Table of Contents

1. Section Modifications

Version	Section / Column	Modification Description	Date	SME
44.0	All	Published version	3/8/2018	TQD
43.5	6.5 Outpatient Cardiac Rehabilitation	Revised for clarity	3/8/2018	W Deseron D Baker E Garibovic
43.4	6.3.1 Participant Eligibility 6.3.2 Individual Counseling - Diabetes/Education Training 6.3.3 Group Counseling - Diabetes/Education Training 6.5.1 Qualifying Cardiac Events 6.5.2 Components of Cardiac Rehabilitation 6.5.3 Limitations for Coverage 12. Revenue Codes 12.2 Accommodation Revenue Codes 12.3 Ancillary Revenue Codes 12.4 Incremental Nursing Codes 0230 – 0234	Removed sections	3/8/2018	W Deseron D Baker E Garibovic
43.3	6.3 Diabetes Education and Training	Added information about revenue code 0942	3/8/2018	W Deseron D Baker E Garibovic
43.2	2.2 Reimbursement	Changed section title; revised for clarity	3/8/2018	W Deseron D Baker E Garibovic
43.1	2.1 General Policy	Moved section up	3/8/2018	W Deseron D Baker E Garibovic
43.0	All	Published version	2/20/2018	TQD
42.1	10.2 Prior Authoriation (PA)	Updated phone number for AND program	2/20/2018	K Eidemiller E Garibovic D Baker
42.0	All	Published version	2/9/2018	TQD
41.9	15.3 Children (Up to 21st Birthday)	Changed “members” to “participants”	2/9/2018	W Deseron D Baker E Garibovic
41.8	15.2 Pregnant Women (PW) Services	Removed sentence about dieticians working for the hospital	2/9/2018	W Deseron D Baker E Garibovic
41.7	14.7 Requests for Reconsideration 14.8 Requests for Reconsideration (Appeals) of Medicaid Ambulance Review	Removed sections	2/9/2018	W Deseron D Baker E Garibovic
41.6	10.1 Overview	Updated ICF/IID acronym	2/9/2018	W Deseron D Baker E Garibovic
41.5	7.1 Overview	Removed “Medicaid Ambulance”	2/9/2018	W Deseron D Baker E Garibovic
41.4	6.3.1 Participant Eligibility	New section	2/9/2018	W Deseron D Baker E Garibovic
41.3	6.3 Diabetes Education and Training 6.3.2 Individual Counseling - Diabetes/Education Training 6.3.3 Group Counseling - Diabetes/Education Training	Moved sections up; updates throughout	2/9/2018	W Deseron D Baker E Garibovic

Version	Section / Column	Modification Description	Date	SME
41.2	5.5 Procedure Codes on Inpatient Claims 5.10 Pregnancy Services	Removed ICD-9 information	2/9/2018	W Deseron D Baker E Garibovic
41.1	4. Durable Medical Equipment (DME) – Hearing Aids	Moved section up	2/9/2018	W Deseron D Baker E Garibovic
41.0	All	Published version	1/29/2018	TQD
40.1	5.6.3 Limitations 8.1.1 Speech and Physical Therapy 8.1.2 Occupational Therapy	Updated cap amounts	1/29/2018	W Deseron D Baker E Garibovic
40.0	All	Published version	1/11/2018	TQD
39.11	Appendix A. ICD-10 Diagnosis Codes Accepted by Idaho Medicaid Supporting Medical Necessity for Cesarean Section	Added Appendix	1/11/2018	W Deseron D Baker E Garibovic
39.10	8.10 Excluded Services	Significant revisions	1/11/2018	W Deseron D Baker E Garibovic
39.9	8.3 Hyperbaric Oxygen Treatment	New section	1/11/2018	W Deseron D Baker E Garibovic
39.8	8.2 Cosmetic Surgery 8.5 Fertility	Removed sections	1/11/2018	W Deseron D Baker E Garibovic
39.7	6.12 Medical Care Unit Prior Authorization	Updated surgeries bullet; removed therapy exceeding cap limitations	1/11/2018	W Deseron D Baker E Garibovic
39.6	6.7 Cesarean Section	Updates to diagnosis codes	1/11/2018	W Deseron D Baker E Garibovic
39.5	6.6 Admission for Substance Abuse	Updates to reflect current policy	1/11/2018	W Deseron D Baker E Garibovic
39.4	6.4 Transfers	Removed information regarding authorization for intra-facility transfers	1/11/2018	W Deseron D Baker E Garibovic
39.3	5.6.3 Limitations	Updates to documentation review and requirements	1/11/2018	W Deseron D Baker E Garibovic
39.2	5.6.1 PT, OT, and SLP Services	Added to first bullet regarding medically necessary SLP services	1/11/2018	S Scheuerer D Baker E Garibovic
39.1	4.9 Behavioral Health Services	Revised section title; significant revisions	1/11/2018	W Deseron D Baker E Garibovic
39.0	All	Published version	12/29/2017	TQD
38.1	6.7 Cesarean Section	Removed ICD-9 codes; updated list of ICD-10 codes	12/29/2017	W Deseron E Garibovic
38.0	All	Published version	6/27/2017	TQD
37.1	11.5.5 Treat and Release or Respond and Evaluate	Added information for HCPCS A0998	6/27/2017	D Baker
37.0	All	Published version	5/26/2017	TQD
36.7	11.5.5 Treat and Release or Respond and Evaluate	Added statement about participant responsibility	5/26/2017	W Walther D Baker E Garibovic

Version	Section / Column	Modification Description	Date	SME
36.6	11.5.3 Nursing Home Residents 11.5.4 Trips to the Physician's Office 11.7 Requests for Reconsideration 11.8 Requests for Reconsideration (Appeals) of Medicaid Ambulance Review	Changed "Medicaid Ambulance Review" to "Medical Care Unit"	5/26/2017	W Walther D Baker E Garibovic
36.5	11.5.2.1 Definitions	New section	5/26/2017	W Walther D Baker E Garibovic
36.4	11.4 Billing Information	Updated required attachments	5/26/2017	W Walther D Baker E Garibovic
36.3	11.1.2 Definition of Non-Emergency Services	Added statement about bed confinement	5/26/2017	W Walther D Baker E Garibovic
36.2	11.1.1 Definition of Emergency Services	Updated definition	5/26/2017	W Walther D Baker E Garibovic
36.1	11.1 Overview	Updated Medicaid Ambulance Review phone number	5/26/2017	W Walther D Baker E Garibovic
36.0	All	Published version	4/20/2017	S Scheuerer D Baker E Garibovic
35.6	8.1.1 Speech and Physical Therapy 8.1.2 Occupational Therapy	Specified "outpatient" services	4/20/2017	S Scheuerer D Baker E Garibovic
35.5	8.1 Outpatient Therapy Services	Added "Outpatient" to section title	4/20/2017	S Scheuerer D Baker E Garibovic
35.4	5.6.4 Non-covered Services	Updated list	4/20/2017	S Scheuerer D Baker E Garibovic
35.3	5.6.3 Limitations	Clarity regarding caps; updated documentation information; changed six months to 365 days for plan of care; updated information for KX modifier review	4/20/2017	S Scheuerer D Baker E Garibovic
35.2	5.6.2 Supervision	Updated supervision information	4/20/2017	S Scheuerer D Baker E Garibovic
35.1	5.6.1 Overview	Updated frequency for order for continued care	4/20/2017	S Scheuerer D Baker E Garibovic
35.0	All	Published version	4/6/2017	TQD
34.1	5.6.3 Limitations	Updated service limitation amounts	4/6/2017	D Baker
34.0	All	Published version	3/23/2017	TQD
33.1	8.1.1 Speech and Physical Therapy 8.1.2 Occupational Therapy	Updated service limitation amounts	3/23/2017	D Baker E Garibovic
33.0	All	Published version	2/1/2017	TQD
32.1	9.1 Overview	Added statement regarding cost centers	2/1/2017	T Lombard D Baker E Garibovic
32.0	All	Published version	11/17/2016	TQD

Version	Section / Column	Modification Description	Date	SME
31.1	11.5.3 Multiple Runs in One Day	Section rewrite	11/17/2016	W Deseron E Garibovic
31.0	All	Published version	11/3/2016	TQD
30.1	4.8.1 Limitations	Added sentence re: semiprivate room revenue codes	11/3/2016	C Lord D Baker
30.0	All	Published version	8/31/2016	TQD
29.1	4.9 Psychiatric Hospital 4.9.1 Participants under the Age of 21 4.10.2 Pregnancy Services 4.10.3 Split Billing 5.3 Outpatient Observation 6.1 Overview [PA] 6.1.1 Quality Improvement Organization (QIO) 6.6 Admission for Substance Abuse 6.7 Cesarean Section 6.10 Retrospective/Late QIO Reviews 6.11 Contacting the QIO 6.12 Medical Care Unit Prior Authorization 8.3 Bariatric Surgery for Weight Loss 8.4 Transplants	Updated QIO information due to vendor change	8/31/2016	D Boyle D Baker
29.0	All	Published version	5/29/2016	TQD
28.2	8.4 Transplants	Added lung	5/19/2016	R Natal D Baker
28.1	7.2 Prior Authorization (PA)	Updated link to AND Form	5/19/2016	D Baker
28.0	All	Published version	4/25/2016	TQD
27.1	4.10.5. Donor/Transplants	Add lung to the donor list, delete sentence concerning participants under age 21	4/25/2016	E Garibovic
27.0	All	Published version	2/12/2016	TQD
26.2	4.4.1 Present on Admission (POA) Indicators	Updated section/ deleted content	2/11/2016	D Baker J Kennedy
26.1	4.4 Health Acquired Conditions	Content deleted, CMS referral content added, Bill type content updated	2/11/2016	D Baker J Kennedy
26.0	All	Published Version	1/22/2016	TQD
25.5	8.8 Telehealth	Updated with new content	1/22/2015	C Brock D Baker C Loveless
25.4	6.1.1 Qualis Health	Removed reference to Health Home	1/22/2016	C Brock D Baker C Loveless
25.3	5.7.4 Durable Medical Equipment – Hearing Aids	New section	1/22/2016	J Siroky D Baker C Loveless
25.2	5.7.3 Healthy Connections (HC) Referral	Updated to align with PCCM changes	1/22/2016	C Brock D Baker C Loveless
25.1	4.7 Durable Medical Equipment	Made specific to hearing aids	1/22/2016	J Siroky D Baker C Loveless
25.0	All	Published version	12/1/15	TQD
24.3	11.4.2 Medicare Participants	Updated for December 2015 COB changes	12/1/15	C Coyle D Baker
24.2	11.4.1 Third Party Recovery (TPR)	Updated for December 2015 COB changes	12/1/15	C Coyle D Baker
24.1	2.2 Third Party	Updated for December 2015 COB changes	12/1/15	C Coyle D Baker

Version	Section/Column	Modification Description	Date	SME
24.0	All	Published version	9/25/15	TQD
23.1	5.7.2 Emergency Department Co-Payment	Removed "with a referral from their PCP" from bullet about care by PCP or at an urgent care clinic	9/25/15	C Brock D Baker
23.0	All	Published version	8/28/15	TQD
22.1	4.4 Health Acquired Conditions (HAC) 4.4.1 Present on Admission (POA) Indicators 4.10.2 Pregnancy Services 6.7 Cesarean Section	Updated for ICD-10	8/28/15	A Coppinger D Baker C Taylor
22.0	All	Published version	8/14/15	TQD
21.2	5.3 Outpatient Observation	Updated description of observation; updated to reflect new 48 hour rule	8/14/15	A Coppinger C Taylor D Baker
21.1	4.3 Emergency/Observation Room Visit Exceeding Census Hour	Updated to reflect new 48 hour rule	8/14/15	A Coppinger C Taylor D Baker
21.0	All	Published version	6/26/15	TQD
20.3	4.5 Procedure Codes on Inpatient Claims	New section	6/26/15	A Coppinger D Baker
20.2	4.4.1 POA Indicators	Updated link to ICD-9 exemption list	6/26/15	A Coppinger D Baker
20.1	4.4 HAC	Updated link to fact sheet	6/26/15	A Coppinger D Baker
20.0	All	Published version	3/30/15	TQD
19.3	8.3 Bariatric Surgery for Weight Loss	Updated bullet about national medical standards	3/30/15	A Coppinger C Taylor
19.2	5.4 Outpatient Cardiac Rehabilitation, and subsections 5.4.1 - 5.4.5	Added sections	3/30/15	A Coppinger C Taylor
19.1	4.7.3 Rate Changes	Removed section	3/30/15	C Taylor
19.0	All	Published version	3/12/15	All
18.1	8.3 Bariatric Surgery for Weight Loss	Updated requirements	3/12/15	A Coppinger C Taylor D Baker
18.0	All	Published version	2/12/15	TQD
17.1	4.10 Hospital Accommodation Rate Schedule	Removed section	2/12/15	C Taylor D Baker
17.0	All	Published version	1/29/15	TQD
16.1	4.4 Health Acquired Conditions (HAC)	Added information about splitting claims	1/29/15	A Coppinger C Taylor D Baker
16.0	All	Published version	08/15/14	TQD
15.1	8.3 Bariatric Surgery	Removed Medicare reference and added link to Surgical Review Corporation	08/15/14	M Wimmer D Baker C Taylor
15.0	All	Published version	08/08/14	TQD
14.1	8.8 Telemedicine	Added section	08/08/14	C Taylor
14.0	All	Published version	08/01/14	TQD
13.1	4.4 Health Acquired Conditions (HAC)	Removed reference in last bullet to claims being denied.	08/01/14	R Sosin C Taylor
13.0	All	Published version	07/01/14	TQD

Version	Section / Column	Modification Description	Date	SME
12.3	5.6 Emergency Department	Added section for ED; added new subsections 5.6.1 and 5.6.4; updated co-pay amount in 5.6.2	07/01/14	A Coppinger C Taylor D Baker
12.2	4.6 DME Referral	Added section	6/30/14	A Coppinger C Taylor
12.1	4.4.1 POA Indicators	Updated information to clarify and added links to exemption lists for ICD-9 and ICD-10.	6/30/14	R Sosin
12.0	All	Published version	5/28/14	TQD
11.1	9.4 Incremental Nursing codes 0230-0234	Added rev code 0233	5/28/14	A Coppinger C Taylor
11.0	All	Published version	5/23/14	TQD
10.1	9.4 Incremental Nursing codes 0230-0234	Added section	5/23/14	C Taylor D Baker
10.0	All	Published version	4/25/14	TQD
9.4	8.3 Bariatric Surgery	Added last bullet the procedure must be performed in a BSC or BSCE.	4/25/14	D Baker C Taylor
9.3	5.3 Other Provider Preventable Conditions (OPPCs)	Removed section	4/25/14	A Coppinger C Taylor
9.2	4.8.2. Pregnancy Services, Diagnosis Codes; 6.7 Cesarean Section	Updated ICD-10 dates to 2015.	4/25/14	C Taylor D Baker
9.1	4.4 Health Acquired Conditions	Added new section	4/25/14	A Coppinger C Taylor
9.0	All	Published version	3/21/14	TQD
8.2	5.6 ED Limitations	Removed section	3/21/14	C Taylor
8.1	4.2 Inpatient Day	Added additional information	3/21/14	C Taylor
8.0	All	Published version	2/14/14	TQD
7.1	4.7.3	Added bullet for clarity	2/14/14	C Taylor D Baker
7.0	All	Published version	1/24/14	TQD
6.1	4.3 Emergency/Observation Room Visits Exceeding Census Hour	Updated to include observation	1/24/14	D Baker
6.0	All	Published version	1/17/14	TQD
5.2	5.6 ED Limitations	Clarified meaning of “immediate admission”	1/17/14	C Taylor D Baker
5.1	4.3 Emergency Room Visits Exceeding Census Hour	Added section	1/17/14	C Taylor D Baker
5.0	All	Published version	1/10/14	C Taylor
4.1	13.3.2 Children (Up to 21st Birthday	Removed references for PW; added statement that pregnancy related diabetic diagnosis is required.	1/10/14	J Siroky
4.0	All	Published version	10/04/13	TQD
3.4	8.3 Bariatric Surgery	Removed last bullet as the requirement for facilities to have the COE designation perform the bariatric surgery was rescinded.	10/04/13	K Gudmunson C Taylor
3.3	7.5 Billing Procedures	Updated first bullet for Type of Bill to use code 131.	10/04/13	D Baker C Taylor
3.2	4.6.2 Pregnancy Services; 6.7 Cesarean Section	Updated references to ICD-9 to include ICD-10 information	10/04/13	L Neal C Taylor
3.1	3. Swing Beds	Updated reference link to LTC guidelines	10/04/13	K Gudmunson C Taylor

Version	Section / Column	Modification Description	Date	SME
3.0	All	Published version	09/16/13	TQD
2.11	11. Ambulance Service Policy (and all subsections)	Updated to align with current policy	09/16/13	W Walther C Taylor
2.10	10. Hospital Surgical Procedure Billing (and all subsections	Updated to align with current policy	09/16/13	A Farmer C Taylor
2.9	9.1 Revenue Codes Overview	Updated for clarity	09/16/13	A Farmer C Taylor
2.8	8. Coverage Limits (and all subsections)	Updated to align with current policy; removed 8.1 Global Surgery Fees	09/16/13	A Farmer C Taylor
2.7	7. AND (and all subsections)	Updated to align with current policy	09/16/13	A Farmer C Taylor
2.6	6. Prior Authorization (and all subsections)	Updated to align with current policy	09/16/13	A Farmer C Taylor
2.5	5. Outpatient Hospital Policy (and all subsections)	Updated to align with current policy	09/16/13	A Farmer C Taylor J Siroky
2.4	4. Inpatient Hospital Service Policy (and all subsections)	Updated to align with current policy	09/16/13	A Farmer C Taylor
2.3	2.3 Type of Bill Codes	Removed	09/16/13	A Farmer C Taylor
2.2	All	Published version	1/18/12	TQD
2.1	9.0 Hospital Surgical Procedure Billing	Added first two paragraphs to clarify billing procedures	1/18/12	A Ramirez
2.0	All	Published version	8/27/10	TQD
1.2	All	Replaced member with participant	8/27/10	TQD
1.1	All	Updated numbering for sections to accommodate Section Modifications	8/27/10	TQD
1.0	All	Initial document – published version	5/7/10	TQD

2. Introduction

2.1 General Policy

This section describes Medicaid-covered services provided by hospital facilities. It addresses the following:

1. Swing beds
2. Inpatient policy
3. Outpatient policy
4. Prior authorization (PA)
5. Administratively necessary days (AND)
6. Coverage limits
7. Revenue codes
8. Hospital surgical procedure billing
9. Ambulance service policy
10. Diabetes education and training
11. Dietitian service policy

2.2 Reimbursement

Idaho Medicaid does not support billing and payment by cost centers; hospitals should bill all associated revenue codes as identified in the Idaho MMIS Handbook, *UB04 Instructions*. See *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding policy on billing, including requirments for billing other third party resources before submitting claims to Medicaid.

3. Swing Beds

3.1 Overview

Swing bed room and board is not billable using the hospital provider number. For those hospitals that meet the Code of Federal Regulation requirements and are approved by the Centers for Medicare and Medicaid Services (CMS) to provide swing bed care, a separate provider number is needed from the Idaho Medicaid Program. When an application has been approved, the provider will review the *LTC* handbook that explains the billing requirements particular to swing beds.

3.2 Reimbursement

Reimbursement of ancillary services not included in the swing bed rate must be billed on an outpatient claim (bill type **0131**) and settled on a cost basis with other outpatient services. Prescription drugs must be billed on the outpatient hospital claim form.

4. Durable Medical Equipment (DME) – Hearing Aids

Hearing aids are not covered as a hospital inpatient or outpatient service. The claim must be submitted by a hearing aid vendor as a professional claim, and may not be billed as a hospital claim.

5. Inpatient Hospital Service Policy

5.1 Overview

Medicaid pays for inpatient services ordinarily furnished in a hospital for the care and treatment of a patient under the direction of a physician or, under certain circumstances, a dentist.

5.2 Inpatient Day

An inpatient day is counted for a patient who is admitted to the hospital for inpatient services, intends to stay overnight, and is in the inpatient bed at the midnight census hour. Emergency department visits that are followed by an immediate admission on the same date of service should be billed as part of the inpatient service.

5.3 Emergency/Observation Room Visit Exceeding Census Hour

Emergency/Observation room department visits that exceed the 24 hours for dates of service prior to 9/1/2015, or 48 hours on or after 9/1/2015, and result in a direct admit to inpatient status, should be billed as two separate claims. Emergency department and observation services should be billed as an outpatient type of bill. All inpatient services should be billed as an inpatient type of bill. The “from date of service” on the inpatient claim cannot be prior to the admit date.

Note: While Medicare supports the 72-hour rule for combining inpatient and outpatient services, Medicaid does not.

5.4 Health Acquired Conditions (HAC)

- Services needed to treat health acquired conditions are not covered. The system will use the combination of POA indicator, procedure codes, and diagnosis codes to identify HAC. Please refer to CMS for conditions determined to be Health Acquired Conditions. The POA indicator is required for all claims involving Medicaid inpatient admissions.
- Providers must split their claims when a claim with a HAC condition has an indicator of N or U. Covered items on a claim will not be paid when an HAC diagnosis code with a POA of N or U are on the claim.
- When splitting the claim, both new claims will be inpatient bill types with the number of days on each claim before and after the situation that caused an HAC; use an interim bill type. When using a through date that is less than the discharge date, you must have a patient status of 30 to indicate an interim billing.
- Bill type 0110 Non Payment / Zero Claim should be used on a claim with HAC diagnoses.

5.4.1 Present on Admission (POA) Indicators

POA is defined as present at the time the order for inpatient admission occurs. The POA indicator is assigned to each diagnosis submitted.

Figure 4-1: POA Indicators

Code	Definition	Idaho Medicaid
Y	Present at the time of inpatient admission	Idaho Medicaid will pay for all services as usual, including those selected HACs that are coded with a POA indicator of "Y"
N	Not present at the time of inpatient admission	Idaho Medicaid will not pay for services with HACs that are coded with a POA indicator of "N" All other services not identified as HACs will be paid as usual.
U	Documentation is insufficient to determine if condition is present on admission	Idaho Medicaid will not pay for services with HACs that are coded with a POA indicator of "U". All other services not identified as HACs will be paid as usual.
W	Provider is unable to clinically determine whether condition was present on admission or not.	Idaho Medicaid will pay for services as usual, including those selected HACs that are coded with a POA indicator of "W".

5.4.2 Documentation

Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission. Providers must resolve issues related to inconsistent, missing, conflicting, or unclear information.

Providers who do not code their claims correctly in accordance with HIPAA and national coding standards are subject to claim recoupment and review for potential fraud. Federal guidelines require providers to bill Medicaid correctly, and to identify these types of situations, even if the provider does not bill actual charges for the services related to the conditions.

5.5 Procedure Codes on Inpatient Claims

When reporting revenue codes 036x (Operating Room) on inpatient hospital claims, the principal procedure must be reported using the ICD procedure code in Box 74 on the UB-04. International Classification of Diseases procedure codes (ICD-PCS) are required for inpatient hospital claims.

The principal procedure code, as well as other procedure codes (Box 74 a – e), must include all applicable digits. Use the full ICD-10-PCS procedure codes.

5.6 Reimbursement

Medicaid reimburses inpatient charges according to the facility's inpatient reimbursement rate established by the Department.

5.6.1 Accommodation Rates

Birthing room charges should reflect the normal administrative, nursing, and physical resources utilized for the mother and child occupying the same room. Ancillary services may not be combined with the charge for the accommodation.

Private and psychiatric accommodations will not be reimbursed at more than the semiprivate room rates on file with Medicaid except as stated in the next section,

Exceptions. Except as provided in section 4.8.2, hospitals that offer only private room accommodations are instructed to bill Medicaid using semiprivate room revenue codes.

If the participant is placed in a private room for the hospital's convenience, Medicaid will pay the semiprivate or all-inclusive room rate only.

5.6.1.1 Exceptions

Payment is limited to a semiprivate room accommodation rate except when an isolation room or private room is medically necessary and ordered by a physician, in which case Medicaid will pay the private room rate. A copy of the statement of medical necessity signed by the physician must be attached to the claim form.

5.7 Behavioral Health Services

The Department of Health and Welfare will pay for medically necessary inpatient psychiatric services for participants who have a current DSM diagnosis with substantial impairment in thought, mood, perception, or behavior. Both severity of illness and intensity of services criteria must be met for admission.

Inpatient behavioral health services require an authorization if care exceeds three days. An Institute for Mental Disease is only covered for participants under 21 or age 65 and older. Please refer to the QIO Provider Manual.

Note: Failure to request a continued stay review in a timely manner will result in a retrospective review conducted by DHW or its designee and potential penalties. See *Section 6 Prior Authorization (PA)*.

5.8 Diagnostic Tests and Procedures

Physician ordered, medically necessary diagnostic tests and procedures related to the diagnosis and treatment of the participant's medical condition(s) are reimbursable. Those tests and procedures include, but are not limited to:

- Laboratory tests
- Pathology tests
- Diagnostic imaging procedures
- Admission tests

Some procedures may require PA. See *Section 6 Prior Authorization (PA)* for more information.

5.9 Birth/Delivery Billing

Charges for both the mother and the child can be billed on one claim form with the mother's Idaho Medicaid identification (MID) number if both leave the hospital at the same time. Combine all charges for the same revenue codes unless a corresponding CPT/HCPCS is required.

If mother and child are not discharged at the same time, or if the child is admitted to the neonatal intensive care unit (NICU) anytime during the stay, the child's charges must be billed separately under their individual MID.

5.10 Pregnancy Services

The Pregnant Women (PW) Program is restricted to pregnancy-related services only, including the following:

- All pregnancy-related services and services for other conditions that might complicate the pregnancy or are necessary to promote a positive outcome for the mother and/or baby.
- Pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. These include but are not limited to, prenatal care, delivery, postpartum care, and family planning services.

If there is a concern that a claim might be denied as not pregnancy-related, the provider can attach a) a statement to their claim from the attending physician documenting how the treatment is pregnancy-related, or b) a signed Medical Necessity form (pregnancy-related). This form is available on the Molina Medicaid website.

Diagnosis Codes

The primary diagnosis code on your claim must be pregnancy-related or indicate the woman is in a pregnancy or postpartum status. Use the applicable ICD-10-CM codes from Chapter 15.

Family Planning

Family planning services are covered postpartum as long as the woman is eligible under the PW Program. A Healthy Connections referral is not required for family planning.

PW Eligibility

The eligibility period for PW extends to the end of the month of delivery plus two more full months. For example, if a woman delivers on 7/1/09, her eligibility would end on 9/30/09. If she delivers on 7/29/09, her eligibility would still end on 9/30/09. **There are no exceptions to this rule—claims with dates of service after the woman's PW eligibility ends will be denied.**

See *General Participant and Provider Information*, for more information on PE or PW.

Otherwise Ineligible Non-Citizen Participants

An otherwise ineligible non-citizen is only eligible for medical services necessary to treat an emergency medical condition that can reasonably be expected to seriously harm the patient's health, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ without immediate medical attention.

Deliveries are considered emergencies.

Submit application requests for consideration to:

Self-Reliance Program	Phone 1 (877) 456-1233
PO Box 83720	Fax 1 (866) 434-8278
Boise, ID 83720-0026	

Use the general application used to apply for all benefit programs. Hospitals may attach medical records with applications if they are helping the non-citizen participant to apply for assistance.

The Division of Medicaid will determine if the condition is an emergency and if the treatment services will be covered by Idaho Medicaid. If the services are approved, Medicaid eligibility will begin no earlier than the date the participant experienced the medical emergency and ends the date the emergency condition stops. The QIO does not perform reviews for non-citizens.

5.11 Split Billing

When billing, a participant's charges must occasionally be split out and billed on separate claims. Instances when a split billing would occur include:

- Change in participant program eligibility.
- Portions of an inpatient stay which have been denied by the QIO or Idaho Medicaid.
- Inpatient stays that reflect transfers to psychiatric or rehabilitation units with a different Medicaid provider number than the general hospital.
- Inpatient discharges in which administratively necessary days (AND) are billed on an outpatient claim.
- When the participant has other insurance, COB dollars must be prorated and applied between the split claims.

Any inpatient claim submitted with a statement, "Through date that is less than the discharge date," must have a patient status of **30** to indicate that this is an interim billing.

Use Medicaid Automated Customer Service (MACS) to verify changes in a participant's eligibility. Call 1 (866) 686-4272 or 1 (208) 373-1474.

5.12 Rate Changes

When rate change occurs during the span of an inpatient stay and results in multiple rates for the same accommodation revenue code, a separate revenue line should be used. Report each rate with the same revenue code on each line with the applicable dates of service. Failure to split out these multiple rates will result in payment at the lower rate.

5.13 Donor/Transplants

Donor costs for bone, heart, liver, lung, and kidney transplants should be billed using the participant's name and Medicaid Identification (MID) number. Enter *Donor Charges* in the Remarks field of the paper claim form to prevent a denial of the claim as a duplicate. A liver transplant from a live donor is not covered by Medicaid. Claims submitted electronically need to have an attachment indicating that the charges are for the donor.

6. Outpatient Hospital Service Policy

6.1 Overview

Outpatient services are to be provided at a service location over which the hospital exercises financial and administrative control. Financial and administrative control means a location whose relation to budgeting, cost reporting, staffing, policy-making, record keeping, business licensure, goodwill, and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location shall be in close proximity to the hospital where it is based, and both facilities serve the same patient population (e.g., from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or 35 miles from a rural hospital).

All same revenue codes with the same dates of service, with the exception of revenue codes requiring CPT/HCPCS procedure codes, should be billed on one line of the outpatient claim form or the electronic claims screen. See *UB04 Instructions* for valid revenue codes.

Note: All imaging services must include the TC modifier.

6.2 Reimbursement

Medicaid pays the covered charges multiplied by an outpatient reimbursement rate, except for the following:

- Outpatient diagnostic laboratory procedures.
- Diagnostic imaging services.
- Any ancillary services that require a specific CPT/HCPCS code.

Medicaid establishes an upper limit on reimbursement based on Medicare's reasonable cost. Payment will not exceed this limit.

6.3 Diabetes Education and Training

Medicaid covers individual and group counseling for diabetes education and training. Revenue code 0942 with the appropriate HCPCS is used for billing services when provided in an outpatient hospital setting. See the *Allopathic and Osteopathic Physicians* provider handbook for more information.

6.4 Outpatient Observation

Observation is used by the treating physician for a short period of time to assess and decide whether a patient requires admission for inpatient care or should be discharged.

Revenue code 0760 or 0762 should be used to reflect the costs of the routine observation services. Effective 9/1/2015, outpatient observation will be covered up to 48 hours; prior to 9/1/2015, observation is covered for no more than 24 hours.

Observation room and time may not be billed as a substitute for an emergency department visit or nursing services rendered outside the emergency department. Observation time cannot be substituted for stays denied by the QIO when the intensity of services does not justify an inpatient day.

6.5 Outpatient Cardiac Rehabilitation (CR)

Cardiac Rehabilitation is covered in the physician's office or an outpatient hospital setting. Hospitals should use revenue code 0943 with the appropriate diagnosis for billing. See the *Allopathic and Osteopathic Physicians* provider handbook for more information.

6.6 Presumptive Eligibility (PE) and Pregnant Women (PW) Clinic

Presumptive eligibility participants are only eligible for outpatient pregnancy related services. PE only covers prenatal care and not deliveries, miscarriages, or abortions. Some hospitals and district health departments are Pregnant Women (PW) clinics. They must be a Medicaid-approved provider and meet the conditions for PE or PW. Additionally, approved providers must be trained and certified by DHW. For more information on the training process, please contact your local DHW eligibility office.

See *General Provider and Participant Information*, *Presumptive Eligibility (PE)*, for more information.

6.7 Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) Services

6.7.1 Overview

Medicaid covers the following physician-ordered therapy services:

- Medically necessary SLP services provided by a licensed speech language pathologist licensed by the Board of Speech and Hearing and obtained their clinical Competency Certication (CCC) from the American Speech and Hearing Associaion, or is eligible for certiciation within one year per the Bureau of occupational Licenses.
- Medically necessary therapy services when provided by or under the supervision of a licensed physical therapist or occupational therapist.

Services must be part of a plan of care (POC) based on a physician order. The participant's progress must be reviewed and the POC updated and reordered every 90 days by the physician or midlevel practitioner with the following exception. If the therapist has documentation from the participant's primary care provider indicating that the participant has a chronic condition making therapy necessary for more than six months, an order for continued care is required at least every 365 days.

The written physician's order must stipulate the type of services to be provided, the frequency of treatment, the expected duration of therapy, and the anticipated outcomes along with the physician's/midlevel's signature and date. The provider must maintain a copy of the POC and written physician's order in the participant's record.

6.7.2 Supervision

Services provided by OT and PT assistants may be billed to Medicaid when general supervision by the appropriate professional is provided in the hospital outpatient setting. All supervision must be done in accordance with the requirements in the Idaho State Occupational and Physican Therapy Licensure Board regulations.

The therapist is required to co-sign any documentation written by the therapy assistant. Services provided by SLP assistants or aides are considered to be unskilled services, and will be denied or recouped as not medically necessary if they are billed as SLP services.

6.7.3 Limitations

Medicaid aligned its reimbursement caps with Medicare using the caps in effect on January 1, 2012. The current amount of the cap for outpatient PT and SLP services combined is set at $2,010, and there is a separate $2,010 cap for outpatient OT services. Once Medicaid has reimbursed the cap amount for PT and SLP services combined or for OT services, providers should assess the participant and determine:

1. If the services continue to be medically necessary, and
2. The skills of a therapist are required.

If the services continue to be necessary, the provider may continue to bill for services by appending a "KX" modifier to subsequent claims. The KX modifier is the provider's attestation that the services are medically necessary.

The Department may request documentation supporting a claim to conduct a review for medical necessity. Providers must submit the required documentation within ten days of the

receipt of the Department's request. Failure to provide the documentation in a timely fashion will result in denial of the claim.

The required documentation includes:

- Therapy Service Documentation Coversheet
- Physician order (signed and dated)
- Evaluation
- Current plan of care signed and dated by the physician or mid-level. (Reordered every 90 days for acute conditions and every 365 days for chronic conditions.) It must specify:
    - Diagnosis
    - Modalities
    - Anticipated short and long-term goals that are outcome-based with measurable objectives
    - Frequency of treatment
    - Expected duration of treatment
    - Home follow-through program
    - Discharge plan
- Current progress report
- Last 5 sessions of treatment notes

Fax or mail supporting documentation to:

Fax: 1 (877) 314-8779

Mail to:
Medical Care Unit
PO Box 83720
Boise, ID 83720-0009

The Department will select a number of claims billed with the "KX" modifier to review. All other claims will continue through the claims process. If, after the review, it is determined that a service does not meet criteria for coverage, the claim will be denied and all future OT claims submitted in that calendar year for that participant will be denied. If the participant has a setback, has a new condition, or if there is new information available, the provider can submit a prior authorization request to the Department.

6.7.4 Non-covered Services

The following services are not reimbursable by Idaho Medicaid; see *IDAPA 16.03.09.730.03* and *IDAPA 16.03.10.215.*

- Continuing services for participants who do not exhibit the capability to achieve measurable improvement.
- Services that address developmentally acceptable error patterns.
- Services for participants who have achieved stated goals.
- Services that do not require the skills of a therapist or therapy assistant.
- Services provided by unlicensed aides or technicians, even if under the supervision of a therapist.
- Massage, work hardening and conditioning.
- Services not medically necessary, as defined in *IDAPA 16.03.09.011*.
- Duplicate services.
- Group therapy.
- Any non-covered service code.
- Acupuncture and biofeedback therapy (*IDAPA 16.03.09.390.01*)

6.7.5 Daily Entries

According to *IDAPA 16.05.07.101*, "Medicaid providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must be legible and consistent with professionally recognized standards. Documentation must be retained for a period of five years from the date the item or service was provided."

Records limited to checklists with attendance, procedure codes, and units of time are insufficient to meet this requirement. Daily entries should include the following:

- Date and time of service.
- Duration of the session (time in and time out).
- Specific treatment provided and the corresponding procedure codes.
- Problem(s) treated.
- Objective measurement of the participant's response to the services provided during the treatment session.
- Signatures and credentials of the performing provider and, when necessary, the appropriate supervising therapist.

If a session does not occur as scheduled, the provider must document why the POC was not followed. Missed visits are not covered and cannot be billed to Medicaid.

6.8 Emergency Department

6.8.1 Follow-Up for ED Patients

Hospitals are directed to refer Medicaid participants who are not enrolled in Healthy Connections to an HC primary care provider. In coordination with *IDAPA16.03.09.413.02*:

- Policies and procedures must be established for referring Medicaid participants to a Healthy Connections provider, and
- Hospitals must coordinate care of patients who already have a Healthy Connections provider with that PCP

For help finding a provider in the participant's area, call the Healthy Connections Unit at 1 (800) 799-5088.

6.8.2 Emergency Department Co-Payment

A Medicaid participant can be assessed a three dollar and sixty-five cent ($3.65) co-payment for inappropriate emergency room utilization when these three conditions are met:

- The required medical screening indicates that an emergency medical condition does not exist as determined by the emergency room physician applying the prudent layperson standard. A co-payment may not be charged if the physician determines that a prudent layperson would have sought emergency treatment in the same circumstances, even if the care rendered is for a non-emergent condition.
- The Medicaid participant is not a Native American or Alaskan Native.
- There is an alternative setting for the Medicaid participant to receive treatment at no cost. A Medicaid participant can receive no cost treatment from their Healthy Connections primary care provider (PCP) or at an Urgent Care Clinic. The hospital is required to facilitate a referral to an appropriate provider in order to impose a co-pay or deny treatment to a Medicaid participant who does not make a co-payment.

When a hospital determines that a co-payment can be imposed, the hospital can require the Medicaid participant make the co-payment in order to receive treatment.

Note: The collection of the co-payment is at the discretion of the provider and is not required by Idaho Medicaid. However, all the conditions outlined above must be met if a hospital wishes to deny treatment to a Medicaid participant who presents in the emergency room with a non-emergent condition.

6.8.3 Healthy Connections (HC) – Referral

Outpatient hospital services billed on an UB-04 claim form with revenue code **0450** and services billed on a CMS-1500 claim form (with POS **23**) are exempt from the HC referral requirement.

ED services and hospital admissions subsequent to an ED visit do not require a referral when the patient is discharged in coordination with their PCP.

6.9 Sterilization Procedures

Idaho Medicaid is required to meet the Centers for Medicare and Medicaid (CMS) requirements for sterilization consent forms. Medicaid cannot cover sterilizations unless a valid, complete, and legible Sterilization Consent Form is received. For more information refer to Sterilization Procedures Overview in the *Allopathic and Osteopathic* guidelines.

7. Prior Authorization (PA)

7.1 Overview

Multiple entities review requests for authorizations for hospital and related services.

- QIO
- Medicaid Medical Care Unit

7.2 Quality Improvement Organization (QIO)

The Idaho Medicaid Program has contracted with Telligen, a quality improvement organization (QIO), to conduct the medical and surgical reviews of inpatient and selected outpatient hospital services. The appropriateness and necessity of the participant's admission and length of stay are subject to QIO review.

See the QIO Provider Manual for a listing of diagnoses and procedures that require PA for details regarding review processes.

The attending physician is ultimately responsible for obtaining preadmission approval (except for emergencies). However, the QIO will accept preadmission monitoring calls from the surgeon, physician office personnel, or facility personnel when applicable. Healthy Connections (HC) participants require a referral from their primary care provider (PCP) for all inpatient and outpatient hospital services in addition to the QIO PA, except for dental procedures.

Claims for services requiring PA will be denied if the provider did not obtain a PA from the authorizing authority. PAs are valid for one year from the date of authorization by Medicaid unless otherwise indicated on the approval. For HC or HH participants, PA will be denied if the requesting provider is not the PCP or if a referral has not been obtained.

7.2.1 Admitting and Principal Diagnoses

It is very important to include the admitting diagnosis code in field **69** and the principal diagnosis code in field **70** on the claim. These codes are used to determine if the admission requires QIO review.

If the admitting diagnosis and the principal diagnosis are different and one of them is a condition that does require preadmission review, the admission requires QIO preadmission review.

7.2.2 Length of Stay Review

Concurrent review is required when the admission exceeds day three, or day four if the patient had a cesarean delivery, or the number of days assigned by the QIO for a procedure. In the event the admitting diagnosis is different from the principal diagnosis, the diagnosis that allows the greatest length of stay is used to determine the length of stay for the admission. When QIO approval has been given for a portion of the hospital stay, accommodation days are payable only to the QIO's last approved day.

7.2.3 Transfers

Quality improvement organization authorization is not required for transfers from hospital to hospital inpatient status (inter-facility).

7.2.4 Out-of-State Providers

All medical care provided outside the state of Idaho is subject to the same PA and continued stay review requirements and restrictions as medical care provided within Idaho.

The participant's physician(s) or the treating facility may initiate the request for PA. The treating physician(s) and the treating facility are equally responsible for obtaining PA.

If ambulance transport is needed, refer to the *Transportation Services Guidelines*.

7.2.5 Admission for Substance Abuse

Quality improvement organization approval is required for inpatient services under either the psychiatric or the chemical dependency admissions category if care exceeds three days.

7.2.6 Cesarean Section

When billing for a cesarean section under the mother's member identification number (MID), use the appropriate diagnosis code indicating the reason for the cesarean section and the appropriate procedure code.

See *Appendix A* for diagnoses that have a four day length of stay (LOS) for mother only when a separate claim is billed under the newborn MID with a diagnosis in the table below.

If the patient is not discharged after the fourth day and a C-section delivery surgical procedure is not indicated on the mother's claim, or a C-Section diagnosis is not indicated on a separate newborn claim, a review with the QIO is required.

Contact the QIO at 1 (866) 538-9510 for a review or fax your requests to 1 (866) 539-0365.

Cesarean Diagnoses for Newborn	
ICD-10-CM Diagnosis Code	**Description**
P03.4	Newborn affected by Cesarean delivery
Z38.01	Single liveborn infant, delivered by cesarean
Z38.31	Twin liveborn infant, delivered by cesarean
Z38.62	Triplet liveborn infant, delivered by cesarean
Z38.64	Quadruplet liveborn infant, delivered by cesarean
Z38.66	Quintuplt liveborn infant, delivered by cesarean
Z38.69	Other multiple liveborn infant, delivered by cesarean

7.2.7 Medicaid/Medicare PA Requirements

Some Medicare participants have both Medicare and Medicaid coverage for hospitalizations. For those participants with Part A Medicare (inpatient services), QIO review is not necessary if Medicare is the primary payer. Medicare guidelines should be followed. If, however, the participant has only Part B Medicare (outpatient services), the admission is subject to QIO review because Medicaid is the primary payer for the inpatient services. For additional information regarding third party coverage or to verify eligibility, log in to your trading partner account or contact MACS at 1 (208) 373-1424 or 1 (866) 686-4272.

7.2.8 Other Insurance

Any other insurance must be billed prior to billing Medicaid and QIO authorization is also required. For additional information regarding third party coverage or to verify eligibility, log in to your trading partner account or contact MACS at 1 (208) 373-1424 or 1 (866) 686-4272.

7.2.9 Retrospective/Late QIO Reviews

Retrospective Review

Medicaid does not assess penalties to providers for participants who were determined eligible after admission. In these cases, a retrospective review is required.

A QIO review does not override the requirement of timely filing.

Late Review

A late review is defined as a case where the participant was eligible but a PA was not obtained prior to services being provided. The QIO accepts late reviews only when they are notified while the participant is still in the hospital. If the participant has been discharged, providers must request a Retrospective Review Request. Refer to the QIO Provider Manual for more information.

Medicaid assesses penalties if a hospital does not secure a timely QIO review. Penalties are based on the lateness of the review.

One day late =	$260
Two days late =	$520
Three days late =	$780
Four days late =	$1,040
Five days late =	$1,300

The QIO does not have authority to reverse late review penalties. Appeal requests regarding penalties should be directed to:

Hearings Coordinator
Idaho Department of Health and Welfare Administrative Procedures Section
P.O. Box 83720
Boise, ID 83720-0036
Fax: 1 (208) 334-6558

7.2.10 Contacting the QIO

Telligen
670 E Riverpark Ln. Suite 120
Boise, ID 83706
Phone 1 (866) 538-9510
Fax 1 (866) 539-0365

Help desk e-mail: idmedicaidsupport@telligen.com

7.3 Medical Care Unit Prior Authorization

Medicaid PA is required for the following procedures:

- Identified surgeries not reviewed by the QIO that are documented as medically necessary.
- Administratively necessary days (AND).
- Excluded services, including surgeries found medically necessary during a Child Wellness Exam, sometimes referred to as EPSDT.
- Certain genetic pathology and laboratory testing.
- Medical equipment and supplies exceeding specified limits.

See *Section 6.13 Medical Surgical Procedures Requiring Medicaid Prior Authorization (PA)*, for the listing of medical and surgical procedure codes that require PA from Medicaid.

Send PA requests to the Medical Care Unit.

Healthy Connections participants require a referral from their PCP, in addition to a Medicaid or QIO PA, for all inpatient and outpatient hospital services.

7.3.1 Medical Surgical Procedures Requiring Medicaid Prior Authorization (PA)

Please refer to the Idaho Medicaid Medical Care Unit Prior Authorization List.

8. Attachments

Inpatient attachments include:

- **Third party recovery (TPR)**: When billing on a paper claim form, attach the Explanation of Benefits (EOB) statement from the other insurer that includes the adjustment reason codes (ARC). When billing electronically, use the appropriate ARC codes from the other insurer; no attachment is required.
- **Hysterectomies**: Authorization for hysterectomy and documentation of medical necessity.
- **Sterilizations**: Appropriately completed consent form. For more information concerning sterilizations, see *Section 5.8* of this handbook.
- **Therapeutic abortions**: Completed certification of necessity from physician. For more information concerning abortions, see Section *8.11* of this handbook.
- **Private room**: Statement of medical necessity or physician order.

Outpatient attachments include:

- TPR: When billing on a paper claim form, attach the EOB statement from the other insurer that includes the ARC. When billing electronically, use the appropriate ARC from the other insurer; no attachment is required.
- Sterilization: Appropriately completed consent form.

9. Hospital Physicians

Hospital based physician billers should refer to *Allopathic and Osteopathic Physician Guidelines* for more information on submitting a CMS-1500 claim form.

10. Administratively Necessary Days (AND)

10.1 Overview

Administratively necessary days (AND) are intended to allow a hospital the time for an orderly transfer or discharge of inpatients who are no longer in need of a continued acute level of care. Administratively necessary days may be authorized for inpatients that are awaiting placement in a skilled nursing facility (SNF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), in-home services that are not available, or when catastrophic events prevent the scheduled discharge of an inpatient.

10.2 Prior Authorization (PA)

The hospital discharge planner, utilization reviewer, or attending physician must contact the Medical Care Unit by phone or fax to request an AND. The AND form must be submitted to the Medical Care Unit prior to the patient being decertified as needing acute hospital care. This can be done as soon as the discharge planner anticipates a possible discharge issue, even if the final non-certified date is not yet known. The facility must supply the additional required documentation within ten working days of the submitted request.

The Administrative Necessary Day form is located online.

If the AND is not needed, notify the Medical Care Unit immediately at the number below, and the request will be voided.
To request an AND, fax the AND form and required documentation to 1 (877) 314-8779.

For questions, call 1 (866) 205-7403.

The following documentation is required for PA of an AND:

- AND form.
- Summary of patient's medical condition.
- Current history and physical.
- Physician progress notes.
- Statement as to why patient cannot receive necessary medical services in a non-hospital setting.
- Documentation that the hospital has diligently made every effort to locate a facility or organization to deliver appropriate services.

10.3 Retroactive Eligibility

Medicaid will not authorize services retroactively unless:

- The participant's eligibility was approved after services were provided.
- The participant's service limitations were exceeded and medical need is determined.

10.4 Notice of Decision (NOD)

The Department of Health and Welfare will review each AND request and issue a NOD, which contains the PA number and decision.

10.5 Billing Procedures

Administratively Necessary Day services must be billed on the UB-04 claim form as an outpatient service. The first AND should be the same day the participant was discharged from the inpatient acute level of care.

The hospital should utilize the same billing procedure as is currently used for outpatient claims with the following exceptions when billing for an AND:

- Type of Bill (field **4**) use code **131**.
- Revenue Codes (field **42**).
- Supplies and ancillary charges (except those listed in *Section 7.5.1 Revenue Codes*) are part of the content of care.

10.5.1 Revenue Codes

AND should be billed using revenue code **0671**. See *UB04 Instructions* for a list of the only revenue codes that can be billed with an AND.

11. Coverage Limits

11.1 Outpatient Therapy Services

11.1.1 Speech and Physical Therapy

Outpatient therapy services for speech and physical therapy combined are limited to $2,010 annually. Additional services may be covered when medically necessary.

11.1.2 Occupational Therapy

Outpatient OT services are limited to $2,010 annually. Additional services may be covered when medically necessary.

11.2 Bariatric Surgery for Weight Loss

Medicaid will cover bariatric surgeries, including abdominoplasty and panniculectomy, when all conditions listed below are met as defined in *IDAPA 16.03.09.431 Surgical Procedures for Weight Loss-Participant Eligibility* through *section 434 Provider Qualifications and Duties.*

- The participant meets the criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than 40, or
- The participant has a BMI equal to or greater than 35 with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities.
- The serious comorbid medical condition must be documented by the primary physician who refers the patient for the procedure, or a physician specializing in the participant's comorbid condition who is not associated by clinic or other affiliation with the surgeons who will perform the surgery.
- The obesity is caused by the serious comorbid condition, or the obesity could aggravate the participant's cardiac, respiratory, or other systemic disease.

- The participant must have a psychiatric evaluation to determine the stability of personality at least 90 days prior to the date a request for prior authorization is submitted to Medicaid.
- The procedure is prior authorized by the QIO. If approval is granted, the QIO will issue the authorization number and conduct any necessary length-of-stay reviews.
- The procedure(s) must be performed in an Idaho Medicaid-enrolled hospital that is also Medicare certified.
- Hospital practices should be in keeping with national medical standards for weight loss surgery to promote positive outcomes.

11.3 Hyperbaric Oxygen Treatment

For information of coverage and limitations, refer to the *Allopathic and Osteopathic Physicians* handbook.

11.4 Transplants

The Department of Health and Welfare (DHW) may authorize organ transplant services for bone marrow, kidneys, hearts, intestines, livers, and lungs when provided by hospitals approved by the Centers for Medicare and Medicaid Services (CMS) for the Medicare program. The hospital must have completed a provider agreement with DHW.

All transplants, except for cornea transplants, must be prior authorized by the QIO.

Hospitals should obtain and use a separate provider number, issued by Idaho Medicaid, for transplants. This allows the hospital to accurately receive the lesser of 96.5 percent of reasonable costs under Medicare's payment principals or customary charges.

The transplant costs for actual or potential living donors are covered by Medicaid and include all reasonable preparatory, operation, and post-operation recovery expenses associated with the donation. Donor costs for transplants should be billed using the participant's name and Medicaid identification (MID) number. To prevent denial of the claim as a duplicate, enter *Donor Charges* in the remarks field of the paper claim form or for electronic claims attach documentation to explain these are donor charges.
Payments for post-operation expenses of a donor will be limited to the period of actual recovery.

Follow-up care provided to an organ transplant patient by a provider not approved for organ transplants will be reimbursed at the provider's normal reimbursement rates.
Reimbursement to independent organ procurement agencies and independent histocompatibility laboratories will not be covered.

See *IDAPA 16.03.10.090 Organ Transplants* through *096 Organ Transplants - Provider Reimbursements* for additional information.

11.5 Take Home Drugs

Outpatient take home drug charges that exceed $4.00 must be billed as a pharmacy claim through Magellan. For more information go to https://Idaho.fhsc.com. Inpatient take home drugs dispensed upon discharge must also be submitted on the Pharmacy claim form. All outpatient take home drugs must have the National Drug Code (NDC) identified on the claim.

11.6 Mammography Services

Idaho Medicaid will cover screening or diagnostic mammography performed with mammography equipment and by staff that is considered certifiable or certified by the Bureau of Laboratories.

- Screening mammography will be limited to one per calendar year for women who are 40 or more years of age.
- Diagnostic mammography will be covered when a physician orders the procedure for a participant, of any age, who is at high risk.

Note: Use the appropriate CPT code for the type of mammography performed.

11.7 Telehealth

Effective February 1, 2016: The Idaho Medicaid Telehealth Policy has been revised. Multiple policy documents have been revised and providers should review them before providing Telehealth services. The revised policy, Medicaid Information Release MA15-11, and provider handbooks have been updated to provide guidance. Reimbursement for the use of Telehealth equipment (site fees) ends January 31, 2016.

11.8 Dialysis Units

Outpatient dialysis procedures provided by a freestanding dialysis facility should be billed on a UB-04 claim form in the following manner:

- Report with bill type **0721** through **0724**. Refer to the *UB04 Instructions* for more information.
- Dialysis procedures are reported with the following revenue codes:
  - **0821** Outpatient dialysis, CPT code **90999** (hemodialysis composite or other rate)
  - **0270** Dialysis supplies (medical surgical supplies)
  - **0272** Special supplies (sterile supplies)
  - **0634** Epoetin up to 10,000 units (one billing unit = 1000 Units)[CPT]
  - **0635** Epoetin over 10,000 units (one billing unit = 1000 Units)[CPT]
  - **0636** Dialysis drugs CPT (drugs requiring detailed coding); use the appropriate corresponding J-code from the most current *HCPCS Level II Manual* and attach the NDC detail attachment with claim form (see Medicaid Information Release MA03-69)
  - **0831** Peritoneal composite rate, **90945** or **90947**[CPT]
  - **0841** CAPD composite or other rate, **90945/90947** or **90993**[CPT]
  - **0851** CCPD composite or other rate; **90945/90947** or **90993**[CPT]

[CPT] Must indicate a valid CPT procedure code when billing outpatient claims.

Note: When billing using a date span, make sure the header date span is reflected in the detail dates. You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.

When the dates of service are not consecutive, each date of service must be billed on a separate detail line.

11.9 Therapeutic Abortion Coverage

Medicaid will cover abortions only under circumstances where the abortion is necessary to save the life of the woman, or in cases of rape or incest as determined by the courts, or, where no court determination has been made, if reported to a law enforcement agency.

Note: Medicaid does not pay for any type of abortion for participants on the Presumptive Eligibility (PE) Program. Also, PE participants are not covered for any delivery services.

In the case of rape or incest, the following documentation must be provided to the Department with the physician's claim:

a. A copy of the court determination of rape or incest must be provided; or
b. Where no court determination has been made, documentation that the rape or incest was reported to a law enforcement agency.
c. Where the rape or incest was not reported to a law enforcement agency, a licensed physician must certify in writing that, in the physician's professional opinion, the woman was unable, for reasons related to her health, to report the rape or incest to a law enforcement agency. The certification must contain the name and address of the woman.

When the abortion is necessary to save the life of the woman, the following information must be included with the physician's claim. A licensed physician must certify in writing that the woman may die if the fetus is carried to term. The certification must contain the name and address of the woman.

For more information, refer to the *Allopathic and Osteopathic Physicians* handbook.

11.10 Excluded Services

For information regarding non-covered procedures, please see the *Excluded Services* section in the *General Provider and Participant Information* portion of the handbook.

12. Hospital Surgical Procedure Billing

Hospital providers can submit claims for outpatient surgery using bill type **131** and revenue code **0360/0361** with appropriate surgical CPT codes. Hospitals billing as a hospital based Ambulatory Surgical Center (ASC) must establish a separate NPI for their ASC, and must bill type **831** and revenue code **0490** with the appropriate surgical CPT codes.

Providers billing with bill type **131** and revenue code **0360/0361** will be reimbursed based on that provider outpatient interim percentage. Providers who choose to obtain a separate NPI for their ASC services will continue to be reimbursed at 2.5 times the ASC level fee schedule pricing for the corresponding surgical procedure.

Multiple ASC procedures must be listed separately with a CPT code for each procedure. It is not necessary to break out the operating room charges for each line that a procedure is billed under revenue code **0490**. The hospital may list all ASC procedures with only one total charge per revenue code. Any ASC procedure code billed with revenue code **0490** may display the total operating room charges. Each of the other lines billing operating room revenue code **0490** with an ASC procedure code may have a total charge of zero entered. Other ancillary services included in the procedure(s) must be billed with the related total customary charges on each line. Ancillary charges must not be bundled into revenue code **0490**.

12.1 Dental Procedures

An HC referral is not required for dental procedures performed in a hospital outpatient or ASC setting.

All dental procedures performed in an outpatient or ASC setting must be billed under the CPT code **41899** (Surgical). Prior authorized dental procedures should also be billed with CPT code **41899**.

Oral Surgeons, see *Allopathic and Osteopathic Physicians*, *Oral Surgeons* for more information on billing.

12.2 Ambulatory Surgical CPT Codes

See the Medicaid ASC fee schedule for a complete listing of approved ASC CPT codes and payment levels. Consult your *Current Procedural Terminology (CPT) Manual* for complete descriptions of the codes.

13. Ambulance Service Policy

13.1 Overview

Hospital based ambulance service is payable only if used in the event of an emergency situation or after authorization has been obtained from the Medicaid Ambulance Review Unit. The Medicaid Ambulance Review Unit does retrospective medical review of all ambulance transportation requests.

Medicaid Ambulance Review	1 (800) 362-7648
Medicaid Ambulance Review Fax	1 (877) 314-8781

13.1.1 Definition of Emergency Services

Medical necessity is established when the participant's condition is of such severity that use of any other method of transport would endanger the participant's life or health, regardless of whether other transportation is actually available.

13.1.2 Definition of Non-Emergency Service

Medicaid defines non-emergency service as transportation provided when the physical condition of the participant requires ambulance transport and another form of transportation will place the participant's life or health in serious jeopardy. This includes inter-facility transfers, nursing home to hospital transfers, and transfers to the participant's home from the hospital. As such, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation.

Transportation of a participant residing in a long-term care facility (LTC) is the responsibility of the LTC facility unless the condition of the participant requires ambulance transport and PA has been obtained. Claims for services requiring PA will be denied if the provider did not obtain a PA from the authorizing authority.

13.2 Co-Payment for Non-Emergency Use of Ambulance Transportation Services

Ambulance providers may bill Medicaid participants a three dollar and sixty-five cent ($3.65) co-payment for inappropriate ambulance service utilization when the following two conditions are met:

- The Department of Health and Welfare determines that the Medicaid participant's medical condition did not require emergency ambulance transportation.
- The Department of Health and Welfare determines that the Medicaid participant is not exempt from making co-payments according to Federal statute.

The Department of Health and Welfare (DHW) will notify both the ambulance provider and the Medicaid participant on the Notice of Decision letter when a participant may be billed for a co-payment.

Note: Collection of the co-payment is at the discretion of the provider and is not required by Idaho Medicaid.

13.3 Licensing Requirements

Ambulance services providers must hold a current license issued by Emergency Medical Services (EMS) according to the level of training and expertise personnel maintain, and must comply with the rules governing EMS services. Ambulance services providers based outside the state of Idaho must hold a current license issued by that State's EMS licensing authority. No payment will be made to ambulance services providers that do not hold a current license.

Emergency Medical Services (EMS)
EMSPROVLIC@dhw.idaho.gov
1 (877) 554-3367
1 (208) 334-4015 (Fax)

13.4 Billing Information

Hospital based providers must bill on the UB-04 claim form or the electronic claim using hospital revenue codes **540-549**. See Section *9.3 Ancillary Revenue Codes* for more information.

Both ground and air ambulance services owned and operated by hospitals must bill on the UB-04 claim form or the electronic claim using hospital revenue codes. Required attachments include a complete PCR (patient care report), invoice of billed charges, and third party EOB for other insurance payments and denials if applicable.

13.4.1 Third Party Recovery (TPR)

Required attachments to UB-04 claim forms include third party EOB for other insurance payments and denials. The correct Medicare Adjustment Codes (MAC) and other insurance information must be entered on claims submitted electronically. See *General Billing Instructions*, *Third Party Recovery*, *Coordination of Benefits,* and *Crossover Claims* for information on Medicaid policy for billing all other TPR resources before submitting claims to Medicaid.

13.4.2 Medicare Participants

Participants may be dually eligible for Medicare and Medicaid. The provider must first bill Medicare for rendered services. A copy of the Medicare Remittance Notice (MRN) must be included with the Medicaid claim. If billing electronically, the information from Medicare must be entered on the appropriate screens.

For inpatient claims, Medicaid's payment for services will be calculated according to the "Member Responsibility" methodology as described in the *General Billing Instructions*, *Third Party Recovery*, *Coordination of Benefits,* and *Crossover Claims.*

For outpatient claims, Medicaid's payment for services will be calculated according to the "Lesser Of" methodology as described in the *General Billing Instructions*, *Third Party Recovery*, *Coordination of Benefits*, and *Crossover Claims.*

See *General Billing Instructions*, *Third Party Recovery*, *Coordination of Benefits*, and *Crossover Claims* for information on Medicaid policy for billing all other TPR resources before submitting claims to Medicaid. Participants cannot be billed for any non-reimbursed amount. Providers may only bill non-covered services to the participant if the provider has informed the participant of their responsibility to pay, preferably in writing, prior to rendering services.

Electronic Crossovers
Medicaid receives claims electronically from Medicare; these are called Medicare Crossover claims. Claims that have Medicare excluded services and Medicare covered services will cross over. For Medicare covered services denied by Medicare, whether it is the entire claim or a claim detail, submit a paper claim to Medicaid with the Medicare denial EOB. Crossover claims may require rebilling to Medicaid with appropriate Medicaid approved coding for consideration, for example, FQHC/RHC/IHC, LTC.

13.5 Covered Services

13.5.1 Air Ambulance

Air ambulance services are covered when one of the following occurs:

- The point of pickup is inaccessible by a land vehicle.
- Great distances or other obstacles are involved in getting the participant to the nearest appropriate facility and speedy admission is essential.
- The participant's condition and other circumstances necessitate the use of air ambulance.
- If ground ambulance services would suffice and would be less costly, payment is based on the amount that would be paid for a ground ambulance.

Air ambulance must be approved by Medicaid Ambulance Review in advance except in emergency situations.

If the aircraft is owned and operated by a hospital, the service must be billed on a UB-04 claim form or the electronic claim using appropriate revenue codes.

13.5.2 Ground Ambulance

Ambulance services, which are owned and operated by a hospital, must be billed on the UB-04 claim form or the electronic claim using hospital revenue codes.

13.5.2.1 Definitions

Ambulance Run
When an Ambulance picks up a participant, initiates care, delivers the participant to their Destination, and relinquishes their care and returns to service.

Multiple Runs in One Day
When an Ambulance completes a "RUN", then later on the same day completes another "RUN". These are considered 2 separate "RUNS", and are billed completely separate. The second "RUN" is billed with a 76 modifier on the base rate only, to show as a 2nd transport,

same day, not a duplicate. Use the 76 modifier again if more subsequent "RUNS" occur during the same day.

Round Trip

When the Ambulance transfers a participant from an initial point, delivers to a destination, waits for the participant, then returns to the initial point of pick up. The Ambulance has completed the RUN, and returns to service. The provider may bill for one base rate, all the round trip miles, and wait time.

13.5.3 Nursing Home Residents

Ambulance services are covered only in an emergency situation or when a non-emergent and medically necessary transport has been prior authorized by the Medical Care Unit. . Payment for any non-authorized service is the responsibility of the facility, and cannot be billed to the participant.

13.5.4 Trips to Physician's Office

Ambulance transport to a physician's office is not covered unless it has been prior authorized by the Medical Care Unit.

13.5.5 Treat and Release or Respond and Evaluate

The department understands that EMS providers are legally required to respond when dispatched by 911. In the incidents where the provider responded, evaluated, and released without transportation, they may submit a claim utilizing HCPCS A0988 with Modifier II. This code with Modifier II pays a flat fee and is updated annually by CMS for reimbursement. Providers may submit a PA request for HCPCS A0998 for higher levels of services that may have been provided.

Medicaid Ambulance Review may downgrade a transport to respond and evaluate or treat and release if it is determined there was no medical necessity for transport. Prior to rendering services, providers must inform participants when services are not covered under Medicaid. Idaho Medicaid strongly encourages the provider to have the participant sign an informed consent regarding any non-covered services. If the participant chooses to obtain services not covered by Medicaid, it is the participant's responsibility to pay for the services.

See *Section 2.1.2 Provider Responsibilities* in the General Provider and Participant Information Handbook for additional details.

13.5.6 Deceased Participants

Medicaid does not pay for transport of deceased participants. If a participant is pronounced deceased by appropriate personnel between dispatch and upon arrival of ambulance, a respond and evaluate payment may be authorized.

13.6 Reimbursement Information

13.6.1 Customary Fees

Medicaid reimburses hospital owned and operated ambulance services on a usual and customary outpatient Medicaid schedule.

14. Dietitian Service Policy

14.1 Overview

Dieticians may bill the Medicaid program directly for nutritional services provided to women on the PW (pregnant women) program and to children. Nutritional services include intensive nutritional education, counseling, and monitoring. Services must be rendered by either a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university, and has met the academic and professional requirements in dietetics as approved by the American Dietetic Association (ADA). If a dietician works for a hospital, the hospital bills Medicaid directly for the services.

14.2 Pregnant Women (PW) Services

Nutritional services for women enrolled in the PW Program. All listed criteria must be met:

- Must be ordered by the participant's physician, nurse practitioner, or nurse midwife.
- Must be delivered after confirmation of pregnancy.
- Extend only through the 60th day after delivery.

Payment for two visits during the calendar year is available at a rate established under the provisions of *IDAPA 16.03.09.635 Nutritional Services – Provider Reimbursement*.

14.3 Children (Up to 21st Birthday)

Payment for two visits during the calendar year is available at a rate established under the provisions of *IDAPA 16.03.09.635 Nutritional Services – Provider Reimbursement*. Children may receive additional visits when medically necessary and prior authorized.
Mail PA request to:

Division of Medicaid
Medical Care Unit
PO Box 83720
Boise, Idaho 83720-0009

Procedure Codes

Service	Code	Modifier	Description
PW nutritional services	S9470		Nutritional counseling, dietician visit.
Children's nutritional services	S9470	No modifier required	Nutritional counseling, dietician visit.
Education/Training	0942	HCPCS	For diabetes education and training, use HCPCS G0108 (Individual Counseling) and G0109 (Group Counseling). When billing for PW participants, a pregnancy related diabetic diagnosis is required.

Appendix A. ICD-10 Diagnosis Codes Accepted by Idaho Medicaid Supporting Medical Necessity for Cesarean Section

ICD-10 Code	Description
A60.9	Anogenital herpesviral infection, unspecified
A60.04	Herpesviral vulvovaginitis
O10.02	Pre-existing essential hypertension complicating childbirth
O13.4	Gestational (pregnancy-induced) hypertension without significant proteinuria, complicating childbirth
O14.10	Severe pre-eclampsia, unspecified trimester
O14.12	Severe pre-eclampsia, second trimester
O14.13	Severe pre-eclampsia, third trimester
O14.14	Severe pre-eclampsia complicating childbirth
O14.20	HELLP syndrome (HELLP), unspecified trimester
O14.22	HELLP syndrome (HELLP), second trimester
O14.23	HELLP syndrome (HELLP), third trimester
O15.02	Eclampsia in pregnancy, second trimester
O15.03	Eclampsia in pregnancy, third trimester
O15.1	Eclampsia in labor
O15.2	Eclampsia in the puerperium
O15.9	Eclampsia, unspecified as to time period
O24.425	Gestational diabetes mellitus in childbirth, congtrolled by oral hypoglycemic drugs
O26.50	Maternal hypotension syndrome, unspecified trimester
O26.619	Liver and biliary tract disorders in pregnancy, unspecified trimester
O26.833	Pregnancy related renal disease, third trimester
O30.001	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30.002	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30.003	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30.009	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester
O30.101	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30.102	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30.103	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester

ICD-10 Code	Description
O30.109	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester
O30.201	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30.202	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30.203	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30.209	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester
O30.801	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30.802	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30.803	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30.809	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester
O30.90	Multiple gestation, unspecified, unspecified trimester
O30.91	Multiple gestation, unspecified, first trimester
O30.92	Multiple gestation, unspecified, second trimester
O30.93	Multiple gestation, unspecified, third trimester
O31.10X0	Continuing pregnancy after spontaneous abortion of one fetus or more, unspecified trimester, not applicable or unspecified
O31.11X0	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, not applicable or unspecified
O31.30X0	Continuing pregnancy after elective fetal reduction of one fetus or more, unspecified trimester, not applicable or unspecified
O31.31X0	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, not applicable or unspecified
O31.32X0	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, not applicable or unspecified
O31.33X0	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, not applicable or unspecified
O31.8X10	Other complications specific to multiple gestation, first trimester, not applicable or unspecified
O31.8X20	Other complications specific to multiple gestation, second trimester, not applicable or unspecified
O31.8X30	Other complications specific to multiple gestation, third trimester, not applicable or unspecified
O31.8X90	Other complications specific to multiple gestation, unspecified trimester, not applicable or unspecified

ICD-10 Code	Description
O32.1XX0	Maternal care for breech presentation, not applicable or unspecified
O32.2XX0	Maternal care for transverse and oblique lie, not applicable or unspecified
O32.3XX0	Maternal care for face, brow and chin presentation, not applicable or unspecified
O32.4XX0	Maternal care for high head at term, not applicable or unspecified
O32.6XX0	Maternal care for compound presentation, not applicable or unspecified
O32.8XX0	Maternal care for other malpresentation of fetus, not applicable or unspecified
O32.9XX0	Maternal care for malpresentation of fetus, unspecified, not applicable or unspecified
O33.0	Maternal care for disproportion due to deformity of maternal pelvic bones
O33.1	Maternal care for disproportion due to generally contracted pelvis
O33.2	Maternal care for disproportion due to inlet contraction of pelvis
O33.5XX0	Maternal care for disproportion due to unusually large fetus, not applicable or unspecified
O34.21	Maternal care for scar from previous cesarean delivery
O34.211	Maternal care for low transverse scar from previous cesarean delivery
O34.212	Maternal care for vertical scar from previous cesarean delivery
O34.29	Maternal care due to uterine scar from other previous surgery
O34.80	Maternal care for other abnormalities of pelvic organs, unspecified trimester
O34.90	Maternal care for abnormality of pelvic organ, unspecified, unspecified trimester
O35.0XX0	Maternal care for (suspected) central nervous system malformation in fetus, not applicable or unspecified
O35.1XX0	Maternal care for (suspected) chromosomal abnormality in fetus, not applicable or unspecified
O36.4XX0	Maternal care for intrauterine death, not applicable or unspecified
O36.5190	Maternal care for known or suspected placental insufficiency, unspecified trimester, not applicable or unspecified
O36.5930	Maternal care for other known or suspected poor fetal growth, third trimester, not applicable or unspecified
O36.5990	Maternal care for other known or suspected poor fetal growth, unspecified trimester, not applicable or unspecified
O36.60X0	Maternal care for excessive fetal growth, unspecified trimester, not applicable or unspecified
O40.1XX0	Polyhydramnios, first trimester, not applicable or unspecified
O40.2XX0	Polyhydramnios, second trimester, not applicable or unspecified
O40.3XX0	Polyhydramnios, third trimester, not applicable or unspecified
O40.9XX0	Polyhydramnios, unspecified trimester, not applicable or unspecified
O41.00X0	Oligohydramnios, unspecified trimester, not applicable or unspecified
O41.1090	Infection of amniotic sac and membranes, unspecified, unspecified trimester, not applicable or unspecified

ICD-10 Code	Description
O41.1290	Chorioamnionitis, unspecified trimester, not applicable or unspecified
O41.1490	Placentitis, unspecified trimester, not applicable or unspecified
O42.10	Premature rupture of membranes, onset of labor more than 24 hours following rupture, unspecified weeks of gestation
O43.019	Fetomaternal placental transfusion syndrome, unspecified trimester
O44.00	Placenta previa specified as without hemorrhage, unspecified trimester
O44.01	Placenta previa specified as without hemorrhage, first trimester
O44.02	Placenta previa specified as without hemorrhage, second trimester
O44.03	Placenta previa specified as without hemorrhage, third trimester
O44.10	Placenta previa with hemorrhage, unspecified trimester
O44.11	Placenta previa with hemorrhage, first trimester
O44.12	Placenta previa with hemorrhage, second trimester
O44.13	Placenta previa with hemorrhage, third trimester
O45.001	Premature separation of placenta with coagulation defect, unspecified, first trimester
O45.002	Premature separation of placenta with coagulation defect, unspecified, second trimester
O45.003	Premature separation of placenta with coagulation defect, unspecified, third trimester
O45.011	Premature separation of placenta with afibrinogenemia, first trimester
O45.012	Premature separation of placenta with afibrinogenemia, second trimester
O45.013	Premature separation of placenta with afibrinogenemia, third trimester
O45.021	Premature separation of placenta with disseminated intravascular coagulation, first trimester
O45.022	Premature separation of placenta with disseminated intravascular coagulation, second trimester
O45.023	Premature separation of placenta with disseminated intravascular coagulation, third trimester
O45.091	Premature separation of placenta with other coagulation defect, first trimester
O45.092	Premature separation of placenta with other coagulation defect, second trimester
O45.093	Premature separation of placenta with other coagulation defect, third trimester
O45.8X1	Other premature separation of placenta, first trimester
O45.8X2	Other premature separation of placenta, second trimester
O45.8X3	Other premature separation of placenta, third trimester
O45.8X9	Other premature separation of placenta, unspecified trimester
O45.91	Premature separation of placenta, unspecified, first trimester
O45.92	Premature separation of placenta, unspecified, second trimester
O45.93	Premature separation of placenta, unspecified, third trimester
O46.001	Antepartum hemorrhage with coagulation defect, unspecified, first trimester

ICD-10 Code	Description
O46.002	Antepartum hemorrhage with coagulation defect, unspecified, second trimester
O46.003	Antepartum hemorrhage with coagulation defect, unspecified, third trimester
O46.009	Antepartum hemorrhage with coagulation defect, unspecified, unspecified trimester
O46.011	Antepartum hemorrhage with afibrinogenemia, first trimester
O46.012	Antepartum hemorrhage with afibrinogenemia, second trimester
O46.013	Antepartum hemorrhage with afibrinogenemia, third trimester
O46.019	Antepartum hemorrhage with afibrinogenemia, unspecified trimester
O46.021	Antepartum hemorrhage with disseminated intravascular coagulation, first trimester
O46.022	Antepartum hemorrhage with disseminated intravascular coagulation, second trimester
O46.023	Antepartum hemorrhage with disseminated intravascular coagulation, third trimester
O46.029	Antepartum hemorrhage with disseminated intravascular coagulation, unspecified trimester
O46.091	Antepartum hemorrhage with other coagulation defect, first trimester
O46.092	Antepartum hemorrhage with other coagulation defect, second trimester
O46.093	Antepartum hemorrhage with other coagulation defect, third trimester
O46.099	Antepartum hemorrhage with other coagulation defect, unspecified trimester
O46.8X1	Other antepartum hemorrhage, first trimester
O46.8X2	Other antepartum hemorrhage, second trimester
O46.8X3	Other antepartum hemorrhage, third trimester
O46.8X9	Other antepartum hemorrhage, unspecified trimester
O46.90	Antepartum hemorrhage, unspecified, unspecified trimester
O46.91	Antepartum hemorrhage, unspecified, first trimester
O46.92	Antepartum hemorrhage, unspecified, second trimester
O46.93	Antepartum hemorrhage, unspecified, third trimester
O60.03	Preterm labor without delivery, third trimester
O61.0	Failed medical induction of labor
O61.1	Failed instrumental induction of labor
O62.0	Primary inadequate contractions
O62.1	Secondary uterine inertia
O62.2	Other uterine inertia
O62.3	Precipitate labor
O62.4	Hypertonic, incoordinate, and prolonged uterine contractions
O62.9	Abnormality of forces of labor, unspecified
O64.0XX0	Obstructed labor due to incomplete rotation of fetal head, not applicable or unspecified

ICD-10 Code	Description
O64.1XX0	Obstructed labor due to breech presentation, not applicable or unspecified
O64.8XX0	Obstructed labor due to other malposition and malpresentation, not applicable or unspecified
O64.9XX0	Obstructed labor due to malposition and malpresentation, unspecified, not applicable or unspecified
O65.3	Obstructed labor due to pelvic outlet and mid-cavity contraction
O65.4	Obstructed labor due to fetopelvic disproportion, unspecified
O65.5	Obstructed labor due to abnormality of maternal pelvic organs
O65.9	Obstructed labor due to maternal pelvic disproportion, unspecified
O66.0	Obstructed labor due to shoulder dystocia
O66.1	Obstructed labor due to locked twins
O66.40	Failed trial of labor, unspecified
O66.5	Attempted application of vacuum extractor and forceps
O66.8	Other specified obstructed labor
O66.9	Obstructed labor, unspecified
O67.0	Intrapartum hemorrhage with coagulation defect
O67.8	Other intrapartum hemorrhage
O67.9	Intrapartum hemorrhage, unspecified
O68	Labor and delivery complicated by abnormality of fetal acid-base balance
O69.0XX0	Labor and delivery complicated by prolapse of cord, not applicable or unspecified
O69.2XX0	Labor and delivery complicated by other cord entanglement, with compression, not applicable or unspecified
O69.81X0	Labor and delivery complicated by cord around neck, without compression, not applicable or unspecified
O71.00	Rupture of uterus before onset of labor, unspecified trimester
O71.02	Rupture of uterus before onset of labor, second trimester
O71.03	Rupture of uterus before onset of labor, third trimester
O71.1	Rupture of uterus during labor
O75.1	Shock during or following labor and delivery
O75.82	Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks gestation, with delivery by (planned) cesarean section
O76	Abnormality in fetal heart rate and rhythm complicating labor and delivery
O77.0	Labor and delivery complicated by meconium in amniotic fluid
O77.9	Labor and delivery complicated by fetal stress, unspecified
O82	Encounter for cesarean delivery without indication
O88.011	Air embolism in pregnancy, first trimester
O88.012	Air embolism in pregnancy, second trimester

ICD-10 Code	Description
O88.013	Air embolism in pregnancy, third trimester
O88.019	Air embolism in pregnancy, unspecified trimester
O88.02	Air embolism in childbirth
O88.03	Air embolism in the puerperium
O88.119	Amniotic fluid embolism in pregnancy, unspecified trimester
O88.319	Pyemic and septic embolism in pregnancy, unspecified trimester
O88.819	Other embolism in pregnancy, unspecified trimester
O90.0	Disruption of cesarean delivery wound
O9A.12	Malignant neoplasm complicating childbirth
O98.32	Other infections with a predomoninantly sexual mode of transmission complicating childbirth
O98.519	Other viral diseases complicating pregnancy, unspecified trimester
O99.280	Endocrine, nutritional and metabolic diseases complicating pregnancy, unspecified trimester
O99.284	Endocrine, nutritional and metabolic diseases complicating childbirth
O99.411	Diseases of the circulatory system complicating pregnancy, first trimester
O99.412	Diseases of the circulatory system complicating pregnancy, second trimester
O99.413	Diseases of the circulatory system complicating pregnancy, third trimester
O99.419	Diseases of the circulatory system complicating pregnancy, unspecified trimester
O99.42	Diseases of the circulatory system complicating childbirth
O99.43	Diseases of the circulatory system complicating the puerperium
O99.824	Streptococcus B carrier state complicating childbirth