North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

Please visit our website at www.dhhs.state.nc.us/dma

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OB/GYN Billing Guide

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Program Overview

Covered Services

Medicaid covers medically necessary obstetrical and gynecological care, family planning, and inpatient/outpatient services.

Baby Love Program

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- Childbirth Education
- Health and Behavior Intervention

Obstetrics

- Antepartum/ prenatal care
- Laboratory tests
- Diagnostic tests such as amniocentesis, fetal stress and non-stress tests, and ultrasounds
- Delivery - includes anesthesia services (e.g., epidurals)
- Postpartum care

Gynecology

- Pap Smears
- Mammography
- Hysterectomy
- Abortion
- Sterilization

Anesthesia

- Anesthesia Services

Family Planning

- Birth Control

Family Planning Waiver

Refer to page 33 for other services that are covered by Medicaid.

Eligible Recipients

Medicaid-eligible recipients may have service restrictions due to their eligibility category that would make them ineligible for these services. Providers should refer to the Basic Medicaid Billing Guide on Division of Medical Assistance (DMA) website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm for more information on category restrictions.

Recipients with Medicaid for Pregnant Women

Women who do not qualify for regular Medicaid may qualify for the Medicaid for Pregnant Women (MPW) program. This program provides coverage for women whose income level is no more than 185% of federal poverty level. Medicaid coverage for MPW recipients extends through the end of the month in which the 60th postpartum day occurs. This is true for women who have a live birth, as well as women who experience a miscarriage, fetal death, molar pregnancy, neonatal death or therapeutic abortion. MPW coverage is limited to pregnancy-related services and conditions that may complicate the pregnancy.

Presumptive Eligibility

State-approved medical providers may screen patients for MPW eligibility. When presumptively eligible, a woman may receive prenatal ambulatory services until the end of the month following her application. This allows the recipient adequate time to apply for Medicaid at the county department of social services (DSS).

Undocumented Aliens

Individuals requesting Medicaid coverage for medical emergencies must meet categorical and financial eligibility requirements, including state residency. In addition, the medical services rendered must meet the federal definition of "emergency services". The definition of an emergency medical service includes a vaginal or C-section delivery. Undocumented aliens are only authorized for Medicaid services for the actual days they receive an emergency medical service. For all other emergency services, including miscarriages and other pregnancy terminations, the DMA determines the eligibility coverage.

Note:

Sterilizations do not meet the definition of "emergency services" and are not reimbursed for undocumented aliens.

Baby Love Program

In response to concerns over North Carolina's high infant mortality rate, in 1987, the SOBRA and COBRA Congressional Legislative options were adopted to expand the N.C. Medicaid program to provide coverage for pregnant women and children at a higher poverty-based income level.

Through the joint efforts of the DMA and the Division of Public Health (DPH), in cooperation with the Office of Rural Health and Resource Development, the Baby Love Program was introduced to improve access to health care and support services for low-income pregnant women and young children. Key features of the Baby Love Program include:

- expansion of Medicaid eligibility for pregnant women and infants to 185 percent of the federal poverty levels
- program promotion to increase participation rates in Medicaid
- implementation of presumptive eligibility allowing state-approved medical providers to screen individuals for MPW eligibility
- expansion of prenatal services covered by Medicaid
- development of a case management system for pregnant women who are Medicaid eligible

Maternity Care Coordination

Maternity Care Coordination (MCC) is the cornerstone of the Baby Love Program and is aimed directly at eliminating access barriers to recipient utilization of services. The care coordination system is designed to:

- ensure that eligible women receive all health care services necessary for positive pregnancy outcomes.
- facilitate integrated service delivery among the various health and social service providers.
- monitor the effectiveness of care coordination services in meeting the recipient's medical, nutritional, psychosocial, and resource needs

Maternity Care Coordination services are covered for all Medicaid-eligible pregnant women. Maternity Care Coordinators are either registered nurses or social workers who provide assistance to pregnant and postpartum women in meeting their medical, social, financial, and educational needs. Coordinators are located in local county health departments, most rural and community health centers, the Indian Health System, community agencies and physician offices. They work in concert with the recipient's medical provider to assist pregnant women in the Medicaid eligibility process, arrange transportation to medical appointments, make referrals to appropriate community agencies, and provide follow-up in any of these areas as needed. The coordinators develop a supportive relationship with the recipient and provide guidance concerning the importance of continuous prenatal care and assistance in meeting the recipient's plan of care.

Other Maternal Support Services

There are additional services that pregnant and postpartum women may benefit from while receiving Medicaid. The following services are:

- Childbirth Education classes
- Maternal Care Skilled Nurse Home Visit
- Home Visit for Postpartum Assessment and Follow-up Care
- Medical Nutrition Therapy
- Health and Behavior Intervention

Childbirth Education

Childbirth Education classes help prepare pregnant women and their support person for the labor and delivery experience. These classes should be based on a written plan that outlines course objectives and specific content to be covered in the session. Instruction includes, but is not limited to:

- important aspects of prenatal care, including danger signs
- signs of preterm labor
- preparation for labor and delivery
- breathing and relaxation techniques and other comfort measures

Maternal Care Skilled Nurse Home Visit

The Maternal Care Skilled Nurse Home visit includes an assessment and treatment of pregnant women who have one or more of the following high-risk medical conditions: preterm labor, hypertension, preeclampsia, diabetes, suspected fetal growth retardation, multiple pregnancy, renal disease, HIV infection/AIDS, perinatal substance abuse, and/or other high-risk medical conditions. The client must be referred by their prenatal care physician or physician extender (certified nurse midwife, nurse practitioner, physician assistant). This service is provided by a registered nurse.

Home Visit for Postnatal Assessment and Follow-up Care

Home Visit for Postnatal Assessment and Follow-up Care is designed to deliver health, social support, and/or educational services directly to families in their home. It is a means for follow-up on the mother's health; to counsel on family planning and infant care; and to arrange for additional appointments for the infant and mother. Also, referrals are made to other service providers for additional services, if necessary. This service is provided by a registered nurse.

Medical Nutrition Therapy

Medical Nutrition Therapy is a service provided to pregnant women and children who have chronic, episodic or acute conditions for which nutrition therapy is a critical component of medical management or with preventable conditions for which nutrition/diet is the primary therapy. Participants receive a diagnostic nutritional assessment, individualized nutrition care plan and counseling on nutritional/dietary management of nutrition-related medical conditions. Pregnant women can receive therapy until the end of the month in which the 60th postpartum day occurs and children can receive services from birth to age twenty. Services are rendered by a licensed dietician/nutritionist.

Health and Behavior Intervention

Health and Behavior Intervention provides intensive, focused counseling for pregnant and postpartum women who have serious psychosocial needs. It may include individualized treatment therapies designed specifically to aid the recipient in overcoming the identified problems. The service also includes the involvement of the woman's significant other or other service providers. Conditions which warrant these services include, but are not limited to, substance abuse, severe emotional crises associated with situations such as divorce, death, homelessness or job loss, episodic disorders, suicidal tendencies, and HIV infection/AIDS or other life-threatening medical problems. Health and Behavior Intervention is rendered by a licensed clinical social worker.

Newborn Services

There are addition services that newborns may be eligible for under the Baby Love program. The following services are:

- Home Visit for Newborn Care and Assessment
- Child Service Coordination

Home Visit for Newborn Care and Assessment

This home visit, also designed to deliver health, social support, and/or educational services directly to families, focuses on the infant's health. It is a means to counsel on infant care, to follow up on newborn screening, and to arrange for additional appointments for the infant. Also, referrals are made to other service providers for additional services, if needed.

Child Service Coordination

Child Service Coordination provides formal case management services to children who are at risk for or diagnosed with special needs. This is a family centered program designed to identify and provide access to needed preventive and specialized support services for children and their families through collaboration.

Through Child Service Coordination, families will have:

- improved access to services
- the opportunity to reach their maximum potential
- the opportunity to identify concerns and develop or enhance self-reliance skills

Children age birth to three years who are at risk for developmental delay or disability, chronic illness or a social/emotional disorder are eligible to receive these services. Children age birth to five years who are diagnosed with one of the aforementioned criteria are also eligible.

Refer to the clinical coverage polices for Maternity Care Coordination/Child Service Coordination on the DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex/htm for detailed information.

Obstetrics

Coverage and Billing Guidelines

Medicaid covers Obstetric (OB) services performed by qualified providers. Medicaid uses the terms antepartum, date of delivery and postpartum instead of the surgical terms pre-operative, intra-operative and post-operative.

Global Billing

Global billing is defined as all inclusive care including antepartum care, labor/delivery, and postpartum care for uncomplicated maternity and delivery**.** When a provider renders low risk services associated with prenatal care and delivery, it is recommended that OB global codes be utilized.

Billing for High-Risk Pregnancy

The provider may bill for individual services if a pregnancy is known to be high risk and will require more than the normal amount of services for a routine pregnancy or if the provider does not see the patient for a minimum of three consecutive months before delivery.

Package Codes

If a provider is billing a combination of services, package codes may be used.

Billing for Multiple Births

If the recipient has multiple births, Medicaid will only reimburse for a single delivery unless complications are documented through diagnosis and procedure codes. If the claim denied, and there are extenuating circumstances, resubmit the claim with medical records to Medicaid's fiscal agent, Electronic Data Systems (EDS).

Obstetric Procedure Codes and Billing Guidelines

When billing for obstetric procedure codes, the following guidelines should be observed:

Obstetric Codes and Guidelines			
Codes	**Type**	**Description**	**Guidelines**
59400	Global	Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	• The provider billing for OB care must have rendered at least 3 months of consecutive antepartum care to the recipient. • The date the provider first saw the recipient for antepartum care must appear in block 15 of the CMS-1500 form. • The date of service on the claim for the OB care must be the date of delivery. • This code cannot be billed in addition to other OB global codes.
59409	Individual	Vaginal delivery only (with or without episiotomy and or forceps)	• Rendering antepartum care is not a pre-requisite to bill this code. • Office visits and other antepartum services may be billed in conjunction with this code. • Postpartum care services are not included in this code.
59410	Package	Vaginal delivery and postpartum care only	• Rendering antepartum care is not a pre-requisite to bill this code. • Office visits and other antepartum services may be billed in conjunction with this code.
59412	Individual	External cephalic version, with or without tocolysis	• Cannot be billed in conjunction with another delivery code.
59414	Individual	Delivery of placenta (separate procedure)	• Cannot be billed in conjunction with another delivery code.
59425	Package	Antepartum care only, 4-6 visits	• The provider billing for OB care must have rendered at least 3 months of consecutive antepartum care to the recipient. • The date the provider first saw the recipient for antepartum care must appear in block 15 of the CMS-1500 form. • The date of service on the claim must be the date of delivery. • This code cannot be billed in addition to other OB global codes. • A provider can bill this code once during the pregnancy with one unit. • Delivery and postpartum care are to be billed in addition to this code.

59426	Package	Antepartum care only, 7 or more visits	• The provider billing for OB care must have rendered at least 3 months of consecutive antepartum care to the recipient. • The date the provider first saw the recipient for antepartum care must be entered in block 15 of the CMS-1500 form. • The date of service on the claim must be the date of delivery. • This code cannot be billed in addition to other OB global codes. • This code can only be billed once during the pregnancy with one unit. • Delivery and postpartum care are to be billed in addition to this code.
59430	Individual	Postpartum care only (separate procedure)	• This code cannot be billed in addition to other OB global codes. • This includes 60 days postpartum.
59510	Global	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	• The provider billing for OB care must have rendered at least 3 months of consecutive antepartum care to the recipient. • The date the provider first saw the recipient for antepartum care must be entered in block 15 of the CMS-1500 form. • The date of service on the claim for the OB care must be the date of delivery. • This code cannot be billed in addition to other OB global codes.
59514	Individual	Cesarean delivery only	• Rendering antepartum care is not a pre-requisite for billing this code. • Office visits and other antepartum services may be billed in conjunction with this code. • Postpartum care services are not included in this code.
59515	Package	Cesarean delivery and postpartum care only	• Rendering antepartum care is not a pre-requisite for billing this code. • Office visits and other antepartum services may be billed in conjunction with this code.
99360	Individual	Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	• The code may be billed only when the mother's delivery is high risk • Must be requested by a physician. • Diagnosis substantiating the high risk must be on the claim form.

The following table lists the codes that are included in the OB global codes. These codes cannot be billed separately in addition to a global code.

80051	80055	81000-81003	82016-82017	82127	82136	82139	82247-82248	82261
82379	82492	82541-82544	82657-82658	82726	82731	83013-83014	83020-83021	83026
83030	83033	83036	83045	83050-83051	83055	83060	83065	83068-83069
83080	83716	83788-83789	83891-83893	83897	83901	83903-83906	83919	84154
84376-84379	85046	86361	86704-86709	86804	87230	87260	87265	87270
87272	87274	87276	87278	87280	87285	87290	87299	87301
87324	87328-87332	87335	87340	87350	87385	87390-87391	87420	87425
87430	87449-87450	87470-87472	87475-87477	87480-87482	87485-87487	87490-87492	87495-87497	87510-87512
87515-87517	87520-87522	87525-87542	87550-87552	87555-87557	87560-87562	87580-87582	87590-87592	87620-87622
87650-87652	87797-87799	87810	88141-88142	88152	99201-99215	99241-99263		

Antepartum Care

Antepartum care includes the recipient's initial and subsequent medical history; physical examinations; recording of weight, blood pressures, and fetal heart tones; laboratory tests; and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery.

The following guidelines apply to all antepartum procedure codes:

1. The date the provider first saw the patient for antepartum care must be entered in block 15 of the CMS-1500 claim form.

2. An antepartum care package code can only be used once during the pregnancy.

3. The delivery date is used as the date of service for any OB global code.

4. OB global codes include antepartum care. The provider billing an OB global code must have rendered a minimum of three months of antepartum care to the recipient.

5. Pregnancy-related services, determined by diagnosis, are exempt from the legislative 24-visit limitation.

Fetal Surveillance

Fetal assessment includes but is not limited to ultrasound, amniocentesis, stress and non-stress testing, biophysical profile, fetal echocardiography, and fetal pulmonary maturation. Services should only be performed for recipients with a high risk diagnosis. The hospital's facility charges are billed on the UB-92 claim form. Only the facility charges are included in the revenue code. Professional charges must not be included in the RC code. The physician bills for professional charges on a CMS-1500 claim form.

When billing for the fetal surveillance of single or multiple fetuses, the following guidelines should be observed:

Fetal Surveillance Codes		
Codes	**Description**	**Guidelines**
76818 76819	Fetal biophysical profile; with non-stress testing Fetal biophysical profile; without non-stress testing	• Are covered for additional fetuses. • The first fetus should be billed on one detail line, no modifier with 1 unit of service. • Additional fetus(es) should be billed on the next detail line with modifier 59,and the number of units should equal the number of additional fetuses.

NOTE:

Medical records are required for multiple gestation diagnosis codes from the 651 ranges that note "fetal loss" or "other" and/or "unspecified multiple gestation."

A fetal biophysical profile must not be billed for a fetus that has died.

Ultrasounds

Ultrasounds are covered when medically necessary. Medicaid covers three ultrasounds within 280 days for the same or different provider for normal pregnancy. If additional ultrasounds are required, the diagnosis code must indicate high-risk conditions warranting additional ultrasounds.

Ultrasounds for Multiple Fetuses

Claims denied for additional ultrasounds may be resubmitted as an adjustment with documentation to support the medical necessity of a repeat ultrasound on the same date of service.

In cases of fetal demise, the ultrasound procedure that confirms the loss of one or more fetuses may be billed with units to include the total number of additional fetuses, dead and living. Subsequent billings should be billed with the units based on the number of "each additional" living fetus.

When billing for the ultrasound of multiple fetuses, the following guidelines should be observed:

Ultrasound Codes for Multiple Fetuses and Guidelines	
Codes	**Guidelines**
76801 76805 76811	• The CPT code should be billed as one detail line with one unit of service. • One ultrasound code from this group is allowed per day.
76802 76810 76812	• The CPT code should be billed on one detail line with the units of service equaling the number of additional fetuses. • Each add-on code must be billed with the correct primary code. • For "each additional fetus" must be billed with the appropriate multiple gestation diagnosis. • Units billed are for "each additional" living fetus (es). • One ultrasound code from this group is allowed per day.
76815	• Includes "one or more fetuses" and can only be reimbursed for one unit of service.
76816	• Are covered for additional fetuses. • The CPT code for the first fetus should be billed on one detail line with no modifier, and one unit of service. • Additional fetus(es) should be billed on the next detail line with modifier 59,and the number of units should equal the number of additional fetuses. • Appropriate diagnosis code should be billed.
76817	• In addition to the transabdominal ultrasounds, one unit of 76817 is covered on the same date of service if medically necessary. • Medical necessity must be documented in the recipient's medical records.

Fetal Non-stress Tests

If CPT 59020 or 59025 is billed in addition to revenue code RC720 or RC920 for the same recipient, same date of service, the claim with CPT 59020 or 59025 will deny. If a physician and a hospital both bill the non-stress test on the same date of service, the physician's claim will deny. If two separate distinct procedures were performed, the physician's claim may be resubmitted as an adjustment.

Postpartum Care

The postpartum period includes 60 days of follow-up care after the date of delivery. Postpartum care is not reimbursed separately when an OB global code is billed. Medicaid reimburses providers for family planning procedures, including sterilization, when provided during this period.

The spans of dates during and after the pregnancy are very different than the spans of dates typically associated with minor and major surgical pre- and post-operative periods. When a provider renders services on the date of delivery or during the postpartum period that are unrelated to the actual pregnancy or delivery, the provider can bill an Evaluation and Management (E/M) procedure code appended with modifier 24 or 25, as applicable.

Refer to the Special Bulletin II, April 1999, Modifiers (http://www.dhhs.state.nc.us/dma/bulletin/pdfbulletin/0499spec.pdf) for information on when to append a modifier to an E/M code and a description of the modifier. Providers may also use the Automated Voice Response (AVR) system to determine if an obstetrical procedure code is billable with a modifier.

NOTE:

Services rendered that are unrelated to the pregnancy or delivery is not covered for recipients with MPW coverage. These modifiers are only applicable to E/M codes.

Gynecology

North Carolina Medicaid covers gynecological services performed by qualified providers. Mammography, hysterectomy, sterilization, and abortions are covered when requirements are met.

Guidelines for Collection of Pap Smears

Pap smear CPT codes should not be used to bill collection of a specimen. Collection of the smear is included in the reimbursement for office visits and no separate fee is allowed. Providers who do not perform the lab test should not bill the pap smears. Only the provider who actually performs the lab test should bill the pap smear codes, except as noted below for physician interpretation.

Physician Interpretation Procedure Code

CPT procedure code 88141 is the **only** code that physicians may use to bill the **physician interpretation** of a pap smear. Because code 88141 has no components, it must be billed without a modifier. Hospitals billing for the physician interpretation should bill 88141 on the CMS-1500 claim form using the hospital's professional provider number.

NOTE:

Physicians who do not have the equipment in their office to interpret the specimen, should not bill 88141.

Pap Smear Technical Component Procedure Codes

The provider who renders the technical service must choose a procedure code from one of the codes listed below. The codes do not include professional and technical components but are considered technical and should be billed as **technical procedures without modifier TC**. Use add-on code 88155 when appropriate in conjunction with codes 88142 through 88154 and 88164 through 88167.

Pap Smear Technical Component Procedure			
Thin Layer	**Non-Bethesda**	**Bethesda**	**Not Specified**
88142	88150	88164	88147
88143	88152	88165	88148
	88153	88166	
	88154	88167	

Clinical Laboratory Improvements Amendment Information

Providers should refer to the Clinical Laboratory Improvement Amendments (CLIA) website at http://www.cms.hhs.gov/clia/ for a listing of CLIA tests along with correct procedure codes for waived and provider performed microscopy procedures (PPMP) certificate levels.

Outpatient Pathology Services

The hospital is reimbursed for the technical component of pathology procedures and must bill using the UB-92 claim form with an appropriate revenue code and the CPT code. Hospitals that employ pathologists must bill the professional component on the CMS-1500 claim form using the hospital's professional number. The following table includes a list of pathology codes for which payment for the technical component may be made.

For reimbursement of the technical component, outpatient hospitals should bill the CPT procedure code, without a modifier, along with an appropriate laboratory **Revenue Code (RC)** on the UB-92 claim form.

Pathology Codes		
88104 – 88125	88160-88162	88172-88173
88182	88300– 88319	88331 – 88365, 88380

Mammography Guidelines

Screening mammography is a radiological procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer. Mammograms are covered only when performed by an FDA certified screening center/suppliers. Interpretations are to be performed only by physicians who are included under the certification number of a certified screening center/supplier.

Mammography Screening Guidelines

Medicaid only covers a mammography screening for the age range below:

35 through 39	Baseline (only one allowed in this age group)
40 and over	Annual (11 months must have elapsed since the month of last screening)

NOTE:
Months between mammographies are counted beginning with the month after the date of the examination.

Filing Claims for Screening Mammography

Providers must bill the appropriate screening procedure code.

76092	Screening mammogram, bilateral
76083	Computer aided detection used with screening mammography

NOTE:
Providers must bill the appropriate ICD-9-CM screening diagnosis code.

Diagnostic Mammography Guidelines

Diagnostic mammography is a radiologic procedure, without age limits, furnished to a woman with signs or symptoms of breast disease, or a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease. Providers must use appropriate ICD-9-CM codes based on signs, symptoms, and medical necessity for diagnostic mammograms.

Hysterectomy

Hysterectomy and Procedure Codes

The hysterectomy diagnosis must support the medical necessity for the hysterectomy. Hysterectomy claims for recipients with a diagnosis of cervical dysplasia, pelvic pain, or pelvic inflammatory disease should be submitted with the following medical records: history and physical, operative notes, pathology report, discharge summary and reports for treatments performed prior to the hysterectomy (such as laparoscopic procedures, D & Cs, conizations, or cervical biopsies).

Hysterectomy CPT codes				
51925	58200	58262	58275	58951
58150	58210	58263	58280	59135
58152	58240	58267	58285	59525
58180	58260	58270	58550	

Note:
All providers must bill the same hysterectomy procedure code for the same recipient, same date of service.

Hysterectomy ICD-9-CM		
68.3	68.5	68.7
68.4	68.6	68.8

Note:
When billing ICD-9 procedure codes, providers must code to the highest level of specificity.

Completing a Hysterectomy Statement

- Complete one of the three federally approved hysterectomy statements to include: the recipient's MID, recipient's address, recipient's signature and date, witness' signature, date of surgery, and surgeon's signature, if applicable.
- If the recipient is mentally impaired, the recipient's name must be on the hysterectomy statement and two witnesses must sign the statement (one witness signature must be that of the legal guardian).
- If the recipient signs with an X, the statement must be witnessed by two people and two witness signatures must appear on the hysterectomy statements.
- If the recipient is a minor, the recipient's name should be on the statement and two witnesses must sign the statement (one witness signature must be that of the legal guardian). Submit with records to include: history and physical exam, operative notes, pathology report, discharge summary and reports for treatments performed prior to the hysterectomy.
- According to federal regulations, improperly worded, incomplete, altered or traced hysterectomy statements cannot be processed.
- When an electronically submitted claim is received and no hysterectomy statement is on file, Medicaid's fiscal agent will "suspend" the claim for two weeks to allow time for the statement to be received and processed.

MID:_____

Examples of Acceptable Hysterectomy Statements (these examples should be recreated on office letterhead – exact wording must be used)

If the patient signs the hysterectomy statement prior to surgery:

I HAVE BEEN INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WILL RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN:

Patient's Signature _____

Patient's Address _____

_____

Date Signed _____ Witness Signature_____

If the provider fails to obtain the patient's statement prior to surgery, however has informed her that she would be incapable of bearing children (this is an exception, not a rule, and will be reviewed as such):

PRIOR TO MY SURGERY ON ____(Date of Surgery)_____, I WAS INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WOULD RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN

Patient's Signature _____

Patient's Address _____

_____

Date Signed _____ Witness Signature_____

If the patient is sterile due to age, a congenital disorder, a previous sterilization or if the hysterectomy was performed on an emergency basis because of life-threatening circumstances (life-threatening should indicate that the patient is unable to respond to the information pertaining to the acknowledgement agreement. Federal regulations do not recognize metastasis of any kind as life threatening or an emergency):

Patient's Name _____

Patient's Address _____

_____

The above named patient was sterile prior to the hysterectomy due to:

_____

or

A hysterectomy was performed on the above named patient on an emergency basis and was unable to respond because of the following life-threatening circumstances: _____

_____

Physician Signature _____Date_____

Submitting Hysterectomy Statements Separately

Hysterectomy statements may be submitted separately from the claim. This allows electronic submission of claims by eliminating the necessity of claim attachments. When submitting hysterectomy statements separately from the claim, follow the instructions below:

- **Write the recipient's Medicaid identification (MID) number** in the upper right corner of the statement form. Medicaid's fiscal agent must have the MID to enter the form into the system.
- **Verify** that all the information on the form is correct.
- **Mail the statement** to : EDS
  PO Box 300012
  Raleigh, NC 27622
- **Send Only** hysterectomy statements submitted separately from the claim to PO Box 300012**.**

Upon receipt, Medicaid's fiscal agent will review the statement to ensure adherence to federally mandated guidelines.

- File claims electronically or you may mail paper claims submitted without a statement to:

(Physicians)
EDS
PO Box 30968
Raleigh, NC 27622

(Hospitals)
EDS
PO Box 300010
Raleigh, NC 27622

Outpatient Hysterectomies

Medicaid covers and reimburses for outpatient hysterectomies. The N.C. Medicaid program does not routinely cover observation charges for hysterectomies. These charges are covered only in situations where a patient exhibits an uncommon or unusual reaction or other postoperative complications that require monitoring or treatment beyond the usual provided in the immediate post operative period. When observation charges are billed and no records are included with the claim, the claim will be denied for medical records to substantiate necessity for the service. The claim should be submitted with records supporting medical necessity and must include: history and physical, operative records, pathology report, and discharge summary. **Routine recovery room services are not to be billed as observation services.**

Abortion

Coverage of Non-therapeutic Abortions

Non-therapeutic abortion is a spontaneous termination of pregnancy where there has been no manual or surgical interruption of pregnancy. Missed or incomplete spontaneous abortions are examples of nontherapeutic abortions. Use the following CPT code chart:

Non-therapeutic Abortions		
Claim Type	**Procedure**	**Abortion Statement Required**
Physician (CMS-1500)	59830, 59870, 59100, 59812, 59820, 59821	No
Hospital (UB 92)	69.0, 69.5	Possible (medical record review will determine if statement is required)

Note:

When billing ICD-9 procedure codes, providers must code to the highest level of specificity.

Coverage of Therapeutic Abortions

Therapeutic abortion is an elective termination of pregnancy. Medicaid considers a therapeutic abortion as a termination of pregnancy where fetal heart tones are present at the time of the abortive procedure. The termination of pregnancy may be induced medically (prostaglandin suppositories, etc.) or surgically (dilation and curettage, etc.). This includes termination of a pregnancy due to the result of rape or incest. In addition, the delivery of a non-viable (incapable of living outside the uterus) but live fetus, if labor was augmented by pitocin drip, laminaria suppository, etc. would be considered a therapeutic abortion.

Medicaid covers legal therapeutic abortions only under the following circumstances:

1. **In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by physician, place the woman in danger of death unless an abortion is performed** (revised wording required by law)
   - Medicaid must receive the physician's abortion statement with the wording that "the abortion was necessary due to a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by physician, place the woman in danger of death unless an abortion was performed." (The statement must include the recipient's complete name and address.)
   - The medical diagnosis and medical records must support the statement and must be submitted with the claim.
   - If the abortion was necessary to save the life of the mother, regardless of whether the pregnancy was a result of rape or incest, the diagnosis and medical records must support the medical situation.
   - An appropriate diagnosis code "legally induced abortion" must be entered on the claim.
   - A minor must have parental consent for an abortion, pursuant to current state law (see General Statues regarding minors and abortions on page 22).

2. **Incest**
   - Medicaid must receive the physician's abortion statement attesting that the recipient was a victim of incest. The statement must contain the recipient's complete name and address.
   - Diagnosis code "other specified family circumstances" must be listed on the claim. The medical record documentation must support this diagnosis and the abortion statement. It is not required to submit medical records with the claim, but records must be available for review if necessary.
   - A minor must have parental consent for an abortion, pursuant to current state law (see General Statues regarding minors and abortions on page 22).

3. Rape

- Medicaid must receive the physician's abortion statement attesting that the recipient was a victim of rape. The statement must contain the recipient's complete name and address.
- Diagnosis code "rape" must be listed on the claim. The medical record documentation must support this diagnosis and the abortion statement. It is not required to submit medical records with the claim, but records must be available for review if necessary.
- A minor must have parental consent for an abortion; pursuant to current state law (see General Statues on minors and abortions on page 22).

Use the following CPT code chart:

Therapeutic Abortions		
Claim Type	**Procedure**	**Abortion Statement Required**
CMS- 1500	59830, 59840, 59841, 59850, 59851, 59852, 59855 59856, 59857	Yes, with records
		Yes
		Yes
UB 92	69.0, 69.5, 69.9, 74.9, 75, 96.4	Yes, with records
		Yes
		Yes

Note:

When billing ICD-9 procedure codes, providers must code to the highest level of specificity.

Completing the Abortion Statement

All therapeutic abortions must be submitted with an abortion statement (see page 21). The following information must be entered on the Abortion Statement:

1. Recipient's name
2. Recipient's address
3. Recipient's MID number
4. The gestational age of the fetus at the time of the abortion
5. Check block if the therapeutic abortion is necessary to save the life of the mother
6. Check block if the pregnancy is a result of rape
7. Check block if the pregnancy is a result of incest
8. Physician's name
9. Physician's signature
10. The physician's signature date

Note:

If #5 is checked, medical records consisting of history and physical, operative report, discharge summary, ultrasound report (if applicable), consults and pathology report must accompany the claim.

Example of the Abortion Statement

This example should be recreated on the provider's office letterhead: exact wording must be used.

1. Recipient's Name: _____
2. Address: _____
   _____
3. Medicaid Identification Number: _____
4. Gestational Age: _____

On the basis of my professional judgment, I have performed an abortion on the above named recipient for the following reason:

5. _____ The abortion was necessary due to a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion was performed.
6. _____ Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.
7. _____ Based on all the information available to me, I concluded that this pregnancy was the result of an act of incest.

My signature on this statement is an attestation that the requirements were met and documentation is on file.

8. _____ Physician's Name

9. _____ Physician's Signature

10. _____ Date

General Statutes Regarding Minors and Abortions

General Statute (G.S.) 90 – 21.7 requires parental or judicial consent for an unemancipated minor's abortion. "Unemancipated minor" or "minor" means any person under the age of 18 who has not been married or has not been emancipated pursuant to Article 56 of Chapter 7A of the General Statutes. Before an abortion is performed upon an unemancipated minor, the consent form must be signed by the **minor, and**

1. A parent with custody of the minor; **or**

2. The legal guardian or legal custodian of the minor; **or**

3. A parent with whom the minor is living; **or**

4. A grandparent with whom the minor has been living for at least six months immediately preceding the date of the minor's written consent.

The pregnant minor may petition the district court judge assigned to the juvenile proceedings in the district court where the minor resides or where she is physically present, on her own behalf or by guardian ad litem for a waiver of the parental consent requirement if:

1. None of the persons from whom consent must be obtained is available to the physician performing the abortion or the referring physician within a reasonable time or manner; **or**

2. All of the persons from whom consent must be obtained refuse to consent to the performance of an abortion; **or**

3. The minor elects not to seek consent of the person from whom consent is required (under G.S.90-21.9).

The requirements of parental consent shall not apply when a **medical emergency** exists that so complicates the pregnancy as to require an immediate abortion.

When Abortion is not Unlawful

General Statute (G.S.) 14-45.1 establishes further conditions that govern coverage of abortions in cases of rape or incest.

a) Notwithstanding any of the provisions of G.S. 14-44 and 14-45, it shall not be unlawful during the first 20 weeks of a woman's pregnancy, to advise, procure, or cause a miscarriage or abortion when the procedure is performed by a physician licensed to practice medicine in North Carolina in a hospital or clinic certified by the Department of Health and Human Services to be a suitable facility for the performance of abortions.

b) Notwithstanding any of the provisions of G.S. 14-44 and 14-45, it shall not be unlawful, after the twentieth week of a woman's pregnancy, to advise, procure, or cause a miscarriage or abortion when the procedure is performed by a physician licensed to practice medicine in North Carolina in a hospital licensed by the Department of Health and Human Services, if there is substantial risk that continuance of the pregnancy would threaten the life or gravely impair the health of the woman.

c) The Department of Health and Human Services shall prescribe and collect on an annual basis, from hospitals or clinics where abortions are performed, such representative samplings of statistical summary reports concerning the medical and demographic characteristics of the abortions provided for in this section as it shall deem to be in the public interest. Hospitals or clinics where the abortions are performed shall be responsible for providing these statistical summary reports to the Department of Health and Human Services. The reports shall be for statistical purposes only and the confidentiality of the patient relationship shall be protected.

d) The requirements of G.S. 130-43 are not applicable to abortions performed pursuant to this section.

e) Nothing in this section shall require a physician licensed to practice medicine in North Carolina or any nurse who shall state an objection to abortion on moral, ethical, or religious grounds, to perform or participate in medical procedures which result in an abortion. The refusal of such physician to perform or participate in these medical procedures shall not be a basis for damages for such refusal, or for any disciplinary or any other recriminatory action against such physician.

f) Nothing in this section shall require a hospital or other health care institution to perform an abortion or to provide abortion service.

Nonobstetrical D & C codes

Dilation and curettage (D&C) is a surgical procedure used to locate and treat the cause of sudden, heavy bleeding. It is done by passing a small instrument called a curette through the vagina into the uterus and scraping the endometrium.

CPT Codes for Nonobstetrical D & C Procedure	
58120	59160

ICD- 9-CM Codes for Nonobstetrical Procedure	
69.0	69.5

NOTE:
When billing ICD-9 procedure codes, code to the highest level of specificity.

Sterilization

Diagnosis and Procedure Codes for Sterilization

The following codes are the only codes to be considered for sterilization:

Sterilization Diagnosis Code
V25.2

Sterilization ICD-9-CM Codes		
63.7	66.2	66.3

Sterilization CPT Codes		
58600	58611	58670
58605	58615	58671

Note:
When billing ICD-9 procedure codes, providers must code to the highest level of specificity.

Federal Sterilization Guidelines

The sterilization consent form is a federally mandated document. The form must be on file with Medicaid's fiscal agent and all federal regulations pertaining to the completion of the form **must** be satisfied prior to payment of a sterilization claim.

The N.C. Medicaid program is bound by stringent federal guidelines in regard to coverage of sterilization procedures. Federal funding is available for an individual to be sterilized only if the following guidelines listed in 42 CFR 441.253 are met:

1. The individual is at least 21 years old at the time the sterilization consent is obtained.
2. The individual is not a mentally incompetent individual.
3. At least 30 days, but not more than 180 days have passed between the date of informed consent and the date of the sterilization except under the following circumstances:
   - **Premature delivery** - Informed consent must be given at least 30 days before the expected date of delivery and at least 72 hours must have passed since the informed consent was given and the consent form signed.
   - **Emergency abdominal surgery** - At least 72 hours must have passed since the informed consent was given and the consent form signed.
4. The individual has voluntarily given informed consent in accordance with all the requirements prescribed in 42 CFR 441.257 and 441.258. The individual must be:
   - Given an opportunity to ask and receive answers to questions concerning the procedure and provided a copy of the consent form.
   - Advised that sterilization consent may be withdrawn at any time before the sterilization procedure without affecting the right to future care or treatment and without loss of or withdrawal of any federally funded program benefits to which the recipient might otherwise be entitled.
   - Counseled in alternative methods of family planning and birth control.
   - Advised that the sterilization procedure is considered to be irreversible.
   - Provided a thorough explanation of the specific sterilization procedure to be performed.
   - Provided a full description of the possible discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
   - Provided a full description of the benefits or advantages that may be expected as a result of the sterilization.
   - Provided suitable arrangements to insure that information is effectively communicated if the recipient is blind, deaf, or otherwise handicapped.
   - Provided an interpreter if the recipient does not understand the language used on the consent form or the language used by the person obtaining consent.
   - Permitted to have a witness of his or her choice present when the consent is obtained.

The sterilization consent form is a three-copy form. The pink copy should be given to the recipient for their records, the physician should retain the yellow copy, and the white copy should be submitted to the fiscal agent. Consent forms may be obtained by calling Medicaid's fiscal agent at 1-800-688-6696.

NOTE:

If the recipient's name on the claim and the consent form is different, a signed name change statement that verifies the recipient whose name appears on the claim and consent are the same person must be included (see page 29 for an example of the name change statement). A name change statement can be submitted with the consent form when the form is submitted separately from the claim.

Medicaid will not pay for sterilization reversals.

If a judicial court orders a sterilization for a recipient who is a ward of the county and is mentally incompetent, Medicaid is not responsible for reimbursement for the sterilization.

Completing the Sterilization Consent Form

Instructions

Following is the list of fields included in the federal consent form requirements for sterilization. All areas are required to be completed except area 9 (race) and areas 10, 11, 12, if not applicable. ***Fields in bold print cannot be altered.*** This guide will assist in correct completion of consent forms and should help to decrease the number of denials related to errors in completing the form.

1. Person or facility that provided information concerning sterilization.
2. Type of sterilization procedure to be performed.
3. Recipient date of birth (must be at least 21 years of age when the consent form is signed), Date of birth must match recipient files.
4. Name of recipient as it appears on the MID card.
5. The full name of the physician scheduled to do the surgery (abbreviations, initials, or "doctor on call" are unacceptable). May use "Physician on call for Any Provider OB/GYN clinic."
6. Type of sterilization procedure to be performed.
7. ***Recipient's signature (must be dated) cannot be altered, traced over, or corrected. Initials are not acceptable. Signature must be legible. If not, the recipient's name may be typed or printed under the signature.***
8. ***Date the consent form was signed. The date of the recipient's signature must be at least 30 days and no more than 180 days prior to the date of the sterilization. The count begins the day following the recipient's signature date.***
9. Race and ethnicity (not required).
10. Language in which the form was read to the recipient, if an interpreter was used.
11. ***Signature of the interpreter.***
12. ***Signature date of the interpreter (same as # 8 and # 16).***
13. Name of recipient.
14. Name of sterilization procedure.
15. ***Signature of person witnessing consent must be dated (see # 16). Must be legible. If not legible, the witness' name may be typed or printed above or below the signature.***
16. ***Date (this date must be the same as the recipient signature date). Note: the doctor can also be the witness.***
17. The full name and address of the facility, including street name and number, city, state, and zip code where the consent was obtained and witnessed.
18. Name of recipient.
19. Actual date of sterilization. Date of surgery may be changed on consent form with submission of operative records verifying date of service.
20. Type of sterilization procedure performed.
21. The box is to be checked if the delivery was premature (write the recipient's expected delivery date in the space provided).
22. The box is to be checked if emergency abdominal surgery was performed. Claim must be submitted with operative records.
23. Physician's signature must be legible or name must be printed below the signature. A signature stamp may be used. Signature cannot be initials.
24. Date must be on or after the date of service.

Copy of the Sterilization Consent Form

MID#_____

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (1) (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (2). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded program.

I am at least 21 years of age and was born on (3) (Month Day Year)

I, (4), hereby consent

of my own free will to be sterilized by (5) (doctor)

by a method called (6). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:
Representatives of the Department of Health, Education, and Welfare or
Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.
I have received a copy of this form.

(7) Signature Date: (8) Month Day Year

You are requested to supply the following information, but it is not required:

(9) Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

(If an interpreter is provided to assist the individual to be sterilized)

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (10) language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(11) Interpreter (12) Date

STATEMENT OF PERSON OBTAINING CONSENT

Before (13) name of individual signed the consent form, I explained to him/her the nature of the sterilization operation (14), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(15) Signature of person obtaining consent (16) Date

(17) Facility

Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (18) Name of individual to be sterilized on (19) Date of sterilization

(19 cont'd) operation, I explained to him/her the nature of the sterilization operation (20) specify type of operation, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

(21) ☐ Premature delivery
(22) ☐ Individual's expected date of delivery:
☐ Emergency abdominal surgery:
(describe circumstances):

(23) Physician (24) Date

372-116 White: PATIENT Yellow: PHYSICIAN Pink: STATE AGENCY

Consent

Form Completion Tips

- **Changed, altered or traced over** recipient or witness signatures and/or dates are not acceptable on the consent form. Carefully review the consent form for any of these problems. If any problems are noted, the consent form must be voided and a **completely new consent form** initiated at that time. A new consent form cannot be initiated after the sterilization.
- **Inclusion of the EDC** (Estimated Date of Confinement) on the sterilization consent form often prevents unnecessary delays in processing the claim, and must be present in case of premature delivery or emergency abdominal surgery. The physician's signature must be dated *on or after* the date of service (procedure date). A signature stamp may used. **Handwritten signatures must be legible or the name must be printed below the written signature.**
- In the case of **premature delivery**, the consent form must have been signed at least **30 days before the expected date of delivery** and at least 72 hours must have passed since the informed consent was given. In these instances, place a check in box #21 and write the **date** the recipient was expected to deliver after the statement "individuals expected date of delivery."
- In the case of **emergency abdominal surgery**, there must be **at least 72 hours** between the signing of the consent form and the surgery.

Interpreter Signature on Sterilization Consent Form

When telephone interpreter services are needed to complete the sterilization consent form for non-English speaking Medicaid recipients, the interpreter's signature, date of the interpreter's service, and the language used are required on the sterilization consent form. In lieu of getting the interpreter's signature on the sterilization consent form at the time the service is provided, the interpreter who explains the procedure by telephone may fax or mail the attestation of their interpreter services. Criteria for the faxed or mailed attestation are as follows:

- The wording of the attestation should be taken directly from the sterilization consent form.
- The interpreter must write his or her signature and the date the interpreter services were rendered on the attestation form.
- The date of the recipient, interpreter, and witness signatures must all be the same.
- The attestation form must include the recipient's name as it appears on the MID card as well as the MID number.
- A copy of the attestation must be attached to the consent form when the provider submits the statement to Medicaid's fiscal agent.
- The provider must maintain the original attestation document with the consent form in the patient's medical record.

Abbreviations/Guide for Completion of Sterilization Consent Form

The following abbreviations are acceptable on the sterilization consent form as a description of the type of sterilization procedure:

- BTF = Bilateral tubal fulguration
- BTS = Bilateral tubal sterilization
- BTC = Bilateral tubal cauterization
- BTL = Bilateral tubal ligation
- BPS = Bilateral postpartum sterilization
- PPBTL = Postpartum bilateral tubal ligation
- LTC = Laparoscopic Tubal Cautery

Written wording that is acceptable

- Application of fallopian rings/laparoscopic
- Elective cauterization of tubes
- Hulka clip occlusion
- Laparoscopic tubal ligation
- Pomeroy
- Modified Pomeroy
- Parkland
- Tubal banding
- Tubal sterilization
- Yeon Rings

Unacceptable wording (not specific to type of procedure)

- Tubal occlusion
- Tubal coagulation

Submitting Sterilization Consents Separately

When submitting sterilization consents separately from the claim, follow the instructions below:

- **Write the recipient's MID number** in the upper right corner of the consent form. Medicaid's fiscal agent must have the MID to enter the form into the system.

- **Verify** that all the information on the form is correct.

- **Mail the consent to**: EDS
  PO Box 300012
  Raleigh, NC 27622

- **Send only** sterilization consents submitted separately from the claim to PO Box 300012**.**

Upon receipt, Medicaid's fiscal agent will review the consent to ensure adherence to federally mandated guidelines.

- File claims electronically or you may mail paper claims submitted without a consent to:

(Physicians)
EDS
PO Box 30968
Raleigh, NC 27622

(Hospitals)
EDS
PO Box 300010
Raleigh, NC 27622

Note:

When denial EOB's for sterilization request additional information, (i.e., records to verify a procedure code or verification of a date of service), the verification attachments must be submitted with a claim.

Sterilization for Undocumented Aliens

Undocumented residents are eligible for Medicaid emergency services only. Physicians must not bill Medicaid for sterilizations performed on undocumented aliens.

Undocumented aliens are only authorized for Medicaid services for the actual days they receive an emergency medical service. If an inpatient or outpatient hospital claim is submitted for an undocumented alien with the ICD-9-CM surgical procedure codes, the claim will deny indicating recipient eligible for emergency services only. Providers must resubmit the claim as an adjustment placing non-emergent charges (i.e., sterilization) in non-covered column and note change in remarks field.

When completing the adjustment, the provider must attach a claim that has both requirement items:
1. Charges in the non-covered column on the claim form.

2. In the remarks field on the claim, the provider must indicate that the sterilization charges have been pulled out and placed in the non-covered column on the claim.

Note:
Failure to complete both the non-covered column and the remarks field will result in denial.

Name Change Policy for Surgical Procedures

If the recipient name on the claim and the name on the hysterectomy, abortion, and sterilization form is different, a signed name change statement that verifies the recipient whose name appears on the claim and statement are the same person, must be included (refer to example below). This example should be recreated on the provider's office letterhead.

Name Change Statement (Example)

Dr. Any Provider
101 Any Hwy
Any City, NC 22222

Medicaid ID Number: 88888888T

To Whom It May Concern:

Jane Recipient has changed her name to Jane Doe.

Dr. Any Provider (Signature of representative at providers office is required)

Billing for Anesthesia Services Related to OB/GYN Services

Anesthesia Procedure Codes

The following anesthesia CPT code should be billed when performing anesthesia for obstetrical and gynecological services.

Anesthesia CPT Codes for Obstetrical and Gynecological Services		
Code	**Description**	Billing Unit
00840	Anesthesia for intraperitoneal procedure in lower abdomen including laparoscopy; not otherwise specified	One minute = 1 unit
00846	Anesthesia for intraperitoneal procedure in lower abdomen including laparoscopy; radical hysterectomy	One minute = 1 unit
00848	Anesthesia for intraperitoneal procedure in lower abdomen including laparoscopy; pelvic exenteration	One minute = 1 unit
00851	Anesthesia for intraperitoneal procedure in lower abdomen including laparoscopy; tubal ligation/transection	One minute = 1 unit
00944	Anesthesia for vaginal procedures; vaginal hysterectomy	One minute = 1 unit
01960*	Anesthesia for vaginal delivery only	One minute = 1 unit
01961*	Anesthesia for vaginal cesarean only	One minute = 1 unit
01962*	Anesthesia for urgent hysterectomy following delivery	One minute = 1 unit
01963	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care	One minute = 1 unit
01964	Anesthesia for abortion procedures	One minute = 1 unit
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery	1 Unit (Flat Rate)
01968*	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia	One minute = 1 unit Add on code
01969*	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia	One minute = 1 unit Add on code

NOTE:

CPT 01968 and 01969 are add-on codes that must be billed in conjunction with 01967.

**Effective with date of service October 1, the maximum unit limitation for these obstetric anesthesia codes that are billed with units of time will be 180 units per date of service.*

Anesthesia Modifiers

The following guidelines for anesthesia modifiers must be used when billing anesthesia services. One of the modifiers listed below must be appended to the anesthesia CPT code each time anesthesia is billed.

Anesthesia Modifiers	
AA	Anesthesia services performed personally by anesthesiologist
QX	CRNA Service: with medical direction
QZ	CRNA Service: without medical direction
QY	Medical direction of one CRNA by an anesthesiologist
QK	Medical direction of 2, 3 or 4 concurrent anesthesia procedures

NOTE:

CPT code 01996 *Daily hospital management of epidural or subarachnoid continuous drug administration* is a management service and does not require anesthesia modifiers. This service will be reimbursed only once per day.

Only Anesthesiologists and Certified Registered Nurse Anesthetists are required to append anesthesia modifiers when billing CPT code 01967 *Neuraxial labor analgesia/anesthesia for planned vaginal delivery.*

QS Monitored Anesthesia Care

When monitored anesthesia care is billed, the QS modifier must be billed along with the following:

- AA or QZ to indicate that the service was either personally performed or
- QK, QX or QY to indicate that the service was medically directed

NOTE:

The time plus base units are used in calculating the reimbursement.

Hysterectomy Anesthesia Codes		
01962	01969	00848
01963	00846	00944

Sterilization Anesthesia Codes		
00840	00851	00921

Abortion Anesthesia Code
01964

Family Planning

Birth Control Coverage and Guidelines

Medicaid covers medically approved birth control methods such as Nuva Ring, Ortho Evra, emergency contraceptive counseling, contraceptive management procedures, and pharmaceuticals to prevent conception.

Birth Control Pills

Birth control pills may be dispensed through a pharmacy. A recipient may receive up to a 3-month supply.

Diaphragms

Medicaid recipients can choose a diaphragm as a birth control method. A physician can fit the recipient and bill using the CPT code for diaphragm fitting. However, Medicaid does not cover the diaphragm.

Intrauterine Devices (IUDs)

The codes for IUD insertion correspond to the specific intrauterine device (IUD).

- J7300 Para gard (T380A)
- J7302 Mirena

When billing for IUD insertion, CPT code 58300 is used. The CPT code for removal of IUD is 58301, which includes an office visit.

Depo-Provera

Depo-Provera contraceptive injection, J1055, is a covered service. Providers are advised to use an appropriate diagnosis code for contraceptive management. The appropriate office visit code may be billed separately, unless the service is only the administration of the injectable drug in which case a provider can bill the injectable administration fee in addition to the Depo-Provera injection code.

Norplant

Medicaid covers the removal of Norplant. The global period for CPT 11976 is one (1) pre-care day and ninety (90) post-operative days.

Emergency Contraceptives

Medicaid covers Emergency contraception for women who recently have had unprotected intercourse or a contraceptive failure and who do not want to become pregnant. Ideally, the recipient should also be given information about efficacy, side effects, mechanism of action, other contraceptive methods, and methods to prevent STIs.

Family Planning Waiver

Effective with date of service October 1, 2005, DMA will implement a 5-year 1115 Medicaid demonstration waiver project for family planning services for the citizens of North Carolina.

The Family Planning Waiver is a Medicaid program designed to reduce unintended pregnancies and improve the wellbeing of children and families in North Carolina by extending eligibility for family planning services to eligible women between the ages 19 through 55 and men ages 19 through 60 whose income is at or below 185% of the federal poverty level.

The name of the waiver program is the "BE SMART" program.

Objectives of the Family Planning Waiver are:

- Increase the number of reproductive age women and men receiving either Title XIX or Title X funded family planning services by improving access to and use of Medicaid family planning services.
- Reduce the number of inadequately spaced pregnancies by women in the target group thus improving birth outcomes and health of these women.
- Reduce the number of unintended and unwanted pregnancies among women eligible for Medicaid.
- Impact positively the utilization of and "continuation rates" for contraceptive use among the target population.
- Increase the use of more effective methods of contraception in the target population.

Key Features of the Family Planning Waiver include:

- Providing comprehensive family planning services to eligible women and men who otherwise do not have access to these services.
- Providing screening, early detection, and education of sexually transmitted infections (STI), including Human Immunodeficiency Virus (HIV)/AIDS for women and men.

The Family Planning Waiver will also serve as the intervention and referral site for other health concerns for women and men. There is no co-payment for any services received under the Family Planning Waiver.

Refer to the August 2005 Special Bulletin , Family Planning Waiver "Be Smart" on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm#special for additional information on the "Be Smart" Family Planning Waiver.

Other Medicaid Services

Medicaid recipients with MPW coverage are limited to treatment for medical illness, injury or trauma that in the physician's judgment may complicate pregnancy. These conditions may: **(1)** stem from the pregnancy, **(2)** be pre-existing, or **(3)** represent new pathological conditions that adversely affect the best possible outcomes from the pregnancy. These services include:

Behavioral Health Services

- Medicaid covers professional counseling services provided to the pregnant woman when provided by a psychiatrist, a Mental Health Center, or a direct enrolled Medicaid mental health practitioner. These services must be prior approved at designated trigger points and must be for conditions related to the pregnancy or the health of the unborn child. These services can be provided for 6 months post partum if they meet the stated requirements.

Dental Services

- MPW recipients are covered during the prenatal period only. It is recommended that MPW recipients be referred to the dental provider by the attending OB provider.

Durable Medical Equipment (DME) Services

- Some items require prior approval. Refer to Clinical Coverage Policy #5A for items that require prior approval. Some items are not covered including breast pumps.
- Diabetic Recipients - Blood glucose monitors and related supplies are covered by Medicaid if the recipients are insulin dependent or have gestational diabetes. They are covered through the DME program and the Home Health services program.

Home Health Agencies Services

- Diabetic supplies are also available through home health agencies. The Medicaid recipient does not have to be homebound nor have to receive any skilled services from the home health agency in order to qualify for these supplies. A registered nurse from the home health agency must make an assessment visit to the patient's home initially and establish a plan of care, which the referring physician signs. Services must be re-authorized every 60 days. The assessment visit is covered by Medicaid.

Hospital Services

- Visits to outpatient departments of a hospital for diagnostic, therapeutic, rehabilitative, and palliative items necessary for the care of a pregnant woman are covered.
- Procedure code 5983 (septic abortion) treatment can be billed as a non-therapeutic or a therapeutic. Providers must use the appropriate therapeutic or non-therapeutic diagnosis. If the procedure code is billed as a therapeutic abortions, it must have an Abortion Statement and appropriate medical records.
- For undocumented aliens:
    - Medicaid reimbursement is 100% of the DRG-allowable for the delivery DRG.
    - No outlier or disproportionate share payments are made.
    - The hospital cannot bill the undocumented alien recipient when Medicaid has paid for a delivery.

Independent Laboratories Services

- Laboratory and radiological services- Laboratory and x-ray services are those professional and technical laboratory and radiological services order by a physician or licensed practitioner in his office or by a certified independent laboratory.

Medical Optometric Services

- Eye examinations require prior approval. The optical provider (not the OB provider) must submit to the fiscal agent a prior approval request, including documentation of medical necessity, and the following information: blood sugar, blood pressure, hemoglobin, urine protein, and weeks of gestation.

Pharmacy Services

- Pharmacy services - FDA approved and Medicaid covered drugs prescribed for a complicating condition are covered. There is no co-payment for pregnancy related prescriptions.
- If the physician communicates verbally that the recipient is pregnant, the pharmacist should document this on the face of the prescription. If a pregnant recipient is a non-MPW recipient and the physician has indicated this as outlined above, the pharmacist must place a "4"in the prior authorization field on a point-of-sale claim or a "P" in the location field on a batch or manual claim so that EDS claims processing system will know to exempt co-payment. MPW recipient is not subjected to co-pay on prescriptions.

Physician Providers

- The date the provider first saw the recipient for antepartum care must appear in block 15 of the CMS-1500 form.
- Remember to include the recipients MID number in the top right hand corner of the hysterectomy statement and sterilization consent form.

- Procedure code 5983 (septic abortion) treatment can be billed as a non-therapeutic or a therapeutic**.** Providers must use the appropriate therapeutic or non-therapeutic diagnosis. If the procedure code is billed as a therapeutic abortions, it must have an Abortion Statement and appropriate medical records.
- Certified Registered Nurse Anesthetist (CRNA) charges for anesthesia are to billed on the CMS-1500.

Transportation Ambulance Services

- Ambulance transportation must be medically necessary and is subject to limitations. Medical necessity is indicated when the recipient's condition is such that any other means of transportation would endanger the recipient's health. Ambulance transportation is not considered medically necessary when another means of transportation can be safely used. Unavailability of other means of transportation does not constitute medical necessity.
- Emergency ground transportation is medically necessary ground transportation to the nearest appropriate facility where prompt medical services are given in an emergency situation (i.e., accidents, acute illness, injuries).
- For OB/GYN cases, although ambulance criteria state that ambulance transport in obstetric cases is covered only if the woman is crowning, medical necessity supersedes this guideline. Medical necessity may be present in the following situations:
    - Crowning
    - Hemorrhage or Abortion
    - Preterm labor (prior to 37 weeks)
    - Premature rupture of membranes
    - Abruptio placenta
    - Transport from a small hospital to a tertiary hospital when the recipient is in preterm labor
- Providers rendering prenatal care should encourage pregnant women, prior to their due date, to seek the assistance of their county case worker or Maternity Care Coordinator in securing appropriate transportation to the hospital for delivery.

Transportation Non- ambulance Services

- Eligible Medicaid recipients may apply for assistance with their county DSS for transportation to appropriate medical appointments.

Prior Approval

Due to the limitation on services covered for MPW recipients, prior approval is required for services. To determine if a service requires prior approval, call the AVR system at 1-800-723-4337.

Claim Examples

PLEASE DO NOT STAPLE IN THIS AREA [redacted]

STERILIZATION

HEALTH INSURANCE CLAIM FORM

PICA PICA

CARRIER

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
( ) (Medicare #) (X) (Medicaid #) ( ) (Sponsor's SSN) ( ) (VA File #) ( ) (SSN or ID) ( ) (SSN) ( ) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 888888888X

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Recipient, John	09 11 71 M (X) F ( )	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
111 Recipient Street	Self ( ) Spouse ( ) Child ( ) Other ( )	
CITY: Raleigh / STATE: NC	8. PATIENT STATUS: Single ( ) Married (X) Other ( )	CITY / STATE
ZIP CODE: 12345 / TELEPHONE (Include Area Code): (919) 999-9999	Employed ( ) Full-Time Student ( ) Part-Time Student ( )	ZIP CODE / TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ( ) NO ( )	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ( ) F ( )
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ( ) F ( )	b. AUTO ACCIDENT? YES ( ) NO ( ) PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ( ) NO ( )	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE: 1234567		20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. V25.2 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 01 05 1001 05	11		55450	FP		38744	1				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ( ) NO ( )	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	12345		$ 387 44	$	$ 387 44

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Signature on file
SIGNED 8/30/05 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Provider Incorporated
123 Provide Street
Raleigh, NC 12345
PIN# 3333333 GRP# 4444444

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

NON-THERAPEUTIC ABORTION

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 111111111X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE MM DD YY SEX M F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Raleigh STATE: NC

8. PATIENT STATUS: Single [X] Married Other

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 999-9999

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 630. 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 08 19 05	08 19 05	11		59870			400 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $ 400 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 400 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

signature on file SIGNED 8/30/05 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Provider Incorporated
123 Provide Street
Raleigh, NC 12345

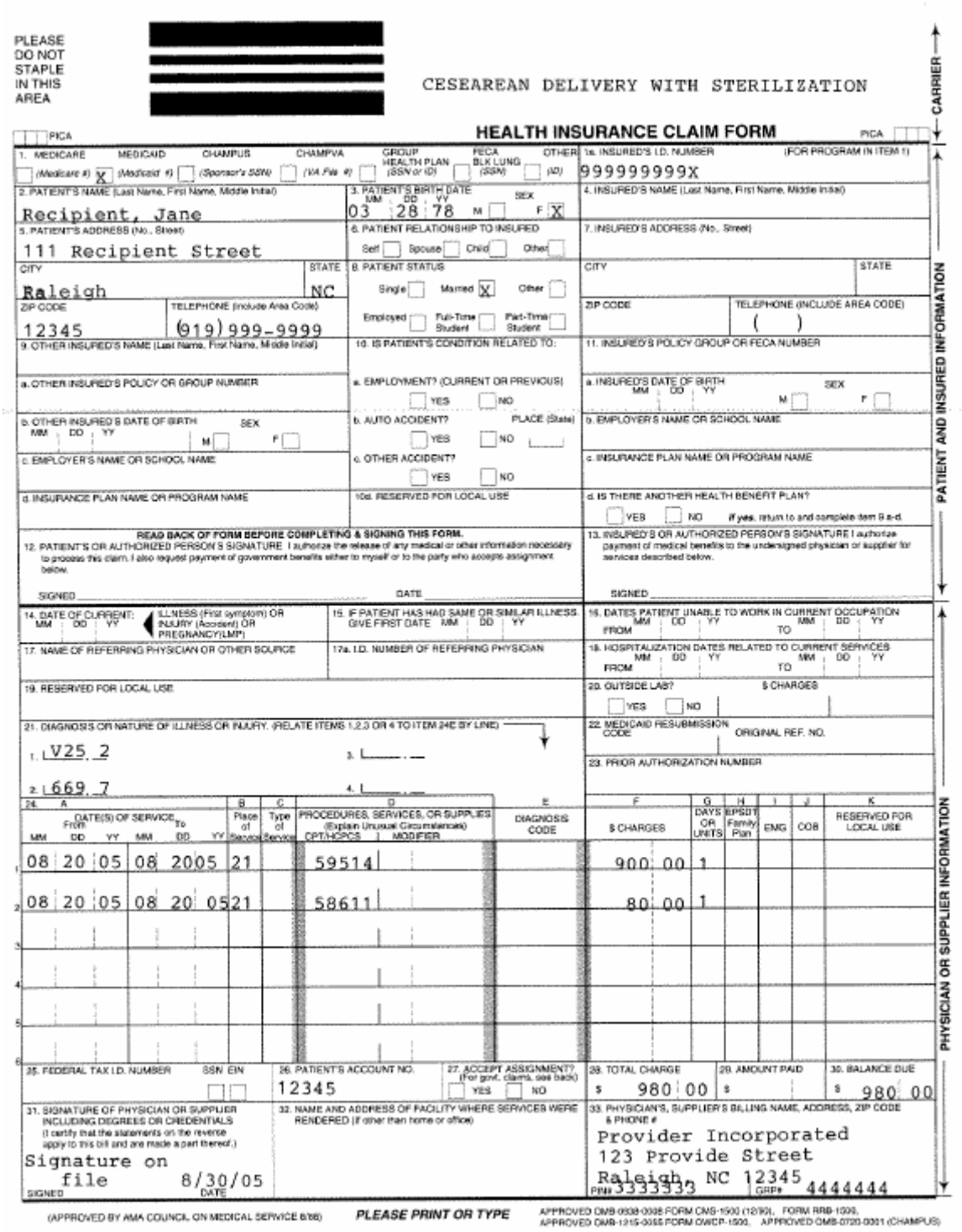
PIN# 3333333 GRP# 4444444

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

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CESEAREAN DELIVERY WITH STERILIZATION

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
(Medicare #) [X] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE: 03 28 78 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Raleigh STATE: NC

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V25.2
2. 669.7
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 08 20 05	08 2005	21		59514			900 00	1				
2 08 20 05	08 20 05	21		58611			80 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO. 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 980 00

29. AMOUNT PAID $

30. BALANCE DUE $ 980 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Signature on file SIGNED 8/30/05 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

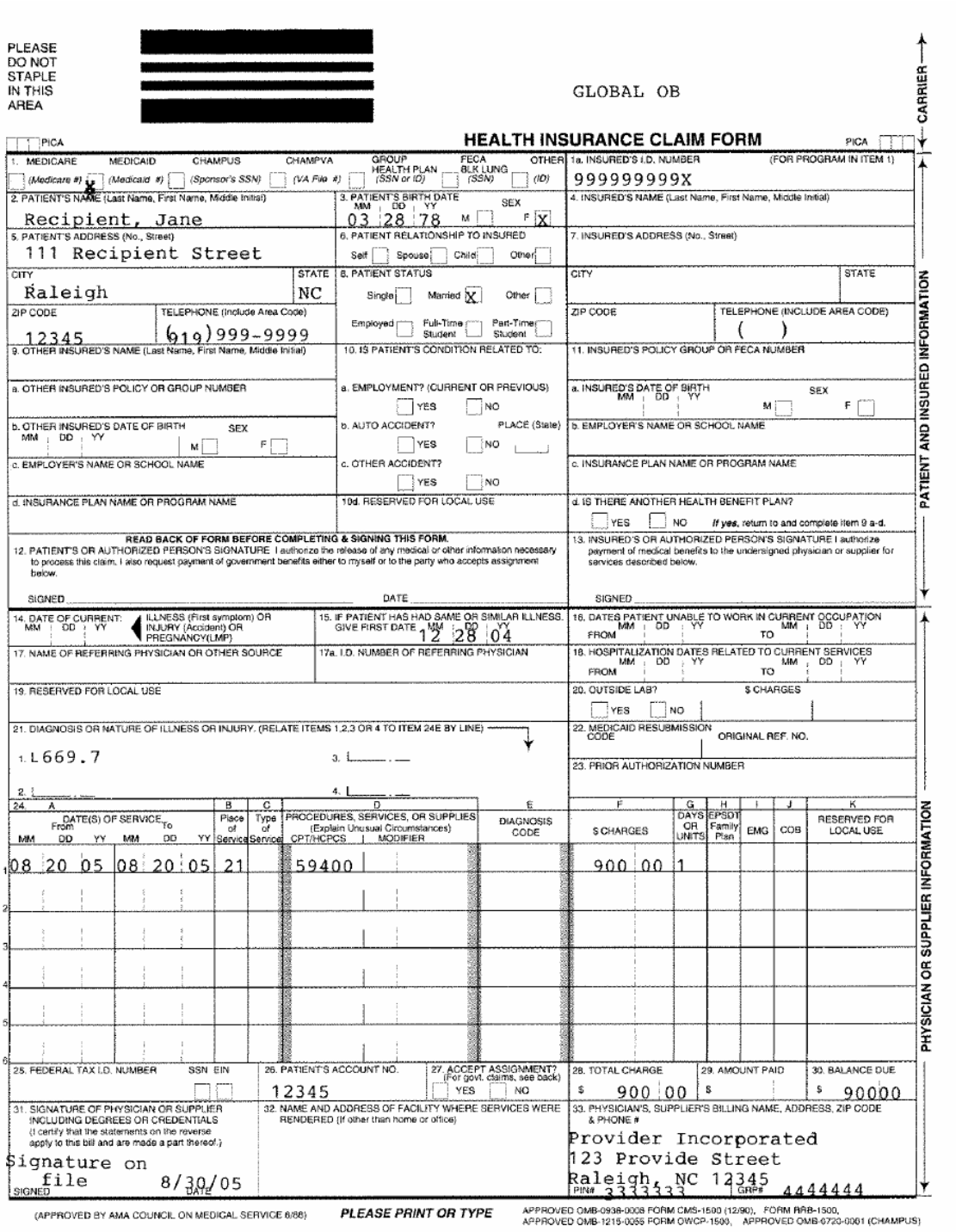
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Provider Incorporated
123 Provide Street
Raleigh, NC 12345
PIN# 3333333 GRP# 4444444

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

GLOBAL OB

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 03 28 78 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Raleigh STATE: NC

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919)999-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: 12 28 04

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L669.7 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 08 20 05	08 20 05	21		59400			900 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 900 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 90000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

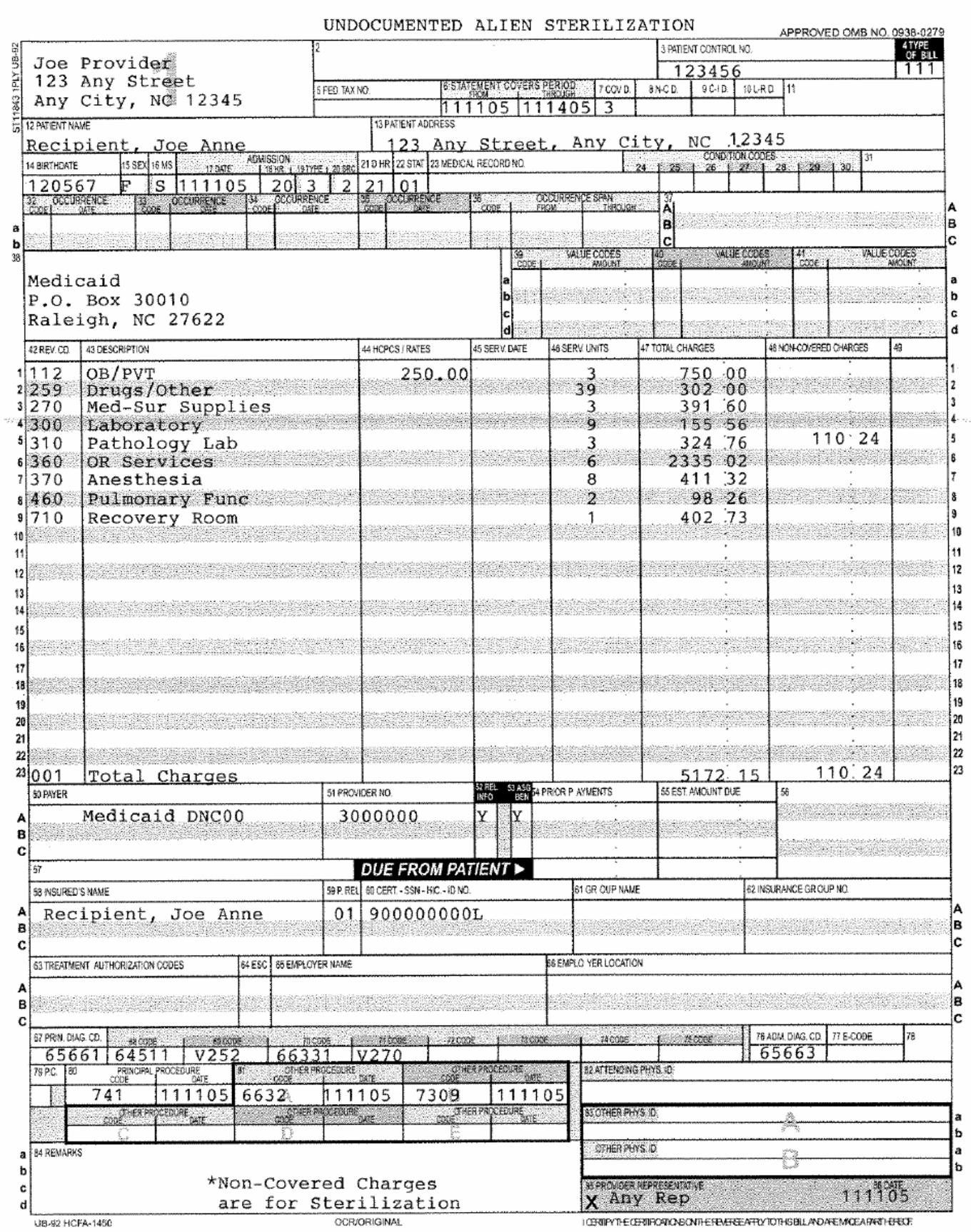
Signature on file SIGNED 8/30/05 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Provider Incorporated
123 Provide Street
Raleigh, NC 12345
PIN# 3333333 GRP# 4444444

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



UNDOCUMENTED ALIEN STERILIZATION

APPROVED OMB NO. 0938-0279

ST1184J 1PLY UB-92

Joe Provider
123 Any Street
Any City, NC 12345

2

3 PATIENT CONTROL NO.: 123456

4 TYPE OF BILL: 111

5 FED TAX NO.

6 STATEMENT COVERS PERIOD: FROM 111105 THROUGH 111405

7 COV D.: 3

8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Recipient, Joe Anne

13 PATIENT ADDRESS: 123 Any Street, Any City, NC 12345

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
120567	F	S	111105	20	3	2	21	01			

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37 A B C
a b											

38 Medicaid
P.O. Box 30010
Raleigh, NC 27622

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	112	OB/PVT	250.00		3	750 00		
2	259	Drugs/Other			39	302 00		
3	270	Med-Sur Supplies			3	391 60		
4	300	Laboratory			9	155 56		
5	310	Pathology Lab			3	324 76	110 24	
6	360	OR Services			6	2335 02		
7	370	Anesthesia			8	411 32		
8	460	Pulmonary Func			2	98 26		
9	710	Recovery Room			1	402 73		
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	Total Charges				5172 15	110 24	

	50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN	54 PRIOR P. AYMENTS	55 EST. AMOUNT DUE	56
A	Medicaid DNC00	3000000	Y	Y			
B							
C							

57 DUE FROM PATIENT ▶

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GR OUP NAME	62 INSURANCE GR OUP NO.
A	Recipient, Joe Anne	01	900000000L		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOY ER NAME	66 EMPLO YER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
65661	64511	V252	66331	V270					65663		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	741	111105	6632 A	111105	7309	111105

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
C		D		E	

82 ATTENDING PHYS. ID:

83 OTHER PHYS. ID: A

a b

OTHER PHYS. ID: B

a b

84 REMARKS

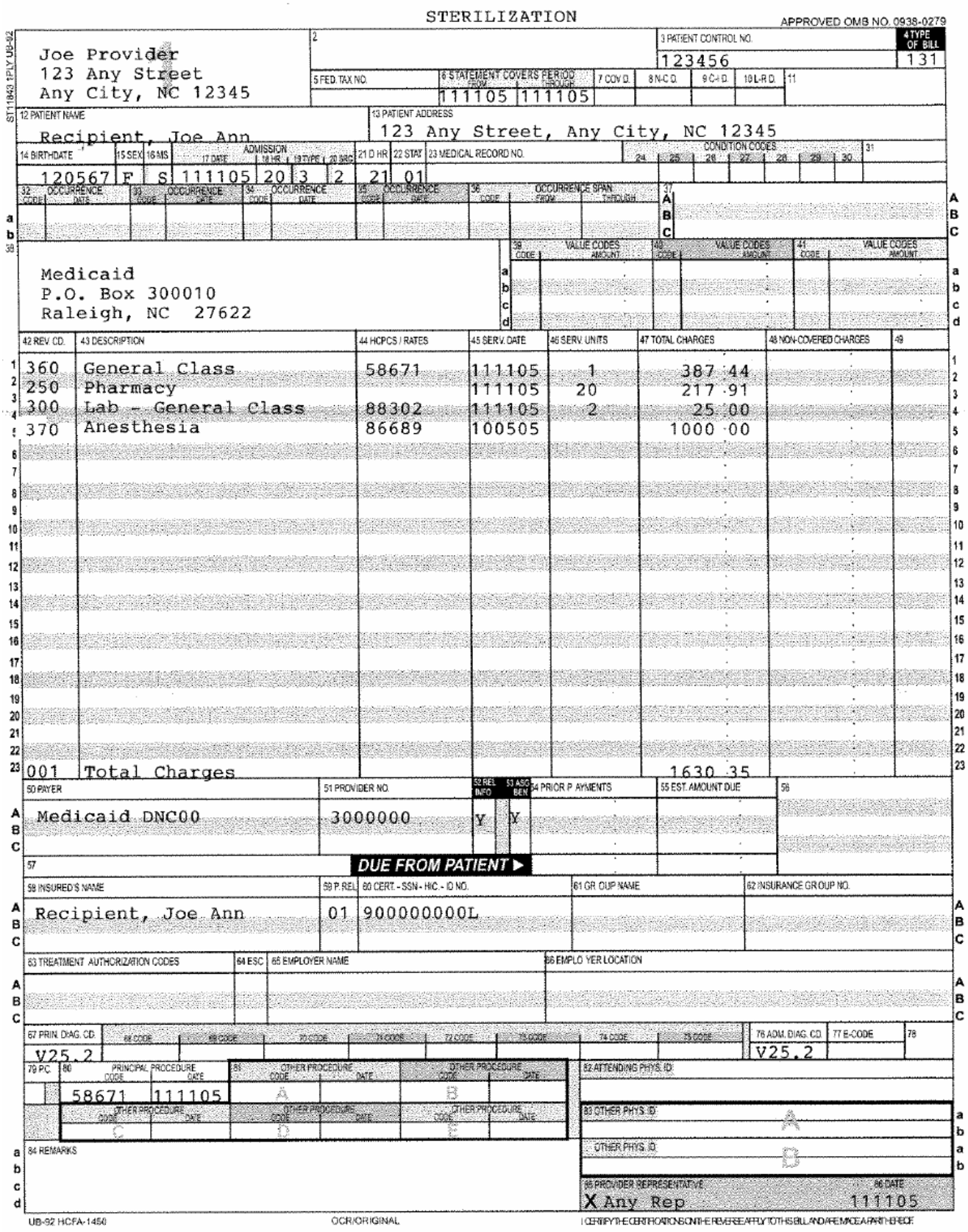
*Non-Covered Charges
are for Sterilization

85 PROVIDER REPRESENTATIVE: X Any Rep

86 DATE: 111105

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



STERILIZATION

APPROVED OMB NO. 0938-0279

Joe Provider 123 Any Street Any City, NC 12345	3 PATIENT CONTROL NO. 123456
4 TYPE OF BILL: 131	5 FED. TAX NO.
6 STATEMENT COVERS PERIOD: FROM 111105 THROUGH 111105	7 COV D. / 8 N-C D. / 9 C-I D. / 10 L-R D. / 11
12 PATIENT NAME: Recipient, Joe Ann	13 PATIENT ADDRESS: 123 Any Street, Any City, NC 12345

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
120567	F	S	111105	20	3	2	21	01			

32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
Medicaid P.O. Box 300010 Raleigh, NC 27622						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	360	General Class	58671	111105	1	387 44		
2	250	Pharmacy		111105	20	217 91		
3	300	Lab - General Class	88302	111105	2	25 00		
4	370	Anesthesia	86689	100505		1000 00		
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	Total Charges				1630 35		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid DNC00	3000000	Y	Y			

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Recipient, Joe Ann	01	900000000L		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
V25.2									V25.2		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	80 PRINCIPAL PROCEDURE DATE	81 OTHER PROCEDURE CODE	81 OTHER PROCEDURE DATE	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE
	58671	111105	A		B	
OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	OTHER PROCEDURE CODE	OTHER PROCEDURE DATE	
C		D		E		

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID A

OTHER PHYS. ID B

84 REMARKS

85 PROVIDER REPRESENTATIVE: X Any Rep

86 DATE: 111105

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Abortion

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

Joe Provider
123 Any Street
Any City, NC 12345

2

3 PATIENT CONTROL NO. 123456

4 TYPE OF BILL 131

5 FED. TAX NO. 56-000000

6 STATEMENT COVERS PERIOD FROM 111105 THROUGH 111405

7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Recipient, Betty

13 PATIENT ADDRESS: 123 Any Street, Any City, NC 12345

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24–30	31
12051967	F	S	111105	05	3	1	10	01			

32–35 OCCURRENCE CODE / DATE; 36 OCCURRENCE SPAN CODE FROM THROUGH; 37 A B C

38
Medicaid
P O Box 300010
Raleigh, NC 27622

39–41 VALUE CODES CODE AMOUNT (a b c d)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 250	Pharmacy		111105	4	240 40		
2 250	Pharmacy		111405	2	93 15		
3 270	Med-Sur Supplies		111405	2	241 00		
4 272	Sterile Supply		111405	3	88 00		
5 300	Automated Hemogram	85027	111105	1	52 00		
6 300	Blood Typing, RH (D)	86901	111105	1	36 00		
7 302	Blood Typing, ABO	86900	111105	1	32 00		
8 310	Tissue Exam by Patholog	88304	111405	1	118 00		
9 360	Abortion	59841	111405	1	697 00		
10 370	Anesthesia		111405	1	141 00		
11 710	Recovery Room		111405	1	424 00		
12 730	Electrocardiogram, Trac	93005	111105	1	57 00		
23 001	Total Charges				2219 55		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicaid DNC00	3000000	Y	Y			
B							
C							

57 DUE FROM PATIENT ▶

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Recipient, Betty	01	900000000K		
B					
C					

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
63572	4254	4240	V140						63572		

79 P.C. | 80 PRINCIPAL PROCEDURE CODE 6951 DATE 111405 | 81 OTHER PROCEDURE CODE DATE A, B, C, D, E

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID A

OTHER PHYS. ID B

84 REMARKS

85 PROVIDER REPRESENTATIVE X Any Rep | 86 DATE 090205

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

List of Denial EOB's

Hysterectomy

EOB	Description	Resolution
145	No hysterectomy statement on file. Attach or submit appropriate statement and file as a new claim.	There is currently no record of the hysterectomy statement on file with the fiscal agent. The hysterectomy statement needs to be submitted to the fiscal agent.
199	Resubmit claim with hysterectomy statement and medical records to include history and physical, operative records, pathology and discharge summary.	A claim needs to be submitted to the fiscal agent with hysterectomy statement and medical records to include history and physical, operative records, pathology and discharge summary.
868	Verify date of service, correct your claim, and resubmit with operative records for documentation, i.e. Date on claim differs from consent form or statement.	Verify the date of service for the procedure code that you are billing. The date of service on the claim differs from the date of service on the statement. The claim or consent form needs to be corrected and submitted with operative records for documentation.
869	Illegible witness and/or patient signature on hysterectomy statement. Identify signature and resubmit with claim.	Witness or patient signature is illegible. Print signature below and resubmit with claim.
1156	A valid hysterectomy statement is on file. Resubmit records to review for medical necessity include:History/physical/operative records/pathology report and discharge summary	Medical records are been requested to determine if procedure was medically necessity. Please submit claim with history and physical, operative report, discharge summary and pathology report (the typed final reports)

Hysterectomy (cont'd)

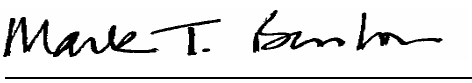
EOB	Description	Resolution
1396	Observation is not routinely allowed. Submit records to review for medical necessity include: History/physical/operative records/pathology report and discharge summary.	Observation is not routinely allowed. Please submit claim with records supporting medical necessity and include: History/physical/operative records/pathology report and discharge summary to determine if the procedure will be covered while the patient was in observation.

Abortion

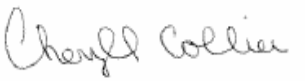
EOB	Description	Resolution
042	Sterilization/Abortion guidelines not met.	See abortions or sterilizations on pages 17 -29.
131	Resubmit as a new claim with operative record and/or labor & delivery record, history & physical, discharge summary, pathology report, and ultrasound report.	Claim requires additional medical review. Please submit as a new claim with operative record and/or labor & delivery record, history & physical, discharge summary, pathology report, and ultrasound report
683	Missing or invalid documentation	There is currently no record of the abortion statement on file with the fiscal agent. The abortion statement needs to be submitted to the fiscal agent

Sterilization

EOB	Description	Resolution
041	Attach sterilization consent form to claim.	There is currently no record of the sterilization consent on file with the fiscal agent. The sterilization consent and the claim needs to be submitted to the fiscal agent.
042	Sterilization/Abortion guidelines not met	See abortions or sterilizations on pages 17 -29.
082	Service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis	Correct diagnosis and resubmit claim.
222	Recipient name that appears on the claim is not the same name as on the attachment.	Attach a name change form to confirm that claim and consent are for the same person.
505	Unacceptable consent form copy	Resubmit consent form copy with all fields showing.
666	Previously submitted sterilization claim and consent have been approved with a different date of service	Resubmit with records to verify your date of service, or correct if necessary .
823	The consent/statement is incomplete	Complete all blank spaces with appropriate information. Resubmit with claim and records.
1608	Recipient eligible for emergency services only. Submit as an adjustment, placing non-emergent charges (i.e, sterilization) in non-covered column & note change in remarks field	Submit adjustment, attach claim placing non-emergent charges (i.e, sterilization) in non-covered column & note change in remarks field.



Mark T. Benton, Senior Deputy Director and
Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services



Cheryll Collier
Executive Director
EDS