- A comprehensive psychosocial evaluation of the recipient and family by a board-certified psychiatrist, to include the recipient's history of substance abuse and compliance with medical treatment;
- An evaluation of the recipient's discharge plans, including assessment of adequate support systems; and
- All information necessary to support the need for a transplant, including the evaluation for possible contraindications.

Children's Medical Services Enrollment

If the recipient is enrolled in the CMS, the CMS nurse must be contacted for coordination and processing of all medical records. All necessary documents must be forwarded to the Medicaid Organ Transplant Coordinator. The CMS nurse will also provide pretransplant and post transplant case management.

Pretransplant and Post Transplant Care

A recipient who receives a transplant that is not covered under Medicaid may be eligible for pretransplant and post transplant care. Pretransplant and post transplant medical care are reimbursable if medically necessary and appropriate as determined by the Medicaid medical consultant.

Medicaid can reimburse for those services considered as "wrap around charges" for the pre- and post transplant episode of any non-reimbursable transplant service, provided the clinical protocol is reviewed by Medicaid and the transplant service is approved through the prior authorization process by the AHCA Organ Transplant Advisory Council.

Pretransplant medical care coverage ends the day before the transplant surgery.

Post transplant medical care coverage begins when the recipient is discharged from the inpatient hospital following the transplant procedure.

All Medicaid program limitations apply to the services received.

Organ and Bone Marrow Transplant Services, continued

Anti-Rejection Medications	Anti-rejection medications and other medications prescribed specifically for use in preventing organ rejection are reimbursable under the Medicaid Prescribed Drug Program, even if the transplant was not reimbursed by Medicaid. Medications must be FDA approved for use as a primary or adjunct therapy for the prevention of organ rejection. All Medicaid Prescribed Drug Program limitations and restrictions apply.
Non-FDA Approved Medications	Medicaid reimbursement is not available for non-FDA approved medications. Reimbursement is not available for transplant surgery if experimental or non-FDA approved medications are included in the transplant protocol.
Procurement	Organ procurement costs and allogenic tissue typing, searches, and matches are included in the reimbursement for the transplant procedure. These costs are not separately billable items.
Donor Expenses	Medicaid does not reimburse for cadaveric or living donor expenses, even if the donor is a Medicaid-eligible recipient. Medicaid does not reimburse for organ transplant procedures involving living donor organs, except for kidney transplants.

Florida Inpatient Admissions

Authorization for Inpatient Admissions

Effective March 1, 2002, Medicaid recipient admissions in Florida for medical, surgical, and rehabilitative services must be authorized by a peer review organization (PRO). The purpose of authorizing inpatient admissions is to ensure that inpatient services are medically necessary.

Certain types of admission, e.g., emergencies, are exempt from prior authorization by the PRO; other types do not require authorization to be admitted to the hospital, but the PRO must authorize the concurrent and continued inpatient stays. The hospitalization of certain recipients is also exempt from prior authorization by the PRO. Details are provided in Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, UB-04.

For recipients who are retroactively Medicaid eligible and already discharged from the hospital, the PRO performs a retrospective prepayment review of their admission and inpatient stay before Medicaid payment can be made.

The PRO issues a ten-digit prior authorization number to the hospital provider for each approved admission and continued stay. The entry of the prior authorization number on the UB-04 claim form is required for Medicaid payment. The ten-digit authorization number must be entered in Form Locator 63A if Medicaid is the primary payer, or 63B if Medicaid is the secondary payer.

Prior authorizations are valid for 120 days.

Note: See the Florida Medicaid Provider Reimbursement Handbook, UB-04, for information on the authorization process and exemptions.

Admission Day

The day of admission is covered under the inpatient per diem. Admission and discharge on the same day is reimbursable as one day of service.

Discharge Day

The day a recipient is discharged from the hospital is not a covered day, unless, as noted above, admission and discharge are on the same day.

Grace Days or Administrative Days

Grace days or administrative days are non-medically necessary days following the day of formal discharge when the recipient continues to occupy a hospital bed until an outside facility or residence can be found. These days are not reimbursable by Medicaid except for children under 21 years of age on "Department of Children and Families hold." Medicaid will pay up to 48 hours of inpatient stay beyond the formal discharge day for these children while an alternative placement is located.

Late Discharges

Medicaid does not reimburse for late discharges when a recipient, who for personal reasons continues to occupy a room beyond discharge checkout time.

Florida Inpatient Admissions, continued

23-Hour Stay

When a Medicaid patient is admitted to a hospital bed, but later is discharged or is transferred to another hospital in less than 24 hours, the services can be billed as inpatient if severity of illness (SI) and medical necessity are present. If on admission to the hospital the patient does not meet SI screens and the utilization review committee determines that the stay is not medically necessary, the services must be billed as outpatient.

When the peer review organization (PRO) retrospectively denies an inpatient stay, the hospital can void the inpatient hospital bill and rebill the services as outpatient services if Medicaid covers the services for the outpatient setting. This requires the hospital to bill services using appropriate and covered revenue center codes from Appendix B of this handbook. Only one day's services are billable on one outpatient claim.

Inpatient Accommodations

The inpatient per diem rate pays for a bed in a semi-private room with two, three, or four beds in a room. The same semi-private rate is paid whether the recipient is placed in a private room, medically necessary or not, or ward accommodations.

Private Room: Medically Necessary

A private room is medically necessary when isolation of a recipient is required to avoid jeopardizing his health or recovery, or that of other patients who are likely to be alarmed or disturbed by the recipient's symptoms or treatment or subjected to infection by the recipient's communicable disease. Communicable diseases, heart attacks, cerebro-vascular accidents, and psychotic episodes, for example, may require isolation of the recipient for certain periods.

A physician must order a medically-necessary private room.

Only Private Rooms Available

A private room is considered medically necessary (even if the recipient's condition does not require isolation) when the recipient's medical condition requires immediate hospitalization and the hospital does not have semi-private or ward accommodations available at the time of admission.

In this situation, Medicaid reimbursement at the semi-private rate is payment in full. The recipient cannot be billed the charge differential between the private and semi-private room.

Florida Inpatient Admissions, continued

Private Room for Personal Convenience

A hospital having both private and semi-private accommodations may charge the recipient, relative, or other person acting on his behalf, a differential for a private room if:

- The private room is not medically necessary; and
- The recipient, relative, or other person acting on his behalf, has requested the private room and the hospital informs him at the time of the request of the amount of the charge.

The private room differential may not exceed the difference between the customary charge for the accommodations furnished and the most prevalent semi-private accommodation rate in effect at the time of the recipient's admission. Customary charge means the amount the hospital is uniformly and currently charging for specific services and accommodations. The most prevalent rate or charge is the rate that applies to the greatest number of semi-private or private beds in the hospital.

All-Private Room Hospitals

If a Medicaid recipient is admitted to a hospital that has only private room accommodations and no semi-private or ward accommodations, medical necessity will be deemed to exist for the accommodations furnished. Recipients may not be subjected to an extra charge for a private room in an all-private hospital.

Leaves of Absence

The day on which a hospital inpatient begins a leave of absence is treated as a day of discharge and is not counted as an inpatient day. The day on which the recipient returns is treated as a new admission. However, if the patient returns to the hospital before midnight of the same day he left, this day is covered as an inpatient day and is not treated as a noncovered discharge day. This circumstance does not affect the inpatient's length of stay.

Florida Inpatient Admissions, continued

Outpatient to Inpatient Transfers

A recipient is sometimes admitted to the hospital as an inpatient after receiving outpatient services. In these circumstances, the following situations need to be considered for billing purposes.

- If a recipient is admitted as an inpatient on the same day that he received outpatient services, the inpatient admit date is the date he received the outpatient services. The outpatient charges incurred are added to the inpatient bill. No outpatient claim is billed to Medicaid;
- When a recipient is admitted as an inpatient before midnight of the day following the day he received outpatient services, the inpatient admit date is the date he is admitted as an inpatient. All outpatient services provided within two calendar days of an inpatient admission, including observation services, are added to the inpatient bill. No outpatient claim is billed to Medicaid; and
- When a recipient has surgery in the outpatient setting before being transferred to the inpatient setting on the day following the outpatient surgery, the inpatient admit date is the date he is admitted as an inpatient. However, because outpatient charges have to be transferred on to the inpatient bill, the outpatient surgery ICD-9 procedure code also has to be entered on the inpatient bill. Although this is a correct entry, the surgery date will be outside the covered period on the inpatient claim. For proper handling, such claims must be sent to the area Medicaid office for exceptional processing.

Note: See the Florida Medicaid Provider General Handbook, Appendix C, for the addresses and phone number of the area Medicaid offices. The addresses and phone numbers are also on the AHCA website at http://ahca.myflorida.com.

Florida Inpatient Psychiatric and Substance Abuse Services

Introduction

This section describes the conditions under which inpatient psychiatric and substance abuse services in Florida can be reimbursed by Medicaid.

Inpatient Psychiatric Services

Medicaid payment for psychiatric services is limited to general acute care hospitals. Medicaid does not reimburse for inpatient services provided in a freestanding psychiatric hospital.

Inpatient psychiatric services must be medically necessary.

Who Can Render Services

Inpatient psychiatric and substance abuse services must be rendered personally by a psychiatrist, a resident under the personal supervision of a psychiatrist who is a member of the medical faculty at a teaching hospital as defined in Chapter 395, Florida Statutes, or an advanced registered nurse practitioner who has a specialty in mental health.

The psychiatrist must have a psychiatric specialty on his Medicaid provider file on the Florida Medicaid Management Information System (FMMIS). The advanced registered nurse practitioner must have a mental health specialty on his Medicaid provider file.

Medicaid does not reimburse services rendered by psychologists.

Note: See the Florida Medicaid Provider General Handbook and in the Florida Medicaid Physician Services Coverage and Limitations Handbook for information on adding a specialty code to the provider file.

Authorization for Inpatient Psychiatric and Substance Abuse Services

Psychiatric and substance abuse admissions must be prior authorized for all Medicaid recipients, except for recipients who are:

- Enrolled in a Health Maintenance Organization (HMO), Provider Service Network (PSN), or Prepaid Mental Health Plan (PMHP); or
- Dually-eligible for Medicare and Medicaid.

Prior authorization must be requested for any ICD-9-CM diagnosis in the range of 290 through 314.9 when psychiatric accommodations are provided.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, UB-04, for detailed information on prior authorization.

Florida Inpatient Psychiatric and Substance Abuse Services, continued

Non-Emergency Psychiatric and Substance Abuse Admissions	Authorization for non-emergency inpatient psychiatric or substance abuse admissions must be requested from the psychiatric PRO 24 hours prior to admission.
Emergency Psychiatric and Substance Abuse Admissions	Authorization for emergency inpatient psychiatric and substance abuse admissions must be requested from the psychiatric PRO within four hours of admission.
Alcohol or Drug Detoxification Services	Inpatient alcohol or drug detoxification services are considered medical versus psychiatric services. Inpatient admissions for such services are authorized by the PRO contracted for medical inpatient services. The psychiatric PRO is not responsible for the authorization of such services. Inpatient claims billed with any one of the detox bed accommodation revenue codes 0116, 0126, 0136, 0146, or 0156 indicates detoxification services were rendered. An authorization number from the medical PRO, not the psychiatric PRO, is required before Medicaid payment can be made. Note: See the Florida Medicaid Reimbursement Handbook, UB-04, for more information on the prior authorization process for medical admissions.
Duration of Authorization	Hospital inpatient psychiatric and substance abuse admissions are authorized for a period not to exceed three days. If a hospitalization is anticipated to exceed three days, the psychiatric PRO must be contacted 24 hours prior to the last approved day for a continued stay review.
Prior Authorization Number	One ten-digit prior authorization number is provided by the psychiatric PRO for each hospitalization. Note: See the Medicaid Provider Reimbursement Handbook, UB-04, for billing instructions.

Florida Inpatient Psychiatric and Substance Abuse Services, continued

Transfer from Non-Psychiatric Status to Psychiatric and Substance Abuse Status	If a recipient is admitted to the hospital for a non-psychiatric diagnosis and during the same hospitalization transfers to the psychiatric unit for treatment of psychiatric or substance abuse diagnoses, the recipient must be discharged from non-psychiatric admission and re-admitted for psychiatric or substance abuse treatment. The psychiatric admission must be prior authorized by the psychiatric PRO. Two separate claims must be billed. The claim for the non-psychiatric portion of the hospitalization must have a medical PRO PA number; the claim for the psychiatric portion must have a psychiatric PRO PA number.
Transfer Within First Day of Hospitalization	If a recipient transfers to the psychiatric unit for inpatient treatment of psychiatric or substance abuse diagnoses on the first day of a non-psychiatric admission, that day must be billed as non-psychiatric. Submittal of only one claim is required.
Discharges from Psychiatric and Substance Abuse Inpatient Stays	Hospital providers must notify the psychiatric PRO of the recipient's exact discharge day no later than five days after the discharge.

Outpatient Psychiatric and Substance Abuse Services

Introduction

This section described the conditions under which outpatient psychiatric and substance abuse services can be reimbursed by Medicaid.

Payment for Outpatient Psychiatric Services

Medicaid payment for outpatient psychiatric services is limited to hospitals that are not enrolled in Medicaid as a provider of community mental health services.

Medicaid payment for outpatient psychiatric services is limited to general acute care hospitals. Medicaid does not reimburse for inpatient services provided in a freestanding psychiatric hospital.

A psychiatrist or the primary physician must order medically-necessary ancillary services, such as laboratory, etc.

Who Can Render Services

Outpatient psychiatric and substance abuse services must be rendered personally by a psychiatrist, a resident under the personal supervision of a psychiatrist who is a member of the medical faculty at a teaching hospital as defined in Chapter 395, Florida Statutes, or advanced registered nurse practitioner who has a specialty in mental health.

The psychiatrist must have a psychiatric specialty on his Medicaid provider file on the Florida Medicaid Management Information System (FMMIS). The advanced registered nurse practitioner must have a mental health specialty in on his Medicaid provider file.

Medicaid does not reimburse services rendered by psychologists.

Outpatient Psychiatric and Substance Abuse Services, continued

Psychiatric Evaluation

An evaluation must be performed for each recipient being considered for entry into an outpatient psychiatric treatment program. This applies to any organized program where a recipient may receive outpatient psychiatric care. The following requirements must be met.

- A written evaluation that assesses the recipient's mental condition to determine whether treatment in an outpatient program would be appropriate;
- The evaluation team must include a physician and an individual experienced in diagnosis and treatment of mental illness. (The same individual can satisfy both criteria if an appropriately qualified board candidate or board-certified psychiatrist personally renders the services); and
- For each recipient who enters the program, the assessment must include a certification by the evaluation team that the program is appropriate to meet the recipient's treatment needs. The assessment must be incorporated into the recipient's medical record.

Plan of Care

The evaluation team must develop an individual plan of care. The plan should be designed to improve the recipient's condition to the point where continued participation in the program (beyond occasional maintenance visits) is no longer necessary.

The plan of care must be signed by the psychiatrist and included in the recipient's medical record. The following information must be included in the plan of care:

- A written description of the treatment objective;
- The treatment regimen, that is, the specific medical and remedial services, therapies, and activities that will be used to meet the treatment objectives;
- A projected schedule for service delivery including the expected frequency and duration of each type of planned therapeutic session or encounter;
- The type of personnel that will be furnishing the services; and
- A projected schedule for completing re-evaluations of the recipient's condition and updating the plan of care.

Outpatient Psychiatric and Substance Abuse Services, continued

Documentation Requirements

The outpatient hospital program should develop and maintain sufficient written documentation to support each medical or remedial therapy service, activity, or session for which billing is made. This documentation, at a minimum, should consist of material that includes the following:

- The specific services rendered, the date, and actual time the services were rendered and who authorized them;
- Who rendered the services and the setting in which the services were rendered; and
- The amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the recipient's progress.

For services that are not specifically included in the recipient's treatment regimen, documentation should also include:

- A detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the recipient's plan of care; and
- A detailed explanation for any medical or remedial therapy session or encounter that departs from the plan of care in terms of need, scheduling, frequency, or duration of services furnished.

Plan of Care Review

At least every 90 days, the evaluation team must review the recipient's plan of care in order to determine the recipient's progress toward the treatment objectives, the appropriateness of the services being furnished, and the need for the recipient's continued participation in the program. The reviews must be documented in detail in the recipient records, kept on file, and made available as requested for state and federal audit purposes.

Excluded Services

Introduction	Services and items described in this section are not reimbursed by the Medicaid Hospital Services Program.
Child Health Check-Up Screening	Child Health Check-Up screenings are not reimbursable by the Medicaid Hospital Services Program. These screenings are reimbursable through the Medicaid Child Health Check-Up program.
Cosmetic Services	Cosmetic surgery for aesthetic purposes is not reimbursable by Medicaid.
Custodial Care	Care given to assist a person to meet his daily living activities and that does not consist of providing continuous medical or paramedical attention is not reimbursable by the Medicaid Hospital Services Program. Personal care is reimbursable through the Medicaid Home Health Program.
Diabetic Education	Outpatient hospital diabetic education programs that educate recipients in the self-management of diabetes are not reimbursed by the Medicaid Hospital Services Program.
Drugs and Supplies	Drugs, supplies, appliances, and equipment for use outside the hospital are not reimbursable by the Medicaid Hospital Services Program. This includes take home medications and prescription refills. Prescribed drugs are reimbursed through the Medicaid Prescribed Drug Program.
Durable Medical Equipment	Durable medical equipment, such as wheelchairs, walkers, crutches, canes, leg braces, and hospital beds, whether rented or purchased, are not reimbursable under the Medicaid Hospital Services Program. Durable medical equipment is reimbursable through the Medicaid Durable Medical Equipment Program.

Excluded Services, continued

Experimental Procedures	Experimental procedures are not reimbursable by Medicaid. Note: See the Glossary, Appendix D, in the Florida Medicaid Provider General Handbook for the definition of experimental procedures.
Eyeglasses	Eyeglasses, eyeglass adjustments and repairs, and eye examinations primarily for the diagnosis and correction of refractive errors are not reimbursable by the Medicaid Hospital Services Program. Eyeglasses are reimbursable through the Medicaid Visual Services Program. Eye exams are reimbursable through the Medicaid Optometric Services and Physician Services Programs.
Hospice Related Care	If the hospital admission of a hospice patient is related to the terminal diagnosis or a related condition, the hospice is responsible for payment of the hospital claim. Medicaid reimburses the hospice provider for the hospital charges, not the hospital provider. The hospice provider reimburses the hospital based on the contract between the hospice and the hospital.
Immunizations	Immunization services provide vaccines to induce a state of being immune to or protected from a disease. Immunizations not related to treatment of injury or disease are not reimbursable by the Medicaid Hospital Services Program. Vaccines are reimbursable through the Medicaid Advanced Registered Nurse Practitioner, County Public Health Department Clinic, Federally Qualified Health Center, Physician, Physician Assistant, and Rural Health Clinic Programs.
No Charge Items and Services	Services and items that are provided at no expense to the recipient are not reimbursable by Medicaid.

Excluded Services, continued

Nurses' Private Duty Services	Private duty nursing services are not reimbursable by the Medicaid Hospital Services Program. Private duty nursing services for children 20 and under are reimbursable through the Medicaid Home Health Program.
Partial Hospitalization for Psychiatric Services	Partial hospitalization for psychiatric services furnished in the outpatient hospital setting is not reimbursable under the Medicaid Hospital Services Program.
Personal Items	Items not directly related to the treatment and care of an illness or injury, such as rental television, massage, haircuts, guest trays, and guest beds, are not reimbursable by the Medicaid Hospital Services Program.
Prosthetic Devices for Use Outside the Hospital	Prosthetic devices, hearing aids, orthopedic shoes, maternity support hose and foundation garments, syringes, needles, colostomy bags, and like items for use solely outside the hospital are not reimbursable under the Medicaid Hospital Services Program. Medical supplies are reimbursable under the Medicaid Durable Medical Equipment and Medical Supply Services Program. Hearing aids are reimbursable under the Medicaid Hearing Services Program.

Excluded Services, continued

Routine Checkups	Routine physical checkups without specific illness, except outpatient mammography screenings, are not reimbursable by the Medicaid Hospital Services Program for recipients of any age. Adult heath screenings are reimbursable under the Medicaid Advanced Registered Nurse Practitioner, County Public Health Department Clinic, Federally Qualified Health Center, Physician, Physician Assistant, and Rural Health Clinic Programs. Note: See Mammography under Covered Services and Limitations in this chapter for information on mammography screenings.
Supplies, Appliances, Equipment for Use Outside Hospital	Supplies, appliances, and equipment furnished to an inpatient for use outside the hospital are not separately reimbursable by the Medicaid Hospital Services Program. Items such as cardiac valves, tracheotomy or drainage tubes, or other items temporarily installed in or attached to the recipient's body while receiving inpatient treatment that are necessary to facilitate the recipient's release from the hospital are covered by the hospital's inpatient per diem reimbursement.
Services Outside the United States	Inpatient and outpatient care provided in hospitals located outside the United States is not reimbursable by Medicaid.
Venipuncture and Handling Charges	Venipuncture and the collection, handling, and transportation of specimens are not reimbursable by Medicaid.
Well-Baby Checkups	Well-baby checkups are not reimbursable under the Medicaid Hospital Services Program.

CHAPTER 3
HOSPITAL SERVICES
REVENUE, PROCEDURE, AND SPECIAL SITUATION CODES

Overview

Introduction

This chapter contains the codes that are to be used for billing inpatient and outpatient hospital services.

In This Chapter

This chapter contains:

Copayment and Coinsurance

Copayment and Deductibles

Medicaid recipients, unless they are exempt, are responsible for a $3.00 copayment for hospital outpatient department or clinic non-emergency services and a $3.00 copayment for each inpatient admission.

Note: See the Florida Medicaid Provider General Handbook for the categories of recipients who are exempt from copayments.

Note: See the Florida Medicaid Provider General Handbook for reimbursement information for Medicare Part A deductibles.

Coinsurance for Emergency Room Services

Medicaid recipients using the hospital emergency room for non-emergency services are responsible for a five percent coinsurance on the first $300 of the Medicaid payment. There is zero coinsurance on the amount in excess of the first $300. All the recipient exemptions for copayments also apply in the assessment of the coinsurance.

Recipients who are responsible for the coinsurance are not also responsible for the copayment.

Note: See the Florida Medicaid Provider General Handbook for the categories of recipients that are exempt from this coinsurance.

Revenue Center Codes

Revenue Center Codes

Codes from the National Uniform Billing Manual are used to indicate the various services provided during a hospitalization. These codes are entered in Form Locator 42 of the UB-04. Their descriptors are entered in Form Locator 43 of the same form.

Revenue Center Codes: Inpatient

Appendix A in this handbook provides a list of inpatient revenue center codes. This list is included as a reference source only.

Revenue Center Codes: Outpatient

See Appendix B for a list of revenue center codes exclusively for outpatient hospital billing. The codes are specifically selected for Medicaid outpatient hospital coverage.

For each different outpatient revenue code, Medicaid will pay the outpatient rate one time per day regardless of the charges or the number of units billed. Exceptions to the rate payment are outpatient laboratory and pathology revenue center codes 0300 through 0314.

Note: See Laboratory and Pathology Codes in this chapter for additional information.

Outpatient Claims with Procedure Codes

Healthcare Common Procedure Coding System (HCPCS)

To maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid requires HCPCS procedure codes instead of ICD-9 procedure codes on all outpatient hospital claims where procedure codes are necessary.

An outpatient claim with one or more of the following revenue center codes requires a HCPCS procedure code in Form Locator 44 on the UB-04 claim form: 0360, 0361, 0722, 0750, or 0790.

Laboratory and Pathology Codes

Outpatient Billing

Outpatient laboratory and pathology services are billed with revenue center codes in the range of 0300 through 0314. A five-digit laboratory code must be placed in Form Locator 44 for every revenue center code in the range stated above. The five-digit lab code identifies the lab service that was performed. The outpatient lab codes are on the Florida Medicaid Provider Reimbursement Schedule.

These codes are reimbursed the lesser of the amount charged or the established Medicaid technical fee.

Note: The Florida Medicaid Provider Reimbursement Schedule is available on the Medicaid fiscal agent's website at http://mymedicaid-florida.com. Click on Provider Support, and then on Fees.

Screening and Diagnostic Mammography Codes

Types of Mammography

Mammography diagnosis codes must be used when billing for either screening or diagnostic mammography. Each type of mammography has its own list of appropriate diagnosis codes.

Note: See Appendix D in this handbook for the diagnosis codes required to bill mammography services.

Exemptions to Outpatient Cap

Exemptions from the $1,500 Outpatient Cap

The $1,500 cap applies to outpatient services provided to Medicaid recipients ages 21 and over.

Certain medical and surgical procedures, dialysis services, and chemotherapy services are exempt from the recipient's fiscal year $1,500 outpatient entitlement. If any of the exempt codes appear on an outpatient claim form, the amount Medicaid pays for the services rendered does not reduce the $1,500 cap. If one or more exempt codes are entered on the claim form, the whole claim is exempt from the cap.

Outpatient services due to an emergency admission may be eligible for payment beyond the $1,500 cap limit, if emergency criteria in the federal Balanced Budget Act of 1997 (BBA) are met. If the emergency criteria are met, providers may submit a claim for reimbursement over the $1,500 outpatient cap.

Recipients under the age of 21 have no limit on outpatient services, but services must be medically necessary as determined by a physician.

Note: See Appendix B of this handbook for asterisked outpatient revenue center codes that are exempt from the $1,500 cap. Procedures in the HCPCS range 10000-69999 that are reimbursable in the outpatient setting are exempt from the $1,500 cap.

Note: See Appendix F for the BBA exceptions to the 45-day cap limit and for claim submission details.

Ultrasound High-Risk Diagnosis Codes

Ultrasounds for High-Risk Pregnant Women

Ultrasounds for high-risk pregnant women are covered without documentation of medical necessity if the high-risk diagnosis code is listed in Appendix H of this handbook. An initial ultrasound and a maximum of three follow-up ultrasounds are allowed for high risk pregnant women, with the exception of multiple gestations, which have no limit on the number of follow-up ultrasounds.

One ultrasound is covered for a low-risk pregnant woman, per pregnancy.

APPENDIX A
INPATIENT REVENUE CENTER CODES
(For Reference Only)

APPENDIX A
INPATIENT REVENUE CENTER CODES
(For Reference Only)

Major Category

0001 **Total Charge**

010X **All-Inclusive Rate**

Flat fee charge incurred on either a daily basis or total stay basis for service rendered.

Charge may cover room and board plus ancillary services or room and board only.

Subcategory	Standard Abbreviation
0-All-Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC
1-All-Inclusive Room and Board	ALL INCL R&B

011X **Room and Board - Private Medical or General**

Routine service charges for single-bed rooms.

Rationale: Most third party payers require that private rooms be separately identified.

Subcategory	Standard Abbreviation
0-General Classification	ROOM-BOARD/PVT
1-Medical/Surgical/Gyn	MED-SUR-GY/PVT
2-OB	OB/PVT
3-Pediatric	PEDS/PVT
4-Psychiatric	PSTAY/PVT
5-Hospice	HOSPICE/PVT
6-Detoxification	DETOX/PVT
7-Oncology	ONCOLOGY/PVT
8-Rehabilitation	REHAB/PVT
9-Other	OTHER/PVT

Appendix A, Inpatient Revenue Center Codes, continued

012X **Room & Board - Semi-private Two Bed (Medical or General)**

Routine service charges incurred for accommodations with two beds.

Room and Board - Semi-Private (cont.)

Rationale: Most third party payers require that semi-private rooms be identified.

Subcategory	Standard Abbreviation
0-General Classification	ROOM-BOARD/SEMI
1-Medical/Surgical/Gyn	MED-SUR-GY/2 BED
2-OB	OB/2 BED
3-Pediatric	PEDS/2 BED
4-Psychiatric	PSYCH/2 BED
5-Hospice	HOSPICE/2 BED
6-Detoxification	DETOX/2 BED
7-Oncology	ONCOLOGY/2 BED
8-Rehabilitation	REHAB/2 BED
9-Other	OTHER/2 BED

013X **Semi-Private - Three and Four Beds**

Routine service charges incurred for accommodations with three and four beds.

Subcategory	Standard Abbreviation
0-General Classification	ROOM-BOARD/3&4 BED
1-Medical/Surgical/Gyn	MED-SUR-GY/3&4 BED
2-OB	OB/3&4 BED
3-Pediatric	PEDS/3&4 BED
4-Psychiatric	PSTAY/3&4 BED
5-Hospice	HOSPICE/3&4 BED
6-Detoxification	DETOX/3&4 BED
7-Oncology	ONCOLOGY/3&4 BED
8-Rehabilitation	REHAB/3&4 BED
9-Other	OTHER/3&4 BED

Appendix A, Inpatient Revenue Center Codes, continued

014X **Private (Deluxe)**

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategory	Standard Abbreviation
0-General Classification	ROOM-BOARD/PVT/DLX
1-Medical/Surgical/Gyn	MED-SUR-GY/DLX
2-OB	OB/DLX
3-Pediatric	PEDS/DLX
4-Psychiatric	PSTAY/DLX
5-Hospice	HOSPICE/DLX
6-Detoxification	DETOX/DLX
7-Oncology	ONCOLOGY/DLX
8-Rehabilitation	REHAB/DLX
9-Other	OTHER/DLX

015X **Room & Board Ward (Medical or General)**

Routine service charge for accommodations with five or more beds.

Rationale: Most third party payers require ward accommodations to be identified.

Subcategory	Standard Abbreviation
0-General Classification	ROOM-BOARD/WARD
1-Medical/Surgical/Gyn	MED-SUR-GY/WARD
2-OB	OB/WARD
3-Pediatric	PEDS/WARD
4-Psychiatric	PSTAY/WARD
5-Hospice	HOSPICE/WARD
6-Detoxification	DETOX/WARD
7-Oncology	ONCOLOGY/WARD
8-Rehabilitation	REHAB/WARD
9-Other	OTHER/WARD

Appendix A, Inpatient Revenue Center Codes, continued

016X Other Room & Board

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes.

Rationale: Provides the ability to identify services as required by payers or individual institutions.

Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

Subcategory	Standard Abbreviation
0-General Classification	R&B
4-Sterile Environment	R&B/STERILE
7-Self Care	R&B/SELF
9-Other	R&B/OTHER

017X Nursery

Accommodation charges for nursing care to newborn and premature infants in nurseries.

Subcategories 1-4 to be used by facilities with nursery services designed around distinct areas and/or levels of care. Levels of care defined under Florida regulations supersede national guidelines.

Level I - Well-baby care services which include sub-ventilation care, intravenous feedings, and gavage to neonates.

Level II - Services which include the provision of ventilator services, and at least 6 hours of nursing care per day. Restricted to neonates of 1000 grams birth weight and over with the exception of those neonates awaiting transfer to Level III.

Level III - Services which include the provision of continuous cardiopulmonary support services, 12 or more hours of nursing care per day, complex pediatric surgery, neonatal cardiovascular surgery, pediatric neurology and neurosurgery, and pediatric cardiac catheterization.

Level IV - Not applicable under Florida licensure.

Subcategory	Standard Abbreviation
0-General Classification	NURSERY
1-Newborn	NURSERY/NEWBORN
2-Premature	NURSERY/PREMIE
5-NeoNatal ICU	NURSERY/ICU
9-Other	NURSERY/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

018X Leaves of Absence

Charges for holding a room while the patient is temporarily away from the provider.

Subcategory	Standard Abbreviation
0-General Classification	LEAVE OF ABSENCE OR LOA
1-Reserved	
2-Patient Convenience	LOA/PT CONV
3-Therapeutic Leave	LOA/THERAPEUTIC
4-ICF/MR - any reason	LOA/ICF/MR
5-Nursing Home (for hospitalization)	LOA/NURS HOME
9-Other Leave of Absence	LOA/OTHER

019X Subacute Care

Accommodation charges for subacute care to inpatients in hospitals or skilled nursing facilities.

Level I - Skilled Care: Minimal nursing intervention. Comorbidities do not complicate treatment plan. Assessment of vitals and body systems required 1-2 times per day.

Level II - Comprehensive Care: Moderate nursing intervention. Active treatment of comorbidities. Assessment of vitals and body systems required 2-3 times per day.

Level III - Complex Care: Moderate to extensive nursing intervention. Active medical care and treatment of comorbidities. Potential for comorbidities to affect the treatment plan. Assessment of vitals and body systems required 3-4 times per day.

Level IV - Intensive Care: Extensive nursing and technical intervention. Active medical care and treatment of comorbidities. Potential for comorbidities to affect the treatment plan. Assessment of vitals and body systems required 4-6 times per day.

Subcategory	Standard Abbreviation
0-General Classification	SUBACUTE
1-Subacute Care – Level I	SUBACUTE/LEVEL I
2-Subacute Care – Level II	SUBACUTE/LEVEL II
3-Subacute Care – Level III	SUBACUTE/LEVEL III
4-Subacute Care – Level IV	SUBACUTE/LEVEL IV
9-Other Subacute Care	SUBACUTE/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

020X Intensive Care

Routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Rationale: Most third party payers require that charges for this service are to be identified.

Subcategory	Standard Abbreviation
0-General Classification	INTENSIVE CARE OR (ICU)
1-Surgical	ICU/SURGICAL
2-Medical	ICU/MEDICAL
3-Pediatric	ICU/PEDS
4-Psychiatric	ICU/PSTAY
6-Post ICU	POST ICU
7-Burn Care	ICU/BURN CARE
8-Trauma	ICU/TRAUMA
9-Other Intensive Care	ICU/OTHER

021X Coronary Care

Routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.

Rationale: If a discrete unit exists for rendering such services, the hospital or third party may wish to identify the service.

Subcategory	Standard Abbreviation
0-General Classification	CORONARY CARE or (CCU)
1-Myocardial Infarction	CCU/MYO INFARC
2-Pulmonary Care	CCU/PULMONARY
3-Heart Transplant	CCU/TRANSPLANT
4-Post-CCU	POST CCU
9-Other Coronary Care	CCU/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

022X Special Charges

Charges incurred during an inpatient stay or on a daily basis for certain services.

Rationale: Some hospitals prefer to identify the components of services rendered in greater detail and thus break out charges for items that normally would be considered part of routine services.

Subcategory	Standard Abbreviation
0-General Classification	SPECIAL CHARGES
1-Admission Charge	ADMIT CHARGE
2-Technical Support Charge	TECH SUPPT CHG
3-U.R. Service Charge	UR CHARGE
4-Late Discharge, Medically Necessary	LATE DISCHG, MED
9-Other Special Charges	OTHER SPEC CHG

023X Incremental Nursing Charge Rate

Charge for nursing service assessed in addition to room and board.

Subcategory	Standard Abbreviation
0-General Classification	NURSING INCREM
1-Nursery	NUR INCR/NURSERY
2-OB	NUR INCR/OB
3-ICU	NUR INCR/ICE
4-CCU	NUR INCR/CCU
5-Hospice	NUR INCR/HOSPICE
9-Other	NUR INCR/OTHER

024X All Inclusive Ancillary

A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only.

Rationale: Hospitals that bill in this manner may wish to segregate these charges.

Subcategory	Standard Abbreviation
0-General Classification	ALL INCL ANCIL
1-Basic	ALL INCL BASIC
2-Comprehensive	ALL INCL COMP
3-Specialty	ALL INCL SPECIAL
9-Other Inclusive Ancillary	ALL INCL ANCIL/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

025X Pharmacy (Also see 063X, an extension of 025X)

Charges for medication produced, manufactured, packaged, dispensed and distributed under the direction of a licensed pharmacist. This category includes blood plasma, other components of blood, and IV solutions.

Rationale: Additional breakdowns are provided for items that individual hospitals may wish to identify because of internal or third party payor requirements. Subcode 4 is for providers that cannot bill drugs used for other diagnostic services under revenue code 0929. Subcode 5 is for providers that cannot bill drugs used for radiology under revenue code 0329 or 0339.

Subcategory	Standard Abbreviation
0-General Classification	PHARMACY
1-Generic Drugs	DRUGS/GENERIC
2-Non-generic drugs	DRUGS/NONGENERIC
3-Take Home Drugs	DRUGS/TAKEHOME
4-Drugs Incident to Other Diagnostic Services	DRUGS/INCIDNT OTHER DX
5-Drugs Incident to Radiology	DRUGS/INCIDNT RAD
6-Experimental Drugs	DRUGS/EXPERIMT
7-Non-prescription	DRUGS/NONPRSCPT
8-IV Solutions	IV SOLUTIONS
9-Other Pharmacy	DRUGS/OTHER

026X IV Therapy

Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists.

Rationale: For outpatient home intravenous drug therapy equipment, which is part of the basic per diem fee schedule, providers must identify the actual cost for each type of pump for updating of the per diem.

Subcategory	Standard Abbreviation
0-General Classification	IV THERAPY
1-Infusion Pump	INFUSION PUMP
2-IV Therapy/Pharmacy Srvcs	IV THER/PHARM/SERV
3-IV Therapy/Drug/Supply Delivery	IV THER/DRUG/SUPPLY DELV
4-IV Therapy/Supplies	IV THER/SUPPLIES
9-Other IV Therapy	IV THERAPY/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

027X **Medical/Surgical Supplies and Devices**

Charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	Standard Abbreviation
0-General Classification	MED-SUR SUPPLIES
1-Non-Sterile Supply	NON-STER SUPPLY
2-Sterile Supply	STERILE SUPPLY
3-Take Home Supplies	TAKEHOME SUPPLY
4-Prosthetic Devices	PROSTHETIC DEV
5-Pacemaker	PACEMAKER
6-Intraocular Lens	INTRAOC LENS
7-Oxygen-Take Home	O2/TAKEHOME
8-Other Implants **(a)**	SUPPLY/IMPLANTS
9-Other Supplies/Devices	SUPPLY/OTHER

(a) Implantables:

That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposed.

Examples of Other Implants (note all-inclusive):

Stents, artificial joints, shunts, grafts, pins, plates, screws, anchors, and radioactive seeds.

Experimental devices that are implantable and have been granted an FDA Investigational Device Exemption (IDE) number should be billed with revenue code 0624.

Appendix A, Inpatient Revenue Center Codes, continued

028X **Oncology**

Charges for the treatment of tumors and related diseases.

Subcategory	Standard Abbreviation
0-General Classification	ONCOLOGY
9-Other Oncology	ONCOLOGY/OTHER

029X **Durable Medical Equipment (Other Than Renal)**

Charge for medical equipment that can withstand repeated use (excluding renal equipment).

Rationale: Medicare requires a separate revenue center for billing.

Subcategory	Standard Abbreviation
0-General Classification	MED EQUIP/DURAB
1-Rental	MED EQUIP/RENT
2-Purchase of new DME	MED EQUIP/NEW
3-Purchase of used DME	MED EQUIP/ USED
4-Supplies/Drugs for DME Effectiveness (Home Health Agency only)	MED EQUIP/SUPPLIES DRUGS
9-Other Equipment	MED EQUIP/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

030X **Laboratory (Clinical Diagnostic)**

Charges for the performances of diagnostic and routine clinical laboratory tests.

Rationale: A breakdown of the major areas in the laboratory is provided in order to meet hospital needs or third party billing requirements.

Subcategory	Standard Abbreviation
0-General Classification	LABORATORY or (LAB)
1-Chemistry	LAB/CHEMISTRY
2-Immunology	LAB/IMMUNOLOGY
3-Renal Patient (Home)	LAB/RENAL HOME
4-Non-Routine Dialysis	LAB/NR DIALYSIS
5-Hematology	LAB/HEMATOLOGY
6-Bacteriology & Microbiology	LAB/BACT-MICRO
7-Urology	LAB/UROLOGY
9-Other Laboratory	LAB/OTHER

031X **Laboratory (Pathological)**

Charges for diagnostic and routine laboratory tests on tissues and culture.

Rationale: A breakdown of the major areas that hospitals may wish to identify is provided.

Subcategory	Standard Abbreviation
0-General Classification	PATHOL/LAB)
1-Cytology	PATHOL/CYTOLOGY
2-Histology	PATHOL/HISTOL
4-Biopsy	PATHOL/BIOPSY
9-Other	PATHOL/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

032X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes: taking, processing, examining and interpreting radiographs and fluorographs.

Rationale: A breakdown is provided of the major areas and procedures that individual hospitals or third party payers may wish to identify.

Subcategory	Standard Abbreviation
0-General Classification	DX X-RAY
1-Angiocardiography	DX X-RAY/ANGIO
2-Arthrography	DX X-RAY/ARTH
3-Arteriography	DX X-RAY/ARTER
4-Chest X-ray	DX X-RAY/CHEST
9-Other	DX X-RAY/OTHER

033X Radiology – Therapeutic and/or Chemotherapy Administration

Charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances. Excludes charges for chemotherapy drugs, which should be reported under the appropriate revenue code (025X/063X).

Rationale: A breakdown is provided of the major areas that hospitals or third parties may wish to identify.

Subcategory	Standard Abbreviation
0-General Classification	RX X-RAY
1-Chemotherapy Administration: Injected	CHEMOTHER/INJ
2-Chemotherapy Administration: Oral	CHEMOTHER/ORAL
3-Radiation Therapy	RADIATION RX
5-Chemotherapy Administration: IV	CHEMOTHERP-IV
9-Other	RX R-RAY/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

034X Nuclear Medicine

Charges for procedures and tests and radiopharmaceuticals provided by a department handling radioactive materials are required for diagnosis and treatment of patients.

Rationale: A breakdown is provided in case hospitals desire or are required to identify the type of service rendered.

Subcategory	Standard Abbreviation
0-General Classification	NUC MED
1-Diagnostic Procedures	NUC MED/DX
2-Therapeutic Procedures	NUC MED/RX
3-Diagnostic Radiopharmaceuticals	NUC MED/DX RADIOPHARM
4-Therapeutic Radiopharmaceuticals	NUC MED/RX RADIOPHARM
9-Other	NUC MED/OTHER

035X Computer Tomographic (CT) Scan

Charges for computed tomographic scans of the head and other parts of the body.

Rationale: Due to coverage limitations some third party payers require that the specific test be identified.

Subcategory	Standard Abbreviation
0-General Classification	CT SCAN
1-Head Scan	CT SCAN/HEAD
2-Body Scan	CT SCAN/BODY
9-Other CT Scans	CT SCAN/OTHER

036X Operating Room Services

Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery as well the operating room (heat, lights) and equipment.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0-General Classification	OR SERVICES
1-Minor Surgery	OR/MINOR
2-Organ Transplant-Other Than Kidney	OR/ORGAN TRANS
7-Kidney Transplant	OR/KIDNEY TRANS
9-Other Operating Room Services	OR/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

037X Anesthesia

Charges for anesthesia services in the hospital.

Rationale: Provides additional identification of services. In particular, acupuncture was identified because it is not covered by some payers, including Medicare. Subcode 1 is for providers that cannot bill anesthesia administered for radiology procedures under radiology. Subcode 2 is for providers that cannot bill anesthesia administered for other diagnostic procedures.

Subcategory	Standard Abbreviation
0-General Classification	ANESTHESIA
1-Anesthesia Incident to Radiology	ANESTH/INCIDENT RAD
2-Anesthesia Incident to Other Diagnostic Services	ANESTH/INCDNT OTHER DX
4-Acupuncture	ANESTHE/ACUPUNC
9-Other Anesthesia	ANESTHE/OTHER

038X Blood

Rationale: Charges for blood must be separately identified for private payer purposes.

Subcategory	Standard Abbreviation
0-General Classification	BLOOD
1-Packed Red Cells	BLOOD/PKD RED
2-Whole Blood	BLOOD/WHOLE
3-Plasma	BLOOD/PLASMA
4-Platelets	BLOOD/PLATELETS
5-Leucocytes	BLOOD/LEUCOCYTES
6-Other Components	BLOOD/COMPONENTS
7-Other Derivatives (Cryopricipitates)	BLOOD DERIVATIVES (Cryopricipitates)
9-Other Blood	BLOOD/OTHER

039X Blood Storage and Processing

Charges for administration, processing, and storage of whole blood, red blood cells, platelets, and other blood components (such as, plasma and plasma derivatives.)

Subcategory	Standard Abbreviation
0-General Classification	BLOOD/STOR-PROC
1-Administration (e.g. Transfusions)	BLOOD/ADMIN
9-Other Storage & Processing	BLOOD/OTHER STOR

Appendix A, Inpatient Revenue Center Codes, continued

040X **Other Imaging Services**

Subcategory	Standard Abbreviation
0-General Classification	IMAGE SERVICE
1-Mammography	MAMMOGRAPHY
2-Ultrasound	ULTRASOUND
3*-Screening Mammography	SCRN MAMMOGRAPHY
4-Positron Emission Tomography	PET SCAN
9-Other Imaging Services	OTHER IMAG SVS

*__Note__: Medicare will require the hospitals to report the ICD-9 diagnosis codes (Form Locator 77) to substantiate those beneficiaries considered high risks. These high risk codes are as follows:

ICD-9 Codes	*Definitions*	*High Risk Factor*
V10.3	Personal History-Malignant neoplasm breast cancer	A personal history of breast cancer
V16.3	Family History-Malignant neoplasm breast cancer	A mother, sister or daughter who has breast cancer
V15.89*	Other specified personal history, representing hazards to health	Not given birth prior to 30. A personal history of biopsy-proven benign breast disease.
*Must use the appropriate 4th and 5th digit.		

041X **Respiratory Services**

Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0-General Classification	RESPIRATORY SVC
2-Inhalation Services	INHALATION SVC
3-Hyperbaric Oxygen Therapy	HYPERBARIC O2
9-Other Respiratory Services	OTHER RESPIR SVS

Appendix A, Inpatient Revenue Center Codes, continued

042X Physical Therapy

Charges for therapeutic exercises, massage and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0-General Classification	PHYSICAL THERP
1-Visit Charge	PHYS THERP/VISIT
2-Hourly Charge	PHYS THERP/HOUR
3-Group Rate	PHYS THERP/GROUP
4-Evaluation or Re-evaluation	PHYS THERP/EVAL
9-Other Physical Therapy	OTHER PHYS THERP

043X Occupational Therapy

Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities; therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosthetic devices; adaptation of environments; and application of physical agent modalities.

Subcategory	Standard Abbreviation
0-General Classification	OCCUPATION THER
1-Visit Charge	OCCUP THERP/VISIT
2-Hourly Charge	OCCUP THERP/HOUR
3-Group Rate	OCCUP THERP/GROUP
4-Evaluation or Re-evaluation	OCCUP THERP/EVAL
9-Other Occupational Therapy	OTHER OCCUP THER

044X Speech-Language Pathology

Charges for service provided to persons with impaired functional communications skills.

Subcategory	Standard Abbreviation
0-General Classification	SPEECH PATHOL
1-Visit Charge	SPEECH PATH/VISIT
2-Hourly Charge	SPEECH PATH/HOUR
3-Group Rate	SPEECH PATH/GROUP
4-Evaluation or Re-evaluation	SPEECH PATH/EVAL
9-Other Speech-Language Pathology	OTHER SPEECH PATH

Appendix A, Inpatient Revenue Center Codes, continued

045X **Emergency Room**

Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care. (To include holding room and meals.)

Rationale: Permits identification of particular items for payers. Under the provisions of EMTALA (Emergency Medical Treatment and Active Labor Act) a hospital with an emergency department must provide upon request and within the capabilities of the hospital, an appropriate medical screening examination and stabilizing treatment to any individual with an emergency medical condition and to any woman in active labor, regardless of the individual's eligibility for Medicare (Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985).

Subcategory	Standard Abbreviation
0-General Classification	EMERG ROOM
1-EMTALA Emergency Medical Screening Services	ER/EMTALA
2-ER Beyond EMTALA Screening	ER/BEYOND EMTALA
6-Urgent Care	URGENT CARE
9-Other Emergency Room	OTHER EMER ROOM

USAGE NOTES

1. FL 76 – Patient's Reason for Visit should be reported in conjunction with 045X.
2. An "X" in the matrix below indicates an acceptable coding combination.

	0450 (a)	0451 (b)	0452 (c)	0456	0459
0450					
0451			X	X	X
0452		X			
0456		X			X
0459		X		X	

(a) General Classification code 0450 should not be used in conjunction with any subcategory. The sum of 0451 and 0452 is equivalent to 0450. Payers that do not require a breakdown should roll-up 0451 and 0452 into 0450.

(b) Stand alone usage of 0451 is acceptable when no services beyond an initial screening/assessment are rendered.

(c) Stand alone usage of 0452 is not acceptable.

Appendix A, Inpatient Revenue Center Codes, continued

046X **Pulmonary Function**

Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of this service if it exists in the hospital.

Subcategory	Standard Abbreviation
0-General Classification	PULMONARY FUNC
9-Other Pulmonary Function	OTHER PULMON FUNC

047X **Audiology**

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0-General Classification	AUDIOLOGY
1-Diagnostic	AUDIOLOGY/DX
2-Treatment	AUDIOLOGY/RX
9-Other Audiology	OTHER AUDIOL

Appendix A, Inpatient Revenue Center Codes, continued

048X **Cardiology**

Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

Rationale: This category was established to reflect a growing trend to incorporate these charges in a separate unit.

Subcategory	Standard Abbreviation
0-General Classification	CARDIOLOGY
1-Cardiac Cath Lab	CARDIAC CATH LAB
2-Stress Test	STRESS TEST
3-Echocardiology	ECHOCARDIOLOGY
9-Other Cardiology	OTHER CARDIOL

049X **Ambulatory Surgical Care**

Subcategory	Standard Abbreviation
0-General Classification	AMBUL SURG
9-Other Ambulatory Surgical Care	OTHER AMBL SURG

050X **Outpatient Services**

Outpatient charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service.

Subcategory	Standard Abbreviation
0-General Classification	OUTPATIENT SVS
9-Other Outpatient Services	OUTPATIENT/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

051X **Clinic**

Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, preventative, curative, rehabilitative, and education services on a scheduled basis to ambulatory patients.)

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	Standard Abbreviation
0-General Classification	CLINIC
1-Chronic Pain Center	CHRONIC PAIN CL
2-Dental Clinic	DENTAL CLINIC
3-Psychiatric Clinic	PSYCH CLINIC
4-OB-GYN Clinic	OB-GYN CLINIC
5-Pediatric Clinic	PEDS CLINIC
6-Urgent Care Clinic*	URGENT CLINIC
7-Family Practice Clinic	FAMILY CLINIC
9-Other Clinic	OTHER CLINIC

***Usage Note:**

FL 76 – Patient's Reason for Visit should be reported in conjunction with 0516.

052X **Free-Standing Clinic**

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	Standard Abbreviation
0-General Classification	FREESTAND CLINIC
1-Rural Health-Clinic	RURAL/CLINIC
2-Rural Health-Home	RURAL/HOME
3-Family Practice	FR/STD FAMILY PRACTICE
6-Urgent Care Clinic*	FR/STD URGENT CLINIC
9-Other Freestanding Clinic	OTHER FR/STD CLINIC

Appendix A, Inpatient Revenue Center Codes, continued

053X Osteopathic Services

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor osteopathy.

Rationale: There is a service unique to osteopathic hospitals and cannot be accommodated in any of the existing codes.

Subcategory	Standard Abbreviation
0-General Classification	OSTEOPATH SVS
1-Osteopathic Therapy	OSTEOPATH RX
9-Other Osteopathic Services	OTHER OSTEOPATH

054X Ambulance

Charges for ambulance service, usually on an unscheduled basis to the ill and injured who require immediate medical attention.

Rationale: Provides subcategories that third party payers or hospitals may wish to recognize. Heart mobile is a specially designed ambulance transport for cardiac patients.

Subcategory	Standard Abbreviation
0-General Classification	AMBULANCE
1-Supplies	AMBULANCE/SUPPLY
2-Medical Transport	AMBUL/MED TRANS
3-Heart Mobile	AMBUL/HEARTMOBL
4-Oxygen	AMBUL/OXY
5-Air Ambulance	AIR AMBULANCE
6-Neonatal Ambulance Services	AMBUL/NEONAT
7-Pharmacy	AMBUL/PHARMACY
8-Telephone Transmission EKG	AMBUL/TELEPHONE EKG
9-Other Ambulance	OTHER AMBULANCE

055X Skilled Nursing

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

Subcategory	Standard Abbreviation
0-General Classification	SKILLED NURSING
1-Visit Charge	SKILLED NURS/VISIT
2-Hourly Charge	SKILLED NURS/HOUR
9-Other Skilled Nursing	SKILLED NURS/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

056X **Medical Social Services**

Charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.

Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by hospital.

Subcategory	Standard Abbreviation
0-General Classification	MED SOCIAL SVS
1-Visit Charge	MED SOC SERV/VISIT
2-Hourly Charge	MED SOC SERV/HOUR
9-Other Med Social Services	MED SOC SERV/OTHER

057X **Home Health Aide (Home Health)**

Charges made by a home health agency for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0-General Classification	AIDE/HOME HEALTH
1-Visit Charge	AIDE/HOME HEALTH/VISIT
2-Hourly Charge	AIDE/HOME HEALTH/HOUR
9-Other Home Health Aide	AIDE/HOME HEALTH/OTHER

058X **Other Visits (Home Health)**

Charges by a home health agency for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0-General Classification	VISIT/HOME HLTH
1-Visit Charge	VISIT/HOME HLTH/VISIT
2-Hourly Charge	VISIT/HOME HLTH/HOUR
9-Other Home Health Visits	VISIT/HOME HLTH/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

059X **Units of Service (Home Health)**

Revenue code used by a home health agency that bills on the basis of units of service.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0-General Classification	UNIT/HOME HEALTH
9-Home Health Other Units	UNIT/HOME HLTH/OTHER

060X **Oxygen (Home Health)**

Charges by a home health agency for oxygen equipment supplies or contents, excluding purchased equipment.

If a beneficiary has purchased a stationary oxygen system, an oxygen concentrator or portable equipment, current revenue codes 0292 or 0293 apply. DME (other than oxygen systems) is billed under current revenue codes 0291, 0292, or 0293.

Rationale: Medicare requires detailed revenue coding; therefore, codes for this series may not be summed at the zero level.

Subcategory	Standard Abbreviation
0-General Classification	02/HOME HEALTH
1-Oxygen – State/Equip/Suppl/or Cont	02/STAT EQUIP/SUPPL/CONT
2-Oxygen – State/Equip/Suppl/Under 1 LPM	02/STAT EQUIP/UNDER 1 LPM
3-Oxygen – State/Equip/Over 4 LPM	02/STATE EQUIP/OVER 4 LPM
4-Oxygen – Portable Add-On	O2/PORTABLE ADD-ON

Appendix A, Inpatient Revenue Center Codes, continued

061X MRI

Charges for Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) of the Brain and other parts of the body.

Rationale: Due to coverage limitations some third party payers require that the specific test be identified.

Subcategory	Standard Abbreviation
0-General Classification	MRI
1-MRI - Brain (including Brainstem)	MRI - BRAIN
2-MRI - Spinal Cord (including Spine)	MRI – SPINE
3-Reserved	
4-MRI – Other	MRI – OTHER
5-MRA – Head and Neck	MRA – HEAD AND NECK
6-MRA – Lower Extremities	MRA – LOWER EXT
7-Reserved	
8-MRA – Other	MRA – OTHER
9-Other MRT	MRT – OTHER

062X Medical/Surgical Supplies (Extension of 27X)

Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures.

Subcategory	Standard Abbreviation
1-Supplies Incident to Radiology	MED-SUR/INCDNT RAD
2-Supplies Incident to Other Diagnostic Services	MED-SUR SUPP/INCDNT ODX
3-Surgical Dressings	SURG DRESSING
4-FDA Investigational Devices	FDA INVEST DEVICE

Appendix A, Inpatient Revenue Center Codes, continued

063X **Pharmacy (Extension of 025X)**

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of a licensed pharmacist. The category is an extension of 025X for reporting additional breakdown where needed.

Subcategory	Standard Abbreviation
0-General Classification	DRUGS
1-Single Source Drug	DRUG/SNGL
2-Multiple Source Drug	DRUG/MULT
3-Restrictive Prescription	DRUG/RSTR
4-Erythropoietin (EPO) less than 10,000 units	DRUG/EPO<10,000 UNITS
5-Erythropoietin (EPO) 100,000 or more units	DRUG/EPO>10,000 UNITS
6-Drugs Requiring Detailed Coding (a)	DRUG/DETAIL CODE
7-Self-Administrable Drugs (b)	DRUGS/SELF ADMIN

Usage Notes:

(a) Charges for drugs and biologicals (with the exception of radiopharmaceuticals, which are reported under Revenue Codes 0343 and 0344) requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in Form Locator 44. The specified units of services to be reported should be in hundreds (100s), rounded to the nearest hundred (no decimal).

(b) Charges for self-administrable drugs not requiring detailed coding. Use Value Codes A4, A5, and A6 to indicate the dollar amount included in covered charges for self-administrable drugs. Amounts for non-covered self-administrable drugs should be charged using revenue code 0637 in the non-covered column.

Appendix A, Inpatient Revenue Center Codes, continued

064X **Home IV Therapy Services**

Charges for intravenous drug therapy services which are performed in the patient's residence. For chemotherapy patients during an inactive phase enter HCPCS code to the right of the dotted line adjacent to revenue code 0642.

Subcategory	Standard Abbreviation
0-General Classification	IV THERAPY SVC
1-Nonroutine Nursing Central Line	NON RT NURSING/CENTRAL
2-IV Site Care, Central Line	IV SITE CARE/CENTRAL
3-IV Start/Change Peripheral Line	IV STRT/CHNG/PERIPHRL
4-Nonroutine Nursing Peripheral Line	NONRT NURSING/PERIPHRL
5-Training Patient/Caregiver Central Line	TRNG PT/CAREGVR/CENTRAL
6-Training, Disabled Patient, Central Line	TRNG DSBL PT/CENTRAL
7-Training, Patient/Caregiver Peripheral Line	TRNG/PT/CARGVR/PERIPHER
8-Training, Disabled Patient Peripheral Line	TRNG/DSBL PT/PERIPHERL
9-Other IV Therapy Services	OTHER IV THERAPY SVC

Note: Units need to be reported in one-hour increments. Revenue code 0642 relates to the HCPCS code.

Appendix A, Inpatient Revenue Center Codes, continued

065X Hospice Services

Charges for hospice care services for a terminally ill patient if he elects these services in lieu of other services for the terminal condition.

Rationale: The level of hospice care provided for each day during a hospice election period determines the amount of Medicare and Medicaid payment for that day.

Subcategory	Standard Abbreviation
0-General Classification	HOSPICE
1-Routine Home Care	HOSPICE/RTN HOME
2-Continuous Home Care	HOSPICE/CTNS HOME
3-Reserved	
4-Reserved	
5-Inpatient Respite Care	HOSPICE/IP RESPITE
6-General Inpatient Care (Non-Respite)	HOSPICE/IP NON-RESPITE
7-Physician Services (Hospice)	HOSPICE/PHYSICIAN
9-Other Hospice	HOSPICE/OTHER

To receive the Continuous Home Care rate from Medicare and Medicaid under code 0652, a minimum of 8 hours of care, not necessarily consecutive, in a 24-hour periods required. Less than 8 hours is reported under code 0651. A portion of an hour counts as an hour for this determination.

Billing to Medicare and Medicaid under code 0657 must be accompanied by a physician procedure code, which must be entered in Form Locator 44. This code is used by the hospice to bill for charges for physician services furnished to hospice patients by physicians employed by the hospice or receiving compensation from the hospice for services rendered.

066X Respite Care

Charges for non-hospice respite cares.

Subcategory	Standard Abbreviation
0-General Classification	RESPITE CARE
1-Hourly Charge/Nursing	RESPITE/NURSE
2-Hourly Charge/Aide/Homemaker/ Companion	RESPITE/AIDE/HMEMKR/COMP
3-Daily Respite Charge	RESPITE DAILY
9-Other Cast Room	RESPITE/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

067X **Outpatient Special Residence Charges**

Residence arrangements for patients requiring continuous outpatient care.

Subcategory	Standard Abbreviation
0-General Classification	OP SPEC RES
1-Hospital-Based	OP SPEC RES/HOSP BASED
2-Contracted	OP SPEC RES/CONTRACTED
9-Other Special Residence Charges	OP SPEC RES/OTHER

068X **Trauma Response**

Charges for a trauma team activation.

Subcategory	Standard Abbreviation
1-Level I	TRAUMA LEVEL I
2-Level II	TRAUMA LEVEL II
3-Level III	TRAUMA LEVEL III
4-Level IV	TRAUMA LEVEL IV
9-Other Trauma Response	TRAUMA OTHER

Usage Notes:

1. To be used by trauma center/hospitals as licensed or designated by the state or local government authority authorized to do so or as verified by the American College of Surgeons and involving a trauma activation.
2. Revenue Category 068X is used for patients for whom a trauma activation occurred. A trauma team activation/response is a “Notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient’s arrival.”
3. Revenue Category 068X is for reporting trauma activation costs only. It is an activation fee and not a replacement or a substitute for the emergency room visit fee; if trauma activation occurs, there will normally be both a 045X and 068X revenue code reported.
4. Revenue Category 068X is not limited to admitted patients.
5. Revenue Category 068X must be used in conjunction with FL19 Type of Admission code 05 (Trauma Center), however, FL19, code 5 can be used alone.

   Only patients for whom there has been pre-hospital notification, who meet either local, state, or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response, can be billed the trauma activation fee charge. Patients who are “drive-by” or arrive without notification cannot be charged for activations, but can be classified as trauma under Type of Admission Code 5 for statistical and follow-up purposes.
6. Levels I, II, III, IV refer to designations by the state or local government authority or as verified by the American College of Surgeons.
7. Subcategory 9 is for states or local authorities with levels beyond IV.

Appendix A, Inpatient Revenue Center Codes, continued

069X **Not Assigned**

070X **Cast Room**

Charges for services related to the application, maintenance and removal of casts.

Rationale: Permits identification of this service if necessary.

Subcategory	Standard Abbreviation
0-General Classification	CAST ROOM
9-Other Cast Room	OTHER CAST ROOM

071X **Recovery Room**

Rationale: Permits identification of particular services if necessary.

Subcategory	Standard Abbreviation
0-General Classification	RECOVERY ROOM
9-Other Recovery Room	OTHER RECOV RM

072X **Labor Room/Delivery**

Charges for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

Subcategory	Standard Abbreviation
0-General Classification	DELIVROOM/LABOR
1-Labor	LABOR
2-Delivery	DELIVERY ROOM
3-Circumcision	CIRCUMCISION
4-Birthing Center	BIRTHING CENTER
9-Other Labor Room/Delivery	OTHER/DELIV-LABOR

Appendix A, Inpatient Revenue Center Codes, continued

073X EKG/ECG (Electrocardiogram)

Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.

Rationale: Provides a breakdown of items that may require further clarification. Infant circumcision is included because all third party payers do not cover it.

Subcategory	Standard Abbreviation
0-General Classification	EKG/ECG
1-Holter Monitor	HOLTER MONT
2-Telemetry	TELEMETRY
9-Other EKG/ECG	OTHER EKG-ECG

074X EEG (Electroencephalogram)

Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

Subcategory	Standard Abbreviation
0-General Classification	EEG
9-Other EEG	OTHER EEG

075X Gastro-Intestinal Services

Any service or procedure room charges for endoscopic procedures not performed in the operating room.

Subcategory	Standard Abbreviation
0-General Classification	GASTR-INTS SVS
9-Other Gastro-Intestinal	OTHER GASTRO-INTS

Appendix A, Inpatient Revenue Center Codes, continued

076X Treatment or Observation Room

Charges for the use of a treatment room or for the room charge associated with outpatient observation services.

Observation services are those services furnished by a hospital on the hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. The reason for observation must be stated in the orders for observation. Payers should establish written guidelines that identify coverage of observation services.

Subcategory	Standard Abbreviation
0-General Classification	TREATMENT/OBSERVATION RM
1-Treatment Room	TREATMENT RM
2-Observation Room	OBSERVATION RM
9-Other Treatment/Observation Room	OTHER TREATMENT/OBSERV RM

077X Preventative Care Services

Revenue code used to capture preventative care services established by payers.

Subcategory	Standard Abbreviation
0-General Classification	PREVENTATIVE CARE SERV.
1-Vaccine Administration	VACCINE ADMIN
9-Other	OTHER PREVENT

078X Telemedicine

Facility telemedicine charges related to a three-year Medicare demonstration project commencing October 1, 1996.

Subcategory	Standard Abbreviation
0-General Classification	TELEMEDICINE
9-Other Telemedicine	TELEMEDICINE/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

079X **Lithotripsy**

Charges for the use of lithotripsy in the treatment of kidney stones.

Subcategory	Standard Abbreviation
0-General Classification	LITHOTRIPSY
9-Other Lithotripsy	LITHOTRIPSY/OTHER

080X **Inpatient Renal Dialysis**

A waste removal process performed in an inpatient setting that uses an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Rationale: Specific identification required for billing purposes.

Subcategory	Standard Abbreviation
0-General Classification	RENAL DIALYSIS
1-Inpatient Hemodialysis	DIALY/INPT
2-Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
3-Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
4-Inpatient Continuous Cycling Peritoneal Dialysis	DIALY/INPT/CCPD
9-Other Inpatient Dialysis	DAILY/INPT/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

081X Acquisition of Body Components

The acquisition and storage costs of body tissue, bone marrow, organs, and other body components, not otherwise identified, used for transplantation.

Note: To reference the specific organ(s) used in the transplantation procedure, see the specific ICD-9-CM codes.

Rationale: Living donor is a living person from whom an organ is obtained for transplantation. Cadaver is an individual who has been pronounced dead according to medical and legal criteria, and whose organs may be harvested for transplantation. Use the unknown subcategory whenever the status of the individual source of the organ cannot be determined. The other category should be used whenever the organ is non-human.

Medicare requires detailed revenue coding; therefore, codes for this series may not be summed at the zero level.

Subcategory	Standard Abbreviation
0-General Classification	ORGAN ACQUISIT
1-Living Donor	LIVING DONOR
2-Cadaver Donor	CADAVER DONOR
3-Unknown Donor	UNKNOWN DONOR
4-Unsuccessful Organ Search -Donor Bank Charges*	UNSUCCESSFUL SEARCH
9-Other Organ Acquisition	OTHER DONOR

*Note: Revenue code 0814 is to be used only when costs incurred for an organ search do not result in an eventual organ acquisition and transplantation.

082X Hemodialysis - Outpatient or Home

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Subcategory	Standard Abbreviation
0-General Classification	HEMO/OP OR HOME
1-Hemodialysis/Composite Rate	HEMO/COMPOSITE
2-Home Supplies	HEMO/HOME/SUPPL
3-Home Equipment	HEMO/HOME/EQUIP
4-Maintenance/100%	HEMO/HOME/100%
5-Support Services	HEMO/HOME/SUPSERV
9-Other Outpatient Hemodialysis	HEMO/HOME/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

083X Peritoneal Dialysis - Outpatient or Home

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategory	Standard Abbreviation
0-General Classification	PERITONEAL/OP OR HOME
1-Peritoneal/Composite Rate	PERTNL/COMPOSITE
2-Home Supplies	PERTNL/HOME/SUPPL
3-Home Equipment	PERTNL/HOME/EQUIP
4-Maintenance/100%	PERTNL/HOME/100%
5-Support Services	PERTNL/HOME/SUPSERV
9-Other Outpatient Peritoneal Dialysis	PERTNL/HOME/OTHER

084X Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home

A continuous dialysis process performed in an outpatient or home setting that uses the patient peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0-General Classification	CAPD/OP OR HOME
1-CAPD/Composite Rate	CAPD/COMPOSIT
2-Home Supplies	CAPD/HOME/SUPPL
3-Home Equipment	CAPD/HOME/EQUIP
4-Maintenance 100%	CAPD/HOME/100%
5-Support Services	CAPD/HOME/SUPSERV
9-Other Outpatient CAPD	CAPD/HOME/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

085X **Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home**

A continuous dialysis process performed in an outpatient or home setting that uses a machine to make automatic exchanges at night.

Subcategory	Standard Abbreviation
0-General Classification	CCPD/OP OR HOME
1-CCPD/Composite Rate	CCPD/COMPOSITE
2-Home Supplies	CCPD/HOME/SUPPL
3-Home Equipment	CCPD/HOME/EQUIP
4-Maintenance 100%	CCPD/HOME/100%
5-Support Services	CCPD/HOME/SUPSERV
9-Other Outpatient CCPD	CCPD/HOME/OTHER

086X **Reserved for Dialysis (National Assignment)**

087X **Reserved for Dialysis (National Assignment)**

088X **Miscellaneous Dialysis**

Charges for dialysis services not identified elsewhere.

Rationale: Ultrafiltration is the process of removing excess fluid from the blood of dialysis patients by using a dialysis machine but without the dialysate solution. The designation is only used when the procedure is not performed as part of a normal dialysis session.

Subcategory	Standard Abbreviation
0-General Classification	DIALY/MISC
1-Ultrafiltration	DIALY/ULTRAFILT
2-Home Dialysis Aid Visit	HOME DIALYSIS AID VISIT
9-Misc. Dialysis Other	DIALY/MISC/OTHER

089X **Reserved for National Assignment**

Appendix A, Inpatient Revenue Center Codes, continued

090X Psychiatric/Psychological Treatments

Subcategory	Standard Abbreviation
0-General Classification	PSTAY TREATMENT
1-Electroshock Treatment	ELECTRO SHOCK
2-Milieu Therapy	MILIEU THERAPY
3-Play Therapy	PLAY THERAPY
4-Activity Therapy	ACTIVITY THERAPY
9-Other	OTHER PSTAY RX

091X Psychiatric/Psychological Services

Charges for providing nursing care and employee, professional services for emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment.

Rationale: Provides additional identification of services as necessary.

Subcategory	Standard Abbreviation
0-General Classification	PSYCH SERVICES
1-Rehabilitation	PSYCH/REHAB
2-Partial Hospitalization-Less Intensive	PSYCH/PARTIAL HOSP
3-Partial Hospitalization-Intensive	PSYCH/PARTIAL INTENSIVE
4-Individual Therapy	PSYCH/INDIV RX
5-Group Therapy	PSYCH/GROUP RX
6-Family Therapy	PSYCH/FAMILY RX
7-Bio Feedback	PSYCH/BIOFEED
8-Testing	PSYCH/TESTING
9-Other	PSYCH/OTHER

092X Other Diagnostic Services

Charges for other diagnostic services not otherwise categorized.

Subcategory	Standard Abbreviation
0-General Classification	OTHER DX SVS
1-Peripheral Vascular Lab	PERI VASCUL LAB
2-Electromyelogram	EMG
3-Pap Smear	PAP SMEAR
4-Allergy Test	ALLERGY TEST
5-Pregnancy Test	PREG TEST
9-Other Diagnostic Service	ADDITIONAL DX SVS

Appendix A, Inpatient Revenue Center Codes, continued

093X Medical Rehabilitation Day Program

Medical rehabilitation services as contracted with a payer and/or certified by the state. Services may include physical therapy, occupational therapy, and speech therapy.

The subcategories of 093X are designed as zero-billed revenue codes (i.e., no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract. Therefore, zero would be reported in FL47 and the number of hours provided would be reported in FL46. The specific rehabilitation services would be reported under the applicable therapy revenue codes as normal.

Subcategory	Standard Abbreviation
1-Half Day	HALF DAY
2-Full Day	FULL DAY

094X Other Therapeutic Services (also see 095X, an extension of 094X)

Charges for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviation
0-General Classification	OTHER RX SVS
1-Recreational Therapy	RECREATION RX
2-Education/Training	EDUC/TRAINING
3-Cardiac Rehabilitation	CARDIAC REHAB
4-Drug Rehabilitation	DRUG REHAB
5-Alcohol Rehabilitation	ALCOHOL REHAB
6-Complex Medical Equipment-Routine	CMPLX MED EQUIP-ROUT
7-Complex Medical Equipment-Ancillary	CMPLX MED EQUIP-ANC
9-Other Therapeutic Services	ADDITIONAL RX SVS

095X Other Therapeutic Services-(Extension of 094X)

Charges for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviation
0-Reserved	
1-Athletic Training	ATHLETIC TRAINING
2-Kinesiotherapy	KINESIOTHERAPY

Appendix A, Inpatient Revenue Center Codes, continued

096X **Professional Fees (See also 097X and 098X)**

Charges for medical professionals that the hospitals or third party payers require to be separately identified on the billing form. Services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.

Subcategory	Standard Abbreviation
0-General Classification	PRO FEE
1-Psychiatric	PRO FEE/PSTAY
2-Opthalmology	PRO FEE/EYE
3-Anesthesiologist (MD)	PRO FEE/ANES MD
4-Anesthetist (CRNA)	PRO FEE/ANES CRNAOTHER PRO
9-Other Professional Fees	FEE

097X **Professionals Fees (Extension of 096X)**

Subcategory	Standard Abbreviation
1-Laboratory	PRO FEE/LAB
2-Radiology - Diagnostic	PRO FEE/RAD/DX
3-Radiology -Therapeutic	PRO FEE/RAD/RX
4-Radiology – Nuclear Medicine	PRO FEE/NUC MED
5-Operating Room	PRO FEE/OR
6-Respiratory Therapy	PRO FEE/RESPIR
7-Physical Therapy	PRO FEE/PHYSI
8-Occupational Therapy	PRO FEE/OCUPA
9-Speech Pathology	PRO FEE/SPEECH

Appendix A, Inpatient Revenue Center Codes, continued

098X **Professionals Fees (Extension of 096X and 097X)**

Subcategory	Standard Abbreviation
1-Emergency Room	PRO FEE/ER
2-Outpatient Services	PRO FEE/OUTPT
3-Clinic	PRO FEE/CLINIC
4-Medical Social Services	PRO FEE/SOC SVC
5-EKG	PRO FEE/EKG
6-EEG	PRO FEE/EEG
7-Hospital Visit	PRO FEE/HOS VIS
8-Consultation	PRO FEE/CONSULT
9-Private Duty Nurse	PRO FEE/NURSE

099X **Patient Convenience Items**

Charges for items that are generally considered by the third party payers to be strictly convenience items and, as such, are not covered.

Rationale: Permits identification of particular services as necessary.

Subcategory	Standard Abbreviation
0-General Classification	PT CONVENIENCE
1-Cafeteria/Guest Tray	CAFETERIA
2-Private Linen Service	LINEN
3-Telephone/Telegraph	TELEPHONE
4-TV/Radio	TV/RADIO
5-Nonpatient Room Rentals	NONPT ROOM RENT
6-Late Discharge Charge	LATE DISCHARGE
7-Admission Kits	ADMIT KITS
8-Beauty Shop/Barber	BARBER/BEAUTY
9-Other Patient Convenience Items	PT CONVENCE/OTHER

Appendix A, Inpatient Revenue Center Codes, continued

100X to 209X Reserved for National Assignment

210X Alternative Therapy Services

Charges for therapies not elsewhere categorized under other therapeutic service revenue codes (042X, 043X, 044X, 091X, 094X, 095X) or services such as anesthesia or clinic (0374,m 0511).

Alternative therapy is intended to enhance and improve standard medical treatment. The following revenue code(s) would be used to report services in a separately designated alternative inpatient or outpatient unit.

Subcategory	Standard Abbreviation
0-General Classification	ALT THERAPY
1-Acupuncture	ACUPUNCTURE
2-Accupressure	ACCUPRESSURE
3-Massage	MASSAGE
4-Reflexology	REFLEXOLOGY
5-Biofeedback	BIOFEEDBACK
6-Hypnosis	HYPNOSIS
9-Other Alternative Therapy Services	OTHER ALT THERAPY

211X to 300X Reserved for National Assignment

310X Adult Care

Charges for personal, medical, psycho-social, and/or therapeutic services in a special community setting for adults needing supervision and/or assistance with Activities of Daily Living (ADLs).

Subcategory	Standard Abbreviation
0-Not Used	
1-Adult Day Care, Medical and Social-Hourly	ADULT MED/SOC/HR
2-Adult Day Care, Social-Hourly	ADULT SOC/HR
3-Adult Day Care, Medical and Social-Daily	ADULT MED/SOC/DAY
4-Adult Day Care, Social- Daily	ADULT SOC/DAY
5-Adult Foster Care-Daily	ADULT FOSTER/DAY
9-Other Adult Care	OTHER ADULT

311X to 999X Reserved for National Assignment

APPENDIX B
MEDICAID-COVERED OUTPATIENT REVENUE CENTER CODES

APPENDIX B
MEDICAID-COVERED OUTPATIENT REVENUE CENTER CODES

Leading zero on revenue center codes is required for dates of service on and after October 16, 2003.
***Asterisked codes are exempt from the outpatient $1500 cap.**

Category	Description
025X	**PHARMACY**
	Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of a licensed pharmacist.
0250	General Classification
0251	Generic Drug
0252	Non-Generic Drug
0254	Drugs Incident to Other Diagnostic Services
0255	Drugs Incident to Radiology
0258	IV Solutions
0259	Other Pharmacy (Effective 01/01/05)
026X	**IV THERAPY**
	Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment.
0260	General Classification (Effective 10/01/01)
0261	Infusion Pump
0262*	Pharmacy Services
0264*	Supplies
0269*	Other IV Therapy (Effective 01/01/05)
027X	**MEDICAL/SURGICAL SUPPLIES AND DEVICES**
	Charges for supply items required for patient care.
0270	General Classification (Effective 01/01/05)
0271	Non-Sterile Supply
0272	Sterile Supply
0275	Pace Maker

Appendix B, Covered Outpatient Revenue Codes, continued

0276*	Intraocular Lens
0278	Other Implants (a)
	Note: This code can be used to bill the subdermal contraceptive implant or any other medically necessary, non-experimental implant as described below. Cochlear implant handling can also be billed using code 0278. (Effective 01/01/05)
	(a) Implantables: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes.
0279*	Other Supplies/Devices
	Note: This code can be used to bill the burn pressure garment fitted to burn patients.
030X	**LABORATORY-CLINICAL DIAGNOSTIC**
	Charges for the performance of diagnostic and routine clinical laboratory tests.
	Note: The lab revenue codes require a HCPCS code from Appendix C in this handbook.
0300	General Classification
0301	Chemistry
0302	Immunology
0304	Non-Routine Dialysis
0305	Hematology
0306	Bacteriology and Microbiology
0307	Urology
031X	**LABORATORY-PATHOLOGICAL**
	Charges for diagnostic and routine laboratory tests in tissues and culture.
	Note: The pathology revenue codes require a HCPCS code from Appendix C in this handbook.
0310	General Classification
0311	Cytology
0312	Histology
0314	Biopsy

Appendix B, Covered Outpatient Revenue Codes, continued

032X	**RADIOLOGY-DIAGNOSTIC**
	Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining, and interpreting radiographs and fluorographs.
0320	General Classification
0321	Angiocardiography
0322	Arthrography
0323	Arteriography
0324	Chest X-Ray
0329	Other Radiology Diagnostic (Effective 01/01/05)
033X	**RADIOLOGY-THERAPEUTIC AND/OR CHEMOTHERAPY ADMINISTRATION**
	Charges for therapeutic radiology services and chemotherapy administration required for the care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances. Excludes charges for chemotherapy drugs, which should be reported under the appropriate revenue code (025X/063X).
0330*	General Classification
0331*	Chemotherapy Administration-Injected
0332*	Chemotherapy Administration-Oral
0333*	Radiation Therapy
0335*	Chemotherapy Administration-IV
0339*	Other Radiology Therapeutic (Effective 01/01/05)
034X	**NUCLEAR MEDICINE**
	Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.
0340	General Classification
0341	Diagnostic
0342	Therapeutic
0343	Diagnostic Radiopharmaceuticals (Effective 01/01/05)
0344	Therapeutic Radiopharmaceuticals (Effective 01/01/05)
0349	Other Nuclear Medicine (Effective 01/01/05)

Appendix B, Covered Outpatient Revenue Codes, continued

035X	**COMPUTED TOMOGRAPHIC (CT) SCAN**
	Charges for computed tomographic scans of the head and other parts of the body.
0350	General Classification
0351	Head Scan
0352	Body Scan
0359	Other CT Scans (Effective 01/01/05)
036X	**OPERATING ROOM SERVICES/GENERAL**
	Charges for services provided to patients by specially trained personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery, as well as for the operating room (heat, light) and equipment.
0360*	General Classification
0361*	Minor Surgery
0362*	Bone Marrow Transplant
0369*	Other Operating Room Services (Effective 01/01/05)
037X	**ANESTHESIA**
	Charges for anesthesia services in the hospital.
0370	General Classification
0371	Anesthesia Incident to Radiology
0372	Anesthesia Incident to Other Diagnostic Services
0379	Other Anesthesia (Effective 01/01/05)
038X	**BLOOD**
	Charges for blood and blood components.
0380	General Classification
0381	Packed Red Cells
0382	Whole Blood
0383	Plasma
0384	Platelets
0385	Leucocytes

Appendix B, Covered Outpatient Revenue Codes, continued

0386	Other Components
0387	Other Derivatives (Cryopricipitates)
0389	Other Blood (Effective 01/01/05)

039X	**BLOOD AND BLOOD COMPONENT ADMINISTRATION, PROCESSING AND STORAGE**
	Charges for administration, processing, and storage of whole blood, red blood cells, platelets, and other blood components, such as plasma and plasma derivatives.
0390	General Classification
0391	Administration (e.g., Transfusions)
0399	Other Processing and Storage (Effective 01/01/05)

040X	**OTHER IMAGING SERVICES**
0400	General Classification
0401	Diagnostic Mammography
	Note: See Appendix E in this handbook for covered diagnostic mammography codes.
0402	Ultrasound
	Note: Ultrasounds for pregnant women are covered for high-risk pregnancies only. See Appendix J in this handbook for covered diagnoses for high-risk pregnant women.
0403	Screening Mammography
	Note: See Appendix E in this handbook for covered screening mammography diagnosis codes.
0404	Positron Emission Tomography
0409	Other Imaging Services (Effective 01/01/05)

041X	**RESPIRATORY SERVICES (All Ages)**
	Charges for the administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.
0410	General
0412	Inhalation
0413	Hyperbaric Oxygen Therapy
0419	Other Respiratory Services (Effective 01/01/05)

Appendix B, Covered Outpatient Revenue Codes, continued

042X	**PHYSICAL THERAPY (All Ages)**
	Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.
0421	Visit Charge
0424	Evaluation or Re-Evaluation
043X	**OCCUPATIONAL THERAPY (Limited to Under Age 21)**
	Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work.
0431	Visit Charge
0434	Evaluation or Re-Evaluation
044X	**SPEECH-LANGUAGE PATHOLOGY (Limited to Under Age 21)**
	Charges for services provided to persons with impaired functional communications skills.
0441	Visit Charge
0444	Evaluation or Re-Evaluation
045X	**EMERGENCY ROOM**
	Charges for emergency treatment to those ill and injured recipients who require immediate unscheduled medical or surgical care.
	Rationale: Under the provisions of EMTALA (Emergency Medical Treatment and Active Labor Act), a hospital with an emergency department must provide upon request and within the capabilities of the hospital, an appropriate medical screening examination and stabilizing treatment to any individual with an emergency medical condition and to any woman in active labor…(Consolidated Omnibus Budget Reconciliation Act of 1985).
0450	General Classification
	• Use General Classification code 0450 when recipients require emergency medical care beyond the EMTALA emergency medical screening services. Code 0450 cannot be used in conjunction with 0451. • All other appropriate and covered outpatient revenue codes can be billed with 0450 to reflect services rendered to the patient during the course of emergency medical treatment. • No MediPass authorization is required when billing 0450, if the type of admission in Form Locator 19 on the claim is "1" (Emergency). MediPass authorization is required when the condition of the patient is not an emergency.
	This revenue code will be paid at the line item rate.

Appendix B, Covered Outpatient Revenue Codes, continued

0451 EMTALA Emergency Medical Screening Services (Effective 7/1/96)

- Report the EMTALA Medical Screening code 0451 when, other than the screening and exam, no further emergency medical care or treatment is necessary. If ancillary services are necessary to determine whether or not emergency care or further treatment is required, report the ancillary charges using the appropriate revenue center codes in conjunction with code 0451. Note that 0451 cannot be used in conjunction with 0450.

This revenue code will be paid at the line item rate.

046X PULMONARY FUNCTION

Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases.

0460 General Classification

0469 Other Pulmonary Function (Effective 01/01/05)

047X AUDIOLOGY

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

0471 Diagnostic

0472 Treatment

048X CARDIOLOGY

Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to, heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

0480 General Classification

0481 Cardiac Cath Laboratory

0482 Stress Test

0483 Echocardiology

0489 Other Cardiology (Effective 01/01/05)

049X AMBULATORY SURGICAL CARE

Charges for ambulatory surgery that are not covered by any other category.

0490 Ambulatory Surgical Care

Note: Observation is not reported under this code. It is reported under revenue code 0762.

Appendix B, Covered Outpatient Revenue Codes, continued

051X **CLINIC**

Charges for scheduled non-emergency outpatient clinic visits for the purpose of providing diagnostic, preventative, curative, rehabilitative services.

0510 General Classification

Medicaid policy regarding limited usage of code 0510.

- Code 0510 (Clinic visit) can be reported on a hospital claim only when it accompanies any of the revenue center codes identifying therapy and other medical services listed below in this section. Code 0510 cannot be billed to Medicaid as a stand-alone code; and
- Code 0510 is limited to the billing of charges associated with the use of the hospital's clinic setting, whether the location of the clinic is contiguous with the main hospital or off-site, when any therapy or medical service listed below is rendered on such premise. If the site or location is not referred to or known as a "clinic" setting, then code 0510 should not be reported on the claim when reporting therapy or other medical services noted below.

General classification code 0510 can be billed with any one or more of the services identified by the following revenue center codes:

- 0258 Pharmacy/IV Solutions;
- 0261 Infusion Pump;
- 0262 IV Therapy/Pharmacy Services;
- 0264 IV Therapy/Supplies;
- 0269 Other IV Therapy;
- 0330 Therapeutic Radiology/General;
- 0331 Therapeutic Radiology/Injected Chemotherapy;
- 0332 Therapeutic Radiology/Oral Chemotherapy;
- 0333 Therapeutic Radiology/Radiation Therapy;
- 0335 Therapeutic Radiology/Chemotherapy-IV;
- 0339 Other Therapeutic Radiology;
- 0410 Respiratory Services/General (All Ages);
- 0412 Respiratory Services/Inhalation (All Ages);
- 0413 Respiratory Services/Hyperbaric Oxygen Therapy (All Ages);
- 0419 Other Respiratory Services;
- 0421 Physical Therapy/Visit Charges (All Ages);
- 0424 Physical Therapy/Evaluation and Re-Evaluation (All Ages);
- 0431 Occupational Therapy/Visit Charges (Under 21 Only);
- 0434 Occupational Therapy/Evaluation and Re-Evaluation (Under 21 Only);
- 0441 Speech-Language Pathology/Visit Charges (Under 21 Only); and
- 0444 Speech-Language Pathology/Evaluation and Re-Evaluation (Under 21 Only).

Appendix B, Covered Outpatient Revenue Codes, continued

0510 (continued)

- 0480 Cardiology/General;
- 0481 Cardiology/Cardiac Cath Lab;
- 0482 Cardiology Stress Test;
- 0483 Cardiology/Echocardiology Cath;
- 0489 Other Cardiology;
- 0821 Hemodialysis OP;
- 0831 Peritoneal Dialysis OP;
- 0880 Miscellaneous Dialysis/General;
- 0881 Ultrafiltration; and
- 0943 Other Therapeutic Services/Cardiac Rehab.

Clinic revenue code 0510 is not covered and not billable to Medicaid when the services identified below are rendered in hospital-owned clinics. Instead, the hospital should bill these services to Medicaid on the CMS-1500 claim form exclusively, using the appropriate 5-digit CPT or HCPCS procedure codes covered under the Medicaid Physician Services program.

- Primary care services;
- Routine prenatal and postnatal care;
- Well-checkups and screenings for children and adults;
- Dental services rendered in hospital-owned dental clinics;
- Services rendered in psychiatric clinics (See revenue code 0513 covered for that purpose);
- All services rendered in walk-in clinics, wound care centers, urgent care centers.
- Services rendered in family practice clinics; and
- Any type of service rendered in a hospital-owned clinic that could also be accessed and furnished in a physician's office.

Effective November 1, 2004, revenue code 0510, Clinic/General, is reimbursable by Medicaid for health care services (except dental) in outpatient clinic facilities where a public hospital assumed the fiscal and operating responsibilities of one or more primary care centers previously operated by the Florida Department of Health or the local county government.

0513 Psychiatric Clinic

Note: Use code 0513 in conjunction with the following revenue center codes:

- 0914 Psychiatric Clinic Visit/Individual Therapy
- 0918 Psychiatric Testing
- 0944 Drug Rehabilitation
- 0945 Alcohol Rehabilitation

Appendix B, Covered Outpatient Revenue Codes, continued

061X	**MAGNETIC RESONANCE TECHNOLOGY (MRT)**
	Charges for Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) of the brain and other parts of the body.
0610	General Classification
0611	MRI-Brain (Including Brain Stem)
0612	Spinal Cord (Including Spine)
0614	MRI-Other (Effective 01/01/05)
0615	MRA-Head and Neck (Effective 12/11/02)
0616	MRA-Lower Extremities (Effective 12/11/02)
0618	MRA-Other (Effective 01/01/05)
0619	Other MRT (Effective 01/01/05)
062X	**MEDICAL/SURGICAL SUPPLIES – EXTENSION OF 027X**
	Charges for supply items required for patient care. This category is an extension of 028X for reporting additional breakdown where needed.
0621	Supplies Incident to Radiology
0622	Supplies Incident to Other Diagnostic Services
0623	Surgical Dressings
063X	**PHARMACY-EXTENSION OF 025X**
	This category is an extension of 025X for reporting additional breakdown where needed.
0634*	Erythropoietin (EPO) less than 10,000 units (Effective 1/1/99)
0635*	Erythropoietin (EPO) 10,000 or more units (Effective 1/1/99)
0636	Pharmacy/Coded Drugs (Effective 10/1/01)
0637	Self-Administrable Drugs (Effective 10/1/97)
	Note: Use code 0637 to bill Medicaid only for dually eligible recipients when self-administrable drugs are not covered by Medicare. Only codes 0637 and 0001 (Total Charge) can be reported in that circumstance. The outpatient hospital rate will be applied once to such claim.

Appendix B, Covered Outpatient Revenue Codes, continued

070X	**CAST ROOM**
	Charges for services related to the application, maintenance, and removal of casts.
0700	General Classification
071X	**RECOVERY ROOM**
0710	General Classification
	Note: Use code 0710 to bill routine post-operative monitoring during a normal recovery. Recovery room services must not be billed as observation services.
072X	**LABOR ROOM/DELIVERY**
	Charges for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in a delivery suite.
0721	Labor
0722*	Delivery
073X	**EKG – ECG (Electrocardiogram)**
	Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.
0730	General Classification
0731	Holter Monitor
0732	Telemetry
0739	Other EKG - ECG
0740	**EEG (Electroencephalogram)**
	Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.
0740	EEG/General
0749	Other EEG (Effective 01/01/05)

Appendix B, Covered Outpatient Revenue Codes, continued

075X	**GASTRO-INTESTINAL SERVICES**
	Any service or procedure room charges for endoscopic procedures not performed in the operating room.
0750	General Classification
0759	Other Gastro-Intestinal (Effective 01/01/05)
076X	**TREATMENT/OBSERVATION ROOM**
	Charges for the use of a treatment room or for the room charge associated with outpatient observation services.
	Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. The reason for observation must be stated in the orders for observation.
0761	Treatment Room
0762	Observation Room
	Note: Medicaid will cover up to 48 hours (2 days) of observation. These services are billed one day per claim similarly to all other outpatient hospital billing.
079X	**LITHOTRIPSY**
	Charges for the use of lithotripsy in the treatment of kidney stones.
0790*	General Classification
082X	**HEMODIALYSIS – OUTPATIENT**
	A waste removal process, performed in an outpatient setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.
0821*	Hemodialysis Outpatient/Composite
083X*	**PERITONEAL DIALYSIS - Outpatient**
	A waste removal process, performed in an outpatient setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.
0831*	Peritoneal Dialysis Outpatient/Composite Rate

Appendix B, Covered Outpatient Revenue Codes, continued

088X	**MISCELLANEOUS DIALYSIS**
	Charges for dialysis not identified elsewhere.
	Rationale: Ultrafiltration is the process of removing excess fluid from the blood of dialysis patients by using a dialysis machine but without the dialysate solution. The designation is only used when the procedure is not performed as part of a normal dialysis session.
0880*	General Classification
0881*	Ultrafiltration (Effective 01/01/05)
090X	**PSYCHIATRIC TREATMENT**
0901*	Electroshock Treatment
091X	**PSYCHIATRIC SERVICES**
	Charges for providing nursing care and employee, professional services for emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment.
0914	Individual Therapy
	Note: Medicaid covers individual psychiatric therapy for the occasional, episodic incidences of illness. See Chapter 2 of this handbook for details. Medicaid does not cover services rendered by psychologists. Code 0513 (Psychiatric Clinic) may be billed with code 0914.
0918	Testing (Effective 1/1/99)
	Note: Code 0513 (Psychiatric Clinic) may be billed with code 0918.
092X	**OTHER DIAGNOSTIC SERVICES**
	Charges for other diagnostic service not otherwise categorized.
0920	General Classification (Effective 10/01/01)
0921	Peripheral Vascular Lab
0922	Electromylegram
0924	Allergy Test

Appendix B, Covered Outpatient Revenue Codes, continued

094X	**OTHER THERAPEUTIC SERVICES**
	Charges for other therapeutic services not otherwise categorized.
0943	Cardiac Rehabilitation
0944	Drug Rehabilitation
	Note: Code 0513 (Psychiatric Clinic) may be billed with 0944.
0945	Alcohol Rehabilitation
	Note: Code 0513 (Psychiatric Clinic) can be billed with code 0945.

APPENDIX C
LABORATORY SERVICES
PANEL COMPONENTS AND PROCEDURE CODES

APPENDIX C
LABORATORY SERVICES
PANEL COMPONENTS AND PROCEDURE CODES

When all of the individual component tests that make up a particular panel are ordered and performed, reimbursement will be made for the panel, but not the individual tests. When the components of one panel are duplicated in another panel, only one panel code may be billed. Individual tests not included in the panel may be billed separately.

Panel Name and Procedure Code	Description of Individual Panel Components	Procedure Code
Basic Metabolic Panel Procedure Code 80048	1. Calcium 2. Carbon dioxide 3. Chloride 4. Creatinine 5. Glucose 6. Potassium 7. Sodium 8. Urea Nitrogen (BUN)	82310 82374 82435 82565 82947 84132 84295 84520
Electrolyte Panel Procedure Code 80051	1. Carbon dioxide 2. Chloride 3. Potassium 4. Sodium	82374 82435 84132 84295
Comprehensive Metabolic Panel Procedure Code 80053	1. Albumin 2. Bilirubin, total 3. Calcium 4. Carbon dioxide bicarbonate) 5. Chloride 6. Creatinine 7. Glucose 8. Phosphatase, alkaline 9. Potassium 10. Protein, total 11. Sodium 12. Transferase, alanine amino (ALT)(SGPT) 13. Transferase, aspartate amino (AST)(AGOT) 14. Urea Nitrogen (BUN)	82040 82247 82310 82374 82435 82565 82947 84075 84132 84155 84295 84460 84450 84520
Obstetric Panel Procedure Code 80055	1. Hemogram, automated, and manual differential WBC count (CBC) or 2. Hemogram and platelet count, automated, and automated complete differential WBC count (CBC) 3. Hepatitis B surface antigen (HbsAg) 4. Antibody, rubella 5. Syphilis test, qualitative (eg. VDRL, RPR, ART) 6. Antibody screen, RBC, each serum technique 7. Blood typing, ABO and 8. Blood typing, Rh (D)	85022 85025 87340 86762 86592 86850 86900 86901

Appendix C, Laboratory Services, Panel Components and Procedure Codes, continued

Panel Name and Procedure Code	Description of Individual Panel Components	Procedure Codes
Lipid Panel Procedure Codes 80061	1. Cholesterol, serum, total 2. Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) 3. Triglycerides	82465 83718 84478
Renal Function Panel Procedure Code 80069	1. Albumin 2. Calcium 3. Carbon dioxide (bicarbonate) 4. Chloride 5. Creatinine 6. Glucose 7. Phosphorus inorganic (phosphate) 8. Potassium 9. Sodium 10. Urea nitrogen (BUN)	82040 82310 82374 82435 82565 82947 84100 84132 84295 84520
Acute Hepatitis Panel Procedure Code 80074	1. Hepatitis A antibody (HAAb), IgM antibody 2. Hepatitis B core antibody (HbcAb), IgM antibody 3. Hepatitis B surface antigen (HbsAg) 4. Hepatitis C antibody	86709 86705 87340 86803
Hepatic Function Panel Procedure Code 80076	1. Albumin 2. Bilirubin, total 3. Bilirubin, direct 4. Phosphatase, alkaline 5. Protein, total 6. Transferase, alanine amino (ALT) (SGPT) 7. Transferase, aspartate amino (AST) (SGOT)	82040 82247 82248 84075 84155 84460 84450

APPENDIX D
MAMMOGRAPHY DIAGNOSIS CODES

APPENDIX D
MAMMOGRAPHY DIAGNOSIS CODES

Screening Mammography

DX Code	Description
V10.3	Personal History of malignant neoplasm; breast
V15.89	Other specified personal history presenting hazards to health
V16.3	Family history of malignant neoplasm; breast
V70.0	Routine general medical examination at a health care facility

Diagnostic Mammography

DX Code	Description
V10.3	Personal History of malignant neoplasm; breast
V15.89	Other specified personal history presenting hazards to health
V16.3	Family history of malignant neoplasm; breast
V70.0	Routine general medical examination at a health care facility
V10.3	Personal history of malignant neoplasm; breast
V10.40	Personal history of malignant neoplasm; female genital organ unspecified
V10.41	Personal history of malignant neoplasm; cervix uteri
V10.42	Personal history of malignant neoplasm; other parts of uterus
V10.43	Personal history of malignant neoplasm; ovary
V10.44	Personal history of malignant neoplasm; other female genital organs
V10.45	Personal history of malignant neoplasm; male genital organ unspecified
V10.46	Personal history of malignant neoplasm; prostate
V10.47	Personal history of malignant neoplasm; testis
V10.48	Personal history of malignant neoplasm; epididymis
V10.49	Personal history of malignant neoplasm; other male genital organs
V10.71	Lymphosarcoma and reticulosarcoma
V10.72	Hodgkin's disease
V10.79	Other lymphatic and hematopoeitic neoplasms
V10.81	Personal history of malignant neoplasm; bone
V10.82	Malignant melanoma of skin
V10.83	Other malignant neoplasm of skin
V10.84	Personal history of malignant neoplasm; eye
V10.85	Personal history of malignant neoplasm; brain
V10.86	Personal history of malignant neoplasm; other parts of the nervous system
V10.87	Personal history of malignant neoplasm; thyroid
V10.88	Personal history of malignant neoplasm; other endocrine glands and related structures
V10.79	Other lymphatic and hematopoeitic neoplasms
V10.81	Personal history of malignant neoplasm; bone
V10.82	Malignant melanoma of skin
V10.83	Other malignant neoplasm of skin
V10.89	Personal history of malignant neoplasm; other sites

Appendix D, Mammography Diagnosis Codes, continued

Diagnostic Mammography, continued

DX Code	Description
V52.4	Fitting and adjustment of breast prosthesis and implant
V71.1	Observation for suspected malignant neoplasm
V76.10-76.12	Special screening for malignant neoplasms; breast
174.0	Malignant neoplasm of female breast; nipple and areola
174.1	Malignant neoplasm of female breast; central portion
174.2	Malignant neoplasm of female breast; upper-inner quadrant
174.3	Malignant neoplasm of female breast; lower-inner quadrant
174.4	Malignant neoplasm of female breast; upper-outer quadrant
174.5	Malignant neoplasm of female breast; lower-outer quadrant
174.6	Malignant neoplasm of female breast; axillary tail
174.8	Malignant neoplasm of female breast; other specified sites
174.9	Malignant neoplasm of breast (female); unspecified
175.0	Malignant neoplasm of breast (male); nipple and areola
175.90	Malignant neoplasm of breast (male); other and unspecified sites
198.2	Secondary malignant neoplasm, skin
198.81	Secondary malignant neoplasm, breast
214.1	Lipoma, skin and subcutaneous tissue
217	Benign neoplasm of breast
233.0	Carcinoma in situ; breast
238.3	Neoplasm of uncertain behavior; breast
239.3	Neoplasm of unspecified nature; breast
457.0	Postmastectomy lymphedema syndrome
457.1	Other lymphedema
610.0	Solitary cyst of breast
610.1	Diffuse cystic mastopathy
610.2	Fibroadenosis of breast
610.3	Fibrosclerosis of breast
610.4	Mammary duct ectasia
610.8	Other specified benign mammary dysplasias
611.0	Inflammatory disease of breast
611.1	Hypertrophy of breast
611.2	Fissure of nipple
611.3	Fat necrosis of breast
611.4	Atrophy of breast
611.5	Galactocele
611.6	Calactorrhea not associated with childbirth
611.71	Mastodynia
611.72	Lump or mass in breast
611.79	Other signs and symptoms in breast
611.8	Other specified disorders of breast
611.9	Unspecified breast disorder

Appendix D, Mammography Diagnosis Codes, continued

Diagnostic Mammography, continued

DX Code	Description
757.6	Specified anomalies of breast
771.5	Neonatal infective mastitis
785.6	Enlargement of lymph nodes
793.8	Nonspecific abnormal findings on radiological and other examination of breast
879.0	Open wound of breast, without mention of complication
879.1	Open wound of breast, complicated
926.19	Crushing injury of breast
942.11	Burn of breast
942.31	Burn of breast; full thickness skin loss (third degree, not otherwise specified)
942.41	Burn of breast; deep necrosis of underlying tissues (deep third degree) without mention of loss of a body part
942.51	Burn of breast; deep necrosis of underlying tissues (deep third degree) with loss of a body part
996.54	Complication of breast prosthesis
V15.89	Other specified personal history presenting hazards to health

APPENDIX E
LABORATORY CODES FOR FAMILY PLANNING WAIVER RECIPIENTS

APPENDIX E

LABORATORY CODES FOR FAMILY PLANNING WAIVER RECIPIENTS

Code	Description
81000	Urinalysis, by dipstick; non-automated, with microscopy
81001	automated, with microscopy
81002	non-automated, without microscopy
81003	automated, without microscopy
81005	Urinalysis; Qualitative or semiqualitative
81007	Urinalysis; bacteriuria screen, by kit
81015	Urinalysis; bacteriuria screen, microscopic only
81025	Urine pregnancy test, by visual color comparison
82947	Glucose; quantitative
84702	Gonadotropin, chorionic (hCG); quantitative
84703	Gonadotropin, chorionic (hCG); qualitative
85007	Blood count; manual differential WBC count
85018	Hemoglobin
85014	Hematocrit, other than spun
86255	Fluorescent antibody; screen, each antibody (HIV & Herpes)
86382	Neutralization test, viral
86403	Rubella screen (IgG)
86580	Tuberculosis, intradermal
86585	Tuberculosis, tine test
86592	Syphilis test; qualitative (e.g., VDRL, RPR,ART)
86593	Syphilis test; quantitative
86689	HTLV or HIV antibody, confirmatory test (western blot)
86694	Herpes simplex, non-specific type test
86695	Herpes simplex, type I
86701	HIV-1
86703	HIV-1 and HIV-2, single assay
86706	Hepatitis B surface antibody (HBsAb)
86707	Hepatitis Be antibody (HBeAb)
86762	Rubella titer
86781	Antibody; Treponema Pallidum (Syphilis Confirmatory)
86803	Hepatitis C antibody
87060	Throat culture
87070	Culture, bacterial, definitive; any other source (GC)
87075	Culture, bacterial, any source; anaerobic (isolation)
87081	Culture, bacterial, screening only (GC)
87082	Culture, presumptive, pathogenic organisms, by kit (GC)
87086	Culture, bacterial, urine; quantitative, colony count
87087	commercial kit
87110	Culture, chlamydia
87164	Dark field examination
87205	Neisseria gonorrhoeae smear
87206	Smear, primary source, with interpretation; (chlamydia)

Appendix E, Laboratory Codes for Family Planning Waiver Recipients, continued

Code	Description
87210	Smear, primary source, wet mount isolation, with stain
87252	Virus identification; tissue culture inoculation & observation
87340	Hepatitis B surface antigen (HBsAg)
87350	Hepatitis Be antigen (HBeAg)
87480	Candida species, direct probe technique
87481	Candida species, amplified probe technique
87490	Chlamydia trachomatis, direct probe technique
87491	Chlamydia trachomatis, amplified probe technique
87510	Gardnerella vaginalis, direct probe technique
87511	Gardnerella vaginalis, amplified probe technique
87515	Hepatitis B virus, direct probe technique
87516	Hepatitis B virus, amplified probe technique
87520	Hepatitis C virus, direct probe technique
87521	Hepatitis C virus, amplified probe technique
87528	Herpes simplex virus, direct probe technique
87529	Herpes simplex virus, amplified probe technique
87590	Neisseria gonorrhoeae, direct probe technique
87591	Neisseria gonorrhoeae, amplified probe technique
87620	Papillomavirus, human, direct probe technique
87621	Papillomavirus, human, amplified probe technique
88141	Cytopathology, cervical or vaginal (any system phy interpret)
88142	Cytopathology, cervical or vaginal (preservative fluid)
88143	Cytopathology, cervical or vaginal (manual screen & re-screen
88144	Cytopathology, cervical or vaginal (man. screen & computer re-screen
88145	Cytopathology, cervical or vaginal (cell selection)
88150	Cytopathology, smears, cervical or vaginal
88152	with manual cytotech screening under physician supervision
88153	Cytopathology, slides (man. screen & re-screen)
88154	Cytopathology, slides (man. screen & computer re-screen
88155	Cytopathology, smears, with definitive hormonal eval
88156	Cytopathology, smears (the Bethesda System (TBS))
88158	with manual cytotech screening under physician supervision
88164	Cytopathology (Bethesda, manual screening)
88165	Cytopathology (Bethesda, manual screen & re-screen)
88166	Cytopathology (Bethesda, manual screen & computer re-screen
88167	Cytopathology (Bethesda, cell selection)

APPENDIX F
BBA EXCEPTIONS TO CAP LIMITS FOR EMERGENCY CLAIMS

APPENDIX F
BBA EXCEPTIONS TO CAP LIMITS FOR EMERGENCY CLAIMS

Florida Medicaid recipients age 21 and older are limited to 45 hospital inpatient days and $1,500 in hospital outpatient services each state fiscal year (July 1 to June 30), with the outpatient exemptions indicated on Appendix B, Medicaid-Covered Outpatient Revenue Center Codes. However, if emergency criteria in the federal Balanced Budget Act of 1997 (BBA) are met, providers may submit hospital emergency claims for consideration of payment above and beyond the inpatient and outpatient cap limits.

INPATIENT CLAIMS

Which Claims Qualify for Submission?

- Emergency claims for adults who have exhausted their Medicaid hospital inpatient benefit.
- Emergency claims for adults who have exhausted their Medicaid HMO hospital inpatient benefit.
- Emergency claims for MediPass adults who have exhausted their Medicaid hospital inpatient benefit.

Emergencies are indicated by type of admission "1" (Emergency) or "5" (Trauma) in Form Locator 19 of the UB-04 claim form.

What Is the Time Limit for Submissions?

The 12-month filing limit applies to all claims submitted for BBA consideration. Claim packages must be submitted no later than 12 months from the date of service or the date of discharge. The only exception is if the recipient's eligibility determination is delayed, the claim must be submitted within 12 months of the date that the recipient's eligibility is updated on the Florida Medicaid Management Information System (FMMIS).

What Claims Are NOT Eligible for BBA Consideration?

- Claims for adults with Medicare, commercial, or other third party insurance, even when benefits are exhausted under these non-Medicaid primary insurers. (Medicaid does not assume coverage of emergencies for other insurers.)
- Claims more than 12 months past the date of service or the date of discharge.
- Non-emergency claims.

What Must Be Included in the Submission Package?

- A **cover letter** on hospital letterhead. The letter must state the request for an exception to the 45-day cap; must be legibly signed by a person who can be contacted, if necessary; must include a business phone number where the contact person can be reached; and must include a return address.
- Clean **UB-04** for unpaid days
  - The type of bill in Form Locator 4 should be 111, 112, 113, or 114.
  - Report **only** the days for which you are seeking additional reimbursement in Form Locator 6. Even if the patient's hospital benefits were exhausted in the middle of a hospitalization, **BILL ONLY THE UNPAID DAYS**.
  - The admission date in Form Locator 17 must be the actual admission date of the patient. Do not post date or alter the admission date.

Appendix F, BBA Exceptions to Cap Limits for Emergency Claims, continued

- Form Locator 19 (Type of Admission) must indicate an emergency admission. Please note that changing the type of admission for the sole purpose of seeking Medicaid BBA payment is a billing impropriety. Any unauthorized or improper claim alteration such as this is an invitation to further investigation of billing practices.
- Certain revenue center codes, such as 0360 (Operating Room), require an accompanying ICD-9 procedure code in Form Locator 80. Make sure claims include the procedure code and the actual date of the procedure when such revenue center codes are listed. Not doing so causes an Edit 196 denial, which cannot be overridden.
- Form Locator 63 (Treatment Authorization Codes) may be left blank.
- Otherwise, complete the UB claim as usual with the required entries.

- A copy of the **Remittance Voucher** showing the denial or cutback due to benefits being exhausted. For recipients in an HMO, submit documentation from the HMO that benefits have been exhausted.
- **Medical records**:
  - History and Physical
  - Discharge Summary
  - Physician Orders and Progress Notes

DO NOT send nurses' notes or pages of medications the patient was administered in the hospital.

Please note that Medicaid is not to be billed for the cost of printing records or mailing them to AHCA. Copying costs are not compensable by Medicaid, but can be included in the hospital's cost report.

Proper Packaging of Claims

- DO NOT use staples on any documents in the package; use rubber bands instead to hold the package together.
- IMPORTANT: Packages that are not complete upon arrival at AHCA will be immediately returned to the provider without being reviewed.
- Mail packages to the following address:

  Agency for Health Care Administration
  Bureau of Medicaid Services
  2727 Mahan Drive, Mail Stop 20
  Tallahassee, FL 32308
  ATTENTION: BBA Claims Processing

What Happens to the Claim After It Is Submitted?

Emergency inpatient claims submitted for consideration of BBA payment are reviewed by Medicaid's physician consultant. If approved, the UB-04 is forwarded to the Medicaid fiscal agent for processing. If denied, the UB-04 is returned to the provider with a cover memo stating the denial reason. If the Medicaid physician consultant requests additional information, the entire claim package is returned to the provider with a cover memo indicating what other documents need to be submitted.

Please note that once the review has taken place, all medical records are shredded.

Appendix F, BBA Exceptions to Cap Limits for Emergency Cla*ims*, continued

OUTPATIENT CLAIMS

Which Claims Qualify for Submission?

- Emergency claims for adults who have exhausted their Medicaid hospital outpatient benefit.
- Emergency claims for adults who have exhausted their Medicaid HMO hospital outpatient benefit.
- Emergency claims for MediPass adults who have exhausted their Medicaid hospital outpatient benefit.

Emergencies are indicated by type of admission "1" (Emergency) or "5" (Trauma) in Form Locator 19 of the UB-04 claim form.

What Is the Time Limit for Submissions?

The 12-month filing limit applies to all claims submitted for BBA consideration. Claim packages must be submitted no later than 12 months from the date of service. The only exception is if the recipient's eligibility determination is delayed, the claim must be submitted within 12 months of the date that the recipient's eligibility is updated on the Florida Medicaid Management Information System (FMMIS).

What Claims Are NOT Eligible for BBA Consideration?

- Claims for adults with Medicare, commercial, or other third party insurance, even when benefits are exhausted under these non-Medicaid primary insurers. (Medicaid does not assume coverage of emergencies for other insurers.)
- Claims more than 12 months past the date of service.
- Non-emergency claims.

What Must Be Included in the Submission Package?

- A **cover letter** on hospital letterhead. The letter must state the request for an exception to the $1500 outpatient cap; must be legibly signed by a person who can be contacted, if necessary; must include a business phone number where the contact person can be reached; and must include a return address.
- Clean **UB-04** for unpaid services
  - The type of bill in Form Locator 4 should be 131 (straight outpatient).
  - Form Locator 19 (Type of Admission) must indicate an emergency condition. Please note that changing the type of admission for the sole purpose of seeking Medicaid BBA payment is a billing impropriety. Any unauthorized or improper claim alteration such as this is an invitation to further investigation of billing practices.
  - One of the revenue center codes entered in Form Locator 42 must be 0450 (Emergency Room).
  - Certain revenue center codes, such as 0360 (Operating Room), require an accompanying HCPCS CPT procedure code in Form Locator 44. Make sure claims include the procedure code and the actual date of the procedure when such revenue center codes are listed. Not doing so causes an Edit 196 denial, which cannot be overridden.
  - Otherwise, complete the UB claim as usual with the required entries.
- A copy of the **Remittance Voucher** showing the denial or cutback due to benefits being exhausted. For recipients in an HMO, submit documentation from the HMO that benefits have been exhausted.

DO NOT send medical records.

Appendix F, BBA Exceptions to Cap Limits for Emergency Claims, continued

Proper Packaging of Claims

- DO NOT use staples on any documents in the package; use paper clips or rubber bands instead to hold the package together.
- IMPORTANT: Packages that are not complete upon arrival at AHCA will be immediately returned to the provider without being reviewed.
- Mail packages to the following address:

  Agency for Health Care Administration
  Bureau of Medicaid Services
  2727 Mahan Drive, Mail Stop 20
  Tallahassee, FL 32308
  ATTENTION: BBA Claims Processing

What Happens to the Claim After It Is Submitted?

Emergency outpatient claims submitted for consideration of BBA payment are reviewed by the BBA records analyst. If approved, the UB-04 is forwarded to the Medicaid fiscal agent for processing. If denied, the UB-04 is returned to the provider with a cover memo stating the denial reason.

Please note that once the review has taken place, all supporting documents are shredded.

APPENDIX G
BILLING FOR NEWBORN HEARING SCREENING SERVICES

APPENDIX G
BILLING FOR NEWBORN HEARING SCREENING SERVICES

INPATIENT HOSPITAL: Maximum fee reimbursement (Effective 10/01/00 through present)

Medicaid reimburses the maximum fee (technical component + professional component) for newborn hearing screening services when a hospital provider utilizes hospital-owned hearing screening equipment and hospital-employed personnel to perform the screening.

Revenue Center Code (FL 42)	HCPCS Code (FL 44)	Code Description
0471	92585	Auditory evoked potentials for evoked response audiometry and testing or testing of the central nervous system
0471	92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)

INPATIENT HOSPITAL: Fee for technical component only (Effective 10/16/03 through present)

Medicaid reimburses a technical component to a hospital that has a contract with an individual from the community to perform hearing screening tests on Medicaid newborns at the hospital. This individual utilizes hospital-owned hearing screening equipment. Medicaid reimbursement to the hospital is for usage of this equipment.

0471	92585-TC	Auditory evoked potentials for evoked response audiometry and testing or testing of the central nervous system; technical component only
0471	92587-TC	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products); technical component only

OUTPATIENT HOSPITAL: Maximum fee reimbursement (Effective 10/01/00 through present)

Medicaid reimburses the maximum fee (technical component + professional component) for newborn hearing screening services when a hospital provider utilizes hospital-owned hearing screening equipment and hospital-employed personnel to perform the screening.

Revenue Center Code (FL 42)	HCPCS Code (FL 44)	Code Description
0471	92585	Auditory evoked potentials for evoked response audiometry and testing or testing of the central nervous system
0471	92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
0471	92588	Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and distortion or distortion product otoacoustic emissions at multiple levels and frequencies)

Appendix G, Billing for Newborn Hearing Screening Services, continued

OUTPATIENT HOSPITAL: Fee for technical component only (Effective 10/16/03 through present)

Medicaid reimburses a technical component only to a hospital that has a contract with an individual from the community to perform hearing screening tests on Medicaid newborns at the hospital. This individual utilizes the hospital's own hearing screening equipment. Medicaid reimbursement to the hospital is for usage of this equipment.

0471	92585-TC	Auditory evoked potentials for evoked response audiometry and testing or testing of the central nervous system; technical component only
0471	92587-TC	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products); technical component only
0471	92588-TC	Evoked otoacoustic emissions; compreh. or diagnostic eval. (comparison of transient and distortion or distortion product otoacoustic emissions at multiple levels and frequencies; technical only

APPENDIX H
ULTRASOUND DIAGNOSIS CODES FOR HIGH RISK PREGNANT WOMEN

APPENDIX H
ULTRASOUND DIAGNOSIS CODES FOR HIGH RISK PREGNANT WOMEN

Code	Description
042	Human immunodeficiency virus (HIV) disease
199.0	Malignant neoplasm without specification of site; disseminated
199.1	Malignant neoplasm without specification of site; other
282.0	Hereditary hemolytic anemia; hereditary spherocytosis
282.1	Hereditary hemolytic anemia; hereditary elliptocytosis
282.2	Hereditary hemolytic anemia; anemia due to disorders of glutathion metabolism
282.3	Hereditary hemolytic anemia; other anemia due to enzyme deficiency
282.4	Hereditary hemolytic anemia; thalassemias
282.5	Hereditary hemolytic anemia; sickle cell trait
282.60	Sickle cell anemia; unspecified
282.61	Sickle cell anemia; Hb-S disease without mention of crisis
282.62	Sickle cell anemia; Hb-S disease with mention of crisis
282.63	Sickle-cell/Hb-C disease
282.69	Sickle cell anemia; other
282.7	Other hemoglobinopathies
282.8	Other specified hereditary hemolytic anemias
282.9	Hereditary hemolytic anemia; unspecified
345.00	Generalized nonconvulsive epilepsy; without mention of intractable epilepsy
345.01	Generalized nonconvulsive epilepsy; with intractable epilepsy
345.10	Generalized convulsive epilepsy; without mention of intractable epilepsy
345.11	Generalized convulsive epilepsy; with intractable epilepsy

Appendix H, Ultrasound Diagnosis Codes for High Risk Pregnant Women, continued

Code	Description
345.2	Petit mal status
345.3	Grand mal status
345.40	Partial epilepsy, with impairment of consciousness; without mention of intractable epilepsy
345.41	Partial epilepsy, with impairment of consciousness; with intractable epilepsy
345.50	Partial epilepsy, without impairment of consciousness; without mention of intractable epilepsy
345.51	Partial epilepsy, without impairment of consciousness; with intractable epilepsy
345.60	Infantile spasms; without mention of intractable epilepsy
345.61	Infantile spasms; with intractable epilepsy
345.70	Epilepsia partialis continua; without mention of intractable epilepsy
345.71	Epilepsia partialis continua; with intractable epilepsy
345.80	Other forms of epilepsy; without mention of intractable epilepsy
345.81	Other forms of epilepsy; with intractable epilepsy
345.90	Epilepsy, unspecified; without mention of intractable epilepsy
345.91	Epilepsy, unspecified; with intractable epilepsy
493.00	Extrinsic asthma; without mention of status asthmaticus
493.01	Extrinsic asthma; with status asthmaticus
493.02	Extrinsic asthma; with acute exacerbation
493.10	Intrinsic asthma; without mention of status asthmaticus
493.11	Intrinsic asthma; with status asthmaticus
493.12	Intrinsic asthma; with acute exacerbation
493.20	Chronic obstructive asthma; without mention of status asthmaticus or acute
493.21	Chronic obstructive asthma; with status asthmaticus
493.22	Chronic obstructive asthma; with acute exacerbation

Appendix H, Ultrasound Diagnosis Codes for High Risk Pregnant Women, continued

Code	Description
493.90	Asthma, unspecified; without mention of asthmaticus or acute
493.91	Asthma, unspecified; with status asthmaticus
493.92	Asthma, unspecified; with acute exacerbation
632	Missed abortion
640.03	Threatened abortion; antepartum condition or complication
641.03	Placenta previa without hemorrhage; antepartum condition or complication
641.23	Premature separation of placenta; antepartum condition or complication
642.03	Benign essential hypertension complicating pregnancy, childbirth, and puerperium; antepartum condition or complication
642.13	Hypertension secondary to renal disease, complicating pregnancy, childbirth, and the puerperium; antepartum condition or complication
642.23	Other pre-existing hypertension complicating pregnancy, childbirth, and the puerperium; antepartum condition or complication
642.33	Transient hypertension of pregnancy; antepartum condition or complication
642.43	Mild or unspecified pre-eclampsia; antepartum condition or complication
642.53	Severe pre-eclampsia; antepartum condition or complication
642.63	Eclampsia; antepartum condition or complication
642.73	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension; antepartum condition or complication
644.03	Threatened premature labor; antepartum condition or complication
645.13	Post term pregnancy; antepartum condition or complication
645.23	Prolonged pregnancy; antepartum condition or complication
646.23	Habitual aborter; antepartum condition or complication
646.73	Liver disorders in pregnancy; antepartum condition or complication
647.03	Syphilis; antepartum condition or complication
647.33	Tuberculosis; antepartum condition or complication

Appendix H, Ultrasound Diagnosis Codes for High Risk Pregnant Women, continued

Code	Description
648.03	Diabetes mellitus; antepartum condition or complication
648.13	Thyroid dysfunction; antepartum condition or complication
648.23	Anemia; antepartum condition or complication
648.33	Drug dependence; antepartum condition or complication
648.53	Congenital cardiovascular disorders; antepartum condition or complication
648.63	Other cardiovascular diseases; antepartum condition or complication
648.83	Abnormal glucose tolerance; antepartum condition or complication
651.03	Twin pregnancy; antepartum condition or complication
651.13	Triplet pregnancy; antepartum condition or complication
651.23	Quadruplet pregnancy; antepartum condition or complication
651.83	Other specified multiple gestation; antepartum condition or complication
651.93	Unspecified multiple gestation; antepartum condition or complication
652.23	Breech presentation without mention of version; antepartum condition or complication
653.53	Unusually large fetus causing disproportion
655.03	Central nervous system malformation in fetus; antepartum condition or complication
655.13	Chromosomal abnormality in fetus; antepartum condition or complication
655.23	Hereditary disease in family possible affecting fetus; antepartum condition or complication
655.33	Suspected damage to fetus from viral disease in the mother; antepartum condition or complication
655.43	Suspected damage to fetus from other disease in the mother; antepartum condition or complication
655.53	Suspected damage to fetus from drugs; antepartum condition or complication
655.63	Suspected damage to fetus from radiation; antepartum condition or complication
655.73	Decreased fetal movements; antepartum condition or complication
655.83	Other known or suspected fetal abnormality, not elsewhere classified; antepartum condition or complication

Appendix H, Ultrasound Diagnosis Codes for High Risk Pregnant Women, continued

Code	Description
655.93	Unspecified abnormality affecting management of mother; antepartum condition or complication
656.13	Isoimmunization, Rhesus
656.23	Isoimmunization from other and unspecified blood-group incompatibility; antepartum condition or complication
656.43	Intrauterine death; antepartum condition or complication
656.53	Poor fetal growth; antepartum condition or complication
656.63	Excessive fetal growth; antepartum condition or complication
657.03	Polyhydramnios; antepartum condition or complication
658.03	Oligohydramnios
658.13	Premature rupture of membranes; antepartum condition or complication
659.43	Grand multiparity; antepartum condition or complication
659.53	Elderly primigravida; antepartum condition or complication
659.63	Elderly multigravida; antepartum condition or complication
671.23	Superficial thrombophlebitis; antepartum condition or complication
671.33	Deep phlebothrombosis, antepartum condition or complication
671.53	Other phlebitis and thrombosis; antepartum condition or complication
789.07	Abdominal pain; generalized
V08	Asymptomatic human immunodeficiency virus infection status (HIV)