



## Inpatient Hospital Provider Specific Policy

### Revision Table

Revision Date	Sections Revised	Description
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
11/01/02	5.1.2, 5.2.1, 5.2.2.2, 5.2.2.4, 5.2.3.4	There is no change in policy. Additional language is added to clarify current policy.
1/1/03	Added sections 2.8.2.1 through 2.8.2.4	Reimbursement policy regarding interim payment to inpatient hospitals is being added. This update to the reimbursement methodology gives the provider access to funds sooner than normal.
06/09/04	5.2 through 5.5	A section is being inserted to clarify policy regarding prior authorization for admission into an out-of-state rehabilitation hospital. The inserted section will cause sections 5.2 – 5.4 to be renumbered 5.3 – 5.5.
06/09/04	6.2.1	Correcting the Fax number and removing the Attention line in the address for prior approval requests.
10/06/05	Added new section 2.2.1 and 2 new subsections 2.2.1.1 and 2.2.1.2. Added new heading 2.2.2 and renumbered subsections to the following 2.2.2.1, 2.2.2.2 and 2.2.2.3	Updated policy to reflect payment regarding readmission within 10 days to acute care hospital services. Added new heading for certified inpatient physical rehabilitation unit transfer and reformatted section to maintain consistency.
10/06/05	All sections referencing DSS.	Revised throughout to reflect the creation of the Division of Medicaid & Medical Assistance (DMMA).
11/21/05	5.3	Changed heading title to clarify section.
11/21/05	5.3.2.1	Renamed Map-25. Now titled Comprehensive Medical Report.
11/21/05	12.0	Removed the Appendix F-Map 25 form. This form is provided by DMMA at the time of application. Titled section Reserved.
2/2/06	2.8.2.2	Revised the interim payment policy for high cost client cases.
6/29/06	4.1.3	Clarified coverage of inpatient psychiatric services for 18-21 year olds.

9/04/07	2.2.1.1, 2.2.1.2	Clarification of review criteria and removal of reference to different facilities.
9/21/07	2.8.2.4	Removed entire section
7/3/08	2.8.2, 2.8.3 and 2.5, 2.4.5	Updated manual to reflect agency policy regarding reimbursement occurrence with valid Medical Assistance eligibility and renumbered section. 2.4.5 updates the sterilization of the mentally incompetent policy language.
7/17/08	3.4	Updated manual to reflect agency policy regarding reimbursement occurrence with valid Medical Assistance eligibility.
9/18/08	Overview	Removed obsolete numbering.
9/1/09	1.8.1	Clarification of dental services.
7/12/10	2.5 through 2.5.9.9	Added section on transplants
7/12/10	2.9 through 2.9.3	Added section on bariatric surgery

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## **Inpatient Hospital Provider Specific Policy Manual**

Inpatient hospital services are provided to the majority of Medicaid clients through a Managed Care Organization (MCO). This manual reflects the policies as they relate to Medicaid clients who are exempt from managed care coverage (see list of those exempt from managed care coverage in the Managed Care section of the General Policy), or Medicaid clients who are enrolled with an MCO and the Division of Substance Abuse and Mental Health (DSAMH) is managing their behavioral health problems and has authorized an inpatient treatment for behavioral health.

### **1.0 General Information**

#### **1.1 Overview**

- 1.1.1 This manual contains information specifically applicable to:
  - 1.1.1.1 Acute care inpatient general hospitals
  - 1.1.1.2 Certified physical rehabilitation wing of an acute care inpatient general hospitals
  - 1.1.1.3 Psychiatric hospitals
  - 1.1.1.4 Rehabilitation hospitals
  - 1.1.1.5 Specialty hospitals
- 1.1.2 The information in this section of the manual is applicable to all the above facilities. Further, each of the above facilities has a section in the manual that includes information that is specific to the type of facility.
- 1.1.3 A hospital, for the purpose of this policy manual, is defined as an institution primarily engaged in providing, by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and provides:
  - 1.1.3.1 Continuous twenty-four (24) hour nursing services to patients confined therein
  - 1.1.3.2 Standard dietary, nursing, diagnostic, and therapeutic facilities
  - 1.1.3.3 Staff composed of physicians, surgeons, and doctors of podiatric medicine and dental surgery, etc. and
  - 1.1.3.4 Is licensed and certified by the appropriate State agency to participate under the requirements of Title XVIII and/or Title XIX of the Social Security Act

- 1.1.4 A practitioner, for the purpose of this policy manual, is a duly licensed Doctor of Medicine, Doctor of Dental Surgery, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, or Certified Nurse Midwife. Practitioner services furnished in a hospital facility are services provided:
- 1.1.4.1 Within the scope of practice as defined by state law, and
  - 1.1.4.2 By or under the personal supervision of an individual licensed under state law to practice medicine.
- 1.1.5 A discharge is deemed to have occurred when a patient:
- 1.1.5.1 Is formally released from the hospital
  - 1.1.5.2 Expires while a patient
  - 1.1.5.3 Is transferred to another hospital if the transferring hospital is not the appropriate type of hospital to meet the medical needs of the patient
  - 1.1.5.4 Is transferred from inpatient care to a certified physical rehabilitation unit of the same acute care inpatient hospital
- 1.1.6 An inpatient, for the purpose of this policy manual, is a person who has been admitted to a hospital for bed occupancy for the purpose of receiving inpatient hospital services. A person is considered an inpatient when, at the time of formal admission, it is anticipated that (s)he will remain at least overnight and occupy a bed, even though it later develops that he can be discharged or that (s)he is transferred to another hospital and does not actually use a hospital bed overnight.

## **1.2 Quality Assurance**

- 1.2.1 The hospital must have either an organized governing body or persons legally responsible for its conduct as an institution. The governing body must assure that the hospital meet standards with respect to medical staff, the chief executive officer, care of patients, institutional plans and budgets, contracted services, and emergency services. The hospital must:
- 1.2.1.1 Appoint qualified members to the medical staff, assure that the medical staff has bylaws and other rules and regulations, and ensure that appropriate criteria are used to determine who will be appointed to staff membership.
  - 1.2.1.2 Appoint a chief executive officer who is responsible for managing the hospital.

- 1.2.1.3 Assure every patient is under the care of an appropriately-qualified physician, assure that a doctor of medicine or osteopathy is on call at all times, and maintain proper written protocols to identify potential organ donors.
- 1.2.1.4 Have an overall institutional plan that includes budgeting, capital expenditures, and sources of financing. The plan must be submitted for review to the appropriate state-planning agency and it must be reviewed and updated annually.
- 1.2.1.5 Be responsible for services furnished in the hospital whether or not the services are furnished under contracts and ensure that services furnished under contract are performed in a safe and effective manner.
- 1.2.1.6 Assure that emergency services standards are complied with if hospital provides emergency services or if the hospital does not provide emergency services, assure that medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.
- 1.2.2 The governing body must ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of patient care. Included must be evaluation of contractor services, medication therapy, diagnosis and treatment, discharge planning, and transfers or referrals. The hospital must take and document appropriate remedial action to address deficiencies found through the quality assurance program. The hospital must document the outcome of remedial actions.

### **1.3 License/Certification**

- 1.3.1 The hospital must be in compliance with applicable Federal laws related to the health and safety of patients.
- 1.3.2 The hospital must:
  - 1.3.2.1 Be licensed or approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals.
  - 1.3.2.2 Assure that personnel are licensed or meet other applicable standards that are required by State or local laws.

### **1.4 Provider Responsibility**

- 1.4.1 All providers have the ethical and programmatic responsibility to direct clients to the most appropriate, medically necessary, and cost-efficient care possible.



- 1.4.2 Employees of the hospital should be aware of their responsibility when signing or completing an order or prescription for any service covered by the Delaware Medical Assistance Program (DMAP) on behalf of a Medicaid client. The decision to allow or deny some necessary services is based on the signed assessment of the patient's condition. If the hospital employee misrepresents or falsifies the essential information upon which federal/state funds is based, (s)he may, upon conviction, be subject to a fine and imprisonment under federal/state laws. In order to avoid potential prosecution, the hospital employee must clearly and accurately represent his/her clinical assessment of the patient's condition and the functional status (s)he is using in prescribing the necessary services.

## **1.5 Inpatient Certification of Medical Necessity**

Federal regulation requires inpatient hospital services to be periodically certified as medically necessary by the practitioner. In compliance with federal regulation, the DMAP requires practitioners to formally certify medical necessity every sixty (60) days for inpatient acute care services. Thus, a statement of certification must be made at the time of admission or, if an individual applies for assistance while in a hospital, before the DMAP authorizes payment. Further, a statement of recertification of medical necessity of the inpatient hospital care must be documented by the attending practitioner in the progress notes at least once every sixty (60) days. The statement by the attending practitioner at both admission and at recertification must be clearly identifiable and specific that the services are medically necessary.

## **1.6 Medical Records Service - Retention and Disclosure**

- 1.6.1 The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital. Contents of medical records must contain information to:
- 1.6.1.1 Justify admission and continued hospitalization
  - 1.6.1.2 Support the diagnosis
  - 1.6.1.3 Describe the patient's progress and response to medications and services.
- 1.6.2 Documentation should include properly executed informed consent forms for procedures and treatments where written patient consent is required. There should be a discharge summary with the outcome of hospitalization, disposition of case, and provisions for follow-up care.
- 1.6.3 The hospital must maintain or make available at a location within the State of Delaware, such records as are necessary or deemed necessary by the DMAP to fully disclose and substantiate the nature and extent of items and services rendered to the DMAP eligible, including all records necessary to verify the

comparable charges for such items and services provided to non-DMAP individuals.

- 1.6.4 All records must be made available without notice for inspection and reproduction to authorized Federal or State representatives, including but not limited to Delaware's Medicaid Fraud Control Unit, for the purpose of conducting audits to substantiate claims, costs, and to determine the reasonableness and necessity of items or services provided to Medicaid clients, or for any other appropriate purpose.
- 1.6.5 The hospital must retain medical, financial, and other supporting records relating to each DMAP claim for not less than five (5) years after the claim is submitted. In the event that the contract with the DMAP and the hospital is terminated, the hospital's records must remain subject to the DMAP regulations. Records involving litigation must be retained for one (1) year following the termination of such litigation.

## **1.7 General Billing Information**

- 1.7.1 Revenue Center and Diagnosis Codes
  - 1.7.1.1 Providers are required to use the UB92 billing form if billing on paper or the ANSI ASC X12N 837 Institutional if billing electronically and to accurately indicate revenue and ICD-9 diagnosis codes for charges. In addition to revenue and diagnosis codes, the facility must use ICD-9 procedure codes when billing the DMAP for an inpatient stay where surgical procedures were performed. All such codes are critical to receiving correct payment from the Delaware Medical Assistance Program (DMAP). Valid revenue codes can be found in the National Uniform Billing Data Element Specifications Manual developed by the National Uniform Billing Committee. Valid ICD-9 diagnosis codes can be found in a current International Classification of Diseases publication.
  - 1.7.1.2 The provider must maintain the required documentation to support the service billed.
- 1.7.2 Inpatient Hospital Days

The number of days of care charged for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight to midnight method is to be used in reporting days of care even if the hospital uses a different definition of days for statistical or other purposes.
- 1.7.3 Discharge
  - 1.7.3.1 Room and board charges for the day of discharge are NOT covered and should not appear on the claim; however, charges for ancillary services on the day of discharge are covered and should be included on the claim. If admission and

discharge occur on the same day, the day is considered a day of admission and counts as one (1) inpatient day.

1.7.3.2 The DMAP will not cover any additional costs associated with a hospital stay when a patient, for personal reasons, chooses to continue to occupy his/her hospital accommodation beyond the time that the discharge order is issued.

1.7.3.3 Hospital services that are not medically necessary or “non-covered” (such as dental services for adults, plastic surgery and cosmetic treatment services, or infertility-related services) should not be included on the claim form.

## **1.8 Non-Covered Services**

Some services are NEVER covered by the DMAP (refer to the General Policy for a list of these services). If the inpatient hospital admission is only for dental services for persons age 21 and over, plastic surgery, cosmetic treatment services, or infertility related services, the hospital shall not bill the DMAP. If the inpatient hospital admission is for covered diagnoses and dental services for persons age 21 and over, plastic surgery, cosmetic treatment services, or infertility related services are delivered, they may not be included in the inpatient bill. The procedure code(s) and charges shall NOT be reported. The following are non-covered services that cannot be billed to the DMAP.

### **1.8.1 Dental Services**

All (routine and non-routine) dental services are restricted to Medicaid eligible children through age twenty (20) or DHCP eligible children through age eighteen (18) and must be provided by a DMAP participating oral health care provider. No dental procedures or services related to dental treatment (such as drugs, anesthesia, etc.) are covered in any setting for clients age 21 or older.

### **1.8.2 Plastic Surgery and Cosmetic Treatment Services**

The DMAP does not reimburse any provider for cosmetic treatment or procedures or plastic surgery. Cosmetic services are defined as beautification or aesthetic procedures, surgery, drugs, etc. designed to improve the appearance of an individual’s physical characteristic that is within the broad range of normal, by surgical alteration or other means.

### **1.8.3 Infertility Related Services**

The DMAP does not cover any services relating solely to the treatment of infertility. Examples of these non-covered services include:

- Drug therapy
- Surgical procedures
- Laboratory testing
- Radiology services

- Hospital services
- Physician services

## **1.9 Room Accommodations**

- 1.9.1 Charges are allowed to be included on the claim form for the reasonable cost of a private room or other accommodations more expensive than semi-private or ward. Such accommodations are allowed only when medically necessary. Private rooms will be considered medically necessary when the patient's condition requires him to be isolated for his/her own health or that of others. Private room certification of medical necessity by the physician must be on file before discharge.
- 1.9.2 Charges may also be included for the use of special facilities, such as intensive care, coronary care, etc., where medically necessary.

## **1.10 Diagnostic/Therapeutic Services**

- 1.10.1 Diagnostic or therapeutic items or services ordinarily furnished to inpatients by the hospital or by others under arrangements with the hospital are covered. This category of covered services encompasses items and services not otherwise specifically listed as covered inpatient hospital services. Examples of these items/services include, but are not limited to, clinical laboratory services, therapies, surgical dressing splints, casts, prosthetic devices, braces, artificial limbs, etc. With respect to items that leave the hospital with the patient when they are discharged, the rules for determining whether the item is covered are the same as the rules set forth in the Supplies, Appliances and Equipment section.
- 1.10.2 The facility is prohibited from billing the DMAP for any service for which an enrolled DMAP provider intends to bill directly.

## **1.11 Nursing Services**

Nursing services must meet applicable standards with respect to organization, staffing and delivery of care, and preparation and administration of drugs. The services of a private-duty nurse or other private-duty attendant are excluded as inpatient hospital services.

## **1.12 Pharmaceutical Services**

- 1.12.1 The hospital must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. There must be a full-time, part-time, or consulting pharmacist who is responsible for developing, supervising, and coordinating all the activities of the pharmacy. There must also be an adequate number of personnel to ensure quality pharmaceutical services.

Current and accurate records must be kept for the receipt and disposition of all scheduled drugs. Drugs provided to patients must meet federal and state law and comport with applicable standards of safety and practice.

- 1.12.2 Biologicals (any preparation made from living organisms or the products of living organisms and used as diagnosis, preventive, or therapeutic agents. Kinds of biologics are: antigens, antitoxins, serums, and vaccines) for use in the hospital, which are ordinarily furnished by the hospital for the care and treatment of inpatients, are covered and are recognized as an allowable cost item. If biologicals are supplied by other departments, reasonable oversight and care must be applied similar to the criteria specified for pharmaceutical services.

### **1.13 Radiology Services**

The hospital must maintain, or have available, diagnostic radiology services. A qualified full-time, part-time, or consulting radiologist must supervise the ionizing radiology services and must interpret only those radiology tests that are determined by the medical staff to require a radiologist's specialized knowledge.

### **1.14 Laboratory Services**

- 1.14.1 The hospital must maintain, or have available, adequate clinical laboratory services that are performed in a Medicare approved hospital or independent laboratory. Emergency laboratory services must be available 24 hours a day. The laboratory must have procedures for proper receipt and reporting of tissue specimens. The director of the laboratory must be a pathologist or otherwise qualified by training and experience.

- 1.14.2 There must be facilities for the procurement, safekeeping, and transfusion of blood. The hospital must ensure that blood products are readily available, either through the hospital's own properly supervised blood storage facility or through an outside blood bank with which the hospital has an agreement. There must be procedures for prompt blood grouping, antibody detection, compatibility testing, and laboratory investigation of transfusion reactions. Samples of each unit of transfused blood must be retained for further testing in the event of reactions.

### **1.15 Medical Social Services**

Social services that contribute meaningfully to the treatment of a patient's condition, and are ordinarily furnished by the hospital are covered as inpatient hospital services. Such services include, but are not limited to:

- Assessment of the social and emotional factors related to the patient's illness - their need for care, their response to treatment, and their adjustment to care in the facility;
- Appropriate action to obtain casework services to assist in resolving problems in these area;

- Assessment of the relationship of the patient's medical and nursing requirements to their home situation, their financial resources, and the community resources available to them in making decision regarding discharge.

### **1.16 Medical Services of an Intern or Resident**

The medical services provided by an intern or resident under an "approved teaching program" of a hospital are included in the discharge rate where applicable.

### **1.17 Supplies, Appliances and Equipment**

1.17.1 Supplies, appliances, and equipment which are ordinarily furnished by the hospital for the care and treatment of the client solely during his/her inpatient stay in the hospital are covered inpatient hospital services.

Under certain circumstances, the supplies, appliances, and equipment used during the inpatient stay are covered even though they leave the hospital with the patient when s/he is discharged. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the times to the periods during which the individual is an inpatient.

1.17.2 A temporary or disposable item which is medically necessary to permit or facilitate the patient's departure from the hospital and which is required until the patient can obtain a continuing supply, is covered as an inpatient hospital service. Examples of items covered under this rule includes, but are not limited to, tracheostomy or drainage tubes, bandages, etc.

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## **2.0 Acute Care Inpatient Hospital**

### **2.1 Overview**

2.1.1 Acute care inpatient hospital services are covered by the DMAP only if the hospital is accredited by the Joint Commission on Accreditation of Hospitals and certified by the State agency responsible for licensing and certification.

2.1.2 Reserved

### **2.2 Specific Billing Information**

2.2.1 Readmission within 10 Days to Acute Care Hospital

2.2.1.1 The DMAP Medical Review Team will review claims for acute care hospital services for patients readmitted within 10 days of discharge from the same hospital. When submitting claims for readmission within 10 days of a previous admission, attach discharge summaries for both admissions.

2.2.1.2 If it is determined that the readmission resulted from a premature discharge based on information that the provider would have known or events that could have been anticipated at the time of discharge, payment will not be made for the second admission. In this situation, the second admission is considered to have been reimbursed in the discharge rate for the initial admission.

2.2.2 Transfer to a Certified Inpatient Physical Rehabilitation Unit

2.2.2.1 If a patient is transferred from an acute care bed to a certified inpatient physical rehabilitation unit, the patient must be discharged from acute care and readmitted to the physical rehabilitation unit. The hospital should bill one discharge for acute care and one discharge for physical rehabilitation using the appropriate revenue codes, provider identification numbers and taxonomy. The acute care discharge must not include any rehabilitation accommodation revenue codes.

2.2.2.2 A transfer from an acute care bed to the certified inpatient physical rehabilitation unit must be primarily for the purpose of receiving physical rehabilitation services. Admission records should include adequate documentation to justify physical rehabilitation.

2.2.2.3 Patients must be admitted to the physical rehabilitation unit using the appropriate accommodation code(s) on the claim.

### **2.3 Observation Services**



- 2.3.1 The DMAP covers outpatient observation services in acute care settings. Outpatient observation services must be physician-ordered services, provided by a facility which are reasonable and necessary to evaluate an outpatient's condition or determine the medical necessity of an inpatient admission. Observation services are those hospital services furnished on a hospital's premises and are not required to be provided in the actual outpatient area or on a designated unit. The observation services can be provided in any area of the facility with periodic monitoring by the hospital staff.
- 2.3.2 Observation services are implemented for an anticipated short length of stay.
- 2.3.3 Observation services must not exceed forty-eight (48) continuous hours. The physician must indicate in the order that the patient should be moved to an observation bed or service. The patient is still considered an outpatient. The provider should clearly document the time at which the patient is admitted as an outpatient in observation status.
- 2.3.4 The following types of services are not covered as observation services:
- 2.3.4.1 Services that are not reasonable and necessary for the diagnosis of the patient
- 2.3.4.2 Services provided for the convenience of the patient or provider
- 2.3.4.3 Services that are not physician ordered.
- 2.3.5 Providers are not expected to substitute outpatient observation service for medically appropriate inpatient admissions. Same day surgeries that require care beyond the customary stay will be subject to the observation criteria review by the DMAP if admitted for one (1) day.
- 2.3.6 If a patient is admitted as an inpatient from observation services, all outpatient services rendered by the admitting facility prior to the admission are included in the inpatient discharge payment and may not be billed separately as an outpatient claim. During the review process, the DMAP will consider only the medical evidence available to the attending physician at the time the admission decision was made.

## **2.4 Sterilization and Hysterectomies**

- 2.4.1 The DMAP reimburses acute care inpatient hospitals for voluntary sterilization (for both males and females) and medically necessary hysterectomies if the criteria set by federal and state regulations are met and if it is medically necessary that the procedure be performed in an inpatient setting.
- 2.4.2 Voluntary Sterilization - Consent Form

- 2.4.2.1 When a voluntary or elective sterilization is performed, the hospital is required to attach the DMAP's standardized Consent Form to the UB92 claim form. It is the responsibility of the hospital to secure a properly executed Consent Form from the operating surgeon. The DMAP does NOT cross-reference claims. Refer to Appendix D for a copy of the Consent Form.
- 2.4.3 Hysterectomies - Awareness Form
- 2.4.3.1 The Awareness Form is required to be attached to the UB92 claim form for medically necessary hysterectomy procedures that may result in sterilization. It is the responsibility of the hospital to secure a properly executed Awareness Form from the operating surgeon. The DMAP does NOT cross-reference claims. Refer to Appendix E for a copy of the Awareness Form.
- 2.4.4 Unilateral/Bilateral Sterilization Procedure Codes
- 2.4.4.1 Certain procedure codes may describe a procedure that is performed for the purpose of voluntary sterilization or may describe a medically necessary procedure that may or may not result in sterilization. Claims for these procedures must be accompanied by either an Awareness or Consent Form depending on the exact nature of the surgery. A unilateral procedure requires an Awareness Form while a bilateral procedure requires a Consent Form. It is the responsibility of the hospital to secure a properly executed Consent or Awareness Form from the operating surgeon. The DMAP does NOT cross-reference claims.
- 2.4.5 In accordance with 42 CFR 441.254, the DMAP does not reimburse for the sterilization of a mentally incompetent or institutionalized individual.

## **2.5 Transplants**

- 2.5.1 The DMAP will review requests for coverage of the following transplants;
- 2.5.2 Heart
- 2.5.3 Lung
- 2.5.4 Liver
- 2.5.5 Bone Marrow
- 2.5.6 Pancreas
- 2.5.7 Kidney
- 2.5.8 Intestinal
- 2.5.9 The attending specialist and the admitting facility must request prior authorization by sending a letter with the following information:
- 2.5.9.1 Type of transplant, including detailed information, i.e., method proposed, expected outcome, etc. Diagnosis, prognosis, and a brief outline of all medical problems, history, and indications for transplant

- 2.5.9.2 Documentation must be provided by the appropriate attending specialist and admitting facility that all of the following conditions are met: The facility performing the transplant must have approval for performing the surgery through the Certificate of Need (CON) process and must supply supporting documentation of this.
- 2.5.9.3 Current medical therapy has failed and will not prevent progressive disability and death.
- 2.5.9.4 The patient does not have other major systemic disease that would compromise the transplant outcome.
- 2.5.9.5 There is every reasonable expectation, upon considering all the circumstances involving the patient, that there will be strict adherence by the patient to the long-term difficult medical regimen that is required.
- 2.5.9.6 The transplant is likely to prolong life for at least two years and to restore a range of physical and social function suited to activities of daily living.
- 2.5.9.7 The patient is not both in an irreversible terminal state (moribund) and on a life support system.
- 2.5.9.8 The patient has a diagnosis appropriate for the transplant.
- 2.5.9.9 The patient does not have multiple non-correctable severe major system congenital anomalies.

## **2.6 Abortions**

- 2.6.1 Endangerment to Mother's Life
  - 2.6.1.1 Federal regulation permits the DMAP to reimburse acute care inpatient general hospitals for abortions if the "life of the mother would be endangered by the pregnancy" and if the inpatient admission is medically necessary.
  - 2.6.1.2 Effective November 13, 1997 Federal law enacted new Hyde Amendment requirements for federally funded abortions. One of those requirements is that, in order for Medicaid to reimburse for an abortion, a physician must certify that a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.
  - 2.6.1.3 The hospital must obtain an Abortion Justification Form from the attending physician that will detail the above Hyde Amendment requirement (see Appendix G for a copy of the Abortion Justification Form). In addition to the Abortion Justification Form the hospital must attach the complete medical record to the UB 92.
  - 2.6.1.4 It is the responsibility of the facility to secure a copy of the Abortion Justification Form and the complete medical record (including hospital record) from the attending practitioner for their billing purposes.

- 2.6.2 Rape or Incest
  - 2.6.2.1 Effective December 31, 1993, in compliance with the Hyde Amendment provision, the DMAP may reimburse for abortions to terminate pregnancies resulting from an act of rape or incest.
  - 2.6.2.2 The practitioner must submit a letter stating that the request for the abortion is due to rape or incest and provide written documentation that the incident was reported to the police. In cases of incest where the victim is under 18 years of age, the incident must also have been reported to the Department of Services for Children, Youth and their Families.
  - 2.6.2.3 It is the responsibility of the facility to secure a copy of the practitioner's letter that documents the incident was reported to the police and if applicable, to the Department of Services for Children, Youth and Their Families.
  - 2.6.2.4 If an adult has just cause for not reporting a rape to the police, the practitioner must document the reason in writing. The DMAP will consider coverage on a case-by-case basis.

## **2.7 Hospitalization for Severely & Persistently Ill Clients**

- 2.7.1 Individuals who are enrolled with a managed care organization (MCO) but are determined severely and persistently ill (SPI) by the Division of Substance Abuse, and Mental Health (DSAMH) may receive inpatient psychiatric services in an acute care hospital when authorized by DSAMH.
- 2.7.2 The procedure for obtaining authorization and payment for this population is as follows:
  - 2.7.3 The hospital will identify a referred patient as SPI by either:
    - 2.7.3.1 Calling the MCO for service authorization and being informed by the MCO that the patient is the responsibility of DSAMH, or
    - 2.7.3.2 Receiving the referral from DSAMH with immediate information about the SPI status of the patient.
  - 2.7.4 The hospital will contact the DSAMH Program Directors for authorization for admission or continued stay. If these individuals or their designees are not available or if the hospital needs authorization during evening or weekend hours, the hospital may call the Mobile Crisis Intervention Service.
  - 2.7.5 DSAMH will fax or send you an authorization form.

- 2.7.6 Reserved
- 2.7.7 The bill must be submitted to Medicaid with a copy of the DSAMH authorization form through the fiscal agent, using normal manual billing procedures. Any billing without this authorization will deny. There must be an exact match between your bill and the authorization form for the fields.
  - 2.7.7.1 Client name
  - 2.7.7.2 Client ID#
  - 2.7.7.3 Hospital name
  - 2.7.7.4 Hospital ID#
  - 2.7.7.5 Admission date and
  - 2.7.7.6 Approved duration of stay (total number of nights authorized).
- 2.7.8 If the authorization does not match your billing information, call your DSAMH contact for an updated form before billing.

## **2.8 Reimbursement**

- 2.8.1 An acute care inpatient hospital facility is reimbursed one of two prospectively set payments per discharge distinguished by revenue codes.
  - 2.8.1.1 Nursery Discharge (excluding neo-natal ICU)
  - 2.8.1.2 General Discharge (all other valid Room and Board revenue codes)
- 2.8.2 A client must have valid Medical Assistance eligibility on the date of admission.
- 2.8.3 Discharges which exceed a pre-determined cost threshold may be reimbursed an outlier amount in addition to the discharge payment.
  - 2.8.3.1 High cost outliers will be identified when the cost of the discharge exceeds the threshold of three times the hospital-operating rate per discharge. Outlier cases will be reimbursed at the discharge rate plus 79 percent of the difference between the outlier threshold and the total cost of the case. Costs of the case will be determined by applying the hospital-specific cost to charge ratio to the allowed charges reported on the claim for discharge.

- 2.8.3.2 Effective January 1, 2006, any provider with a high cost client case (outlier) may request an interim payment; that is, a payment prior to the discharge of that patient when the charge amount reaches the designated level. An interim payment will be made for that inpatient stay when the client's charges have reached twenty-five (25) times the general discharge rate of that facility, or when the client's stay is greater than sixty (60) days. Additional interim payments will be made when either of the outlier conditions for an interim payment is met again. The interim payment amount is based on the current reimbursement methodology used to pay outliers. Upon the discharge of the client, the facility will receive the balance of the payment that would have been paid if the case were paid in full at the time of discharge. Contact the HP Enterprise Services, LLC, Provider Relations Manager for instructions on billing an interim payment.
- 2.8.3.3 Transplant cases will be treated as outliers and when appropriate, will be subject to the outlier payment policy. Organ acquisition costs will not be reimbursed separately, but will be included in the per discharge rate.
- 2.8.4 Out-of-state hospital reimbursements are based on the discharge and outlier rates paid to a similar in-State facility.

## **2.9 Bariatric Surgery**

- 2.9.1 The DMAP may cover bariatric surgery for treatment of obesity in adults when the patient's obesity is causing significant illness and incapacitation and when all other more conservative treatment options have failed.
- 2.9.2 All requests for bariatric surgery must be prior authorized. This includes the surgeon, assistant surgeon (if medically necessary), anesthesiologist, and facility.
- 2.9.3 Requests for prior authorizations of bariatric surgery must be submitted in writing.

## **3.0 Certified Physical Rehabilitation Wing of an Acute Care Inpatient Hospital**

### **3.1 Overview**

3.1.1 As used in the context of this policy, “certified” means a hospital that is accredited by the Joint Commission on Accreditation of Hospitals or meets Medicare standards as a distinct physical rehabilitation unit.

### **3.2 Specific Billing Information**

3.2.1 Requests for reimbursement from the DMAP for certified physical rehabilitation services provided in an acute care setting must meet the following criteria:

3.2.1.1 The acute care inpatient hospital must be certified to provide inpatient physical rehabilitation services in order to receive reimbursement from DMAP for admission to inpatient physical rehabilitation wings.

3.2.1.2 A certified rehabilitation provider number and taxonomy must be used to submit any claim for an admission to a certified inpatient physical rehabilitation wing in an acute care inpatient hospital.

3.2.2 Claims submitted for DMAP reimbursement under the certified physical rehabilitation provider number may only include rehabilitation accommodation revenue codes. Accommodations must be entered in revenue code sequence. In addition, the claim must include the appropriate ICD-9-CM diagnosis code corresponding to the diagnosis of the patient condition that prompted admission to the certified physical rehabilitation unit.

3.2.3 Inpatient acute care hospitals are required to bill one discharge, which includes charges from admission to discharge of the patient, for each certified physical rehabilitation unit stay.

### **3.3 Prior Approval**

3.3.1 Except for providers located in New Jersey, Pennsylvania, Maryland, and the District of Columbia, all certified physical rehabilitation services in acute care inpatient hospitals outside of Delaware requires approval prior to reimbursement. Refer to the General Policy for details regarding approval procedures.

### **3.4 Reimbursement**

3.4.1 A certified physical rehabilitation wing in an acute care inpatient hospital is reimbursed based upon the facility’s *current* acute care Medicaid reimbursement

methodology. Refer to Section 2.8, Acute Care Inpatient Hospital Reimbursement.

- 3.4.1.1 A client must have valid Medical Assistance eligibility on the date of admission.
- 3.4.2 The DMAP established standards for DMAP reimbursement of certified physical rehabilitation services provided in an acute care inpatient hospital. The scope of these standards do not apply to psychiatric and addiction rehabilitation units. Services provided in psychiatric, detoxification and substance abuse rehabilitation units for Medicaid clients are not covered under this category for DMAP reimbursement and should not appear on the claim form. For individual 20 years of age and under and for individuals 65 years and older, these services may be covered under other DMAP related categories and programs. They must *not* be billed under the certified physical rehabilitation provider number.



## **4.0 Inpatient Psychiatric Hospital/Facility**

### **4.1 Overview**

- 4.1.1 Long-term inpatient psychiatric hospital/facility services are covered by the DMAP for individuals under age 21 and over age 65 years, and only in facilities for mental diseases that have been accredited by the Joint Commission on Accreditation of Hospitals and certified by the State agency responsible for licensing and certification.
- 4.1.2 Reserved
- 4.1.3 Individuals must be found to require an intermediate level of care and inpatient psychiatric services. Referrals for this program, for individuals over age 65 years, should be made to the appropriate Long Term Care Medicaid Financial Eligibility Unit (refer to the General Policy for the address and telephone number). Medicaid eligible clients through age 17 years must be approved for this program by the Department of Services for Children, Youth & Their Families. Inpatient psychiatric services may be covered for individuals between the ages of 18 and 21 as part of a managed care benefit package or on a fee for service basis if the individual is not enrolled in managed care or has exhausted the managed care benefit.
- 4.1.4 Mental health and substance abuse services are covered, with limits, for individuals ages 21 through 64 who are enrolled with a Managed Care Organization (refer to the General Policy, Section 2, Diamond State Health Plan, Coverage Under the MCO Benefits Package).

### **4.2 Specific Criteria**

- 4.2.1 A psychiatric hospital/facility must:
  - 4.2.1.1 Be primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons
  - 4.2.1.2 Meet all federal requirements
  - 4.2.1.3 Maintain clinical records on all patients including records sufficient for the DMAP to determine the degree and intensity of treatment.

### **4.3 Specific Billing Information**

Specific billing information for psychiatric hospital/facility services may be found in the Billing Instructions of this manual.

#### **4.4 Hospitalization for Severely and Persistently Ill Clients**

- 4.4.1 Individuals who are enrolled with a managed care organization (MCO) but are determined severely and persistently ill (SPI) by the Division of Substance Abuse, and Mental Health (DSAMH) may receive inpatient psychiatric services in a psychiatric hospital/facility when authorized by DSAMH. For more information, refer to the Acute Care Inpatient Hospital section of this manual.

#### **4.5 Reimbursement**

- 4.5.1 The DMAP always covers the deductible/co-insurance after Medicare *except* for services provided in a psychiatric hospital/facility for individuals ages 21 through 64 years. Medicaid does not cover this service for this age group even if Medicare does.
- 4.5.2 Inpatient psychiatric hospital/facility reimbursement is a prospectively set per diem based on annually reported costs, not to exceed the Medicare rate for the same service.
- 4.5.3 An out-of-state inpatient psychiatric hospital/facility is reimbursed at the Medicaid rate established by the State in which the hospital/facility is located.

## **5.0 Inpatient Rehabilitation Hospitals (In State and Out-of-State Facilities)**

Inpatient rehabilitation hospitals must be accredited by the Joint Commission on Accreditation of Hospitals and certified by the State agency responsible for licensing and certifications. Inpatient rehabilitation hospital services are provided only for physical rehabilitation.

### **5.1 Medical Necessity Evaluation**

- 5.1.1 Inpatient rehabilitative care in a hospital must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the individual's medical condition. The individual must require:
  - 5.1.1.1 Close medical supervision by a physician with specialized training or experience in rehabilitation.
  - 5.1.1.2 Twenty-four (24) hours nursing supervision.
  - 5.1.1.3 An intense level of physical therapy, occupational therapy, or if needed, speech therapy, psychological services, or prosthetic-orthotic services (at least 3 hours per day of physical and/or occupational therapy, in addition to any other required therapies or services).
  - 5.1.1.4 A multidisciplinary team approach to the delivery of the program and a coordinated program of care.
- 5.1.2 The initial assessment from the out-of-state facility must document that there is a reasonable expectation that the intensive rehabilitation program will lead the individual to experience significant practical improvement.
- 5.1.3 Realistic rehabilitative goals must be established for the individual.

### **5.2 Prior Authorization for Out-of-State Rehabilitation Hospital Services**

- 5.2.1 Admission into an out-of-state rehabilitation hospital must be prior authorized by Medicaid's Medical Review Team. Requests for admission into an out-of-state rehabilitation hospital must be submitted in writing and mailed or faxed to:

Division of Medicaid & Medical Assistance  
P.O. Box 906, Lewis Building  
New Castle, DE 19720  
FAX:302-255-4481

### **5.3 Eligibility for Payment for Out-of-State Rehabilitation Hospitals**

- 5.3.1 Authorization for payment to an out-of-state rehabilitation hospital will not be finalized until Medicaid financial eligibility is approved. Inpatient hospitals or the family should make referral for Medicaid financial eligibility via Medicaid Hospital Project.
- 5.3.2 Referrals for out-of-state rehabilitation hospital services must be made to the Pre-Admission Screening Units located at the Robscott Building in Newark and the Milford State Service Center (refer to the Index in the back of the General Policy for address information). Referrals must include:
- 5.3.2.1 A Comprehensive Medical Report completed by the attending physician.
- 5.3.2.2 Denial letter(s) and a comprehensive assessment from a rehabilitation wing(s) of an acute care hospital located in Delaware that documents that they have been denied admission to an in-state facility because the needed rehabilitation services are not available.
- 5.3.2.3 Name of the rehabilitation hospital to which the patient is being referred.
- 5.3.2.4 Evaluation for medical necessity completed by the Medical Review Team (including all information from Policy 5.1 and a Pre-admission Screening [PAS] summary).
- 5.3.3 Eligible Medicaid clients must be referred to a facility that is licensed as a rehabilitation hospital and which is enrolled, or will become enrolled, as a provider with the DMAP. Medical eligibility for this program is determined by the Medicaid Medical Review Team. If the referral is approved, the rehabilitation hospital will be notified by the DMAP. A letter of notification from the DMAP will include:
- 5.3.3.1 Name of Medicaid client
- 5.3.3.2 Client's Medicaid ID #
- 5.3.3.3 Dates for which inpatient rehabilitation hospital services are approved (date of admission and scheduled date of discharge)
- 5.3.3.4 Request for extension information mailed to the Medical Review Team located in the Lewis Building (refer to General Policy, Section 18.1 for address information).
- 5.3.3.5 Approval/authorization number

## **5.4 Specific Billing Information**

Rehabilitation hospital providers are required to accurately indicate the accommodation revenue codes. In addition, the claim should include the

appropriate ICD-9-CM diagnosis code corresponding to the diagnosis of the patient condition.

## **5.5 Reimbursement**

- 5.5.1 Out-of-state inpatient rehabilitation hospitals are reimbursed at the Medicaid rate established by the State in which the hospital is located.

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## 6.0 Inpatient Specialty Hospital

### 6.1 Overview

6.1.1 A specialty hospital may be a wing in an acute care hospital or a freestanding facility and must be certified/licensed by the Joint Commission on Accreditation of Hospitals as a "Specialty Hospital". Currently, Delaware does not have a certified/licensed specialty hospital.

6.1.2 Reserved

6.1.3 Specialty hospitals do not have operating or emergency rooms. Therefore, major surgical procedures are not performed in specialty hospitals.

### 6.2 Prior Approval

6.2.1 Admission into a specialty hospital must be approved by Medicaid's Medical Review Team. Requests for admission into a specialty hospital must be submitted in writing and mailed or faxed to:

Division of Medicaid & Medical Assistance P.O. Box 906, Lewis Building New Castle, DE 19720 FAX 302-255-4481
---

6.2.2 The attending physician must provide the following information:

6.2.2.1 The patient's diagnoses and treatment provided to date.

6.2.2.2 What services will be provided in the specialty hospital that cannot be provided in Delaware.

6.2.2.3 What does the physician wish to accomplish by the admission into a specialty hospital?

6.2.2.4 Length of stay required.

6.2.2.5 Name, address, telephone number of the facility.

6.2.2.6 Name of contact person within the facility.

6.2.3 If approval is given for the admission of an eligible Medicaid client into an enrolled specialty hospital, the Medicaid Out-of-State Coordinator will assign an authorization number.

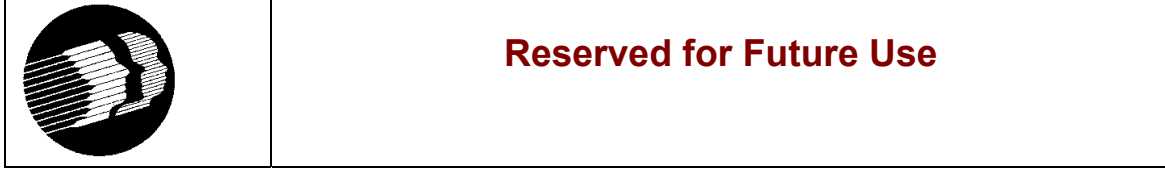
6.2.4 If the specialty hospital is not enrolled with the DMAP, the Out-of-State Coordinator will initiate enrollment procedures through Medicaid's Fiscal Agent.

### **6.3 Reserved**

### **6.4 Reimbursement**

6.4.1 Out-of-state specialty hospitals are reimbursed at the Medicaid rate established by the State in which the hospital is located.

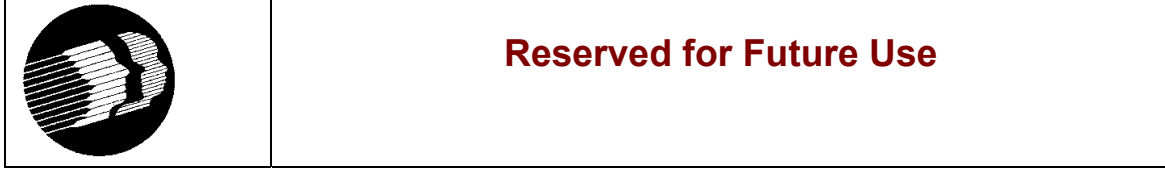




**7.0**

**Appendix A - Reserved for Future Use**

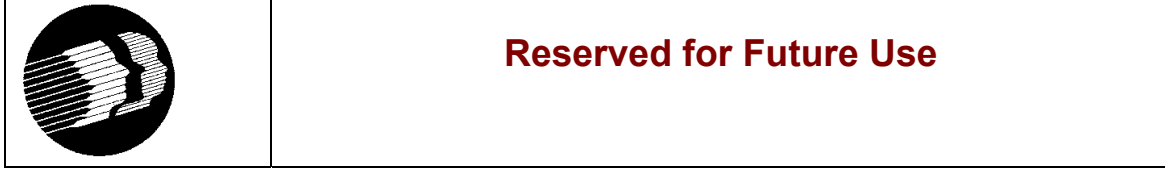
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**8.0**

**Appendix B - Reserved for Future Use**

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**9.0**

**Appendix C - Reserved for Future Use**

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## Consent Form

### 10.0 Appendix D - Consent Form

#### DELAWARE MEDICAL ASSISTANCE PROGRAM 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 \_\_\_\_\_ (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 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 \_\_\_\_\_. 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 programs.

I am at least 21 years of age and was born on \_\_\_\_\_, \_\_\_\_\_, hereby consent of my own free will to be sterilized by \_\_\_\_\_ (Doctor) by a method called \_\_\_\_\_. 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.

\_\_\_\_\_  
Signature Date: \_\_\_\_\_  
Month Day Year

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

Race and ethnicity designation (Please Check)

- |   |   |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black (not of Hispanic origin) |
| <input type="checkbox"/> Asian or Pacific Islander        | <input type="checkbox"/> Hispanic                       |
|   | <input type="checkbox"/> 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 \_\_\_\_\_ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

\_\_\_\_\_  
Interpreter Date

DOC. NO. 35-07-81-89-08-02-ES-14

##### STATEMENT OF PERSON OBTAINING CONSENT

Before \_\_\_\_\_ signed the consent form, I explained to him/her the nature of the sterilization 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 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.

\_\_\_\_\_  
Signature of Person Obtaining Consent Date  
\_\_\_\_\_  
Facility  
\_\_\_\_\_  
Address

##### PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon \_\_\_\_\_ ON \_\_\_\_\_ I explained to him/her the nature of the sterilization 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 appears 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):

- Premature delivery
  - Individual's expected date of delivery;
  - Emergency abdominal surgery;
- (describe circumstances): \_\_\_\_\_

\_\_\_\_\_  
Physician Date

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### 11.0 Appendix E – Awareness Form

441.255 Sterilization by hysterectomy

(a) FFP is not available in expenditures for a hysterectomy if --

(1) It was performed solely for the purpose of rendering an individual permanently incapable of reproducing, or

(2) If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing

(b) FFP is available in expenditure for a hysterectomy not covered by paragraph (a) of this section if --

(1) The person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing; and

(2) The individual or her representative, if any, has signed wither a written acknowledgement of receipt of that information.

Patient's Name: \_\_\_\_\_

Medicaid No. \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Surgical Procedure: \_\_\_\_\_

\*\*\*\*\*

**Section A:** Complete this section for patient's apparently presently capable of reproducing:

**1. Patient acknowledgement:**

It has been explained to me that the surgical procedure to be performed is medically necessary and as a result will render me permanently incapable of reproducing.

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature (or Patient's Representative)

Date: \_\_\_\_\_

\_\_\_\_\_  
Interpreter's Signature

**2. Physician Certification:**

The surgical procedure to be performed on \_\_\_\_\_ is medically  
Patient's Name

indicated and is not solely for the purpose of rendering her permanently incapable of reproducing.

Date: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

\*\*\*\*\*

**Section B:** Complete this section for other patients:

The surgical procedure to be performed on this patient is medically necessary and is unrelated to her ability to reproduce for the following reasons:

\_\_\_\_\_ This patient was surgically sterilized on \_\_\_\_\_  
approximate date

\_\_\_\_\_ This patient is post menopausal.

\_\_\_\_\_ This patient's reproductive capability will be maintained.

\_\_\_\_\_ Other as specified: \_\_\_\_\_

Date: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

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## **12.0      Reserved**

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